

FOR-PROFIT HOSPITALS AND INSURERS

# In Universal Health Care Countries

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# Contents

Executive Summary	/ iii
Introduction	/ 1
1 Canadian Perceptions	/ 2
2 Definitions of Institutions	/ 3
3 International Comparisons of Universal-Access Health-Care Systems—Where to Look for High Performance	/ 5
Six countries, two questions	/ 8
4 The Role of Private for-Profit Health Insurance in Universal-Access Health-Care Systems	/ 9
Australia	/ 10
France	/ 12
Germany	/ 13
The Netherlands	/ 15
Sweden	/ 16
Switzerland	/ 17
4 Private for-Profit Hospitals in Universal-Access Health-Care Systems	/ 20
Australia	/ 20
France	/ 22
Germany	/ 23
The Netherlands	/ 24
Sweden	/ 25
Switzerland	/ 26
5 The Canadian Context	/ 28
6 Conclusion	/ 31
References	/ 33
About the Authors	/ 40
Acknowledgments	/ 41
About the Fraser Institute	/ 42
Publishing Information	/ 43
Supporting the Fraser Institute	/ 44
Purpose, Funding, and Independence	/ 45
Editorial Advisory Board	/ 46



## Executive Summary

The poor access to medical services and middling outcomes and safety in Canada's health-care system despite high spending suggest a need for reform of health-care policies. Yet, while Canadians seem open to the possibility of fundamental reform, faulty perceptions of how other countries deliver and finance universal health care still exist, while misperceptions and unfounded beliefs about particular policies plague the popular debate. This paper seeks to correct and inform one such misperception: the belief that private, for-profit institutions are incompatible with universal-access health care.

According to at least two recent polls, many Canadians consider for-profit provision of health care to be incompatible with universality. For example, a 2013 poll commissioned for the Fraser Institute found Canadians believe strongly that private for-profit health care is incompatible with the goals of Medicare. Similarly, a 2012 Ipsos Reid poll found that 80% of Canadians preferred a not-for-profit model of health care when presented with a binary choice between a not-for-profit and a for-profit model. The Ipsos Reid poll also found that 53% of respondents preferred a mixed model incorporating both when this was included as a third option. This all suggests that Canadians are open to a mix of policies as long as they are perceived to be compatible with a universal-access health-care system.

In answering the question of whether for-profit providers are compatible with universal-access health care, we examine the health-care systems of six nations with universal health-care systems: Australia, France, Germany, the Netherlands, Sweden, and Switzerland. Each of these nations spends a proportion of their GDP on health care comparable to that spent in Canada, and each provides similar or superior access to, and quality of, care in comparison with Canada. In order to determine the compatibility of for-profit institutions with universal health care, we look at the presence of for-profit hospitals and for-profit health care insurers in each of these nations.

Private for-profit health-care insurers are found in all six nations. Notably, private for-profit companies compete to offer the primary (mandatory) health-care insurance package in the Netherlands, offer a private substitute for public health-care insurance in Germany, and offer a private option alongside the public system for patients in Australia and Sweden. In France and Switzerland, private for-profit insurers play a complementary or supplementary role, though for-profit companies in Switzerland may compete to offer the primary (mandatory) health-care insurance package on a not-for-profit basis.

Private for-profit hospitals are also found in all six nations. While universally accessible services are generally provided through public hospitals

in Australia and Sweden, governments also contract with private for-profit hospitals for the provision of universally accessible services including, in Sweden, acute care. In the Netherlands, in-patient hospital care is provided by independent not-for-profit private corporations while independent treatment centers that provide same-day non-emergency treatments can operate on a for-profit basis. In Germany, France, and Switzerland, universally accessible hospital care is delivered by public, private not-for-profit, and private for-profit hospitals. [Table E1](#) provides a breakdown of the number of hospitals in each of these countries by ownership.

**Table E1: Hospitals in universal-access health-care systems  
(by ownership and profit motive)**

	Public	Private, not-for-Profit	Private, for-Profit
Australia (2011)	753	115	477
France (2012)	928	688	1,041
Germany (2012)	833	1,040	1,356
Netherlands (2012)	0	180	79
Sweden (n/a)	77	3	3
Switzerland (2013)	61	82	150

These policy approaches are distinct from those pursued in Canada, where private for-profit parallel insurance is disallowed and where a small number of private, for-profit hospitals can be found in a climate that does not encourage their formation. It is important however to remember the reality in other areas of Canadian health care: private (and for-profit) companies provide medical laboratory services, long-term care, supplementary extended health insurance (which is not the same as parallel health insurance), and even diagnostic and surgical procedures (which differ from hospital services). So, in some sectors, Canada's health-care system already allows private for-profit involvement.

While the proliferation and extent of services offered by private for-profit institutions in Australia, France, Germany, the Netherlands, Sweden, and Switzerland varies, all have incorporated for-profit hospitals and insurers into their universal health-care policy framework. This reality should dispel the mistaken notion that private, for-profit institutions (in either the insurance or hospital sector) are incompatible with universally accessible health care. On the contrary, their presence is the norm among high performing universal health-care systems.

## Introduction

Canada's health-care system forces patients to endure remarkably long waits for treatment (Barua and Fathers, 2014), offers relatively poor access to medical professionals and medical technologies, and provides middling outcomes and safety in comparison with the universal-access health-care systems of other developed nations (Globerman, 2013; Murphy et al., 2014). These realities, combined with the fact that Canada's health-care system ranks among the most expensive universal-access health-care systems in the developed world, suggests a need for reform of health-care policies.

While more Canadians seem open to the possibility of fundamental reform of the country's health-care system, major hurdles still exist as a result of faulty perceptions of how other countries providing universally accessible health-care deliver and finance health care. Further, discussions of health policy in Canada are also often plagued with misperceptions and unfounded beliefs about particular health-policy options, effectively removing them from serious consideration.

This paper seeks to correct and inform one such misperception: the belief that private for-profit institutions are incompatible with universal-access health care (see, for example, Canadian Health Coalition, 2015, The Council of Canadians, 2010, 2015; Fuller, 2015; Canadian Doctors for Medicare, 2015). Universal access is the principle that all citizens (or residents) can obtain health-care services irrespective of income or pre-existing health status.

The first section of this paper gives an overview of Canadian perceptions regarding the compatibility of private for-profit institutions within a universally accessible health-care framework. The second section defines the terms "public" and "private," and discusses critical differences in the structures of public and private (both non-profit and for-profit) institutions. Section three identifies six international universally accessible health-care systems for comparison with Canada on the basis of cost and performance. Sections four and five describe the availability of private for-profit insurance and the prevalence of private for-profit hospitals in the six health-care systems studied. Section six explores the scope and proliferation of private for-profit insurance and medical services within Canada. A conclusion follows.

## 1 Canadian Perceptions

In 2013, the Fraser Institute commissioned a private poll from Compas Inc. The accompanying report concluded that “Canadians see all elements of private health care as incompatible with the gamut of desirable principles ranging from universality and patient-focused care to portability and the patient’s right to choose” (Compas Inc., 2013). Further, of 10 health-related terms and concepts, for-profit health-care providers were the only group to elicit negative perceptual scores on average. Simply put, Canadians were found to believe strongly that private for-profit health care is incompatible with the stated or implicit goals of Medicare.

One significant factor contributing to this perception of incompatibility may be that Canadians are repeatedly presented with the view that for-profit health care and universality are competing, mutually exclusive, concepts. In other words, Canadians are often likely to be presented with the status quo in Canada—a universal health-care system dominated by government—opposed to an alternative where for-profit insurers and hospitals are present but universality is sacrificed. This should not be a surprise given the proximity of Canada to the United States and our access to debates about health care there. For example, Ipsos Reid polled Canadians about which system of funding they primarily support and found that “when only given a choice between a not-for-profit and a for-profit model, four out of five (80%) Canadians said they preferred a not-for-profit model of health care” (Stechyson, 2012). However, when the options were expanded to include a model that mixed for-profit and not-for-profit options, 53% of respondents preferred the mixed model. Further, 76% supported “the idea of Canadians being allowed to buy private health insurance for all forms of medically necessary treatment that could then be obtained outside of the current system, including cancer care and heart surgery” (Stechyson, 2012).

