THE STRUCTURE, DYNAMICS AND IMPACT OF THE PUBLIC/PRIVATE MIX OF FINANCING ON HEALTH CARE SYSTEMS

30 April 2001

by Colleen M. Flood, Mark Stabile and Carolyn Hughes Tuohy.*

TABLE OF CONTENTS

1. INTRODUCTION

II. HOW DO COUNTRIES DETERMINE THE PUBLIC/PRIVATE MIX?
- **(a) Canada**
- **(b) Australia**
- **(c) Netherlands**
- **(d) US**
- **(e) New Zealand**
- **(f) UK**

III. EVIDENCE ON THE IMPACT OF THE PUBLIC/PRIVATE MIX ON HEALTH OUTCOMES, UTILIZATION, SPENDING, AND WAITING TIMES
- **(a) The Public/Private Mix And Health Outcomes**
- **(b) Country Specific Evidence On Health Outcomes And The Public/Private Mix**
- **(c) The Impact of the Public/Private Mix on Utilization of Health Care Services**
- **(d) The Public/Private Mix And The Impact On Health Spending**
- **(e) The Impact Of Private Financing On Public Health Care Systems**
- **(f) Waiting Times**

IV. CONCLUSION

---

* Respectively at the Faculty of Law, Department of Economics and Department of Political Science, University of Toronto. Email addresses: colleen.flood@utoronto.ca; mark.stabile@utoronto.ca; c.tuohy@utoronto.ca We would like to thank our research assistants Tom Archibald, Andrew Ashenhurst and Tracey Epps for their valuable assistance in preparing this paper. Thanks also to Michael J. Trebilcock for his comments on this paper.

I. INTRODUCTION

In this paper we examine the structure, dynamics, and impact of the public/private mix of health care spending for Canada, the US, the UK, New Zealand, Australia, and the Netherlands. We begin by examining the mix of public and private funding in each country and explain the philosophical approach each country takes in deciding what services to publicly fund and how to ration health care. We look at court challenges by citizens in these countries who are dissatisfied with rationing decisions and we also examine the extent to which these different countries have sought to respond to citizens' concerns through the establishment of Patients' Bills or Charters of Rights. We then examine what evidence there is showing how changes in the public/private mix impact on health outcomes and health care spending and what the impact is of increased private financing on publicly funded health care systems. We specifically address whether or not allowing a two-tier system (where people can access care in the private sector and avoid queuing in the public system) reduces the length of queues for those remaining in the public system.

We have identified four basic models in term of the public/private mix[1] and the countries we are studying provide examples of these four basic models.

1. Parallel public and private systems: For a given range of services, a separate privately financed system exists as an alternative to the public sector. England, New Zealand, and Australia are examples of this type of "two-tier" system where people (who either have the resources or private insurance) can go to private hospitals and jump long queues for treatment in the public sector. The services that are provided in the private sector are primarily elective surgery.
2. Co-payment: Across a broad range of services, financing is partially subsidized by the public sector, with the remainder financed through user charges (out-of-pocket payments) and/or private insurance. The degree of co-payment may be scaled according to the income of the patient. In New Zealand there are significant co-payments for family doctor services – some people have to pay this as a user charge (directly out of their own pocket) but 37% of the population have private insurance helping to cover the cost of the co-payment. In Australia there are co-payments for a range of different services albeit with a complicated system of safety nets in place so as not to deter access by those on low incomes. In the US, the benefits provided under the public programs of Medicaid and Medicare, with a few exceptions, require co-payments.
3. Group-based: Certain population groups are eligible for public coverage; others rely on private insurance. The Netherlands and the US are examples of such a system. However, the Netherlands differs from the US in an important respect as in the Netherlands the majority of people are included in a mandatory social insurance plan whereas in the US most people either hold private insurance or have no insurance.
4. Sectoral: Certain health care sectors are entirely publicly financed; others privately financed. The primary example of this is the Canadian system where almost 100% of hospital and physician services are publicly funded but where there is much more private financing of drugs, gene therapy, home care etc.

It is helpful to keep these models in mind as we proceed with our discussion.

II. HOW DO COUNTRIES DETERMINE THE PUBLIC/PRIVATE MIX?

In this section we provide a detailed breakdown of the public/private mix of financing in each country; explain each country's philosophical approach to health care; and explain how it is decided what services will be publicly funded (making a distinction between explicit and implicit rationing). As publicly funded systems like Canada, New Zealand, Australia, and the UK have increasingly engaged in explicit and implicit rationing of health care dissatisfied citizens are increasingly turning to the courts and we examine court challenges that have occurred to rationing decisions in each country. Another measure that we explore is the introduction of a Patients' Bill or Charter of Rights, particularly insofar as these initiatives speak to patients' entitlements to publicly-funded health care services or timely treatment.

(a) CANADA

i. Public/Private Mix

The most recent spending figures break down total health spending in Canada for the year 2000 are as follows: Federal government direct spending 3.8%, provincial governments 65.2%, municipal governments 0.8%, social security funds (in the Canadian context social security funds refer to Workers' Compensation) 1.2%, and private funds/insurance 29%.[2] Looking more closely at private spending, user charges (out-of-pocket payments) by patients account for approximately 17% of total health care spending.[3] The mix of public and private funding varies depending on the nature of the service. Hospital and physician services are nearly 100% publicly funded but, by comparison, only 35% of spending on drugs and (at most) 75% of spending on home care[4] is publicly funded.

ii. Philosophical Approach

In terms of Canada's philosophical approach to health care, the primary principle is that health care services should be allocated on the basis of need and not ability to pay. The National Forum on Health identified the two most important values in Canada's health care system as equality of access and quality of care.

> The Canadian approach to the provision of health care services continues to receive strong and passionate support. The public does not want to see any significant changes, which would alter the fundamental principles of our publicly administered health care system. They have an abiding sense of the values of fairness and equality and do not want to see a health system in which the rich are treated differently from the poor.[5]

However, there are explicit limits to the principle that care should be allocated on the basis of need and, as described in the introduction, the Canadian system falls within the "sectoral" model in terms of the public/private mix, with certain services being fully publicly funded. The Canada Health Act primarily protects and ensures 100% public funding for hospital and physician services. The foundations of Medicare were laid down in the 1960s when, understandably, hospital and physician care was seen as of key importance. However, since then advents in technology and demographics have seen the rise in importance of drug therapy, gene therapy, home care etc. but the Canada Health Act does not protect or ensure public funding for these goods and services.

iii. Processes for Determining What is Publicly Funded

How does the Canadian system determine what services are publicly funded? Most Canadians view the Canada Health Act ("CHA") as encapsulating their entitlements to publicly funded health care. The CHA is a strong political symbol of Canadian values in health but in legal terms it is a spending statute setting out the conditions upon which the Federal government will make transfer payments to the provinces. The provinces, pursuant to the Constitution, are responsible for operating their own respective health care systems.[6] Through the CHA the Federal government seeks to reconcile its respect for the fact that the courts have interpreted the

Constitution in such a way that health care is largely viewed as a provincial matter with a desire to have national standards. The CHA sets out five criteria that each provincial insurance plan must comply with in order to obtain federal funding: comprehensiveness, accessibility, universality,[7] portability[8], and public administration.[9] Although all the criteria of the CHA are very important and interact together as the principles that guide Canada's health care system we will discuss here just two of the principles: comprehensiveness and accessibility.

In terms of "accessibility" s. 12 of the CHA provides that a province's plan must provide "insured health services" on uniform terms and conditions and in a way that ensures reasonable access. However, the key sections of the Act speaking to accessibility are those that expressly prohibit user charges and extra-billing for medically necessary hospital and physician services. A "user charge" occurs when a patient has to pay out of his or her own pocket to cover some or all of the cost of care. "Extra-billing" occurs where a doctor (or another care provider) charges a patient additional amounts beyond that received from the government and thus the patient must either pay for this difference out-of-pocket (a user charge) or obtain private insurance to cover the difference. The CHA requires the Federal government to claw-back, on a dollar-for-dollar basis, from transfer payments those sums that are paid as user charges or extra-billing in a province. The CHA is very clear about what must happen in the event of the existence of user charges or extra-billing and that financial barriers should not constrain access. However, the CHA has nothing explicit to say about constraining access through waiting or implicit rationing.

In terms of comprehensiveness, section 9 requires provinces to insure "all insured health services provided by hospitals, medical practitioners or dentists." Section 2 defines "insured health services" as "hospital services, physician services and surgical-dental services provided to insured persons...". The substantive content of "hospital services" coverage is set by a specific list of in-patient services[10] that are "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability". "Physician services" are defined as "any medically required services rendered by medical practitioners." The CHA does not define the terms "medically necessary" or "medically required". Thus, provinces have discretion as to which hospital and physician services will receive public funding. The exact range of services that are publicly funded in each province is negotiated between each provincial ministry of health and each provincial medical association although in practice the provinces cover a similar range of services. The results of these negotiations determine what services are publicly funded and these services then become what are "medically necessary" or "medically required." In other words, the phrases "medically required" and "medically necessary" are not used as a principled basis upon which to determine what should be publicly funded but are labels applied ex post negotiations between the Ministries and provincial medical associations. In recent years, provinces have begun explicit rationing of health resources by choosing to "delist" or "deinsure" some health services. In other words, they have announced that certain services will no longer be publicly funded on the grounds that they are not "medically necessary"[11] but this process has not had a significant impact on health care spending.[12]

The vagueness of "medically necessary" and "medically required" allows for implicit rationing to occur under conditions of resource constraint.[13] Although "medically necessary" hospital and physician services may be insured, e.g. hip operations are medically necessary and thus as a general class of service are publicly funded, this does not mean that every Canadian who needs a hip operation will receive it or receive it in a timely fashion. Although the Act requires there be "reasonable access" this is a difficult criteria to measure and thus enforce. Thus there is little in the CHA preventing the provinces from restricting the flow of resources into the public system so that physicians must make increasingly harder choices between patients and their various health needs. One can perhaps see that although the entitlement to a comprehensive range of benefits is a cornerstone value of the Canadian health system, it is subject to erosion by provinces and/or providers operating under financial constraints or competition.

