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# THE BORDERS OF SOLIDARITY: HOW COUNTRIES DETERMINE THE PUBLIC/PRIVATE MIX IN SPENDING AND THE IMPACT ON HEALTH CARE

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## I. INTRODUCTION

**THERE IS VIGOROUS DEBATE** about the appropriate roles of public and private finance in health care in many countries. How do different countries determine the mix of public/private health care funding? What is the role of the courts in determining who should receive publicly funded services and in what time frame? What is the potential for a “Patients’ Bill of Rights” to address these kinds of issues? And what differences do we find in terms of performance when we consider different mixes of public/private funding?

In this paper we examine six countries: Canada, the United States, the United Kingdom, New Zealand, Australia, and the Netherlands. We have selected these countries because they are of roughly similar wealth and, with the notable exception of the

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United States, aspire to have national health care systems. However, the structure and dynamics of each system is sufficiently different that each of these countries can learn lessons from the others about the impact of different mixes of public and private financing. For each country we begin by looking at the processes by which the public/private mix in spending is determined and the philosophical approach each country takes in deciding what services to publicly fund and how to ration health care. We look at court challenges by citizens in these countries who are dissatisfied with rationing decisions and we also examine the extent to which these different countries have sought to respond to citizens' concerns through the establishment of Patients' Bills of Rights. We then turn to examine what evidence there is on the impact of the public/private mix on health outcomes, utilization, spending and waiting lists and times.

We have identified four basic models in term of the public/private mix,<sup>1</sup> and the countries we are studying provide examples of these four models:

1. Parallel public and private systems: For a given range of services, a separate privately financed system exists as an alternative to the public sector. Britain, New Zealand, and Australia are examples of this type of "two-tier" system where people, who either have the resources or private insurance, can go to private hospitals and jump queues for treatment in the public sector. The services that are provided in the private sector are primarily elective (non-emergency) care.

2. Co-payment: Health care services are partially subsidized by the public sector, with the remainder financed by out-of-pocket payments and/or private insurance. The level of charges may be scaled according to the patient's income. In New Zealand there are significant user charges for family doctor services—although thirty-seven percent of the population have private insurance to help cover this cost, but many must pay out-of-pocket. In Australia there are out-of-pocket payments for a range of different services, albeit with a compli-

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<sup>1</sup> Carolyn H. Tuohy, Colleen M. Flood & Mark Stabile, *How Does Private Finance Affect Public Health Care Systems?: Marshalling the Evidence from OECD Nations 1-2* (June 1, 2001) (working paper) (on file with Health Matrix).

cated system of safety nets in place, so as not to deter access by those on low incomes. In the United States, the benefits provided under the Medicaid and Medicare public programs, with some exceptions, require out-of-pocket payments.

3. Group-based: Certain population groups, such as the elderly and those on social assistance, are eligible for public coverage; others rely on private insurance. The United States and the Netherlands are examples of such a system. However, the Netherlands differs from the United States in an important respect: in the Netherlands the majority of people are included in a mandatory social insurance plan, whereas in the United States most people are ineligible for public insurance and either hold private insurance or have no insurance.

4. Sectoral: Certain health care sectors are entirely publicly financed; others are privately financed. The primary example of this is the Canadian system where almost 100% of hospital and physician services are publicly funded, but where there is much more private financing of drugs, experimental therapies, and home care.

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

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

In this section we provide a detailed breakdown of the public/private mix of financing in each country, explain each country's philosophical approach to allocating health care, and explain how it is decided what services will be publicly funded and whether services are rationed explicitly or implicitly. As predominantly public systems like Canada, New Zealand, Australia, and the United Kingdom have engaged in explicit and implicit rationing of health care, dissatisfied citizens are increasingly turning to the courts. Thus, we examine court challenges launched against rationing decisions. Another measure that we explore is the introduction of Patients' Bills of Rights, particularly insofar as these initiatives speak to expanding pa-

tients' entitlements to publicly funded health care services or to ensuring timely treatment.

## A. Canada

### 1. Public/Private Mix

The most recent spending figures break down total health spending in Canada for the year 2000 as follows: Federal government direct spending - 3.8%; provincial governments - 65.2%;<sup>2</sup> municipal governments - 0.8%; social security funds - 1.2%;<sup>3</sup> and private funds/insurance - 29%.<sup>4</sup> Looking more closely at private spending, out-of-pocket payments by patients account for approximately 17% of total health care spending.<sup>5</sup> The importance of private financing varies depending on the particular health service or good under at issue; for example, private financing of retail prescription drugs accounted for 58.6% of the total spent.<sup>6</sup>

### 2. Philosophical Approach

Canada's primary principle in allocating health care services is that care should be allocated on the basis of need and not ability to pay.<sup>7</sup> However, there are explicit limits to the principle that care should be allocated on the basis of need, i.e., it only applies to certain kinds of goods and services. As described in the introduction, the Canadian system falls within the "sectoral" model in terms of the public/private mix, with certain

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<sup>2</sup> Provincial spending is subsidized by federal transfer payments but the real extent of the subsidization is difficult to determine and is hotly contested.

<sup>3</sup> In the Canadian context social security funds refer to Workers' Compensation.

<sup>4</sup> CANADIAN INST. FOR HEALTH INFO., HEALTH EXPENDITURES DATA 2000 (2001), available at [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=spend\\_nhhex\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=spend_nhhex_e).

<sup>5</sup> ORGANISATION FOR ECON. CO-OPERATION AND DEV., OECD HEALTH DATA 2000: A COMPARATIVE ANALYSIS OF 29 COUNTRIES (2001) [hereinafter OECD HEALTH DATA]. See the organization's web site at <http://www.oecd.org/> for more updated information.

<sup>6</sup> CANADIAN INST. FOR HEALTH INFO., HEALTH CARE IN CANADA 2001, at 77 (2001), available at [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=AR\\_43\\_E&cw\\_topic=43](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_43_E&cw_topic=43). The CIHI notes that in 1998 Canadians paid for 2% of retail prescription drugs out-of-pocket and private insurers financed another 34.6%. *Id.*

<sup>7</sup> NAT'L FORUM ON HEALTH, CANADA HEALTH ACTION: BUILDING ON THE LEGACY - VOLUME I (1997), <http://www.nfh.hc-sc.gc.ca/publicat/finvol1/idxvol1.htm>.

services being fully publicly funded and others being left much more to a mix of private and public funding. The Canada Health Act<sup>8</sup> (CHA) primarily protects and ensures 100% public funding for “medically necessary” hospital services and “medically required” physician services.<sup>9</sup> The foundations of Canada’s publicly funded system<sup>10</sup> were laid down in the 1960s. Understandably, at this time, hospital and physician care was seen to be of key importance as having to pay for the cost of this care could be the source of financial catastrophe for patients. However, since then, advances in technology have caused a rise in the importance of potentially very expensive drug therapy, gene therapy, and home care; yet the CHA does not protect or ensure public funding for these goods and services.

### 3. Processes for Determining What Is Publicly Funded

How does the Canadian system determine what services are publicly funded? Most Canadians view the CHA as encapsulating their entitlements to publicly funded health care. The CHA is a strong political symbol of Canadian values in health, but in legal terms it is a spending statute setting out the conditions upon which the federal government will make transfer payments to the provinces.<sup>11</sup> The provinces, pursuant to the Constitution, are responsible for operating their own respective health care systems. Through the CHA the federal government seeks to reconcile its desire to ensure national standards with its respect for the fact that the courts have interpreted the Constitution in such a way that health care is largely viewed as a provincial matter. The CHA sets out five criteria that each provincial insurance plan must comply with in order to obtain federal fund-

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<sup>8</sup> R.S.C., ch. C-6, § 1 (1993).

<sup>9</sup> Colleen M. Flood, *The Structure and Dynamics of Canada’s Health Care System*, in CANADIAN HEALTH LAW AND POLICY 18-28 (Jocelyn Downie & Timothy Caulfield eds., 2000).

<sup>10</sup> This system is known as medicare—not to be confused with the U.S. Medicare program for those over 65.

<sup>11</sup> Flood, *supra* note 9, at 18; see also R. DEBER ET AL., NAT’L FORUM ON HEALTH, SUMMARY OF THE PUBLIC-PRIVATE MIX IN HEALTH CARE (Feb. 1997), available at <http://www.nfh.hc-sc.gc.ca/publicat/issuesum/deber1.htm> (listing the five federal conditions established in the CHA as universality, accessibility, comprehensiveness, portability and public administration); *infra* notes 10-12 and accompanying text.

ing: comprehensiveness, accessibility, universality,<sup>12</sup> portability<sup>13</sup>, and public administration.<sup>14</sup> Although all the criteria of the CHA are very important and interact together as values that guide medicare, we discuss below the two principles that are most relevant to determining what services will be publicly funded: comprehensiveness and accessibility.

In terms of "accessibility," § 12 of the CHA provides that, in order to qualify for federal funding, a province's plan must provide "insured health services" on uniform terms and conditions and in a way that ensures "reasonable access." However, the most explicit sections of the Act speaking to accessibility are those that expressly prohibit out-of-pocket payments and extra-billing for medically necessary hospital and physician services. A "user charge" occurs when a patient has to pay out of her own pocket to cover some or all of the cost of care.<sup>15</sup> "Extra-billing" occurs where a doctor charges a patient additional amounts beyond that received from the government, resulting in a patient paying for this difference out-of-pocket (a user charge) or, if they have it, their private insurer covering the difference. The CHA requires the federal government to claw-back, on a dollar-for-dollar basis, from transfer payments those sums that are paid for medically necessary hospital and physician services as user charges or extra-billing in a province. The

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<sup>12</sup> A provincial plan must entitle 100% of the insured persons of the province to the "insured health services . . . on uniform terms and conditions." Canada Health Act § 10. An "insured person" is defined, with some exclusions, as a "resident" of a province. *Id.* § 2. A "resident" is further defined as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province." *Id.*

<sup>13</sup> A province's plan must insure all residents within 3 months of arrival in the province and pay for the cost of insured health services provided to insured persons while temporarily absent from the province at the rate approved by the insurance plan of the province in which the services are provided or otherwise by agreement. *Id.* § 11(1). Section 11(2), however, states that the criterion of portability is not contravened if the administrator of a provincial plan requires a patient to obtain the administrator's consent before receiving non-emergency health services in another province "if the services in question were available on a substantially similar basis in the province." *Id.* § 11(2).

<sup>14</sup> Despite the emphasis on "public" administration, there is nothing preventing a provincial ministry of health from contracting with a private corporation to manage its health insurance plan. In 1997, the New Brunswick Ministry of Health had entered into a contract (now terminated) with Blue Cross of Atlantic Canada to build a new Medicare billing system and process Medicare billings for the province.

<sup>15</sup> Patients may, if they do not hold private insurance to cover the user charge, have to pay for the cost thereof out-of-pocket.

CHA is very clear about what must happen in the event of the existence of user charges or extra-billing and that financial barriers should not constrain access. However, the CHA has nothing explicit to say about constraining access where the system does not have the capacity to meet a particular need or meet a particular need in a timely fashion.

In terms of “comprehensiveness”, § 9 requires provinces to insure “all insured health services provided by hospitals, medical practitioners or dentists.”<sup>16</sup> Section 2 defines “insured health services” as “hospital services, physician services and surgical-dental services provided to insured persons”<sup>17</sup> The substantive content of “hospital services” coverage is set by a specific list of in-patient services that are “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.”<sup>18</sup> “Physician services” are defined as “any medically required services rendered by medical practitioners.”<sup>19</sup> The CHA does not define the terms “medically necessary” or “medically required.” In practice this leaves provinces with discretion as to which hospital and physician services will receive public funding. The services that are publicly funded are negotiated between each provincial ministry of health and each provincial medical association. The results of these negotiations thus determine what services are “medically necessary” or “medically required.” In other words, the phrases “medically required” and “medically necessary” are not used as

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<sup>16</sup> Canada Health Act § 9.

<sup>17</sup> *Id.* § 2.

<sup>18</sup> *Id.* Section 2 provides in full:

“hospital services” means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required, (b) nursing service, (c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations, (d) drugs, biologicals and related preparations when administered in the hospital, (e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, (f) medical and surgical equipment and supplies, (g) use of radiotherapy facilities, (h) use of physiotherapy facilities, and (i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations.

*Id.* § 2.

<sup>19</sup> *Id.*



a principled basis upon which to determine what should be publicly funded, but are labels applied *ex post* to negotiations between the provincial ministries and provincial medical associations.

In recent years, Canadian provinces have begun explicit rationing of health resources by choosing to “delist” or “deinsure” some health services, and announced that certain services will no longer be publicly funded on the grounds that they are not “medically necessary.”<sup>20</sup> Although this process has been controversial, the range of services delisted has been limited and has had only a small impact on total health care spending.<sup>21</sup> Most of the rationing that occurs is not explicit but implicit as the vagueness of “medically necessary” and “medically required” allows for implicit rationing to occur under conditions of resource constraint.<sup>22</sup> Although “medically necessary” hospital and physician services may be insured, such that hip operations are considered medically necessary, there are no national standards with regard to the time frame within which hip-operations will be provided to those in need. The CHA does require that provinces ensure “reasonable access” to services but this is a difficult standard to measure, and thus, enforce.<sup>23</sup> Consequently there is little in the CHA preventing the provinces from restricting the flow of resources into the public system so that physicians must make increasingly harder choices between patients and their various health needs. One can perhaps see that although the entitlement to a comprehensive range of benefits is a cornerstone principle of Canadian medicare, this principle is at risk of erosion when provinces and/or providers operate under increasing financial constraints.

It is important to note that the CHA protects and ensures a national standard of full public funding for hospital and physi-

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<sup>20</sup> Michael M. Rachlis, *Defining Basic Services and De-Insuring the Rest: The Wrong Diagnosis and the Wrong Prescription*, 152 CAN. MED. ASS'N J. 1401, 1401 (1995).

<sup>21</sup> See CAROLYN HUGHES TUOHY, ACCIDENTAL LOGICS: THE DYNAMICS OF CHANGE IN THE HEALTH CARE ARENA IN THE UNITED STATES, BRITAIN, AND CANADA 220 (1999) (noting that “[t]arget savings through delisting met or under consideration by 1997 amounted to 2% or less of the respective provincial governments’ expenditures on physician services”).

