

Understanding Universal Health Care Reform Options: **Private Insurance**



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Executive Summary

Canada's health care system has prominent features that distinguish it from virtually all other high-income countries that provide universal health care coverage. One such feature is the absence of private insurance markets for medically necessary services.

The Canada Health Act, along with the potential loss of federal government funding if the Act is violated, has resulted in provincial governments either prohibiting or severely discouraging health care providers from treating patients under both public and private insurance schemes. Providers are also prohibited or discouraged from operating completely outside of the public insurance scheme. Consequently, there is little legal scope or economic opportunity for suppliers of private insurance to operate in Canada, either by offering insurance coverage that replicates coverage under the public scheme or by supplementing coverage under the government insurance scheme. Conversely, in most high-income countries with universal coverage, residents are free to choose between two options: full private coverage of all medically necessary services, or supplementary private coverage that facilitates faster access to medical procedures and treatments, wider selection of providers, and amenities such as private hospital rooms.

The Canadian health care system also provides "first-dollar coverage" for medically necessary services. That is, there is no patient cost sharing for services provided under the public insurance scheme. Hence, there is no market demand for private insurance, including self-insurance, to cover expenditures incurred using the government insurance plan. The absence of patient cost sharing for publicly insured basic health care services is another feature of the Canadian health care system that distinguishes it from other countries with universal health insurance coverage. The overall result of restrictions on private payments for medically necessary services and first-dollar coverage is that there is no private insurance coverage or out-of-pocket payment for basic health care services in Canada, which distinguishes Canada's health care system from those of other high-income countries.

Opposition in Canada to private insurance markets for medically necessary services is ostensibly based on two concerns. These concerns are that allowing private insurance coverage will result in substantially

reduced access to health care under the public insurance scheme; or that private insurance will result in inequities whereby wealthier Canadians obtain “better” health care than other Canadians. The former concern is linked to an argument that the growth of private insurance options will weaken political support for the tax-funded public insurance option leading to reduced funding for the government plan and, consequently, reduced coverage for medically necessary services under that plan. In fact, the experience of other high-income countries that allow private insurance markets does not support this argument. Specifically, there is no evidence that the availability and use of private insurance options for basic health care services leads to reduced access to health care under the public insurance scheme.

The argument that a private insurance market will result in inequities in access to health care services along socioeconomic lines is complex, and any evaluation of the argument is conditioned by the standard used to assess the overall social welfare impact of allowing private insurance for basic health care. For example, it is likely that wealthier Canadians would enjoy faster access to services and, perhaps, a wider choice of providers and in-patient amenities compared to their less-wealthy counterparts. However, it is also likely that the existence of a private insurance market would reduce wait times for those Canadians exclusively using the public insurance scheme, especially in the case of services provided on an out-patient basis. This substitution phenomenon, whereby those using private insurance reduce their demand for services insured under the public scheme, has been observed in a number of European countries, especially where private insurance is used to obtain quicker access to health care services than through the public insurance scheme.

The inference from the evidence is that a private health insurance market in Canada would reduce wait times for most, if not all, Canadians. In this regard, lower-income Canadians would enjoy improved access to health care services, notwithstanding that their improved access would not be identical to that enjoyed by wealthier Canadians. However, the existence of a single-payer system does not ensure identical access, either. Under the current system, wealthier Canadians can obtain faster service by paying out of pocket for health care delivered outside the country. Moreover, a major concern about wait times for medically necessary services is that waiting will compromise the health of patients, resulting in the loss of income, reduced quality of life, and increased morbidity and mortality. Hence, to the extent that a private insurance market would reduce wait times in Canada for many patients, allowing private insurance is a significant policy instrument to improve the efficiency of Canada’s health care system.

The linkage between single-payer coverage and longer wait times is underscored by Canada having the longest wait times for medically necessary services among all high-income countries with universal coverage. At the same time, there is no consistent evidence that a “two-tier” health care system, in which some people use private insurance to pay for medically necessary services, results in unequal outcomes in health. More specifically, there is no evidence that the poorer health typically suffered by individuals with below-average incomes and education is linked to the usage of private insurance markets by wealthier and more highly educated individuals.

While reducing wait times would be a substantial improvement in Canada’s health care system, perhaps the most significant benefit of allowing a private insurance market is that it will promote welfare-enhancing innovation in the provision of health care. Strong arguments can be made that private markets promote welfare-improving innovations. Improvements in health care technology should benefit all Canadians. As developments proceed in areas such as artificial intelligence and genomics, the health care sector is arguably already realizing breakthroughs in diagnostic and treatment protocols that promise major improvements in morbidity and mortality rates. In this context, continuing to restrict the emergence of a private insurance market for medical services threatens to impose major costs on Canadians in the form of foregone improvements in the quality and timeliness of delivered health care services.

Arguments surrounding the pros and cons of private health insurance received some attention in the Chaoulli court case in Quebec, as well as in the case brought by Dr. Brian Day in British Columbia. That said, a systematic reevaluation of allowing access to private health insurance for basic services seems appropriate, especially in light of theory and evidence that argues, on balance, that doing so would have net social benefits.

Introduction

Canada’s federal government significantly shapes the policies that characterize provincial health care systems through its funding of those systems via cash transfer payments into general revenues. The terms and conditions of these payments—enshrined in the Canada Health Act—have contributed to Canada’s health care system having features distinct from most other developed countries characterized as providing universal health insurance coverage. One such feature is the absence of private insurance markets for medically necessary services.

Sections 18–21 of the Canada Health Act (CHA), which prohibit user fees and extra billing for “medically necessary services,”¹ are an important feature of Canada’s health care system. Specifically, health care providers in Canada cannot charge patients for services in addition to payments recovered from the provincial government health care plan. Furthermore, there are no deductibles, co-pays, or other forms of patient cost sharing. Physicians in Canada are either prohibited or severely discouraged by provincial legislation from treating patients in both the public system and private practice. They are also either prohibited or discouraged from operating completely outside the public system. Specifically, as discussed in Gagnon (2018), currently five provinces (Prince Edward Island, Ontario, Manitoba, Alberta, and British Columbia) prohibit private insurance of hospital and medical services obtained outside their provincial Medicare plans.

Following the Chaoulli judgment (discussed later in this essay), Quebec lifted its prohibition of private insurance but only for a narrow subset of medically required treatments, namely hip, knee, and cataract surgeries. However, as might be expected, no private insurance market has emerged for such a narrow set of procedures. While other provinces do not prohibit private insurance markets for medically necessary services, they have policies in place that strongly discourage such markets. For example, Nova Scotia prohibits doctors who opt out of the public system from billing

¹ In Canada, medically necessary services exclude dental care outside a hospital setting, outpatient pharmaceuticals, vision, and cosmetic services. Insured services therefore encompass hospital services, physician services, and surgical-dental services. See <https://laws-lois.justice.gc.ca/eng/actsc-6/page-1.html>.

their private patients more than the public sector tariff. This obviously discourages physicians from moving out of the public system.

While the CHA clearly states that the insurance plan of a province must be administered on a not-for-profit basis, the legal status of providers who work entirely outside the public system is ambiguous under the CHA. Regulations surrounding shared costs of capital equipment with the public system and the vague wording of the CHA have contributed to an environment whereby provincial governments, fearing the loss of federal government funding, have implemented legislation (as mentioned above) that effectively prohibits private payment for medically necessary services (Barua and Gliberman, 2019). The effective prohibition on private payment for what might be called basic health care effectively extinguishes private insurance markets for such care in Canada.² The effective constraint on private insurance for basic health care is currently the focus of a legal challenge in British Columbia by Dr. Brian Day. His trial before the B.C. Supreme Court recently ended, although a decision had not yet been rendered at the time of writing.

The issue of whether basic health care insurance should be provided by either public or private insurers (or some combination of both) is conceptually separate from the issue of whether there should be patient cost sharing or whether there should be first-dollar coverage. For example, one can imagine a system where private insurers provide coverage for basic health care and where insurance premiums are calibrated so that cost sharing is not required to sustain the insurers' financial survival.³ Likewise, one can imagine a system where the public insurer imposes patient cost sharing but does not allow private insurers to offer policies that cover cost sharing expenses. In this case, the only way for patients to ensure they can cover cost-sharing expenses is to self-insure.

