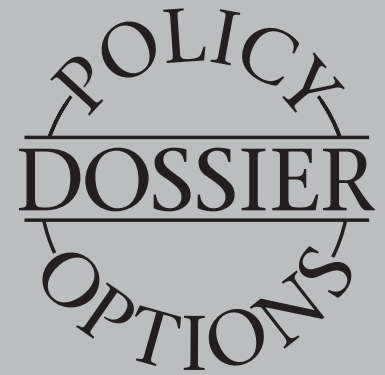


# SINGLE-PAYER HEALTH INSURANCE WORKS BEST

Paul M. Jacobson



The Supreme Court's *Chaoulli* decision, disallowing prohibition of private health insurance in Quebec, raises questions of efficiency and equity in delivering health care. Paul M. Jacobson suggests that, however the service is delivered, a single-payer system (government) remains the most efficient model. He argues that alternative insurance will create incentives for service providers to move into more remunerative market segments and away from the principle of universality. He also suggests "a fragmented insurance market will lead to increased inefficiencies in the system."

Le jugement *Chaoulli* de la Cour suprême désavouant l'interdiction d'acheter une assurance-maladie privée au Québec soulève des questions d'équité et d'efficacité en matières de soins de santé. Mais peu importe leur mode de prestation, croit Paul M. Jacobson, le système de payeur unique (le gouvernement en l'occurrence) reste le modèle le plus efficace. Selon lui, un régime alternatif inciterait les fournisseurs de services médicaux à viser des segments de marché plus lucratifs et à s'éloigner du principe d'universalité. Et « la fragmentation du marché de l'assurance accentuerait les insuffisances du système ».

One of the major debates in recent years has been the extent of private funding of medically necessary services. This discussion has been intensified by the recent Supreme Court decision, the *Chaoulli* case, which struck down the prohibition of private insurance for medical services in Quebec. In a previous article in *Policy Options* (August, 2004), I emphasized the elements of market failure in health care markets that can be exploited by private insurance markets in the absence of heavy government regulation. Some of these issues will be discussed again. The first important point to emphasize is that access to alternative insurance systems for acute-care services will provide incentives for the health care delivery system, largely in private hands, to move resources to the more remunerative private payment areas, without really increasing access to everyone. Second, a fragmented insurance market will lead to increased inefficiencies in the system. The focus of this article is on the efficiencies of single-payer systems, their potential for cost control and the myth that private care is the panacea for waiting lists.

Why should our Canadian health systems emphasize single-payer insurance modalities? There are two arguments in favour of a single-payer system — efficiency and equity. In this discussion, we will focus on the efficiency issues. Essentially, this article outlines the proposition that Canadian health care can be most efficiently delivered to all Canadians through a single-payer system because of the effi-

ciency gains from larger scale, simpler administration; restrictions on the impact of inevitable market failures; and better cost control.

Efficiency can be defined in a number of ways. One possible definition is that the maximum resources are devoted to health care and the minimum to health care administration, with the best possible outcomes for the most individuals. This is really summarized as the effective use of resources.

In Canada, scale efficiencies can best be obtained through the single-payer modality. Most businesses and even most economists generally expect to see a relationship between efficiency and scale. Larger firms, often with more focused outputs, are usually able to produce those outputs with proportionately fewer resources than smaller firms. The Canadian health care system is relatively small and fragmented. In scale, even Ontario isn't really that significant. With an adult source population of just under 10 million, or 12.5 million total population, OHIP covers only slightly more people, allowing for dependents, than a single integrated health insurer, Kaiser Permanent, does in the US. The latter has about 8.3 million enrollees. If our health system was organized in even smaller units, there would be a corresponding increase in duplicated administrative costs.

As a system becomes more fragmented, the overheads associated with marketing and other activities become significant. More importantly, the bureaucratic challenges of

administration become significant. In a series of articles, Harvard professor David Himmelstein and his colleagues have highlighted the inefficiencies of the US system. In the most recent article, which appeared in the *International Journal of Health Services* in 2004, they estimated that administrative expenses consumed almost \$400 billion (US) out of a total health expenditure of \$1.6 trillion in 2003. Incidentally, the authors estimate that adopting a single-payer system in the US would free up sufficient funds to allow universal coverage. Their analysis is supported by OECD data showing that administration and insurance costs in the US were equivalent to 1 percent of GDP in 2002 compared to 0.2 percent for Canada for *both* public and private insurance. In the discussion of the Supreme Court decision, much was made of the availability of private insurance markets in European countries such as Germany, the Netherlands and Switzerland. The complex health insurance systems in those countries result in much higher administration and insurance costs, equivalent to 0.6, 0.4 and 0.5 percent of GDP, respectively.