<sup>22</sup> See generally Timothy A. Caulfield, *Wishful Thinking: Defining “Medically Necessary” in Canada*, 4 HEALTH L.J. 63 (1996) (discussing the difficulties in defining “medically necessary”).

<sup>23</sup> Canada Health Act § 3.

cian services, but this is not the case for prescription drugs outside of the hospital, home care, genetic tests, medical equipment, etc. When a patient receives care in a hospital or from a physician it is fully publicly funded. But if the patient receives care in her own home, or from a non-physician provider, then the patient may have to pay all or part of the cost thereof either out-of-pocket or through her private insurer. As the locations of care have shifted away from hospitals and into homes and communities, the way that medicare is structured has opened the way to passive privatization of the system. This means that care is increasingly allocated on ability to pay and not need. It also has regressive effects on the uptake of care that remains fully publicly funded. For example, physician services are fully publicly funded but prescribed medications resulting from a visit to a physician are not. In Canada, individuals consumed, on average, 6.9 doctor's visits per year in 1995 and the average Canadian received 8 prescriptions per year in 1995—more than one prescription per visit.<sup>24</sup> Stabile compared the use of doctors and hospital services by individuals with private insurance and individuals with no insurance (public or private) and found that those individuals with insurance use ten percent more doctors' services than individuals without such coverage.<sup>25</sup> Since access to private drug insurance is highly correlated with income, the impact of these differences on access to care is likely concentrated among the less well off.

Thus, in sum, the processes for determining what is publicly funded are primarily implicit rather than explicit, and indirect rather than direct. The CHA essentially ensures almost 100% public funding of most hospital and physician services. However, it relies upon physicians to ration/allocate limited public resources across different patients and medical needs. Moreover, as the locations of care have shifted and drugs and new technology have increased in importance, private financing is accounting for an increased share of total spending in Canada through a process of passive privatization.

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<sup>24</sup> HEALTH CANADA, DRUG COSTS IN CANADA 18-19 (1997), available at <http://www.hc-sc.gc.ca/hppb/healthcare/costs.htm>.

<sup>25</sup> Mark Stabile, *Private Insurance Subsidies and Public Health Care Markets: Evidence from Canada*, 34 CAN. J. ECON. 921 (2001).

#### 4. Court Challenges

As medicare undergoes difficult rationing exercises, and in some areas falls short of public expectations of speed and quality, citizens are turning to the courts to challenge health policy decisions both through administrative law and under the Canadian Charter of Rights and Freedoms.

Under the Charter of Rights and Freedoms, the most prominent cases are *Eldridge v. British Columbia*,<sup>26</sup> *Cameron v. Nova Scotia*<sup>27</sup> and *Auton v. British Columbia*.<sup>28</sup> In *Eldridge*, the Supreme Court of Canada held that the British Columbia government's failure to fund sign-language interpreters for the deaf in hospitals as part of the public health insurance plan discriminated against deaf persons. This was because in the absence of interpretation services, deaf individuals would not be able to access publicly funded hospital and physician services, as other Canadian citizens are able to (with communication being essential to the doctor/patient relationship.)<sup>29</sup> In *Cameron*, the Nova Scotia Court of Appeal ruled that the Nova Scotia government's decision not to fund a male infertility treatment discriminated against infertile persons. However, the Court went on to find such discrimination justified under § 15 (a reasonable limit prescribed by law and demonstrably justified in a free and democratic society) largely because of the cost of treatment.<sup>30</sup> In a more recent case, *Auton*, there was a challenge to the British Columbia government's decision not to fund a treatment for autistic children. The plaintiffs were successful in their argument before the British Columbia Supreme Court, claiming that as a consequence of the government's failure there had been a breach of their § 15 rights to equal protection and benefit of the law.<sup>31</sup>

Another significant case is *Chaoulli c. Quebec Procureur general*,<sup>32</sup> which was a direct Charter challenge to Quebec's prohibition on private health insurance for services that fall within the public plan. This may *prima facie* seem an odd chal-

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<sup>26</sup> [1997] 3 S.C.R. 624.

<sup>27</sup> [1999] 177 D.L.R.4th 611.

<sup>28</sup> [2000] 78 B.C.L.R.3d 55.

<sup>29</sup> See *Eldridge*, at 690-91 (noting that "the provision of substandard medical services to the deaf necessarily diminishes the overall quality of their lives").

<sup>30</sup> *Cameron*, 177 D.L.R.4th at 611.

<sup>31</sup> *Auton*, 78 B.C.L.R.3d at 55.

<sup>32</sup> C.A. Que. Montreal 500-09-009693-003 (Cour d'appel du Quebec 2000).

lenge, but some people want private insurance even though services are publicly insured so they can avoid queues in the public system. Finding as a fact that the health care system in the province of Quebec suffered serious gaps and deficiencies, the prohibitions under attack were found to violate liberty and security of the person. However, after balancing the individual right to choose and access necessary health services against the collective goal of ensuring equal access to all, the Court found these violations to be in accordance with fundamental justice, and thus not in violation of § 7 of the Charter.<sup>33</sup>

Although litigants have historically not been successful in using the Charter to extend the range of goods and services that must be publicly funded, or even in challenging prohibitions on private insurance for services that should be provided in the public system, this may be changing. In *Eldridge* the hearing-impaired plaintiffs were successful but it was clear that they were not asking for any *new* health care good or service but the *means* (interpretation services) to utilize health care services that similarly situated patients without a hearing impairment would have been entitled to. However, this means of limiting the precedent of *Eldridge* in opening up claims for public funding of new health care services was roundly rejected in the *Auton* case where the plaintiffs were successful in their Charter challenge to the British Columbia government's failure to fund treatments for autistic children.<sup>34</sup> Nonetheless, although there are hints that plaintiffs may become more successful in Charter claims, this is obviously an unsatisfactory way to deal with most grievances or concerns that citizens may have due to the expense and delay inherent in Charter litigation.

In two provinces, Ontario and British Columbia, there are administrative tribunals in place to deal with claims that the respective provincial governments should be publicly funding particular treatments. In Ontario, a high profile case involved that of Fiona Webster, who successfully argued before the Health Services Appeal and Review Board that the provincial government should fund the BRCA1 genetic test she required to determine whether she had a predisposition to breast cancer.<sup>35</sup>

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<sup>33</sup> *Id.*

<sup>34</sup> *Auton*, 78 B.C.L.R.3d at 55.

<sup>35</sup> See C. Abraham, *Tenacious Woman Scores Medical Victory: Fiona Webster's Fight Opens Access to Genetic-Breast Cancer Test*, GLOBE & MAIL (Toronto), Aug. 27, 1999, at A1.

These kinds of administrative mechanisms provide an outlet for patients' concerns about the breadth of publicly funded schemes and arguably are a much more efficient and fair mechanism for resolution of these kinds of disputes than expensive and protracted Charter litigation.

A key concern of Canadians is increasing waiting lists and times.<sup>36</sup> However, none of the Charter cases or the administrative regimes speak to a right to access health care in a timely fashion. The only successful claim before the courts with regard to waiting times has been *Stein v. Quebec*.<sup>37</sup> In this case Mr. Stein waited months for surgery, even though his doctors warned his life was in danger if he was not operated on within four to eight weeks. He was successful before the Quebec Superior Court in overturning the Quebec health insurance board officials' refusal to pay for his treatment in a New York hospital on the grounds that, given the facts of the case, the decision was patently unreasonable.<sup>38</sup> This was the first successful case to argue for payment for a procedure that was available in Canada, but because of waiting lists, meant that it could not be done quickly enough.

### 5. Patients' Bill of Rights

In Canada, some hospitals and other institutions have their own internal codes of rights for patients and, in some occasions, have appointed individuals who mediate between patients and the institution and providers to resolve complaints and concerns. In May 2001, the Quebec government introduced Bill 27 providing for the establishment of a Health and Social Services Ombudsman.<sup>39</sup> Apart from Quebec, Patients' Bills of Rights are

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<sup>36</sup> See Shelley Martin, *Almost 1 in 2 Canadians Says Health System Needs Major Surgery* 165 CAN. MED. ASS'N J. 465 (2001) (indicating twenty-two percent of Canadians feel that longer waiting times have contributed to the system's decline).

<sup>37</sup> No. C.S. Que. Montreal 500-05-045298-989 (Cour superieure du Quebec Aug. 5, 1999).

<sup>38</sup> *Id.*

<sup>39</sup> An Act Respecting the Health and Social Services Ombudsman and Amending Various Legislative Provisions, 36th National Assembly, 2d Sess., ch. 43, (2001), available at <http://www.assnat.qc.ca/eng/Publications/Projets-loi/Publics/ind ex.htm>. The Bill provides that, except in certain specific cases, the Ombudsman will only examine a complaint after it has been heard at first instance by an institution, a regional board or the Corporation d'urgences-santé de Montréal Métropolitain. *Id.* at ch.3, div.I. The Ombudsman may hold an inquiry as part of the examination of a complaint. *Id.* Following an examination Bill 27 provides that the Ombudsman must

also under consideration in Ontario, Saskatchewan, and Manitoba.<sup>40</sup> The flurry of activity in various provinces within Canada reflects a desire on the part of provincial government to respond in a tangible way to mounting public concern about the quality, timeliness, and accessibility to medicare. Whether a Patients' Bill of Rights will quell these concerns or actually improve the quality, timeliness or accessibility of medicare is unclear given the experiences of other jurisdictions with similar legislative initiatives, as discussed further below.

## B. Australia

### 1. Public/Private Mix

Australia's public/private split on health care mirrors that of Canada's with 69.3% of total health care spending coming from public sources and 30.7% coming from private sources.<sup>41</sup> However, unlike Canada, there is much more direct spending from the federal level, with the Commonwealth government paying for approximately 45% of total health care spending.<sup>42</sup> Australian state and local governments account for 23.4% of total health care spending.<sup>43</sup> Approximately 16.2% of total health care spending comes from out-of-pocket payments by

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communicate his or her conclusions, including reason, to the complainant, together with any appropriate recommendations addressed to the institution or regional board or the highest authority of the entity whose services are the subject of complaint. *Id.* In the event that the entity in question does not satisfactorily respond to the Ombudsman's recommendations, he or she may advise the Minister, and may make it the subject of a special report to the Minister. *Id.*

<sup>40</sup> See Honourable Hilary M. Weston, Lieutenant Governor of the Province of Ontario, Speech from the Throne on the Opening of the First Session of the Thirty-Seventh Parliament of the Province of Ontario (Oct. 21, 1999), <http://www.premier.gov.on.ca/english/library/thronespeech-Oct2199.htm> (stating that "[y]our government will introduce a *Patient's Bill of Rights* that protects patients' rights to access health services, to complete information about their health, and to respect for their privacy, personal dignity and safety"). In Saskatchewan, the Patients' Rights Association submitted a draft Bill of Rights to the Premier in September 2000, but legislation has yet to be introduced into the House. Also, in April 2000 a private member's bill was introduced to create an office of a Health System Ombudsman for Saskatchewan. We also understand there have been calls for such legislation in Manitoba.

<sup>41</sup> OECD HEALTH DATA, *supra* note 5.

<sup>42</sup> AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE, AUSTRALIA'S HEALTH 2000, at 233, available at <http://www.aihw.gov.au/publications/health/ah00/index.html>.

<sup>43</sup> *Id.*

patients.<sup>44</sup> In particular, out-of-pocket payments by patients account for a large proportion of spending on dental care (62.2%) and pharmaceuticals (46.2%).<sup>45</sup> The Commonwealth government administers a pharmaceutical benefits plan that provides universal access, albeit with significant out-of-pocket payments for users. Private insurance accounts for a very small proportion of spending on pharmaceuticals but does account for 13% of spending on hospital and other institutional services and 7.4% of spending on non-institutional services.<sup>46</sup>

## 2. Philosophical Approach

There is tension within Australia's philosophical approach to the allocation of care. As in most developed countries the guiding principle is that care should be allocated on the basis of need and not ability to pay. However, the Australian system is also guided by a historical commitment (the origins of which are unclear) to encourage tripartite funding from the government, private insurance and from out-of-pocket payments. The latter two sources of financing are usually viewed as regressive. Then, in order to reconcile the desire to encourage tripartite funding of the system with the goal of redistribution, Australia has a complicated system of safety nets and exceptions to its requirements for out-of-pocket payments. There is also a complicated system of direct and indirect public subsidies to the private insurance sector to ensure its sustainability.

## 3. Processes for Determining What Is Publicly Funded

The relevant legislation provides that Australians are entitled to a benefit of either 75% or 85% (depending on the service) of a centrally set schedule of fees for physician services.<sup>47</sup> There is an upper limit on the amount a patient must pay for a service and the legislation provides that the government pay for the entire service less the "greatest permissible gap," (A\$50.40)

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<sup>44</sup> See OECD HEALTH DATA, *supra* note 5

<sup>45</sup> See AUSTL. INST. OF HEALTH AND WELFARE, AUSTRALIA'S HEALTH 2000, at tbl.S41 (2000), available at <http://www.aihw.gov.au/publications/health/ah00/>

<sup>46</sup> See *id.*

<sup>47</sup> See AUSTL. DEP'T OF HEALTH AND AGING, THE AUSTRALIAN HEALTH CARE SYSTEM: AN OUTLINE 7-8 (2000), available at <http://www.health.gov.au/haf/ozhealth/ozhealth.pdf>.

which can be borne by the patient.<sup>48</sup> Concessional patients<sup>49</sup> are not required to pay anything for physician services.

The Commonwealth government in Australia is more directly involved in administrating the health system than, for example, Canada's federal government, and it largely finances and administers physician services. However, the process of deciding what services will be publicly funded is similar to what occurs at the provincial level in Canada. In Australia, the Minister of Health sets the fee schedule after receiving non-binding advice from a Medicare Benefits Advisory Committee (MBAC), which is composed mainly of medical practitioners, and after "detailed discussion with the Australian Medical Association (AMA)."<sup>50</sup> Thus as in Canada, what services are publicly funded is largely a matter of negotiation between the Ministry of Health and physician bargaining associations.

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

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

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<sup>48</sup> See AUSTL. DEP'T OF HEALTH AND AGING, AUSTRALIA: SELECTED HEALTH CARE DELIVERY AND FINANCING STATISTICS tbl.6 (Sept. 2000), available at <http://www.health.gov.au/haf/ozhealth/tablesupp.pdf>.