It is important to note that the CHA protects and ensures full public funding for hospital and physician services but not for prescription drugs, home care, genetic tests, medical equipment, etc. When a patient receives care in a hospital or from a physician it is fully publicly funded. But if the patient receives care in his/her own home or from a different health care provider then the patient may have to pay all or part of the cost thereof either out-of-pocket or through their private insurer. As the sites or places of care have increasingly shifted away from hospitals and into homes and communities the way that Medicare is structured has opened the way to passive privatization of the system. This passive privatization process means more and more that care is allocated on ability to pay and not need but it also has regressive effects on the uptake of care that remains fully publicly funded. For example, physician services are fully publicly funded but prescribed medications resulting from a visit to a physician are not. In Canada, individuals consumed, on average, 6.9 doctor's visits per year in 1995. The average Canadian received eight prescriptions per year in 1995, or more than 1 prescription per visit.[14] Stabile compared the use of doctors and hospital services by individuals with private insurance and individuals with no insurance (public or private) and found that those individuals with insurance use 10% more doctors' services than individuals without such coverage.[15] Since access to private drug insurance is highly correlated with income, the impact of these differences on access to care is likely concentrated among the less well off.

iv. Court Challenges

As Medicare undergoes difficult rationing exercises and in some areas falls short of public expectations of speed and quality, citizens are turning to the courts to challenge health policy decisions both through administrative law and under the Canadian Charter of Rights and Freedoms. Physicians[16] have used the Charter successfully to strike down provincial restrictions designed to limit the number of physicians working in a province and/or designed to relocate physicians from urban to rural and remote areas. Patients have also attempted to use the Charter to challenge rationing decisions. Litigants have invoked the equality, "life, liberty and security of the person", mobility, expression, and religious rights and freedoms contained in the Charter. The most prominent cases in this respect are *Eldridge* and *Cameron*.[17]

In *Eldridge*, the Supreme Court of Canada held that the B.C. government's failure to fund sign-language interpreters for the deaf in hospitals as part of the public health insurance plan discriminated against deaf persons. This was because in the absence of interpretation services, deaf people would not be able to access publicly funded hospital and physician services as other Canadian citizens are entitled to (communication being such an important aspect of the doctor/patient relationship.) In *Cameron*, the Nova Scotia Court of Appeal ruled that the Nova Scotia government's decision not to fund infertility treatments discriminated against infertile persons. However, the Court went on to find such discrimination justified under s.1 largely because of the cost of treatment.

A significant Quebec case in 1999, *Chaoulli* c. *Quebec (Procureure generale)*[18], was a direct Charter challenge to that province's prohibition on private health insurance for publicly insured services. Finding as a fact that the health care system in Quebec suffered serious gaps and deficiencies, the prohibitions under attack were found to violate liberty and security of the person. However, after balancing the individual right to choose and access necessary health services against the collective goal of ensuring equal access to all, the Court found these violations to be in accordance with fundamental justice, and thus not in violation of Section 7 of the Charter.

So far then, litigants have not been particularly successful in using the Charter to extend the range of goods and services that must be publicly funded or even in challenging prohibitions on private insurance for services that should be provided in the public system. *Eldridge* is the exception, but in that case it was clear that the hearing-impaired plaintiffs were not asking for any *new* health care good or service but the *means* (interpretation services) to utilize health care services that similarly situated patients without a hearing impairment would have been entitled to.

In two provinces, Ontario and British Columbia, there are administrative tribunals in place to deal with claims that the respective provincial governments should be publicly funding particular treatments. In Ontario, a high profile case involved that of Fiona Webster, who successfully argued before the Health Services Appeal and Review Board[19] that the provincial government should fund the BRCA1 genetic test she required to determine whether she had a predisposition to breast cancer.[20] These kinds of administrative mechanisms provide an outlet for patients' concerns about the breadth of publicly funded schemes and arguably are a much more efficient and fairer mechanism for resolution of these kind of disputes than expensive and protracted Charter litigation.

iv. Patients' Bill or Charter of Rights

No province in Canada has put in place a Patients' Bill or Charter of Rights, although these are under consideration in Ontario, Saskatchewan, Manitoba and Quebec.[21] However, various hospitals and other institutions have their own internal codes of rights for patients and, in some occasions, have appointed individuals who mediate between patients and the institution and providers therein to resolve complaints and concerns.

(b) AUSTRALIA

i. Public/Private Mix

Australia's public/private split on health care mirrors that of Canada's with 69.3% of total health care spending coming from public sources and 30.7% coming from private sources.[22] The Commonwealth (equivalent of Canada's Federal) government accounts for approximately 45% of total health care spending and state and local governments account for 23.4% of total health care spending.[23] Approximately 16.2% of total health care spending come from out-of-pocket payments by patients.[24] Out-of-pocket payments by patients account for a large proportion of spending on pharmaceuticals (46.2%) and non-institutional services like dental care (30.4%). The Commonwealth government's pharmaceutical benefits scheme, which ensures universal access to drugs (albeit with user charges) seems to make private insurance largely unnecessary for drugs. Private insurance accounted for 13% of spending on hospital and other institutional services and 15.8% of spending on non-institutional services.

ii. Philosophical Approach

There is tension within Australia's philosophical approach to the allocation of care. As in most developed countries - with the notable exception of the US - the guiding principle seems to be access on the basis of need and not ability to pay. However, the Australian system is also guided by a historical commitment, which seems to have no basis in principle, to encourage tripartite funding from the government, private insurance and from out-of-pocket payments. The latter two sources of financing are usually viewed as regressive so in order to reconcile the desire to encourage tripartite funding of the system with the goal of redistribution, Australia has a complicated system of safety-nets and exceptions to its requirements for out-of-pocket payments (user charges). There is also a complicated system of direct and indirect public subsidies to the private insurance sector to ensure its sustainability.

iii. Processes for Determining What is Publicly Funded

The relevant legislation provide that Australians are entitled to a benefit of either 75% or 85% of a centrally set schedule of fees for physician services, depending on the service. There is an upper limit on the amount a patient must pay for a service and the legislation provides that the government pay for the entire service less the “greatest permissible gap” (A$50.40) which can be borne by the patient. Concessional patients (people who receive certain pensions, benefits or cards administered by the Departments of Family and Children’s Services or Veterans' Affairs, or who meet certain criteria for being declared to be disadvantaged) are not required to pay anything for physician services.

The Commonwealth government in Australia is more directly involved in administrating the health system than Canada's Federal government and it largely finances and administers physician services. The Commonwealth Minister of Health is empowered to decide which medical services will attract fees and which ones will not. The process of deciding what services will be publicly funded is similar, however, to what occurs at the provincial level in Canada. In Australia, the Minister of Health sets the fee schedule after receiving (non-binding) advice from a Medicare Benefits Advisory Committee (MBAC), which is composed mainly of medical practitioners and after “detailed discussion(s) with the Australian Medical Association (AMA).”[25] Thus as in Canada, what services are publicly funded is largely a matter of negotiation between the Ministry of Health and physician bargaining associations.

With regard to hospital services, as in Canada, the Commonwealth (or federal government) requires states to abide by certain principles in return for funding for hospital services. There are no user fees for treatment at public hospitals so long as the patient accepts an assigned physician.

Unlike Canada, the Australian Commonwealth government administers and finances a national drug plan. With regard to drug coverage, general patients are required to pay up only up to A$20.60 per prescription item up to A$612 per year after which they are required to only pay A$3.30 per prescription item. Concessional patients are only required to pay A$3.20 per prescription item up to annual cap of A$166.40, beyond which prescriptions are free. The Pharmaceutical Benefits Advisory Committee (PBAC) advises the Minister of Health what drugs to include in the national formulary.

iv. Court Challenges

We have not been able to identify any cases in Australia where patients have challenged explicit or implicit limits on the publicly funded system. However, in a recent and high profile case, a major pharmaceutical firm challenged the decision of the Minister of Health not to include Viagra among its list of covered drugs.[26] PBAC had recommended against including Viagra on the basis of medical and cost-effectiveness factors. Pfizer, the drug firm, argued that the PBAC erred in considering cost factors when making its recommendation to the Minister, stating that such factors should only be considered by the Minister after receiving the PBAC’s recommendation based on medical effectiveness factors. In the result, Pfizer lost, with the Court reasoning that the PBAC did not err in considering the cost-effectiveness of the drug. Recently, Australia has joined

South Africa (and other countries) on the Pharmaceutical Research and Manufacturers of America "WATCH LIST" of countries judged hostile to multi-national pharmaceutical industry profitability.

iv. Patients' Bill or Charter of Rights

Each state in Australia is required to establish a "Public Patient's Hospital Charter" (PPHC) and a complaints body. The Tasmanian PPHC is typical of the kinds of rights that are protected and provides for a right to give an informed consent ("(t)o be given a clear explanation of proposed treatment including risks and alternatives, before you decide whether you will agree to the treatment"); and the right to confidentiality ("…information about your hospital care will be confidential unless the law allows otherwise").[27] As can be seen, the PPHCs tend to list rights (such as informed consent and the right to confidentiality) which already exist in the common law or are already required on the part of health care professionals through their own ethical codes and enforced through the self-regulating colleges. These Charter of Rights do not speak to patients' entitlements to access publicly funded care nor to timeliness.

To ensure the safety of private patients, Australia's Commonwealth government created a Private Health Insurance Ombudsperson in 1995.[28] The Ombudsperson can deal with complaints, investigate, make recommendations to the Minister of Health and publish information about complaints against private insurers.[29] This and other initiatives need to be taken into consideration as Canada considers how best to regulate its own growing privately financed sector and ensure fair access and treatment.

(c) NETHERLANDS

i. Public/Private Mix

The mix of funding for health care in the Netherlands is as follows (1998 figures): Exceptional Medical Expenses Scheme (36%), Sickness Fund Scheme (35%), private health insurance (15%), governmental (5%) and other sources (including patient co-payments) – 9%.[30] The mandatory Exceptional Medical Expenses and Sickness Fund schemes are funded through employer and employee contributions. The OECD records the percentage of public spending of total health care spending at 70.4% for 1998.[31] However, this figure misrepresents the Dutch government's role for the figure includes within it the mandatory social insurance schemes which are financed by employer and employee contributions and not through general taxation revenues. The government has only a very minor role in directly financing the system (accounting for between 4% and 5% of total health care spending). Indirectly the government does have a significant role in the system by requiring certain groups to buy insurance and by regulating social and private insurers. Compared to other countries, only a relatively small component of health care (7%) is financed by user charges (out-of-pocket) payments.[32] Thus, the Dutch system is not publicly funded but it is nonetheless progressively funded, as most contributions are set as a percentage of an employee's salary and the role of user charges (out-of-pocket payments) is small.

ii. Philosophical Approach

Scholars often describe the philosophical approach of the Netherlands to the allocation of health care as one of "solidarity." There is a strong commitment to ensuring access to health care on the basis of need and not ability to pay. This *prima facie* seems surprising given reliance in the Netherlands upon private insurers, which are generally viewed as a regressive means of financing health care. However, the Dutch are much more open to using regulation of private insurance to ensure the goal of solidarity and whilst committed to progressive funding are not committed to public funding for its own sake. Also it is very important to note that having private insurance in the Netherlands does not allow people to jump queues. It is seen as against a physician's ethical code to prefer a patient with private insurance to a patient without and both kinds of patients are treated side-by-side in the same hospitals.[33]

iii. Processes for Determining What is Publicly Funded

Despite its apparent reliance on private insurance, nearly 100% of the population of the Netherlands has health insurance coverage and the range of services covered is more generous than in Canada. There are three important government-mandated insurance schemes. The "Exceptional" or "Catastrophic" medical expenses scheme covers the entire population for long-term care and mental health care. The Sickness Fund scheme ensures coverage for about 64% of the population earning less than 64,600 Guilders (one guilder is worth approximately 0.65 Canadian dollar)[34] and covers the cost of hospital and physician services, drugs, and home care.[35] Finally, the Civil servant scheme is mandatory for all civil servants (approximately 6% of the population)[36] and covers all medicines and related products and hospital treatment and pays 80 to 90% of other health care costs.[37] In addition to these three government mandated schemes, the government also regulates private insurers to prevent them risk rating premiums in order to avoid the result of unaffordable premiums or no coverage at all for high-risk individuals.[38] The benefit package offered by private insurers in the Netherlands is similar to that offered by the non-profit Sickness Funds.[39]