Interestingly, the above data provides some evidence suggesting that Canadians are open to a mix of policies when these are presented as complementary rather than incompatible. This suggests that the views and preferences of the Canadian public regarding the extent to which they are willing to accept private for-profit health-care insurance and institutions in the country depends to a great degree on its perceived compatibility with a universal-access health-care system.

This study explores the narrow issue at the heart of this perception: the compatibility of private for-profit health care and universality.



## 2 Definitions of Institutions

Prior to the specific analysis of the compatibility of for-profit health care and universality, it is worth considering a number of institutional definitions. There are two dimensions worth reviewing: (1) public compared to private, and (2) not-for-profit compared to for-profit within the private sphere.

### Public and private

Public institutions are owned and operated by government. This means decision-making power ultimately rests with government, even in cases where an independent or semi-independent authority is given control over day-to-day decision making. Taxpayers via government are the beneficiaries of any surpluses generated by public institutions. [1] Conversely, taxpayers via government are responsible for any shortfalls and debt.

Private institutions are owned by non-governmental entities, be they an individual or a group of individuals. Private institutions can be further separated into two groups that differ in terms of who has ownership over or rights to surpluses or profits: not-for-profit organizations and for-profit organizations.

### For-profit and not-for-profit

For-profit institutions have non-government owners with a right or claim to surpluses or profits. These owners may be a private person, a group of private persons (a partnership), a private corporation (with either a sole owner or group of owners), or a public corporation owned by shareholders. These private owners/operators hold decision-making power for the institution. In economic terms, for-profit institutions have a residual claimant, or a clearly identified person or group of persons that have a claim over any income generated by the operation of the institution or its value after the sale of assets and disposition of debts.

The key defining difference between private for-profit and private not-for-profit institutions is that the latter are not permitted to pay a profit or surplus to the sponsor(s). Rather, surpluses or profits must be either held for use by the organization in the future or reinvested into the organization. This does not mean that the sponsor(s) or organization(s) may not benefit from surpluses or profits generated by the not-for-profit institutions; it does

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[1] While it is conceivable that public-sector organizations can earn net revenues, it is highly unlikely, particularly in the absence of hard budget constraints.

however restrict the methods by which the surplus can be used. [2] As with for-profit private institutions above, it is the organization itself that holds decision-making power in a private not-for-profit institution.

Both public and private organizations, and both private for-profit organizations and not-for-profit organizations, can generate surpluses or profits. Profits or surpluses are simply an excess of revenues over expenses. The key difference between the organizations is what can be done with those surpluses or profits, and who has the right to them if they are to be distributed. The surpluses of public institutions revert to government, while surpluses of private not-for-profit organizations revert to the private organization. Only the surpluses of private for-profit institutions can be directly paid to the owners of the organization.

Beyond these basic groupings are many circumstances and arrangements that are some hybrid or combination of ownership structures. For example, some private organizations receive all or nearly all of their income from government, are heavily regulated by government, have management boards dominated by government appointees, or may have implicit guarantees from government. All of these can affect who actually holds decision-making power for the organization both operationally and strategically. In other cases, arrangements may be made where the capital structures are publicly owned while the operation is run independently by a rent-paying private organization. Such complexities are important to consider when examining the technical ownership structure (or legal registration) of institutions in a given country.

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[2] While there are a number of meaningful distinctions between the economic-decision environments facing not-for-profit and for-profit firms, the salient one here is that, if not-for-profit decision makers “are unable to extract residual income in the form of cash ... [they] will choose to take it in other forms” (Pauly, 1987: 257). Among these “other forms” are “better office facilities, more congenial colleagues, more relaxed personnel policies, or any other personally rewarding activity even if it is more costly to the non-proprietary (not-for-profit) hospital than its proprietary counterpart” (Clarkson, 1972: 365). In other words, rather than solely maximizing profits, managers in the not-for-profit setting may be willing to sacrifice profits in order to enhance their own pecuniary and non-pecuniary income.

### 3 International Comparisons of Universal-Access Health-Care Systems—Where to Look for High Performance

Nearly every developed nation maintains a universally accessible health-care system. At the same time, nearly all allow a parallel private health-care sector for insurance and hospital services, and the majority allow private hospitals (both for-profit and not-for-profit) to provide services under the universal scheme. In this study, we examine those nations that conform to the following criteria:

- 1 the country shares Canada's goal of providing access to high-quality care, regardless of a patient's ability to pay;
- 2 the country spends a proportion of their GDP on health care comparable to Canada's expenditure;
- 3 the country provides similar or superior access to, and quality of care, in comparison with Canada's health-care system across a range of metrics;
- 4 there is readily available public data on the health-care system.

Six countries were identified that generally meet these criteria—Australia, France, Germany, the Netherlands, Sweden, and Switzerland—from comprehensive reviews of health-care policies and health-system performance by Esmail and Walker (2008) in addition to our review of data from the Organisation for Economic Co-operation and Development (2015a) and the Commonwealth Fund (2013).

**Table 1** provides a general overview [3] of the cost and performance of the health-care systems in these countries. The age-adjustment methodology used for measures of spending and access is from Esmail and Walker, 2008. [4]

[3] The indicators presented here are chosen on the basis of those included in Nadeem Esmail's research examining the universal health-care systems of Australia, Germany, Sweden, and the Netherlands (Esmail, 2013a, 2013b, 2013c, 2014).

[4] Age-adjustment is based on the percentage of the population over age 65 in a given country relative to the average of OECD nations that maintain universal access. A complete description of the methodology is available in Esmail and Walker, 2008: 17–22, with a mathematical example shown in Box 2, page 21.

**Table 1: Comparison of health-system performance in Canada, Australia, France,**

Indicator
<b>Total health expenditures</b> (age-adjusted, % of GDP)
<b>Physicians</b> (age-adjusted, per 1,000 pop.)
<b>Nurses</b> (age-adjusted, per 1,000 pop.)
<b>MRI units</b> (age-adjusted, per million pop.)
<b>CT scanners</b> (age-adjusted, per million pop.)
<b>Hospital beds—total</b> (age-adjusted, per 1,000 pop.)
<b>Hospital beds—curative</b> (age-adjusted, per 1,000 pop.)
<b>Same- or next-day appointment with doctor or nurse when sick or needed care</b> (%)
<b>Waited less than four weeks for specialist appointment</b> (%)
<b>Waited two hours or more before being treated</b> (%)
<b>Waited six days or more for access to doctor or nurse when sick or needed care</b> (%)
<b>Waited two months or more for specialist appointment</b> (%)
<b>Waited four months or more for elective surgery</b> (%)
<b>Obstetric trauma vaginal delivery without instrument</b> (crude rate per 100 vaginal deliveries; 15 and older)
<b>Obstetric trauma vaginal delivery with instrument</b> (crude rate per 100 vaginal deliveries; 15 and older)
<b>Post-operative sepsis—all surgical discharges</b> (crude rate per 100 000 hospital discharges; 15 and older)
<b>Retained surgical item or unretrieved device fragment</b> (crude rate per 100 000 hospital discharges; 15 and older)
<b>Uncontrolled diabetes hospital admission</b> (age-sex standardized rate per 100 000 population; 15 and older)
<b>Chronic obstructive pulmonary disease hospital admission</b> (age-sex standardized rate per 100 000 population; 15 and older)
<b>Asthma hospital admission</b> (age-sex standardized rate per 100 000 population; 15 and older)
<b>Admission-based Ischemic stroke 30-day in-hospital mortality</b> (age-sex standardized rate per 100 hospital discharges; 45 and older)
<b>Admission-based hemorrhagic stroke 30-day in-hospital mortality</b> (age-sex standardized rate per 100 hospital discharges; 45 and older)
<b>Admission-based AMI 30-day in-hospital mortality</b> (age-sex standardized rate per 100 hospital discharges; 45 and older)
<b>Colorectal cancer five-year relative survival</b> (age-standardised survival %; age 15–99)
<b>Cervical cancer five-year relative survival</b> (age-standardised survival %) (age 15–99)
<b>Breast cancer five-year relative survival</b> (age-standardised survival %; age 15–99)

Sources: OECD, 2015a; Commonwealth Fund, 2013; calculations by authors. Note: \* or most recent year or range.