<sup>49</sup> These are people who receive certain pensions, benefits or cards administered by the Departments of Family and Children's Services or Veterans' Affairs, or who meet certain criteria for being declared to be disadvantaged.

<sup>50</sup> ANDREW PODGER & PHILIP HAGAN, DEP'T OF HEALTH AND AGED CARE OCCASIONAL PAPERS SERIES NO. 1, REFORMING THE AUSTRALIAN HEALTH CARE SYSTEM: THE ROLE OF GOVERNMENT 15 (Mar. 1999), available at <http://www.health.gov.au/pubs/hfsocc/ocpanew1.pdf>.



#### 4. Court Challenges

We have not been able to identify any cases in Australia where patients have challenged explicit or implicit limits on the publicly funded system. However, in a recent and high profile case, *Pfizer Pty Ltd v. Birkett*.<sup>51</sup> a major drug company brought an action challenging the decision of the Pharmaceutical Benefits Advisory Committee (PBAC) to recommend against inclusion of Viagra on the list of publicly subsidized drugs. The PBAC had recommended against including Viagra on the basis of medical and cost-effectiveness factors. The Full Federal Court of Australia rejected Pfizer's contention that PBAC was wrong in taking into account the likely overall cost of subsidizing Viagra under the scheme. However, the Federal Court did find that PBAC should have notified or allowed Pfizer the opportunity to comment on the information it had concerning the fact that "another drug for the same condition was used at a considerably higher rate than originally predicted."<sup>52</sup> This information contributed to PBAC's conclusion that "Viagra would be used at a greater rate than that estimated by Pfizer and hence cost the Commonwealth more than the figures submitted by Pfizer."<sup>53</sup> Thus PBAC's initial decision was overturned and it has been asked to reconsider its decision after giving this information to Pfizer and receiving submissions thereon.

#### 5. Patients' Bill of Rights

Each state in Australia is required to establish a "Public Patient's Hospital Charter" (PPHC) and a complaints body. The Tasmanian PPHC rights are typical of the kinds of rights that are protected. This Charter provides for a right to give an informed consent—to "[r]eceive a clear and concise explanation of the operation or procedure you are about to undergo"—and the right to confidentiality—"to expect that details of your condition and treatment are kept confidential, except where the law requires otherwise."<sup>54</sup> As can be seen, the PPHCs tend to list rights that already exist in the common law or are already re-

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<sup>51</sup> (2001) FCA 828, available at [http://www.fedcourt.gov.au/judgments/judgments\\_video01.html](http://www.fedcourt.gov.au/judgments/judgments_video01.html).

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> NORTH WEST REGIONAL HOSPITAL, TASMANIA, at <http://www.nwrh.dhhs.tas.gov.au/patientinformation/> (last modified Nov. 19, 2001).

quired of health care professionals through their own ethical codes and self-regulating colleges. These Charters of Rights do not speak to patients' entitlements to access publicly funded care or to timeliness.

To ensure the safety of private patients, Australia's Commonwealth government created a Private Health Insurance Ombudsperson in 1995. The Ombudsperson can deal with complaints, investigate, make recommendations to the Minister of Health, and publish information about complaints against private insurers. Australia expressly endorses a policy of encouraging private insurance and this may explain why it has established an ombudsperson to protect private patients. By contrast, Canada, where private insurance is growing as a result of passive privatization and not explicit government policy, does not have similar legislation.

### C. Netherlands

#### 1. Public/Private Mix

The mix of funding for health care in the Netherlands, based on 1998 figures, is as follows: Exceptional Medical Expenses Scheme - 36%; Sickness Fund Scheme - 35%; private health insurance - 15%; governmental - 5%; and other sources (including patient co-payments) - 9%.<sup>55</sup> The mandatory Exceptional Medical Expenses and Sickness Fund schemes, described below, are social insurance schemes funded through employer and employee contributions. The Organisation for Economic Co-operation and Development (OECD) records the percentage of public spending of total health care spending at 70.4% for 1998.<sup>56</sup> However, this figure may lead to confusion about the true extent of the Dutch government's role in financing care as the figure of 70.4% includes within it the mandatory social insurance schemes, which are financed by employer and employee contributions and not through general taxation revenues. The government has only a very minor role in *directly* financing

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<sup>55</sup> PIETER HUIJBERS & ALISON MARTIN, NETHERLANDS INSTITUTE OF GERONTOLOGY, ELDERLY CARE IN THE NETHERLANDS: HEALTH CARE INSURANCE IN THE NETHERLANDS, [http://www.kenniscentrum-ouderen.nl/new/kco/facts/facts\\_healthcare\\_insurance.html](http://www.kenniscentrum-ouderen.nl/new/kco/facts/facts_healthcare_insurance.html) (last visited Jan. 22, 2002).

<sup>56</sup> OECD HEALTH DATA, *supra* note 5.

the system (five percent of total health care spending).<sup>57</sup> Indirectly the government does have a significant role in the system by requiring certain groups to buy insurance and by regulating social and private insurers. Compared to other countries, only a relatively small component of health care—seven percent—is financed by out-of-pocket payments.<sup>58</sup> Thus, the Dutch system is not publicly funded but it is nonetheless progressively funded, as most contributions are set as a percentage of an employee's salary and the role of out-of-pocket payments is small.

## 2. Philosophical Approach

Dutch scholars often describe the philosophical approach of the Netherlands towards the allocation of health care as one of "solidarity." The word "solidarity" encapsulates a strong commitment on the part of Dutch citizens to ensuring access to health care on the basis of need and not ability to pay. This *prima facie* seems surprising given reliance in the Netherlands upon private insurers, which are generally viewed as a regressive means of financing health care. However, the Dutch regulate private insurers to ensure the goal of solidarity, and so, although committed to progressive funding, are not committed to public funding for its own sake. Also, it is very important to note that having private insurance in the Netherlands does not allow people to jump queues. It is seen as against a physician's ethical code to prefer a patient with private insurance to a patient without. Moreover, unlike the United Kingdom and New Zealand, there are not separate private hospitals, and in the Netherlands, social insurance and private patients are treated side-by-side in the same hospitals.<sup>59</sup>

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<sup>57</sup> *Id.*

<sup>58</sup> MINISTERIE VAN VOLKSGEZONDHEID, WELZIN EN SPORT, HEALTH INSURANCE IN THE NETHERLANDS 7 (Jan. 2000). The 1998 figure from the OECD 2000 is 5.9%. OECD HEALTH DATA, *supra* note 5.

<sup>59</sup> See W.B.F. Brouwer & F.T. Schut, *Priority Care for Employees: A Blessing in Disguise?*, 8 HEALTH ECON. 65 (1999) (stating that the Netherlands' uniform treatment of all is based on the principle of equity in health care); see also generally Werner B.F. Brouwer & Herbert E.G.M. Hermans, *Private Clinics for Employees as a Dutch Solution for Waiting Lists: Economic and Legal Arguments*, 47 HEALTH POL'Y 1 (1999) (concluding that priority treatment of one person over another is justifiable if both the intended purpose is justified and if such treatment is a means to achieve this intended purpose).

### 3. Processes for Determining What is Publicly Funded

Despite its apparent reliance on private insurance, nearly 100% of the population of the Netherlands has health insurance coverage and the range of services covered is generous. There are three important government-mandated insurance schemes, largely funded by employer and employee contributions:

1. The "Exceptional" or "Catastrophic" medical expenses scheme is mandatory and covers the entire population for long-term care and mental health care.

2. The Sickness Fund scheme is mandatory for about 64% of the population earning less than 64,600 Guilders<sup>60</sup> and covers the cost of hospital and physician services, drugs, and home care.

3. Finally, the Civil servant scheme is mandatory for all civil servants (approximately six percent of the population) and covers all medicines and related products and hospital treatment, and pays 80 to 90% of other health care costs.<sup>61</sup>

In addition to these three government-mandated schemes, the government also regulates private insurers. This is to prevent them from risk rating premiums in order to avoid the result of unaffordable premiums or to prevent them from offering no coverage at all for high-risk individuals.<sup>62</sup> The benefit package offered by private insurers in the Netherlands is similar to that offered by the non-profit Sickness Funds.<sup>63</sup>

How do the Dutch determine what services will be covered by the compulsory social insurance plans? As in Australia and Canada, this has largely been left to a process of contractual negotiations between payers (social and private insurers) and

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<sup>60</sup> One guilder is worth approximately 0.65 Canadian dollar or 0.42 U.S. dollars.

<sup>61</sup> MINISTERIE VAN VOLKSGEZONDHEID, WELZIN EN SPORT, *supra* note 58, at 56.

<sup>62</sup> *See id.* at 51 (describing the apportionment contribution).

<sup>63</sup> *See* R.L.J.M. Scheerder, *The Financing of the Dutch Health Care System*, in *HEALTH AND HEALTH CARE IN THE NETHERLANDS* 163, 165 (A.J.P. Schrijvers & Liliane Droyan Kodner eds., 1997).

physician bargaining associations.<sup>64</sup> However, the Dutch have also attempted to develop a filtering mechanism to aid the determination of what services should be included in the mandatory social insurance schemes. In 1992, the Government Committee on Choices in Health Care<sup>65</sup> argued for a more careful evaluation of what would and would not be included in the basic package of services covered by the proposed compulsory basic insurance plan for all citizens.<sup>66</sup> The Dunning Committee proposed that four criteria be used to sift out those services that should not be included in the basic package of care. These criteria were as follows: first, that the community in general considers the care to be necessary; second, that the services are effective; third, that the services are efficient using cost-effectiveness analyses or cost-utility analyses; and, finally, that it is not appropriate for patients themselves to pay for the health services in question. It was proposed that care not meeting the four requirements be left to the unregulated private sector.<sup>67</sup> Political pressures have frustrated attempts to systematically implement rationing using the Dunning criteria.<sup>68</sup> However, as discussed below, the courts have sometimes turned to the Dunning criteria to justify rationing practices.

#### 4. Court Challenges

Apart from explicit rationing by excluding certain services from the mandatory social insurance schemes, implicit rationing can occur through limitations on the budgets of institutions and health care providers, who are then required to make hard choices between different patients' health care needs. Dutch

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<sup>64</sup> See Bradford L. Kirkman-Liff, *Cost Containment and Physician Payment Methods in the Netherlands*, 26 INQUIRY 468 (1989) (describing the Netherlands' negotiating agreements structure as a solution for cost containment which could be adopted by Medicare and Medicaid in the U.S.).

<sup>65</sup> This is known as the Dunning Committee, after its Chairman.

<sup>66</sup> GOV'T COMM. ON CHOICES IN HEALTH CARE, NETHERLANDS MINISTRY OF WELFARE, HEALTH AND CULTURAL AFFAIRS, CHOICES IN HEALTH CARE 29-33 (1992) (observing that care and social services that are made available to all people "must be necessary, effective and appropriate, and it must not be able to be left to the responsibility of the individual patient").

<sup>67</sup> Frederik T. Schut & Herbert E.G.M. Hermans, *Managed Competition Reform in the Netherlands and Its Lessons for Canada*, 20 DALHOUSIE L.J. 437, 456 (1997).

<sup>68</sup> See Herbert Hermans & Andre den Exter, *Priorities and Priority-Setting in Health Care in the Netherlands* 39 CROATIAN MED. J. 346 (1998) (discussing reforms to the Dutch health care system).

courts have shown some sympathy for patients who are denied care because of excessively budget-conscious institutions. However, they have been reluctant to nullify contractual budget targets, especially where they are viewed as reasonable, or require treatment where an insurer does not have a contract with the institution in question.<sup>69</sup> According to Dutch scholars Hermans and den Exter, Dutch courts “attach much importance to the Dunning criteria—in particular the necessity criterion.”<sup>70</sup> For example, the courts have decided that citizens are not entitled to coverage for services simply because they are available and appropriate.<sup>71</sup> Countries like Australia and Canada may wish to consider the benefits of having a principled mechanism, like the Dunning criteria, to determine what services should be publicly funded. Although there may be political impediments to systematically implementing a principled scheme of rationing nation-wide, such a framework should assist in negotiations between ministries of health and medical associations and also assist courts in their decisions regarding patient entitlements.

Increasingly, citizens in the European Union are bringing challenges to limitations imposed by national social insurance plans on the ability of patients to be reimbursed for treatment received in a member state of which they are not a resident.<sup>72</sup> Will this result in patients being able to argue for compensation for care that is not covered or available in the country where they reside, or for which there are long waiting lists in the country in which they reside, but which is available in another member state? In *B.S.M Geraets-Smits v. Stichting Ziekenfonds*

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<sup>69</sup> See *id.* at 353 (discussing the courts’ reactions to patients’ claims for health care benefits).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> The judgments in *Decker v. Caisse de Maladie des Employes Privés*, [1998] E.C.R. I-1831, reprinted in [1998] 2 C.M.L.R. 879 and *Kohll v. Union des Caisses de Maladie*, [1998] E.C.R. I-1931, reprinted in [1998] 2 C.M.L.R. 928, set a precedent requiring member states to reimburse their residents up to the tariffs set by their respective social insurance plans for goods and services purchased in other member states. Thus, for example, in *Decker*, a resident of Luxembourg was successful in having the Luxembourg plan reimburse him up to its own flat fee tariff for spectacles and corrective lenses purchased in Germany despite the fact that he did not obtain prior authorization as required by domestic legislation. Similarly, *Kohll* held that the treatment of a Luxembourg national’s daughter by an orthodontist in another member state outside a hospital infrastructure and for remuneration was a service within the meaning of Article 60 E.C.

VGZ,<sup>73</sup> the European Court of Justice (ECJ) found that the provisions of an EC Treaty do not preclude a Member State, like the Netherlands, from having legislation enabling a sickness insurance fund to require prior authorization before paying for the cost of care provided in a hospital in another Member State. Before authorization is given, a sickness insurance fund is entitled to require that “the treatment must be regarded as normal in the professional circles concerned” and “the insured person’s medical treatment must require that treatment.”<sup>74</sup> The ECJ found that the imposition of these kinds of conditions was in principle acceptable.<sup>75</sup> However, in order to comply with the EC Treaty, the condition that the treatment be regarded as normal must be construed so that authorization cannot be refused on the grounds that it is not general practice in the Netherlands if it is nonetheless sufficiently tried and tested by international medical science.<sup>76</sup> Also, the ECJ stated that the authorization can only be refused on the ground of medical necessity if the same or equally effective treatment can be obtained without undue delay at a hospital or other institution with which the insured’s sickness insurance fund has a contract.<sup>77</sup>

It should be noted that although the ECJ took seriously the need to maintain the financial integrity of sickness insurance schemes and to ensure continuity in planning the delivery of hospital services, the judgment has been interpreted by some commentators as meaning that patients were entitled to seek treatment abroad, unless it could be provided domestically without ‘undue delay.’<sup>78</sup> However, this misinterprets the ECJ judgment. It was an interpretation by courts *in the Netherlands* of their own domestic legislation that resulted in the notion that in deciding whether a patient needed the medical treatment (and thus could be obtained in another jurisdiction) one must consider whether the treatment was available without undue delay in the Netherlands. It is not at all certain that the ECJ could require a Member State with long waiting lists to reimburse pa-

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<sup>73</sup> 2001 ECJ CELEX LEXIS 1147 (E.C.J.).

