CDM BULLETIN: MEDICARE AND THE "EUROPEAN MODEL"

Does parallel private insurance in other countries reduce wait times and improve cost efficiency?

Canadians have long rejected the approach to health insurance that we see in the U.S.—one in which tens of millions of Americans have no health insurance at all and medical costs are the number one cause of bankruptcy.

In recent years some advocates of private health insurance have pointed to well-functioning European systems in which some people pay for privileged access to care. For example, Dr. Brian Day has argued that "if you have a system, such as in Germany, or Belgium, where private and public operate side by side, there are no waiting lists in either."

What can Canada learn from the European models that Dr. Day and other privatization advocates espouse?

An evidence-based approach to international comparisons

That "A" and "B" both exist doesn't mean that "A" causes "B". Smoking rates are higher in France than Canada; the French have lower rates of coronary heart disease than Canadians. It doesn't follow that smoking prevents heart disease. "A" in our health policy example is parallel private care and "B" is a well-functioning system, in particular the absence of long waiting lists and gross inequities. We therefore need to ask some fundamental questions about European healthcare to determine the possible impact of private-pay options in their systems – and the possible impact in ours.

1. Is the association consistent?

The use of Germany and Belgium (which do have shorter waiting lists than Canada) as examples is cherry-picking. Great Britain, Italy, Spain, Portugal —one could keep going—have privately funded systems of care, serious inequities, and waiting list problems more severe than Canada's. Despite the claims of privatization advocates, there is no consistent association between the availability of private insurance and shorter public waiting times.

2. What is the dose-response relationship?

As the proportion of private funding increases, do problems get better or worse?

The U.S. has by far the lowest proportion of publicly funded health care among high-GDP countries—only 44% (in comparison to Canada's 70%). Americans have a lower life expectancy than Canadians, a higher infant mortality rate, and worse outcomes in a wide variety of specific health problems, from renal failure to cystic fibrosis. Their higher expenditures—they spend 15% of their GDP on health care, in comparison to our 10%—don't translate into better health. Virtually all of the well-functioning European health systems pointed to by Dr. Brian Day actually have *higher* proportions of publicly funded health care than Canada. Success tracks with more public funding, failure with more private funding.

3. Are the comparators accurate?
Despite frequent references to France and Germany, neither of these countries actually has a two-tiered duplicate parallel insurance system of the kind being advocated by some in Canada. In Germany there is no parallel private insurance—private insurance must provide full coverage for the higher income segments of the population that buy it, rather than cherry-picking lucrative procedures like cataracts and joint replacements. Significantly, physicians are generally paid the same whether they provide care to the majority receiving publicly insured service, or the wealthy who must pay for private insurance. In France, insurance is used primarily to cover the large user fees charged in the public system. And, due to equity concerns, regulations are increasingly aimed at preventing physicians from charging more privately than publicly.

4. The closest comparison to the Canadian option
Australia has moved in the direction that is being advocated by some in Canada, with a large portion of the population now covered by private insurance. The experiment has not worked well at all. The government has had to financially bail out the private insurance part of the system, and introduce tax incentives to convince people to buy private insurance. Waiting lists remain long for publicly-funded patients, problems of quality of care persist, and Australians face major equity problems that Canadians do not. Australia provides an excellent example of how not to conduct health care reform.

The cost of healthcare in multiple-payer systems

In order to make money, private insurance companies must develop insurance packages, market those policies against the competition, explain the policies to potential users, evaluate applications for insurance, assess claims, and still satisfy their investors with yearly profits.

Our Medicare plan bears none of these costs. This explains why the U.S. spends 31% of its health care dollars on administration, while Canada spends only 17%. The fact that private insurance inevitably increases administrative costs is evident everywhere in the world, including Canada: administrative costs are far higher in parts of our health care system with high levels of private

insurance (in particular, drugs) than in those with low or absent private insurance (physician and hospital services).

> Private insurers, which dominate the U.S. system, have overhead costs averaging 11.7 per cent. That compares to 3.6 per cent for U.S. Medicare, and 1.3 per cent for provincial health plans in Canada.

Another in-Canada comparison provides an additional source of evidence. In the last decade, costs of the publicly funded parts of the Canadian system, physician and hospital services, have remained stable. Costs in the privately funded areas, particularly pharmaceuticals, have exploded.

What can we learn from the Europeans?

To the extent that French and German health care systems really do function well—in fact, they have cost pressures similar to ours—what is the reason?

Canada relies more on private funding of health care than do most industrialized countries. While our physician and hospital services are largely publicly funded, drugs, home care, eye care and dental care are not. Indeed, Canada's 70% public funding is *smaller* than average: 18 of 30 industrialized countries have higher proportions of public versus private funding. France and Germany in fact fund more of their healthcare systems publicly than we do through funding of dental, pharmaceutical and other services.

Second, France and Germany spend more of their GDP on health care than does Canada. Indeed, among OECD countries, Canada is in the middle in proportion of GDP spent on health care.

Third, European health care dollars stretch farther because, among other reasons, administrative costs in public systems are lower. Because more aspects of European systems receive public funding than in Canada, this has led to greater cost efficiency.

As a result, what we can learn from the Europeans is not that we should adopt a parallel private insurance model, but instead that there is room, and good reasons, for us to expand the scope of health care coverage in our public system.

Finally, although pro-privatization advocates in Canada pointing to the European model don't advertise this, European countries also save money by paying their health professionals less than they receive in Canada. It is unlikely that this is an aspect of European systems that Canadian doctors wish to emulate.

The CMA's own review of the evidence

Based on the CMA's own review of the evidence in its June 2006 discussion

paper *It's About Access*, private insurance for medically necessary physician and hospital services:

- Does not improve access to publicly insured services
- Does not lower costs or improve quality of care
- Can increase wait times for those who are not privately insured
- Could exacerbate human resource shortages in the public system.

> *"Although private health insurance can provide greater choice and access to services for those who can afford it, it has not been found to improve access to publicly insured services, lower costs or improve quality." - It's About Access! CMA Paper*

Bottom line

The National Health Forum of 1997, the Kirby Senate report, and the Romanow Commission all recommended against introducing parallel private insurance, and in favour of enlarging the scope of publicly funded health care. That's because a dispassionate look at the evidence -- including international comparisons -- shows that public payment provides better access, and better value for money.

Conclusion

As physicians we all know that the multitude of interests and opinions on the issue of private insurance can make it difficult to get to the bottom of what the evidence truly shows. Adding to the confusion is the fact that despite multiple independent reviews of the evidence (e.g., Romanow, Kirby, and most recently the CMA) concluding that private parallel private insurance would likely worsen wait times for most Canadians, there continues to be a push for yet more "impartial reviews" that might lead to a different conclusion.

In fact, all the impartial reviews have led us right back to Medicare.

References and evidence on these issues can be found at www.canadiandoctorsformedicare.ca

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The mission of CDM is to provide a voice for Canadian doctors who believe in and support Canada's publicly funded system for physician and hospital care, and who reject private insurance and direct payment for these medically necessary services.

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