**Germany, the Netherlands, Sweden, and Switzerland**

Year*	Canada	Australia	France	Germany	Netherlands	Sweden	Switzerland
2012	11.8	10.1	11.3	9.6	11.9	8.8	11.2
2012	2.7	3.7	3.2	3.4	3.2	3.6	3.8
2012	10.1	11.4	8.8	9.6	12.1	10.2	16.2
2012	9.5	16.7	8.4	9.6	12.0	—	20.3
2012	15.7	56.3	13.1	15.9	11.1	—	33.9
2012	3.0	4.2	6.1	7.1	4.7	2.4	4.7
2012	1.9	3.8	3.3	4.6	3.4	1.8	2.9
2013	41	58	57	76	63	58	—
2013	39	51	51	72	75	54	80
2013	48	25	36	23	17	21	18
2013	33	14	16	15	14	22	—
2013	29	18	18	10	3	17	3
2013	18	10	4	3	1	6	4
2011	3.1	2	0.6	2.1	2.5	3.5	3.7
2011	17	7.4	2.6	8.1	3.3	12.7	7.1
2011	682.1	789.5	892.8	827.6	—	1420.3	244.7
2011	9	9.4	5.7	6.6	—	4.4	11.5
2011	15.8	6.9	—	55.5	—	53.8	23.3
2011	199.5	317	101.9	211.8	162.1	168.8	95.1
2011	13.6	68.1	36.6	19.6	31.8	22.2	30.2
2011	9.7	10	8.5	6.7	7.5	6.4	7
2011	22.2	22.2	24	17.5	25.9	15.8	16.5
2011	5.7	4.8	6.2	8.9	6.8	4.5	5.9
2005–2010	63.5	66.2	—	64.3	62	61.7	—
2005–2010	66	67.5	—	64.5	64.5	67.3	—
2005–2010	87.7	87.7	—	85	85.8	85.9	—

## Six countries, two questions

In sections 4 and 5, we focus on the answers to two questions about the universal-access health-care systems found in Australia, France, Germany, the Netherlands, Sweden, and Switzerland:

- 1 Are private, for-profit health-care insurers present?
- 2 Are private, for-profit hospitals [5] present?

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[5] This study does not examine the delivery of primary health care because the level of variance in the setting and types of such care does not easily allow for a division between for-profit and not-for-profit institutions. Such care is generally provided by GPs, physiotherapists, pharmacists, psychologists, and midwives (Schäfer et al., 2010). These individuals can be independent entrepreneurs, work in a partnership, as well as in a hospital. As such, the extent of their role, and the rules that govern their profit motive is harder to describe in the current context. That being said, research by the Commonwealth Fund (2015) suggests that the majority of primary and ambulatory care (in the six countries examined) is provided by physicians who are self-employed and working for multi-provider private practices. Sweden is an exception to this, using a mixed system in which only 40% of primary-care practices are privately owned.

## 4 The Role of Private for-Profit Health Insurance in Universal-Access Health-Care Systems

Esmail and Walker's survey of 28 OECD countries in 2008 found that private health-care insurance is routinely present in various forms. In some, "all individuals are covered by, or have the choice to be covered by, some private or competitive insurance scheme". In others, private insurance (and delivery) is used in addition to public insurance (and delivery) as "a way to attain expedited health care when faced with long waiting lists" or as a way to receive better accommodation in hospitals, or cover out-of-pocket expenses as a result of cost-sharing. Finally, in a small number of countries, "a private insurance sector exists to provide health care to those wealthy enough to leave the mandatory social insurance system" (Esmail and Walker, 2008: 58). Each of these approaches is represented among the six nations examined in this study.

Notably, private for-profit companies compete to offer the primary (mandatory) health-care insurance package in the Netherlands, substitutive [6] health-care insurance in Germany, and duplicative [7] health-care insurance in Australia. Private for-profit companies compete to offer voluntary (complementary/supplementary) [8] health-care insurance in each of the six countries in our cohort.

This section provides a detailed description of each country's universal-access health-care system and highlights the presence of for-profit companies in either the primary, substitute, duplicate, or voluntary health-care insurance sectors.

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[6] Offers a private substitute for the public plan; individuals opt out of the latter.

[7] Offers a private alternative for the public plan; individuals remain covered by the latter.

[8] Generally, complementary insurance offers an extension of coverage in the same area as statutory health-care insurance, while supplementary insurance offers additional coverage in areas of care not covered by statutory health-care insurance. The distinction between complementary and supplementary insurance is not always clear when comparing health-care systems in different countries because of the way statutory health-care insurance is defined in each (Comité Européen des Assurances, 2011). For simplicity, this text often combines the two terms and refers to them as voluntary health-care insurance (VHI).

## Australia

Australia's universal-access health-care system can be characterized as primarily a tax-funded public system that is deeply integrated with a parallel private sector. Private for-profit companies provide duplicative and voluntary health-care insurance. [9]

### 1 Primary coverage

Australia's universal-access health-care system is primarily funded through general taxation in conjunction with a 1.5% Medicare levy for individuals over a certain income threshold, as well as a 1% surcharge for high-income earners who do not have private insurance for hospital treatment. Patients are generally covered for consultations with their physician of choice (GP and Specialist), diagnostic tests, most surgical and therapeutic procedures performed by doctors, eye examinations (by optometrists), certain dental procedures (by approved dentists), and prescription drugs.

Patients are billed directly for consultations by General Practitioners (GPs) and specialists, and are reimbursed 100% and 85% of the schedule fee set by the Federal Government, respectively. Physicians who do not charge more than the reimbursed portion of the schedule fee are able to bill government directly if they choose. Physicians can also charge prices in excess of the schedule fee for their services, though they lose the ability to bill government directly for even a portion of the service.

### 2 Secondary coverage

In contrast to Canada, Australia relies to a large extent on a private, parallel health-care sector both for insurance and for delivery of medical services (discussed in the next section). In fact, it is considered one of Australia's policy objectives to "ensure that the public sector is complemented by a private sector that expands choice, and which is fair, affordable, and represents good value for money" (Healy, Sharman, Lokuge, 2006; 116). Several policy initiatives have been adopted by the Federal Government to encourage individuals to purchase private insurance; these include the income-tax surcharge mentioned above, lifetime community rating, and a rebate on private health-insurance premiums (Esmail, 2013a). In 2013, 12.6 million Australians were covered by some form of private health insurance and had access to "over 25,700 private health insurance products, provided across 34 registered private health insurers. This equates to an average of around 100 different (open and closed) policies per insurer in each state or territory and includes differentiated levels of both hospital and general treatment cover options" (PHIAC, 2013: 31).

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[9] This section is primarily based on information found in Healy, Sharman, Lokuge, 2006 and Esmail, 2013a.



Private health insurance companies “can be registered as an open or restricted fund, [10] and as a for-profit or not-for-profit fund” (PHIAC, 2013: 30). The first record of a for-profit private health-insurance company dates back to 1989. In 2013, out of 34 private health-insurance companies, there were 8 for-profit insurers (7 open, 1 restricted) and 26 not-for-profit companies (12 restricted, 14 open). The two largest for-profit insurers (Medibank Private and BUPA) accounted for about 53.8% of the market in 2012 (both were originally not-for-profit companies). Medibank was initially owned by the government’s Health Insurance Commission. In 1998, Medibank Private “was separated from the Health Insurance Commission and set up as a new corporate entity with the Commonwealth Government as a shareholder” (PHIAC, 2013: 18). It has been described by Esmail as a “government business enterprise” (2013a: 22).

In addition to covering services not included in the universal basket, private insurance is generally used to top up the unfunded [11] portion of medical services and to pay for hospital accommodation costs. For example, patients who chose to be treated as private patients at either public or private hospitals receive a public subsidy of 75% of the schedule fee (and no subsidy for hospital accommodation), with private insurance funding the remainder. [12] Private patients in either public or private hospitals may also exercise choice of physician.