How do the Dutch determine what services will be covered by the compulsory social insurance plans? As in Australia and Canada, this has largely been a process of contractual negotiations between payers (social and private insurers) and physician bargaining associations. However, the Dutch have attempted to develop a filtering mechanism to aid the determination of what services should be included in the mandatory social insurance schemes. In 1992, the Government Committee on Choices in Health Care (known as the Dunning Committee after its Chairman) argued for a more careful evaluation of what would and would not be included in the basic package of services covered by the proposed compulsory basic insurance plan for all citizens.[40] The Dunning Committee proposed that four criteria be used to effectively sift out those services that should not be included in the basic package of care. These criteria were as follows: first, that the community in general considers the care to be necessary; second, that the services are effective; third, that the services are efficient using cost-effectiveness analyses or cost-utility analyses; and, finally, that it is not appropriate for patients themselves to pay for the health services in question. It was proposed that care that did not meet the four requirements be left to the unregulated private sector.[41] Political pressures seem to have frustrated attempts to systematically implement rationing using the Dunning criteria. For example, the Dutch Consumers Association was successful in having Parliament reinstate coverage for the cost of dentures to both Sickness fund and standard private insurer packages.[42] However, as discussed further below, the courts have sometimes turned to the Dunning criteria to justify rationing practices.

iv. Court Challenges

Apart from explicit rationing by excluding certain services from the mandatory social insurance schemes, implicit rationing can occur through limitations on the budgets of institutions and health care providers, who are then required to make choices between different patients' health care needs. Dutch courts have shown some sympathy for patients who are denied care because of excessively budget-conscious institutions, but have been reluctant to nullify contractual budget targets (especially where they are viewed as reasonable) or require treatment where an insurer does not have a contract with the institution in question.[43] According to Dutch scholars, Hermans and den Exter, Dutch courts, "attach much importance to the Dunning criteria – in particular the necessity criterion."[44] For example, the courts have decided that citizens are not entitled to coverage for services simply because they are available and appropriate.[45] This experience suggests that Canada should consider the benefits of having a principled approach to determining the scope of what will be publicly funded rather than relying on negotiations between provincial ministries of health and bargaining units of physicians.

v. Patients' Bill or Charter of Rights

The Netherlands has a complex web of patient complaint and appeal procedures designed to bring accountability to the decisions of all social and private insurers. The appeal route depends on the nature of the complaint as well as the insurer in question. Patients' first recourse for complaints about entitlements to coverage or quality of care under the mandatory social plans (the Exceptional Medical Expenses, the Sickness Fund, and the Civil Servants plans) is to the Board of the relevant social insurer. In certain cases, the insurer's Board is required to consult with an external Health Care Insurance Board in arriving at its decision on the complaint. Patients receiving an adverse decision from their insurer may then appeal to administrative agencies set up by the government to review insurers' decisions. This may mean an appeal to the Central Appeals Tribunal (in the case of Sickness Fund appeals), and in some cases to the National Ombudsman. Under the private insurance plans, the main recourse for complaints is the civil courts.[46]

(d) US

i. Public/Private Mix

Government programs in the US, federal and state combined, comprised 43.6% of health care spending in 1998. Private health insurance comprised 33.1%, out of pocket payments 19.6%, and other private funds 3.7%.[47] As of 1997 about 71% of people had some form of private health insurance, with some 92% of private coverage provided through employment relationships.[48] This split has remained fairly stable since 1994.

There are two significant public programs, Medicare and Medicaid. Medicare is a federally funded health insurance plan available to persons over 65, some of the disabled and those suffering from permanent kidney failure. All benefits attract a mix of co-payments, co-insurance, user-charges or deductibles.[49] Medicaid is a federal/state entitlement program that pays for medical assistance for some of the poor (the cut-off level being determined state by state basis). To be eligible for federal funds, States are required to provide Medicaid coverage for individuals who receive federally assisted income maintenance programs. The amount of federal funding for Medicaid has no set limit, rather the federal government matches what individual states provide.[50] The scope of coverage under the Medicaid plan varies considerably from state to state.

The private share of spending depends on the nature of the health service in question. Prescription drugs, for instance, remain primarily privately financed although the public share has been gradually increasing. In 1998, public spending accounted for only 15.4% of spending on drugs, though this is up from the 1990 figure of 10.9%,[51] and still well below the OECD average of 57.6% of public funding for drugs (1997). For inpatient institutional medical services, the U.S. private share is much less, though still much higher than the OECD average. In 1998, 60.8% of inpatient spending was public financed, up from almost 54% in 1990.[52]

ii. Philosophical Approach

The overarching philosophy in the US with respect to allocating health care is best described as minimalist. Rights to public funding of a minimally necessary set of health services are confined to specific disadvantaged groups – those over 65, the elderly, the terminally ill and some of the disabled. This is in contrast to the Canadian system and nearly every other developed country in the world where all persons, regardless of status, are entitled to a basket of medically necessary hospital and physician services without out-of-pocket payment. In the US, people who do not belong to these groups must rely on private insurance or their own financial resources to pay for health care. Consequently, the US leaves a significant proportion of its population (16.3%)[53] without the security of any health insurance.

iii. Processes for Determining What is Publicly Funded

Whilst both Parts A and B of Medicare (the public program for those over 65) offer a wide range of benefits, albeit subject to various forms of copayments, deductibles and user charges, some services are not covered by Medicare at all. These include drugs outside of institutions, dental care, cosmetic surgery, custodial care in the home or nursing home, routine physical examinations, routine eye care, some vaccinations and some preventive screening tests.

Medicaid, the public insurance program for the poor, allows each state to set its own eligibility standards, determine the type, amount, duration, and scope of services, sets the rate of payment for services and administer its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. However, a state's Medicaid program *must* offer medical assistance for certain *basic* services to the most categorically needy populations.[54] States may also, with certain exceptions, impose nominal deductibles, coinsurance, or co-payments on Medicaid.[55]

Oregon received dispensation from the federal requirement of coverage of certain basic services for its Medicaid program as part of an experiment designed to increase the number of people who could be covered by Medicaid by rationing the range of services to be publicly funded. Oregon’s unique reforms to its state Medicaid program have attracted attention because of its explicit public process for determining the scope of Medicaid entitlements.[56] The Oregon Basic Health Services Act, passed in 1989, was designed to extend coverage of the Medicaid package in Oregon to include all those at or below the poverty line, primarily by means of explicitly rationing the services provided.[57] In determining what priorities should be given to different health care services in the standard package, the Oregon Health Service Commission solicited public input through consultation.[58] The priorities accorded to services as a result of this process were the subject of much criticism. In particular, health care providers criticized the fact that low cost treatments were ranked over life-saving treatments.[59] Health providers were particularly concerned that the ranking violated the ethical "rule of rescue" requiring physicians to act in the case of a life-threatening situation. As a result of these criticisms the Commission recompiled the list of priorities using a methodology that largely eliminated cost considerations and diluted the influence of public input.

Between 1990 and 1997, the percentage of uninsured Oregon residents dropped from 18 to 11%, As well, there were significant drops in the levels of uncompensated care in hospitals.[60] The end result of the Oregon process was that essentially the same package of benefits that had previously been available to Medicaid recipients was extended to more people -- in other words few if any services were dropped from the list to be publicly funded. It seems that if the process of rationing is made explicit that there is little political will to actually enforce rationing principles. Although these results do not render the Oregon experiment an unqualified success, the political consultation model of rationing it embodies still represents an important innovation in how states make difficult choices between cost and quality.[61]

v. Court Challenges.

Since the advent of managed care there have been numerous cases challenging limitations by insurance companies on the range of health care services supplied. Initially it was difficult for patients to attach liability to managed care organizations (MCOs) in malpractice actions and patients were left with recourse only to the physician or other health care provider. However, as MCOs have undertaken increasingly pivotal roles in decisions affecting the delivery of health care, judges have begun to impose liability as incentive payments and other aspects of the inner workings of MCOs are better understood. The result has been that MCOs are now being held liable for failure to manage the care that they arrange.[62]

Class actions against MCOs are emerging as well. In late 1999, a large number of new class action lawsuits covering over 32 million managed care enrollees were launched against several large MCOs.[63] The actions, brought under federal anti-racketeering legislation, allege that the MCOs promised a certain level of quality but knowingly failed to deliver it by denying needed services in order to increase profits. Among the allegations are that the MCOs apply pressure through financial incentives for physicians – often hidden from the patient – in order to cut costs by rationing medical services on the basis of available resources as much as on medical need. Clearly these kinds of large class actions, if successful, may have a huge impact on the development of managed care in the U.S.

As well, there have been court challenges to rationing on the part of various Medicaid programs. Some of the challenges have centred on arguments that the state in question has violated the federal Medicaid funding requirements; however, these kinds of challenges are generally unsuccessful as the federal requirements afford states a wide discretion.[64] Other challenges have focused on constitutional rights to equal treatment but do not seem to have met with great success.[65]

vi. Patients' Bills or Charters of Rights

On the tail of the managed care revolution has been a flurry of federal and state legislation aimed at protecting those with insurance from limitations on access to and diminishment in quality of health care. It should be noted that these regulatory measures do not promote any kind of universal right to medically necessary health services but rather comprise a set of consumer rights protecting those who already have private insurance.