In short, the null status of private insurance in Canada for basic health care reflects specific features of Canada's health care system, notably the reliance on a single-payer government insurer, first-dollar coverage of basic health care services, and effective prohibitions on private payment for basic health care outside the public system. As long as these features are in place, there is no viable role for private insurance markets to play in

² In this context, private insurance can either be purchased from a third party or take the form of self-insurance manifested in out-of-pocket payments. In this essay, the term "basic health care" is synonymous with medically necessary or essential health care as those terms are used by different national governments and regulators, although the precise sets of services encompassed by these definitions vary across countries.

³ The issue of whether cost sharing enhances efficiency is dealt with in a separate and forthcoming essay by Bacchus Barua as part of a series of essays on health care reforms in Canada of which this essay is one.

the financial coverage of basic health care. However, this is clearly different from concluding that the previously mentioned features of Canada's health care system are necessitated by the undesirability of relying on private insurance in the context of basic health care. While prohibitions on private payment for basic health care constrain the *de facto* role that private insurance can play, there is no conceptual barrier to allowing private insurance to substitute for public insurance in Canada, even with some or all of Canada's restrictions on private practitioners charging for their services and first-dollar coverage under provincial insurance plans.⁴

The purpose of this essay is to identify and evaluate arguments for and against allowing private insurance markets for coverage of basic health care services. This includes the concern that private insurance for basic health care will destroy a parallel public universal scheme.

To circumscribe the focus of this essay and because the issue of cost sharing is addressed in Barua's forthcoming study as mentioned above, the analysis in this essay considers normative arguments for and against allowing private insurance to serve as a partial or total substitute for government-run insurance plans independent of whether the government-run plans impose cost sharing on patients.⁵ The use of private insurance for cost sharing in different countries is identified; however, as the focus of the essay is on insuring basic health care services, the essay does not address insurance for so-called supplementary services, that is, services not covered by the basic package of services as defined by health care authorities in different countries. All high-income countries are characterized by private insurance, including self-insurance, for supplemental health care.

The essay proceeds as follows. The second section identifies the widespread reliance on private markets for health insurance in countries that provide universal health-insurance coverage. The main point here is that universal insurance coverage does not require complete or even partial direct or indirect prohibition of private insurance markets to pay for some or all of the costs of basic health care. Section three discusses the conceptual advantages and disadvantages of private health insurance that have been raised in the literature, while section four considers some available evidence bearing upon the conceptual advantages and disadvantages. Concluding comments are provided in the final section of the essay.

⁴ For example, deductibles and co-pays for privately insured patients might be constrained by government regulations. Beyond prohibitions on service providers billing extra for services for which they are paid by the government insurance plan, providers in Canada cannot bill for services entirely privately if any costs of providing those services are imposed on or shared with the public insurance system. See Barua, Clemens, and Jackson (2019).

⁵ Most universal health care systems are characterized by cost sharing. See Globberman (2016).

Private Health Insurance in High-Income Countries

There are significant complications in trying to identify differences across high-income countries in their reliance on private health insurance. The Organisation for Economic Co-operation and Development's (OECD) online database reports statistics on health care financing; however, the "government funding" category is combined with "compulsory insurance schemes."⁶ The latter includes private insurance plans that individuals are either required by government to join or for which individuals are financially penalized if they do not join, as was the case for the Affordable Care Act in the United States.⁷ In short, the OECD database does not separately identify the share of health insurance that is privately provided, perhaps because it sees no significant distinction between government-provided health insurance and private insurance mandated and regulated by government. Whether or not there is a significant distinction will be considered in the next main section of this essay.

In the context of this essay, it is useful to distinguish between how health insurance is paid for and the mechanisms for carrying out the insurance function. In the context of basic health care, which is the focus of this essay, all countries characterized as providing universal health insurance coverage primarily employ general taxes or social insurance contributions to fund basic health care to a greater or lesser extent. However, the actual insurance function is often carried out by private-sector market participants, either for the entire package of basic services or for specific features that augment or differentiate the basic package in some way, for example, faster delivery of one or more basic services. In all high-income countries providing universal coverage, private insurance (often self-insur-

⁶ For this OECD data, see OECD.Stat at <http://www.stats.oecd.org/index.aspx?ThemeTreeld=9>.

⁷ Combining government-funded health insurance with compulsory health insurance results in the United States having a higher share of total health expenditures in this combined category than does Canada.

Figure 1: Classification of the Applications of Private Insurance

Category	Application
Primary	Covers all services deemed medically necessary by government health authority.
Secondary	Supplements coverage under public scheme. Primarily used to expedite access to services, expand choice of providers and gain amenities such as private hospital rooms.
Cost sharing	Through third-party insurance or out-of-pocket payments covers cost sharing associated with using the public scheme.

ance) is the mechanism for insuring against cost sharing for basic services under the public insurance scheme, in those countries where the government insurance scheme has cost-sharing arrangements.

Since insurance arrangements can differ across countries in myriad and detailed ways, the essay adopts a classification system that consolidates the arrangements into three broad categories (summarized in Figure 1). When expenses for all medically necessary services, excluding cost sharing for those services, are insured using private sector agents (for-profit or not-for-profit), the arrangement is identified as primary private insurance. When expenses incurred to augment or differentiate medically necessary services are insured using private-sector agents, the arrangement is identified as secondary private insurance. As noted above, such expenses are often associated with faster access to specific health care services, wider choice of providers, amenities such as private hospital rooms, and so forth. When expenses for sharing the costs of medically necessary services under the government insurance scheme covering basic health care are insured privately, the arrangement is simply identified as private insurance for cost sharing.

Unfortunately, a single source that summarizes insurance arrangements in all high-income countries with universal coverage could not be identified. Several studies provide insight into insurance arrangements in select high-income countries. For example, Joumard, Andre, and Nieq (2010) describe the insurance plans of a subset of OECD countries with universal health insurance coverage. Their description is qualitative and describes a range of characteristics of health insurance schemes including the nature of underlying regulations. They broadly identify three high-

income countries as relying extensively on private insurers to provide primary coverage for basic health care: Germany, the Netherlands, and Switzerland.⁸ That is to say, basic health care is essentially insured (for some or all residents) through private, albeit highly regulated, markets.

In Switzerland, mandatory universal health insurance coverage is funded through social insurance and general taxation and provided by competing nonprofit insurers supervised by the Federal Office of Public Health.⁹ In addition to what was identified earlier as primary private insurance, there is also secondary private insurance coverage for things such as free choice of hospital doctors and a higher level of accommodation in hospitals. While deductibles and co-insurance fees are a fundamental feature of basic insurance in Switzerland, contracts for secondary health insurance coverage (which can be offered on a for-profit basis) cannot cover cost sharing for the mandatory benefits package (OECD/WHO, 2011).

Basic health care in the Netherlands is financed primarily through social insurance levies and subsidies from general taxation. All residents are mandated to purchase statutory health insurance from private insurers (i.e., primary private coverage).¹⁰ For most residents, primary insurance coverage is provided by four large insurance conglomerates. All Dutch residents pay a premium directly to the insurer of their choice. There is also an employer contribution deducted from workers' pay and transferred to the Health Insurance Fund, which allocates resources among the insurers according to a risk-adjustment system. Adults are generally required to share in the cost of treatment for specialist services and hospital care (depending on treatment) through a deductible program (see Kroneman et al., 2016).

Health insurance is mandatory for all citizens and permanent residents of Germany. It is provided by two systems: 1) competing, not-for-profit, nongovernmental health insurance funds (i.e., so-called sickness funds); and 2) private health insurance. All employed citizens (and other groups such as pensioners) earning less than Euro 56,200 per year as of 2016 are mandatorily covered by one of the 118 sickness funds under the statutory health insurance (SHI) system. Individuals whose gross wages exceed the threshold, as well as select other groups such as civil servants, are legally able to buy private insurance for basic coverage. There were 42 private insurance companies providing primary private insurance in April

⁸ Jourmard, Andre, and Nieq (2010) do not identify differences across these countries in precisely what qualifies as basic health care.

