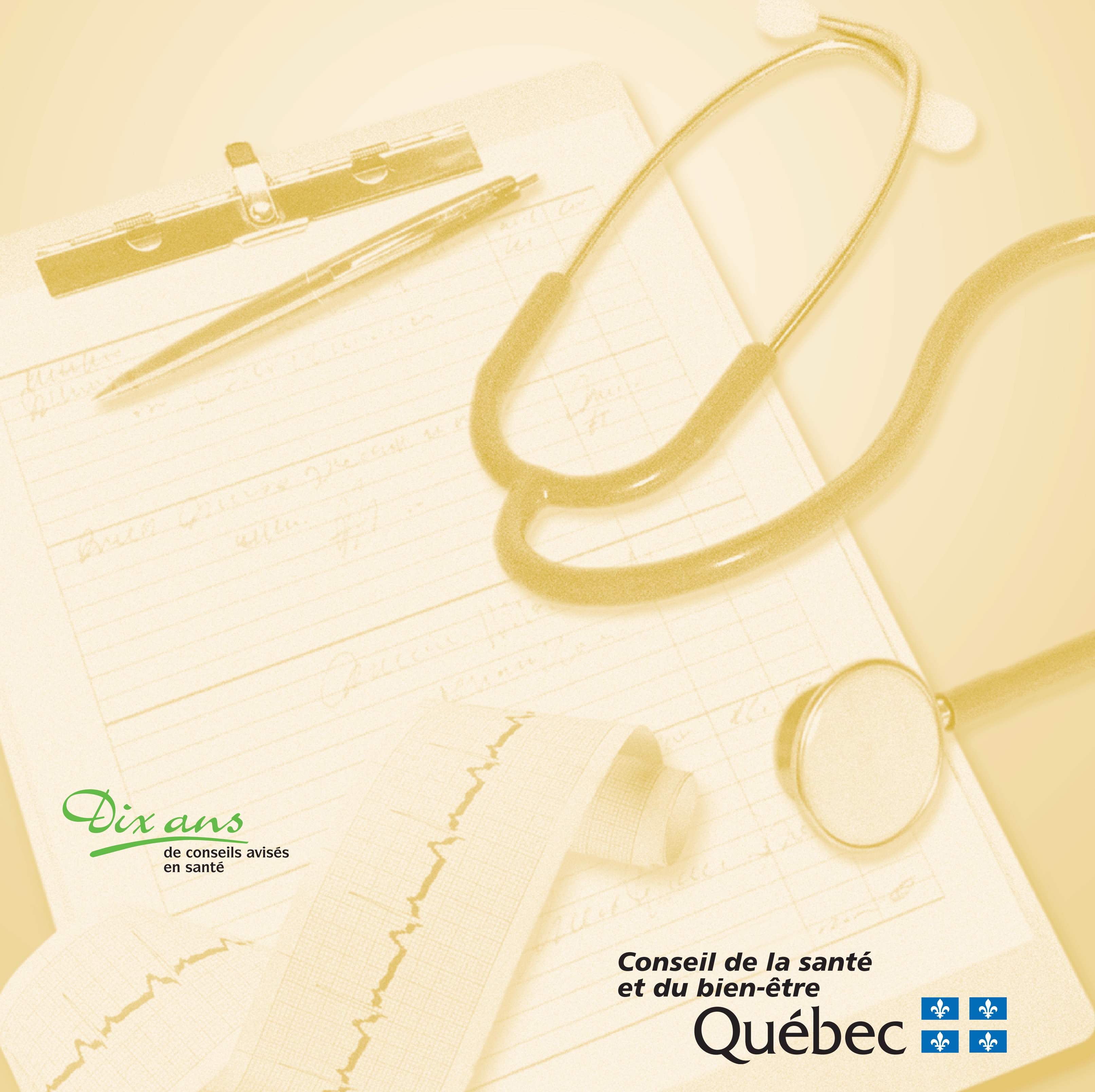
Opinion

Private Funding of Medical and Hospital Services



Dix ans de conseils avisés en santé

Conseil de la santé et du bien-être

Québec

Opinion

Private Funding
of Medical and Hospital Services

The Conseil de la santé et du bien-être adopted this opinion at a special meeting on December 18, 2002 and submitted it to the Minister of Health and Social Services on December 23, 2002.

The Conseil de la santé et du bien-être was established by legislation in May 1992. Its mission is to contribute to the enhancement of Quebecers' health and well-being by advising the Minister of Health and Social Services, informing the public, fostering debate and establishing partnerships. These initiatives focus on the objectives and best means of achieving this goal.

The Conseil comprises 23 members representing users of health and social services, community agencies, interveners, researchers and administrators in the health and social sectors and sectors whose intervention strategies affect Quebecers' health and well-being.

This opinion was produced by the

Le Conseil de la santé et du bien-être
880, chemin Sainte-Foy, RC
Québec (Québec) G1S 2L2

Telephone: (418) 643-3040

Fax: (418) 644-0654

E-mail: csbe@msss.gouv.qc.ca

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Francine Pilon communication

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The Conseil asked a committee comprising the following members to prepare this opinion:

François Béland, *Chairman*
André Archambault
Christophe Auger
Martine Couture
Vicky Trépanier
Hélène Morais
Stanley Vollant

Lionel Robert and Anne Marcoux also participated in the committee's deliberations.

The following employees of the Conseil provided professional and technical support:

Éric Laplante
Michel Bernier
Nathalie Bolduc
Julie Levasseur
Gerard Donnelly
Ginette Langlois
Carole Noël
Céline Vaillancourt
Lyne Vézina

Coordination and publishing

Anne Marcoux

This opinion is based on a research report written by François Béland in collaboration with Steven Lewis.

