



**MEI**

Ideas for a  
More Prosperous  
Society



**RESEARCH  
PAPERS**

**FEBRUARY 2022**

# **REAL SOLUTIONS FOR WHAT AILS CANADA'S HEALTH CARE SYSTEMS**

## **LESSONS FROM SWEDEN AND THE UNITED KINGDOM**

(Incluant un sommaire et une introduction en français)

By Maria Lily Shaw



910 Peel Street, Suite 600  
Montreal (Quebec)  
H3C 2H8 Canada

Phone: 514-273-0969  
[www.iedm.org](http://www.iedm.org)

The Montreal Economic Institute is an independent, non-partisan, not-for-profit research and educational organization. Through its publications, media appearances and conferences, the MEI stimulates debate on public policies in Quebec and across Canada by proposing wealth-creating reforms based on market mechanisms. It does not accept any government funding.

The opinions expressed in this study do not necessarily represent those of the Montreal Economic Institute or of the members of its board of directors. The publication of this study in no way implies that the Montreal Economic Institute or the members of its board of directors are in favour of or oppose the passage of any bill.

Reproduction is authorized for non-commercial educational purposes provided the source is mentioned.

©2022 Montreal Economic Institute  
ISBN 978-2-925043-17-1

Legal deposit: 1<sup>st</sup> quarter 2022  
Bibliothèque et Archives nationales du Québec  
Library and Archives Canada  
Printed in Canada

**Maria Lily Shaw**

**Real Solutions for What Ails  
Canada's Health Care Systems  
Lessons from Sweden and  
the United Kingdom**

Montreal Economic Institute

•  
February 2022



**TABLE OF CONTENTS**

HIGHLIGHTS.....5

FAITS SAILLANTS .....7

ENGLISH INTRODUCTION.....9

INTRODUCTION FRANÇAISE..... 11

CHAPTER 1 – ROLE MODELS FOR HEALTH CARE REFORM..... 13

    Comparative Exercise .....13

    Sweden Case Study .....13

    UK Case Study .....29

CHAPTER 2 – ENACTING MEANINGFUL HEALTH CARE REFORM  
IN CANADA..... 39

    The Regulatory Barriers Preventing Canadian Provinces from Liberalizing  
    Their Health Systems ..... 39

    Lessons Quebec and BC Can Learn from Sweden and the UK.....50

CONCLUSION ..... 65

ABOUT THE AUTHOR ..... 66



## HIGHLIGHTS

The Swedish and British health care systems have undergone profound and widespread transformations since the 1980s. As a result of the transition to a mixed system, their populations now benefit from more flexible health systems that respond to their needs in a timely manner—all with a price tag similar to or lower than the cost of many provincial health systems in Canada. With the shortcomings of Canadian health care more glaringly obvious than ever, having two concrete examples of universal health care systems that successfully transitioned to a liberalized model can be a valuable guide to policy-makers across the country.

### Chapter 1 – Role Models for Health Care Reform

- The number of physicians per 1,000 population is nearly three times higher in Sweden than in Quebec and British Columbia, and the relative number of nurses is around twice as high.
- Even though Sweden spends somewhat more on health care, their system's performance is undeniable. Meanwhile, the UK, while spending less than Quebec or BC, manages to do more with less.

### Sweden Case Study

- Sweden's deteriorating economic climate throughout the 1970s led to a critical public debate about the organization of social services, which were wasteful, overly bureaucratic, and deprived the Swedish people of their right to choose.
- The main focus of the health reforms that occurred in Sweden in the 1980s and early 1990s was reducing costs and transferring the responsibility of health care provision from the national level to the county councils.
- Decentralization efforts continued for several years after the 1985 Dagmar Reform, but during the first half of the 1990s, the main focus became accessibility and reducing waiting lists.
- County councils began introducing DRG funding, by which hospitals receive a fixed amount for each patient they treat based on the type of patient treated, the severity of the medical issues, and other criteria, thus encouraging both efficiency and cost containment.

- Starting in the late 1990s, the pharmaceutical sector in Sweden was decentralized and liberalized and the oral health care system was reformed.
- In the late 1990s and early 2000s, the management of several hospitals was delegated to entrepreneurs, including the Saint Göran hospital in Stockholm, which from the patient's point of view is no different from any other public hospital and which is a model of efficiency.
- In 2010, Sweden made duplicate private health insurance available, and gave patients the ability to choose their primary care provider through the *Patient Choice Act*.

### UK Case Study

- Before liberalization, secondary care institutions in the United Kingdom were funded by historical budgets, and the health care system was being described as "a rigid organisation with too many layers of decision making."
- The *National Health Service and Community Care Act* of 1990 introduced an "internal market," within which the health care system would be structured around a novel separation of the roles of purchaser and provider of health services.
- In 1997, political power was devolved to national administrations in England, Scotland, Wales, and Northern Ireland.
- Competition between institutions in England was subsequently reinforced by the use of the entrepreneurial sector in the provision of clinical care, taking competition one step further than the prior internal market.
- In 2003, England introduced the Payment by Results tariff, an activity-based funding scheme (the equivalent of DRG funding in Sweden) that provides incentives to improve performance.
- In 2006, every patient in England was given the freedom to choose their hospital for secondary care, creating financial incentives for providers to improve their clinical performance.

## Chapter 2 – Enacting Meaningful Health Care Reform in Canada

- The *Canada Health Act* (CHA) does not prohibit duplicate insurance that covers services similar to those provided by Medicare, nor does it explicitly prohibit mixed practice or delegating the management of public hospitals to entrepreneurs.
- The Canadian provinces that prohibit the purchase of duplicate insurance are among the only universal health systems in the world to do so.
- Despite one often-raised objection, doctors practising in countries that allow mixed practice, such as Australia and Denmark, do not spend any less time caring for patients in the public system.
- In the *Chaoulli* case, the Supreme Court of Canada ruled that the ban on duplicate health insurance in Quebec was void and unenforceable. In the words of then-Chief Justice Beverley McLaughlin, “Access to a waiting list is not access to health care.”
- Quebec’s National Assembly, however, did not completely strike down the ban on duplicate insurance, as would seem to have been required by the Supreme Court’s decision.
- The ongoing *Cambie* case challenges the constitutionality of every disposition of British Columbia health law that has the effect of blocking the emergence and development of a parallel decentralized and liberalized health care system.
- If successful in whole or in part before the Supreme Court of Canada, the *Cambie* case has the potential to rapidly accelerate the development of a parallel health care system across Canada.

### Lessons Quebec and BC Can Learn from Sweden and the UK

- The reforms presented in this section are included based on their compliance with the CHA and their real-world use and success in other countries with universal health care.
- What’s more, the order in which these reforms are applied is arguably just as important as the reforms themselves.

1. Adopt Electronic Patient Records and Expand Access to Health Data
2. Remove the Prohibition on Duplicate Health Insurance
3. Remove the Prohibition on Dual Practice
4. Increase the Supply of Medical Professionals with Three Reforms
5. Adopt Funding and Payment Mechanisms Conducive to Performance, Efficiency, and Productivity
6. Transfer the Management of Some Hospitals to Entrepreneurs and Expand Private Care Provision.

No matter how profoundly the reforms that were adopted in Sweden and the United Kingdom have transformed health care in those countries, the universality of their health systems was maintained. These systems, therefore, are models that Canadian politicians can use to show that the growth of entrepreneurial involvement in the provision of care need not be done at the expense of the principle of equality of access. Now is the time for policy-makers to acknowledge the benefits of a liberalized health care system by looking beyond the current legislation and taking note of what has been accomplished elsewhere.