Private insurers can develop preferred provider networks and directly negotiate contracts with hospitals and doctors. They are regulated by the government, are obliged to charge community-rated premiums (which can be indexed by age), and cannot penalize individuals for transferring between insurers. The government also operates a risk-equalization system in order to compensate insurers for risk without affecting equitable access to private parallel insurance.

The private health-care sector in Australia shares medical resources with its public sector. Dual practice is permitted for physicians, allowing them to serve both public and private hospital patients in both public and private hospital settings.

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[10] Open membership organizations provide policies to the general public. Restricted membership organizations provide policies only through specific employment groups, professional associations, or unions (PHIO, 2015a).

[11] Legally, private insurers are only allowed to pay for physician services related to hospital care. They cannot cover gap payments for ambulatory GP or specialist care. More recently, private insurers were permitted to “cover out-of-hospital services that substitute for or prevent in-hospital care” as well as disease management programs (Commonwealth Fund, 2015: 13).

[12] Subject to any deductibles or cost sharing.

## France

France's universal-access health-care system is based on a statutory health insurance [SHI] model where individuals are required to purchase a health insurance policy (based on their employment) from a regulated insurance company, and where strong state regulations ensure universal access to that insurance. [13] France maintains a financing and delivery system with both public and private health insurers purchasing care from a common pool of public and private hospitals. Private for-profit insurance companies compete in the voluntary insurance market, offering complementary and supplementary health insurance benefits.

### 1 Primary coverage

The universal insurance scheme is financed through contributions from both employers and employees. [14] The majority of the population (95%) is covered by three Statutory Health Insurance (SHI) plans based on their area of employment. [15] Coverage is mandatory as employees and their dependents cannot opt-out. Those not generally covered through employment can opt-in to the SHI system by paying a fixed premium, while lower-income individuals are provided with basic health insurance coverage [16] (regardless of their employment status) through the *Couverture Maladie Universelle* (CMU).

Insurance generally covers about 75% of the basic benefit-package expenditure with patients responsible for the balance. As in Australia, physicians are not bound by the fee schedule and can charge prices of their own choosing, though they lose certain social benefits if they choose to do so. Patients are also required to pay a flat rate of €18 per day for hospital stays.

### 2 Secondary coverage

Private voluntary insurance of a complementary or supplementary nature is available in France. This insurance is used to top up coverage, fund

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[13] This section is primarily based on information found in Chevreul, Durand-Zaleski, Bahrami, Hernández-Quevedo, and Mladovsky, 2010; Commonwealth Fund, 2015; and Labrie and Boyer, 2008.

[14] Chevreul and colleagues note that “employees’ payroll contributions have been almost fully substituted by an earmarked tax called the ‘general social contribution’ (*contribution sociale généralisée*) based on total income and not only on earned income” (2010: xxv). Additional revenue is also generated from other taxes.

[15] The General Health Insurance scheme (for employees in commerce and industry and their families and civil servants), the Agricultural Scheme, and the National Insurance Fund for Self-Employed People.

[16] Additional support covering supplementary and complementary payments is offered through the *Couverture Maladie Universelle Complémentaire* (CMU-C).

co-payments, and provide coverage additional to what is provided in the universal scheme, such as vision and dental care. In 2007, 88% of the French population had some form of private voluntary health insurance (Chevreul, Durand-Zaleski, Bahrami, Hernández-Quevedo, and Mladovsky, 2010).

There are three types of insurers competing in the voluntary health insurance market: 480 *mutuelles*, 28 provident institutions, and 96 private for-profit commercial insurance companies (Franc and Pierre, 2015). The first two (*mutuelles* and provident institutions) are not-for-profit organizations, offer complementary health insurance, and focus primarily on covering co-payments in the statutory scheme. *Mutuelles* pre-date the French Social Security system, and are regulated by the Mutual Insurance Code (*code de la mutualité*). They operate on the principles of solidarity and mutual aid, make limited use of risk rating, and some companies adjust premiums based on income. They generally cover both individual and group contracts, and are “financed almost entirely by subscriber fees and payments” (Moore, 2013: 475). Provident institutions are also not-for-profit organizations, but focus more specifically on group contracts and are “jointly managed by representatives of employers and employees” (Franc and Pierre, 2015: 113). They were developed after the Second World War to manage retirement pensions and entered the health insurance market in the 1980s. They are generally regulated by the Social Security Code (*code de la sécurité sociale*), although the Commercial Insurance Code regulates individual contracts. The private for-profit insurance companies on the other hand tend to provide both supplementary and complementary health insurance for select services.

Since 2013, the government has required all employers to offer complementary health insurance (CHI) to their employees (Franc and Pierre, 2015).

## Germany

Germany’s universal-access health-care system actually consists of two insurance systems—Social Health Insurance and Private Health Insurance—both funded by premiums. [17] [18]

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[17] Public employees, including teachers and university professors, may also participate in the private insurance sector for the share of health costs not reimbursed by government. The remainder of the German population, such as soldiers or policemen, are covered under special programs that may pay for health services directly. Germany does have a small uninsured population including mainly the self-employed (both higher and lower income), and those who failed to pay their insurance contributions.

[18] This section is primarily based on information found in Busse and Blumel, 2014 and Esmail, 2013b.

## 1 Social Health Insurance (SHI)

The Social Health Insurance (SHI) is a system, covering about 86% of the population (Busse and Blumel, 2014: 122), where insurance is provided by about 145 competing independent, not-for-profit sickness funds. SHI is mandatory for employees earning less than €50,850. Premiums are based on a fixed percentage of gross salaries or wages (14.6%), split between employers and employees (7.3% each) (*Bundesministerium für gesundheit*, 2015). Coverage for unemployed spouses and dependents is provided without additional cost to the employer or employee. Premium payments are pooled with tax contributions in the national German Health Care Fund. Funds are then redistributed among insurers on a risk-adjusted basis. [19]

SHI insurance requires patients to share in the cost of medical goods and services like prescription drugs (€5–€10), hospital stays (€10 per day), and prescription medical aids (€5–€10). Cost-sharing is not required to be paid for services rendered to children, and annual limits based on income apply for all adults (Commonwealth Fund, 2015).

## 2 Private Health Insurance (PHI)

The Private Health Insurance (PHI) is a system, covering 11% of the population, where insurance is provided by 24 for-profit and 19 not-for-profit insurance companies. PHI is optional for those earning more than €50,850 and the self-employed. Further, family members are not automatically covered and must pay separate premiums. Premiums are risk-rated at entry but contracts are based on lifetime underwriting, meaning that premiums do not increase with age. PHI insurers are also not permitted to cancel contracts or reduce coverage as long as premiums are paid, and cannot refuse insurance to those with pre-existing conditions. Individuals who leave the SHI system for PHI cannot return to the former, and regulations ensure those who have made the permanent switch do not face large premium increases as they age and are protected from a high premium burden if their income decreases. Patients with PHI generally must pay all costs up front, and apply to their insurer for reimbursement of a portion of the cost. PHI policies may provide services additional to those available through SHI, such as ensuring treatment is provided by senior or head physicians, superior hospital accommodations, and access to practitioners who do not participate in the SHI system.

### Complementary and supplementary insurance

Regardless of their coverage by the SHI or a PHI, Germans may seek care privately if they choose to do so (Esmail, 2013b). Individuals can also purchase

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[19] The risk-adjustment model is known as Morbi-RSA; it adjusts payments based on population characteristics like age, sex, and 80 pre-defined chronic and serious illnesses (Esmail, 2013b).

voluntary private health insurance for supplementary and complementary services. Since 2004, sickness funds have also been allowed to offer complementary and supplementary insurance providing benefits beyond the basic package. These insurance plans can cover things like private or semi-private hospital rooms with extra beds, or treatment by the head of service and co-payments. In 2012, 23.1 million individuals in the SHI systems also had some kind of supplementary or complementary insurance. In general, both SHI and PHI individuals most often purchased packages that provided sick pay insurance, hospital daily benefits, and supplementary long-term care insurance (Busse and Blummel, 2014).