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Members of the Conseil de la santé et du bien-être

Hélène Morais
President

André Archambault
Director General
Auberge communautaire du Sud-Ouest

Christophe Auger
Director of Human Resources
Confédération des syndicats nationaux

Linda Beauchamp Provencher
Denturist
Chairwoman of the Board of Directors
of the CLSC-CHSLD-CH de la MRC d'Asbestos

François Béland
Researcher and full professor
GRIS – Faculté de médecine
Université de Montréal

Luc Boileau
President and CEO
Régie régionale de la Montérégie

Gylaine Boucher
Director General
CLSC Jean-Olivier-Chénier

Jean-Yves Bourque
Assistant Deputy Minister
Ministère de l'Emploi et de la Solidarité sociale

Yvon Caouette
Retired educator

Paul-André Comeau
Visiting professor – ENAP

Martine Couture
Director General
CH-CHSLD-CLSC Cléophas-Claveau

Jocelyne Dagenais
Assistant Deputy Minister
Ministère de la Santé et des Services sociaux

Gisèle Dubé
Coordinator of diocesan pastoral care
Diocèse de Gaspé

Jacques Fiset
Director General
CLD Québec-Vanier

Michel Hamelin
Assistant Secretary
Ministère du Conseil exécutif

Yolette Lévy
Municipal councillor
Ville de Val-d'Or

Louise-Andrée Moisan
Director of Communications
Fédération québécoise des municipalités

Marie Soleil Renaud
Psychologist
Centre hospitalier de Gaspé

Marielle Tremblay
Professor
Université du Québec à Chicoutimi

André Thibault
Vice-President
Professor
Université du Québec à Trois-Rivières

Vicky Trépanier
Member of the Board of Directors
of Centraide Québec

Stanley Vollant
Head of the general surgery service
Centre hospitalier régional de Baie-Comeau

Lionel Robert
Secretary

Anne Marcoux
Interim Secretary General

Foreword

In Québec and in the western nations, debate on health care is a key social issue. Among the problems noted, mention should be made of prolonged waiting in emergency rooms, waiting lists for specialized services, and the difficulty of obtaining services from family practitioners and home services. Such problems appear to stem from the aging of the population, technological change and the problem of maintaining the viability of public health care systems. All ministers of health and social services have had to face these problems in recent years. Recent task force reports in Canada and Québec also deal with these problems.

Debate has also centred on solutions, some of which concern the organization and funding of services, including additional funding and the search for new sources of funding.

The Conseil de la santé et du bien-être has focused on several occasions on the question of health care funding, private funding and the private sector's role in delivering health care. The Conseil's decision to re-examine the question reflects an important shift in the type of services covered by private funding.

Some observers are calling for private funding of services received from physicians or hospitals. Until now, private funding has developed, above all, in categories of services not covered or only partially covered by the public sector, e.g. dental services, home care and prescription drugs. The Conseil believes that decision-makers, service providers and the public must carefully assess this change. Even if additional short-term public funding is being allocated to health care, the Conseil is taking a stance now because it is convinced that the question is of long-term interest and is not confined to Québec.

In this opinion, entitled Private Funding of Medical and Hospital Services, the Conseil examines the key arguments in favour of the private funding of medical and hospital services in light of current knowledge. In this way, it is seeking to go beyond ideological debate and analyse the facts. It wishes to introduce into debate and decision-making an assessment of the known benefits and consequences of this type of funding for this type of services.

Hélène Morais
President

Summary

Whether we are fully or poorly informed, directly or indirectly concerned, we all have an opinion on private funding of medical and hospital services. Newspapers regularly report and comment on the topic, which is discussed in the workplace and the home. Here are some widespread, seemingly sensible notions:

- We should be able to pay for medical care if we can afford it and wish to do so.
- The private sector could play a useful accessory role without jeopardizing care for the least privileged members of society.
- User fees could limit abuses that are putting a strain on the system.

This opinion examines each of these affirmations in light of current thinking, experience here and elsewhere, and the findings of the most recent research.

First, the problem of definitions and figures arises. For example, what do we mean by “private funding of medical and hospital services”? It is a question of making the users of such services contribute to their cost.

When people say that “30% of overall health care spending is already covered by private funding,” what exactly do they mean? In fact, private funding covered only 4% of spending on medical and hospital services in Québec in 2001. The 30% figure applies to Canada and encompasses health-related services such as ambulance transportation, residential facilities and long-term care, home care and diagnostic tests.

Another claim that warrants attention is that the government is finding it so hard to fund medical and hospital services that private funding is necessary. It is true that health care spending rose by nearly 40% between 1991 and 2001. However, government health care spending as a proportion of gross domestic product (GDP) fell from 7.2% to 6.4% between 1993 and 2001 and the proportion of GDP devoted to medical and hospital services decreased from 5.2% to 4.3% during the same period.

It is claimed that the introduction of private funding will broaden the availability of medical and hospital services. Unless medical staffing increases, the additional funds will essentially bolster the income of health professionals, as British and American experience has shown. It has yet to be proven that more extensive private funding leads to an overall increase in the availability of health care services.

Private funding of medical and hospital services is also supposed to reduce waiting lists in the publicly funded health care sector. Recent experience in Manitoba shows that waiting time for cataract surgery more than doubled when physicians remunerated simultaneously by private and public funding sources, rather than physicians working solely in the public health care sector performed the surgery.

It is also hoped that private funding will reduce recourse to health care services deemed less necessary. However, studies have shown that the effect on abuse of user fees is minimal and that the fees also curtail the use of services deemed both necessary and less necessary.

Another little-known facet of private funding is that it often significantly increases the administrative costs of health care services. For example, private health care management in the United States costs considerably more per capita than public health care management in Canada.

Private funding of medical and hospital services engenders cumbersome management and accounting. Extensive private funding would necessitate the elaboration of a legislative framework to govern private insurers, which would seek to obtain tax benefits, which in turn would create new shortfalls for the government.

This opinion seeks to foster debate on the validity of significant private funding of medical and hospital services.

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Introduction

We must first clarify what private funding of medical and hospital services means. Specifically, users pay for services received, either by directly paying in whole or in part the service provider, e.g. a physician or hospital, through private health insurance, user fees (payment by the patient of a deductible in order to obtain a government-insured service that the government does not cover entirely), and an array of fiscal measures.

Mixed health care payment formulas can take extremely diverse forms. For example, through taxation, the government could allow taxpayers to deduct from their taxable income all expenses for medical and hospital services, which would be equivalent to indirect private funding of such services. In another example, also focusing on the taxation system, the government would pay all medical and hospital expenses but would add to the taxpayer's taxable income the full cost of such care, which is disguised partial privatization.

Private- and public-sector funding can coexist as they do in France where, despite the universal public health care system, many people adhere to private insurance plans. The services offered are public and universal but direct funding through personal income tax does not cover all costs.

Private- and public-sector funding can overlap in highly diverse ways.

The United States is a particular case in the West in that it is the country in which the private sector maintains, proportionally, the broadest presence. Individually or through their employers, a majority of Americans adhere to private health insurance plans. In the US, where public health care is minimal, public programs, albeit partial and subject to numerous conditions, exceptions and limits, are available to the poorest members of society (Medicaid), the elderly (Medicare) and, in some states, to children.