## FAITS SAILLANTS

Les systèmes de santé suédois et anglais ont subi des transformations vastes et profondes depuis les années 1980. Résultat de la transition vers un système mixte : la population de ces pays a désormais accès à un système de santé plus flexible qui répond aux besoins rapidement – le tout à un prix semblable ou inférieur à celui de plusieurs systèmes de santé provinciaux au Canada. Les faiblesses du système de santé canadien étant aujourd'hui plus flagrantes que jamais, ces deux exemples concrets de systèmes universels efficacement transformés selon un modèle libéralisé peuvent servir à orienter les décideurs aux quatre coins du pays.

### Chapitre 1 – Modèles de réforme des soins de santé

- Le nombre de médecins par 1 000 habitants est presque trois fois plus grand en Suède qu'au Québec et en Colombie-Britannique, et le nombre relatif d'infirmiers et d'infirmières, presque deux fois plus élevé.
- Bien que la Suède dépense un peu plus pour ses soins de santé, l'efficacité de son système est indéniable. En parallèle, le Royaume-Uni, qui dépense moins que le Québec et la Colombie-Britannique, arrive à en faire plus avec moins.

### Étude de cas : la Suède

- Dans les années 1970, la dégradation du climat économique en Suède a suscité un grand débat public autour de l'organisation des services sociaux; inefficaces et hautement bureaucratiques, ils privaient le peuple suédois de sa liberté de choix.
- La cible principale des réformes de santé adoptées en Suède dans les années 1980 et au début des années 1990 était de réduire les coûts et de transférer la responsabilité, alors nationale, de prestation des soins aux comtés régionaux.
- Les efforts de décentralisation se sont poursuivis durant plusieurs années après la réforme Dagmar de 1985, mais la première moitié des années 1990 a été axée sur l'amélioration de l'accès et la réduction des listes d'attente.
- Les comtés régionaux ont commencé à utiliser le financement fondé sur les DRG, selon lequel les hôpitaux reçoivent pour chaque patient traité un

montant fixe basé sur le type de patient, la gravité des problèmes de santé et d'autres critères, ce qui encourage l'efficacité et la maîtrise des dépenses.

- À partir de la fin des années 1990, l'industrie pharmaceutique de Suède a été décentralisée et libéralisée, et le système de soins dentaires, réformé.
- À la fin des années 1990 et au début des années 2000, la gestion de plusieurs hôpitaux a été transférée à des entrepreneurs, notamment celle de l'hôpital Saint Göran à Stockholm; du point de vue du patient, il est semblable à n'importe quel autre hôpital public tout en étant un modèle d'efficacité.
- En 2010, la Suède a autorisé l'assurance-maladie privée duplicative et a donné aux patients la possibilité de choisir leur fournisseur de soins primaires par sa loi sur le choix du patient.

### Étude de cas : le Royaume-Uni

- Avant leur libéralisation, les établissements de soins de deuxième ligne au Royaume-Uni étaient financés par des budgets historiques, et le système de santé était décrit comme « une organisation rigide aux trop nombreuses strates décisionnelles ».
- La *National Health Service and Community Care Act* de 1990 a introduit le concept de « marché interne », selon lequel la structure du système de santé s'appuie sur une séparation novatrice des rôles d'acheteur et de fournisseurs de services de santé.
- En 1997, le pouvoir politique a été délégué aux administrations nationales en Angleterre, en Écosse, au pays de Galles et en Irlande du Nord.
- En Angleterre, la concurrence entre les établissements s'est ensuite intensifiée en raison du recours au secteur privé pour la prestation de soins, dépassant ainsi celle qui régnait jusqu'alors dans le marché interne.
- En 2003, l'Angleterre a instauré le mode de paiement selon les résultats, un schéma de financement fondé sur les activités (l'équivalent du financement fondé sur les DRG en Suède) qui encourage l'amélioration du rendement.

- En 2006, tous les patients d'Angleterre ont pu choisir l'hôpital où ils recevraient des soins de deuxième ligne, ce qui a généré des incitatifs financiers encourageant les fournisseurs à améliorer leur rendement sur le plan clinique.

## Chapitre 2 – Lancer une réforme significative du système de santé canadien

- La *Loi canadienne sur la santé* (LCS) n'interdit pas l'assurance duplicative couvrant des services semblables à ceux offerts par le régime d'assurance-maladie, et n'interdit pas non plus explicitement la pratique mixte ou la délégation de la gestion des hôpitaux publics à des entrepreneurs.
- Les provinces canadiennes qui interdisent l'achat d'une assurance duplicative sont parmi les seuls États au système de santé universel à le faire dans le monde.
- Bien que cette objection soit fréquemment soulevée, les médecins pratiquant dans des pays autorisant la pratique mixte, comme l'Australie et le Danemark, ne passent pas moins de temps à s'occuper de patients dans le système public.
- Dans l'affaire Chaoulli, la Cour suprême du Canada a statué que l'interdiction de souscrire une assurance-maladie duplicative au Québec était nulle et inexécutable. Pour reprendre les paroles de la juge en chef de l'époque Beverley McLaughlin, « l'accès à une liste d'attente n'est pas l'accès à des soins de santé ».
- L'Assemblée nationale du Québec, toutefois, n'a pas complètement levé l'interdiction de souscrire une assurance duplicative, comme semblait l'exiger la décision de la Cour suprême.
- L'affaire Cambie (en cours) conteste la constitutionnalité de chaque disposition de la loi sur la santé de la Colombie-Britannique qui a pour effet de bloquer l'émergence et le développement d'un système de santé parallèle, décentralisé et libéralisé.
- Si le plaignant a gain de cause, en tout ou en partie, devant la Cour suprême du Canada, l'affaire Cambie pourrait rapidement accélérer la création d'un système de santé parallèle d'un bout à l'autre du Canada.

## Leçons à tirer de la Suède et du Royaume-Uni au Québec et en Colombie-Britannique

- Les réformes présentées dans cette section ont été sélectionnées parce qu'elles sont conformes à la LCS, que leur réussite a été démontrée dans d'autres pays aux soins de santé universels.
- Par ailleurs, l'ordre d'application de ces réformes est probablement aussi important que la réforme elle-même.
  1. Adopter le dossier médical électronique et améliorer l'accès aux données sur la santé
  2. Lever l'interdiction touchant l'assurance-maladie duplicative
  3. Lever l'interdiction touchant la pratique mixte
  4. Augmenter les effectifs de professionnels de la santé par trois réformes
  5. Adopter des mécanismes de financement et de paiement encourageant le rendement, l'efficacité et la productivité
  6. Transférer la gestion de certains hôpitaux à des entrepreneurs et faire plus de place aux soins privés

Malgré l'ampleur de la transformation du système de santé engendrée par les réformes adoptées en Suède et au Royaume-Uni, l'universalité en a été préservée. Ces systèmes sont ainsi des modèles sur lesquels peuvent s'appuyer les politiciens canadiens pour montrer que la participation du secteur privé à la prestation des soins peut s'accroître sans nuire au principe de l'égalité d'accès. Il est temps que les décideurs politiques reconnaissent les avantages d'un système de santé libéralisé en regardant au-delà des lois actuelles et en étudiant les réussites d'autres pays.

## ENGLISH INTRODUCTION

The Swedish and British health care systems have undergone profound and widespread transformations since the 1980s. Concrete steps were taken to increase system productivity through policy reforms and the introduction of competition. These reforms have resulted in more flexible systems that encourage the creation of partnerships between public and private providers, support the delegation of health facility management, and offer patients greater freedom of choice and increased access.

When the current Medicare system was first championed in Canada 74 years ago,<sup>1</sup> the development of the universal health system paralleled that of other universally accessible government-run systems in countries like Sweden and the United Kingdom.<sup>2</sup> Today, while both of these countries have moved on to “mixed” health care systems of one form or another that incorporate both public and private components, the Canadian system has unfortunately stagnated. As a result of the transition to a mixed system, the populations of Sweden and the UK now benefit from more flexible health systems that respond to their needs in a timely manner—all with a price tag similar to or lower than the cost of many provincial health systems in Canada.<sup>3</sup>

The health care systems in Sweden and the UK, and their evolution since the 1980s, is of particular interest in the context of future health care reform across Canada for several reasons. First and foremost, both countries have maintained the universality of their health care systems, meaning access to publicly funded health services is available to everyone, while at the same time greatly decentralizing decision-making and allowing for major operational autonomy across their respective regional authorities and institutions, as detailed in the first chapter below. The experience of Sweden and the UK will therefore be instructive to provinces that are proceeding with, or contemplating, the decentralization of their health care and hospital system management.