⁹ A discussion of the Swiss health insurance system is also found in Sturny (undated).

¹⁰ The Dutch health system is also discussed in Wammes, Jeurissen, Westert, and Tanke (undated).

2016 of which 24 were for-profit (Blumel and Busse, undated). In addition, private insurance covers expenses associated with access to better amenities, that is, secondary private insurance, as well as co-payments for certain services acquired through the SHI system.

Joumard, Andre, and Nieq (2010) also identify countries in which private insurers provide secondary coverage, mainly to facilitate faster access to medical services and to a wider choice of providers. These include Australia, Ireland, and New Zealand. In Australia, about half the population has private insurance for faster access to nonemergency services and greater choice of providers (particularly in hospitals). When accessing hospital services, patients can opt to be treated under the public insurance scheme (with full fee coverage) or as a private patient (with 75 percent fee coverage) and with private insurance covering the expenses not covered by the public insurance scheme (Glover, undated). There are no deductibles or out-of-pocket costs for public patients using public hospital services, although general practitioners and specialists can choose to charge above the reimbursement rate under the public insurance plan. Hence, there is private co-payment insurance as well as secondary private insurance.

In New Zealand, private health insurance is offered by a variety of organizations. About one-third of the population has some form of private insurance, which is used mostly to cover cost-sharing requirements under the public scheme, as well as for elective surgery in private hospitals and private outpatient specialty consultations. It is also used to ensure faster access to nonurgent treatment.¹¹ In Ireland, about 40 percent of residents take out a private insurance policy. Private insurance is used to reduce long wait times for basic services covered by the government insurance scheme, as well as to pay for additional costs associated with using private facilities and “high-tech” hospitals (TransferWise, 2017). It is also used to cover cost-sharing expenses under the public insurance scheme.

Hence, Joumard, Andre, and Nieq (2010) identify six high-income countries that can be characterized as having primary or secondary private health insurance markets. In four of the previously discussed countries—that is, those that have a public insurance scheme for basic health care—private insurance is also used to compensate for cost sharing under the public insurance scheme. They also identify the role of private insurance in France and Belgium as primarily for cost sharing under the government scheme.

In France, basic insurance is technically provided by mutual benefit associations with residents being automatically affiliated with an association. Given the extensive involvement of the state in the acquisition of basic health insurance, many consider the French system for basic health

¹¹ Information about New Zealand’s health care system is also provided by Gould (undated).

insurance to be a single-payer system (Rodwin, 2018). There are co-payments for basic services covered under the public plan, as well as for vision and dental care that is only minimally covered by the government insurer. Private insurance provided by mutual benefit associations, along with out-of-pocket payments, cover such cost sharing under the public scheme. Private insurance also covers specific amenities, such as the cost of a single room in a hospital, up to a daily limit. However, private insurance is generally not used to obtain faster treatment or to access a wider choice of providers (Chevreul, Brigham, and Perronnin, 2016).

In Belgium, compulsory health insurance is organized through six private, nonprofit national associations of sickness funds and one public national association. A broad package of services is covered by the sickness funds with co-payments for inpatient care and pharmaceuticals. Individuals in Belgium entitled to health insurance must join or register with a sickness fund. Belgian sickness funds receive a prospective budget from the government's National Institute for Sickness and Disability Insurance to finance the health care costs of their members.¹²

Karl (2014) uses a variety of publicly and privately available sources of information to classify countries into categories based on how basic health insurance is funded. He does so for 11 wealthy OECD countries.¹³ The health care system of six of his sample countries has already been discussed. In the cases of Italy and the United Kingdom, Karl classifies the role of private insurance as providing what we earlier called secondary insurance. In the case of Italy, the National Health Service does not allow opting out into private insurance schemes. Hence, there is no primary private insurance. However, around six million people have secondary private insurance, which facilitates access to a wider choice of providers, as well as a higher standard of comfort and privacy in hospital facilities. Private health insurance policies also cover co-payments for certain prescribed procedures or specialist visits.¹⁴ Thorlby and Arora (undated) state that around 11 percent of the U.K. population had private insurance in 2015. Secondary private insurance offers more rapid and convenient access to care, especially for elective hospital procedures. There are also limited cost-sharing arrangements for publicly covered services including out-of-pocket payments for selective services provided by general practitioners.

¹² See Vandijck and Annemans (2009/2010). Foreign nationals working in Belgium can opt out of the state insurance scheme if they have acceptable private insurance.

¹³ They include Australia, Belgium, Canada, Denmark, France, Germany, Italy, Japan, the Netherlands, Switzerland, and the United Kingdom. All of these countries have universal insurance coverage.

¹⁴ See Donatini (undated) for additional information about Italy's health care system.

Karl (2014) identifies the role of private insurance in Denmark and Japan as covering cost sharing in the public insurance scheme.¹⁵ However, Vrangbaek (2018) notes that in the case of Denmark, nearly 1.5 million people (around 25 percent of the country's population) also hold private insurance to gain expanded access to private providers. Primarily private employers purchase this insurance as part of their employees' benefit package. In Canada, private insurance is only used to cover health care services not included in the government's basic health care package. Hence, there are no private insurance markets for what we identify as either primary insurance, secondary insurance, or cost sharing under the government scheme.¹⁶

In order to expand upon the use of private insurance markets in high-income countries with universal health insurance coverage, an additional literature search was undertaken. Information was available for Austria, Sweden, Norway, and Finland.

In the case of Austria, the General Social Insurance Act regulates nine regional social insurance funds that insure about three-fourths of the population. In addition, there are five company health insurance funds that cover the employees of five large companies. There is no competition between these funds and all cover broadly the same benefits. Since 2000, a number of self-employed groups (physicians, pharmacists, lawyers, architects, public accountants, veterinarians, and notaries) have the right to opt out of the statutory social insurance system. The latter must take up either voluntary self-insurance offered by a social insurance fund or private health insurance (often regulated by professional chambers).¹⁷ In this context, there is primary private insurance coverage for a portion of Austria's population similar to that in Germany. Private insurance can also be used to provide accommodation in "special fee class" rooms in hospitals and a wider choice of hospital physicians and ambulatory care providers.¹⁸ There is also cost sharing for various services under the basic social insurance fund package which entails out-of-pocket payments.

¹⁵ Japan provides universal health care coverage to residents through a statutory health insurance program comprising noncompeting public and employer-based insurance funds (Matsuda, undated).

¹⁶ Since single-payer insurance for basic health care in Canada has first-dollar coverage, there is no demand for private insurance to pay for cost sharing under the public scheme.

¹⁷ Details about health insurance options in Austria are provided in Bochner et al. (2018). See also Bobek, Lepuschutz, and Bochner (2019).

¹⁸ See https://www.euro.who.int/_data/assets/pdf_file/0009/182167/hit-austria-eng.pdf.

In Sweden, the county councils and nine regional bodies are responsible for insuring and delivering health care services (see Glenngard, undated). At the local level, 292 municipalities are responsible for care of the elderly and disabled. About 83 percent of health care expenditures was publicly funded in 2014. County councils account for almost 57 percent of funding, while municipalities account for around 25 percent of funding. The national government's funding share is only around 2 percent. General government grants redistribute funding among municipalities and county councils based on need and for specific initiatives such as reducing wait times. Private health insurance primarily covers services that are not part of the basic basket of services covered by public insurance. However, private insurance also covers health care advice and planning and elective surgeries, although this form of insurance accounts for a small percentage of total health care expenditures.¹⁹ In this respect, the Swedish system is closer to Canada's than are most other high-income countries in the modest role that private insurance markets in Sweden play in terms of primary and secondary coverage.²⁰ However, note that Sweden has no regulations prohibiting physicians (including specialists) and other staff who work in public hospitals or primary care practices from also seeing private patients outside the public system.