<sup>74</sup> *Id.* at \*50. This latter condition had been interpreted by the national court in the Netherlands as requiring consideration of the methods of treatment available there and whether adequate treatment can be available without undue delay, in the Netherlands.

<sup>75</sup> *B.S.M Geraets-Smits*, 2001 ECJ CELEX LEXIS 1147 at \*33-\*37.

<sup>76</sup> *Id.* at \*14.

<sup>77</sup> *Id.* at \*51.

<sup>78</sup> *Medicine sans Frontières*, THE ECONOMIST, Sept. 2001, at 48, 49.

tients for care obtained in other Member States if there is not in place domestic legislation that provides, or is interpreted to provide, that treatment should be available without undue delay.

### 5. Patients' Bill of Rights

The Netherlands has a complex web of patient complaint and appeal procedures designed to bring accountability to the decisions of all social and private insurers. The appeal route depends on the nature of the complaint as well as the insurer in question.<sup>79</sup> Patients' first recourse for complaints about entitlements to coverage or quality of care under the mandatory social plans, the Exceptional Medical Expenses, the Sickness Fund, and the Civil Servants plans, is to the Board of the relevant social insurer.<sup>80</sup> In certain cases, the insurer's Board is required to consult with an external Health Care Insurance Board in arriving at its decision on the complaint.<sup>81</sup> Patients receiving an adverse decision from their insurer may then appeal to administrative agencies set up by the government to review insurers' decisions. This may mean an appeal to the Central Appeals Tribunal (in the case of Sickness Fund appeals), and in some cases to the National Ombudsman.<sup>82</sup> Under the private insurance plans, the main recourse for complaints is the civil courts.<sup>83</sup> It is instructive to compare the complaint and appeal procedures provided for in the Netherlands, particularly vis-à-vis insurers or purchasers of care with the relative lack of mechanisms to ensure accountability on the part of administrators of public insurance plans in countries like Canada, the United Kingdom, and New Zealand.

### D. United States

#### 1. Public/Private Mix

Government programs in the United States, federal and state combined, comprised 43.6% of total health care spending

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<sup>79</sup> Telephone Interview with Andre den Exter, Erasmus University, Rotterdam (March 5, 2001). We are grateful to Mr. den Exter, for explaining to us the various appeal routes and mechanisms in the Netherlands.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*



in 1998.<sup>84</sup> Private health insurance comprised 33.1%, out of pocket payments comprised 19.6%, and other private funds made up 3.7%.<sup>85</sup> As of 1999 about 73% of people under age sixty-five had some form of private health insurance, with approximately 92% of private coverage provided through employment relationships.<sup>86</sup>

There are two significant public programs, Medicare and Medicaid. Medicare is a federally funded health insurance plan available to persons over age sixty-five, some of the disabled, and those suffering from permanent kidney failure. All benefits attract a mix of co-payments, co-insurance, or deductibles.<sup>87</sup> Medicaid is a federal/state entitlement program that pays for medical assistance for some of the poor.<sup>88</sup> To be eligible for federal funds, States are required to provide Medicaid coverage for individuals who receive federally assisted income maintenance programs. The amount of federal funding for Medicaid has no set limit; rather, the federal government matches what individual States provide.<sup>89</sup> The scope of coverage under the Medicaid plan varies considerably from state to state.

The private share of spending depends on the nature of the health service in question. Prescription drugs, for instance, remain primarily privately financed, although the public share has been gradually increasing. In 1998, public spending accounted for only 15.4% of spending on drugs, and although up from the 1990 figure of 10.9%, this is still well below the OECD average of 57.6% of public funding for drugs, based on 1997 figures.<sup>90</sup> By comparison, public spending on inpatient institutional medi-

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<sup>84</sup> CTR. FOR DISEASE CONTROL AND PREVENTION & NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES, 2000, at 327 tbl.119 (2000) [hereinafter HEALTH, UNITED STATES], available at <http://www.cdc.gov/nchs/data/hus/hus00.pdf>.

<sup>85</sup> *Id.*

<sup>86</sup> *See id.* at 339 tbl.128.

<sup>87</sup> Co-payments are out-of-pocket payments levied on patients per use (e.g., a \$10 fee). Deductibles and co-insurance refer to amounts the user must pay privately to share the cost of the service with Medicare. Deductibles are one-time charges, whereas co-insurance charges are sometimes made in addition to deductibles on a periodic basis to shift ongoing costs to the patient.

<sup>88</sup> The cut-off level being determined on a state by state basis.

<sup>89</sup> HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID SERVICES, at [www.hcfa.gov/medicaid/mservice.htm](http://www.hcfa.gov/medicaid/mservice.htm) (last visited Jan. 17, 2002). The U.S. Health Care Financing Administration is now called the Center for Medicare and Medicaid Services.

<sup>90</sup> OECD HEALTH DATA *supra* note 5.

cal services is much higher, accounting for 60.8% of total inpatient spending in 1998, up from almost 54% in 1990.<sup>91</sup> Thus one can see here that, whereas in countries like Canada the share of *private* financing has been increasing incrementally, in the United States the share of *public* financing has been increasing incrementally.

## 2. Philosophical Approach

The overarching philosophy in the United States with respect to allocating health care is best described as a commitment to providing safety nets. This is in contrast to nearly every other developed country in the world where all persons, regardless of status, are entitled to at least some public subsidy for a range of medically necessary hospital and physician services. In the United States, entitlements to public funding of a minimally necessary set of health services are confined to specific disadvantaged or groups that are deemed morally worthy: those over 65, the elderly, the terminally ill, and some of the disabled. People who do not belong to these groups must rely on private insurance or their own financial resources to pay for health care. Consequently, the United States leaves a significant proportion of its population (16.3%) without the security of health insurance.<sup>92</sup>

## 3. Processes for Determining What Is Publicly Funded

While both Parts A and B of Medicare offer a wide range of benefits, albeit subject to various forms of coinsurance, deductibles and out-of-pocket payments, some services are not covered by Medicare at all. These include drugs outside of institutions, dental care, cosmetic surgery, custodial care in the home or nursing home, routine physical examinations, routine eye care, some vaccinations, and some preventive screening tests.

Medicaid, the public insurance program for the poor, allows each State to set its own eligibility standards, determine the type, amount, duration, and scope of services, set the rate of payment for services, and administer its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geo-

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<sup>91</sup> *Id.*

<sup>92</sup> HEALTH, UNITED STATES, *supra* note 84, at 365 tbl.146.

graphic proximity. However, a State's Medicaid program *must* offer medical assistance for certain *basic* services to the most categorically needy populations.<sup>93</sup> States may also, with certain exceptions, impose nominal deductibles, coinsurance, or co-payments on Medicaid.<sup>94</sup>

The State of Oregon received dispensation from the federal requirement to cover certain basic services for its Medicaid program as part of an experiment, designed to increase the number of people covered, by rationing the range of services to be publicly funded. Oregon's unique reforms to its State Medicaid program have attracted attention because of its explicit public process for determining the scope of Medicaid entitlements.<sup>95</sup> The Oregon Basic Health Services Act,<sup>96</sup> passed in 1989, was designed to extend coverage of the Medicaid package in Oregon to include all those at or below the poverty line, primarily by means of explicitly rationing the services provided.<sup>97</sup> In determining what priorities should be given to different health care services in the standard package, the Oregon Health Service Commission solicited public input through consultation.<sup>98</sup> The priorities accorded to services as a result of this

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<sup>93</sup> These services generally include the following: inpatient hospital services; outpatient hospital services; prenatal care; vaccines for children; physician services; nursing facility services for persons aged twenty-one or older; family planning services and supplies; rural health clinic services; home health care for persons eligible for skilled-nursing services; laboratory and x-ray services; pediatric and family nurse practitioner services and nurse-midwife services. HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID SERVICES, at [www.hcfa.gov/medicaid/msservice.htm](http://www.hcfa.gov/medicaid/msservice.htm) (last visited Jan. 17, 2002). The U.S. Health Care Financing Administration has been renamed the Center for Medicare and Medicaid Services.

<sup>94</sup> The following Medicaid recipients, however, *must* be excluded from cost sharing: pregnant women, children under age eighteen, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. *Id.* In addition, all Medicaid recipients must be exempt from co-payments for emergency services and family planning services. *Id.*

<sup>95</sup> See COLLEEN M. FLOOD, INTERNATIONAL HEALTH CARE REFORM: A LEGAL, ECONOMIC AND POLITICAL ANALYSIS 156-57 (2000) (noting that the Oregon Health Service Commission used public input in establishing the ranking system for coverage).

<sup>96</sup> OR. REV. STAT. §§ 414.705-.751 (1999).

<sup>97</sup> See Caitlin Halligan, Note, "Just What the Doctor Ordered: Oregon's Medicaid Rationing Process and Public Participation in Risk Regulation 83 GEO. L.J. 2697, 2703 n.21 (1995) ("Prior to passage of the reforms, only those individuals who satisfied family status requirements and had incomes equal to or less than 51% of the poverty line were eligible for Oregon Medicaid services.").

<sup>98</sup> See *id.* at 2708-11 (discussing OHSC's public solicitation processes).

process were the subject of much criticism. In particular, physicians criticized the fact that some routine procedures were ranked over life-saving treatments.<sup>99</sup> Physicians were particularly concerned that the ranking violated the ethical "rule of rescue" requiring physicians to act in the case of a life-threatening situation. As a result of these criticisms, the Commission recompiled the list of priorities using a methodology that largely eliminated cost considerations and diluted the influence of public input.

Between 1990 and 1997, the percentage of uninsured Oregon residents dropped from 18% to 11% and there was a significant drop in the levels of uncompensated care in hospitals.<sup>100</sup> The end result of the Oregon process was that essentially the same package of benefits that had previously been available to Medicaid recipients was extended to more people—in other words few services were dropped from the list to be publicly funded.<sup>101</sup> It seems that if the rationing process is made explicit then there is little political will to actually enforce hard rationing criteria. Although those who are in favor cost containment may therefore think that implicit rationing is to be preferred over explicit rationing, the latter seems a much fairer, transparent, and more accountable method. The consultation model employed in Oregon represents an important innovation in developing processes for making difficult choices between cost and quality, and warrants close study by other nations looking to develop fair rationing processes.

#### 4. Court Challenges

Since the advent of managed care there have been numerous cases challenging limitations by insurance companies on the range of health care services supplied. Initially it was difficult for patients to attach liability to managed care organizations (MCOs) in malpractice actions and patients were left with re-

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<sup>99</sup> *Id.* at 2712 (noting, for example, that tooth capping for exposed roots ranked above surgery for ectopic pregnancy, even though the surgery is nearly 100% effective in treating an otherwise serious condition).

<sup>100</sup> Howard M. Leichter, *Oregon's Bold Experiment: Whatever Happened to Rationing?*, 24 J. HEALTH POL. POL'Y & L. 147, 158 (1999).

<sup>101</sup> See Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 166-168 (1999) (reviewing the myths, realities, and politics of health care rationing in Oregon under the Oregon Health Plan (OHP)).

course only through suits against physicians or other providers. However, as MCOs have undertaken increasingly pivotal roles in decisions affecting the delivery of health care, judges have begun to impose liability as incentive payments and other aspects of the inner workings of MCOs are better understood. The result has been that MCOs are now in certain situations being held liable for failure to manage the care that they arrange.<sup>102</sup> Federal legislation in the form of the Employee Retirement Income and Security Act of 1974 (ERISA)<sup>103</sup> still places limits on the capacity of patients to sue managed care plans, as the ERISA legislation largely pre-empts state regulation of self-insuring employee benefit plans.<sup>104</sup> The U.S. Supreme Court ruled in *Pegram v. Herdrich*<sup>105</sup> that patients cannot file federal ERISA lawsuits over health plans' financial incentives to deny care. It appears the Court was concerned about the prospect of turning the federal courts into a venue for malpractice cases. However, more recently the Pennsylvania Supreme Court in *Pappas v. Asbel*<sup>106</sup> found, notwithstanding the *Pegram* decision, that managed care plans that make "mixed"<sup>107</sup> decisions can be sued by patients in state courts for negligence in their medical decisionmaking.

Class actions against MCOs are emerging. In late 1999, a large number of new class action lawsuits covering over thirty-two million managed care enrollees were launched against several large MCOs.<sup>108</sup> The actions, brought under federal anti-racketeering legislation, allege that the MCOs promised a certain level of quality but knowingly failed to deliver it by deny-

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<sup>102</sup> Edward F. Shay, *Managed Care Liability*, PHYSICIAN'S NEWS DIGEST, Nov. 1996, <http://www.physiciansnews.com/law/1196shay.html>.

<sup>103</sup> 29 U.S.C. §§ 1001-1461 (2000).

<sup>104</sup> See Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?* 13 YALE L. & POL'Y REV. 339, 345 (1995) (noting that the ERISA preemption clause is very broad, since "[p]reemption is presumed if the state law 'relate[s] to' any employee benefit plan").

<sup>105</sup> 530 U.S. 211 (2000) (holding that HMO doctors' mixed treatment and eligibility decisions are not considered fiduciary decisions under the meaning of ERISA).

<sup>106</sup> 768 A.2d 1089 (2001).

<sup>107</sup> This is a decision in which administrative (or coverage) benefit determinations are intertwined with medical judgment.