In addition, these two countries are among those that seriously experimented with the principles of managed competition and internal markets, ideas that have been central to the international debate about health system

reform since the late 1980s.<sup>4</sup> Canadian provinces can therefore learn from the outcomes of these experiments and apply similar policies or reforms. The model of managed competition in a system of publicly funded health care is based on the idea that health services will be delivered to the population not by a monopolistic organization, as health care is mainly delivered in Canadian provinces, but by a number of independent providers, both government-run and private, that compete for patients and funding.<sup>5</sup> The information generated by the Swedish and British experiences could be of considerable interest to provincial decision makers as they grapple with questions regarding the methods that should be used to pay for the services of hospitals, doctors, and other providers.

**The populations of Sweden and the UK now benefit from more flexible health systems that respond to their needs in a timely manner.**

Having two concrete examples of universal health care systems that have successfully transitioned from a fully nationalized health network to a liberalized model can thus be a valuable guide to policy-makers across Canada who wish to improve their health care systems. Not every feature of these two health systems need be adopted in order to successfully liberalize provincial health care systems, however, just those that best suit the needs of the population. As such, the most impactful health care reforms will be presented in the first chapter of this research paper, along with an overview of some key characteristics and operational features of the Swedish and British health systems before and after the reforms took place.

For similar changes to be feasible in the Canadian context, however, it is necessary to determine which public policies and legal components currently represent the greatest obstacles to the liberalization of our provincial health care systems. An analysis of the most restrictive aspects of the Quebec and British Columbian health care systems will thus be presented in the second chapter. These two provinces were chosen because they are

1. Danielle Martin, et al., “Canada’s universal health-care system: achieving its potential,” *The Lancet*, Vol. 391, April 28, 2018, p. 1718.

2. Monica Andersson, *Liberalisation, privatisation and regulation in the Swedish healthcare sector/hospitals*, Pique, November 2006, p. 6; Steve Gold, “Four healthcare systems divided by the English language,” *The Guardian*, June 7, 2011.

3. See Table 1-1.

4. Donald W. Light, “Cost Containment and the Backdraft of Competition Policies,” *International Journal of Health Services*, Vol. 31, No. 4, October 2001, pp. 695-697.

5. Productivity Commission, *Managed Competition in Health Care*, Commonwealth of Australia, 2002, p. XI.

not only among those with the most legal barriers to liberalization, but the legislative frameworks of both systems have also been challenged in court due to the consequences of said barriers.

**Having two concrete examples of universal health care systems that have successfully transitioned to a liberalized model can be a valuable guide to policymakers across Canada.**

In Quebec, the Chaoulli case (2005) was the first serious challenge to the monopolistic Canadian public health system. Among other legislation, it addressed the question of whether a province can forbid its residents from purchasing duplicate insurance to cover the cost of services that are normally covered by the provincial health care system.<sup>6</sup> In British Columbia, in the Cambie case,<sup>7</sup> which has been ongoing since 2009, the plaintiffs have asked the court to invalidate every single legislative disposition of British Columbian health law that has the effect of blocking the emergence and the development of a parallel decentralized and liberalized health care system.<sup>7</sup> Accordingly, this second chapter will also explore the Chaoulli case and the changes it brought about in the Quebec health care system—limited though these were, for reasons that will be discussed—as well as the opportunities that could arise from the Cambie case in the context of a favourable ruling.

---

6. Bruna Chagnon, "The Chaoulli Case and Its Impacts on Public and Private Health Insurance," Canadian Institute of Actuaries, p. 1.

7. Colleen M. Flood and Bryan Thomas, *Is Two-Tier Health Care the Future?* University of Ottawa Press, 2020, p. 84.

## INTRODUCTION FRANÇAISE

Les systèmes de soins de santé suédois et britannique ont subi de profondes et vastes transformations depuis les années 1980. Des mesures concrètes ont été prises pour accroître la productivité du système au moyen de réformes en matière de politiques et de l'introduction de la concurrence. Ces réformes ont permis de mettre en place des systèmes plus souples qui favorisent la création de partenariats entre les intervenants publics et privés, la délégation de la gestion des établissements de santé, ainsi qu'une plus grande liberté de choix et un meilleur accès pour les patients.

Lorsque le système d'assurance maladie actuel a été introduit au Canada il y a 74 ans<sup>1</sup>, ce système universel s'apparentait à d'autres systèmes publics à accès universel dans des pays comme la Suède et le Royaume-Uni<sup>2</sup>. Aujourd'hui, alors que ces deux pays sont passés à une forme ou une autre de systèmes de soins de santé « mixtes » qui intègrent des composantes publiques et privées, le système canadien a malheureusement stagné. Grâce à leur transition vers un système mixte, les populations de la Suède et du Royaume-Uni disposent maintenant de systèmes de santé plus souples, capables de répondre à leurs besoins dans des délais raisonnables, et dont les coûts sont similaires ou inférieurs à ceux de nombreux systèmes de santé provinciaux au Canada<sup>3</sup>.

Les systèmes de soins de santé de la Suède et du Royaume-Uni, et leur évolution depuis les années 1980<sup>4</sup>, revêtent un intérêt particulier dans le contexte de la future réforme des soins de santé au Canada, et ce, pour plusieurs raisons. D'abord et avant tout, les deux pays ont maintenu l'universalité de leurs systèmes de soins de santé, de leurs systèmes de soins de santé, ce qui signifie que les services de santé financés par l'État sont demeurés accessibles à tous. En même temps, ils ont largement décentralisé le processus décisionnel et conféré à leurs autorités régionales et à leurs établissements une grande autonomie opérationnelle, comme l'explique de façon détaillée le premier chapitre du présent document. L'expérience de la Suède et celle du Royaume-Uni

pourront donc servir d'exemple aux provinces qui ont entrepris ou envisagent la décentralisation de la gestion de leur système de soins de santé et de leur système hospitalier.

Par ailleurs, ces deux pays sont parmi ceux qui ont sérieusement mis à l'essai les principes de la concurrence réglementée et des marchés intérieurs, des notions qui sont au cœur du débat international sur la réforme des systèmes de santé depuis la fin des années 1980. Les provinces canadiennes peuvent donc s'inspirer des résultats de ces expériences et adopter des politiques ou des réformes similaires. Le modèle de concurrence réglementée dans un système de soins de santé financé par l'État repose sur l'idée que les services de santé sont offerts à la population non pas par une entité monopolistique, comme c'est le cas en grande partie dans les provinces canadiennes, mais plutôt par un certain nombre de fournisseurs indépendants, tant publics que privés, qui se livrent concurrence pour attirer les patients et le financement<sup>5</sup>. Les données issues des expériences suédoise et britannique pourraient être fort utiles aux décideurs provinciaux qui s'interrogent sur les méthodes à privilégier pour le paiement des services dispensés par les hôpitaux, les médecins et les autres fournisseurs.

**Les populations de la Suède et du Royaume-Uni disposent maintenant de systèmes de santé plus souples, capables de répondre à leurs besoins dans des délais raisonnables.**

Ainsi, les décideurs canadiens qui souhaitent améliorer leur système de soins de santé peuvent s'inspirer de deux exemples concrets de systèmes de soins de santé universels qui ont réussi la transition d'un réseau de santé entièrement nationalisé à un modèle libéralisé. Cependant, ce ne sont pas toutes les caractéristiques de ces deux systèmes de santé qui doivent être adoptées pour réussir la libéralisation des systèmes de santé provinciaux, mais seulement celles qui répondent le mieux aux besoins de la population. À ce titre, nous présenterons dans le premier chapitre de ce cahier de recherche les réformes les plus efficaces en matière de soins de santé, ainsi qu'un aperçu de certaines caractéristiques et particularités opérationnelles clés des systèmes

1. Danielle Martin, et al., « Canada's universal health-care system: achieving its potential », *The Lancet*, vol. 391, 28 avril 2018, p. 1718.