In the case of Norway, health care is financed primarily through national and municipal taxes.²¹ For some patient groups, cost sharing is reimbursed through social security contributions. Private health insurance is provided by for-profit insurers and purchased for quicker access to services, as well as to a greater choice of providers. About 9 percent of the population has some kind of private insurance, primarily paid for directly by employers. Hence, the Norwegian system seems best characterized as similar to those of Australia, Italy, and the United Kingdom in that private insurance facilitates quicker access to health care services and a wider range of service providers.

Finally, in the case of Finland, funding for health care is primarily through tax revenues collected by different levels of government, although the OECD (2017) notes that discussions toward implementing a single-payer system are ongoing in Finland. The Statutory National Health Insurance scheme covers all residents and is run by the Social Insurance Insti-

¹⁹ See <https://www.sciencedirect.com/science/article/pii/S01688510183000605>. In this regard, Sweden might be said to have a small secondary private-insurance market.

²⁰ However, there are out-of-pocket co-payments, primarily for pharmaceuticals, that account for around 5 percent of total health care expenditures.

²¹ For a discussion of Norway's health care system, see Lindahl (undated).

Figure 2: Functions of the Private Insurance Market

Country	Primary	Secondary	Cost Sharing
Australia		*	*
Austria	*	*	*
Belgium			*
Canada			
Denmark		*	*
France			*
Finland		*	*
Germany	*	*	*
Ireland		*	*
Italy		*	*
Japan			*
Netherlands	*		
New Zealand		*	*
Norway		*	*
Sweden		*	*
Switzerland	*	*	
United Kingdom		*	*

Sources: Journard, et al. (2010); Karl (2014); Bochner, et al. (2018); OECD (2017); Lindhal (undated); Glennard (undated); Keskimaki, et al. (2019); Matsuda (undated); Thorlby and Arora (undated); Glover (undated); TransferWise (2017).

tution.²² Private insurance is used to gain a wider choice of primary and specialist service providers and for shorter wait times. Out-of-pocket payments cover those treatment costs for which the public insurance scheme provides only partial reimbursement, particularly for services provided by private-sector physicians and hospitals (Keskimaki et al., 2019).

The qualitative descriptions of the role of private health insurance markets in high-income countries with universal health insurance coverage are summarized in Figure 2. Specifically, the functions of private insurance in covering basic health care expenditures are shown for 17 OECD countries.²³ By way of review, primary coverage means that private-in-

²² See OECD (2017) for an overview of Finland's health care system. About 20 percent of the Finnish population has private insurance.

²³ Since the focus of this essay is on insurance covering basic health care services, the

insurance markets essentially provide full coverage for basic health care for some or all of the population. Secondary coverage encompasses private insurance that is primarily used to facilitate faster access to medical services, as well as access to a wider selection of service providers. Cost-sharing private insurance is primarily used to cover some or all of the cost sharing imposed by public insurance schemes.

As shown in Figure 2, the majority of the sample countries utilize primary or secondary private health insurance to a greater or lesser extent in the context of paying for basic health care services. In four countries, private insurance markets provide primary coverage, while in 13 countries, private insurance markets exist for either primary or secondary coverage. Canada is unique in that it has no private insurance markets for any of the three possible applications discussed in this section.

Note that while there is cost sharing in Switzerland and Netherlands, as discussed earlier, we do not identify cost-sharing insurance to exist in either country in Figure 2, because those countries are considered to use private insurance (rather than public insurance) for basic health coverage. As well, while nongovernment insurers are used to administer basic health care coverage in Belgium and Japan, the national health service in each country contracts for insurance on behalf of the insurees. Hence, they are not classified in Figure 2 as having primary private-insurance markets. The identification of the United Kingdom as having private coverage for cost sharing is associated with a small set of specialized services provided under the National Health System. Finally, Sweden is identified as having secondary private insurance, although the percentage of the population with such coverage is quite small.

While there is room for debate about the identification of specific private insurance applications in particular countries, an inference that can be safely drawn from the information summarized in Figure 2 is that allowing private-insurance markets is compatible with universal health insurance coverage, given the many countries with universal coverage that have some type of private insurance associated with partial or total coverage of medically necessary services. To be sure, objections to relaxing restrictions on private health insurance markets in Canada are rooted primarily in concerns about a resulting “two-tier” health care system in which higher-income individuals receive “better” health care than lower-income individuals (Globerman and Vining, 1996).²⁴ In the next section,

use of private insurance to cover non-basic health care services, which is ubiquitous, is not reported.

²⁴ This can result from deterioration in the “quality” of care received under the public insurance scheme or superior care under private-insurance coverage, where the latter disproportionately covers higher-income patients.

we identify and discuss potential advantages and disadvantages of allowing private-insurance markets in the financing of basic health care services.

Conceptual Issues Surrounding Private Health Insurance

Perhaps the most fundamental objection to having private health insurance serve as the primary insurance plan for health care services is that it might result in significant numbers of people unable to afford health care.²⁵ In particular, to the extent that health-insurance premiums to individuals are risk-rated, elderly individuals and individuals with prior health conditions may be unable to afford the premiums charged by private insurers. In other cases, even relatively healthy individuals may have insufficient incomes to afford basic health care coverage. If a goal of society is that everyone has insurance that covers a fairly robust package of basic health care services, some cross-subsidization from relatively low-risk or high-income participants to relatively high-risk or low-income participants will likely be needed. In unregulated competitive markets, such cross-subsidies will not be implemented, since profit-maximizing insurers will compete to attract relatively low-risk customers by offering them risk-adjusted prices, thereby competing away the economic rent that could in principle be used to subsidize relatively high-risk, low-income customers.

Government insurance and affordability

A single-payer health insurance scheme subsidized through taxes is a robust mechanism to accomplish cross-subsidization, since taxes are mandatory, and the tax system can be progressive. All individuals can be offered the same basic health care coverage regardless of health status, and a progressive tax structure results in higher-income individuals subsidizing lower-income individuals. However, the features of a single-payer public system that facilitate universal coverage have other less desirable potential consequences. In particular, a government insurer has weak incentives to differentiate its insurance offerings to more closely match customer preferences. For example, some subset of customers might want access to faster delivery of health care services and would be willing to pay more for

²⁵ See De Wolf and Toebes (2016) for an extended discussion of this objection.

insurance packages that can “guarantee” short wait times. Since taxes are mandatory and need not be earmarked to particular services, there is no direct way for those wanting “short-wait-list guarantees” to signal their desires to bureaucrats. Furthermore, there is no direct reward to bureaucrats for modifying insurance plans to match customer desires more closely.

Williamson (1999) discusses the implications of redistributive transactions for the issue of public versus private provision of different types of services. He distinguishes between redistributive transactions that are for general purposes and broadly based (e.g., social security and Medicare) and those that are narrowly focused and special interest (e.g., the U.S. sugar support program). He argues that it is not at all obvious that a public bureau — with its low-powered incentives, red tape, and security of employment — is superior to a private bureau in discharging the operating duties for the underlying transactions in the case of broadly based redistribution schemes. On the other hand, highly politicized and special interest redistribution might favour the use of an agency with more direct access to government.

Government insurance and innovation

A related incentive problem with single-payer coverage is that the government insurer has asymmetrical incentives when it comes to dealing with health care innovations. Innovations in health care typically involve increased expenditures, at least in the short run. However, they are likely to provide substantial improvements in the quality of care with potential cost savings in the long run, as morbidity and related health care costs are reduced. Indeed, in the case of some new biological drugs, cures for previously incurable diseases are possible, thereby saving future costs of continued treatment. A problem here is that politicians in power may have to raise taxes to pay for medical innovations with large upfront costs and do not anticipate being in power in the more distant future when it might be possible to reduce taxes because of longer-run efficiency gains from those innovations.²⁶ Put simply, the government insurer has an incentive bias against modifying insurance coverage in a way that promotes the adoption of social welfare-improving health care innovations, particularly those with large upfront cost burdens and long-run distributed benefits.

