



Why not private health insurance?

1. Insurance made easy

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Abstract

HOW REALISTIC ARE PROPOSALS TO EXPAND THE FINANCING of Canadian health care through private insurance, either in a parallel stream or an expanded supplementary tier? Any successful business requires that revenues exceed expenditures. Under a voluntary health insurance plan those at highest risk would be the most likely to seek coverage; insurers working within a competitive market would have to limit their financial risk through such mechanisms as "risk selection" to avoid clients likely to incur high costs and/or imposing caps on the costs covered. It is unlikely that parallel private plans will have a market if a comprehensive public insurance system continues to exist and function well. Although supplementary plans are more congruous with insurance principles, they would raise costs for purchasers and would probably not provide full open-ended coverage to all potential clients. Insurance principles suggest that voluntary insurance plans that shift costs to the private sector would damage the publicly funded system and would be unable to cover costs for all services required.

Canada's health care system publicly insures and pays for a range of "medically necessary" services, most of which are delivered by private providers. The national elements of Canada's health care system rest on 2 pillars: the Canada Health Act defines 5 terms and conditions (universality, comprehensiveness, accessibility, portability and public administration) with which provincial hospital and medical plans must comply to receive federal funding, and the Canada Health and Social Transfer program establishes the funding formula for the amount of money the federal government will transfer to the provinces. The provinces have considerable latitude in defining how they organize their health care services, what services they will cover and how much they will pay. At most, the Canada Health Act establishes a base, leaving the provinces free to insure beyond the specified requirements. For example, the comprehensiveness condition defines "insured services" as medically necessary procedures delivered in hospitals or by practitioners (usually physicians). Given that much health care is moving from the hospital setting to the community, some services now escape the constraints of the Canada Health Act.

Waiting lists and timely access to health care have become significant issues as governments have attempted to constrain health care costs; fearful that underfunding will result in a lack of services, many providers and consumers have begun to argue for increased private financing. Proposals have taken 2 forms: a parallel private stream that would allow people to purchase private insurance for services also found in the public system (currently inconsistent with the Canada Health Act) and an expanded supplementary tier that would cover services delivered either outside of hospitals or by providers other than physicians (e.g., pharmaceutical drugs, rehabilitation, long-term care) for those willing and able to purchase them.

Although the CMA's general membership has continued to endorse an ongoing substantial role for public sector financing,² some physicians have been among the louder voices calling for a parallel private stream;³⁻⁵ these views have also been supported by the Reform Party of Canada⁶ and some health care economists.⁷ The proposals have been given a sense of urgency by provincial cost cutting,⁸ which has increased physician disaffection and militancy,^{4,5,9-11} and by public fears that health care may become inaccessible. To date, the argument about the role for private in-

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insurance has focused on issues of equity and access and has assumed that insurers are eager to enter the market. An overview of these issues will be provided here.

The private–public mix

The distinction between how health care systems are financed in Canada — publicly for services falling under the Canada Health Act — and how services are delivered — primarily privately, albeit often not for profit — has been noted previously.¹ Opponents of private financing have tended to argue on the grounds of fairness (distributive justice), with support from a considerable body of evidence indicating that public or quasi-public single-source financing is most efficient for controlling the costs of services.^{1,12–25} Economically, administrative costs for a single-payer system are lower; costs do not fall disproportionately on larger employers; a single payer has greater “monopsony” bargaining power with service providers; and there is less incentive to “risk select.” The risk selection argument, in turn, rests on the nature of insurance.

Insurance and actuarial principles

Insurance is a way of distributing risks by pooling costs over time and people. To give an arbitrary example, imagine 10 000 homes distributed across many communities, each valued at \$300 000, and that, on average, 1 will be destroyed each year by lightning. An insurance premium of \$40 per household would create a pool of \$400 000 — enough to reimburse 1 unlucky homeowner and still create a profit for the insurer; each individual homeowner pays a \$40 premium to avoid a potential loss of \$300 000. Insurers will conduct business this way as long as the yield from premiums is higher than the expected payout to subscribers. Because the number of affected individuals is unpredictable, however, insurance systems require large risk pools so that peaks and valleys average out.

Providing insurance to some people is a greater risk than providing it to others, and some people may take greater risks once they know they are insured; these issues become more pressing if the purchase of insurance is voluntary rather than compulsory. “Moral hazard” can arise if insurance is purchased primarily by individuals who know they are likely to need it or by those who engage in risky behaviour precisely because they are insured. It is unlikely that people will abuse their health solely because they will not have to pay for health care, but moral hazard does explain why insurers are unwilling to insure such things as cosmetic surgery. Recognizing that people at higher risk are more likely to purchase coverage, insurers are not eager to focus on the “individual” insurance market. By its nature, the employment-based group insurance policy covers a younger and healthier population (since those too ill to work are excluded) and, in effect, imposes compulsory coverage on all group members.

“Risk selection” often occurs when insurers can decide whom they are willing to insure. Premiums may be based on solidarity principles, where everyone pays the same rate (i.e., community rating), or on actuarial principles, where individuals pay risk-rated premiums based on probable claims (i.e., medical underwriting).²⁶ In a competitive market, insurers are motivated to entice those at low risk by offering lower premiums or greater benefits (e.g., wellness programs) and to risk select against individuals more likely to submit costly claims. Any insurer willing to cover high-risk cases usually becomes uncompetitive because they are left with the most costly claims.²⁷ Accordingly, solidarity-based markets are inherently unstable if competition is allowed, and without government regulation, coverage for those considered high risk will probably be priced out of reach. For example, a study of the US private insurance market by the US General Accounting Office reported that insurers “virtually always denied coverage” to individuals with certain diseases (e.g., AIDS and heart disease) and often would not cover pre-existing conditions, such as chronic back pain, anemia, knee injury, glaucoma and asthma.²⁸ Any move away from a single-payer system is likely to evoke both actuarial (risk selection) and efficiency problems (because of the small size of the risk pools), as well as the more commonly raised issues of equal access.