2. Monica Andersson, *Liberalisation, privatisation and regulation in the Swedish healthcare sector/hospitals*, Pique, novembre 2006, p. 6; Steve Gold, « Four healthcare systems divided by the English language », *The Guardian*, 7 juin 2011.

3. Voir le Tableau 1-1.

4. Donald W. Light, « Cost Containment and the Backdraft of Competition Policies », *International Journal of Health Services*, vol. 31, no 4, octobre 2001, p. 695-697.

5. Productivity Commission, *Managed Competition in Health Care*, Commonwealth of Australia, 2002, p. XI.

de santé suédois et britannique avant et après ces réformes.

Pour que de tels changements soient réalisables dans le contexte canadien, il est toutefois nécessaire de relever les politiques publiques et les aspects juridiques qui constituent actuellement les plus grands obstacles à la libéralisation de nos systèmes de santé provinciaux. À cette fin, une analyse des aspects les plus restrictifs des systèmes de soins de santé du Québec et de la Colombie-Britannique sera présentée dans le deuxième chapitre. Ces deux provinces ont été choisies dans la mesure où elles figurent non seulement parmi celles qui présentent le plus d'obstacles juridiques à la libéralisation, mais également parce que les cadres législatifs de ces deux systèmes ont été contestés devant les tribunaux du fait des conséquences de ces obstacles.

**Les décideurs canadiens peuvent s'inspirer de deux exemples concrets de systèmes de soins de santé universels qui ont réussi la transition à un modèle libéralisé.**

Au Québec, l'affaire Chaoulli (2005) a été la première contestation sérieuse du système public monopolistique de soins de santé au Canada. Elle portait, entre autres, sur la question de savoir si une province peut interdire à ses résidents de souscrire une assurance duplicative pour couvrir le coût des services qui sont normalement couverts par le système de santé provincial<sup>6</sup>. En Colombie-Britannique, dans l'affaire Cambie qui se poursuit depuis 2009, les plaignants ont demandé au tribunal d'invalider chaque disposition législative de la loi sur la santé de la Colombie-Britannique qui a pour effet de bloquer l'émergence et le développement d'un système de santé parallèle décentralisé et libéralisé<sup>7</sup>. Dans ce contexte, le deuxième chapitre explorera également l'affaire Chaoulli et les changements qui en ont découlé dans le système de santé québécois – aussi limités soient-ils, pour des raisons qui seront abordées – de même que les bénéfices qui pourraient découler de l'affaire Cambie advenant un jugement favorable.

---

6. Bruna Chagnon, « The Chaoulli Case and Its Impacts on Public and Private Health Insurance », Canadian Institute of Actuaries, p. 1.

7. Colleen M. Flood et Bryan Thomas, *Is Two-Tier Health Care the Future?* University of Ottawa Press, 2020, p. 84.

## CHAPTER 1

### Role Models for Health Care Reform

#### Comparative Exercise

Before diving into the reforms that have occurred in Sweden and the United Kingdom in recent decades, it is useful to have an overview of a selection of indicators related to the performance of the health care systems of these two countries and the two provinces we will focus on, Quebec and British Columbia (see Table 1-1).

When it comes to health care system cost per capita, Sweden spends the most, public and private spending combined—specifically, \$586 more per capita than Quebec, and \$785 more than British Columbia. For this relatively modest amount, Sweden's health care system outperforms those of the selected Canadian provinces in many respects. As for the United Kingdom, it outperforms the two provinces in most respects for nearly \$1,000 less per capita than Quebec spends.

For instance, the number of physicians per 1,000 population, which can be interpreted as a measure of access to a medical professional, is nearly three times higher in Sweden than in Quebec and British Columbia. The UK also exceeds the Canadian provinces in this regard, though by a smaller margin. As for the number of nurses per 1,000 population, another measure of access to medical staff, Sweden has twice the manpower of the Canadian provinces, while the UK has slightly less than they do.

The performance indicators begin to diverge even more when we look at the proportion of the population that has waited over a year to see a specialist, which speaks to the efficiency of a health system. Sweden and the United Kingdom both display greater efficiency, with less than 5% of their respective populations being subject to a year-long wait before being seen by a specialist, compared to approximately 13% in both British Columbia and Quebec. As for hip and knee replacements, all four regions succeed in scheduling the required operation within the medically recommended wait time of 6 months (180 days).<sup>8</sup> However, Sweden and the UK still outshine Quebec and BC, to the great benefit of patients.

8. Canadian Institute for Health Information, *Your Health System*, consulted October 26, 2021.

Overall, the health care systems in Quebec and British Columbia lag in terms of accessibility and efficiency when compared to those in Sweden and the United Kingdom. And even though Sweden spends more on health care, their system's performance is undeniable. Meanwhile, the UK, while spending less than Quebec or BC, manages to do more with less. It is evident that Canada has a lot to learn from both of these pioneering countries.

#### Sweden Case Study

##### Before Liberalization

Prior to the reforms that began in the 1980s, Sweden's health care system underwent a wave of nationalization and a rapid expansion of hospitals and primary health care. Despite this expansion, there was very little room for independent practitioners to operate in parallel to the public health care system.

**Overall, the health care systems in Quebec and British Columbia lag in terms of accessibility and efficiency when compared to those in Sweden and the United Kingdom.**

The introduction of compulsory national health insurance, combined with the "Seven Crowns" reform (1969), created a system with little to no incentive for private practice.<sup>9</sup> Indeed, the Seven Crowns reform instituted a single uniform outpatient service fee of seven crowns (approximately \$1.41 CAD at the time) to be paid by the patient to the institution upon arrival.<sup>10</sup> This made private office practice less attractive to patients because public hospital outpatient care was virtually free, whereas patients being treated in independently-owned clinics were required to pay the full cost of treatment upfront, to be reimbursed later from public funds for a portion of the fee.<sup>11</sup> What's more, all publicly-employed doctors

9. Monica Andersson, *op. cit.* footnote 2, p. 6.

10. Anders Anell, Anna H. Glenngard, and Sherry Merkur, *Health Systems in Transition: Sweden Health system review*, European Observatory on Health Systems and Policies, Vol. 14, No. 5, 2012, p. 22.

11. Ellen M. Immergut, "The rules of the game: The logic of health policy-making in France, Switzerland, and Sweden," in Sven Steinmo, Kathleen Thelen, and Frank Longstreth (eds.), *Structuring Politics: Historical Institutionalism in Comparative Analysis*, Cambridge University Press, 1992, p. 82.

Table 1-1

	QUEBEC	BRITISH COLUMBIA	SWEDEN	UNITED KINGDOM
<b>Health care expenditure per capita, public and private spending combined, 2019</b>	<b>\$6,781</b>	<b>\$6,582</b>	<b>\$7,367</b>	<b>\$5,791</b>
Number of physicians* per 1,000 population	2.56	2.56	6.92	3.9
Number of nurses** per 1,000 population	12.1	10.8	20.14	9.88
Proportion of the population that has waited <b>over a year</b> to see a specialist (%)	13.1%	12.9%	4.4%	4.8%
Median wait time for hip replacement (days)	105 <sup>§</sup>	96 <sup>§</sup>	71	85 <sup>‡</sup>
Median wait time for knee replacement (days)	118 <sup>§</sup>	123 <sup>§</sup>	96	90 <sup>‡</sup>
Average length of stay in hospital (days)	7.7 <sup>†</sup>	7.8 <sup>†</sup>	5.7 <sup>‡</sup>	6.9 <sup>‡</sup>

\* The number of physicians may be subject to different definitions, depending on the jurisdiction. In Quebec and British Columbia, it refers to the number of active members registered with a regulatory body who were eligible to practise in the given year. In Sweden and the UK, it refers to the number of physicians licensed to practise.