Rumman et al. (2017) discuss an example of this bias in the case of antitumor necrosis factor (anti-TNF) therapy, which is a highly effective

²⁶ Equivalently, they will not be seeking election from voters who enjoy better long-run health care outcomes because of insurance coverage decisions made while they were in power.

but costly treatment for inflammatory bowel disease (IBD). Specifically, they report the results of a retrospective cohort study of IBD patients who were prescribed anti-TNF therapy (2007 – 2014) in Ontario. They assessed if the insurance type was a predictor of timely access to anti-TNF therapy and nonroutine health utilization (emergency department visits and hospitalizations). After holding other relevant factors constant, they found that publicly insured patients were less likely to receive timely access to anti-TNF therapy compared with those privately insured and that publicly funded patients were more than twice as likely to require hospitalization and emergency department visits.

An enduring and powerful argument for private ownership is the incentive that the owner has to innovate in order to earn entrepreneurial profits. Indeed, in a classic article, Shleifer (1998) argues that the choice of public versus private provision depends on how different ownership patterns affect the incentives to deliver “non-contractual” quality, as well as the cost of such delivery.²⁷ When assets are publicly owned, the public manager has relatively weak incentives to reduce costs or improve quality through innovation. In contrast, private contractors have much stronger incentives because they get more of the returns on investment in innovation. All else constant, the case for private delivery of insurance becomes stronger, the more important is innovation in structuring and administering insurance policies. Given the emergence of major technological developments such as artificial intelligence and gene therapy, medical innovations are becoming increasingly prominent, and insurers will be increasingly called upon by their customers to design and administer insurance plans that provide customers with access to welfare-improving medical innovations.²⁸

Some private health insurance schemes in OECD countries operate on a for-profit basis and others on a not-for-profit basis. As Shleifer notes, the incentives of for-profit organizations to innovate are “high-powered,” that is, the incremental profits that can be earned from innovation. While it is beyond the scope of this essay to discuss the circumstances influencing when insurers (or other types of organizations) will choose for-profit or not-for-profit status, Glaeser and Shleifer (2001) discuss why not-for-profit organizations can still be innovative and entrepreneurial. In the latter case, high-powered profit incentives are obviously not operative; however, residual claimants in nonprofits (which can include key employ-

²⁷ Non-contractual quality can be thought of as qualitative features of an output that are difficult to specify in an enforceable contract.

²⁸ For examples of innovative initiatives by private insurance companies in the United States in the area of financing access to expensive new technologies, see Gliberman (2019).

ees) can enjoy other benefits from increased donations including more generous employment benefits and other perquisites.²⁹

Supporters of government health insurance schemes identify advantages to such schemes that might offset their inferior incentives to innovate as discussed above. One, as noted earlier, is that public insurance schemes can be designed so that relatively low incomes or preexisting health conditions do not result in uninsured status. In fact, the reliance upon private insurers in Switzerland and the Netherlands for primary health care coverage is clear evidence that universal insurance coverage does not require government health insurance plans. Low incomes as a barrier to acquiring insurance can be addressed through direct or indirect government subsidies to low income individuals.³⁰ Preexisting health conditions as a barrier to affordable health insurance can be addressed by regulations that require private insurers to provide coverage for all applicants with funding mechanisms in place to compensate insurers that accept a disproportionate share of high-risk insurees.³¹ For example, in the Netherlands, private insurance companies are obligated to accept every resident in their area of activity and to provide a basic health insurance package designed by the government (DeWolf and Toebes, 2016).³²

Complexity and economies of scale

Another argument sometimes made in favour of having a government insurer provide a standardized package of benefits is that health insurance is complicated and that many, if not most, individuals cannot choose health insurance efficiently. Feldstein (1996) acknowledges that choosing health insurance is a complex decision but this does not mean that individuals should not be able to choose among competing insurers. Rather, if there is an information market failure, the role of government is to increase the

²⁹ Glaeser and Shleifer (2001) discuss the factors that influence an organization's choice of for-profit versus not-for-profit status.

³⁰ For example, payments through social insurance programs made by individuals are a function of income, so that higher-income payers subsidize the insurance premiums of lower-income payers. Direct income-based subsidies from government can also be utilized as, for example, in Switzerland.

³¹ Whether an independent regulator will be more or less efficient than bureaucrats working within a public bureaucracy such as a ministry of health depends upon the activities being regulated, among other things. See Williamson (1999).

³² Barua and Esmail (2015) provide an extensive discussion of the activities of for-profit insurers and hospitals in Australia, France, Germany, the Netherlands, Sweden, and Switzerland.

supply of useful information to consumers, perhaps through government information programs. He further argues that the ability of government bureaucrats to make informed decisions about health insurance is, itself, doubtful.

Yet another argument against private health insurance is that competition will either be attenuated or wasteful. The basic notion here is that there are economies of scale in administering health care plans and, therefore, that there is limited scope for a significant number of private companies to compete while operating at efficient scale, especially in small domestic economies. Without gainsaying the argument that there may be economies of scale in administration, the existence of private health insurers in small countries such as Switzerland and the Netherlands demonstrates that whatever administrative economies of scale exist, they do not economically mandate the use of a single health insurance provider.³³

Note also that the use of market power possessed by a single insurance provider to negotiate lower prices from suppliers is a pecuniary economy of scale and not necessarily a savings in real resources. Pecuniary economies of scale represent transfers of income, in this case from suppliers to a monopoly buyer. Cooper, Craig, Gaynor, and Van Reenan (2019) report evidence from the United States that in concentrated insurer markets (i.e., relatively few insurers), hospitals have lower prices and bear more financial risk. They also find that Medicare payments (i.e., payments by the federal government insurer) are substantially lower than payments by private insurers for the same services. However, these findings do not necessarily show that the lower prices extracted as a consequence of insurer buying power result in the hospital sector operating more efficiently at lower payment rates.

While a small number of private insurers departs from the classical model of perfect competition, there is no evidence that supplying health insurance is a natural monopoly, that is, only a single supplier can achieve the size necessary to exhaust all potential economies of scale. It should be acknowledged that private health insurers, especially those providing primary and secondary health insurance policies, are typically regulated. It is beyond the scope of this essay to describe in detail the regulations that the different countries listed in Figure 2 apply to private-sector insurers.³⁴ In most cases, there are prohibitions against charging risk-rated premiums for basic insurance. Some countries regulate premium costs, as

³³ Araral (2009) discusses the more general point that government provision is not necessarily the socially preferred organizational structure even under conditions of so-called natural monopoly.

³⁴ Joumard, Andre, and Nieq (2010) and Karl (2014) provide extensive discussions.

well as deductibles and co-pays. The main point here is that any concerns about market power on the part of private insurers can conceptually be addressed by regulations. A goal of any regulatory regime should be to preserve the incentives of the regulated entity to be innovative and efficient. Whether regulated private health insurers are more innovative and efficient than public insurers is ultimately an empirical issue, and we are unaware of any reliable comprehensive evidence on the issue.³⁵ However, it seems likely that as long as the regulatory regime allows for the owners of private insurance entities to retain some of the financial benefits of their innovative activities—that is, incentive regulation—private insurers will retain an innovative advantage over public insurers.

Equity

Efficiency is not the only criterion that features in considerations of using private or public health insurance. Equity is also a consideration. In particular, those promoting universal health insurance generally argue that a preeminent social objective is to ensure that all people obtain the health services they “need” without suffering financial hardship when paying for them.³⁶ Meeting this objective is the fundamental rationale for universal health care schemes that cover a minimally acceptable basic package of services, whether for-profit or not-for-profit private insurance markets are used for basic coverage. A more subtle equity issue that distinctly relates to the use of secondary private insurance markets is whether equity means that all members of society have equal access to the identical health care package. As discussed earlier, in countries that allow secondary private health insurance, the latter is typically used to obtain faster access to services, as well as access to a wider range of providers and, in some cases, amenities such as private hospital rooms. In this regard, if income differences or risk-rated premiums leave some individuals unable to afford secondary private insurance, while other individuals obtain such policies, this narrow definition of equity will obviously be violated.

Concerns about violating this very narrow definition of equity ostensibly underlie, at least in part, Canada’s resistance to embracing private health care markets in conjunction with the government’s basic health-insurance scheme. While Canadian politicians have decried two-tier health care as unfair, some academics have argued for a more utilitarian criterion

³⁵ In the next section, we consider evidence relating the performance of national health care regimes to the nature of the health insurance system.