It should also be emphasized that the US system includes overheads not required in a single-payer tax-based system. These include obvious costs such as bill collecting, competitive marketing, many levels of administration and the requirement for charitable care for individuals without insurance coverage. This point is made very starkly in a table in a recent *Health Affairs* study about the concerns of health executives in five countries. It was only in the US that executives were concerned about losing patients to other facilities. Only in the US is competitive marketing an issue.

In a 2003 study of the US health system by the OECD, the authors noted that "[a]lthough evidence is limited, it is not clear that the good clinical outcomes obtained are justified by the high relative spending levels, as other countries attain comparable outcomes for less." In a recent study by Hussey et al. published in *Health*

*Affairs*, there were differences in outcomes in all systems with no clear winners or losers across the board. For example, survival rates for liver and kidney transplants were lower in the

US than in the other countries, including Canada. Breast cancer survival rates were better in the US than Canada but rates for colorectal cancer were better in Canada than in the US.

TABLE 1. SELECTED INTERCOUNTRY COMPARISONS

	Year	AUS	CAN	NZ	UK	US
		% of GDP <sup>1</sup>				
1. Health expenditure/GDP	2001	9.1	9.4	8.0	7.5	13.9
2. Public health exp./GDP	2001	6.2	6.6	6.1	6.2	6.2
3. Health expenditure/GDP	1989	7.4	8.6	6.5	5.9	11.2
4. Public health exp./GDP	1989	4.6	6.4	5.6	4.9	4.4
<b>Top two problems facing your hospital</b>	<b>2003</b>	% of executives surveyed <sup>2</sup>				
5. Inadequate funding or finances		58	62	57	39	10
6. Inadequate reimbursements		8	0	0	0	60
7. Staffing shortages		45	60	54	64	47
8. Inadequate/overcrowded/ outdated facilities		32	39	54	42	7
9. Access to capital		3	15	0	10	15
10. Cost of indigent/uninsured care		0	0	0	0	17
11. Regulations		4	4	7	18	7
12. Malpractice insurance costs		6	0	0	0	11
<b>Health system views</b>	<b>2002</b>	% of sicker adults in 2002 <sup>3</sup>				
13. Very satisfied		15	21	14	25	18
14. Sum of "not very" or "not at all" satisfied		35	36	48	31	44
<b>Two biggest problems with health care system</b>	<b>2002</b>	% of sicker adults in 2002 <sup>3</sup>				
15. High cost of health care		19	13	21	6	48
16. Inadequate coverage of services		9	8	6	8	25
17. Shortages of health professionals/ hospital beds		31	54	20	33	5
18. Waiting times		31	27	41	39	3
19. Inadequate government funding		20	16	23	24	1
<b>Survival rates (outcome)</b>	<b>1990-1999</b>	Relative to lowest score <sup>4</sup>				
20. Breast cancer		107	104	100	106	114
21. Cervical cancer		111	106	100	105	108
22. Colorectal cancer		116	113	100	123	108
23. Childhood leukemia, ages 0-15		100	118	109	102	110
24. Non-Hodgkin's lymphoma		116	107	100	115	109
25. Kidney transplant		106	113	104	104	100
26. Liver transplant		110	123	100	in Aus	102

Sources:

<sup>1</sup> OECD 2004.<sup>2</sup> R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert, and E. Raleigh (2004), "Confronting Competing Demands To Improve Quality: A Five-Country Hospital Survey," *Health Affairs*, 23 (3) 119-135.<sup>3</sup> R. J. Blendon, C. Schoen, C. DesRoches, R. Osborn, and K. Zapert (2003), "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* (Millwood), 22 (3) 106-121.<sup>4</sup> P. S. Hussey, G. F. Anderson, R. Osborn, C. Feek, V. McLaughlin, J. Millar, and A. Epstein (2004), "How Does The Quality of Care Compare in Five Countries?," *Health Affairs*, 23 (3) 89-99.

