BULLETIN

The effects of for-profit health insurance on public healthcare delivery: Examining the research

September 24, 2019

The effects of for-profit health insurance on public health care delivery: Examining the research
By Samantha Ponting, HSA Communications

Given Canada's close proximity to the US, Canadians often hear horror stories from Americans about healthcare, whose bodies and bank accounts are at the mercy of a very broken system. We hear anecdotes of multi-thousand dollar medical bills, personal bankruptcy, preventable deaths due to refused care, and group trips across the border for cheaper prescriptions. This contrast with the Canadian experience is perhaps one of the reasons Canadians value their public health care system so dearly.

However, it's important to remember that the US medical system isn't strictly a private one. It's actually a two-tiered system whereby state medical programs, such as Medicaid, exist alongside privately-insured medical coverage. In fact, the US government actually spends more per capita on health care than Canada.

And according to Dr. David Himmelstein and Dr. Steffie Woolhandler, co-founders of the US-based organization Physicians for a National Health Program, the US system provides an excellent case study for understanding the effects of for-profit health insurance on public health care programs. Their research is a sober reminder of how important it is to protect Canada's universal public health system.

The BC Health Coalition hosted the pair to speak about their healthcare research at an event in June before Himmelstein took the stand as an expert witness in the Brian Day case.

The case, which began in September 2016 at the BC Supreme Court, threatens to knock down the laws that limit the expansion of a two-tiered public health system in Canada. Plaintiff Brian Day, CEO of the private, for-profit Cambie Surgeries Corporation, has launched a constitutional challenge, and is asking the court to allow private insurance companies to sell insurance for medically-necessary services provided through the public healthcare system.

Himmelstein and Woolhandler have studied health care systems around the world, and said that where a private sector exists, the public health system is undermined. They contend that a private health sector does not expand the amount of care delivered, nor does it reduce waitlists – key arguments put forth by plaintiff Brian Day. A two-tiered system, however, is proven to be quite costly for the public purse.

Himmelstein points to how the US system, which has a booming private health sector, ranks second in the world in terms of total government expenditures spent per capita on health care. According to Himmelstein, "The US spends about $6,500 per person in government money on health care, and that is more than any nation, except Switzerland, spends on their entire health care system."

A recent study published in *Health Affairs* by researchers Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan attributes the US's high healthcare spending to higher prices for medical services and prescriptions, including higher salaries for doctors and nurses.

The study also found that despite this, the country has fewer nurses and doctors per capita than the median for OECD (Organization for Economic Cooperation and Development) countries, based off of 2015 data. Their study concludes that high spending does not indicate increased access to health care resources.

Woolhandler and Himmelstein said that the data demonstrates that it's the supply of health care resources – such as an increased supply in hospital beds or physicians – that determines wait times, not financing. They contend that the introduction of private health insurance into Canada's health care system would not lead to decreased wait times.

"The premise of the Cambie surgical case as I understand it is that it [private health insurance] would actually add resources to care and therefore decrease the backlog or shortages of care in the system as a whole," said Himmelstein.

"And yet the experience in both Quebec and in the US is that as you increase the financial possibilities for doctors, as you increase how many people who have coverage, they don't actually work any more hours or deliver more care. They simply shift the care that they're delivering."

He said that this is not a North American phenomenon, but the same trend has been documented by their international research.

"The care would stay the same, but it would go to the wealthy," said Woolhandler**.**

And yet, Himmelstein said that even insured Americans face long waitlists for medical services.

"Even for people with insurance, we often have quite substantial waits."

He said wait times can vary greatly depending on where someone lives. "For a primary care visit in Franklin County, Massachusetts, part of the relatively more rural part of the state, the most recent survey said there is a 100-day wait for the first primary care appointment. And that's for someone with private insurance."

For those covered by state health care programs, such as Medicaid, wait times are even worse. With 76 million Americans enrolled in Medicaid, "we're not talking about a fringe program."

He says that "Medicaid, the program for the poor, pays lower fees than private insurance and many fewer doctors are willing to accept it. And the wait times there are often extremely long and often care is unavailable."

He referenced a "secret shopper" study by researcher Karen Rose, who found that when her team called to request appointments from medical professionals such as orthopedic surgeons, psychiatrists, and dermatologists, around 12 per cent were prepared to see a patient with Medicaid insurance and 96 per cent were prepared to see a patient with private insurance.

Woolhandler said that people with higher-paying private insurance are also more likely to be seen sooner by a clinic, even among doctors who claim to accept Medicaid.

"It translates into unequal care and actually very inefficient care. Because the decision about whether to squeeze a patient in or not should be based on 'they really need to be squeezed in because they're sick,' not because the patient has twice the reimbursement."

"So you worsen the efficiency of the system from the point of view of population health. You end up with

resources going to the wrong place," said Woolhandler.

These problems are magnified further when examining the enrollment practices of private insurance companies.

Himmelstein said that profit-driven insurance companies are working very hard to make sure those who need insurance don't have it, and those who don't need it are enrolled.

"If you're an insurance company, the last thing on earth that you would want to do is enroll a sick person." Himmelstein said that insurance companies are performing very sophisticated data analysis to avoid the sale of insurance to sick people.

"Amazon can tell whether I am buying large-sized clothes or smaller-sized clothes. And our insurance companies are purchasing that data about me. And that may be indicative as to whether or not I'm a good customer or a bad customer," said Himmelstein.

This data analysis and targeted marketing contribute to high overhead costs for insurance providers.

Woolhandler said that compared to public insurance, private insurance has extremely high administrative overhead. She said that Canada's national program is administered for under two percent.

"In contrast our private health insurance industry runs an overhead of over 12 per cent," she said, and this administrative waste represents a huge amount of money.

According to Himmelstein, 2017 figures indicate that $227 billion would be saved each year if US private insurance companies had the same overhead expenses as Canada's national public healthcare program. He said that this trend is a universal one – in fact, the overhead of Canada's private health insurers is in fact higher.

Because private insurance companies in the US are contracted to administer parts of the public system's Medicaid and Medicare programs, these high administrative costs are directly impacting public health expenditures.

The two-tiered system also impacts Americans' personal finances.

Himmelstein said that in the US, medical debt is the most common reason for bad credit ratings and the most common reason for debt collection calls. When they conducted studies on medical bankruptcy, they found that most of those who were medically bankrupted had some form of health insurance.

In the United States**,** 29 million people – 10 per cent of the population – don't have health insurance. Between 30-50 million more are "underinsured."

This article was originally published in the September 2019 issue of *The Report* Magazine. Click here to view the full issue.

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