³⁶ See DeWolf and Toebes (2016) for one such conceptualization of equity in health care.

to be employed (Globerman and Vining, 1996). Specifically, if private insurance allows some people to be better off, while others are no worse off, society as a whole will be better off by allowing private insurance markets to operate. In the literature addressing the utilitarian criteria surrounding private insurance, the framing of the issue is typically whether allowing some (presumably wealthier) individuals to buy primary or secondary insurance in private markets harms individuals (presumably poorer) who acquire basic health insurance through government plans.

This broad issue is also beyond the scope of this essay. However, the main economic arguments are discussed in detail in Globerman and Vining (1998). The critical consideration is what, if anything, changes for poorer individuals if and when wealthier individuals have increased private market options for health insurance. One possibility is that if wealthier individuals buy private insurance to duplicate coverage that they are paying for through taxes, albeit only allowing faster access to health care services, their political support for funding the public system might weaken. If a sufficient number of voters were prepared to support politicians running on platforms that called for lower taxes on higher-income individuals and reduced spending on basic health care through the public scheme, such that the policy was implemented, lower-income individuals would presumably be worse off, as funding of the public scheme was reduced.

Globerman and Vining suggest that this political outcome is unlikely given that the “median voter” in Canada is likely to be in an income bracket where political support for maintaining (or increasing) financial support for the public insurance scheme dominates political support for reducing financial support. Indeed, Globerman and Vining argue that if wait times became increasingly onerous, a growing share of lower-income voters might see it in their interest to pay more out of pocket (directly or indirectly) for faster access to care (and presumably spend less on other goods and services), thereby weakening the median voter’s support for funding the public insurance scheme. In effect, primary or secondary private insurance might be a “safety valve” that sustains widespread political support for the public insurance scheme by mitigating the potential for relatively long wait times to turn a majority of voters in favour of reducing public financing of basic health care.

Martinussen and Magnussen (2019) investigated whether increased uptake of private health insurance in Norway affected political support for the public health care system, controlling for a variety of other factors. They found no statistical relationship between respondents’ use of private health insurance and their support for public financing of health services. Olesen (2009) also found that the introduction of a private alternative to

the public insurance scheme in Denmark did not result in reduced political support for public insurance funding.

Even if the nominal budget of the public insurer remains constant, the supply of health care services covered by the budget might be adversely affected by additional competition for resources generated by the demand from individuals with private insurance. To illustrate this potential using an extreme example, imagine that there is one operating room in a geographical area currently being used at capacity, and that the use of that operating room is dictated by payment rates — that is, if a private insurance plan will pay more than a public insurance plan — priority in usage of that single operating room is likely to go to patients with duplicate private insurance. In this case, lower-income individuals without private insurance might wind up waiting for treatment longer than they otherwise would.³⁷ This “crowding out” problem might be mitigated if government regulations prevented sharing of facilities by patients covered under public and private insurance schemes. In this case, private insurers could only eliminate wait times for their clients by investing in an additional operating room and passing the cost on to their customers.

The assumption of a fixed supply of operating room services is, of course, extreme and arguably unreasonable in any time period other than the very short run. In particular, private insurers have financial incentives to increase capacity in the most efficient manner possible. For example, to facilitate access for their customers, private insurers might expand the capacity of the single operating room in the hypothetical situation described above or invest in an alternative outpatient operating room, if the latter is a more efficient alternative. In either alternative, there would be increased capacity available for patients both with and without secondary private insurance. Hence, lower-income individuals might wind up with shorter wait times than they would experience in the absence of private health insurers.

Perhaps the most problematic aspect of the “crowding out” objection to allowing private insurance is that the supply of skilled health care providers is limited and a willingness on the part of private insurers to “invest” in increasing that supply is unlikely to have a substantial effect.³⁸ It can certainly be argued that private insurers can, in principle, offer sup-

³⁷ If payment is not used as the rationing mechanism, presumably patient access to the single operating room would be determined through medical triaging, which, in principle, is not necessarily biased against lower-income individuals.

³⁸ This specific objection to private insurance was raised in the Chaouilli case in Quebec, where the constitutionality of wait times for basic medical services (and implicitly restrictions on private insurance) was litigated. See Gagnon (2018).

pliers of health care services sufficient financial rewards so that those suppliers are willing to work more hours, thereby increasing the quantity of services supplied. This expected market response mitigates a concern that high-income patients will “bid away” the services of health care providers from low-income patients. However, in the long run, the supply of health care providers’ services is primarily determined by how many doctors and nurses are educated and trained in domestic educational institutions, as well as how many trained medical professionals are allowed to immigrate into the country.³⁹ Policies regarding education and training of health care providers are the responsibility of provincial governments, while immigration policies are the responsibility of the federal government. If those policies are insufficiently responsive to the demands of Canadians for increased health care services, it will contribute to longer wait times for low-income patients whether or not private insurance markets are allowed to operate. Indeed, demand for private insurance might act as a signal to governments that wait times tied to limitations on the supply of health care providers are increasingly seen as a problem by patients.

The extent to which regulated private insurance markets are generally more innovative and efficient than government bureaucracies, as well as the impact of private insurance on access to health care, are ultimately empirical issues.⁴⁰ In the next section, we examine evidence bearing on these issues.

³⁹ For an analysis of the determinants of the supply of physicians in Canada, as well as projections of future supply, see Gliberman, Barua, and Hassan (2018).

⁴⁰ The realistic presumption is that private health insurance markets will always be highly regulated.

Evidence on the Consequences of Private-Insurance Markets

There are significant conceptual and empirical difficulties in identifying the relationship between the characteristics of health care systems and the efficiency of those systems.⁴¹ These difficulties are particularly acute when trying to link differences in the performance of national health care systems to any specific characteristic of the systems, such as the scope and nature of private-insurance coverage. The OECD notes that estimates of overall system efficiency are most meaningfully correlated with quality-of-care indicators such as avoidable admission rates in the in-care patient system. However, quality-of-care indicators do not have sufficiently wide coverage to permit reliable cross-country comparisons (Journard, Andre, and Nieq, 2010). Barua and Jacques (2018a) offer a comprehensive comparison of the Canadian health care system to those of other OECD countries. They conclude that while Canada is among the most expensive universal-access health care systems, its performance is modest to poor. Their conclusion is not, however, explicitly and exclusively linked to Canada's unique health insurance regime.

Notwithstanding these caveats, it is relevant that several prominent objections to allowing private insurance markets in Canada are not empirically supported in the literature. Most notably, Globerman and Vining (1998) reject the argument that allowing a larger role for private insurance will lead to a reduction of political support and financial support for the public insurance scheme. Their econometric analysis relies upon a cross-section of OECD countries for which they find that earlier period values of public health care financing as a share of total health care financing are unrelated to the future rate of growth of government health care expenditures. They also find that the mix of public versus private funding of health care is not statistically related to inflation rates in the health care

⁴¹ For an extensive discussion of the methodologies used to measure the efficiency of national health care systems and the limitations of the methodologies, see Journard, Andre, and Nieq (2010).

sector once the United States is excluded from the sample of countries.⁴² Based on this finding, they infer that allowing private insurance will not necessarily result in reduced access to medical care resources for individuals relying upon public insurance, at least for countries characterized by universal insurance coverage.

Administration costs

While administrative costs tend to be higher in countries that rely heavily upon market mechanisms to deliver basic health insurance packages—notably Germany, the Netherlands, and Sweden—administrative costs substantially exceed the OECD average in a number of other countries (Joumard, Andre, and Nieq, 2010). The implication is that administrative costs can be relatively high in largely public insurance regimes as well. As noted in the previous section of this essay, administrative costs are sometimes viewed as a diversion of resources away from more productive uses, even though administrative activities (at least in the private sector) can be directed at finding innovative ways to reduce health care costs and improve the quality of health care services (Himmelstein and Woolhandler, 2002). In this regard, the OECD finds no significant correlation between administrative costs and outcome-based efficiency scores in a sample of national health care systems (Joumard, Andre, and Nieq, 2010). The inference is that administrative costs may not be a critical contributor to the overall efficiency of health care systems, and that reducing administrative costs might come at the expense of other productivity-enhancing activities.

