



Using private insurance to finance health care

The recent Supreme Court of Canada ruling in the Chaoulli affair determined that the Quebec government cannot forbid private health insurance from covering medically required services. If the possibility of obtaining private insurance is not thwarted by government moves, it will lead to the advent of a parallel private health care system. This will not mark the end of the public system but will allow for greater overall financing and will increase the ability of the health care system to look after patients more quickly and more effectively.

The dead end of public financing

Canada is one of the few countries in the world – and the only OECD member country – with a health care system that relies exclusively on public financing of treatments considered to be medically necessary. The public system, however, is becoming increasingly costly for taxpayers. With inflation taken into account, per capita public health care spending rose by nearly 90% in 30 years and reached more than \$2,800 in 2004.¹ Despite this increase, waiting lists have become a structural characteristic of the system. Waiting times to undergo treatment went from an average of 9.3 weeks in 1993 to 17.9 weeks in 2004 (see Figure 1).²

In Quebec, more than 43% of provincial government spending goes toward health care, compared to 35% fifteen years ago.³ Public financing has reached a dead end because it is hard to conceive of taxes being raised to provide further health care financing, with Quebec already the jurisdiction where citizens are the most heavily taxed in North America. Demand for health care seems likely to increase in the future, if only because the population is aging and new treatments being discovered tend to



be more sophisticated and more costly. Under conditions like these, it would make sense to take advantage of the added financial resources that could be brought in by the existence of private insurance.

International experience

Private health insurance plays varying roles in OECD countries and fulfils different functions within health care systems. It is possible to distinguish five categories of insurance, from the most comprehensive to those merely serving as a substitute or complement to the public

system (see Sidebar 1).

In some countries, including the Netherlands, Belgium and the United States, certain categories of people are excluded from the public health insurance system. In the Netherlands, for example, this applies to persons who in 2004 were earning more than 32,600 euros per year, equal to about CAN\$48,000. Some 28% of people in the Netherlands thus hold private primary principal insurance. Those earning high incomes must assume their own health care costs while the public system insures the rest of the population.

1. See the study by the Canadian Institute for Health Information titled "National Health Expenditure Trends, 1975-2004," pp. 103-105; available at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_318_E&cw_topic=318&cw_rel=AR_31_E.

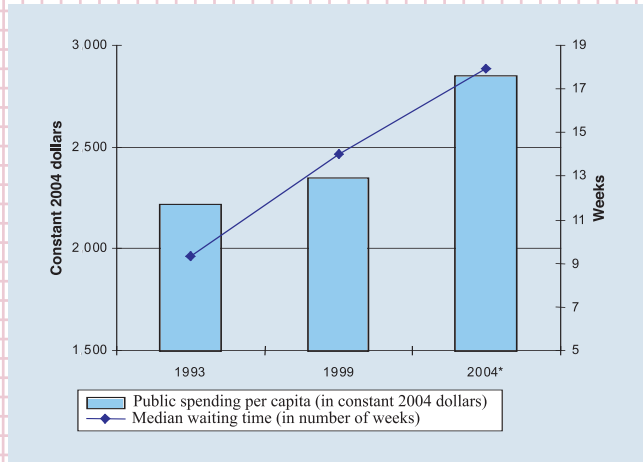
2. This refers to the median waiting time between a referral by a general practitioner and the beginning of treatment, averaged across all specialties. See Nadeem Esmail and Michael Walker, "Waiting your turn. Hospital waiting lists in Canada," 14th edition, Critical Issues Bulletin, Fraser Institute, Vancouver, October 2004, p. 33; available at <http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=705>.

3. Quebec Department of Finance, 2005-2006 Budget. Budget Plan, Section 3, April 2005, pp. 20-21.



Figure 1

Per capita public health care spending and waiting times in Canada 1993-2004



* The 2004 data are estimates.

Sources: Fraser Institute, "Waiting your turn. Hospital waiting lists in Canada," 2000, 2004; Canadian Institute for Health Information, "National Health Expenditure Trends, 1975-2004," p. 103; calculations by the author.