## The Netherlands

The Netherlands has a single compulsory social health-insurance scheme where private health insurers compete in a heavily regulated environment. In this setting, the role of the Dutch government is simply to ensure a properly functioning health-care insurance market. [20]

Residents must purchase a standard insurance package from one of a number of private insurers, who may choose to operate on a for-profit basis in a regulated but competitive market. In addition to paying an annual premium to the insurance company, individuals are also required to make an income-related contribution (6.95% of taxable income up to €51,976) and are subject to cost-sharing (*Belastingdienst*, 2015).

Insurers “operate under private law; can negotiate to a certain extent with health care providers on price, volume and quality of care; and are allowed to make a profit and pay dividends to shareholders” (Schäfer et al., 2010: 54). In 2011, there were 27 health-insurance companies competing in the market, though several were part of larger conglomerates and the four largest health-insurer conglomerates held a market share of over 90%. The market leader (Achmea), with a 32% market share is a for-profit company while the three other largest conglomerates were private not-for-profit companies (OECD, 2012).

Insurers are required to accept all applicants, and are “obliged to offer a core universal insurance package at a fixed price for all” (Netherlands, Gov’t of, 2014). Insurance companies receive funds for the standard statutory insurance product from community-rated premium payments paid by insured individuals as well as payments from the tax-funded Dutch Health Insurance Fund (*Zorgverzekeringsfonds*). While the premium can vary from

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[20] This section is primarily based on information found in Schäfer, Kroneman, Boerma, van den Berg, Westert, Devillé, and van Ginneken, 2010; Esmail, 2014; and Esmail and Barua, 2015.

one insurer to another, they must determine a flat community-rated premium for adults that applies uniformly across the country (irrespective of age, gender, or illness). Insurers are, however, free to choose where and by whom the care is delivered.

Individuals are free to choose the insurer and health plan of their choice, and can switch insurers from year to year, without fear of financial penalty. Adult patients are usually subject to a small deductible, after which they are not expected to make any co-payments for received medical treatment. Individuals must, however, pay an additional income-dependent contribution (with a maximum limit for annual contributions) either through their employer, or directly to the relevant tax authority. [21]

There are several ways in which the Netherlands ensures that individuals receive universal health care irrespective of their financial condition. This is achieved through a combination of premium regulations and subsidies, the operation of a risk equalization scheme for insurers, a low level of cost sharing (with exemptions for certain groups), and a separate publicly funded national insurance program (the *Algemene Wet Bijzondere Ziektekosten*) [22] that specifically covers long-term care for the elderly, chronically ill, and disabled. The Netherlands also operates a risk equalization fund to minimize risk selection and compensate insurers for the adverse effects of mandated community rating.

Private voluntary health insurance (VHI) for services not covered by the Statutory Health Insurance (SHI) is also available in the Netherlands, in many cases from the same insurance companies that offer SHI policies. In 2009, 91% of the insured population had VHI (which is often offered for free for children of insured adults). While such insurance can cover many kinds of out-of-pocket expenses, it cannot cover the compulsory deductible for core services. Insurers can risk-rate premiums and refuse applicants (but not on the basis of individuals purchasing SHI from a different insurer).

## Sweden

The Swedish universal-access health-care system is, in many ways, similar to Canada's. [23] There are, however, some important differences, which are discussed in the following sections.

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[21] It is estimated that together with the public funding of about 5% (Van Kleef, 2012), the income-related contribution covers 50% of the total premium burden with nominal premium charges covering the other half (VWS, 2012).

[22] The range of services covered by this plan is set to change in 2015.

[23] This section is primarily based on information found in Anell, Glenngård, and Merkur, 2012.



## 1 Primary coverage

Residents are covered for core health-care services directly by government through a tax-funded scheme. Taxes are not earmarked for health-care expenditures and tax rates vary [24] from region to region. The federal government operates a national tax-equalization fund in order to redistribute revenues adjusted for differences in structural factors (like age, socioeconomic factors, and geographical conditions) among the county councils who are responsible for health insurance for their populations.

Cost-sharing is a central feature of Sweden's universal health-care system. Flat, direct user charges are applied for both primary and specialist care, as well as for prescription medicines and other services. Cost-sharing is subject to annual caps and exemptions for certain populations to ensure those stricken with illness are not subjected to financial hardship.

## 2 Secondary coverage

Swedish patients are allowed to purchase health-care services privately as well as voluntary private insurance that can provide faster access to a specialist in ambulatory care and elective treatment, both of which can be subject to waiting lists in the public scheme. Private insurance in Sweden also covers other costs associated with illness, effectively complementing welfare and social protection programs (Svensk Försäkring, 2013). Approximately one in 10 Swedish residents had private health insurance in 2014, with much of it paid for by employers (The Local, 2014; Svensk Försäkring, 2013). While data on the number of private health insurers in Sweden is not readily available, research by the Commonwealth Fund (2015) indicates that they are primarily for-profit companies.

The private health-care sector in Sweden shares medical resources with its public sector. Dual practice is permitted for physicians, though specialists cannot treat private patients in public hospitals (Hurst and Siciliani, 2003).

## Switzerland

The Swiss health-care system is based on a largely decentralized model, where the primary responsibility for the delivery of health-care services lies with the country's 26 cantons (member states). The federal government is primarily concerned with ensuring universality (through legislation and supplementary funding) to its citizens in an environment of managed competition among insurance companies and providers of health care. [25]

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[24] The highest total tax rate was in Hofors (35.52%), while the lowest was in Vellinge (28.89%) (Statistics Sweden, 2013).

[25] This sections is primarily based on information found in European Observatory on Health Systems and Policies, 2000; OECD/WHO, 2011; and Esmail and Barua, 2015.

## 1 Primary coverage

Residents must purchase (pay premiums for) basic social health insurance (SHI) packages from one of a number of public and private insurers who compete with each other in a regulated competitive market. Insurers are not allowed to make profits on the basic, compulsory insurance package but may offer supplementary insurance packages on a for-profit basis. It is notable that of the 67 insurers approved to offer social health insurance, [26] 33 are registered as a *Société Anonyme/Aktiengesellschaft* (SA/AG)—that is, as a corporation with shareholders (OFSP, 2014b). All basic SHI insurers [27] are required to provide coverage for a standard package of governmentally determined benefits to all applicants and are required to accept all applicants. While premiums may differ among insurers on the basis of several factors, each can vary premiums for the universal insurance product based only on applicants' place of residence (community rating) [28] and a limited set of broad age ranges (0–18, 19–25, and 25+ years). As in the Netherlands and Germany, Swiss governments operate a risk-redistribution scheme among insurers with the goal of mitigating the adverse effects of community-rated premiums and guaranteed issue (that is, where insurers cannot deny coverage based on health status and risk). The government thus imposes a large degree of regulation on the arena within which the industry operates, although the provision of compulsory health insurance is executed on a private, not-for-profit basis.

In general, patients are free to choose among insurers, free to choose among select plan characteristics including managed care and higher deductibles, and are usually subject to deductibles and cost-sharing for all medical services. The Swiss health-care system provides numerous avenues of assistance to ensure that those who are ill, those with pre-existing conditions, and those with lower incomes are able to receive quality universal care without undue financial burden. This is achieved through a combination of premium regulations and subsidies, the operation of a prospective risk-based financial redistribution scheme among insurers (mentioned previously), and support for cost-sharing.

## 2 Secondary coverage

Patients can also choose to purchase private supplementary health insurance in addition to the basic package. These plans cannot cover the benefits and cost-sharing for the mandatory package but can cover “private rooms in

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[26] Six of the insurers (not SA/AG) are included in the list of approved insurers though they only practice the daily allowance insurance.

[27] i.e., those insurers not dealing exclusively in voluntary supplementary-insurance services.

[28] Health insurers can set a maximum of three regional premium levels within a canton (OFSP, 2014a).



hospitals, dental care, alternative medicines and cash benefits for sickness absence” (OECD/WHO 2011: 63). Plans offering benefits for “inpatient care in private or semi-private departments—allowing choice of physician and superior accommodation” were held by over one third of the population over 15 in 2007 (OECD/WHO 2011: 63).