<sup>108</sup> Rebecca Porter, *Millennium Ends with Wave of Class Actions Against HMOs*, TRIAL, Feb. 2000, at 94, 95 (stating that some of the groups that were sued included Prudential Insurance Co. of America, CIGNA Corp., Foundation Health Systems, Humana, Inc., and PacifiCare Health Systems, Inc.).

ing needed services in order to increase profits.<sup>109</sup> Among the allegations are that the MCOs apply pressure through financial incentives for physicians—often hidden from the patient—in order to cut costs by rationing medical services on the basis of available resources, as much as on medical need. Clearly these kinds of large class actions, if successful, may have a huge impact on the development of managed care in the United States.

There have been court challenges to rationing on the part of various Medicaid programs as well. Some of the challenges have focuses on arguments that the State in question has violated the Federal Medicaid funding requirements; however, these kinds of challenges are generally unsuccessful, as the federal requirements afford states a wide discretion.<sup>110</sup> Other challenges have focused on constitutional rights to equal treatment but do not seem to have met with great success.<sup>111</sup>

### 5. Patients' Bill of Rights

On the tail of the managed care revolution in the United States has been a flurry of federal and state legislation aimed at protecting those with insurance from limitations on access to and diminishment in quality of health care. It should be noted that these regulatory measures do not generally seek to expand the numbers of people covered by private insurance but rather comprise a set of consumer rights protecting those who already have private insurance.

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<sup>109</sup> *Id.* at 95.

<sup>110</sup> *See, e.g.,* DeSario v. Thomas, 139 F.3d 80 (2d Cir. 1998) (discussing the coverage of durable medical equipment (DME) in Connecticut and finding the district court erred in concluding that those challenging the State's regulations for coverage of DME under Medicaid were likely to be successful), *cert granted*, Slekis v. Thomas, 525 U.S. 1098 (1999).

<sup>111</sup> *See, e.g.,* Dexter v. Kirschner, 972 F.2d 1113 (9th Cir. 1992), *amended by* 984 F.2d 979 (1993). In *Dexter*, a Medicaid claimant unsuccessfully challenged Arizona's refusal under its Medicaid program to pay for a leukemia treatment that is far more effective but more costly than the leukemia treatment it was prepared to fund. The main claim was that the decision to fund one, but not another, treatment for leukemia amounted to a violation of the U.S. Constitution's equal protection clause. In other words, by refusing to fund all medically effective leukemia treatments, Arizona treated similarly situated leukemia patients differently solely on their ability to pay privately. The court said that 'similarly situated' means "all patients who can be effectively treated by the same organ transplant procedure." *Id.* at 1119-1120. "Therefore, [the plaintiff] was not unreasonably denied a covered service. She was denied medical assistance because the only procedure that could help her . . . was not covered by the AHCCCS." *Id.* at 1120.

*Explicit* rationing by managed care plans regarding the scope of coverage, duration of benefits, premiums, and choice of providers is regulated, mostly at the state level, by legislative minimum standards as well as by "Patients' Bills of Rights" in many states. In 1996 the U.S. federal government enacted the Health Insurance Portability and Accountability Act (HIPAA)<sup>112</sup> in an effort to reduce the worst effects of risk-avoidance techniques by private insurers and to improve the portability of health insurance for the employed. Although not directly tackling the problem of the uninsured in the system, the Act addresses public concerns over insurers, employers, and managed care plans dropping coverage for people once they become in need of expensive health care services. The Act amends the federal ERISA legislation that, as a result, now prohibits health insurers, including self-insuring employers and managed care plans, from limiting or denying coverage for pre-existing conditions for more than twelve months. After this twelve-month period, coverage is portable to the extent that no new waiting period is allowed to be imposed if an employer switches insurers or if an employee changes jobs, provided that the employee in question maintains coverage with a gap no longer than sixty-three days.<sup>113</sup> Employers are now prohibited from denying coverage to an employee or dropping an employee from coverage or charging a higher premium because of that person's, or a dependant's, health status or medical history.<sup>114</sup> Other provisions of the Act prevent insurers and managed care plans from denying coverage to small employee groups or to those individuals who at some point have had group insurance coverage for eighteen months or more and are ineligible for coverage from any other source.<sup>115</sup> There is nothing, however, to prevent private insurers charging very high premiums to these individuals.

Both the U.S. House of Representatives<sup>116</sup> and the U.S. Senate<sup>117</sup> have passed Bills providing for a Bill of Patients'

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<sup>112</sup> Pub. L. No. 104-191, 110 Stat. 1936 (1996).

<sup>113</sup> 29 U.S.C. § 1181 (2000). A pre-existing condition restriction can only relate to a medical condition diagnosed or treated some time during the six months preceding the twelve month waiting period and cannot be imposed on newborns, newly adopted children less than eighteen years old, or pregnant women. *Id.* § 1181(d)(1)-(3).

<sup>114</sup> See 29 U.S.C. § 1182

<sup>115</sup> Brian K. Atchinson & Daniel M. Fox, *The Politics of the Health Insurance Portability and Accountability Act*, May-June 1997, at 147.

<sup>116</sup> Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. (2001).

Rights. The Bill passed by the Republican House of Representatives varies in some important respects from that passed by the Democratic U.S. Senate so that difficult negotiations are ahead as representatives try to broker a deal that will meet the approval of the Senate, the House, and the President. Both Bills provide national standards of entitlements for those with existing health insurance ensuring; for example, access to specialists, government-sponsored clinical trials, and emergency services.<sup>118</sup> Both Bills also enable patients to appeal decisions of a managed care plan to an independent review board<sup>119</sup> and both also overtake, to varying extents, the limitations of ERISA, enabling patients to sue health care plans in state courts. It is in this latter aspect that the Bill passed by the House of Representatives differs significantly from the Senate Bill. The House Bill places the following kinds of limits on patients' capacity to sue managed care plans in state courts: damage claims for pain and suffering limited to \$1.5 million<sup>120</sup> compared to the \$5 million cap in the Senate Bill;<sup>121</sup> punitive damages limited to \$1.5 million;<sup>122</sup> and any suit in a state court would be subject to special federal standards including a higher standard of proof requiring the plaintiff to overcome a "presumption (rebuttable by clear and convincing evidence) that the designated decisionmaker exercised ordinary care in making such determination."<sup>123</sup>

Where managed care plans give incentives to health care professionals to contain costs, *implicit* rationing may occur.<sup>124</sup> This rationing is more difficult to regulate, although measures have been proposed and adopted to attempt to ensure a proper balance between medical necessity and cost factors in the patient-provider relationship. Schwartz groups managed care regulatory measures into five broad categories according to the pur-

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<sup>117</sup> Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001).

<sup>118</sup> See S. 1052 §§ 114 (explaining timely access to specialists), 119 (providing coverage for individuals participating in approved clinical trials), 113 (explaining access to emergency care); H.R. 2563 (same sections)

<sup>119</sup> See S. 1052, §§ 101-104; H.R. 2563 (same sections).

<sup>120</sup> H.R. 2563, § 402(a).

<sup>121</sup> S. 1052, § 402(a).

<sup>122</sup> H.R. 2563 at § 402(a).

<sup>123</sup> *Id.*

<sup>124</sup> See Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 *NEW ENG. J. MED.* 229 (1999) (stating that implicit in the concept of 'professional control' is "the belief that insurers should have the power to make a conclusive and nonreviewable decision that a particular service is unnecessary and therefore excluded from coverage").



poses they serve.<sup>125</sup> For example, forty-eight of the fifty States prohibit the use of “gag clauses,” where managed care plans prohibit physicians from discussing matters like treatments the plan does not cover, attempted referrals from the doctor refused by the plan, and financial incentives under which doctors deliver care.<sup>126</sup> Similarly, the Bills providing for a Federal Patients’ Bill of Rights provide for the prohibition of gag clauses.<sup>127</sup>

## E. New Zealand

### 1. Public/Private Mix

The New Zealand system is predominantly publicly funded, but the share of public funding has been declining. In 1980, public spending comprised 88% of total health care spending<sup>128</sup> but had declined to 77.1% by 1998.<sup>129</sup> The decline in the per capita public share of health spending in New Zealand was the most dramatic in the OECD.<sup>130</sup> The share paid by private insurance increased slightly from 6.1% in 1993/1994 to 6.8% in 1996/1997.<sup>131</sup> However, the greatest growth has been in out-of-pocket payments by patients, which increased from 10.4% of all health care spending in 1979/1980 to 15.9% in 1998/1999.<sup>132</sup>

Average statistics conceal the fact that there is variation between health care services with respect to the public/private mix. For example, in 1998/1999, the government contributed almost 100% of public hospital spending yet only 61% of community care (personal care including family doctor visits) spending.<sup>133</sup> In the year ending June 1999 the sums paid out-of-pocket by patients amounted to approximately 28% of drug

<sup>125</sup> Robert L. Schwartz, *How Law and Regulation Shape Managed Care*, in *MANAGED CARE: FINANCIAL, LEGAL AND ETHICAL ISSUES* 29 (David A. Bennahum ed., 1999).

<sup>126</sup> *Id.* at 31.

<sup>127</sup> S. 1052, § 131-135; H.R. 2563, §§ 131-135.

<sup>128</sup> OECD HEALTH DATA, *supra* note 5.

<sup>129</sup> NEW ZEALAND MINISTRY OF HEALTH, *HEALTH EXPENDITURE TRENDS IN NEW ZEALAND 1980-99*, at 44 (Aug. 2000), [http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/1e72ae65cce8beb7cc2569740069be92/\\$FILE/hlthexpend99.pdf](http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/1e72ae65cce8beb7cc2569740069be92/$FILE/hlthexpend99.pdf).

<sup>130</sup> *See* OECD HEALTH DATA, *supra* note 5.

<sup>131</sup> NEW ZEALAND MINISTRY OF HEALTH, *supra* note 129, at 54.

<sup>132</sup> *Id.*

<sup>133</sup> *See id.* at 60-61.

spending, 30% of spending on family doctor visits and 58% of specialists' visits.<sup>134</sup> Although overall still a small proportion, private insurers play an important role in the funding of *particular* health care services such as non-emergency surgical services, specialist services, and family doctor charges.

## 2. Philosophical Approach

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

## 3. Processes for Determining What Is Publicly Funded

How is it decided what is in and out of the publicly funded sector in New Zealand and what processes are used to ration health care? In New Zealand, it is based on a crucial distinction between the funding of hospital services and the funding of medical services. Family doctors have retained the right to charge patients whatever they wish for their services over and above whatever subsidy/payment is made by the government.<sup>135</sup> Since 1941, government subsidies have failed to keep pace with the charges fixed by family doctors and an increasing proportion of this care has been privately financed. Also, people who wish to avoid long queues for specialists' services or elective surgery can buy care from specialists and in private hospitals. Apart from rationing by way of price, implicit rationing within the boundaries of the publicly funded system also occurs. Successive governments have restricted the flow of public resources into the public system and have relied on implicit rationing, whereby physicians allocate limited public resources,

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<sup>134</sup> See *id.* at 57

<sup>135</sup> See IAIN HAY, *THE CARING COMMODITY: THE PROVISION OF HEALTH CARE IN NEW ZEALAND* 121 (1989) (indicating that a restriction preventing physicians from accepting payment from patients in excess of government subsidy was removed in the Social Security Amendment Bill).

such as hospitals beds, technology, and nursing services, across various health needs.<sup>136</sup>

The 1993 “internal market” reforms saw the introduction of explicit rationing and an attempt to develop a more principled approach to what services would be publicly funded.<sup>137</sup> A National Advisory Committee on Core Health and Disability Services (Core Services Committee)<sup>138</sup> was created and charged with giving independent advice to the Minister of Health on which core services should be purchased, how they should be distributed, and the terms of access on which they should be available. It was initially thought that the health and disability services that should be publicly funded could be identified in a list. To this end, the Committee consulted consumers and providers around New Zealand. However, by October 1994 this approach was rejected,<sup>139</sup> the Committee having determined that compiling such a list would be complex, time-consuming, expensive, and divisive.<sup>140</sup> Instead, it recommended to the government that the then-publicly funded health and disability services become the core—such services representing the “values and priorities of several past generations of New Zealanders.”<sup>141</sup>

<sup>136</sup> See ROBERT H. BLANK, *NEW ZEALAND HEALTH POLICY: A COMPARATIVE STUDY* 98 (1994).

<sup>137</sup> According to the then Minister of Health, Simon Upton, defining a set of “core health services” more explicitly would help ensure that the services the public believe to be the most important would be provided. SIMON UPTON, *YOUR HEALTH AND THE PUBLIC HEALTH: A STATEMENT OF GOVERNMENT HEALTH POLICY* 80 (1991). It would also acknowledge more honestly that there are limits to the health services the government could afford.

<sup>138</sup> In January 1996 the Core Services Committee was renamed the National Advisory Committee on Health and Disability. NAT’L HEALTH COMM., *ROLE OF THE NATIONAL ADVISORY COMMITTEE ON HEALTH AND DISABILITY*, <http://www.nhc.govt.nz/about/rolenhc.htm> (last visited Jan. 22, 2002).

<sup>139</sup> The Core Services Committee stated:

In the two and a half years we have been working to define core services, the Committee has found that on clinical grounds alone, without any consideration of fairness or equity, explicitly identifying core services is not as straightforward as might first have been thought possible. A ‘yes/no’ or ‘in/out’ list approach is just too simplistic. It would either have to be so broad and lacking in definition as to be meaningless, much the situation the Committee inherited, or its explicitness would make it too arbitrary and inflexible resulting in people being unfairly excluded from services. Either way it would fail.

Lynette Jones, *Core Services Committee: The Core Debate 3*, in ALAN MAYNARD & KAREN BLOOR, *OUR CERTAIN FATE: RATIONING IN HEALTH CARE* 28 (1998).

<sup>140</sup> BLANK, *supra* note 136, at 105.

<sup>141</sup> *Id.*

It also recommended the development of guidelines and clinical assessment criteria to help define when a new service was of sufficient clinical benefit to warrant public funding. The most recent raft of reforms being implemented by the Labour/Alliance government retains the concept of explicit rationing. The New Zealand Public Health and Disability Act 2000 provides that the Minister of Health can appoint a national advisory committee on health and disability which will be charged with the task, among others, of advising the Minister on "the kinds, and relative priorities, of public health services, personal health services, and disability support services that should, in the committee's opinion, be publicly funded."<sup>142</sup> The lesson for other jurisdictions from this experience is that attempting to define a fixed list of services to be publicly funded is difficult and may flounder, but there is fruit to be had in establishing processes to determine *priorities* in health care spending *within* a publicly funded system.

