Private health care with public delivery?

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I had the privilege of spending the last winter holiday season with family in the United States. I enjoyed a good part of the time watching endless hours of satellite television. Dominating the news was the American president's health care reform—a seminal piece of legislation that is intended to help some 47 million US citizens who have no medical insurance. As a Canadian, I was well aware of the health situation south of the border. However, it never quite impacted me until I polled friends and family at the dinner table and asked how many were insured. I was shocked to hear that less than half of the nine had no hospital insurance. Some of the uninsured even had multiple comorbidities. The reasons for not being covered included lack of job or insufficient financial resources. It is unfortunate yet ironic. The unemployed and poor seem to be the *least* able to pay for their own hospital costs. As I drove through suburban southern Atlanta, where many of the city's marginalized communities are, I saw citizens of the same country with unequal access to health care resources. How could a first-world country have disparity of this magnitude for something so vital as the health and well-being of its citizens?

I cannot help but be reminded of Switzerland's health care model—not for its similarity but precisely the opposite. Although there are only 7 million inhabitants, a tiny fraction of the United States, the Swiss government has made it *against the law* for anyone to reside within the country's borders without having basic health insurance coverage. If one is unable to afford the premiums, government assistance is provided. This is the situation that I found myself in while studying abroad on limited income. In many cases, subsidies cover more than half of the monthly premium, and to my knowledge a reasonable number of students and unemployed citizens effectively live this way. Consequently, this small European country does not have the proportion of uninsured that the United States has. Indeed, the confederation is small and wealthy, thus making such laws much more practicable. Switzerland, however, is not immune to the rising cost of health care delivery, and recently there have been discussions regarding increased user fees for outpatient visits to the family physician. Nevertheless, there is still merit in the question of whether private funding with public delivery, or at least a modification of such a system, could work elsewhere.

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There are at least two conceivable advantages of this approach. First, opening health insurance to the private sector cultivates competition, which not infrequently acts to lower premiums. For example, a user is likely to choose the insurer that is able to provide reasonable coverage for the lowest cost. In turn, a competing insurer may reduce rates further to attract another customer, and so forth. The second benefit is heightened user awareness, which is crucial when health care systems are placed under unprecedented constraints. It was not until living in a different system that I considered what type of consumer of health care resources I was and how this impacted the type of coverage I would be required to purchase. As an infrequent user, for instance, it was reasonable to minimize monthly payments by maximizing the "franchise," or deductible. This type of customization cuts user expenses, at least for the younger and healthier subpopulation. But the situation is actually more complicated because this discussion primarily considers medical coverage alone, not accident coverage. Nevertheless this basic understanding of health care economics bolstered my respect for how I use and access health care resources.

A much frequently discussed drawback of private health care with public delivery is the creation of a two-tiered system. I observed this directly in Switzerland, not as a patient but as a clinical clerk. I found myself approaching those who were privately insured

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differently than other patients, knowing that they paid extra for their coverage. Similarly, when patients were under local anesthesia, the health care team's level of engagement was often increased. It almost seemed like operating rooms of privately insured patients were happier places! Biased opinions aside, the *quality* of care for both types of patients was indistinguishable, and this is arguably what most sick patients are interested in. It might be comparable to traveling first class versus coach. The service might be more extensive in one, but all consumers arrive at the same destination (assuming that both groups of patients seek services from the same hospital).

Crossing the Atlantic back to the United States, where more than 40 million people—more than Canada's entire population—do not have supported access to health care services, I think of the people with whom I enjoyed that holiday dinner. Had they lived just a few hours north, every one of them would have been insured—regardless of their financial situation. The new American legislation, however, has sparked excitement in the national community and indeed there is much to be optimistic about. Privatization is *not* part of the reform, but some socialist ideologies are nevertheless incorporated from European models. At this juncture, it will be most interesting to see the influence that our neighbors east of the Atlantic have in the redefinition of both Canadian and American health care, particularly with respect to private funding with public delivery. BCMJ

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