Private insurers offering supplementary insurance “can adjust premiums to an individual’s risk, refuse coverage and terminate contracts if an individual failed to disclose all health and medical conditions” (OECD/WHO, 2011: 40). There were approximately 1,000 supplementary insurance products available to individuals in Switzerland in 2011 offered by private insurance companies and health insurance funds. Three-quarters of the market share for such products was held by private for-profit insurers (OECD/WHO, 2011).

## 4 Private for-Profit Hospitals in Universal-Access Health-Care Systems

A description of the ownership of hospital care providers—public, private not-for-profit, and private for-profit—in our cohort of six high-performing universal-access health-care systems is provided below. Notably, for-profit hospitals are prevalent in each of the six countries in our cohort. [29]

### Australia

Hospital care in Australia is delivered by public, private not-for-profit, and private for-profit hospitals. [30] The distinction between these is somewhat blurred because, while universally accessible services are generally provided through public hospitals, governments also contract with private hospitals for the provision of universally accessible services. Further, public hospitals in Australia have been known to contract certain tasks to private providers, while both public and private hospitals accept privately funded patients. Table 2 provides a breakdown of the number of hospitals in Australia, by ownership.

Public hospitals tend to focus on providing complex treatments, emergency services and intensive care, major surgery and organ transplants

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[29] The data on the number of hospitals (by ownership) is primarily from the OECD, which defines hospitals as “licensed establishments primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing, and other health services to inpatients and the specialised accommodation services required by inpatients. Hospitals provide inpatient health services, many of which can be delivered only by using specialised facilities and professional knowledge as well as advanced medical technology and equipment, which form a significant and integral part of the provision process. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home health care services as secondary activities. The tasks of hospitals may vary by country and are usually defined by legal requirements. In some countries, health care facilities need in addition a minimum size (such as number of beds and medical staff to guarantee 24-hour access) in order to be registered as a hospital” (OECD, 2015c: 1). This definition includes general hospitals, mental health hospitals, and specialized hospitals.

[30] This section is primarily based on information found in Healy, Sharman, and Lokuge, 2006; and Esmail, 2013a.

**Table 2: Hospitals in Australia, by ownership (2011)**

Total	Public	Private	
		Not-for-Profit	For-Profit
1,345	753	115	477

Source: OECD, 2015a.

for patients. [31] Accommodation, medical services, nursing and other care is usually free of cost-sharing under the universal public insurance scheme in these hospitals.

Private hospitals on the other hand are generally smaller in size, cover a narrower range of services, and tend to focus on providing elective surgery (for which there are usually long wait lists in the public system). [32] As table 2 indicates, there were 477 private for-profit hospitals (35.5 % of all hospitals) in Australia in 2011 according to the OECD (2015a). The OECD also reports that there were 14,051 beds in these hospitals, representing 16.6% of the total stock in the country. Data from Paris, Devaux, and Wei (2010) indicates that private hospitals treat 40% of admitted hospital patients, representing about 30% of all hospital days.

Patients can choose to be treated as a private patient in both public and private hospitals. A public subsidy of 75% of the federally determined schedule fee is provided for medical services for such patients. However, no subsidy is offered for accommodation. Such patients can purchase private insurance to cover these types of costs. [33] Patients cannot choose their hospital or physician under the public scheme. However, patients who choose to be treated as private patients in public hospitals can choose their physician (PHIO, 2015b).

The private health-care sector in Australia shares medical resources with its public sector. Dual practice is permitted for physicians, allowing them to serve both public and private hospital patients.

[31] “Large tertiary care hospitals also have a teaching function and the hospitals associated with university medical schools receive government funds to support their teaching role” (Healy, Sharman, and Lokuge, 2006: 74).

[32] Though not as long as the waits are in Canada (Commonwealth Fund, 2015).

[33] Legally, private insurers are only allowed to pay for physician services related to hospital care. They cannot cover gap payments for ambulatory GP or specialist care. More recently, private insurers have been permitted to cover “out-of-hospital services that substitute for or prevent in-hospital care” as well as disease management programs (Commonwealth Fund, 2015: 13).

## France

Universally accessible hospital care in France is delivered by public, private not-for-profit, and private for-profit hospitals. [34] Table 3 provides a breakdown of the number of hospitals in France, by ownership.

**Table 3: Hospitals in France, by ownership (2012)**

Total	Public	Private	
		Not-for-Profit	For-Profit
2,657	928	688	1,041

Source: OECD, 2015a.

Public hospitals make up about one third of all hospitals in France. These hospitals compete with private (for-profit and not-for-profit) hospitals for patients under the universal scheme and are responsible for managing their own finances.

Private not-for-profit hospitals in France are owned variously by “foundations, religious organizations or mutual insurance associations” (Chevreul et al., 2010: 141). These hospitals not only provide health care to patients but also undertake the provision of traditionally public services such as teaching, providing social programs for select populations, and delivering emergency care.

As table 3 indicates, there were 1,041 private for-profit hospitals (39.2% of all hospitals) in France in 2012. Their share of the hospital bed stock is, however, much lower (about 24.1%), reflecting the reality that for-profit hospitals tend to be smaller in size than public and private not-for-profit hospitals (OECD, 2015a). The Commonwealth Fund (2015) reports that approximately 25% of inpatient beds and 40% of outpatient beds were in private for-profit hospitals.

While acute medical, surgical, and obstetric care is provided by all three types of hospitals, their relative level of involvement varies. For example, public hospitals are responsible for the majority of acute medical-care capacity and surgery. Overall, about a third of all surgeries (including more complex procedures) are performed by public hospitals. While private for-profit hospitals also deliver such services and perform more than half of all surgical procedures, they tend to focus on a smaller range of technical procedures (like invasive diagnostic procedures, for example) and specialize in routine procedures with short and predictable in-hospital stays. Obstetric procedures

[34] This section is primarily based on information found in Chevreul, Durand-Zaleski, Bahrami, Hernández-Quevedo, and Mladovsky, 2010; Commonwealth Fund, 2015, and Labrie and Boyer, 2008.

are also mainly delivered by public hospitals, although private for-profit hospitals are responsible for “one-quarter of all obstetrical stays” (Chevreul et al., 2010: 185). Private not-for-profit hospitals provide a range of services including follow-up and rehabilitation, and cancer treatment (including prevention, screening, treatment, surgery and research).

The passage of the 2009 HPST act (*Loi hôpital patients, santé et territoires*; HPST) also resulted in increased potential for private for-profit hospitals to carry out public service duties paid for through contracts with a regional health agency (*agence régionale de santé*). Further cooperation between public and private hospitals was also enabled through new sanitary cooperation group (*groupements de coopération sanitaire*) contracts. [35]

## Germany

Universally accessible hospital care in Germany is delivered by public, private not-for-profit, and private for-profit hospitals. [36] Table 4 provides a breakdown of the number of hospitals in Germany, by ownership.

**Table 4: Hospitals in Germany, by ownership (2012)**

Total	Public	Private Not-for-Profit	Private For-Profit
3,229	833	1,040	1,356

Source: OECD, 2015a.

There has been a general shift in ownership over the last two decades. The number of public hospitals declined by about 39% between 1991 and 2012. At the same time, the number of private for-profit hospitals has increased by about 27% (OECD, 2015a, calculations by author). Much of this shift in ownership can be attributed to the privatization of public hospitals (especially in the eastern part of Germany).

As table 4 indicates, there were 1,356 private for-profit hospitals (42% of all hospitals) in Germany in 2012 according to the OECD (2015a). The OECD also reports that there were 201,218 beds in these hospitals, representing 30% of the total stock in the country. Looking at only the 2,017 inpatient hospitals, 34% were private for-profit hospitals (18% of beds). On the other hand, of

[35] These allow for the combination of public and private health institutions, health centers, nursing homes and medical professionals (Ministère des Affaires sociales, de la Santé et des Droits des femmes, 2015)

[36] This section is primarily based on information found in Busse and Blumel, 2014; and Esmail, 2013b.