In Austria and Germany, people falling into certain categories are free to opt out of the public system completely and to cease paying premiums in order to obtain primary substitute insurance. This option applies, for example, to high-income earners in Germany (more than 45,900 euros per year in 2003, or about CAN\$67,000) and to self-employed persons. It is estimated that 9% of the German population takes out private primary substitute insurance. Anyone with private insurance can still seek care in public hospitals, with costs covered by their private insurance rather than by public insurance.

Duplicate insurance, which allows people to seek care in private hospitals while still being covered by the public system, is illegal only in Canada, in certain provinces. It is available in many countries including Finland, Italy, New Zealand, Ireland and the United Kingdom, and it can attract a large part of the population, as in Australia, where nearly 45% of citizens have such insurance.⁴ In other countries, its place is insignificant because of competition from public health insurance, especially where no waiting lines exist, as in France.

Complementary insurance is generally available in countries such as France, Sweden, Australia and Italy where the public

system requires copayments for certain medical services. This is not the case in Canada, where insured services are offered free of charge. Supplementary insurance exists in all countries, including Canada, where it is well established and covers uninsured services such as medicines and dental care. About two out of three Canadians are covered by supplementary insurance, often linked to employment.

What type of private insurance for Quebec?

Among the five categories of insurance, only one, supplementary insurance, is established in Quebec. Three of the other four are unlikely to be offered, even following the Chaoulli ruling, because of the legal obstacles that remain. The universality clause in the Canada Health Act stipulates that public insurance must be offered to all residents of the provinces and territories. As a result, primary principal insurance, which in other countries covers the health care of persons without legal access to the public system, would run counter to federal law.

The fact that public insurance must be offered to everyone does not mean that all residents are required to accept coverage. The federal act could in theory permit the existence of primary substitute insurance. However, provincial law requires all persons living or staying in Quebec to insure themselves with the Quebec Health Insurance Board (Régie de l'assurance maladie du Québec, or RAMQ)⁵ and, more importantly, to pay the taxes that finance it, with no possibility of opting out.

Complementary insurance could not be sold either. With insured services provided as part of the public system, any payment – whether extra billing by doctors or facility fees – runs counter to federal law. A province violating this principle would lose a corresponding portion of the federal health care transfer.

This leaves just duplicate insurance. Under this category, individuals could remain insured with the RAMQ and maintain access to the public health care network while also paying for the

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4. See "Private health insurance in OECD countries," *OECD Observer*, November 2004, p. 2; available at <http://www.oecd.org/dataoecd/42/6/33820355.pdf>.

5. From Article 9 of the Health Insurance Act: "Every person who is a resident or temporary resident of Quebec must register with the Board in accordance with the regulations."

6. On this subject see the Economic Note from the Montreal Economic Institute titled "Health Care Reforms: Just How Far Can We Go?", April 2003, available at http://www.iedm.org/main/show_publications_en.php?publications_id=46.

**Categories of private health insurance**

Primary principal: Covers the medical care of persons who do not have legal access to the public system.

Primary substitute: Covers the medical care of persons who have the choice of substituting private insurance for public coverage.

Duplicate: Covers the medical care of persons who continue to have access to the public system (and who are obliged to contribute to it through taxes) but who wish to be treated in a parallel private sector.

Complementary: Covers the portion under the responsibility of the insured person (copayments or coinsurance) in the public health insurance system.

Supplementary: Covers extras or services not insured by the public system.

Source: "Private health insurance in OECD countries," OECD Observer, November 2004.

option of being treated in a parallel private system, with no commitment of public funds to cover this care. This type of insurance for treatment in a fully parallel private sector would comply with the Canada Health Act.⁶

The economic advantages of private insurance

Private insurance beyond the complementary or supplementary categories would be a way of increasing the overall resources devoted to health care and, eventually, of reducing waiting times. Waiting lists are also caused by other factors such as the productivity, responsiveness and adaptability of the public system. But an OECD study confirms that the greater the resources (public and private) the shorter waiting times generally become.⁷

The private health care sector – to be financed by private insurance – could serve as a safety valve and fill in when the public system falls short and waiting lists grow too long. It is even conceivable that the RAMQ could turn to this private Quebec health care sector by referring patients instead of sending them to the United States, as it sometimes does now.⁸ The existence of a private health care sector is thus likely to

benefit not only those who are privately insured but also the RAMQ and those insured under the public system.