Explicit rationing by managed care plans regarding the scope of coverage, duration of benefits, premiums, and choice of providers is regulated – mostly at the state level - by legislative minimum standards as well as by "Patients' Bills of Rights" in many states. Where managed care plans give incentives to health care professionals to contain costs, *implicit* rationing may occur.[66] This rationing is more difficult to regulate, although measures have been proposed and adopted to attempt to ensure a proper balance between medical necessity and cost factors in the patient-provider relationship.[67] For example, 48 of the 50 States prohibit the use of "gag clauses" which is where managed care plans prohibit physicians from discussing matters like treatments not covered by the plan, attempted referrals from the doctor that were refused by the plan, and financial incentives under which doctors deliver care.[68]

(e) NEW ZEALAND

i. Public/Private Mix

The New Zealand system is predominantly publicly funded but the share of public funding has been declining. In 1980, public spending comprised 88% percent of total health care spending[69] but had declined to 77.1% by 1998.[70] The decline in the public share of health spending was the most dramatic in the OECD.[71] Of the privately funded share of expenses, the share paid by private for-profit insurance has been increasing slightly from 6.1% in 1994 to 6.8% in 1997. In the period 1980 to 1998/9, the contribution of out-of-pocket payments by patients to total health care spending increased from 10.4% [72] to 15.9%.[73]

Average statistics conceal the fact that there is variation between health care services with respect to the public/private mix. For example, in 1998/99, the government contributed almost 100% of public hospital spending yet only 61% of community care (personal care including family doctor visits) spending.[74] In the year ending June 1999 the sums paid out-of-pocket by patients amounted to approximately 28% of drug spending, 30% of spending on family doctor visits and 58% of specialists' visits.[75] Although overall still a small proportion, private insurance plans a more important role in the funding of <u>particular</u> health care services such as non-emergency surgical services, specialist services, and family doctor charges.[76]

ii. Philosophical Approach

The philosophical approach to health care in New Zealand is that care should be allocated on the basis of need and not ability to pay. However, there are limitations to how far this principle is applied. First there is a long entrenched system of user charges for family doctor services. And second a "two-tier" system is allowed so that individuals with sufficient resources or private insurance can receive specialist care or elective surgery in the private sector and jump long queues in the public system.

iii. Processes for Determining What is Publicly Funded

How is it decided what is in and out of the publicly funded sector in New Zealand and by what processes is health care rationed? New Zealand law does not explicitly recognize a right to receive publicly funded health care,[77] however, the provision of publicly funded care is something that society has long seen as desirable and that governments have sought to make available. There is, however, a crucial distinction between the funding of hospital services and the funding of medical services. Family doctors have retained the right to charge patients whatever they wish for their services over and above whatever subsidy/payment is made by the government.[78] Since 1941, government subsidies have failed to keep pace with the charges fixed by family doctors and an increasing proportion of this care has been privately financed. Also people who wish to avoid long queues for specialists' services or elective surgery can buy care in private hospitals. Apart from rationing by way of price, implicit rationing also occurs. Successive government have restricted the flow of public resources into the public system and have relied on implicit rationing whereby physicians allocate these limited resources across the various health needs.[79]

The 1993 internal market reforms saw the introduction of explicit rationing and an attempt to develop a more principled approach to what services would be publicly funded.[80] A National Advisory Committee on Core Health and Disability Services ("the Core Services Committee")[81] was created and charged with giving independent advice to the Minister of Health on which core services should be purchased, how they should be distributed, and the terms of access on which they should be available. It was initially thought that the health and disability services that should be publicly funded could be identified in a list. To this end, the Committee consulted consumers and providers around New Zealand. However, by October 1994 this approach was rejected,[82] the Committee having determined that compiling such a list would be complex, time-consuming, expensive and divisive.[83] Instead, it recommended to the government that the then publicly funded health and disability services become the core, such services representing the “values and priorities of several past generations of New Zealanders”.[84] It also recommended the development of guidelines and clinical assessment criteria to help define when a new service was of sufficient clinical benefit to warrant public funding. The most recent raft of reforms being implemented by the Labour/Alliance government retains the concept of explicit rationing. The New Zealand Public Health and Disability Act 2000 provides that the Minister of Health can appoint a national advisory committee on health and disability which will be charged with the task, among others, of advising the Minister on “the kinds, and relative priorities, of public health services, personal health services, and disability support services that should, in the committee’s opinion, be publicly funded.”[85] The lesson for Canada from this experience seems to be that whilst attempting to define a fixed list of services to be publicly funded is likely to fail it is more fruitful to put in place processes to determine priorities in health care spending.

iv. Court Challenges

As in other jurisdictions, the introduction of explicit rationing has resulted in some court challenges in New Zealand. The most contentious case involved a 63 year old man, Rau Williams, suffering from renal failure, diabetes, and dementia, who was denied access to renal dialysis treatment by a Regional Health Authority (Northland Health.) [86] A relative of Mr Williams' applied to overturn this decision but was unsuccessful both in the High Court and the Court of Appeal, with the Court of Appeal finding that there was no resource element in the Health Authority's decision; rather, it was a case about the appropriateness of a clinical decision.

The case generated a large amount of public interest and debate. Examples of media statements include the following:

> “Two top kidney doctors say the refusal to give Rau Williams renal dialysis is a rationing decision … Mr McKeown’s renal physician is also reported as saying: Northland’s explanation that Mr Williams was denied treatment on purely clinical grounds … is only 80% of the story.” (Sunday-Star Times, 5 October 1997)[87]
>
> “The Rau Williams case was not about resources but about appropriate medical care; the two issues become thoroughly muddled in the public mind. And the hard facts are that money, for any area of public expenditure, including health care, is limited … There will always be greater calls on the public purse than that purse can, or should, dispense.” (Evening Post, 13 October 1997)[88]

This case and the media commentary around it highlight the murky divide between “clinical decisions”, “resource allocation”, and “rationing”.

v. Patients’ Bill or Charter of Rights

The Code of Health and Disability Services Consumer Rights came into force on 1 July 1996. The Code prescribes ten rights: the right to be treated with respect; the right to freedom from discrimination, coercion, harassment, and exploitation; the right to dignity and independence; the right to services of an appropriate standard; the right to effective communication; the right to be fully informed; the right to make an informed choice and give informed consent; the right to support; rights in respect of teaching or research and the right to complain. These rights are largely rights that are already recognized at common law and in medical codes of ethics. A Health and Disability Commissioner is charged with promoting the rights of consumers and investigating potential breaches of the Code. An awareness survey in 1999 showed that there had been a steady increase in public awareness of the Code and of the role of the Commissioner.[89]

(f) UK

i. Public/Private Mix

Although the percentage of health care paid for by the public sector has declined, the UK still has one of the higher percentages of health care services paid for by the public sector in the OECD. Although the percentage of health care paid for by the public sector has declined the UK still has one of the higher percentages of public funding in the OECD. In 1999, government funded 84.2% of total health care spending.[90] Of total health care spending, approximately 3.5% is attributable to private insurers and 11% to out of pocket payments by patients. Private insurance and out of pocket expenses fund private elective surgeries (so those with private insurance can avoid long queues in the public sector), as well as user charges for pharmaceuticals, eye and dental care. For pharmaceuticals, however, 60% of the population are exempt, because of their low incomes or because they are defined as chronically ill, from user charges (and over 80% of prescriptions are dispensed to those who are exempt.)

ii. Philosophical Approach

The philosophical principle of the UK's National Health Service (NHS) has long been that care should be allocated on the basis of need and not ability to pay.[91] Legislation requires that the Secretary of State, to such extent as he or she considers necessary to meet all reasonable requirements, has a duty to *provide* (and not merely insure) hospital and other like accommodation, medical, dental, nursing and ambulance services, maternity and young child care, preventative, acute and convalescent care, and services required for the diagnosis and treatment of illness. However, there is no guidance about how health care services should be allocated or prioritized amongst different health care needs.

iii. Processes for Determining What is Publicly Funded

On what basis does the UK decide that health care services will be publicly funded? In terms of how resources are allocated, the UK system has historically relied on implicit rationing by physicians as ‘gatekeepers’ to the health care system.[92] It has also relied on implicit rationing through Health Authorities and public hospitals having to work within the confines of a capped annual budget. More recently, however, there has been a shift to more forms of explicit rationing by centrally determining how to rank priorities in health care spending. In 1992, the government issued the White Paper “Health of the Nation" setting out the government's health strategy and identifying key areas for action by the NHS and others. This strategy set national and local health targets in five key areas. In 1998, the Labour government introduced a new policy, which set health targets to be met by the year 2010. The newly created National Centre for Clinical Excellence is also meant to issue evidence-based guidance on the cost-effectiveness of selected services and will recommend whether or not such services should be used across the country.

iv. Court Challenges

As in other jurisdictions, explicit rationing decisions have been the subject of court challenges with patients bringing judicial review actions to challenge funding decisions. *R v. Cambridge District Health Authority Ex Parte B,*[93] involved a 10½ year old girl who had been given six to eight weeks to live and the doctors treating her were of the opinion that she should be given no further remedial treatment. B's father sought the opinion of two further medical experts, both of whom were of the opinion that further treatment (including a second bone marrow transplant) was possible. However, because of the unavailability of beds in the only NHS hospital prepared to carry out such treatment the treatment could only be provided in a private facility. B's father requested therefore the Health Authority responsible for his daughter's care to allocate funds for the treatment in this private facility. The Health Authority refused. The court held that while the Health Authority owes a statutory duty to provide medical services, there is discretion as to how that duty is to be fulfilled. Nevertheless, the father's action was successful to the extent that the Health Authority, while not ordered to fund the treatment, was required to reconsider its decision on several grounds. One of these grounds was that the Health Authority had referred to resource constraints but had not adequately explained the funding priorities that had led to its decision.

Explicit rationing by a Health Authority was the subject of litigation in a more recent case, *Regina v. North West Lancashire Health* Authority. In this case a legal challenge was made in response to the Health Authority's refusal to pay for gender reassignment surgery following its allocation of a low priority to such surgery, which it considered achieved little or not clinical gain.[94] The Court of Appeal applied the decision in the *Cambridge* case, noting Sir Thomas Bingham M.R's statement that the courts "will not seek to allocate scarce resources in a tight budget but will ensure that the health authority has asked the right questions and has addressed the right issues before arriving at a policy that is lawful". On the facts, the court found that the Health Authority had failed to take relevant matters into consideration in allocating a low priority to gender reassignment surgery. Such matters included the question of what is a proper treatment or what is recognized as the illness involved in gender identity dysphoria. Rather, the decision had been made by taking into consideration irrelevant matters. The Health Authority was ordered to reformulate its policy accordingly.

These English cases suggest that whilst courts will be respectful of public authorities taking decisions in the context of constrained public resources, they will not simply accept the argument of constrained resources and will wish to be assured that the public authorities have a principled basis for resource allocation.

v. Patients' Bill or Charter of Rights

A UK "Patients' Charter" was introduced in 1992, with the aim of improving the quality of health service delivery. The Charter published standards of service that people should expect and in doing so, emphasized quality improvement and the attainment of specific service delivery standards such as maximum waiting times. The Charter included broad guarantees at the level of principle, such as the right to "receive health care on the basis of clinical need, regardless of the ability to pay." The one statement in the Charter that entailed an identifiable standard related to waiting lists. Patients were "to be guaranteed [hospital] admission for treatment for a specific date within two years", subsequently reduced to eighteen months and then to a target of twelve months for some procedures. In addition to "rights" the Charter also set out nine "standards" including respect for privacy, dignity, and religious beliefs, and also in relation to waiting times, such as a guarantee of being seen within thirty minutes in an outpatient clinic. However, while the Charter provided a complaints mechanism, it did not create legally enforceable rights.

The Charter has now been replaced by a NHS "Guide", which tells patients what they can expect.[95] It is a guide to patients' rights, responsibilities and highlights the standards and services people can expect from the NHS, including how long a patient can expect to wait before receiving treatment.[96] It also includes what patients can expect in the future, for example, from 2002, if an operation is cancelled on the day of surgery, the hospital will have to offer another date within the next 28 days for the treatment in the hospital of the patient's choice. As with the Charter that preceded it, the guide provides for patients to make complaints but does not create legally enforceable rights that did not already exist.

As Canada considers how to ensure citizen satisfaction with Medicare and enhance the accountability of the system to the people it service, policy-makers should consider in more detail the UK's experience with a Charter of Rights. In particular policymakers should consider the assurances regarding waiting times, which has been an issue of acute concern in Canada in recent years.