Although some commentators have justified a drive for private insurance based on supposedly superior health outcomes in other jurisdictions, the evidence is at best mixed.

Some people will state categorically that having multiple players in a marketplace must bring efficiencies. The challenge to that statement is that those people leave out the key phrase “perfectly competitive.” Simply put, achieving efficiency gains from competitive markets requires characteristics such as no significant barriers to entry, common information available to all market participants, lots of similarly sized players in the market, etc. Health insurance provision is obviously a market with significant barriers to entry that can be exploited to achieve significant market power.

As new health providers face barriers such as scale and regulation, it is possible for existing providers to exploit their market power to raise effective costs. A recent *Economist* survey (July 15, 2004) flags this as a major issue in the US. A study in *Health Affairs* in 2004, entitled “Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning” suggested growing doubts that the market can deliver effective health care.

One of the challenges with health insurance is market failure. As well as the obvious problems of lack of competition, the provision of health care is rife with information asymmetries and agency conflicts. For example, insurance firms could compete to attract health plan members only to drop them if chronic illness arises. In other words, private health insurance will cream any low risk, high profit activities, leaving expensive complicated and chronic cases to public insurance. More importantly, cream-skimming practices would lead to the collapse of many of the insurance firms, leaving a dominant player. By definition, private insurers will not cover bad risks such as anyone who already is sick or has the serious

potential of illness. There is also the possibility that the existence of private health insurance suppliers will fragment the market and increase the market power of health providers.

In Europe, complex risk adjustment administrative schemes are used to prevent some forms of market failure and substantial regulation is used to ameliorate others. While producing many academic papers, the schemes have only been shown to eliminate the gains from risk selection incompletely. Risk selection activities necessarily increase the cost of the system. The

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impact of cream-skimming by private insurers, leaving expensive risks to the public system, is one of the major points of discussion in the pending reforms of German health care, a focus of upcoming elections.

The market power of the various providers, gained either through institutional or professional regulatory bodies or through barriers to entry and local monopolies, can best be offset by a single payer. I discussed this proposition in more detail in a previous *Policy Options* article (August 2004). The article emphasized that the relationship with providers is one of the major issues in the provision of public or private health insurance. Providers have incentives to oversupply services under insurance. For example, in the US, when cataract fees were reduced, ophthalmologists prescribed other services to manage their income. Yet, for health care, the providers must act as agents for the system users. We rely on the providers to direct us to the most cost- and health-effective solutions to our health requirements.

The agency failures in the health care system can result in unneces-

sarily expensive treatments such as higher cost drugs. Issues such as drug advertisements to both doctors and consumers require substantial regulation. Essentially, without public regulation, marketing can be used to encourage the use of inappropriate or unnecessarily expensive therapies. This results in excessive costs, to both private and public insurers. Because their costs are passed on the policy holders, and because of market fragmentation, private insurers have been unable to counteract such problems appropriately. Recent experiences with

high-cost pain relievers indicate a number of issues. A recent study in *Archives of Internal Medicine* indicated that Cox-2 drugs were prescribed for many people who would have been better served by cheaper medicines (NSAIDs). The authors of the study noted “the challenge of limiting innovative therapies to the settings in which they are initially targeted and maximally beneficial.” Generally, in a single-payer health system, the insurance provider is better placed to counteract the negative effects of the market power of the suppliers and the agency failures. It is possible in a single-payer system for the insurance provider to regulate coverage and to mandate use to achieve a more effective health system.

One of the standard myths is that cost growth will be better contained in a system such as that in the US. In a survey on health care finance, “The Health of Nations,” released in 2004 by *The Economist* magazine, the opening graphic dramatically indicates the picture of relative cost effectiveness. Showing total health spending as a share of GDP, the US, as one would expect, leads the parade. More signifi-

cantly, only Switzerland had a larger percentage point increase in that share over the period 1990-2002. Canada, by the way, was fifth in share of GDP and second from the bottom in *The Economist* table for growth in share. Only Denmark recorded less growth.

Part of the myth is that people will consume unnecessary health care.

It should also be emphasized that the US system includes overheads not required in a single-payer tax-based system. These include obvious costs such as bill collecting, competitive marketing, many levels of administration and the requirement for charitable care for individuals without insurance coverage.