#### 4. Court Challenges

As in other jurisdictions, the introduction of explicit rationing has resulted in some court challenges in New Zealand. The most contentious case involved a sixty-three-year-old man, Rau Williams, suffering from renal failure, diabetes, and dementia, who was denied access to renal dialysis treatment by a Regional Health Authority (Northland Health).<sup>143</sup> A relative of Mr. Williams' applied to overturn this decision but was unsuccessful both in the High Court and the Court of Appeal. The Court of Appeal found that the Health Authority did not deny care because it was rationing limited resources; rather, it was a case about the appropriateness of a clinical decision. This case generated a large amount of public interest and debate. Examples of media statements include the following: "Two top kidney doctors say the refusal to give Rau Williams renal dialysis is a rationing decision . . . Mr[.] McKeown's renal physician is also reported as saying: [']Northland's explanation that Mr[.] Williams was denied treatment on purely clinical grounds . . . is only 80% of the story.'"<sup>144</sup> This case and the media commentary around it highlight the murky divide between "clinical deci-

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<sup>142</sup> Public Act 2000, No. 91, § 13(1)(a).

<sup>143</sup> *Shortland v Northland Health Ltd.* [1998] 1 NZRL 433 (C.A.).

<sup>144</sup> Colin M. Feek et al., *Experience with Rationing Health Care in New Zealand*, 318 BRIT. MED. J. 1346, 1348 (1999).

sions,” “resource allocation,” and “rationing” and the need for citizens to know that there are fair and transparent processes for allocating public health care.

### 5. Patients’ Bill or Charter of Rights

The Code of Health and Disability Services Consumer Rights came into force in New Zealand on 1 July 1996. New Zealand’s Health and Disability Commissioner is charged with promoting the rights of consumers and investigating potential breaches of the Code. An awareness survey in 1999 showed that there had been a steady increase in public awareness of the Code and of the role of the Commissioner.<sup>145</sup> The Code prescribes ten rights: (1) the right to be treated with respect; (2) the right to freedom from discrimination, coercion, harassment, and exploitation; (3) the right to dignity and independence; (4) the right to services of an appropriate standard; (5) the right to effective communication; (6) the right to be fully informed; (7) the right to make fully informed choices and decisions; (8) the right to support; (9) rights in respect of teaching or research; and (10) the right to complain.<sup>146</sup> Clearly, these rights are largely rights of a patient vis-à-vis a health professional and most are already recognized at common law and in medical codes of ethics. Of interest is that despite “internal market reforms” in New Zealand in 1993 that provided for Regional Health Authorities to take on a proactive purchasing and management role, the Code of Rights does not speak to rights of patients or citizens vis-à-vis Regional Health Authorities. Moreover, although waiting lists and times are an issue of significant concern to New Zealanders. The Code of Rights does not contain any provisions to ensure the delivery of timely care.

## F. United Kingdom

### 1. Public/Private Mix

Although the percentage of health care paid for by the public sector has declined, the United Kingdom still has one of the

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<sup>145</sup> See RON PATTERSON, ANNUAL REPORT OF THE HEALTH AND DISABILITY COMMISSIONER 17-18 (1999).

<sup>146</sup> The Knowledge Basket, The Code of Health and Disability Services Consumers’ Rights, <http://www.knowledge-basket.co.nz/hdc/about/rghtindx.html> (last visited Jan 26, 2002).

higher percentages of public funding in the OECD. In 1999, government funded 84.2% of total health care spending.<sup>147</sup> Of total health care spending, approximately 3.5% is attributable to private insurers and 11% to out of pocket payments by patients.<sup>148</sup> Private insurance and out of pocket payments fund private elective surgeries, as well as user charges for pharmaceuticals, eye and dental care. For pharmaceuticals, however, 60% of the population are exempt from the requirements for user charges<sup>149</sup> because of their low incomes or because they are defined as chronically ill.

## 2. Philosophical Approach

The philosophical principle of the UK's National Health Service (NHS) has long been that care should be allocated on the basis of need and not ability to pay.<sup>150</sup> Legislation requires that the Secretary of State, to such an extent as he or she considers necessary to meet all reasonable requirements, has a duty to *provide* (and not merely insure) hospital and other like accommodation, medical, dental, nursing and ambulance services, maternity and young child care, preventative, acute and convalescent care, and services required for the diagnosis and treatment of illness. However, there is no guidance about how health care services should be allocated or prioritized amongst different health care needs.

## 3. Processes for Determining What Is Publicly Funded

The U.K. system has a long history of providing public coverage for a comprehensive range of health care services including prescription drugs. In terms of how public resources are

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<sup>147</sup> OECD HEALTH DATA, *supra* note 5.

<sup>148</sup> *Id.*

<sup>149</sup> Note that over eighty percent of prescriptions are dispensed to those who are exempt.

<sup>150</sup> In introducing the National Health Service Plan in July 2000, Prime Minister Tony Blair stated:

The NHS was the greatest achievement of the post-war Labour Government. It was based on one solid founding principle: that health care should be given on the basis of a person's need not their wealth. . . . [T]his side of the House will never abandon what was one of the greatest civilising acts of emancipation this century has ever known.

Prime Minister Tony Blair, Statement on the National Health Service Plan (July 27, 2000), in 10 DOWNING ST. NEWSROOM, at <http://www.number-10.gov.uk/news.asp?NewsId=1166&SectionId=32>.

allocated, the U.K. system has historically relied on implicit rationing by physicians as “gatekeepers” to the health care system. It has also relied on implicit rationing through Health Authorities and public hospitals having to work within the confines of a capped annual budget. More recently, however, there has been a shift to more forms of explicit rationing by centrally determining how to rank priorities in health care spending. In 1992, the government issued *Health of the Nation*, setting out the government’s health strategy and identifying key areas for action by the NHS and others.<sup>151</sup> This strategy set national and local health targets in five key areas. In 1998, the Labour government introduced a new policy, which set health targets to be met by the year 2010. The newly created National Institute for Clinical Excellence is also meant to issue evidence-based guidance on the cost-effectiveness of selected services and will recommend whether such services should be used across the country.

#### 4. Court Challenges

As in other jurisdictions, explicit rationing decisions have been the subject of court challenges with patients bringing judicial review actions to challenge funding decisions. *Regina v. Cambridge District Health Authority*<sup>152</sup> involved a ten-and-a-half-year-old girl who had been given six to eight weeks to live, where the doctors treating her were of the opinion that she should be given no further remedial treatment. The patient’s father sought the opinion of two further medical experts, both of whom were of the opinion that further treatment, including a second bone marrow transplant, was possible. However, because of the unavailability of beds in the only NHS hospital prepared to carry out such treatment, the treatment could only be provided in a private facility. The patient’s father requested therefore the Health Authority responsible for his daughter’s care to allocate funds for the treatment in this private facility. The Health Authority refused. The court held that while the Health Authority owes a statutory duty to provide medical services, there is discretion as to how that duty is to be fulfilled.<sup>153</sup> Nevertheless, the father’s action was successful to the extent

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<sup>151</sup> DEP’T OF HEALTH, *HEALTH OF THE NATION: A STRATEGY FOR HEALTH IN ENGLAND* (1992).

<sup>152</sup> [1995] 1 FLR 1055 (QB).

<sup>153</sup> *Id.*

that the Health Authority, while not ordered to fund the treatment, was required to reconsider its decision on several grounds. One of these grounds was that the Health Authority had referred to resource constraints but had not adequately explained the funding priorities that had led to its decision.<sup>154</sup>

Explicit rationing by a Health Authority was the subject of litigation in a more recent case, *Regina v. North West Lancashire Health Authority*.<sup>155</sup> This case involved a challenge to a Health Authority's refusal to pay for gender reassignment surgery following its allocation of a low priority to such surgery, which it considered achieved little or no clinical gain.<sup>156</sup> The Court of Appeal applied the decision in the *Cambridge* case, noting Sir Thomas Bingham's statement that the courts "will not seek to allocate scarce resources in a tight budget but will ensure that the Health Authority has asked the right questions and has addressed the right issues before arriving at a policy that is lawful."<sup>157</sup> On the facts, the court found that the Health Authority had failed to take relevant matters into consideration in allocating a low priority to gender reassignment surgery. Such matters included the question of what is a proper treatment or what is recognized as the illness involved in gender identity dysphoria. Rather, it was found that the decision was made taking into consideration irrelevant matters. The Health Authority was ordered to reformulate its policy accordingly.

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

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<sup>154</sup> *Id.*

<sup>155</sup> [2000] 1 W.L.R. 977 (C.A.).

<sup>156</sup> In addition, in *Regina v. North East Devon Health Auth.*, [2001] Q.B. 213, 230 (Eng. C.A.), the court stated:

Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the resources of the NHS are, and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand. . . . [Section] 3(1) of [the National Health Service Act 1977] does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy.

<sup>157</sup> *North West Lancashire Health Authority*, [2000] 1 W.L.R. at 988.



### 5. Patients' Bill of Rights

A U.K. "Patients' Charter" was introduced in 1992, with the aim of improving the quality of health service delivery. The Charter published standards of service that people should expect, and in doing so, emphasized quality improvement and the attainment of specific service delivery standards such as maximum waiting times. The Charter included broad guarantees at the level of principle, such as the right to "receive health care on the basis of clinical need, regardless of the ability to pay."<sup>158</sup> The one statement in the Charter that entailed an identifiable standard related to waiting lists. Patients were to be "guaranteed admission for virtually all treatments by a specific date" within two years, subsequently reduced to eighteen months and then to a target of twelve months for some procedures.<sup>159</sup> In addition to "rights" the Charter also set out nine "standards" including respect for privacy, dignity, and religious beliefs, and also in relation to waiting times, such as a guarantee of being seen within thirty minutes in an outpatient clinic. However, while the Charter provided a complaints mechanism, it did not create legally enforceable rights.

The Charter has now been replaced by a NHS "Guide", which tells patients what they can expect.<sup>160</sup> It is a guide to patients' rights and responsibilities, and highlights the standards and services people can expect from the NHS, including how long a patient can expect to wait before receiving treatment. As with the Charter that preceded it, the guide provides for patients to make complaints but does not create new legally enforceable rights. Criticism has been made of the new NHS Guide for not explicitly setting out what patients entitlements are, thus it is argued, making it more difficult for patients to stand up for themselves. For example, whereas the old "Patients' Charter" specifically stated that patients over the age of seventy-five had a right to a yearly health check the new NHS Guide makes

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<sup>158</sup> Chester & Ellesmere Port Community Health Council, *The Patient's Charter* (n.d.), <http://www.nhswatchdog.com/charter.htm> (last visited July 1, 2002).

<sup>159</sup> *Id.*

<sup>160</sup> Press Release, U.K. Department of Health, *Guide Spells Out What Patients Can Expect from the NHS*, (Jan. 26, 2001), <http://www.doh.gov.uk/newsdesk/archive/jan2001/4-naa-26012001.html>.

much broader commitments to, for example, “work continuously to improve quality services and to minimise errors.”<sup>161</sup>

As Canada and other public health care systems consider how to ensure citizen satisfaction with their programs and enhance the accountability of the system to the people it services, policy makers should consider in more detail the United Kingdom’s experience with a Charter of Rights. Citizen concerns about timeliness dominate public discourse in predominantly publicly funded systems like the United Kingdom, New Zealand, and Canada, and threaten to undermine support for the concept of public systems. The United Kingdom did appear to have some success in reducing waiting times in the early part of internal market reforms in the early 1990s. This appeared to be achieved through incentives for Health Authorities and hospitals (NHS Trusts) to achieve waiting lists targets.<sup>162</sup> Policy makers in public funded systems should consider how to gear public systems towards more timely treatment, perhaps through including guarantees as to waiting times in a Patients’ Bill of Rights, coupled with incorporating incentives into the public system to achieve these waiting time targets.

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

#### A. Health Outcomes

##### 1. General

In this part of our paper we turn to examine cross-country evidence on the correlation between health status and public/private spending. We look at four measures of health: life expectancy, infant mortality, the incidence of cancer in the population, and potential years of life lost from all causes.<sup>163</sup> We construct three summary measures of spending:

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<sup>161</sup> *Are We Losing Our Rights as Patients?* TIMES (London), July 17 2001, at 12.

<sup>162</sup> See FLOOD, *supra* note 95, at 146-47 (discussing differences between the United Kingdom and New Zealand in controlling waiting lists).

<sup>163</sup> Potential Years of Life Lost (PYLL) is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, a priori, preventable.

1. how total spending on health as a percentage of GDP is correlated with each of these measures of health status.
2. how public spending on health as a percentage of GDP is correlated with each of these measures.
3. how private spending on health as a share of total health care spending is correlated with each of these measures.

These are simple correlations that do not control for other variables such as the country's income or GDP, age distribution, and spending on other areas of public health. We are simply reporting the correlation between various measures of health spending and various measures of health across countries at a single point in time, which is the most recent year for which data were available. The data come from the OECD statistics on each of these measures. Our results are shown in Table 3 in the Appendix.

As Table 3 demonstrates, evidence from twenty-four OECD countries for which consistent data are available<sup>164</sup> shows how difficult it is to reach any conclusions about the relationship between public/private spending and health outcomes. For female life expectancy we calculate that there is a positive and statistically significant correlation between total health care spending as a percent of GDP and life expectancy. However, for males, while the relationship is still positive, it is not statistically significant. We find no correlation between private health care spending as a share of total health care spending and life expectancy for either males or females. For infant mortality, we find, on average, that there are fewer infant deaths in those countries where health spending, as a share of GDP is greater. For the incidence of cancer in the population we actually find higher levels of cancer in those countries with greater health care spending as a share of GDP, probably reflecting that people in those higher-spending countries are more likely to die of "diseases of affluence" like cancer than other causes. Finally, for potential years of life lost, we find a positive correlation be-

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<sup>164</sup> We omit the Czech Republic, Hungary, Korea, Mexico and Poland because consistent data is not available for these countries.

tween private health care spending as a percent of total health spending and potential years of life lost. This might reflect, in part, the fact that private spending tends to be skewed towards the more well off individuals, where the returns to spending on health are smaller and away from potentially more needy populations where the returns are larger. However, this measure is only a simple correlation at a point in time, and it is beyond the scope of this article to explore whether this correlation holds in a multivariate, multiyear analysis. We do find some evidence that public spending on health as a share of GDP is correlated with better health outcomes. However, this result may be partly capturing the fact that public spending on health care is also correlated with public spending in a number of other areas that contribute significantly to the health status of the population, such as education, housing, and income redistribution. The fact that we find no correlation between public health spending as a share of total *public* spending and health outcomes is consistent with this hypothesis and suggests that it may be public spending on a variety of socially beneficial areas which improves population health and not simply spending on health care.