Two-tier health care

As discussed earlier, a substantive objection in Canada to allowing even secondary private health care insurance is that it will result in a two-tier system in which wealthier individuals would receive better health care than poorer individuals. However, there is no direct evidence that health status inequities are systematically related to the scope and nature of private health insurance. Indeed, an OECD study found that inequalities in health care tend to be lower than average in three of the four countries identified as using private insurance for basic coverage, namely the Netherlands, Switzerland, and Germany (Joumard, Andre, and Nieq, 2010). The authors infer that regulation and financial equalization ensure that indi-

⁴² Put differently, the increase in a price index of health care was not systematically related to the extent of health insurance privately supplied.

viduals with prior health conditions or with relatively low incomes suffer no disadvantages when it comes to accessing health care in systems with primary or secondary private insurance.

Since a major argument in favour of allowing private health insurance in Canada is that it will help reduce wait times, comparisons of wait times in Canada relative to other countries are informative.⁴³ The relatively long wait times in Canada have been amply documented by Barua and Jacques (2018b). Nevertheless, it is useful to present some evidence here.

Wait times

Tables 1 through 5 report surveyed wait times for different types of medical services for eleven high-income countries including Canada.⁴⁴ The first table reports the percentage of respondents able to get a same- or next-day appointment to see a doctor or nurse in 2016. The highest percentage is reported for the Netherlands, while Canada is tied with Norway at the bottom of the list. Table 2 reports the percentage of respondents who often or always receive an answer the same day when contacting their regular doctor's office with a medical concern. France has the "best" performance in this regard, while Canada is again at the bottom of the list of countries. Table 3 reports the percentage of respondents reporting waiting four or more hours the last time they went to the hospital emergency department, while Table 4 reports the percentage of patients who waited four weeks or longer to see a specialist after they were advised or decided to see one in the last two years. While France is the leading country in Table 3 and Switzerland is the leading country in Table 4, Canada is the worst-performing country in the sample for each performance measure. Finally, Table 5 reports the percentage of patients who reported waiting four months or longer for elective surgery in the last two years. Germany is the top performer by this measure, while Canada is the worst performer.

Given the few sample countries in Tables 1 through 5, as well as the absence of any precise and comprehensive measure of the relative importance of private health insurance for basic health care in each country, other than Canada, it is not possible to quantify the relationship between wait times and the reliance upon private insurance across the sample of countries. Indeed, excluding the United States, almost all of the countries listed

⁴³ Increased individual choice of coverage and faster access to welfare-enhancing innovations are also arguments made in support of private health insurance, as noted earlier.

⁴⁴ All of the data reported in Tables 1 through 5 are from the Canadian Institute for Health Information (2017).

Table 1: Percentage Able to Get Same-Day Appointment, 2016

Country	Percentage
Netherlands	77
New Zealand	76
Australia	67
United Kingdom	57
Switzerland	57
France	56
Germany	53
United States	51
Sweden	49
Norway	43
Canada	43

Source: Canadian Institute for Health Information (2017).

Table 2: Percentage Often or Always Receiving a Same-Day Reply, 2016

Country	Percentage
France	86
Germany	79
Australia	76
Switzerland	76
Netherlands	75
New Zealand	74
United States	68
United Kingdom	68
Norway	65
Sweden	61
Canada	59

Source: See Table 1.

Table 3: Percentage Waiting Four or More Hours in Emergency Department, 2016

Country	Percentage
France	1
Germany	3
Netherlands	4
Switzerland	7
United Kingdom	8
New Zealand	10
Australia	10
United States	11
Norway	13
Sweden	20
Canada	29

Source: See Table 1.

Table 4: Percentage of Patients Who Waited Four Weeks or Longer to See Specialist, 2016

Country	Percentage
Switzerland	22
Netherlands	23
United States	24
Germany	25
Australia	35
France	36
United Kingdom	37
Sweden	42
New Zealand	44
Norway	52
Canada	56

Source: See Table 1.

Table 5: Percentage of Patients Who Waited Four or More Months for Elective Surgery, 2016

Country	Percentage
Germany	0
France	2
United States	3
Netherlands	4
Switzerland	6
Australia	8
Sweden	12
United Kingdom	12
Norway	15
New Zealand	15
Canada	18

Source: See Table 1.

in Tables 1 through 5 have universal coverage and primary or secondary private insurance markets. Only France and Canada are exceptions.

While the precise rank order positions of the countries vary from table to table, there is some regularity in those positions. This regularity is identified by calculating the Spearman rank order correlation coefficients between pairs of tables.⁴⁵ While there are ten possible rank order relationships to estimate, we calculated only the rank orders between successive tables, for example, Tables 1 and 2, Tables 2 and 3, and so forth. The correlation coefficients ranged from .61 to .86, which suggests substantial consistency in the relative performance of countries with respect to timely delivery of health care.⁴⁶ Arguably the most important takeaway is that universal health care countries with either primary or secondary private

⁴⁵ The Spearman rank order correlation coefficient is a measure of the correspondence between two series of ordinal numbers (or rankings). An estimated value of one would indicate that the rank order of countries by one measure is identical to the rank order by another measure.

⁴⁶ It is suggestive that Sweden, which has a small secondary private insurance market, most closely compares to Canada with respect to wait times.

health insurance markets typically have shorter wait times than does Canada. Admittedly, France does relatively well with respect to wait times. This might partly reflect cost sharing in France's public system, which discourages low-priority usage of health care resources.

There are studies that examine the relationship between an individual country's insurance regime and wait times or other measures of availability of service under the public insurance scheme. Duckett (2005) discusses evidence in the context of Australia, which suggests that increased private-sector activity is associated with increased public-sector waiting times. However, he also points out that the correlation between the two variables is low. He adds the additional caveat that because he uses a cross-sectional sample, what is being measured is association and not necessarily causation. Hence, increased wait times under the public insurance scheme might have encouraged the growth of private insurance alternatives rather than the reverse.

Other studies that look at how private insurance affects utilization of health care services also provide insight into whether private insurance options will lead to reduced access to medical services covered under the public insurance system. For example, Fabri and Monfardini (2016) examine whether people enrolled into voluntary health care insurance in Italy substitute public consumption with private (opt out) or just enlarge their private consumption without reducing reliance upon public provisions. They conclude that wealthier individuals consume more services under private coverage but concomitantly reduce the services they utilize under the public scheme.

In a similar vein, Sogaard, Pedersen, and Bech (2013) examine the extent to which employer-paid health insurance has led to substitution of public with private hospital use in Denmark. They conclude that the effect of employer-paid health insurance contributed to a significant reduction in the total use of public hospitals.⁴⁷ Finally, Cantaro-Prieto, Pascual-Saez, and Gonzalez-Prieto (2017) report a study of the effect of private health insurance on health care utilization in Spain. They conclude that people with private health insurance use the public health system less than individuals without "double" health insurance coverage. On balance, therefore, available studies suggest that individuals relying upon public insurance will not suffer reduced access to health care services given the existence of private insurance options.

It might be objected that available studies of how private insurance affects the overall demand for health care resources — as well as the wait

⁴⁷ Kiil and Arendt (2017) find that private health insurance in Denmark has increased the net demand for some medical services, but the relationship was not statistically significant in the context of general practice and hospital-based outpatient care.

time data cited earlier — are selective, and perhaps misleading, measures of access to “necessary” health care services paid for by the government insurer. For example, the Commonwealth Fund reports that in 2016, more Canadians (59 percent) who experienced emotional distress were able to get access to mental health care than the average of respondents (54 percent) of the other ten high-income countries listed in Tables 1 through 5 (Canada Institute for Health Information, 2017).⁴⁸ The Commonwealth Fund’s survey of seniors asked respondents to rate the medical care received over the past twelve months from their regular doctor’s practice or clinic. The percentage of Canadian respondents who rated this care as excellent (74 percent) was higher than the average (65 percent) of the other ten high-income countries. On the other hand, only 45 percent of Canadian respondents rated the overall quality of medical care in their country as excellent compared to an average of 51 percent across the ten other high-income countries.⁴⁹

Since seniors are disproportionate users of health care, the relative dissatisfaction of Canadian seniors with their country’s overall quality of medical care is noteworthy. Table 6 provides more detail on how the overall populations of the sample countries rate the quality of health care they receive. Specifically, Table 6 reports the percentage of respondents rating the overall quality of medical care in their country as excellent or very good. While Canada does slightly better on this overall measure than on measures of wait times, it ranks only ninth on the list of eleven countries.⁵⁰ In short, while Canadians might rate specific medical services as delivered in a timely and satisfactory fashion, Canadians are relatively dissatisfied with the overall quality of their health care system compared to other countries with universal health insurance.