Theoretically, under insurance there is an incentive for insured persons to ask for more health services than would be optimal, but it is highly unlikely that most of us would ask for a hip replacement for the fun of it. Yet, we have a serious demand for orthopaedic surgeries. This growth has occurred not because we have more persons with bad hips, but partially because we are living longer, and more importantly as the market for such corrective surgery has expanded, because better technologies and processes have lowered the risks and side effects. This is discussed in an excellent paper by Sherry Glied in the *Journal of Economic Perspectives* in 2002. It is the market expansion created by new technologies and procedures that has been the major driver of the costs of health care rather than increased demand created by public insurance.

More importantly, it is difficult for small insurers and even more difficult for consumers to obtain good value for money from health providers. This issue is highlighted by the substantial incidence of fraud in the US health care system. In a recent commentary in the *Canadian Medical Association Journal* (CMAJ) on the high-costs of for-profit health care, a Harvard professor, Steffie Woolhandler, and colleagues summarize a number of abuses of patients insured by the US government resulting in massive multi-million dollar *qui*

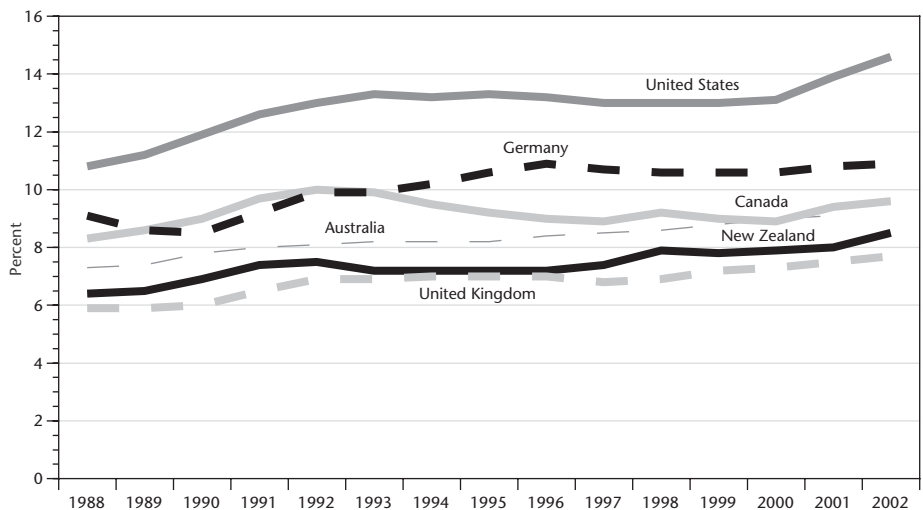
*tam* fines. For example, apparently healthy individuals were given cardiac procedures because it was profitable. That is an example of agency failure as well as outright fraud. In an article in the same issue of the *CMAJ*, P. J. Devereaux and colleagues, in a meta-analysis of a number of studies, showed that after adjusting for appro-

priate factors, private for-profit hospitals result in higher payments for care in the US than private not-for-profit hospitals. A fragmented insurance market would facilitate non-competitive practices by health service providers

Some people define efficiency as efficiency of access, specifically the availability of resources and access to them. Obviously, longer queues imply inefficient access to health care. Some people suggest that allowing queue jumping for the affluent at least makes their systems more efficient by lowering aggregate waiting times. An OECD

study of waiting times for elective surgery indicated that the solution is more efficient management of resources. This has been demonstrated by the success of such systems as Cancer-Care Ontario and similar waiting-list management projects throughout Canada. A comparison of countries for 1998 and 2001 indicated significant improvement in Canada's system and similar or poorer performance with respect to waiting lists in countries such as the UK and New Zealand that have two-tier systems. A later multi-country *Health Affairs* study, with a sample of persons who actually experienced the health care system, indicated concerns about access in Canada contrasted to worries about access due to costs in the US. The same study, by R. J. Blendon et al., entitled "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," indicated greater concerns about waiting times in the UK and New Zealand than in Canada. In Canada, the concern was focused on inadequate staffing levels. Interestingly, the former patients, in each of the five countries surveyed (Australia, Canada, New Zealand, the UK, the US), all expressed similar concerns about medical errors and

FIGURE 1. HEALTH EXPENDITURE AS A SHARE OF GDP, 1988-2002



Source: OECD 2004.

medication issues. In fact, a greater fraction of the former patients in the US than in the other countries believed that a medical error might have been made in their case. The same study indicated that more Canadians felt that they had difficulty accessing a specialist than did health care users in the other countries (Australia, New Zealand, the UK, the US). However, in contrast to

However, the distribution of these wait times is quite broad, with 41.4 percent reporting wait times of less than 1 month. However 17.1 percent reported waiting longer than 30 months.