Conversely, even in those countries with the most advanced public coverage, not all medical services are covered. Quebecers pay for certain services not covered by the Canada Health Act, e.g. elective surgery, or in rare instances, more privileged members of society consult physicians who have opted out and directly bill their patients.

It is important to ascertain the effect of even partial private funding in what is a largely publicly-funded system. It should be noted that, in Québec, 96% of medical and hospital services that are defined by legislation as medically necessary were covered by the public health care system in 2001.

In this opinion, we will focus on medical and hospital services, as described in the Canada Health Act. The federal legislation governs health insurance plans that are the responsibility of the provinces and territories. It stipulates delivery and payment conditions in respect of insured services and extended health care services. Insured services are medically necessary hospital, medical and dental surgery services, i.e. hospital services provided in a hospital to hospitalized patients or outpatients and medical services provided by a physician. Physicians and the provincial and territorial health care plans usually determine medically necessary services as contemplated by the Act. The extended health care services covered by the Act include long-term residential care and the health care component of home care.

Spending on medical and hospital services accounts for 60% of all Québec government health and social services expenditures and 67% of health spending.

Private funding of medical and hospital services would be a novelty since the establishment in 1971 of the public health care system in Québec. Bearing in mind the wide array of mixed health care systems mentioned earlier, we will attempt to rely on existing research and practical experience elsewhere in the world to systematically analyse six basic arguments usually put forward to support the introduction of private funding of medical and hospital services.

The Québec public health care system is getting bad press at the moment. The crises in emergency rooms and problems in gaining access to general or specialized medical services such as cancer treatment give the impression of a system in the throes of a crisis, despite surveys that reveal a fairly high level of satisfaction among users. This assessment of the situation backs up the notion that private funding could only be an improvement by adding to overall health care spending while alleviating various crises. Six claims stem from this general notion.

1) Private funding already exists in the health field. To broaden its role would only strengthen an existing state of affairs.
2) The addition of private funding would only increase the overall availability of medical services.
3) Allowing private funding makes more room in the publicly-funded system and reduces waiting lists.
4) Even partial payment for medical services through user fees will reduce abuses and costs.
5) Private funding does not threaten the integrity of public health care.
6) The introduction of private funding will not have a deleterious social effect on the least privileged members of society, who will continue to rely on publicly-funded health care services.

This opinion examines the presumed advantages and consequences of private funding of medical and hospital services in respect of the six claims. It examines the key arguments in favour of privatization, attempts to ascertain whether the data available corroborate such affirmations, and emphasizes the possible consequences of privatization. Finally, it makes recommendations to the Minister of Health and Social Services.

Does private funding of medical and hospital services represent continuity or a break with the past?

Argument in favour of private funding

Nearly 25% of Quebec health care spending is already privately funded. Indeed, this proportion has risen steadily in Québec over the past 25 years, from $2.3 billion in 1975 to $4.8 billion in 2000, equivalent, as a proportion of the total, to 21.2% and 24.6%, respectively. Under the circumstances, since private funding of health and social services already exists and is becoming more widespread, there is no reason to be alarmed by the private funding of medical and hospital services.

Is this argument founded?

Careful analysis of the available data contradicts this argument in two ways.

Growth in private funding is not a general trend

It would be unwise to confirm in light of experience in the past 25 years that growth in private funding of health services is a general trend that will inevitably affect all health services, including medical and hospital services. In point of fact, the proportion of private funding in relation to overall health spending increased by only 3.4% between 1975 and 2001. While such growth was real, it was modest. Moreover, it was not steady in that it represented a significant proportion of overall health spending between 1980 and 1995 but was modest or even negative between 1995 and 2001.

Private funding has been concentrated on certain types of services

Private health care funding has focused for the past 10 or so years on services that are less extensively funded by the government. New niches have developed that reflect pluralism. Other niches have become more important, e.g. alternative therapies, psychotherapy, personal medical devices, over-the-counter drugs, and so on. For example, 88% of health services provided by professionals other than physicians, such as dentists, psychologists, optometrists, naturopaths and physiotherapists, were privately funded in 2001.

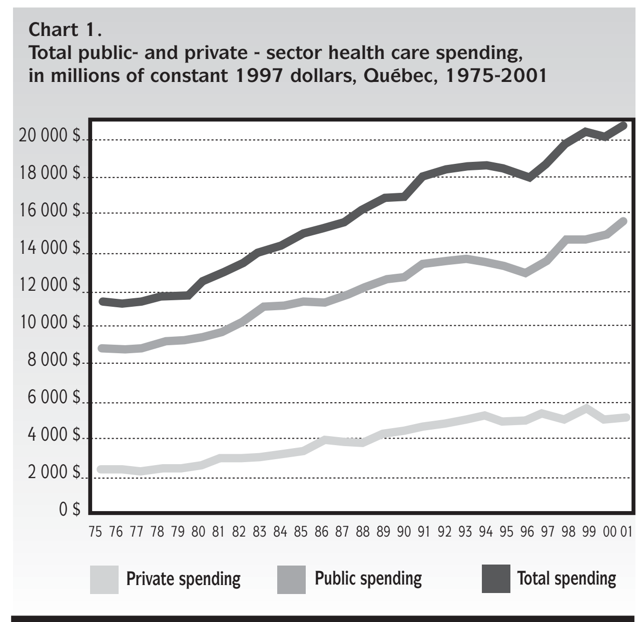


Chart 1.
Total public- and private - sector health care spending, in millions of constant 1997 dollars, Québec, 1975-2001

Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975-2001, Ottawa, 2000: Tables B.1.4, B.2.4 and B.3.4.

In 1975, 37.5% of services not covered by the Canada Health Act, i.e. other professionals, drugs, capital expenditures, home care, ambulance services, eyeglasses, hearing aids, and orthotic and prosthetic devices, were funded privately. This proportion stood at just over 45% in 1998 and 40% in 2001.