To investigate the relationship between private/public spending and health care further, we now turn to country specific studies that examine policy changes in health spending. These studies are much more likely to provide results that can be interpreted as a causal relationship between public/private spending changes and health care outcomes.

## 2. Country Specific Evidence On Health Outcomes

Looking more closely at the structure and dynamics of selected health care systems can provide considerably more insight into the implications of various forms of private spending on the health of the population, and its use of health care services than can be achieved by looking across all OECD nations. We begin by examining evidence on out-of-pocket payments for health care services. Out-of-pocket payments are often suggested as a way to increase private resources within the health care system and as a way to decrease frivolous or unnecessary use of health care services. The literature on cost-sharing and health outcomes in developed countries is somewhat limited since out-of-pocket payments play *on average* a small role in financing most systems. Out-of-pocket payment by patients accounted for a mere 2.7% of total health care spending in the

United Kingdom, based on 1995 figures.<sup>165</sup> By comparison, in 1998, out-of-pocket payments accounted for 17.7% of total health care spending in the United States, 22.9% in New Zealand, 16.2% in Australia, and 5.9% in the Netherlands.<sup>166</sup> The 1998 figures are not available for Canada; however, the 1997 figure was 17.1%.

The United States and New Zealand have the highest levels of cost sharing for primary care, such as family doctor services, and we summarize the relevant literature from the experience of these two countries as well as research on cost-sharing conducted in Canada. We focus on the United States, New Zealand, and Canada for the following reasons. First, much of the research on out-of-pocket payments has focused on the U.S. system. Second, the New Zealand research explicitly examines how out-of-pocket payments affect the first point of contact with the health system—the family doctor. As in many countries, New Zealand uses family doctors as gatekeepers for the rest of the system, and if out-of-pocket payments prevent individuals from seeing their family doctors, they will also prevent individuals from accessing other parts of the health care system. Canada has a sectoral model and while fully protecting hospital and physician services, allows out-of-pocket payments for prescription drugs, home care, etc. Despite Australia's high level of out-of-pocket payments, we do not focus on Australia here as most Australians who are considered unable to afford out-of-pocket payments are exempted from paying them. Concessional patients<sup>167</sup> in Australia are exempted from out-of-pocket payments for physician services, there are no fees for public hospitals, and there are significant safety-net provisions for pharmaceuticals. The absolute percentage of spending coming from out-of-pocket payments may not be as important as who is required to make out-of-pocket payments and for what kinds of services.

A large study of cost sharing in the United States suggests that, unsurprisingly, increasing cost sharing decreases the num-

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<sup>165</sup> OECD HEALTH DATA, *supra* note 5.

<sup>166</sup> *Id.*

<sup>167</sup> Concessional patients are people who receive certain pensions, benefits or cards administered by the Departments of Family and Children's Services or Veterans' Affairs, or who meet certain criteria for being declared to be disadvantaged.

ber of health care services that people use.<sup>168</sup> People in the study who had to pay nothing out-of-pocket used significantly more health care services than those people who had to pay some fee out of their own pocket. The exception to these findings was hospital admissions of children, where it was found that even where people had to pay out-of-pocket there was no difference in the number of admissions. For those people above the poverty line in the United States, increases in out-of-pocket payments did not seem to have any measurable effect on health outcomes. Evidence from expansions in the Medicaid program for poor children in the United States suggests that reducing out-of-pocket payments increases the use of preventive care and decreases adverse health outcomes for children.<sup>169</sup> Evidence from New Zealand also suggests that out-of-pocket payments are barriers to access. In New Zealand, many people have to pay the full cost of a visit to their family doctor, although 37% of the population have private insurance to help cover these costs.<sup>170</sup> There are government subsidies in place for those on lower incomes and those with chronic illness, but they still only cover about half of the fee charged. In a 1997 study, Grant et al. found that out-of-pocket payments are barriers to access for some sectors of the population, and that New Zealanders are less able to access basic primary care than the British, Canadians, or Australians.<sup>171</sup>

Additional evidence from Canada further supports the hypothesis that out-of-pocket payments affect utilization and that there is a disproportionate impact upon those with lower incomes. A Saskatchewan study from the 1970s on out-of-pocket payments for physician services showed that utilization declined among lower income groups, but actually increased among upper income groups during a period in which co-payments were

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<sup>168</sup> JOSEPH P. NEWHOUSE & THE INSURANCE EXPERIMENT GROUP, FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 338, 338 (1993).

<sup>169</sup> See Janet Currie & Jonathan Gruber, *Health Insurance Eligibility, Utilization of Medical Care, and Child Health*, 111 Q. J. ECON. 431, 456-457 (1996) (estimating the effects of Medicaid eligibility on the use of health care resources using the National Health Interview Survey (NHIS)).

<sup>170</sup> NEW ZEALAND MINISTRY OF HEALTH, *supra* note 129, at 35.

<sup>171</sup> Cameron C. Grant et al., *Primary Care and Health Reform in New Zealand*, 110 N.Z. MED. J. 35, 38 (1997); see also Cathy Schoen et al., *Equity in Health Care Across Five Nations: Summary Findings from an International Health Policy Survey* HEALTH POL'Y, Apr. 2000, at 67 (reporting on New Zealander's and Australian's perceived inequities in access to care).

in effect.<sup>172</sup> Barer et al. have argued that these results can be attributed to the behavior of physicians, who sought to compensate for declining demand from lower-income individuals by inducing higher levels of utilization by less price-sensitive upper-income individuals.<sup>173</sup>

Out-of-pocket payments play a much larger role in the prescription drug market in Canada than in other parts of the health care system. Eighty-eight percent of Canadians have some form of prescription drug coverage (69% are covered by private plans and 19% by government), but almost all plans, be they private or public, include deductibles and/or co-payments.<sup>174</sup> Among provincial public plans, the trend over the past ten years has been towards increasing out-of-pocket payments to help control drug spending. A study of the Quebec provincial drug plan found that out-of-pocket payments reduced both the utilization of medications and the health of beneficiaries. For lower income individuals—those receiving income security payments—prescription drug use fell by 14.7%.<sup>175</sup> Tamblyn notes the possibility that individuals have died in Quebec due to lack of medication.<sup>176</sup>

What lessons are there for countries considering whether to maintain or introduce out-of-pocket payments as a way of trying to ensure the fiscal sustainability? Out-of-pocket payments will reduce the use of health care services, provided of course that people simply do not purchase private insurance to reimburse them for the costs incurred, and this may produce some savings. However, there may also be some costs if people don't receive the treatment they need at an early stage and the system ends up having to treat a more acute condition. Any savings in spending will result disproportionately in reductions in utilization by those on lower incomes. While out-of-pocket payments are unlikely to affect the health outcomes of the relatively well off, they are likely to negatively affect the health outcomes of the

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<sup>172</sup> See R.G. Beck & J. M. Horne, *Economic Class and Risk Avoidance: Experience Under Public Medical Care Insurance*, 43 J. RISK & INSUR. 73, 73 (1976).

<sup>173</sup> Morris Barer, Robert Evans & Greg Stoddard, CONTROLLING HEALTH CARE COSTS BY DIRECT CHARGES TO PATIENTS : SNARE OR DELUSION? 33-34 (1979).

<sup>174</sup> HEALTH CANADA, *supra* note 24.

<sup>175</sup> Robyn Tamblyn et al., *Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 JAMA 421 (2001), <http://jama.ama-assn.org/issues/v285n4/full/joc00341.html>.

<sup>176</sup> *Id.*

poor. Therefore, if out-of-pocket payments are introduced, there needs to be careful consideration of how to ensure that those on lower incomes are not deterred from getting the care they need. Lessons may be taken from Australia here, which has a complicated system in place ensuring that Concessional patients are protected from having to pay out-of-pocket costs. It should be kept in mind, however, that implementing a system of out-of-pocket payments and accompanying safety nets will increase the administrative costs of running the system. These latter costs may in some cases outweigh any cost savings.<sup>177</sup>

### B. Utilization of Health Care Services

Health care spending is a function of the price paid for health services and the quantity of services used. Countries which have higher levels of spending could simply be paying higher prices for a given quantity and quality of services (i.e., paying their health care professionals more for delivery of the same services) or could be consuming more of those services at the same prices. Evidence comparing the use of family doctors in Canada versus the United States suggests that it is primarily the former. As the data in Table 1 suggests, the United States spends considerably more on health care, including on primary physician care. Researchers examining the source of these differences conclude that Canadians do not receive fewer primary physician visits than their American counterparts; in fact, they appear to go to their family doctors more often than the average American.<sup>178</sup> Further evidence comparing hospital expenditures in Canada versus the United States reaches similar conclusions. A study published in 1988 by Newhouse et al. concludes that despite large differences in expenditures between the two countries, Canadians do not spend less time in the hospital than

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<sup>177</sup> For example, the New Zealand government abandoned its \$50 a night patient user charge for public hospitals partly because of a public outcry, but also partly because of the high administrative costs involved with collection. By the end of the first quarter (May 1992), after the introduction of out-of-pocket payments for public hospital services, outstanding debts fell in the range of 30-60% of total revenue from charges. Toni Ashton, *Charging for Health Services—Some Anecdotes from the Antipodes*, in STRATEGIC ISSUES IN HEALTH CARE MANAGEMENT 16 (M. Malck et al., eds., 1993).

<sup>178</sup> See Victor R. Fuchs & James S. Hahn, *How Does Canada Do It?: A Comparison of Expenditures for Physicians' Services in the United States and Canada*, 323 NEW ENG. J. MED. 884, 887-888 (1990) (observing that, in the United States, the quantity of services per capita is lower than in Canada).



Americans; in fact, they tend to spend longer as inpatients, on average.<sup>179</sup> A study published in 1998, comparing back and neck hospitalizations in the province of Ontario and Washington State, found that surgical back and neck hospitalizations were three times as common in Washington. However, medical hospitalizations were twice as common in Ontario and people in Ontario were hospitalized longer for both surgical and non-surgical hospitalizations.<sup>180</sup> Thus the evidence tends to suggest that Americans receive higher volumes of surgical and intensive kinds of care but that Canadians receive higher volumes of primary and preventive care.

What should Canada conclude from the evidence on service volumes and private spending? Increasing private spending will not necessarily increase the amount of care Canadians receive. In fact, it appears that Canadians already receive the same level of care, if not more care, as do Americans. However, private spending is likely to shift the mix of services that are performed on patients towards more expensive technologies and increase the price paid for services. Whether these technologies are more effective at providing care, and the value that patients may put on this care, is also important to consider, but beyond the scope of this article.

### C. Health Care Spending

Among the OECD countries we investigate, the United Kingdom has the largest share of public financing of health care expenditures, comprising 84% of all health care expenditures.<sup>181</sup> Among the countries examined, the United Kingdom also spends the least on health as a fraction of GDP - 5.8% in 1997.<sup>182</sup> At the other extreme, the United States finances only 46% of health care expenditures publicly and spends the most on health care as a fraction of GDP - 13.9% in 1997.<sup>183</sup> Com-

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<sup>179</sup> See Joseph P. Newhouse et al., *Hospital Spending in the United States and Canada: A Comparison*, HEALTH AFFS., Winter 1988, at 6, 10-11 (1988) (finding that the hospital length of stay for people over age sixty-five in Ontario and Manitoba is several days longer than the average stay for that same group in the United States as a whole).

<sup>180</sup> Victoria M. Taylor et al., *Hospitalizations for Back and Neck Problems: A Comparison Between the Province of Ontario and Washington State*, 33 HEALTH SERVS. RES. 929, 942 (1998).

<sup>181</sup> OECD HEALTH DATA, *supra* note 5. .

<sup>182</sup> *Id.*

<sup>183</sup> *Id.*

parisons across OECD countries have found some support for the hypothesis that predominately public payers are able control growth in health care prices better than predominantly private payers. Research by Globerman and Vining looks at the relationship between the public share of health care financing in 1980 in OECD countries and the extent to which health care price inflation exceeded general inflation between 1980 and 1996. Their findings suggest that the higher the public share of financing, the lower the increase in prices, supporting the hypothesis that public payers keep prices down<sup>184</sup>. Thus there is some evidence to support the idea that more public spending is associated with a better capacity to restrain growth in health care prices, and the United States experience of relatively very high rates of private financing is associated with high overall health care spending. However, when we examine a larger number of OECD countries but exclude the United States we can find no statistical correlation between public spending and control of total health care spending as a percentage of GDP.<sup>185</sup> Most countries, with the notable exception of the United States, do have high rates of public financing, suggesting that relatively small differences in the total amount of private financing between countries is not enough to have a significant impact on prices. What is required is an examination of different sectors that have much higher rates of private financing than the average. For example, private financing accounts for 64% of spending on the drug sector in Canada and the growth in spending on drugs has been approximately 9% per year since 1987,<sup>186</sup> much higher than the growth rate in spending on hospital and medical care, which are close to 100% publicly funded.

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

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<sup>184</sup> Steven Globerman & Aidan Vining, *A Policy Perspective on "Mixed" Health Care Financial Systems of Business and Economics*, 65 J. RISK & INS. 57, 71 tbl.4 & 75 (1998).

<sup>185</sup> Tuohy, Flood & Stabile, *supra* note 1, at 2-7.

<sup>186</sup> CANADIAN INST. FOR HEALTH INFO, *supra* note 4.

To attempt to answer this question, we previously examined changes in private health spending within each of twenty-four OECD countries over a period of seventeen years and the corresponding changes in the share of the total public budget that was spent on health care over this same period.<sup>187</sup> While the evidence does not definitively show that increases in private financing caused a decline in public financing, the results do show that over a seventeen year span, increases in the private share of health care spending are consistently associated with a decline in public spending on health as a share of total public spending. The decline isn't a dollar for dollar decline, but the numbers suggest that for every \$10 of private money put in the health care system, there is a decline, on average, of between \$1 and \$3 of public funding devoted to health care. A more detailed examination of hospital and pharmaceutical spending in particular revealed that while there is no correlation between increases in private spending and declines in public spending in the hospital sector, there is evidence of such correlations within the pharmaceutical sector. This finding, which is consistent with "crowding-out" of public money by private money in the pharmaceutical sector is not surprising. Most public drug insurance programs involve private co-payments, and most increased the level of co-payment in the 1990s. In this sense the substitution of private for public finance was a matter of deliberate policy design.