III. EVIDENCE ON THE IMPACT OF THE PUBLIC/PRIVATE MIX ON HEALTH OUTCOMES, UTILIZATION, SPENDING, AND WAITING TIMES

(a) The Public/Private Mix And Health Outcomes

In this part or our paper we turn to examine cross-country evidence on the correlations between health status and public/private spending. We look at four measures of health: life expectancy, infant mortality, the incidence of cancer in the population, and potential years of life lost from all causes[97] and construct three summary measures of spending:

1. how total spending on health as a percentage of GDP is correlated with each of these measures of health status:
2. how the share of public expenditure on health as a percentage of GDP is correlated with each of these measures.
3. how the share of private expenditure on health as a share of total health expenditures is correlated with each of these health outcomes. These are simple single year correlations that do not control for other variables such as the country's income or GDP, age distribution, and spending on other areas of public health. The data come from the OECD statistics on each of these measures.

Evidence from a selection of OECD countries confirms the difficulties in associating health care spending, whether private or public, with health outcomes. For female life expectancy we calculate that there is a positive and statistically significant correlation between total health care spending as a percent of GDP and life expectancy. For males, while the relationship is still positive, it is not statistically significant. We find no correlation between private health care spending as a share of total health care spending and life expectancy for either males or females. For infant mortality, we find, on average, that there are fewer infant deaths in those countries where health spending, as a share of GDP is greater. For the incidence of cancer in the population we actually find higher levels of cancer in those countries with greater health care spending as a share of GDP. Finally, for potential years of life lost, we find no correlation between health spending as a share of GDP or measures of public health spending and potential years of life lost. These correlations are presented in Table 3. We do find some evidence that public spending on health as a share of GDP is correlated with better health outcomes. However, this result may be partly capturing the fact that public spending on health care is also correlated with spending on "public health" in a number of other areas that contribute significantly to the health status of the population such as education, housing and income redistribution. To investigate the relationship between private/public spending and health care further, we now turn to country specific studies that examine policy changes in health spending. These studies are much more likely to provide results that can be interpreted as a causal relationship between public/private spending changes and health care outcomes.

(b) Country Specific Evidence On Health Outcomes And The Public/Private Mix

Looking more closely at the structure and dynamics of various health care systems can provide considerably more insight of the implications of various forms of private spending on the health of the population and its use of health care services. We begin by examining evidence on out-of-pocket payments for health care services. Out-of-pocket payments (user fees) are often suggested as a way to increase private resources within the health care system and as a way to decrease frivolous or unnecessary use of health care services. The literature on cost-sharing and health outcomes in developed countries is somewhat limited since out-of-pocket payments play *on average* a small role in financing most systems. User charges (out-of-pocket payments) by patients accounted for a mere 2.7% of total health care spending in the UK (1995 figures). By comparison, in 1998, user charges accounted for 17.7% of total health care expenditures in the US, 22.9% in New Zealand and 5.9% in the Netherlands.[98] The 1998 figures are not available for Canada, however, the 1997 figure was 17.1%.

The US and New Zealand stand out as two exceptions with large levels of cost sharing for primary care (family doctor services, etc.) and we summarize the relevant literature from the experience of these two countries as well as research on cost-sharing conducted in Canada. We focus on the US and New Zealand below for two reasons. First, given that the US has the highest proportion of out-of-pocket payment of the countries we examine, much of the research in this area has focused on this system. Second, the research which focuses on New Zealand has explicitly examined how user charges affect the first point of contact with the health system: the family doctor. As in Canada, New Zealand uses family doctors as gatekeepers for the rest of the system. If user charges prevent individuals from seeing their family doctors, they will also prevent individuals from accessing other parts of the health care system. Despite Australia's high level of out-of-pocket payments, we do not focus on Australia here as most Australians who are considered unable to afford user charges are exempted from paying them (Concessional patients[99] are exempted from user fees for physician services).

A large study of cost sharing in the US suggests that increasing cost sharing decreases the number of health care services that people use. [100] The biggest greatest difference in use of health care was found between those people who pay nothing out-of-pocket and those who have to pay anything out-of-pocket. The exception to these findings was hospital admissions of children, where it was found that even where people had to pay out-of-pocket there was no difference in the number of admissions. For those people above the poverty line in the US, increases in out-of-pocket payments did not seem to have any measurable effect on health outcomes. Evidence from expansions in the Medicaid program for poor children in the US suggests that reducing out-of-pocket payments increases the use of preventive care and decrease adverse health outcomes for children.[101] Evidence from New Zealand also suggests that user charges are barriers to access. In New Zealand, most people have to pay the full cost of a visit to their family doctor (although 37% of the population have private insurance to help cover these costs.)[102] There are government subsidies in place for those on lower incomes and those with chronic illness but they still only cover about half of the fee charged. In a 1997 study, Grant *et al.* found that user charges are barriers to access for some sectors of the population, and that New Zealanders are less able to access basic primary care than the British, Canadians or Australians. [103]

Additional evidence from Canada further supports the hypothesis that user charges or co-payments affect utilization and that there is a disproportionate impact upon those with lower incomes. A Saskatchewan study from the 1970s on user charges for physician services showed that utilization declined among lower income groups but actually increased among upper income groups during a period in which co-payments were in effect.[104] Barer, Evans and Stoddart have argued that these results can be attributed to the behaviour of physicians, who sought to compensate for declining demand from lower-income individuals by inducing higher levels of utilization by less price-sensitive upper-income individuals.[105]

Out-of-pocket payments play a much larger role in the prescription drug market than in Canada than in other parts of the health care system. 88% of Canadians have some form of prescription drug coverage (69% are covered by private plans and 19% by government), but almost all plans, be they private or public, include deductibles and and/or co-payments.[106] Among provincial public plans, the trend over the past 10 years has been towards increasing user charges to help control drug expenditures. A study of the Quebec provincial drug plan found that user charges reduced both the utilization of medications and the health of beneficiaries. For lower income individuals - those receiving income security payments - prescription drug use fell by 14.7%. The Tamblyn Report notes the possibility that individuals have died in Quebec due to lack of medication.[107]

What lessons are there for Canada as it considers whether or not introducing user charges (out-of-pocket payments) as a way of trying to ensure the sustainability of Medicare? User charges will reduce the use of health care services and this may produce some savings. However, the reduction in use will take place disproportionately amongst those on lower incomes. While user charges are unlikely to affect the health outcomes of the relatively well off, they are likely to negatively affect the health outcomes of children and the poor. Therefore, if user charges are introduced there needs to be careful consideration of how to ensure that children and those on lower incomes are not deterred from getting the care they need. Lessons may be taken from Australia here which has a complicated system in place ensuring that Concessional patients (those on lower incomes) are immune from having to pay out-of-pocket costs. It should be kept in mind, however, that implementing a system of user charges and accompanying safety nets will increase the administrative costs of running the system. These latter costs may indeed outweigh any cost savings.[108]

(c) The Impact Of Public/Private Mix On Utilization Of Health Care Services

Health care spending is a function of the price paid for health services and the quantity of services used. Countries which have higher levels of spending could simply be paying higher prices for a given quantity and quality of services or could be consuming more of those services at the same prices. Evidence comparing the use of family doctors in Canada versus the US suggests that it is primarily the former. As the data in Tables 1a and 1b suggest, the US spends considerably more on health care, including on primary physician care. Researchers examining the source of these differences concluded that Canadians do not receive fewer primary physician visits than their American counterparts, in fact, they appear to go to their family doctors more often than the average American.[109] Further evidence comparing hospital expenditures in Canada versus the US reaches similar conclusions. A study published in 1988 by Newhouse, Anderson and Roos concludes that despite large differences in expenditures between the two countries, Canadians do not spend less time in the hospital than Americans; in fact they tend to spend longer as inpatients, on average.[110] A study published in 1998, comparing back and neck hospitalizations in the province of Ontario and Washington State, found that surgical back and neck hospitalizations were three times as common in Washington. However, medical hospitalizations were twice as common in Ontario and people in Ontario were hospitalized longer for both surgical and non-surgical hospitalizations.[111] Thus the evidence tends to suggest that Americans receive higher volumes of surgical and intensive kinds of care but that Canadians receive higher volumes of primary and preventive care.

What should Canada conclude from the evidence on service volumes and private spending? Increasing private spending will not necessarily increase the amount of care Canadians receive. In fact, it appears that Canadians already receive the same level of care, if not more care, as do Americans. However, private spending is likely to affect shift the mix of services that are performed on patients towards more expensive technologies and increase the price paid for services.

(d) The Public/Private Mix And The Impact On Health Spending

Among the OECD countries we investigate, the UK has the largest share of public financing of health care expenditures, comprising 84% of all health care expenditures (OECD). Among the countries examined, the UK also spends the least on health as a fraction of GDP (5.8% in 1997). On the other extreme the US finances only 46% of health care expenditures publicly and spends the most on health care as a fraction of GDP (13.9% in 1997). While it would appear that there is a negative correlation between public financing and total health expenditures as a percent of GDP, this relationship is primarily driven by the US and does not hold if we examine a larger number of OECD countries excluding the U.S.[112]

Comparisons across OECD countries have found some support for the hypothesis that predominately public payers are able control growth in health expenditures better than predominantly private payers. Research by Globerman and Vining looks at the relationship between the public share of health care financing in 1980 in OECD countries and the extent to which health care price inflation exceeded general inflation between 1980 and 1996. Their findings suggest that the higher the public share of financing the lower the increase in prices, supporting the hypothesis that public payers keep prices down[113].

What lessons are there for Canada when we look at differences in the public/private mix and health care spending? There is evidence to support the idea that more public spending is associated with a better capacity to restrain growth in overall health care spending. Thus as Canada considers whether to expand its Medicare program to include home care and prescription drugs it is important to note that whilst this may mean more costs for the public sector it will likely result in an overall better capacity to restrain growth in total (public and private) health care spending.

(e)The Impact Of Private Financing On Public Health Care Systems

In considering the effects of private financing on a health insurance system, a particularly important question is whether as countries increase private financing to their health care system there are corresponding decreases in the amount of public money spent on health care. In the economics literature this is referred to as “crowding-out” taken from the idea that, in this case, private money crowds out public money instead of simply adding to the total funds available for health care.

To attempt to answer this question, Tuohy, Flood, and Stabile examined changes in private health spending within each of 24 OECD countries over a period of 17 years and the corresponding changes in the share of the total public budget that was spent on health care over this same period.[114] While the evidence does not definitively show that increases in private financing caused a decline in public financing the results do show that over a 17 year span, across these 24 countries, increases in the private share of health care spending are consistently associated with a decline in public spending on health as a share of total public spending. The decline isn't a dollar for dollar decline, but the numbers suggest that for every $10 of private money put in the health care system, there is a decline, on average, of about $3 of public funding devoted to health care. A more detailed examination of hospital and pharmaceutical spending in particular revealed that while there is no correlation between increases in private spending and declines in public spending in the hospital sector there is evidence of such correlations within the pharmaceutical sector. This finding, which is consistent with "crowding-out" of public money by private money in the pharmaceutical sector is not surprising. Most public drug insurance programs involve private co-payments, and most increased the level of co-payment in the 1990s. In this sense the substitution of private for public finance was a matter of deliberate policy design.