\*\* The number of nurses may be subject to different definitions, depending on the jurisdiction. In Quebec and British Columbia, it refers to all regulated nurses, meaning the sum of licensed practical nurses, nurse practitioners, registered nurses, and registered psychiatric nurses. In Sweden and the UK, it refers to the number of nurses licensed to practise.

§ Data represents the 50<sup>th</sup> percentile. † Data is for the 2019-2020 fiscal year. ‡ Data is for 2017.

Sources: For the cost. QC and BC. Author's calculations. Canadian Institute for Health Information, "National Health Expenditure Trends, 2020: Data Table – Series D1," 2020, Table D.1.10.3. and Table D.1.5.3. Sweden and UK. OECD Data, Topic, Health, Health Spending, consulted October 29, 2021.

For the number of physicians. QC. Author's calculations. Canadian Institute for Health Information, "Canada's Health Care Providers, 2015 to 2019 — Data Tables," 2020, Table 5. BC. Author's calculations. Canadian Institute for Health Information, "Canada's Health Care Providers, 2015 to 2019 — Data Tables," 2020, Table 10. Sweden. OECD Stats, Health, Health Care Resources, Physicians, Physicians licensed to practice, Density per 1 000 population (head counts), Sweden, 2020, consulted October 29, 2021. UK. OECD Stats, Health, Health Care Resources, Physicians, Physicians licensed to practice, Density per 1 000 population (head counts), United Kingdom, 2020, consulted October 29, 2021.

For the number of nurses. QC. Author's calculations. Canadian Institute for Health Information, "Canada's Health Care Providers, 2015 to 2019 — Data Tables," 2020, Table 5. BC. Author's calculations. Canadian Institute for Health Information, "Canada's Health Care Providers, 2015 to 2019 — Data Tables," 2020, Table 10. Sweden. OECD Stats, Health, Health Care Resources, Nurses, Nurses licensed to practice, Density per 1 000 population (head counts), Sweden, 2020, consulted October 30, 2021. UK. OECD Stats, Health, Health Care Resources, Nurses, Nurses licensed to practice, Density per 1 000 population (head counts), United Kingdom, 2020, consulted October 30, 2021.

For the proportion of the population that has waited over a year to see a specialist. All regions. Canadian Institute for Health Information, "How Canada Compares: Results from the Commonwealth Fund's 2020 International Health Policy Survey of the General Population in 11 Countries — Data Tables," 2021, Question 25.

For the median wait time for hip and knee replacement. QC and BC. Canadian Institute for Health Information, Explore wait times for priority procedures across Canada, Procedure, 2019, 50<sup>th</sup> and 90<sup>th</sup> percentiles, consulted November 26, 2021. Sweden. OECD iLibrary, Health at a Glance: Europe 2020: State of Health in the EU Cycle, Waiting times for elective surgery, Figures 7.28 and 7.29, consulted November 26, 2021. UK. Canadian Institute for Health Information, "Benchmarking Canada's Health Care Systems: International Comparisons," Table 4, 2019.

For average length of stay in hospital. QC and BC. Canadian Institute for Health Information, "Hospitalization and Childbirth, 1995–1996 to 2019–2020 — Supplementary Statistics," 2021, Table 1. Sweden and UK. OECD, Health at a Glance 2019: OECD Indicators, May 2020, p. 197.



were put on a salary with little variation between specialties.<sup>12</sup>

Sweden's deteriorating economic climate throughout the 1970s, however, led to a critical public debate about the organization of social services, which were being described as "wasteful, overly bureaucratic, and, above all, depriving the Swedish people of their right to choose freely what services they preferred."<sup>13</sup>

### Beginning of the Reforms

The transformation of Sweden's health care system began in the 1980s, when a change in attitude toward the role of the public sector occurred within the ruling Social Democratic Party. The finance minister was a prominent advocate of public sector reform, with his primary concern being the sector's productivity and its involvement in local government affairs.<sup>14</sup> During his mandate, nearly all publications released by the ministry promoted the idea of introducing organizational and managerial practices that would mimic certain efficiency-promoting mechanisms of the free-market.<sup>15</sup> Already by the late 1980s, such ideas came to be openly endorsed by the Social Democratic government as a path toward an improved welfare services sector.<sup>16</sup>

### Phase I: 1982-1991, Decentralization and Cost Containment

By around 1980, it was becoming clear that Sweden was facing a public finance crisis of major proportions, at which point cost containment in health care became a serious concern. Indeed, by 1982, total public sector spending had peaked at 67% of GDP, up from 31% in 1960.<sup>17</sup>

As such, the main focus of the health reforms that occurred in the 1980s and early 1990s was reducing costs, as health spending had increased from 7.2% of Swedish

GDP in 1972 to 9.3% in 1982, a substantial increase.<sup>18</sup> These reforms were focused on transferring the responsibility of health care provision from the national level to the county councils.<sup>19</sup>

The first step toward a decentralized health care system was the *Health and Medical Services Act* of 1982, designed to give county councils considerable freedom with regard to the organization and provision of health services.<sup>20</sup>

### 1982 – Health and Medical Services Act

The *Health and Medical Services Act of 1982* made county councils responsible for the delivery and funding of all health care services in their respective jurisdictions.<sup>21</sup> County councils would receive health care funding in the form of block grants, with the amount being based on historical resource use, population size, and demographic characteristics.<sup>22</sup> Such national funds represented just 18%<sup>23</sup> of health care funding, with most health services primarily funded through taxes raised by the county councils themselves from that moment on.<sup>24</sup>

1982 – Health and Medical Services Act	
Before	After
All health care services were organized and financed by the national government.	The county councils became responsible for the planning of health care services, which were financed by a combination of national funds and taxes raised by county councils themselves.

12. Budd Shenkin, "Politics and Medical Care in Sweden: The Seven Crowns Reform," *New England Journal of Medicine*, Vol. 288, No. 11, March 1973, p. 555.

13. Paula Blomqvist, "The Choice Revolution: Privatization of Swedish Welfare Services in the 1990s," *Social Policy & Administration*, Vol. 38, No. 2, April 2004, p. 145.

14. *Ibid.*, pp. 144-145.

15. *Idem*; Ewan Ferlie, "The New Public Management and Public Management Studies," *Oxford Research Encyclopedia of Business and Management*, 2017, p. 3.

16. Paula Blomqvist, *op. cit.*, footnote 13, p. 145.

17. Ragnar Lofgren, *The Swedish Health Care System: Recent Reforms, Problems, and Opportunities*, Fraser Institute, July 2002, p. 9.

18. "OECD Health Data 2006 - Frequently Requested Data" as cited in David Hogberg, "Sweden's single-payer health system provides a warning to other nations," National Center for Public Policy Research, May 1<sup>st</sup>, 2007.

19. A county council, of which there are 21 in Sweden, is a self-governing local authority and one of the principal administrative subdivisions of Sweden.

20. Ministry of Health and Social Affairs, Sweden, "The Health and Medical Services Act," June 30, 1982.

21. Popescu Ljungholm, "Public Health System in Sweden," *AGORA International Journal of Juridical Sciences*, No. 1, 2014, p. 141.

22. Marilyn M. Rosenthal, "Physician Surplus and the Growth of Private Practice: The Case of Sweden," *Scandinavian Studies*, Vol. 61, Nos. 2/3, 1989, pp. 178-179.

23. *Idem*.

24. European Observatory on Health Systems and Policies, "Health Systems in Transition, HiT Summary," WHO Regional Office for Europe, 2005, p. 4.