The availability of private insurance is considered by some to be a panacea for resource access. Yet it does not really create extra supply. The exist-

ences to such an argument. Of more concern, discussed in my August 2004 *Policy Options* article, is that such systems simply lead to more competition for scarce resources driving costs up, not down. There is a substantial body of literature suggesting that there are real systemic constraints to health labour supply in all markets, not just in Canada. Creating options, through competing insurance systems, to exploit that market power outside the public system must raise costs within it. The higher costs in health systems in developed countries with competing insurance systems clearly supports this point.

One of the challenges with health insurance is market failure. As well as the obvious problems of lack of competition, the provision of health care is rife with information asymmetries and agency conflicts. For example, insurance firms could compete to attract health plan members only to drop them if chronic illness arises.

Canada, sicker adults in the US, New Zealand and Australia indicated that they had not accessed medical care because of concerns about cost.

The evaluation of the state of a health care system with respect to waiting times is complex. Required data systems are only recently coming in to play in most jurisdictions. In a study published in 2004, Blendon and colleagues presented results of a survey on health executives that indicated 44 percent of Canadian executives surveyed felt that elective surgery waiting times had increased. However, 46 percent felt the waiting times were unchanged. Interestingly, in the same survey, 27 percent of US executives felt that waiting times had increased. The question about the expected wait time for a routine hip-replacement for a 65 year old male found that 50 percent of Canadian executives expected waits of six months or more. In England, 81 percent of executives expected the waiting time to be that long. Results for Australia and New Zealand were 39 percent and 65 percent, respectively. The general conclusion is that the systems with public and private voluntary insurance have similar waiting list challenges to those faced in Canada.

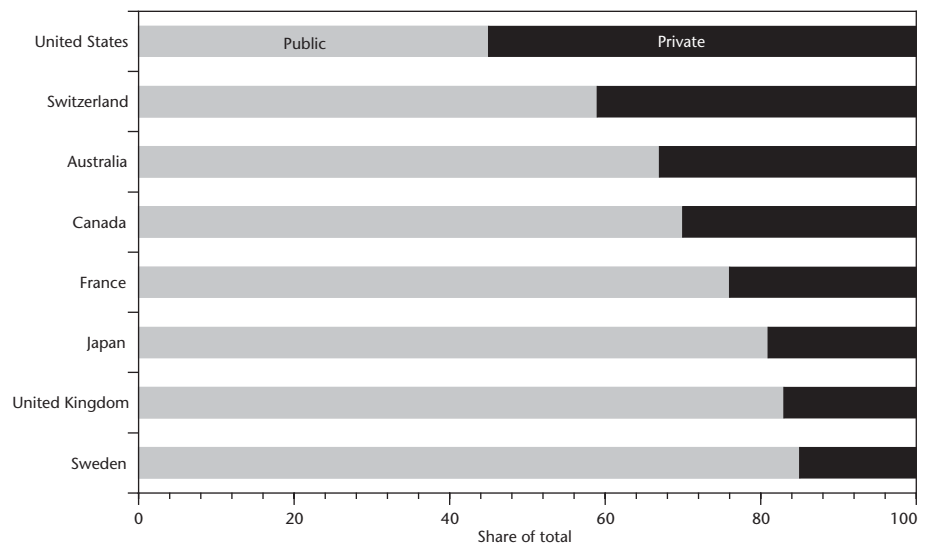
From the Health Access Survey, Statistics Canada has documented a self-reported median wait time of about four weeks for non-emergency surgery.

tence of private insurance simply facilitates a price mechanism for accessing scarce resources rather than allocation based on medical need. It is significant that the Blendon study indicated that sicker adults in Australia, New Zealand and the US were concerned that the cost of private insurance would prevent their access to specialist resources.