What can Canada learn from this evidence? Private spending on health care is likely to replace, at least in part, some of our public spending. Therefore every private dollar spent on health care will not necessarily be a new dollar going into our health care system. The evidence suggests that some of these dollars will be replacing the public money we currently spend on health.

(e) Waiting Times

Whether or not private financing can help alleviate waiting times for care is of particular policy importance to a number of publicly funded countries. As patient expectations for timely and technologically advanced care increase, countries which have traditionally rationed care and technology through waiting times are facing increasing pressure to use private funds as a means of improving access. It is very difficult to ascertain from the available data the extent to which waiting times are truly a problem in Canada or in any other jurisdiction. Most governments are reluctant to collect data on waiting lists because more often than not this information is often used to criticize government performance. However, what data is available for Canada suggests that the percent of the population on waiting lists in Canada increased very slightly (0.08 percentage points) between 1997 and 1999. In the Netherlands, private insurance plays an important role in financing the system but having private insurance does not allow an individual to jump queues in the social insurance system. It is seen as against a physician's ethical code to prefer a patient with private insurance to a patient without and both kinds of patients are treated side-by-side in the same hospitals. [115] In the Netherlands the percent of the population on waiting lists is lower than in Canada, at approximately half a percent in both 1997 and 1999. In New Zealand, where there is a two-tier system, there appears to have been a rapid decline in the numbers waiting from a peak of 2.48% in 1997 down to 1.65% in 1999. However, this apparent decline is misrepresentative of the true state of affairs. In response to criticisms of long and growing waiting lists in the public sector, the New Zealand government in 1997 introduced a "booking system". In the new booking system patients are not "booked" in for surgery unless the system can provide the service within six months. Patients whose needs cannot be meet within this time frame are referred back to their doctor to "manage" their condition. So, what we have is now unofficial wait lists for wait lists! In the UK, the percent of the population on waiting lists was approximately 2.56% in 1997 and declined only slightly to 2.26% in 1999. Our data on percentage of the population waiting and levels of private insurance is shown in Table 2.

In sum, there really is no existing evidence to support the idea that private financing can reduce public waiting lists. Each of the systems that allow for such a sector have waiting lists that are similar to or longer than those in Canada, and indeed New Zealand and the UK are significantly worse on these measures. When waiting times have declined in the UK, it has been in response to infusions of public funding, such as the "Waiting List Initiative" of the late 1980s and early 1990s, and mechanisms to change incentives within the public sector. Not only do parallel private systems not reduce waiting lists in the public system, they may in one respect increase them. Evidence from the UK suggests that parallel private systems may attract healthier patients and perform relatively less complicated procedures, thereby increasing the average complexity and dependency of patients continuing to use the public system. Martin and Smith, for example, found evidence that length of stay in NHS hospitals was longer in areas with high levels of private inpatient facilities, which may suggest that the private facilities "cream off" the less complicated cases, leaving the local NHS facility with a relative complex case mix.[116]

IV. CONCLUSION

This section outlines the state of private financing in each of six OECD countries: Australia, Canada, the Netherlands, New Zealand, the UK, and the US. With the exception of the US, all of the countries studied here are predominantly publicly funded, although they vary as to the extent and purpose of privately financed services. The countries each fall within one of four categories that define the mix between public and private financing. These categories help to explain the changes in private shares over time, and the areas within the health care sector that are primarily affected by these changes. With the possible exception of the Untied States, each country relies predominantly on public financing to help achieve the stated entitlements to care for its citizens. The Netherlands is a special case as its system is progressively financed through mandatory contributions on the part of employers and employees.

Looking more closely at each country's mix of public/private spending we see considerable variation depending on the nature of the health care good or service in question. Although every country except the US seems to adopt the philosophy that health care should be allocated on the basis of need rather than ability to pay there are limitations on the extent to which this principle is applied. For example, in Canada whilst hospital and physician services are fully publicly funded there is much more private financing (where care is allocated on the basis of ability to pay) for drugs, home care and long-term care. In New Zealand, there has long been a system of user charges for family doctor care, thus potentially discouraging patients from entering the health care system at all. In Australia, there is a complicated system of user charges but with a variety of safety nets in place to ensure that those on low-incomes or the chronically ill are not discouraged from accessing the care they need. By comparison, the UK tends to offer first-dollar coverage for a broad range of health care services as does the Netherlands (extending indeed to long term care) for, despite its apparent reliance upon private insurance, it is regulated to ensure the goal of "solidarity".

In the absence of rationing by price or ability to pay (through user charges or out-of-pocket payments) rationing can occur can occur implicitly or explicitly. All countries that aspire to provide their citizens with access to a range of health care services (in other words try to run a health care system) engage in some form of implicit rationing to a greater or lesser degree. In Canada, the UK, New Zealand, Australia and the Netherlands there are capacity constraints put on the system and generally physicians are required to act as gatekeepers to the system, determining which patients and which medical needs to prioritize. Increasingly the private sector in the US is engaging in a similar exercize as this system embraces managed care. In New Zealand and the UK hard constraints on public budgets have resulted in long queues in the public sector for elective surgery and there is a two-tier system so those with private resources can buy quicker treatment in the private sector.

In response to concerns about implicit rationing and declining quality in the public sector there has been moves to develop Patients' Bills or Charters of Rights which are largely a codification of patients' common law rights to give an informed consent and to confidentiality but with an independent enforcement mechanism. However, in the UK some of the patients' rights speak to rights vis-à-vis the managers of the system in terms of waiting times. As Canada considers how to ensure citizen satisfaction with Medicare and enhance the accountability of the system to the people it serves, policy-makers should consider in more detail the UK's experience with a Charter of Rights. In particular policymakers should consider the merits of including in a Patients' Bill of Rights guarantees or assurances with regards to waiting times.

In New Zealand, the Netherlands, and in Oregon in the US (in the context of the Medicaid program for the poor) there has been a movement towards more explicit rationing and attempts have been made centrally to develop processes for deciding what services should be publicly funded. This has proved to be a difficult process in practice. Instead all of these systems as well as the UK have moved towards processes designed to determine what priorities should be given in terms of public spending rather than trying to determine a list of services to be publicly funded. The lesson for Canada from this experience seems to be that whilst attempting to define a fixed list of services to be publicly funded is likely to fail it is more fruitful to put in place processes to determine priorities in health care spending. Canada should consider how to articulate a principled process for determining what is to be publicly funded. Recent court challenges suggest that whilst courts will generally be respectful of public authorities taking decisions in the context of constrained public resources, they will not simply accept an argument of constrained resources and will wish to be assured that the public authorities have a principled basis for resource allocation.

One theme that emerges from examining the entitlement and rationing decisions of these countries is that no single global rationing device appears to be optimal. At some broad level a determination has to be made about the kinds of goods and services that will be publicly funded and the level of public funding (in other words if user charges are appropriate for the good or service in question). However, most of the real allocation decisions happen beyond that macro determination of what broad range of health care goods and services to cover and occur as physicians and other health care providers decide who should receive care, in what sequence, and how quickly. Nonetheless there are obvious problems with relying on implicit rationing particularly where physicians as gatekeepers to the system have no incentive to be sensitive to the cost and benefits of the various services and goods they recommend prescribe to their patients. The response to this in a number of countries, as we shall see in the Management section of this report, has been to devolve budgets to groups of physicians and other primary care providers. As noted in the WHO's *World Health Report 2000*, "Resources should be used for interventions that are known to be effective, in accordance with national or local priorities. Because resources are limited, there will always be some form of rationing but prices should not be the chief way to determine who gets what care. Both hierarchical bureaucracies and fragmented, unregulated markets have serious flaws as ways to organize services: flexible integration of autonomous or semi-autonomous health care providers can mitigate the problem."

Turning now to sum up the evidence on the impact of the public/private mix on health outcomes, utilization, spending, and waiting times, the evidence generally points away from increased private financing as a means to achieve effective health care reform. There does not appear to be a relationship between increased private spending and improved health outcomes. On the contrary, country specific evidence on the effects of private, out of pocket cost sharing on access to care and health outcomes shows that co-payments do indeed create barriers to access and that these barriers can, in certain populations such as children and the poor, result in worse health outcomes.

The evidence on the relationship between private financing and health care spending suggests that countries with higher levels of private financing such as the US have higher costs and higher cost growth than countries with predominantly public payers such as Canada. Furthermore, examining the impact of private financing on public health funding suggests that increases in private financing are associated with declines, over time, in public funds allocated to health care.

Finally, the available evidence does not suggest that private financing is successful in improving waiting times for care. In fact, even in those countries, such as the UK, with a second private health care tier, public initiatives to improve waiting times in the primary tier have proven more successful.

Table 1a
WHO Statistics on Public/Private Expenditure by Source, 1997

Country	total exp % gdp	pub exp % total exp on health	priv exp % total exp on health	out of pocket exp % total exp on health	tax funded and other public as a % of public exp on health	social security exp % of pub exp on health	pub on health % total pub exp
Aust.	7.8	72.0	28.0	16.6	100	--	15.5
Canada	8.6	72.0	28.0	17.0	98.9	1.1	15.3
Nether	8.8	70.7	29.3	16.8	100	--	12.7
NZ	8.2	71.7	28.3	22.0	100	--	12.7
UK	5.8	96.9	3.1	3.1	100	--	14.3
USA	13.7	44.1	55.9	16.6	57.9	42.1	18.5

Table 1b
OECD Statistics on Public/Private Expenditure by Source, 1997

Country	total exp % gdp	public exp % total exp on health	private exp % total exp on health	public on health % total pub exp
Aust.	8.4	66.7	33.3	16.0
Canada	9.2	69.8	30.2	15.2
Nether	8.5	72.6	27.4	12.7
NZ	7.6	77.3	22.7	12.8
UK	6.8	84.5	15.5	14.6
USA	13.9	46.4	53.6	20.3

Table 1c
OECD Statistics on Health Expenditure by Source as a Percent of Total Health Expenditure, 1997

Country	Government Spending, not Social Security	Social Security	Private Insurance	Out of Pocket payments
Aust.	63.8	--	9.4	16.2
Canada	68.5	0.8	10.9	17.1
Nether	4.3	65.4	18.0	6.6
NZ	77.3	--	6.8	22.7
UK	73.9	9.7	3.5	11
USA	31.1	14.3	32.4	17.7

* Note: In some countries rows may not sum to 100 as there are other potential sources of funding.

Table 2: Private Health Insurance and Public Sector Waiting Lists and Waiting Times, Selected Nations, Late 1990s (Source: C. Tuohy, C. Flood & M. Stabile, *The Impact of Private Finance on Public Health Care Systems: Evidence from OECD Nations* (University of Toronto, 2001) [unpublished]

	% of Population on Waiting Lists		**% of Pop. with Supp. Private Hospital Insurance***	**% Reporting Waits of More than 4 months for elective surgery**
	1999	1997	Most recent statistics	1998
CANADA	0.7%	0.62%	0%	10%
NEW ZEALAND	1.65%	2.48%	37% (1996/97)	21%
ENGLAND	2.26%	2.56%	11.5% (1998)	29%
NETHERLANDS	0.50%	0.51%	0%	NA
AUSTRALIA	N/A	0.8%	31.2% (1999)	13%

Table 3: One-year correlations between health outcomes and spending on health across OECD countries.