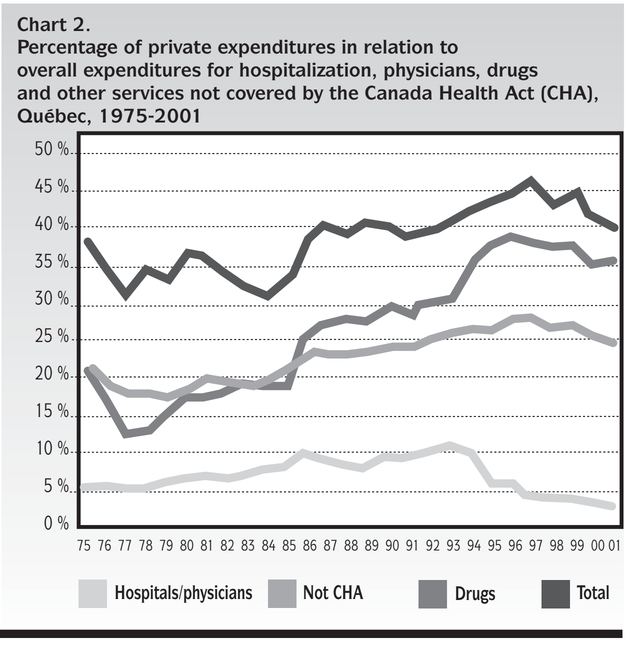


Chart 2.
Percentage of private expenditures in relation to overall expenditures for hospitalization, physicians, drugs and other services not covered by the Canada Health Act (CHA), Québec, 1975-2001

Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975-2001, Ottawa, 2000: Tables D.1.5.1 and D.2.5.1.

Chart 2 also reflects growth in private funding of prescription drugs and, to a lesser extent, of total health care spending. Moreover, it reveals an increase in public funding in the medical and hospital services sector. Following slow growth between 1975 and 1992, the proportion of private investment in medical and hospital services declined from 11% in 1993 to a historic low of 4% in 2001.

If private funding of health services has grown in Québec over the years, such growth has only been modest and funding has been concentrated on services other than medical and hospital services. Consequently, the call for more extensive private funding of medical and hospital services in no way represents historic continuity. To the contrary, it reflects a break with the past since these services are now publicly funded.

Does private funding of medical and hospital services guarantee more extensive services?

Argument in favour of private funding

The delivery of more extensive medical and hospital services requires additional funding, which, because of the financial constraints facing the Québec government, can only come from private-sector sources.

Is this argument founded?

Two factors must be considered.

Additional funding of medical and hospital services does not necessarily lead to more extensive services

In order to broaden medical and hospital services, additional staff must be provided to deliver the services. Indeed, manpower is the key to such service delivery. Labour costs account for 80% of the overall cost of health services. Broadening the delivery of medical and hospital services implies increasing the number of professionals or bolstering the productivity of the professionals available.

It is important from the outset to emphasize that the availability of manpower, especially medical manpower, is inflexible in the short term. An increase in the number of health professionals is subject to rules that are scarcely related to higher remuneration. To achieve such an increase demands time, i.e. control by governments and universities over admissions to university faculties, the length of training, and so on. Increased funding for medical services, whether from private or public sources, would not lead in the short term to an increase in the number of health professionals.

Failing a short-term increase in the number of health professionals, can private funding bolster the productivity of existing manpower? There is no reason to believe so. British experience in this respect speaks for itself. The incomes of physicians who provide privately-funded health services are three or four times higher than those of physicians in the public health service. Working in the private sector has enabled the physicians to increase their incomes, although this has not increased the availability of services. Experience in the United States also seems to indicate that, for the same level of expenditure, less care is produced in the private sector than in the public system.

Unless the government takes advantage of the opportunity to reduce its investment in health care, the introduction of private funding has the drawback of engendering higher overall health care spending. Consequently, a larger share of collective wealth is devoted to such services without an increase in their availability.

Growth in spending on medical and hospital services is not the main financial constraint facing the Québec government

Québec government spending on health and social services has undeniably increased markedly in absolute figures over the past 10 years despite a slowdown in the pace of growth in 1997. Such expenditures increased by $4.8 billion, or 39%, between 1991 and 2002. Spending on health services rose 38% and spending on medical and hospital services was up 28% during the same period.

However, the proportion of gross domestic product (GDP) allocated to government health care spending fell, from 7.2% to 6.4% between 1993 and 2001, as did the proportion of GDP devoted to medical and hospital services, i.e. from 5.2% to 4.3% during the same period.

Another statistical aggregate, based on the proportion of Québec government revenues earmarked for health care, confirms the latter trend. In 1981, the Québec government devoted 22% of its revenues to medical and hospital services, compared with only 18% in 2000.

All in all, the relative importance in the Québec government budget and the Québec economy of spending on medical and hospital services has declined. The financial constraints that the Québec government is facing cannot be attributed primarily to spending on medical and hospital services.

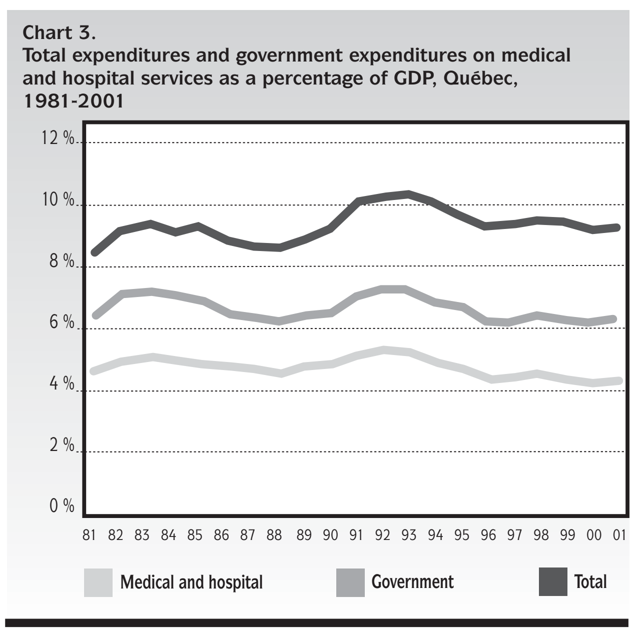


Chart 3.
Total expenditures and government expenditures on medical and hospital services as a percentage of GDP, Québec, 1981-2001

Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975-2001, Ottawa, 2000: Tables D.1.5.1, D.4.5.1 and Appendix A.1.

Does private funding of medical and hospital services free up the public sector?

Argument in favour of private funding

The introduction of private funding would free up the public sector and allow it to better fulfil its role among individuals genuinely in need. The places freed up by users who wish and are able to pay for the services they desire would be made available to other users who continue to rely on publicly-funded services. Thus, waiting lists would disappear.

Is this argument founded?