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

#### D. Waiting Times

Whether private financing can help alleviate waiting times for care is of particular policy importance to a number of publicly funded countries. As patient expectations for timely and technologically advanced care increase, countries which have traditionally rationed care and technology through waiting times are facing increasing pressure to use private funds as a means of improving access. It is very difficult to ascertain from the avail-

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<sup>187</sup> Tuohy, Flood & Stabile, *supra* note 1, at 2-7.

able data the extent to which waiting times are truly a problem in Canada or in any other jurisdiction. Most governments are reluctant to collect data on waiting lists because more often than not this information is often used to criticize government performance. Our data on percentage of the population waiting and levels of private insurance is shown below in Table 2. What data is available for Canada suggests that the percent of the population on waiting lists in Canada increased very slightly, by 0.08 percentage points, between 1997 and 1999.<sup>188</sup> In the Netherlands, private insurance plays an important role in financing the system but having private insurance does not allow an individual to jump queues in the social insurance system. It is seen as against a physician's ethical code to prefer a patient with private insurance to a patient without and both kinds of patients are treated side-by-side in the same hospitals.<sup>189</sup> In the Netherlands the percent of the population on waiting lists is lower than in Canada, at approximately half a percent in both 1997 and 1999.<sup>190</sup> In New Zealand, where there is a two-tier system, there appears to have been a rapid decline in the numbers waiting, from a peak of 2.48% of the total population on waiting lists in 1997 down to 1.65% in 1999.<sup>191</sup> However, this apparent decline is misrepresentative of the true state of affairs. In response to criticisms of long and growing waiting lists in the public sector, the New Zealand government in 1997 introduced a "booking system." In the new booking system patients are not "booked" in for surgery unless the system can provide the service within six months. Patients whose needs cannot be meet within this time frame are referred back to their doctor to "manage" their condition. So, what we have is now unofficial wait lists for wait lists! In the United Kingdom, the percent of the population on waiting lists was approximately 2.56% in 1997 and declined only slightly to 2.26% in 1999.<sup>192</sup>

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<sup>188</sup> *Infra* tbl.2.

<sup>189</sup> See Brouwer & Schut, *supra* note 59, at 65 (stating that "in the Netherlands uniform treatment of all (regardless of socio-economic status) is a broadly accepted principle of equity in health care"); see also Brouwer & Hermans, *supra* note 59, at 7-9 (concluding that special clinics for employees should be allowed because they while they benefit the employees, they also benefit the positions of non-employees).

<sup>190</sup> *Infra* tbl.2.

<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

In sum, there is no existing evidence supporting the idea that private financing can reduce public waiting lists. Each of the systems that allow for such a sector have waiting lists that are similar to or longer than those in Canada, and indeed New Zealand and the United Kingdom are significantly worse on these measures. When waiting times have declined in the United Kingdom, it has been in response to infusions of public funding, such as the "Waiting List Initiative" of the late 1980s and early 1990s, and mechanisms to change incentives within the public sector. Not only do parallel private systems not reduce waiting lists in the public system, they may in one respect increase them. Evidence from the United Kingdom suggests that parallel private systems may attract healthier patients and perform relatively less complicated procedures, thereby increasing the average complexity and dependency of patients continuing to use the public system. Martin and Smith, for example, found evidence that the length of stay in NHS hospitals was longer in areas with high levels of private inpatient facilities, which may suggest that the private facilities "cream off" the less complicated cases, leaving the local NHS facility with a relatively complex case mix.<sup>193</sup>

#### IV. CONCLUSION

In this paper we outlined the mix of public/private funding in six OECD countries: Australia, Canada, the Netherlands, New Zealand, the United Kingdom, and the United States. With the exception of the United States and the Netherlands, each country relies predominantly on government funding to pay for their respective goals of ensuring access to a range of health care on the basis of need and not ability to pay. Although the Netherlands does not rely on government funding, it is representative of the approach taken in a number of European countries. In these countries, health care systems are not financed primarily from general taxation revenues but nonetheless are progressively financed through mandatory social insurance contributions on the part of employers and employees. In each country the lines between what is "public" and what is "private"

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<sup>193</sup> See Stephen Martin & Peter Smith, *Explaining Variations in Inpatient Length of Stay in the National Health Service*, 15 J. Health Econ. 279, 293-295 (1996) (finding that the factors that contribute the most to the length of stay are access to NHS hospitals and private hospitals, elective surgery wait times, poverty indicators, and availability of informal care indicators).

are becoming increasingly blurred. For example, in Australia, there is significant direct and indirect public subsidies and support for private insurers. This calls into question the utility of the terms “public” and “private” and it may be more useful now to speak of “regressive” and “progressive” financing, the latter often being associated with publicly funded systems.

Where each country draws the boundaries between care that is progressively financed and care that is distributed through normal market mechanisms (on ability to pay) makes a great deal of difference to the structure and dynamics of the system in question. When we look closely at each country’s mix of public/private spending we see considerable variation depending on the nature of the health care good or service in question. Although every country except the United States adopts the guiding philosophy that health care should be allocated on the basis of need rather than ability to pay there are significant limitations on the extent to which this principle is applied and variations across countries with regard to these limitations. For example, in Canada hospital and physician services are fully publicly funded but there is significantly more private financing, where care is allocated on the basis of ability to pay, for drugs, home care and long-term care. In New Zealand, there has long been a system of private financing for family doctor care, thereby rationing access into the rest of the public health care system on the capacity to pay the out-of-pocket payments for family doctor care. In Australia, there is a complicated system of out-of-pocket payments but with a variety of safety nets in place to ensure that those on low-incomes or the chronically ill are not discouraged from accessing the care they need. By comparison, the United Kingdom tends to offer first-dollar coverage for a broad range of health care services as does the Netherlands, extending indeed to long-term care, for, despite its apparent reliance upon private insurance, it regulates to ensure the goal of “solidarity.”

In the absence of rationing by price or ability to pay—through out-of-pocket payments—rationing can occur implicitly through limitations on the capacity of the system (the number of beds, providers, technology etc) or explicitly (through limitations on the kinds of services publicly funded). In all of the countries there has historically been little attempt to develop a principled basis for determining the boundaries of the publicly funded system, and most of the systems under study have relied

on negotiations between government and physician bargaining associations to determine what services will be publicly funded. In New Zealand, the Netherlands, and in Oregon in the United States<sup>194</sup> there has been a movement towards more explicit rationing and attempts have been made centrally to develop processes for deciding what services should be publicly funded. This has proved to be a difficult process in practice. Instead most systems have moved towards processes designed to determine what priorities should be given in terms of public spending rather than trying to determine a list of services to be publicly funded. The lesson from these experiences seems to be that while attempting to define a fixed list of services to be publicly funded is likely to flounder there is fruit to be had in determining processes to establish priorities in health care spending. Countries should consider how to articulate a principled process for determining what is to be publicly funded. Recent court challenges suggest that while courts will often be respectful of public authorities taking decisions in the context of constrained public resources, they will not simply accept an argument of constrained resources and will wish to be assured that the public authorities have a principled basis for resource allocation.

In all countries, public and, increasingly, private insurers (through managed care) engage in some form of implicit rationing to a greater or lesser degree. Indeed most of the real allocation decisions happen beyond that macro determination of what broad range of health care goods and services to cover and occur as physicians decide who should receive care, in what sequence, and how quickly. But clearly there are problems with relying on implicit rationing particularly where physicians as gatekeepers to the system have no incentive to be sensitive to the cost and benefits of the various services and goods they recommend or prescribe to their patients.<sup>195</sup> Fiscal constraints in the 1980s resulted in significant slowing in public spending growth in Canada, the United Kingdom, New Zealand, Australia and the Netherlands and capacity constraints and growing waiting lists resulted in mounting public dissatisfaction and concern. A public system is able to achieve what is impossible in a pure

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<sup>194</sup> Which is in the context of the Medicaid program for the poor.

<sup>195</sup> The response to this in a number of countries has been to devolve budgets to groups of physicians and other primary care providers, a topic beyond the reach of this particular paper.

market system, of ensuring access to care for those who need it as opposed to those who can pay for it. But all public systems seem to struggle with ensuring accountability for decision-making at all levels and being responsive and flexible.

Citizens in the European Union are bringing claims that they should be able to receive public funding from their home country for services they obtain in other Member States when there are long waiting lists for treatment in their home country. So far it seems the success of such a claim is related to provision in domestic legislation providing for timely treatment. In response to concerns about long waiting times and concerns about quality in the public sector some jurisdictions have enacted or proposed Patients' Bills or Charters of Rights. These normally, however, are codifications of patients' common law rights to give an informed consent and to confidentiality but with an independent enforcement mechanism. As such they may be very useful to improve the accountability of health care professionals, but most peoples' concerns are not with the decisions of their professionals but with those who manage, or fail to appropriately manage, and fund the system. In the United Kingdom some of the patients' rights speak to rights vis-à-vis the managers of the system in terms of waiting times. Also in systems with either more private insurance—the United States and Australia—or private management—the social insurance funds in the Netherlands—there are mechanisms to ensure accountability on the part of these decisionmakers. As policymakers consider how to ensure citizen satisfaction and enhance the accountability of publicly funded systems, the experiences of those countries that have tried to improve the accountability of decisionmakers that manage resource allocation and waiting times should be closely studied.

Turning now to sum up the evidence on the impact of the public/private mix on health outcomes, utilization, spending, and waiting times, the evidence generally points away from increased private financing as a means to achieve effective health care reform. There appears to be no relationship between increased private spending and improved health outcomes. In fact, we found a positive correlation between private health care spending as a percent of total health spending and potential years of life lost. This result has to be read with some caution as it is only a simple correlation at a point in time. However, one could hypothesize that this result reflects, in part, that private



spending tends to be skewed towards the more well off individuals where the returns to spending on health are smaller and away from potentially more needy populations where the returns are larger. Country specific evidence on the effects of private, out of pocket cost sharing on access to care and health outcomes shows that co-payments do indeed create barriers to access and that these barriers can result in worse health outcomes for the poor. The evidence on the relationship between private financing and health care spending suggests that countries with higher levels of private financing such as the United States have higher costs and higher cost growth than countries with predominantly public payers such as Canada. Furthermore, examining the impact of private financing on public health funding suggests that increases in private financing are associated with declines, over time, in public funds allocated to health care. Finally, the available evidence does not suggest that private financing is successful in improving waiting times for care. In fact, even in those countries, such as the United Kingdom, with a second private health care tier, public initiatives to improve waiting times in the primary tier have proven more successful.

Frustrations with the limitations of publicly funded health care systems often result in calls for increased private financing as a cure to what bedevils the public system. We conclude that there is no magic solution in private financing for publicly funded system. In order to achieve the goals of a publicly funded health care sector—to allocate care on the basis of need and not ability to pay—requires that the *funding* of the system remain concentrated within the realm of the public and quasi-public (social insurance systems). This does not preclude initiatives with the private sector with regard to the *delivery* of health care services. At the heart of concerns about public health care systems are concerns about the decisions of the funders and managers of these systems but these decisionmakers are not normally the targets of health reform initiatives, although interestingly there are likely to be more explicit initiatives to ensure accountability in private systems. In order then to improve publicly funded systems, reforms must look at how to improve the decision-making capacity of funders and managers. Clearly an important step in legitimizing the inevitable allocation decisions that must be made is to develop fairer and better processes for determining the borders of solidarity in health care. Within pub-

licly funded systems we must also look to instill accountability for decision-making at all levels and put in place incentives for responsiveness and flexibility.

## APPENDIX

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

Country	Total exp % GDP	Public exp % total exp. on health	Private exp % total exp. on health	Public on health % total pub. exp.
Australia	8.4	66.7	33.3	16.0
Canada	9.2	69.8	30.2	15.2
Netherlands	8.5	72.6	27.4	12.7
New Zealand	7.6	77.3	22.7	12.8
United Kingdom	6.8	84.5	15.5	14.6
United States	13.9	46.4	53.6	20.3

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

Country	Govt. spending, not social security	Social security	Private insurance	Out of pocket payments
Australia	63.8	--	9.4	16.2
Canada	68.5	0.8	10.9	17.1
Netherlands	4.3	65.4	18.0	6.6
New Zealand	77.3	--	6.8	22.7
United Kingdom	73.9	9.7	3.5	11
United States	31.1	14.3	32.4	17.7

\* Note: In some countries rows may not equal 100% as there are other potential sources of funding.

Table 2: Private Health Insurance and Public Sector Waiting Lists and Waiting Times, Selected Nations, Late 1990s <sup>196</sup>

Country	% of Pop. on waiting lists		% of Pop. with supp. private hosp. insurance.*	% Reporting waits of more than 4 months for elective surgery
	1999	1997	Most recent statistics	1998
Canada	0.7%	0.62%	0%	10%
New Zealand	1.65%	2.48%	37% (1996/1997)	21%
United Kingdom	2.26%	2.56%	11.5% (1998)	29%
Netherlands	0.50%	0.51%	0%	NA
Australia	N/A	0.8%	31.2% (1999)	13%

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

Health Measure / Spending Measure	Male Life Expect.	Female Life Expect.	Incidence of Cancer	Infant Mort.	Potential yrs. of life lost (all causes)
Health spending as a % of GDP	0.3405 (0.1034)	0.4433* (0.0300)	0.4420* (0.0306)	-0.4700* (0.0236)	0.4251 (0.0889)

196 Tuohy, Flood & Stabile, *supra* note 1.

Public expenditure on Health as a % of Total Public Expenditure	0.2771 (0.2240)	0.0571 (0.8057)	0.0721 (0.7563)	0.0355 (0.8818)	0.2599 (0.3310)
Public expenditure on health as a % of GDP	0.5816 (0.0029)	0.6193* (0.0013)	0.6223* (0.0012)	-0.6815* (0.0003)	-0.3178 (0.2139)
Private health spending as a % of total health spending	-0.1593 (0.4572)	-0.0717 (0.7392)	-0.1129 (0.5994)	0.1689 (0.4410)	0.6671* (0.0034)

1. P-Values in parentheses.

2. OECD data, 1997 for life expectancy, 1996 for cancer and infant mortality, 1995 for preventable deaths.

\* denotes significance at the 5% level.