In theory, one could compute a fair risk-adjusted premium for each individual on an actuarial basis and aggregate private and public pools. In practice, however, attempts to introduce such risk-adjusted capitation rates have proven extremely costly and complex.^{29,30} A US attempt to allow seniors to join Health Maintenance Organizations led to risk selection; those enrolled tended to be healthier, and the resulting overpayment of approximately 7% led to windfall profits for the HMOs and cost escalation for the government.³¹

Insurers may also cover services where large claims are unlikely. For example, the cost for ambulance transportation in British Columbia ranges between \$54 and \$274. Insurance for such a relatively modest expense is really unnecessary, but risk-averse people may wish the psychological comfort of full coverage, and insurers profit as long as premiums are set high enough to cover expected payouts. Dental coverage is similar; it spreads out relatively predictable costs and usually imposes limits on both what will be paid for and the total payments.

In summary, a competitive insurance system gives economic incentives for insurers to limit risk in 2 major ways: by defining whom they will and will not cover and by capping total coverage to ensure that liability will not be open ended. Any company not abiding by insurance principles will, by definition, become uncompetitive in the long term.

The private insurance industry in Canada

The private insurance industry, which finances much of the nonpublic health care costs (approximately 30% of total



health costs), comprises a large number of competing financial institutions. Although there are about 90 member companies in the Canadian Life and Health Insurance Association, mergers have resulted in a handful of major players. Much of the business is focused on life insurance, but health and disability coverage are not insignificant to the industry. Casualty insurers, whose trade association is the Insurance Bureau of Canada, play an increasingly important role in health care financing because of mandatory automobile accident coverage.

Historically, there was virtually no market for individual private health insurance in Canada, with about 95% of the volume based on group policies through employers or unions. Insurers offered solidarity-rated premiums to large employers, whereas small businesses were more subject to actuarial risk assessment. With the move toward more contract and part-time employment and as technology makes it easier to monitor individual utilization, it is becoming easier to shift to actuarial principles and offer preferred rates to low-risk healthy individuals, a trend being reinforced by the increased popularity of flexible benefit packages. In turn high-risk individuals will face higher premiums, if they can buy coverage at all.

Discussion and conclusions

There are a number of reasons to challenge proposals for a parallel private insurance tier within a universal health care system. Many have appealed to principles of access and equity, noting that the current Canadian system assumes that priority for scarce resources (including physician time and skills) should be based on need and ability to benefit, with full recognition that this ideal may not always be realized. Introducing the ability to pay into the priority-setting procedure would instead favour those most willing and able to pay, not those in greatest need or most likely to benefit.

Another issue is the impact on evidence-based medicine; insurance is a demand-based market, which by definition is not primarily concerned with appropriateness or effectiveness. Any fixed budget provides incentives to eliminate marginal care, but “marginal” can be defined in a number of ways; effective but expensive care may be considered marginal, whereas ineffective but popular care (which can increase market share) might well survive scrutiny. One can debate whether increasing access to ineffective and inappropriate care for those willing to pay is a desirable policy goal.

Our discussion adds to the debate on one crucial dimension. Previous discussions have assumed that insurers would gladly offer comprehensive coverage to those interested in paying for it. An examination of insurance principles casts considerable doubt on that assumption. Provider proposals for “win-win” parallel tiers, which in theory would speed access to care without diminishing the public sector, in practice do not accord well with insurance principles or a healthy public sector, much less with the imagined comprehensiveness. The ability to evade cost constraints

that might limit utilization, so enticing to providers and patients, is precisely what payers would wish to avoid.

An expanded supplementary tier to pick up deinsured services would appear more feasible, as long as liability was limited. However, with risk selection those in greatest need would be least likely to acquire private insurance, increasing costs (and risks) for any publicly funded plan. There is some evidence to suggest that inadequate access to even routine, nonurgent care can worsen health outcomes and potentially increase costs if patients become ill enough to require extensive treatment.³²

This argument suggests that private insurance can increase both choice and access primarily for those who are already relatively healthy and wealthy. If we accept the premise that certain goods are “commodities,” appropriately allocated on the basis of willingness and ability to pay, there may be some role for private insurance, subject to the issues of moral hazard and limitations on liability. However, employers recognize there are economic benefits to business from the current single-payer system.³³ It is more economically efficient to have a single payer who must take “all comers” regardless of their probability of needing “merit goods” (that is, services that society is unwilling to deny to anyone judged to need them).³⁴ This, however, implies a moral obligation for the payer to ensure that all of those in need of care receive high-quality services in a timely fashion; otherwise, erosive pressures are inevitable.

Our final conclusion is that there is no free lunch. Proposals for parallel insurance represent wishful thinking of providers and some potential recipients of care. We are reminded of the dialogue between Owen Glendower and Harry Hotspur in *Henry IV, Part I*. Glendower states, “I can call spirits from the vasty deep.” To which Hotspur replies, “Why, so can I, or so can any man; but will they come when you do call for them?” Similarly, it is unlikely that any insurer trying to operate in a competitive market will come running to provide universal, comprehensive, affordable coverage to all wishing to purchase it. New funding would mean new powers in different hands and the potential for some results likely to be unpopular with those who provide and receive care.

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