There are discussions that creating a two-tier system would free up resources for the public system. The existence of significant queues in countries with two-tier systems provides obvious counter exam-

The existence of a single-payer health care system does not obviate the requirement to deal with health care providers in a market setting. In Canada, most health care providers are private entrepreneurs. Some, like hospitals, may be not-for-profit corporations. Others, such as many doctors, are organized like classic small businesses. The relationship between the single-payer insurer and these resources will be in a market context. Similarly, all health care workers offer their services in the context of a standard labour market. In other words, prices and wages must be

FIGURE 2. PRIVATE/PUBLIC HEALTH EXPENDITURE 2002



Source: OECD Health Data 2005, taken from *The Economist*, June 16, 2005.

set

and managed in a market setting. The existence of private insurance complicates the market, but does not solve the resource supply problem. Such insurance enhances the relative bargaining position of the providers by creating more remunerative markets than the public one.

Until the *Chaoulli* decision, a number of provinces disallowed private insurance for public services. However, in a 2001 study on the illegality of private health care, Flood et al. indicate some provinces did not restrict insurance. Yet, private insurance markets did not develop in those provinces without the prescription on insurance. The authors attribute this to various prohibitions on the use of public insurance to subsidize the private purchase of health care resources. Specifically, there would be no payment by the public insurance system if a person chose to use private resources to get out-of-queue health care. In other words, private resources must be paid for completely privately. More importantly, many provinces do not allow physicians to practice both in and out of the public insurance plan. Generally, doctors can choose to practice inside the public plan or outside it but cannot use private patients to extend their income from the public health system. If such barriers are gradually lowered, there will be increasing concerns about cross-subsidization. The major resources in the health care system, our public hospitals, diagnostic clinics and similar facilities, have been put in place with public resources. One of the major concerns is that private insurance users will be able to purchase preferred access to public resources. This means that waiting times in the public system will not be improved. Unless private care is completely segregated from the public system, public resources could be diverted to facilitate queue-jumping by the affluent.

Any private insurance system would also have the incentive to leave complex and chronic cases to the public insurance programs. In most coun-

tries with mixed private and public practices, governments use regulation to force doctors to provide desired services to the public system and to prevent the exploitation of public resources for private gain. For example, the portion of beds in hospitals may be controlled or doctors may have to make specific payments to compensate public hospitals for resources used. These forms of cross-subsidization will require careful

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regulation to maintain equitable access to all users. This is particularly important in an environment of constrained physical and human resources in the hospital and other sectors.

The Supreme Court decision referenced the co-existence of private and public health care in most Western European countries. However, it did not emphasize the extensive regulatory environment that exists in those countries. A WHO study by Mossialos et al. indicates significant regulatory challenges in maintaining equity in the health care system in the presence of voluntary health insurance. Another recent WHO report in 2002, *Regulating Entrepreneurial Behaviour in European Health Care Systems*, documents the major requirements for regulation to achieve the standard goals of equity and efficiency in health care systems. Their regulatory environment has been developed in the context of parallel public and private systems. Ours will have to adapt if a significant private system emerges. For example, one of the challenges may be that public hospitals will view patients with extra health insurance as a supplemental revenue source and provide differential access to publicly funded resources.

In this article, the discussion has focused on the rationale for a single-payer health insurance system. The

arguments are very simple. A single-payer system

- Facilitates scale efficiency gains and lower overhead costs
  - Limits the requirement for regulation
  - Balances the market power of the health care providers
  - Provides a balanced mechanism for needs-based cost control
- The creation of private insurance

will complicate the management of resources and enhance the market power of health care providers. In simply allowing private health insurance for publicly insured services, the *Chaoulli* decision has not really caused the earthquake ascribed to it. Largely because of the limited public coverage of pharmaceuticals, the private share of health costs in Canada is larger than that in France, Britain or Sweden. It is important that we avoid further fragmentation. The challenge in the post-*Chaoulli* environment will be to maintain and create clear boundaries between public and private resources to ensure that cross-subsidization of enhanced access by the public funds is limited. Additional overhead is inevitable. Equitable and efficient access to health care for all Canadians will require substantial regulation. Most importantly, it is far from clear that fragmenting the funding of Canada's health care will meet the ultimate criterion: improving the health of Canadians. A strong public health care system remains essential to achieve an equitable future for all Canadians.

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