## 1985 – Dagmar Reform

The county councils' responsibility in the provision of care was reinforced by the 1985 Dagmar Reform, which changed the way private practitioners were remunerated. Previously, private care providers were free to set up practice anywhere and could bill their patients or the national social insurance fund directly for medical services rendered on a fee-for-service basis.<sup>25</sup> The Dagmar Reform changed the reimbursement formula. In addition to the block grants, county councils would receive a per capita allowance to pay for private practitioner fees.<sup>26</sup>

County councils were also given the authority to approve which private practices would be reimbursed by public funds, as well as the number of patients the practices could see per year.<sup>27</sup> They ultimately became the main regulators of the independent health care market.

Physicians who obtained permission from the county councils to operate in a private practice were mostly reimbursed on a capitation basis, where a fixed amount of money per patient per unit of time is paid prospectively for the delivery of health care services.<sup>28</sup> The capitation payment is also adjusted to reflect patients' expected needs. Payment by capitation is often used to contain costs, as it places the physician at financial risk for services provided to patients and provides incentives to eliminate waste. Practitioners receive a fixed amount of money per patient in advance, so any wasteful behaviour or treatments will come out of the doctors' pockets.<sup>29</sup> Capitation payments work best when the practitioner or private clinic can keep any surplus generated, and when payments are tied to quality measures to ensure necessary care is not withheld.

The use of block contracts and capitation payments had considerable success in reducing the rate of spending growth.<sup>30</sup> It can also be argued that they improved efficiency indirectly by constituting the first step toward more effective forms of decentralized management.

1985 – Dagmar Reform	
Before	After
Private practitioners would charge their patients or the national social insurance fund directly for the full cost of services. Patients who paid directly would then be partially reimbursed by the national government.	County councils received population-based sums from the national government which were intended to pay for privately produced care. Regional health authorities could then decide which private practices were eligible for reimbursement and how many patients they could treat.

The new funding mechanisms weren't without their drawbacks, however. The use of population-based grants and capitation payments led to the rationing of care.<sup>31</sup> During the second half of the 1980s, increasingly long wait lists for certain procedures became an important political issue that ultimately led to national government intervention, which took the form of the National Guarantee of Treatment.

## Phase II: 1991-1995, Focus on Accessibility and Populations with Specific Needs

Decentralization efforts continued for several years after the Dagmar Reform, but during the first half of the 1990s, the main focus became accessibility and reducing waiting lists.

### 1992 – Patient Choice and Care Guarantee

In 1992, the Swedish Government, in collaboration with the Federation of County Councils, introduced a national guarantee of treatment for twelve elective treatments. The agreement stated that patients who did not receive care within three months had the right to seek treatment from another hospital, or an independent clinic, at the home hospital's expense.<sup>32</sup> Hospitals that provided the treatment within the target timeframe would receive extra funding.<sup>33</sup> In the first two years after implementation of the guarantee, waiting times fell substantially.<sup>34</sup>

25. Marilyn M. Rosenthal, *op. cit.*, footnote 22, pp. 178-179.

26. World Health Organization, *Health Care Systems in Transition*, 1996, p. 9.

27. Ake Bergmark, "Market Reforms in Swedish Health Care: Normative Reorientation and Welfare State Sustainability," *Journal of Medicine and Philosophy*, Vol. 33, No. 3, 2008, pp. 246-247.

28. The European Observatory on Health Systems and Policies, *The Health Systems and Policy Monitor, Sweden*, 3.7 Payment Mechanisms, 3.7.1 Paying for Health Services, consulted November 4, 2021.

29. Brent James and Gregory Poulsen, "The Case for Capitation," *Harvard Business Review*, July-August 2016.

30. Andrew Twaddle, *Health Care Reform in Sweden, 1980-1994*, Greenwood Publishing Group, 1999, p. 9.

31. David Hogberg, "Sweden's single-payer health system provides a warning to other nations," National Center for Public Policy Research, May 1st, 2007.

32. Ragnar Lofgren, *Health Care Waiting List Initiatives in Sweden*, Fraser Institute, August 2002, p. 3.

33. Ake Bergmark, *op. cit.*, footnote 27, p. 247.

34. Ragnar Lofgren, *op. cit.*, footnote 17, p. 3.

A revised health care guarantee was implemented in 2005, the so-called "0-7-90-90" guarantee. It stipulates zero delay in patients receiving care in primary care settings, and an appointment with a general practitioner within seven days.<sup>35</sup> When a patient is referred for specialist care, an appointment must be offered within 90 days, and the patient must wait no more than 90 days after being diagnosed to receive treatment. For cases in which specialist care cannot be offered within these timeframes, the patient is free to seek care in another county at the expense of the home jurisdiction.<sup>36</sup>

1992 (revised 2005) – National Guarantee of Treatment	
Before	After
Patients were assigned to an institution to receive care, with no guaranteed maximum delay before treatment.	Patients gained the right to choose to be treated elsewhere if they have waited for longer than guaranteed by the national government.

Overall, the national guarantee of treatment was the first step toward patient choice and having funds follow the patient. Prior to this legislation, Swedes were assigned to a hospital or primary care centre based on their place of residence, with no possibility of seeking care elsewhere.

### 1992 – ADEL Reform

Efforts to decentralize the Swedish health care system continued through the ADEL Reform. Arguably one of the most important structural reforms of the 1990s, it transferred responsibility for providing long-term care for the elderly and disabled from county councils to local municipalities.<sup>37</sup>

Clear incentives were introduced to reduce the number of elderly patients waiting to be discharged from hospitals, so-called "bed-blockers," to ensure that hospital beds were only being occupied by those needing them most. If an individual considered fully medically treated by a physician was not discharged in a timely manner, the local municipality was required to pay the county council for care delivered to that patient.<sup>38</sup>

Once discharged, municipalities are responsible for patients' health needs, if any. Local authorities operate public nursing homes and home care services as they see fit. Some municipalities own all such facilities and manage care services themselves, while others contract out 60% to 80% of care services to independent provider organizations.<sup>39</sup> Although the central government exercises influence through legislation and state subsidies, elected municipal bodies have considerable autonomy in shaping their service profiles.

Municipalities were authorized to raise taxes to finance their efforts, and this makes up the main source of funding for long-term care services, with national government grants to municipalities covering up to 12% of costs and a small share (3% to 4%) financed through co-payments and user fees, which are capped and based on income.<sup>40</sup>

1992 – ADEL Reform	
Before	After
County councils were responsible for the provision of long-term care for the elderly and disabled.	Municipalities were made responsible for the provision of long-term care for the elderly and disabled. They were permitted to raise taxes in order to fund their activities.

At this point, each county council and municipality was free to set its own tax rate at a level deemed sufficient to cover its health and other expenditures. During the severe public finance crisis of the 1980s and 1990s, however, the Swedish government mandated that county councils freeze their tax rates for two years, from 1991 to 1993.<sup>41</sup> Presently, more flexibility is permitted, but there are still mechanisms in place that discourage any rapid increase in health care spending. Indeed, county councils or municipalities that raise their yearly expenditures in health by more than 1% can see a reduction in their national grants.<sup>42</sup>

35. Johan Calltorp, "Sweden's 0-7-90-90 care guarantee – where simplicity meets pragmatism?" 2007, p. 12.

36. Anders Anell, Anna H. Glennard, and Sherry Merkur, *op. cit.*, footnote 10, p. 44.

37. World Health Organization, *op. cit.* footnote 26, p. 10.

38. *Idem.*

39. Ake Bergmark, *op. cit.*, footnote 27, p. 243.

40. OECD, "Sweden Long-term Care," May 18, 2011, p. 1.

41. Åke Blomqvist, *International Health Care Models: Sweden*, Standing Committee on Social Affairs, 2011, p. 6.

42. Elias Mossialos and Julian Le Grand, *Cost containment in the EU: an overview*, Routledge, 1999, p. 109; Miriam M. Willey, Mary A. Laschober, and Hellen Gelband, *Hospital Financing in Seven Countries*, Office of Technology Assessment, United States Congress, 1995, p. 126.