Longer wait times in Canada might be less unacceptable to the extent that wait times did not systematically favour wealthier patients, that is, that both higher- and lower-income individuals had identical access to health care services. Since a major concern in Canada about allowing private insurance is that it would result in wealthier individuals gaining preferable access to health care services, data on whether wait times vary

⁴⁸ Note that mental health care services provided on an outpatient basis are not classified as medically necessary and, therefore, can be paid for through private insurance in Canada.

⁴⁹ Survey results specifically for seniors are reported in Canadian Institute for Health Information (2018). Impressions of quality might reflect expectations that, in turn, may differ across countries.

⁵⁰ Data for Table 6 are from Canadian Institute for Health Information (2017).

Table 6: Percentage Rating Overall Quality of Medical Care as Excellent or Very Good, 2016

Country	Percentage
Switzerland	65.5
United Kingdom	63.4
Australia	59.4
New Zealand	57.7
France	52.1
Netherlands	51.1
Norway	50.5
Germany	48.9
Canada	45.1
Sweden	39.1
United States	25.7

Source: See Table 1.

by income levels is quite relevant to policy considerations of the role of private health insurance in the financing of universal coverage.

In this regard, the Commonwealth Fund (2017) reports responses to a survey asking whether respondents waited six days or more for a medical appointment the last time the respondent needed care. The respondents were segmented into two categories: low-income adults and all other adults. The percentage of low-income adults responding in the affirmative is reported in column 1 of Table 7. The percentage of all other adults responding in the affirmative is reported in column 2. Column 3 reports the difference between the two columns for each sample country. A larger calculated difference indicates that low-income adults waited longer than other adults.⁵¹

More equitable timely access to medical services would be consistent with smaller calculated differences as reported in column 3 in Table 7. With regard to this latter measure, Canada performs better (in relative terms) than it does in comparisons of overall wait times, although there are six other countries with a more favorable ranking with respect

⁵¹ Unfortunately, other wait-time data by income are not available.

Table 7: Percentage Waiting Six Days or More for Medical Appointment, 2016

Country	Low-Income (col. 1)	Other (col. 2)	Difference (col. 3)
Netherlands	5	5	0
New Zealand	7	3	4
Australia	11	7	4
Switzerland	14	9	5
United Kingdom	27	16	11
France	27	17	10
Norway	29	25	4
Sweden	32	24	8
United States	35	17	18
Canada	37	27	10
Germany	38	27	11

Source: Commonwealth Fund (2017, June 19).

to equitable access. Indeed, five of the top six countries by this measure of equitable access are characterized by private markets providing either primary or secondary health insurance.

In short, the concern that introducing private insurance markets for basic health care in Canada will accentuate inequities in timely access based on income is not generally supported by the experiences of other universal health care countries. Indeed, the fact that Canada's single-payer system does not top the ranking with respect to equitable access undermines a major argument that has been offered in support of that system. Evidence that the actual delivery of health care might be conditioned by socioeconomic status also undermines the equity defense of a single-payer regime. Alter et al. (2004) provided evidence. The authors examined how patients with myocardial infarction and from different socioeconomic backgrounds perceived their care in Canada's single-payer system and correlated patients' backgrounds and perceptions with actual care received. Their data was drawn from a sample of 2,250 patients from 53 hospitals in Ontario. They found that compared with patients having lower socioeconomic status, more-affluent or better-educated patients were more likely to undergo coronary angioplasty, more likely to receive cardiac re-

habilitation services, and more likely to have follow-up consultations with a cardiologist.⁵²

In summary, there is no systematic and compelling evidence that allowing private health insurance markets necessarily compromises access to medically necessary services or contributes to overall dissatisfaction with the health care services provided. If anything, the single-payer system in Canada is associated with longer wait times than other countries with universal health care. Canadians also rate the overall quality of medical care they receive below that of respondents in all but one of the other countries that provide universal health insurance.⁵³ There are arguably other features of Canada's single-payer system that contribute to Canada's performance relative to other universal health care countries as summarized above, including an absence of any cost sharing for basic health care and global budgeting for hospitals. While it is not possible to parse out the unique contribution of Canada's single government insurer, the argument that allowing private health insurance improves overall timely access to basic health care without compromising equitable access to health care is generally supported by available information.

⁵² However, socioeconomic status was not significantly associated with mortality at one year following hospitalization for myocardial infarction.

⁵³ With reference to Table 6, the United States does not qualify as providing universal health insurance coverage.

Concluding Comments

Opposition in Canada to private health insurance markets for basic health care has, to my knowledge, never been comprehensively explained.⁵⁴ Often opponents point to the many individuals in the United States who have no health insurance or are significantly underinsured as a likely consequence for Canada if private insurance markets for medically necessary services were allowed to exist in Canada. The obvious rebuttal is that private health insurance markets exist in virtually all high-income countries that do qualify as providing universal health insurance coverage. Furthermore, many of these countries allow private insurance markets to cover basic health care, either as primary or secondary insurance.

While it is difficult to estimate statistically whether and how the scale and scope of private insurance activity is related to the efficiency of national health care systems, strong theoretical arguments point to a positive relationship. There is also persuasive empirical evidence that Canada performs poorly in terms of timely access to health care services compared to other high-income universal health care countries — most of which embrace private insurers as either a significant partner, or at least as a “pressure valve.” Opponents of private insurance have often argued that allowing private markets will lead to a system where some patients enjoy “better” health care outcomes than others depending upon income levels and preexisting health status; however, this does not appear to be a systematic outcome in high-income universal health care countries that allow private insurance markets.⁵⁵

Indeed, and ironically, there is evidence that access (and perhaps even outcome) inequality already exists in Canada, notwithstanding arguments that allowing private insurance in Canada will result in inequality of health care along socioeconomic lines. In particular, many wealthier Canadians can and do gain quicker access to health care services by going outside the country and paying out of pocket. Perhaps more notable, in a

⁵⁴ Several of the major arguments against private health insurance were raised in the Chaoulli case, as discussed by Gagnon (2018).

⁵⁵ It can be argued that private insurance facilitates access to faster care and possibly superior inpatient accommodations compared to those covered through public insurance.

recent survey, a sample of Canadian seniors were asked to self-report their health status. Approximately 29 percent of seniors with annual household incomes below \$25,000 described their health as fair or poor, while only about 11 percent of respondents with annual household incomes greater than \$55,000 described their health as fair or poor (Canadian Institute for Health Information, 2018). While it can be reasonably argued that low income, by itself, contributes to poorer health status, one can infer that Canada's single-payer system does not appear to obviate perceived differences in health status across income levels.

In short, it is easier to make a coherent public policy case in favour of allowing private health insurance markets for basic health care services than it is for prohibiting such markets. Furthermore, this is likely to be increasingly so as technological change produces innovations in diagnosing and treating diseases at an accelerating rate using artificial intelligence, genetic screening, and computational biology, among other techniques. Public insurers have incentives more consistent with short-run cost containment than with promoting the adoption of innovations that promise to increase the health status of current and future generations. This incentive system will be increasingly inconsistent with identifying and implementing innovative insurance schemes that promote rather than discourage the access that Canadians should enjoy to new and increasingly life-saving medical therapies.

The issue of whether Canada should allow private insurance markets to provide basic health insurance is obviously complex. However, available empirical evidence justifies a critical reassessment of whether Canadians are best served by continuing the current single-payer system.

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