The promise of enhanced access to medical and hospital services stemming from private funding assumes the maintenance of the capacity to produce publicly-funded services. In fact, it is not sufficient to guarantee that physicians and nurses work a given number of hours in publicly-funded services, nor that technical support centres and other health facilities be reserved for such services at specified times. The publicly-funded sector must maintain a production capacity equivalent to its capacity prior to the introduction of private funding.

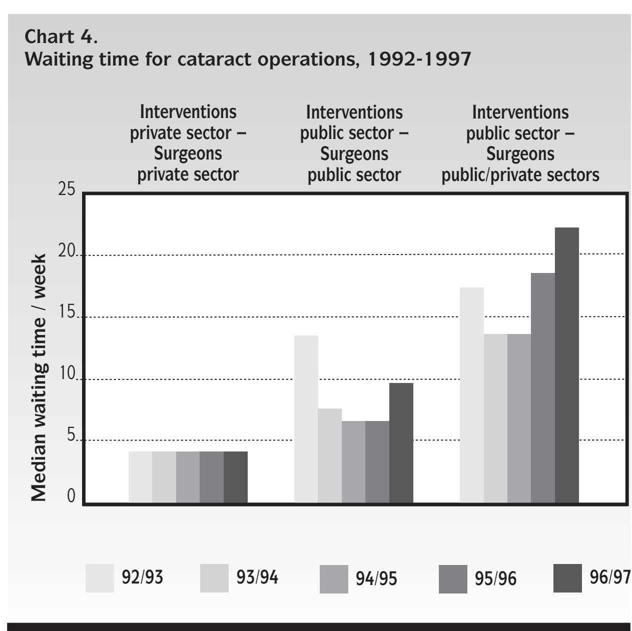
Experience has shown that such is not the case, for two reasons.

The coexistence of public and private funding adds to waiting lists in the public sector

Criticism of the public system often focuses on waiting lists. One example is the availability and private funding of cataract surgery in Québec. However, physicians who only practice in the private sector perform such surgery. When physicians may practice both in the private and public sectors, waiting time increases considerably.

A study conducted in Manitoba concerning cataract surgery reveals that the waiting time for patients who rely on the public sector is shorter when physicians practising solely in the public sector operate on them (from 7 to 14 weeks) than when physicians who also practice in the private sector operate on them (from 14 to 23 weeks). This example shows that simultaneous medical practice in the public and private sectors is not an alternative for patients who rely solely on publicly-funded services.

Chart 4.
Waiting time for cataract operations, 1992-1997



Source : MCHP (2000). Report summary, *Waiting time for surgery in Manitoba*, Université du Manitoba.

Experience in Australia and the United Kingdom has also shown that recourse to privately-funded health services does not shorten waiting lists. In the UK, the longest waiting lists are found in those regions with the greatest number of adherents to private insurance coverage.

Private funding increases demand for public services

Individuals who pay for privately-funded services should not rely more extensively on public services, a condition for ensuring that the publicly-funded system maintains its ability to serve the public. However, medical and hospital procedures are not isolated from each other. For example, it might be thought that private funding of medical and hospital services would allow a patient who so desires to avoid the rationing of publicly-funded services. Even if the patient decides to pay for surgery that he is unable to obtain at his convenience in the publicly-funded sector, the patient will nonetheless obtain from the public health care system pre-operative examinations and tests and post-operative medical and hospital follow-up. Private funding of medical and hospital services will likely increase demand for public services.

Among elderly people in the United States, the most extensive users of the public Medicare system are those who adhere to private plans. In this instance, the public health-insurance plan is indirectly subsidizing privately-funded services.

Between 1980 and 1997 in the OECD countries, growth in private funding of health services always led to a deterioration in the public sector. The assumption that a simple increase in health services would not adversely affect the public is not borne out. Far from engendering a harmonious freeing up of crowding in the public sector, the introduction of private funding instead tends to cannibalize publicly-funded services.

Fact and fiction concerning user fees and the cost private funding of medical and hospital services

Argument in favour of private funding

Many virtues are ascribed to user fees, especially that of discouraging the untimely use of emergency services for minor problems. To demand even partial payment for medical and hospital services appears to encourage potential users to make rational use of such services. In this way, the volume of services would diminish, thus reducing the attendant costs. Moreover, private funding would ensure that users get more for their money.

Is this argument founded?

Two observations must be made.

The imposition of user fees engenders undesirable effects

First, are the abuses mentioned genuine? Are they truly attributable to users? Does the direct payment of user fees truly curtail such abuses?

It is very hard to prove the abusive use of medical and hospital services and, assuming that it were possible to do so, it is equally difficult to pinpoint the culprits.

Instead of talking about abuses, let us note that striking disparities in the performance of certain surgical procedures have been observed in Québec, Canada and the United States, although such variations are not always directly tied to the state of health of the population. Medical and surgical practices vary in light of habits, training and physicians' judgement.

In the Québec system, which largely relies on direct access in respect of front-line health care to general practitioners, only spontaneous consultations with the latter might be subject to abuse, which would affect only a very small portion of the overall cost of medical and hospital services.

Moreover, user fees appear to affect both spontaneous and warranted medical consultations, i.e. the prospect of paying $5 or $10 for a consultation may discourage a patient even if the consultation is objectively necessary. From a strictly utilitarian standpoint, user fees have the perverse effect of postponing for financial reasons necessary consultations in respect of diseases, which, as they progress, will cost more to treat.

This example invalidates the supposition that financial constraints imposed on users lead automatically to more rational use of medical and hospital services. Several studies have shown that direct payment reduces recourse to medical services whether or not they are necessary.

The coexistence of public and private funding increases costs

Private funding is said to allow for more economical management. However, numerous examples, including Switzerland and the United States, reveal an increase in total health care costs when private funding increases.

Private funding increases per capita health care spending. In the event of privatization, the proportion of individual Quebecers' budgets devoted to health care services would increase. In addition to the taxes they pay to cover public services, they would also assume expenses for privately-funded services, e.g. direct expenses, insurance premiums, and so on.

Private funding adds to the cost of managing services. A striking increase in administrative costs has been noted wherever the private sector plays a role in the health care sector. For example, if the Canadian health care system had, all things being equal, the same management costs as in the United States, total health care spending would be 10% higher. Administrative staff in the American health care sector is excessive. There are 85% more managers than in the Canadian system. The management costs of American hospitals account for 26% of their overall costs, a figure that rises to 34% in private hospitals.

