



e-Rounds 14

Privatizing Health Care is not the answer: Lessons from the United States.
Marcia Angell. CMAJ 179(9): 916-919, 2008.

Background: From time to time, a compelling analysis of private health care is published in the peer-reviewed literature. Arising out of a lecture to the American and Canadian Orthopedic Associations in Quebec (2008), Dr. Marcia Angell reviews a wide range of topics and evidence on what Canada might learn from the United States as it relates to both private funding and for-profit delivery of services currently covered under Canada's Medicare program.

Methods and Limitations: Dr. Marcia Angell is a physician and senior lecturer in social medicine, Department of Global Health and Social Medicine, Harvard University, Boston. Dr. Angell is recognized for her work on health reform and offers a compelling perspective to inform Canada's experiments and practices in private health care delivery and funding. This analysis, however, represents the perspective of a single physician academic and may not be representative of the perspectives of other US-based physicians.

Analysis: Proponents for an American-style system argue there is more choice, better quality, faster access, and less public expenditure. Dr. Angell's essay suggests anything but. She reminds us that before Canada's Medicare Act (1966), Canada and the U.S. had similar systems of health care, partially public and partially private, and of a similar cost. Once the last jurisdiction joined Canadian Medicare, the Yukon Territories in 1972, the two systems began to diverge, with the result being that by 2005, U.S. expenditures were \$6697 per person (a figure that has risen to \$7421 as of 2007¹), compared to Canada's \$3326 per person. Moreover, Canada insures all of its people for necessary doctor and hospital care, yet 15% of Americans have no insurance whatsoever and 37% of the population report they have foregone needed care because of cost (compared to 12.6% Canadians).

A critical question is whether there are better outcomes in the U.S. given this divergence in cost. The answer is a resounding "no". Americans now live 2.5 years less than Canadians, have higher infant mortality rates, more preventable deaths, and fewer doctor visits, acute care hospital beds, and nurses. Even with slightly more doctors per capita and more MRI units, US health indicators are worse than those in Canada. The paradox of paying more and getting less is attributed to enormous inefficiency, with healthcare treated as a market commodity as opposed to a social service. Americans under age 65 are dependant on tax-free health care benefits offered only by some employers (not all), who contract with largely private investor-owned, for-profit insurance companies. Insurers shift costs back to beneficiaries through deductibles, co-payments and claims denial, and they avoid sick patients all together through adverse risk-selection practices. Not surprisingly, the cost of administering these practices, together with marketing costs, profit-skimming, and revenues siphoned off by other components of the medical industrial complex, resulted in overhead costs conservatively estimated in 1999 at 31% for every health care dollar, the highest in the world.

Embedded within the U.S. system is the most popular component of American healthcare, Medicare, the single-payer, government funded program for the aged. Medicare is highly efficient, with about 2% overhead (similar to Canada's 1.3% overhead drawn by the provincial single payers) and with universal coverage. However, changes brought about by past US government administrations have weakened the system, increased out-of-pocket expenses, and set off cost inflation to potentially unsustainable levels.

Commenting on Canada's system, Dr. Angell's perspective is that neither the payment or delivery structure of our system are the problems but, rather, constrained funding, which has resulted in some long waiting times for elective procedures and corresponding calls for privatization. She points out, as other Medicare e-Rounds have, that private health care shortens waiting lists for the private system but increases them in the public system by drawing off resources – physicians and other assets. For-profit health care is also more expensive, but no more efficient, than not-for-profit health care, and often of lower quality.

Summary: Dr. Angell's rebuke of the U.S. system is striking. Her caution is that privatizing Canada's health care system, even a little, will increase costs, decrease quality, and lower access. Accordingly, her advice is to "expand and reinforce the public system, not undermine it."

In the near future, we are likely to see changes in the US health care, with 2/3 of Americans and 3/5 of doctors wanting a Canadian-style publicly-financed system. Vigorously opposing this are big private insurance, for-profit facilities, and procedure-orientated specialists.

¹ Hartman, M., Martin, A., McDonnell, P., Catlin, A. et al. *National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth since 1998*, Health Affairs, 28, no. 1: 246-261, 2009.