## 1994 – The Act on Freedom to Establish Private Practice and the Family Doctor Act

The Swedish health care system during the 1980s and the first half of the 1990s was characterized by a lack of freedom of choice of provider. Swedes only had access to the doctors and hospitals they were assigned to, meaning those serving the population of the area where they lived. As more and more citizens expressed their desire to have greater freedom to choose their health care provider, policy-makers addressed the issue by introducing two market-oriented reforms.

First, the *Act on Freedom to Establish Private Practice* removed the county council's ability to regulate the number of patients that could be treated by private practitioners and made the reimbursement of their services more flexible, thereby increasing the possibilities for establishing an independent practice.<sup>43</sup>

Previously, publicly funded private practitioners were obliged to have a contract with the county council in order to obtain public funding. Most often, funds were distributed to practices that positioned their services in areas with the greatest need. Through the *Act on Freedom to Establish Private Practice*, county councils could not refuse funding based on location.<sup>44</sup> In fact, conditions that needed to be met in order to be eligible for public funding were ultimately removed—county councils no longer had the authority to limit the number of private practices on their territory, nor their reimbursement.<sup>45</sup> Moreover, the method of reimbursement for all primary care doctors was changed from a salary, which was unaffected by the number of patients they served, to a system composed of a mix of capitation, fee-for-service, and performance-based reimbursements.<sup>46</sup> As a result, the number of patients seen by doctors rose,<sup>47</sup> as did the number of private practices.<sup>48</sup>

The second reform, the *Family Doctor Act*, was also aimed at expanding patient choice. It introduced the right of patients to select their primary care doctor and guaranteed that the chosen practitioner would become

the patient's regular physician.<sup>49</sup> This was intended to respond to public dissatisfaction surrounding the fact that when treated in a primary care centre, one could not count on being seen by the same doctor every time.<sup>50</sup> Establishing a steady doctor-patient relationship is a way of improving the quality of care, since diagnosis and treatment are likely to be more accurate when the doctor has a more complete knowledge of a patient's personal and medical history.

Another objective was to raise the productivity of primary-care doctors by making their income more directly dependent on the number of patients that chose them as their family doctor.

**The strong movement underway by the early 1990s toward a more patient-focused health care system in Sweden was accompanied by the need to cut costs. County councils thus began introducing a new form of funding for their hospitals.**

Soon after the implementation of these two reforms, however, the cost of funding the independent health care practitioners came to represent a significant proportion of overall health expenditures in some counties.<sup>51</sup> The increased expenditures were somewhat unexpected, since the intention was that the additional cost of providing for private care would be substantially offset by reductions in the cost of care provided through public primary care centres. One of the reasons this did not materialize is that it was difficult for county councils to lay off physicians who attracted few patients, due to Swedish labour legislation at the time.<sup>52</sup> The increased health expenditures, among other factors, prompted the Social Democratic Party to revoke these reforms when they came to power in 1995 and return to the previous system with reduced patient choice and less freedom to establish a publicly-funded private practice.<sup>53</sup>

43. European Observatory on Health Systems and Policies, *Building primary care in a changing Europe*, World Health Organization, 2015, p. 267.

44. Goran Dahlgren, "Reforms in Primary Health Care, Neoliberal Reforms in Swedish Primary Health Care: For Whom and For What Purpose?" *International Journal of Health Services*, Vol. 38, No. 4, 2008, p. 701.

45. World Health Organization, *op. cit.*, footnote 26, p. 56.

46. *Idem.*

47. Ragnar Lofgren, *op. cit.*, footnote 17, p. 23.

48. European Observatory on Health Systems and Policies, *op. cit.*, footnote 43, p. 267.

49. *Idem.*

50. Åke Blomqvist, *op. cit.*, footnote 41, p. 20.

51. *Ibid.*, p. 21.

52. *Idem.*

53. Ragnar Lofgren, *op. cit.*, footnote 17, p. 23; European Observatory on Health Systems and Policies, *op. cit.*, footnote 43, p. 267.

1994 – Act on Freedom to Establish Private Practice	
Before	After
Primary-care physicians were salaried employees of the county councils. Private practitioners could not freely establish a practice in the location of their choice and the number of patients they could treat per year was regulated by the county councils.	Primary-care practitioners were remunerated based on a mix of capitation, fee-for-service, and performance-based payments. County councils could no longer regulate the number of patients treated privately and could not refuse to fund private practices based on the location of their services.
WITHDRAWN IN 1995	

1994 – Family Doctor Act	
Before	After
Patients were assigned to the health care institution serving the population of their place of residence. Their physician was whoever was on duty the day of their visit with no guarantee that the same physician could continue to treat them.	Patients could choose their family physician out of a list of government-run and private providers. Once chosen, it was guaranteed that the same practitioner would continue to act as their primary health care provider upon every visit.
WITHDRAWN IN 1995	

### Phase III: 1995-2010, Reforms Targeting Patient Fees, Payment Mechanisms, and Patient Choice

#### 1995 – Hospital Funding Reform

The strong movement underway by the early 1990s toward a more patient-focused health care system in Sweden was accompanied by the need to cut costs.<sup>54</sup> County councils thus began introducing a new form of funding for their hospitals that could address both of

these issues, namely a Diagnosis-Related Group (DRG) scheme.<sup>55</sup>

Prior to this reform, hospitals were funded via global budgets that were negotiated ahead of time with county councils and in many cases relied on historical costs with little relation to the actual workload of the institution.<sup>56</sup> This form of financing provided few incentives to increase quality, stay within budget, or innovate, and also made it difficult for hospitals to respond promptly to unexpected surges in activity.<sup>57</sup>

A DRG funding system, in contrast, reimburses hospitals based on a patient classification system that standardizes the cost of treatment. Hospitals receive a fixed amount for each patient they treat based on the type of patient that was treated, the severity of the medical issues, and differences in rents of buildings and facilities, among other criteria.<sup>58</sup> DRG funding mechanisms thus encourage efficiency, but also cost containment, as hospitals receive a fixed price per procedure, regardless of how much it actually spends treating the patient. Therefore, if a hospital can effectively treat a patient at a lower cost than the DRG reimbursement, the institution can generate a profit. Alternatively, the hospital will incur a net loss if it is unable to provide the service at the determined rate, incentivizing it to become more efficient.

After introducing DRGs in Sweden, there was an increase in both productivity and quantity of services delivered. By one estimate, productivity increased by no less than 20% in the first two years following the reform.<sup>59</sup> The increased productivity was achieved through a reduction in average length of stay combined with faster patient turnover, and an increase in the number of operations, thereby reducing long wait lists. All of this was achieved without any evidence of patient selection, which is to say that physicians did not choose to treat only patients with mild medical issues.<sup>60</sup>

54. Lisbeth Serden and Mona Heurgren, "Sweden: The history, development and current use of DRGs," *Diagnosis-Related Groups in Europe: Moving Towards Transparency, Efficiency and Quality in Hospitals*, Open University Press, 2011, p. 340.

55. Clas Rehnberg, "The experience of the DRG-reimbursement system in the Stockholm county council," *Applied Health Economics Sweden*, March 27, 2012, p. 5.

56. *Ibid*, pp. 5-6.

57. UBC Centre for Health Services and Policy Research, "Current Hospital Funding in Canada: The Limitations of Global Budgets," February 2014, pp. 1-2.

58. Clas Rehnberg, *op. cit.*, footnote 55, p. 7.

59. Hennamari Mikkola, Ilmo Keskimaki, and Unto Hakkinen, "DRG-related prices applied in a public health care system – can Finland learn from Norway and Sweden?" *Health Policy*, Vol. 59, 2001, p. 42.