The private sector's much-vaunted intrinsically superior efficiency is not confirmed by an examination of the facts, which reveals that administrative costs in the private sector are generally higher than in the public sector. As for the imposition of user fees as a means of streamlining recourse to the system, it can only be of very limited use and can have the perverse effect of dissuading individuals from resorting to the system when it is reasonable and necessary to do so.

Does private funding of hospital and medical services threaten the integrity of the public health care system?

Argument in favour of private funding

Private funding of medical and hospital services would not adversely affect in any way the existing publicly-funded health care system. Such funding would be introduced to a limited extent and parallel to public funding, without altering the public system.

Neither user fees nor private insurance are deemed to threaten the public health-insurance system, which, we are assured, will in any case be maintained.

Is this argument founded?

Private funding will threaten the integrity of the public health care system if its introduction demands changes to the system, its principles of organization and its ability to retain sufficient staff who have adequate equipment at their disposal. This comment reflects lessons drawn from foreign experience and an examination of the complex decisions facing the public system should private funding intrude extensively in the realm of medical and hospital services.

The introduction or strengthening of private insurances plans covering medical and hospital services engenders numerous problems

Private funding may mean that the patient directly pays the service provider, although the patient usually relies on private insurance contracted individually or through employers in the case of sufficiently big companies.

Recourse to partial private funding through the introduction of private insurance plans has given rise to an array of situations in the world from which Québec can draw several lessons. Great Britain and Australia are among the countries that have introduced private funding of medical and hospital services.

It should be noted from the outset that a broad conclusion can clearly be drawn. There are two possibilities: either private funding expands and public health care suffers, or private funding remains minimal and public health care is only marginally affected. Let us first examine the second case. If private funding is minimal, it cannot produce the supposed benefits for the more privileged members of society and is, therefore, pointless. Moreover, if insurance companies deem the intrusion by private funding to be insufficient because such companies traditionally adopt a very cautious approach, the volume of services that private funding generates will be insignificant.

Let us now examine the two examples mentioned above in which an attempt was made to introduce massive private funding of medical and hospital services.

In Great Britain, the funding of parallel private services has focused on the availability in private or public hospitals of a limited number of fee-charging surgical services. Physicians may work in the privately- and publicly-funded sectors. During the 1990s, the private sector accounted for less than 10% of funding for health care services. In 1998, approximately 11.5% of the population had private insurance coverage. Despite the adoption of tax incentives that are costly to the State to encourage individuals to obtain private insurance, few of them have done so. We can thus conclude that the intrusion of private funding of medical and hospital services threatens the integrity of the public system because of tax incentives that represent a drain on the government's ability to act. This threat is unwarranted insofar as it does not encourage the citizens of Great Britain to take out private insurance.

Australia is also a noteworthy example. The states that make up the federation share jurisdiction over health care with the federal government, which plays a major role, contrary to Canada. Over the past 20 years, the organization and funding of health care services in Australia have undergone extensive changes stemming from successive policy shifts. Labour and Conservative governments have imposed radical changes by introducing, curtailing, eliminating and reintroducing various forms of private funding. From the 1950s until 1974, Australian governments fostered private health-insurance schemes, through fiscal measures and cumbersome regulation. In 1974, the government introduced a public, universal system that was dismantled the following year.

The proportion of Australians covered by private health-insurance plans has varied enormously, i.e. from 80% in the early 1970s to 30% in the late 1990s. Since then, it has risen slightly. It is noteworthy that tax abatements stemming from contracting private insurance stood at AU$2.2 billion in 1998-1999, while direct savings in the government's budget related to

transfers to the private sector reached AU$800 million, i.e. a AU$1.4-billion shortfall for the government as a result of the privatization of funding. This is a clear example of the perverse effect of privatization, which ultimately increases the government's financial burden.

Private funding would engender complex decisions and impact that threaten the public health care system

The partial privatization of health care is characterized by complex relationships from a regulatory and financial standpoint between the private and public sectors. As the Australian example shows, complex taxation that is usually costly for the State must be established in the wake of private funding. Furthermore, as the American example reveals, enormous administrative expenses arise in the private sector, especially because of the relationships between existing private and public programs. The number of practical decisions to be made when significant private funding is introduced is enormous and the situations that arise can be unexpectedly complex. The decisions focus on four categories of questions, indicated below.

1) Would private funding of the new health care sector be partial (user fees) or complete, as is now true of some elective surgery?

2) What services would be covered by the new system, i.e. all services or only some of them? If the objective of privatization is to accelerate access to care, there is no reason to confine private funding to only one category of services, all the more so as various services are often interrelated. Why authorize private funding of a given type of surgery when medical follow-up is provided by the publicly-funded health care system?

3) Could privately-funded health care services be delivered in existing publicly-funded establishments? Would they be delivered solely in private clinics? Both delivery methods are possible. The second method is the most radical one and can ultimately lead to the establishment of a complete private health care network separate from the public network. As for the first solution, which is the most likely and "reasonable" one, it would, paradoxically, engender complex regulations and raise numerous questions, especially with respect to billing. At what cost would physicians in the private sector rent publicly-funded equipment? What tax status would be accorded the "profits" generated by such rentals?

4) On what basis would professionals providing private services in publicly-funded establishments be remunerated?

It is essential to acknowledge the veritable Pandora's box that the introduction of private funding of medical and hospital services would represent in financial and administrative terms.

As private funding increases, private insurers will become increasingly interested and the government will have to regulate the insurers' operations and adopt tax measures to support their operations.

It is hard to draw general conclusions in light of the diversity of private funding methods. Each of the applications has a complex effect on public health insurance plans and the attendant relationships between private and public funding will be just as complex.

Rules and procedures should be elaborated in addition to legislation to govern these relationships. They would substantially alter the functioning of the entire public health care sector.

The private and the public sectors and the rich and the poor

Argument in favour of private funding

The objective of private funding of medical and hospital services is not to modify income redistribution between individuals but to enhance access to health care services.