This is already the case with the Workplace Health and Safety Board in Quebec and its counterparts in the other provinces, which are exempt from the Canada Health Act. To keep payments from running too high while accident victims await treatment, lawmakers considered it essential that they be treated and returned to work as soon as possible. But if the private sector benefits these public bodies, why would it not benefit ordinary citizens?

According to OECD economists, "in countries where [private health insurance] plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive."⁹

A threat to the public system?

Advocates of a public monopoly in health insurance contend that private insurance threatens the public system. They present a number of arguments, the main one being that the advent of a parallel private system would not bring any new resources into the health care sector. What the private sector wins, the public sector would lose. But this claim ignores two major factors.

First, the system's capacity and productivity can be increased by adding equipment (magnetic resonance imagers, ultrasound scanners, etc.) and by building new hospitals or clinics (meaning more beds, more operating rooms, etc.). These resources are all available on the market in the short term if additional funds allow for them to be acquired.

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7. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries," OECD Health Working Papers, No. 7, 2003; available at <http://www.oecd.org/dataoecd/31/10/17256025.pdf>.

8. If the RAMQ pays all expenses, this remains in compliance with the Canada Health Act.

9. Francesca Colombo and Nicole Tapay, "Private Health Insurance in OECD Countries: The Benefits and Costs of Individuals and Health Systems," OECD Health Working Papers, No. 15, 2004, p. 4; available at <http://www.oecd.org/dataoecd/34/56/33698043.pdf>.



Second, contrary to a widely held belief, it is also possible to increase professional capacity in fairly short order. Existing medical staff, largely underused because of salary caps and quotas, could be permitted immediately to work more. Doctors currently have an incentive not to work additional hours once they have reached certain caps, even if patients continue to suffer on waiting lists. To achieve doctor availability comparable to what exists in other OECD countries, it would also be necessary to modify regulations that actually prevent doctors who participate in the public system from receiving payment in the private sector for insured services.¹⁰ In addition, easing recognition of foreign diplomas would quickly increase the number of health care professionals practising in Quebec.

Competition between the private and public systems could possibly require the latter to offer higher remuneration and better working conditions to medical staff as a way of holding onto them. Far from being a problem, such competition would not take long to attract new human resources. They can reach the Quebec market in several years if faculties of medicine remove quotas, or immediately through immigration or through the return of qualified medical staff from other provinces, from the United States or from abroad. For example, there may be several hundred Quebec nurses in hospitals and clinics in Switzerland.¹¹

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Another argument from advocates of government monopoly is that the existence of a private alternative would necessarily cause public financing to decline and the public system to wither. This thesis is contradicted by reality, however. Per capita public spending is higher in Germany or France, where each has a parallel private sector, than in Canada, where this is forbidden. Public health care spending has continued to rise in other countries where a parallel private sector has developed, including Australia, New Zealand, Ireland and the United Kingdom.¹²

Conclusion

Without private insurance, only the wealthiest of Canadians could, in the event of illness, obtain treatment from private establishments, often outside Canada, paying directly from their pockets. The Supreme Court ruling provides a route to the emergence of private insurance, a sensible means of financing private health care when the public system falls short. Through the payment of premiums, this care could become accessible here in Quebec to a broader part of the population. If the Quebec government allows it to emerge, a dynamic and more extensive private health care sector would benefit everyone in Quebec directly and indirectly.

10. This would require revising Article 22 of the Health Insurance Act.

11. See Isabelle Paré, "McGill repêche des infirmières québécoises... en Suisse," *Le Devoir*, November 10, 2003.

12. Organization of Economic Cooperation and Development, *OECD Health Data 2004. A comparative analysis of 30 countries*, Paris, 2004.



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