1,212 institutions dedicated to preventative and rehabilitative care, 55% were for-profit institutions (66% of beds) (data from OECD, 2015a and Busse and Blumel, 2014; calculations by author).

Private and public hospitals in Germany serve both the SHI and PHI schemes, with 99% of all hospital beds being accessible to SHI-covered patients. There are only a few private for-profit hospitals that serve only PHI patients. While SHI patients can generally choose the hospital where they are treated, their choice of physician within the hospital is restricted to the doctor on duty or doctor assigned by the hospital. PHI patients on the other hand may not only choose the hospital but also the physician; this includes access to senior physicians.

Hospitals are financed in two ways: capital investments through the regional government or *Länder* (irrespective of ownership), and operational costs through sickness funds, private health insurers, and self-pay patients. However, tax-funded subsidies have fallen considerably since the 1990s. Since 2004, the German health care system (SHI and PHI) has relied, for all inpatient hospital services (with the exception of psychiatric care), on a Diagnosis Related Group (DRG) activity-based funding model where hospital funding is based on the number and type of patient cases treated.

## The Netherlands

Inpatient hospital care in the Netherlands is provided by independent private not-for-profit corporations. [37] In fact, the 1971 Hospital Facilities Act (*Wet Ziekenhuisvoor-zieningen*) explicitly disallowed hospitals offering inpatient services to operate on a for-profit basis. Independent treatment centres (known as ZBCs) provide same-day non-emergency treatments.

The ability of medical institutions (more generally speaking) to provide services on a for-profit basis has been in a state of flux recently. For example, Schäfer et al. note that “[s]ince 2008 ... a few pilots have started that allowed paying out a part of the profit to shareholders” (2010: 152). Meanwhile, the lower house of the Dutch parliament passed legislation in 2014 that would allow hospitals to operate on a for-profit basis and distribute profits to investors (*Tweede Kamer*, 2015). [38] This bill was still pending approval by the senate as of June 12, 2015 (VWS, 2015).

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[37] This section is primarily based on information found in Schäfer, Kroneman, Boerma, van den Berg, Westert, Devillé, and van Ginneken, 2010; Esmail, 2014; and Esmail and Barua, 2015.

[38] Foreign investment companies would not be allowed to invest in hospitals, and there would be regulations to ensure that investments were “long term” (*Volksrant*, 2014).

By the OECD's definition of hospitals used throughout this study, there were 79 for-profit hospital organizations in the Netherlands in 2012. The hospitals run by these organizations did not, however, "have a license for health insurance coverage" (OECD, 2015c) and likely only offered specialized non-acute care at the time. Data on the number of beds in these for-profit hospitals is not available from the OECD.

Table 5 presents data on hospitals in the Netherlands.

**Table 5: Hospitals in the Netherlands, by ownership (2012)**

Total	Public	Private	
		Not-for-Profit	For-Profit
259	0	180	79

Note: Refers to organizations, not locations.

Source: OECD, 2015a.

## Sweden

Hospitals in Sweden are generally publicly owned and operated, though there is a distinct split between purchasers and providers where public funds are distributed on an activity-funded basis to both public and private institutions. [39] As the OECD does not provide comprehensive data on hospitals in Sweden on the basis of ownership, the data presented in table 6 is primarily based on an examination of statements about hospital ownership in Anell, Glenngård, and Merkur, 2012.

**Table 6: Hospitals in the Sweden, by ownership**

Total	Public	Private	
		Not-for-Profit	For-Profit
83	77	3	3

Source: Anell, Glenngård, and Merkur, 2012.

There are 70 public hospitals and six private hospitals that provide hospital services in Sweden. In addition, highly specialized care is provided by seven regional or university hospitals. Three of the six private hospitals are not-for-profit (*Sophiahemmet*, *Ersta*, and *Röda Korset*). While these hospitals are privately owned and operated, they hold contracts with Stockholm county council to provide care to a certain number of patients under the

[39] This section is primarily based on information found in Anell, Glenngård, and Merkur, 2012.

public scheme. The other three private hospitals are for-profit institutions (*Sankt Görans*, *Lundby*, and *Simrishamn*). As with the not-for-profit private hospitals, these providers are fully financed by county councils on a contract basis.

*Sankt Görans* is a particularly interesting case study. It was originally a public hospital and was slated for closure in the mid-1990s. However, around 2000, its management and operation was contracted out to a private company (though the bricks and mortar are still publicly owned). Today, it is the only private for-profit, acute-care hospital in Sweden, is run by a publicly traded company (Capio), and is regularly recognized as one of the most efficient and high-quality acute-care hospitals in the country (*Economist*, 2013).

## Switzerland

There appears to be some ambiguity about hospital ownership in Switzerland. For example, the OECD suggests that “[d]ifferentiation according to ownership and profit is not relevant in Swiss health system” (OECD, 2015b: 5). This may be a function of the fact that hospitals in Switzerland, whether public or private, compete with one another for patients under the universal scheme under an activity-based funding model in which there is little differentiation between the two from the insurers’ or patients’ perspectives.

That being said, Switzerland’s *Office fédéral de la statistique* [OFS] (2015) provides data on hospitals in Switzerland, broken down into the following categories: *SA/Sàrl* (150) [40]; *Association/foundation* (73) [41]; *Raison individuelle/société individuelle* (9) [42]; and *Entreprises publiques* (61) [43].

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[40] Includes: Partnership company (*soc. en nom collectif*, SNC); limited partnership company (*soc. en commandite*, SCS); company limited by shares (*soc. en commandite par actions*); public limited company (*société anonyme*, SA); limited liability company (*soc. à responsabilité limitée*, Sàrl) (OFS, 2015).

[41] Includes: Cooperative (*Société coopérative*); association (*association*); foundation (*fondation*) (OFS, 2015).

[42] Includes: Self-employed (*raison individuelle*, RI); ordinary partnership (*société simple*) (OFS, 2015).

[43] Includes: Federal administration (*administration fédérale*); cantonal administration (*adm. Cantonale*); district administration (*adm. de district*); communal administration (*adm. Communale*); other corporation under public law (*autre corporation de droit public*); federal establishment (*établissement fédéral*); cantonal establishment (*établi. Cantonale*); district establishment (*établi. de district*); communal or corporate establishment (*établi. communal ou d'une corporation*) (OFS, 2015).



Using this data [44], it is possible to present the number of hospitals in Switzerland by ownership according to the categories previously used in this study. In general, these numbers suggest that approximately 51% of all hospitals in Switzerland are private for-profit institutions (table 7).

**Table 7: Hospitals in Switzerland, by ownership (2013)**

Total	Public	Private Not-for-Profit	Private For-Profit
293	61	82	150

Source: Office fédéral de la statistique, 2015.

[44] Although it does not break down the data by ownership, the OECD reports 298 hospitals in Switzerland in 2012. This number is close to the sum of the four categories of hospitals reported by the *Office fédéral de la statistique* (293), which suggests that the numbers are comparable.

## 5 The Canadian Context

As noted previously, there is a prevailing perception held by many Canadians that for-profit health care is incompatible with universality. Aside from ignoring the wealth of evidence to the contrary from other countries, this perception also ignores the reality within Canada itself.

To begin with, it is often forgotten that physicians—the core human resource in the medical sector—are “independent private practitioners, contracting their services to the state or general public” [45] (Makarenko, 2010). Further, private for-profit (and private not-for-profit) companies provide supplementary (extended) health insurance, medical laboratory services, long-term care, and even diagnostic and surgical procedures (including publicly covered services) across Canada. While a detailed description of the proliferation of these companies, and the extent of services offered is beyond the scope of this paper, it will be useful to examine their presence in the two areas focused on in this paper: insurance and hospital care.

No discussion of private and for-profit companies in health care can be had in Canada without understanding the role of the Canada Health Act [CHA]. Vitaly, the CHA is often held up as the reason for a lack of private for-profit participation in the health-care system in Canada, whether private for-profit parallel insurance and provision of services or private for-profit provision of universally accessible services. Such arguments misrepresent both how the CHA operates and how its various rules and regulations affect provincial policy making.