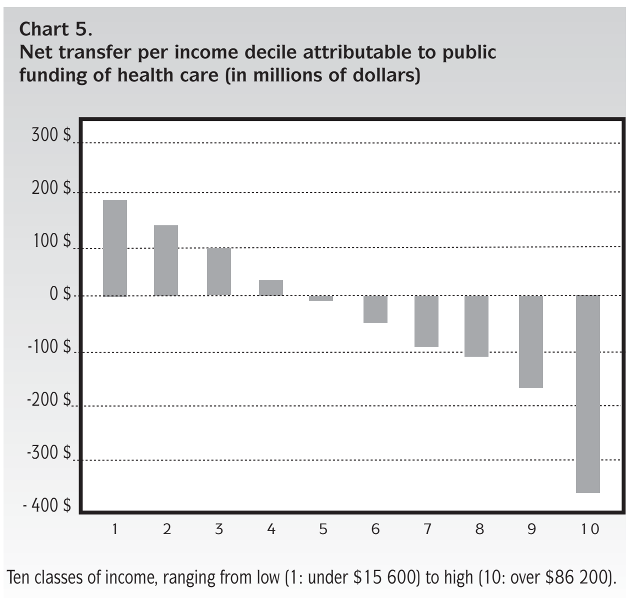
The advocates of a privately-funded health care system in Québec are not promoting such a system for social reasons. Their goal is to foster better access to services, streamline the management of health care, shorten waiting lists, and so on. They maintain that the introduction of private funding would not adversely affect the budgets of less privileged members of society.

Is this argument founded?

The poorer individuals are, the sicker they are. The wealthier individuals are, the healthier they are. The more social, cultural and economic resources individuals have at their disposal, the better their state of health. The health care needs of less privileged individuals exceed those of more privileged members of society. Québec health insurance programs are essentially funded through a progressive income tax system. The progressive graduation of the taxation system ensures that wealthier individuals pay a higher proportion of their income in taxes than less privileged individuals. Consequently, the contribution made by the rich to funding health care services is proportionally higher than the contribution made by less privileged members of society. A study conducted in Manitoba clearly shows the effect of redistributing income in a public health care system. The study divided Manitoba households into 10 classes of income, then compared the tax contribution to health care services attributable to households in the 10 classes of income, as well as health care spending attributable to each one. Chart 5 indicates the discrepancies between tax contributions in respect of health care services and health care spending for each of the 10 classes of income.

The discrepancy in respect of the poorest households is +$170 million, since such households paid $45 million in taxes for health care services and received $215 million worth of services. For the wealthiest households, the discrepancy is -$375 million, since such households paid $475 million in taxes for health care services and received $100 million worth of services. For the other income classes, the trend is linear.

Chart 5.
Net transfer per income decile attributable to public funding of health care (in millions of dollars)



Ten classes of income, ranging from low (1: under $15 600) to high (10: over $86 200).

Source: Mustard et al, 1998; Evans, 2002b.

Low-income elderly people in the United States devote up to 30% of their total budgets to privately-funded health care services, while the most privileged individuals spend less than 10%.

American households resort extensively to private insurance to cover services excluded by the public health care system or to obtain services more rapidly. They allocate a significant portion of their income to direct payments for health care services. These expenditures are extremely costly for low-income households, which pay little tax but are earmarking a growing portion of their income for health-related expenses. The situation is especially serious for people over 65 with low incomes.

The Manitoba study clearly reveals the redistribution achieved by publicly-funded health care services and the American example clearly shows the opposite effect of a very partial publicly-funded health care system.

It is untrue to claim that private funding of health services does not redistribute income. To reduce the effect on low-income earners of income redistribution and the restriction of access stemming from premiums, deductibles and other private expenditures, an exemption as been proposed. This exclusion of the least privileged members of society only transfers to individuals on the low-income threshold the perverse effect of personal expenditures for medical and hospital services. This solution in no way solves the problem of negative income redistribution imposed by private funding of medical and hospital services.

To conclude, any public, universal health-insurance system transfers income from the more privileged to the less privileged members of society. Conversely, any measure that introduces private funding of health care services will reduce such transfers. It will always be in the interest of the least privileged members of society to take advantage of complete public, universal health care coverage and in the interest of the wealthiest members of society to limit such coverage.

Recommendations

Private funding of medical and hospital services would reduce social solidarity, curtail access to services for the underprivileged and generally jeopardize public and individual health. Moreover, its introduction would require major changes to the structure and operation of the Québec health and social services system, i.e. the reorganization of medical practices, differential remuneration in the private and public sectors and patients who become consumer-payers, at a time when current spending on medical and hospital services, far from skyrocketing as is sometimes claimed, has declined in recent years as a percentage of GDP and government revenues.

Consequently, the Conseil de la santé et du bien-être has formulated four recommendations.

Recommendation 1

Prevent private funding of medical and hospital services

The Conseil de la santé et du bien-être recommends that the Minister of Health and Social Services prevent private funding of medical and hospital services and protect the integrity of the Québec health and social services system.

Recommendation 2

Defend the Québec health and social services system

The Conseil de la santé et du bien-être recommends that the Minister of Health and Social Services vigorously defend the benefits of public funding of health services in Québec. It is important to publicize the advantages of public funding, especially from the standpoint of social solidarity, fairness, access to services and cost control if we are to ensure the system's success and long-term survival.

Recommendation 3

Fulfil the government's commitment to the public

The Conseil de la santé et du bien-être recommends that the Minister of Health and Social Services ensure the fulfilment of the government's commitment to the public to maintain access to universal, free health care services.

Recommendation 4

Strive to enhance the strictly publicly-funded health care system

The Conseil de la santé et du bien-être recommends that the Minister of Health and Social Services implement remedial measures in the Québec health and social services system that have been necessary for a long time, several of which are included in the Plan de la santé et des services sociaux that it unveiled in November 2002 and in the Conseil's opinion entitled *Un juste prix pour les services de santé* (1995).

Three types of remedial measures are necessary. The first type consists in adopting clear **objectives** that are shared throughout the Québec health and social services system and making the system accountable for the achievement of such objectives. The second type focuses on **enhanced access** to services, especially through the consolidation of front-line services and home care services and further reflection on the scope of public insurance coverage in respect of prescription drugs and home care services. The third type centres on the **mobilization** of interveners concerned with Quebecers' health and well-being, i.e. health care professionals and staff, individuals, families and communities, which requires broader decentralization.

The Conseil recommends that the Minister introduce a dynamic for the planned management of change and support for innovation and experimentation in order to meet the true challenge facing the Québec health and social services system in light of the aging of the population, technological progress and epidemiological transition.

Conclusion

This opinion focuses on private funding of medical and hospital services in Québec. Two reasons justify this choice. First, the attention given to private funding of medical and hospital services in public debate is new, which explains the priority that the Conseil is giving to elaborating an opinion on it. Second, while the questions raised by the delivery and private funding of health services are interrelated in several ways, they are sufficiently important to be dealt with separately.