Health Measure/Spending Measure	Male Life Expectancy	Female Life Expectancy	Incidence of Cancer	Infant Mortality	Potential Years of life lost (all causes)
Health spending as a % of GDP	0.3405 (0.1034)	0.4433* (0.0300)	0.4420* (0.0306)	-0.4700* (0.0236)	0.4251 (0.0889)
Public expenditure on Health as a % of Total Public Expenditure	0.2771 (0.2240)	0.0571 (0.8057)	0.0721 (0.7563)	0.0355 (0.8818)	0.2599 (0.3310)
Public expenditure on health as a percent of GDP	0.5816 (0.0029)	0.6193* (0.0013)	0.6223* (0.0012)	-0.6815* (0.0003)	-0.3178 (0.2139)
Private health spending as a percent of total health spending	-0.1593 (0.4572)	-0.0717 (0.7392)	-0.1129 (0.5994)	0.1689 (0.4410)	0.6671* (0.0034)

1. P-Values in parentheses.
2. OECD data, 1997 for life expectancy, 1996 for cancer and infant mortality, 1995 for preventable deaths.
3. * denotes significance at the 5% level.

---

[1] C. Tuohy, C. Flood & M. Stabile, *The Impact of Private Finance on Public Health Care Systems: Evidence from OECD Nations* (University of Toronto, 2001) [unpublished].

[2] Canadian Institute for Health Information, *Health Expenditures Data 2000*, (Ottawa: CIHI, 2001) available at: http://www.cihi.ca/facts/nhex/hexdata.shtml.

[3] OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000).

---

[4] P. Coyte, “Home Care in Canada: Passing the Buck” (University of Toronto, 2000) [unpublished]. We say at least as this figure likely under-estimates the true private cost of home care as it does not account for the cost of informal care by family members for which no actual monetary transactions occur.

[5] *Ibid.*at 11.

[6]For a full discussion see C. Flood, “The Structure and Dynamics of the Canadian Health Care System” in J. Downie & T. Caulfield eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999).

[7]A provincial plan must entitle 100% of the insured persons of the province to the “insured health services” on “uniform terms and conditions. An "insured person" is defined in section 2 of the Act, with some exclusions, as a "resident" of a province. A "resident" is further defined as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

[8]A province's plan must insure all residents within 3 months of arrival in the province and pay for the cost of insured health services provided to insured persons while temporarily absent from the province at the rate approved by the insurance plan of the province in which the services are provided or otherwise by agreement. Section 11(2), however, states that the criterion of portability is not contravened if the administrator of a provincial plan requires a patient to obtain the administrator's consent before receiving non-emergency health services in another province "if the services in question were available on a substantially similar basis in the province."

[9]Despite the emphasis on "public" administration, there is nothing preventing a provincial ministry of health from contracting with a private corporation to manage its health insurance plan. In 1997, the New Brunswick Ministry of Health had entered into a contract (now terminated) with Blue Cross of Atlantic Canada to build a new Medicare billing system and process Medicare billings for the province -- see "Termination of contract for Medicare billing system (News Release, New Brunswick Health and Community Services, 1584, (26 September 1997)).

[10]Section 2 provides "'hospital services' means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purposes of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely, (a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required, (b) nursing service, (c) laboratory, radiological and other diagnostic procedures together with the necessary interpretations, (d) drugs, biological and related preparations when administered in the hospital, (e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, (f) medical and surgical equipment and supplies, (g) use of radiotherapy facilities, (h) use of physiotherapy facilities, and (i) services provided by persons who receive remuneration therefor from the hospital, but does not include services that are excluded by the regulations."

[11]35For a criticism of relying on delisting and deinsuring as a means of containing health care costs, see M. Rachlis, "Defining Basic Services and De-Insuring the Rest: The Wrong Diagnosis and the Wrong Prescription" (1995) 152: 9 CMAJ 1401.

[12]C. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford: Oxford University Press, 1999) at 220.

[13]T. Caulfield, "Wishful Thinking: Defining "Medically Necessary" in Canada" (1996) 4 Health L. J. 63.

[14] Health Canada,“Drug Costs in Canada” (Ottawa: Health Canada, 1997).18-19.

[15] M. Stabile, *Private Insurance Subsidies and Public Health Care Markets: Evidence from Canada* (University of Toronto, 2000) [unpublished].

[16] *Waldman* v. *British Columbia (Medical Services Commission)* (1999), 177 D.L.R. (4th) 321 (B.C.C.A.), per Hall J.A., reversing in part (1997) 150 D.L.R. (4th) 405 (B.C.S.C.), per Levine J.

[17] *Eldridge* v. *British Columbia (Attorney General)* [1997] 3 SCR 624. (S.C.C.); *Cameron* v. *Nova Scotia (AG)* (1999) 177 DLR (4th) 611 (N.S.C.A.).

[18] [2000] J.Q. No. 470 (QL) (C.S.Q.), *per* Piche J. This judgment is only available in French.

[19]See *Ministry of Health Appeal and Review Boards Act*, 1998, S.O. 1998, c. 18.

[20] C. Abraham, “Tenacious Woman Scores Medical Victory” *The [Toronto] Globe & Mail* (27 August 1997) A1.

[21]In Ontario see the "Speech from the Throne, Address of the Honourable Hilary M. Weston, Lieutenant Governor of the Province of Ontario on the Opening of the First Session of the Thirty-Seventh Parliament of the Province of Ontario, October 21, 1999 at www.premier.gov.on/ca/english/library/thronespeech.Oct2199.htm. In Saskatchewan, the Patients' Rights Association submitted a draft Bill of Rights to the Premier in September 2000, but legislation has yet to be introduced into the House. Also, in April 2000 a private member's bill was introduced to create an office of a Health System Ombudsman for Saskatchewan. We also understand there have been calls for such legislation in Quebec and Manitoba.

[22]OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000).

[23] Australian Institute of Health and Welfare, *Australia’s Health 2000* (Canberra: AIHW, 2000) at 235.

[24]OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000). This figure is for 1997.

---

[25] A. Podger & P. Hagan, "Reforming the Australian Health Care System: The Role of Government" in *Department of Health and Aged Care, Occasional Papers: New Series No. 1* (Canberra: Department of Health and Aged Care, 1999) at 15.

[26] *Pfizer Pty Ltd* v. *Birkett* [2000] FCA 303 (Fed Ct Austr.)

[27] Tasmania Department of Health and Human Services, "Public Patients' Hospital Charter", online: www.dchs.tas.gov.au/moreinfo/online_policies/charter.html (date accessed: 24 January 2001).

[28] Australia. Private Health Insurance Ombudsman, "Who are we", online: www.phio.org.au/onlineaction.htm (date accessed: 29 January 2001).

[29] *Ibid*.

[30] P. Huijbers & A. Martin, "Health Care Insurance in the Netherlands", online: Netherlands Institute of Gerontology, <www.nig.nl/facts&figures/healthcareinsurance_en.html> (date accessed: 12 February 2001).

[31] OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000). The OECD records government spending as a percentage of total health expenditure for 1998 as being 4.2. This is to be distinguished from the figure cited in the text which is public spending as a percentage of total health expenditure.

[32] Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport), *Health Insurance in the Netherlands* (The Hague: Ministerie van Volksgezondheid, Welzijn en Sport, 2000) [hereinafter Health Insurance in the Netherlands] at 7.

[33] See W. B. F Bouwer & F. T. Schut, "Priority Care for Employees: A Blessing in Disguise?" (1999) 8 Health Economics 65. See also W. Brouwer & H. E.G.M. Hermans, "Private Clinics for Employees as a Dutch Solution for Waiting Lists: Economic and Legal Arguments" (1999) 47 *Health Policy* at 7.

[34] Brouwer & Hermans, *Ibid.* at 27.

[35] *Ibid.* at 14-19.

[36] Health Insurance in the Netherlands, *supra* note 32 at 56.

[37] *Ibid.* at 56.

[38] *Ibid.*. at 51.

[39] R. Scheerder, "The Financing of the Dutch Health Care System" in *Health and Health Care in the Netherlands* at 165.

[40] See Netherlands. Ministry of Welfare, Health and Cultural Affiairs, *A Report By The Government Committee On Choices In Health Care* (Rijswijk: Ministry of Welfare, Health and Cultural Affairs, 1992).

[41] F.T. Schut & H.E.G.M. Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada" (1997) 20:2 Dalhousie Law Journal 437 at 457.

[42] H. Hermans & A. den Exter, "Priorities and Priority-Setting in Health Care in the Netherlands" (1998) 39:3 *Croatian Medical Journal* 346 at 349.

[43] Hermans & den Exter, *supra* note 42 at 351.

[44] *Ibid*. at 353.

[45] *Ibid*.

[46] Information taken from electronic mail of A. den Exter to C. Flood (5 March 2001). Copy on file with authors.

[47] United States. Center for Disease Control and Prevention and National Center for Health Statistics, *Health, United States, 2000*, (Hyattsville, Maryland: National Center for Health Statistics, 2000) [hereinafter *Health 2000*], Table 119, "Personal health care expenditures, according to type of expenditure and source of funds: United States, selected years 1960–98".

[48] *Ibid*. at Table 128. "Health care coverage for persons under 65 years of age, according to type of coverage and selected characteristics: United States, selected years 1984–97".

[49] Co-payments are user charges levied on patients per use (e.g. a $10 fee). Deductibles and co-insurance refer to amounts the user must pay privately to share the cost of the service with Medicare. Deductibles are one-time charges, whereas co-insurance charges are sometimes made in addition to deductibles on a periodic basis to shift ongoing costs to the patient.

[50] Health Care Financing Administration, 2001. http://www.hcfa.gov/medicaid/mservice.htm.

[51] OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2001).

[52] *Ibid.*

[53] *Health 2000, supra* note 47 at table 146: "Persons without health care coverage by geographic division and State: United States, selected years 1987–98".

[54] These services generally include the following: inpatient hospital services; outpatient hospital services; prenatal care; vaccines for children; physician services; nursing facility services for persons aged 21 or older; family planning services and supplies; rural health clinic services; home health care for persons eligible for skilled-nursing services; laboratory and x-ray services; paediatric and family nurse practitioner services and nurse-midwife services.

[55] The following Medicaid recipients, however, *must* be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid recipients must be exempt from co-payments for emergency services and family planning services.

---

[56] For a discussion of the Oregon plan, see C. M.Flood, *International Health Care Reform: A Legal, Economic & Political Analysis* (London: Routledge, 2000), ch. 4.

[57] The *Oregon Basic Health Services Act*, Or. Rev. Stat. §§414.705-414.750 (1993). Prior to implementation of this Act only those individuals who satisfied family status requirements and had incomes equal to or less than 51 percent of the poverty line were eligible. See Oregon Health Services Commission, *Prioritization Of Health Services: A Report To The Governor And Legislature* (Oregon Health Services Commission, 1991) at xvii, as cited in C. Halligan, "'Just What The Doctor Ordered': Oregon's Medicaid Rationing Process and Public Participation In Risk Regulation" (1995) 83:7 *Georgetown Law Journal* 2697.