The CHA does not set health-care policies, but rather is a financial act providing the terms under which provinces will maintain access to the entirety of their cash transfers from the federal government. Provinces could deviate from the requirements (and federal interpretations) of the CHA if they were willing to forego federal cash transfers. Thus, it is provinces that set health-care policy in Canada, including policies surrounding who will deliver and who can pay for health care services, but the CHA imposes significant disincentives for particular policy choices.

The CHA is also not prescriptive when it comes to the provision and financing of health care other than requiring no cost sharing or partial private funding for universally accessible services, no extra billing for universally accessible services, and no competition in the universally accessible insurance marketplace (Clemens and Esmail, 2012). The CHA does not expressly

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[45] They cannot, however, set their own fees for services (the schedule for which must be negotiated with the province).

disallow either private parallel health-care services or insurance, or private for-profit delivery of universally accessible hospital services, though the room given for federal interpretations of the act in particular with respect to the undefined “reasonable access” requirement in section 12 may be used to do so (Clemens and Esmail, 2012). Other authors in their examinations of the CHA have come to similar findings. For example, Madore and Tiedmann state that

the Canada Health Act does not prevent private, or for-profit, providers from delivering and being reimbursed for publicly insured health services, so long as private payment by patients (through user charges and extra-billing) is not involved ... [and] ... does not prevent the provinces from allowing private health care providers, whether individual or institutional, to operate outside the publicly funded health care system. (Madore and Tiedmann, 2005: 8)

For various reasons, most provinces have however chosen to limit the activity of private for-profit institutions in the delivery of medically necessary hospital services, and in the financing and delivery of parallel health-care services, and have discouraged parallel delivery by restricting physicians’ ability to opt out or practice in both publicly funded and privately funded sectors. [46] On the other hand, private independent physicians (both general practitioners and specialists) are the norm across Canada.

While nearly all public hospitals in Canada are technically private not-for-profit entities, it should be recognized that this is a legal distinction rather than a true description of their ownership and operational status. Hospitals across Canada are “governed largely by a political process, given wage schedules for staff, are told when investment can be undertaken, denied the ability to borrow privately for investment, told which investments will be funded for operation, and forcibly merged or closed by provincial governments” (Esmail and Walker, 2008: 38). Indeed, the OECD records no private not-for-profit hospitals in Canada at all, choosing to classify them as public hospitals instead.

That being said, there actually is a small amount of private (and for-profit) diagnostic and surgical activity across Canada. For example, the OECD reports eight private for-profit hospitals in Canada (of a total 725). This is likely an underestimate since the Canada Health Act annual report (2014) identifies six private for-profit hospitals in Canada, not counting the four largest provinces (Ontario, Quebec, British Columbia, and Alberta).

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[46] Madore and Tiedmann note that “Newfoundland & Labrador is the only province that both allows private insurance to cover services insured under its provincial insurance plan and does not use other means to discourage physicians from opting out of the public plan” (2005: 7).

Further, medically necessary surgical care, and diagnostic imaging, is also provided by private for-profit clinics that specialize in specific procedures. When including such institutions, research indicates that there were approximately “72 private for-profit surgical hospitals [and/or clinics] operating in 7 provinces, excluding those that sell purely unnecessary [sic] services such as cosmetic surgery and the abortion clinics” in 2007/2008 (Mehra, 2008: 42). Mehra (2008) also recorded 42 private for-profit MRI/CT clinics.

Finally, Canada has a large private insurance sector focused on the financing of supplementary services (services other than those provided by physicians and hospitals). This area of health-care insurance is not covered by the Canada Health Act (which is restricted to “medically necessary” physician and hospital services) and thus is subject to much greater governmental policy freedom. Such insurance is used to cover services like prescription drugs, vision and dental services, as well as semiprivate or private hospital accommodations and medical appliances. It is estimated that between two thirds and three quarters of the Canadian population holds some form of private insurance (Commonwealth Fund, 2015; CLHIA, 2014). The majority of supplementary insurance providers in Canada are private for-profit companies. The Canadian Life and Health Insurance Association reports 129 companies participating in the supplementary insurance market in 2013, including “65 life insurance companies, 48 property and casualty insurers, [47] 8 fraternal benefit societies, and 8 not-for-profits” (CLHIA 2014: 24).

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[47] The CLHIA report that “[l]ife insurance companies and not-for-profit health care providers sold 98 per cent of these products” (CLHIA, 2014: 24).

## 6 Conclusion

This study set out with the intention of examining the presence of private for-profit institutions in six high-performing universal-access health-care systems: Australia, France, Germany, the Netherlands, Sweden, and Switzerland. More specifically, we sought to answer the following two questions:

- 1 Are private, for-profit health care insurers present?
- 2 Are private, for-profit hospitals present?

The data comprehensively indicate that the answer to both questions is “yes” though, as might be expected, there is a great degree of variation among countries.

As [table 8](#) indicates, there is widespread presence of private for-profit institutions in the voluntary (supplementary/complementary) insurance sector. However, some countries even allow private for-profit insurers to compete for coverage of the universally accessible insurance product as well. For example, in the Netherlands, residents are mandated to purchase Statutory Health Insurance for core medical services from one of a number of private insurers. The leader in that market (Achmea) is a for-profit conglomerate

**Table 8: Private health-care insurance (by type available) and distribution of insurers (by profit motive)**

<b>Australia</b>	Duplicate and voluntary private insurance is available from 8 for-profit and 26 not-for-profit companies. (PHIAC, 2013)
<b>France</b>	Voluntary private insurance is available from 96 for-profit and 508 not-for-profit companies. (Franc and Pierre, 2015)
<b>Germany</b>	Substitutive private insurance is available from 24 for-profit and 19 not-for-profit companies. Voluntary private insurance is also available. (Busse and Blumel, 2014).
<b>Netherlands</b>	Primary insurance is available from 27 not-for-profit and for-profit companies. A for-profit conglomerate held about 32% of the market. Voluntary private insurance is also available. (OECD, 2012)
<b>Sweden</b>	Voluntary private insurance is available from for-profit companies (Commonwealth Fund, 2015)
<b>Switzerland</b>	67 insurers approved to offer primary insurance, of which 33 are registered as SA/AG (although they cannot earn profit on the primary insurance portion of their package). (OFSP, 2014a) Private for-profit companies supply three quarters of the voluntary insurance market. (OECD/WHO, 2011)

Note: The term “voluntary” is used for convenience to denote both or either “supplementary” and “complementary” insurance.

that held 32% of the market in 2011 (OECD, 2012). In Germany, substitutive private health-care insurance is available from 24 for-profit (and 19 not-for-profit) companies. On the other hand, the Swedish universal-access health-care system is, in many ways, similar to Canada's: residents are covered for core health care services by government, with private for-profit insurers playing supplementary and complementary roles, but unlike Canada funding medically necessary physician and hospital services.

As [table 9](#) indicates, the presence of private for-profit institutions is relatively more common in the delivery of hospital care (compared to the insurance sector). For example, in 2012 approximately 42% of the 3,229 hospitals in Germany were for-profit institutions. Even in Sweden, three out of 83 hospitals are for-profit institutions, though only one (*Sankt Görans*) offers acute inpatient care.

**Table 9: Hospitals in universal-access health-care systems (by ownership and profit motive)**

Country	Public	Private		Year (source)
		Not-for-Profit	For-Profit	
Australia	753	115	477	2011 (OECD,2015a)
France	928	688	1,041	2012 (OECD,2015a)
Germany	833	1,040	1,356	2012 (OECD,2015a)
Netherlands	0	180	79	2012 (OECD,2015a)
Sweden	77	3	3	n/a (Anell, Glenngård, and Merkur, 2012)
Switzerland	61	82	150	2013 (Office fédéral de la statistique, 2015)

Even within Canada, private for-profit companies can be found providing supplementary (extended) health insurance, as well as some diagnostic and surgical procedures (including publicly covered services).

While the proliferation and extent of services offered in each of the countries examined may vary, the research presented in this study should help dispel the mistaken notion that private for-profit institutions (in either the insurance or hospital sector) are incompatible with universal-access health care. On the contrary, their coexistence is the norm.

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