An examination of experience elsewhere and the information available reveals to what extent private funding of medical and hospital services is a poor choice for Québec. Such funding would either be introduced to a limited extent and make no contribution or it would be introduced massively and the resulting changes in the general economy of the Québec health care system would hamper the system's smooth operation. Specifically, access by most Quebecers to quality services would be reduced; the health of vulnerable individuals would be under greater threat; underprivileged members of society and those who are sick would have to spend more on health services while the tax burden of the most privileged members of society would be reduced; the management of health services would become more cumbersome; and so on.

Three facets of this assessment warrant closer attention.

First, contrary to popular belief, allowing affluent members of society to pay directly for medical and hospital services of their choice will in no way alleviate pressure in the supposedly overburdened public health care system. Additional funding will not, in the short term, increase the available manpower nor has it been shown that such funding will bolster productivity. However, based on past experience, the introduction of private funding would likely lead to higher incomes for medical practitioners and higher overall health care costs.

Second, despite certain claims to the contrary, the private funding of medical and hospital services does not enhance access to publicly-funded services and thus reduce waiting time. Not only does the introduction of privately-funded services in the public health care system lengthen waiting time but it also generates additional demand for public health services.

Third, the imposition of user fees in respect of services covered by the public health care system restricts access to medical and hospital services among the lowest income earners, discourages recourse to medical services whether or not they are necessary, and in no way contributes to reducing spending on health care.

The Conseil has concluded, in the course of elaborating this opinion, that private funding of medical and hospital services is pointless at best and harmful at worst. What can be said, however, about private funding of other health and social services in Québec? It is clear that several of these services, which the *Canada Health Act* does not cover, are now subject to both public and private funding. It is highly likely that private funding of such services is engendering pernicious effects similar to those stemming from private funding of medical and hospital services. Only a thorough analysis of the situation would allow us to confirm this observation. Such an affirmation would only further support the consensus now emerging from numerous recent official reports according to which we must re-examine the Québec health and social services system and according to which the public sector, through the funding it provides, can and must contribute to this renewal.

Appendix: Definitions

Definitions private, public and total health care spending

(Statistics Canada, 2001)

Public health care expenditures:

Spending by the provincial and territorial governments (in this instance, the Québec government) on insured health care services and extended health care services covered by funds transferred by the federal government and the funds of the provincial and territorial governments.

Public health care expenditures:

Such expenditures comprise three types of disbursements, which indicate the origin of the funds and the source of data. The first two types are expenditures by health insurance companies and direct spending by individuals. The third type of disbursement is made up of the revenues of health care establishments derived from patient services paid for by private insurers or patients, such as additional costs for private rooms and coinsurance for long-term care; fees for services obtained by non-residents of Canada; fees for services obtained by uninsured residents; fees for services that are not medically necessary; revenues from sources other than patient services, such as dietetic services, investment income, charitable donations and allied operations such as parking and concessions; capital expenditures; and health research expenses.

Total health care expenditures:

Such expenditures reflect overall public and private expenditures.

Use of funds (categories)

(Classification of the Canadian Institute for Health Information, CIHI 2000)

Hospitals:

Public expenditures in this category include provincial government spending, direct federal government spending and the expenditures of the Commission de la santé et de la sécurité du travail, and spending in public, private and federal government hospitals that provide acute care, chronic care and rehabilitation services. This includes acute care hospitals, psychiatric hospitals, specialized hospitals (paediatrics, cardiology, neurology, and so on), convalescent hospitals, maternity centres and cancer centres.

Private expenditures include fees for rooms, investment income, fees for services obtained by uninsured individuals, funds from charitable activities, and revenue from parking and concessions.

Other establishments:

This category includes all approved establishments that are subsidized by or hold a permit from the ministère de la Santé et des Services sociaux, such as residential and extended care centres, hospital pavilions and rehabilitation centres. It does not include establishments that offer only day care services, transient centres and centres for delinquents.

Physicians:

This category includes services provided by physicians.

Public expenditures include payment for clinical services, salaries and other forms of contractual income, honoraria paid by the CSST, and direct spending by federal agencies. The remuneration of physicians employed by hospitals and public health departments is not included in this category, nor is remuneration for administrative activities.

Private expenditures are drawn from the reports submitted by private-sector insurers but, above all, the Family Expenditure Survey (Statistics Canada).

Other professionals:

This category includes dentists, psychologists, denturists, optometrists, podiatrists, osteopaths, naturopaths, private nurses and physiotherapists. Expenditures pertaining to eye care are included in this category. In the case of the private sector, they are covered instead by the "other expenditures" category. It should be noted that the services of dentists account for approximately 65% of the total in this category, according to data for Québec obtained from the Canadian Institute for Health Information (CIHI).

Private expenditures are drawn from the reports submitted by private-sector insurers and the *Family Expenditure Survey*.

Prescription drugs:

This category includes expenditures on prescription or over-the-counter drugs and personal health products such as medical devices, orthotic and prosthetic devices, and so on. It excludes expenditures related to prescription drugs delivered in hospitals and other establishments (posted to these categories).

Capital expenditures:

This category encompasses expenditures related to construction and equipment purchases for hospitals, clinics, hospital centres for long-term care, and rehabilitation centres.

Other expenditures:

This category can be divided into three sub-groups from the standpoint of overall expenditures: public health; ambulance services, eyeglasses and eye care; and miscellaneous services (home care, hearing aids, orthotic and prosthetic devices, administrative costs preceding payment, research and miscellaneous expenditures). Data for the private sector are drawn, by and large, from insurers' reports and the *Family Expenditure Survey*.

Definitions in the Canada Health Act

The insured health services covered by the Act are medically necessary hospital, medical and dental surgery services that are delivered to insured individuals.

Under the Canada Health Act, insured hospital services designate medically necessary services provided in a hospital to hospitalized patients or outpatients, such as regular or ward care, nursing services, certain diagnostic procedures such as blood tests and radiographs, the administration of drugs supplied to patients in the hospital, and the use of operating rooms, birthing rooms and anaesthesia facilities.

As defined by the Act, insured medical services are medically necessary services provided by physicians. Physicians and provincial and territorial health insurance plans usually jointly determine medically necessary services.

Dental surgery services are services provided by a dentist in a hospital that can only be suitably offered in such an establishment.

The extended health care services covered by the Canada Health Act include long-term care provided in establishments (nursing home intermediate care service and adult residential care service), home care service, and ambulatory health care service.