[58]For a fuller description of the processes, see Halligan, *ibid*. at 2708--11.

[59]*Ibid*. at 2711-12.

[60] H. Leichter, "Oregon's bold experiment: Whatever happened to rationing?" (1999) 24:1 *Journal of Health Politics, Policy and Law* 147.

[61] L. Jacobs, T. Marmor & J. Oberlander, "The Oregon Health Plan and the political paradox of rationing: What advocates and critics have claimed and what Oregon did" (1999) 24:1 *Journal of Health Politics, Policy and Law* 161.

[62] E.F. Shay, "Managed Care Litigation" (November 1996) *Physician's News Digest*, accessed online at http://www.physiciansnews.com/law/1196shay.html 6 March 2001.

[63] R. Porter, "Millennium ends with wave of class actions against HMOs" (2000) 36:2 *Trial* (online version accessed).

[64] *DeSario* v. *Thomas* (1998), 139 F. 3d 80 (U.S.C.A. 2d Circ.)

[65] *Dexter* v. *Kirschner* (1992) 972 F. 2d 1113 (U.S.C.A. 9th Circ.) where a Medicaid claimant (unsuccessfully) challenged Arizona's refusal under its Medicaid program to pay for a leukaemia treatment that is far more effective but more costly than the leukaemia treatment it was prepared to fund. The main claim was that the decision to fund one, but not another, treatment for leukaemia amounted to a violation of the U.S. Constitution's equal protection clause. In other words, by refusing to fund all medically effective leukaemia treatments, Arizona treated similarly situated leukaemia patients differently solely on their ability to pay privately. The court said that "similarly situated" means "all patients who can be treated effectively by the same organ transplant procedure. Therefore, the plaintiff was not unreasonably denied a covered service. She was denied medical assistance because the only procedure that could help her… was not covered by the Arizona Medicaid program" at 1119-1120

[66] S. Rosenbaum et al., "Who Should Determine When Health Care is Medically Necessary?" (1999) 340:3 New England Journal of Medicine 229.

[67] Schwartz groups managed care regulatory measures into five broad categories according to the purposes they serve: S. Schwartz, "How Law and Regulation Shape Managed Care", ch. 3 of D. Bennahum ed., *Managed Care: Financial, Legal and Ethical Issues* (Cleveland: Pilgrim Press, 1999).

[68] *Ibid*. at 22.

[69] OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2001).

[70] New Zealand Ministry of Health, "Health Expenditure Trends in New Zealand 1980-99" (Wellington: August 2000) at 44, online: http://www.moh.govt.nz.

[71] OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000).

[72]New Zealand Ministry of Health, *supra* note 70 at 54 (Appendix 4A).

[73] *Ibid*. at 42.

[74] *Ibid*. at 60 (Appendix 6A).

[75] *Ibid*. at 57 (Appendix 5A).

[76] In the year ending June 1999, private insurers funded 10 percent of general practitioner services, 25 percent of diagnostics, 17 percent of miscellaneous specialist services and 44.5 percent of private institution treatments excluding disability support services. See *ibid*. at 56 (Appendix 5A).

[77] Note, however, that the Bill of Rights 1990 provides in section 8 that "no one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice". However, this is unlikely to be interpreted by the courts as encompassing a positive right to health care. It is also worthwhile to note that the Universal Declaration of Human Rights, 1948 provides in article 25 that "everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothes, housing, and medical care and necessary social services and the right to security event of unemployment or sickness …". The International Covenant on Economic, Social and Cultural Rights provides in article 12 that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. These rights are not enforceable in New Zealand because they have not been incorporated into domestic law.

[78]I. Hay, *The Caring Commodity -- The Provision Of Health Care In New Zealand* (Auckland: Oxford University Press, 1989) at 121.

[79] R. Blank, *New Zealand Health Policy: A Comparative Study* (Auckland: Oxford University Press, 1994) at 98.

[80] According to the then Minister of Health, Simon Upton, defining a set of 'core health services' more explicitly would help ensure that the services the public believe to be the most important would be provided. It would also acknowledge more honestly that there are limits to the health services the government could afford. See S. Upton, "Your Health and the Public Health – A Statement of Government Health Policy" (Wellington: Minister of Health, 1991 at 80. Core

---

health services were defined in the Health and Disability Services Act 1993 as "those health care services to which society believes everyone should have access on affordable terms and without unreasonable waiting time".

[81] In January 1996 the Core Services Committee was renamed the National Advisory Committee on Health and Disability ("National Advisory Committee").

[82] The Core Services Committee stated: "In the two and a half years we have been working to define core services, the Committee has found that on clinical grounds alone, without any consideration of fairness or equity, explicitly identifying core services is not as straightforward as might first have been thought possible. A 'yes/no' or 'in/out' list approach is just too simplistic. It would either have to be so broad and lacking in definition as to be meaningless, much the situation the Committee inherited, or its explicitness would make it too arbitrary and inflexible resulting in people being unfairly excluded from services. Either way it would fail." L. Jones "Core Services Committee. The core debate 3." in A. Maynard & K. Bloor, *Our Certain Fate: Rationing in Health Care* (London: Office of Health Economics, 1998) at 28.

[83] R.H. Blank, *New Zealand Health Policy: A Comparative Study* (Auckland: Oxford University Press, 1994) at 105.

[84] *Ibid*.

[85] *New Zealand Public Health and Disability Act 2000*, s. 13.

[86] [1998] 1 NZLR 433 (C.A.).

[87] *Sunday-Star Times* (5 October 1997), quoted in C. Feek *et al*., "Experience with rationing health care in New Zealand" (1999) 318 *BMJ* 1346.

[88] *Evening Post* (13 October 1997), quoted in Feek *et al., ibid*.

[89] New Zealand. Health and Disability Commissioner, *Report of the Health and Disability Commissioner for the year ended 30 June 1999* (Wellington, October 1999) at 17-18.

[90] OECD Data 2000, *supra* note 2.

[91] In introducing the National Health Service Plan in July 2000, Prime Minister Tony Blair stated that "the NHS was the greatest achievement of the post-war Labour Government. It was based on one solid founding principle: that health care should be given on the basis of a person's need not their wealth … this side of the House will never abandon what one of the greatest civilising acts of emancipation this century has ever known." 10 Downing Street Newsroom, News Release, "Prime Minster's Statement on the National Health Service Plan" (27 July 2000), online: http://www.number-10.gov.uk..

[92] H. van de Water & L. van Herten, "Health Policies on Target? Review of Health Target and Priority Setting in 18 European Countries" (Netherlands: TNO Prevention and Health, 1998) at 82.

[93] [1995] 1 FLR 1055 (QB)

[94] [2000] 1 W.L.R 977 (C.A.). See also *Regina v. North and East Devon Health Authority, Ex parte Coughlan*, [2000] 2 W.L.R. 622. In this case the court noted that "recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand … section 3(1) of the [National Health Service Act 1977] does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy".

[95] The guide is called "Your Guide to the NHS". See Department of Health, News Desk, News Release, "Guide spells out what patients can expect from the NHS" (26 January 2001), online: http://www.doh.gov.uk/newsdesk/recent/4-naa-26012001.html.

[96] Department of Health, News Release, "Your Guide to the NHS Launched" (26 January 2001), online: http://www.doh.govt.uk.

[97] Potential Years of Life Lost (PYLL) is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, a priori, preventable. OECD, OECD Health Data 2000: A Comparative Analysis of 29 Countries (Paris: OECD, 2000).

[98] Figures are from the OECD Data 2000, *ibid.*

[99] Concessional patients are people who receive certain pensions, benefits or cards administered by the Departments of Family and Children's Services or Veterans' Affairs, or who meet certain criteria for being declared to be disadvantaged.

[100] The results of this experiment are extensively reported in J. Newhouse, *Free For All*? (Cambridge, MA: Harvard University Press, 1993).

[101] J. Currie & J. Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," (1996) 111:2 Quarterly Journal of Economics 431-66.

[102] New Zealand Ministry of Health, "Health Expenditure Trends in New Zealand 1980-99", *supra* note 72.

[103] C. Grant, C. Forrest & B. Starfield, "Primary Care and Health Reform in New Zealand", (1997) 110 New Zealand Med. Jn*l* at 35. See C. Schoen *et al*., "Equity in Health Care Across Five Nations: Summary Findings From an International Health Policy Survey" (New York: The Commonwealth Fund, 2000) at 6.

[104] R.Beck & J.Horne, "Economic Class and Risk Avoidance: Experience under Public Medical Insurance" (1976) 43 *Journal of Risk and Insurance* 73-86.

---

[105] M. Barer, R.Evans & G. Stoddard, *Controlling Health Care Cost by Direct Charges to Patients: Snare or Delusion?* (Toronto: Ontario Economic Council, 1979) at 33-34.

[106] Health Canada, “Drug Costs in Canada” (Ottawa: Health Canada, 1997).

[107] R. Tamblyn *et al.*, *Evaluation of the Impact of the Quebec Drug Insurance Plan* (McGill University, 1999).

[108] For example, the New Zealand government abandoned its $50 a night patient user charge for public hospitals partly because of a public outcry, but also partly because of the high administrative costs involved with collection. By the end of the first quarter (May 1992), after the introduction of user charges for public hospital services, outstanding debts fell in the range of 30-60 percent of total revenue from charges -- 'Hospital Fees Unpaid Up To 63 percent', June 18, 1992, New Zealand Herald, as cited by T. Ashton, 'Charging for Health Services -- Some Anecdotes from the Antipodes' in M. Malck *et al.* (eds.), *Strategic Issues in Health Care Management*, (Great Britain: John Wiley and Sons, 1993) 9 at p. 16.

[109] V. Fuchs & J. Hahn, “How Does Canada Do It? A Comparison of Expenditures for Physicians’ Services in the U.S. and Canada,” (September 1990) *New England Journal of Medicine* 884-890.

[110] J. Newhouse, G. Anderson & L. Roos, “Hospital Spending in the U.S. and Canada: A Comparison,” (Winter 1988) *Health Affairs* 6-16.

[111] V.M. Taylor *et ors*, "Hospitalization for Back and Neck Problems: A Comparison between the Province of Ontario and Washington State" (1998) 33 Health Services Res 929-45.

[112] C. H.Tuohy, C. M.Flood & M. Stabile, *supra* note 1.

[113] S. Globerman & R. Vining “A Policy Perspective on “Mixed Health Care Financial Systems of Business and Economics” (1996) Journal of Risk and Insurance 71.

[114] C. Tuohy, C. Flood & M. Stabile, *supra* note 1.

[115] See W. B. F Bouwer & F. T. Schut, "Priority Care for Employees: A Blessing in Disguise?" (1999) 8 Health Economics 65. See also W. Brouwer & H. E.G.M. Hermans, “Private Clinics for Employees as a Dutch Solution for Waiting Lists: Economic and Legal Arguments” (1999) 47 Health Policy at 7.

[116] S. Martin & P. Smith, “Explaining Variations in Inpatient Length of Stay in the National Health Service” (1996) 15 Journal of Health Economics 294-95.