60. Natasa Mihailovic, Sanja Kocic, and Mihajlo Jakovljevic, "Review of Diagnosis-Related Group-Based Financing of Hospital Care," *Health Services Research and Managerial Epidemiology*, Vol. 3, 2016, p. 4.

Quality of care can therefore also be enhanced with this type of system because it makes the patient a source of revenue for hospitals instead of a cost. By having the money follow the patient, a degree of competition is introduced between hospitals that can now only secure their funding if they successfully attract patients.

Since Sweden's first DRG reimbursement model had no ceiling or production limits, volumes and productivity increased dramatically during the mid-1990s. Consequently, county councils registered large deficits as their service costs exceeded their revenues. Clearly, the system provided strong incentives for treating as many patients as possible, but it did not provide a means to contain costs. As such, in the late 1990s, a ceiling on production tailored to each hospital was introduced, thereby combining incentives to increase admission with a cap on total hospital costs.<sup>61</sup>

As of now, the DRG mechanism funds approximately 75% of all in-patient care, with the rest being financed by fixed payments to cover extra costs for extreme cases, payments for performance, and payment based on patient choice.<sup>62</sup>

1995 – Hospital Funding Reform	
Before	After
Hospitals were funded using block grants, a form of funding that transfers a lump-sum of money in advance. Block grants do not incentivize the improvement of clinical care and fail to take into account unexpected pressures on hospital activity such as increased patient demand.	County councils adopted DRG-based funding for their hospitals. Secondary care institutions received a fixed price for each patient treated based on the procedure itself and the type of patient receiving the care. If hospitals could provide the service at a lower cost than the regional rate, they could keep the difference.

### 1996, 2002, and 2009 – National Drug Reform

One of the first reforms to occur in the late 1990s was related to the pharmaceutical sector, specifically with regard to the distribution and reimbursement of prescription drugs. From 1980 to 1996, total spending on prescription medicines had been rising at an average

rate of 9.1% per year.<sup>63</sup> But between 1996 and 2009, the Swedish pharmacy market underwent a significant transformation, driven by a series of three reforms involving the introduction of competition between providers of prescription and over-the-counter medicines and aimed at tackling the rising cost of prescription drugs (see Figure 1-1).

Throughout this period, however, the cost of prescription drugs has continued to be shared between the government and the patient. Patients pay for a portion of their prescription drugs, known as a co-payment, with the rest being covered by the government. Over the course of a year, moreover, Swedes will never pay more than a cumulative 2,350 Swedish Krona (approximately \$341 CAD) for their medicines, as per the Swedish "high-cost protection."<sup>64</sup> Under this program, a deductible is paid for each prescription (barring certain exclusions) until SEK 2,350 has been reached. The amount of the deductible decreases gradually according to a "high-cost ladder" (see Box 1-1).

In 1996, the national Swedish government began to share responsibility for financing pharmaceutical consumption, and fully transferred the responsibility for reimbursing prescription drugs to county councils and patients. The decentralization process was intended to increase awareness among the county councils with regard to pharmaceutical spending and thereby reduce public drug expenditures.<sup>65</sup> As a result, the proportion of the total cost of prescription drugs paid by the patient rose to 27.8% as early as 1997, up from 21.1% one year earlier.<sup>66</sup> Still, the cost of reimbursing prescription drugs was a strain on public funds and continued to rise in the following years.

In 2002, Sweden thus introduced a new pricing and reimbursement scheme, and revised the conditions that must be met for a drug to be subsidized by the government.<sup>67</sup> Henceforth, new pharmaceuticals had to meet certain criteria related to cost-effectiveness to be eligible for public reimbursement. This was intended to link the social value of a given drug with its reimbursement

63. Author's calculations. Price increases based on US dollars per capita. OECD Data, Topic, Health, Pharmaceutical Spending, consulted November 8, 2021.

64. Vardguiden, Treatment & aids, Treatment with drugs, Getting a prescription and buying medicines, What do prescription drugs cost? consulted November 8, 2021.

65. Jonas Lundkvist, "Pricing and reimbursement of drugs in Sweden," *The European Journal of Health Economics*, Vol. 3, No. 1, 2002, p. 67.

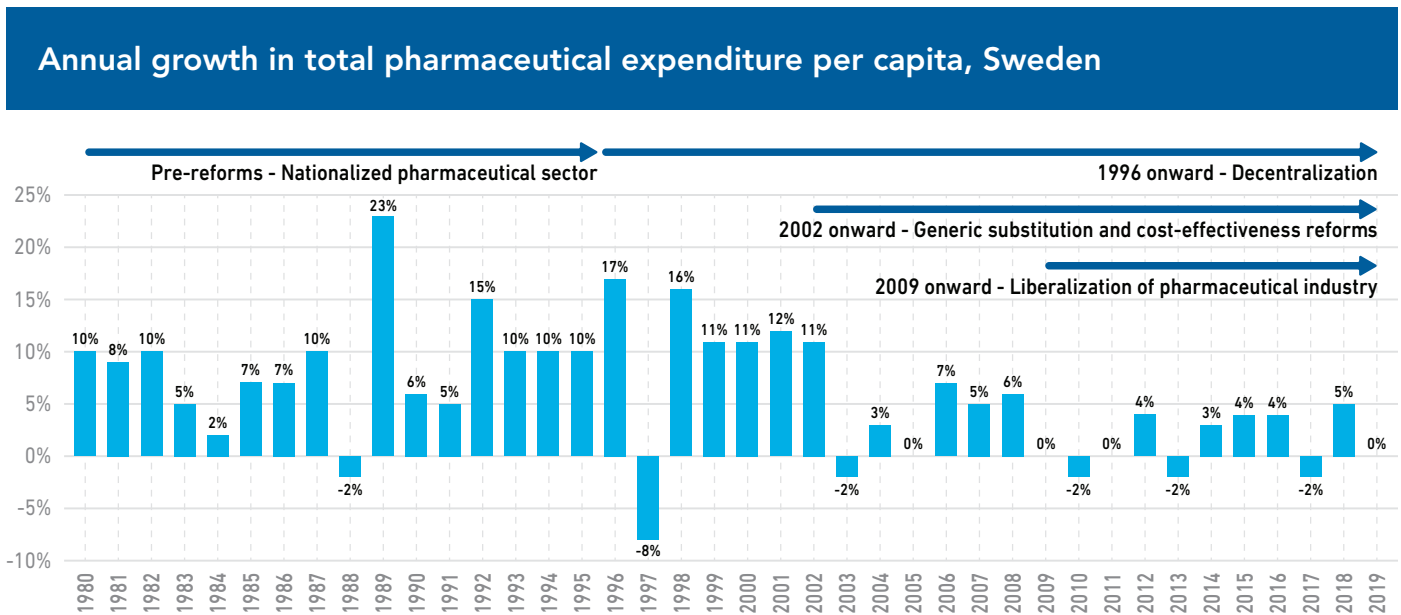
66. Ragnar Lofgren, *op. cit.*, footnote 17, p. 4.

67. Pierre Moïse and Elizabeth Docteur, *Pharmaceutical pricing and reimbursement policies in Sweden*, OECD Health Working Papers, No. 28, 2007, p. 46.

61. Clas Rehnberg, *op. cit.*, footnote 55, p. 6.

62. *Idem.*

Figure 1-1



**Note:** Price increases based on US dollars per capita.  
**Sources:** OECD Data, Topic, Health, Pharmaceutical Spending, consulted November 8, 2021.

price. It did not, however, guarantee a reduction in the cost of the reimbursement program. This was achieved through the second feature of the reimbursement scheme, namely the mandatory substitution of the lowest-cost generic alternative.<sup>68</sup>

The generic substitution policy was designed to achieve cost savings by encouraging price competition among generics. As of October 2002, pharmacies were obliged to substitute the drug a physician prescribed with the lowest-priced generic substitute, which significantly reduced pharmaceutical expenditures for both patients and county councils.<sup>69</sup> Since 2003, the average growth rate of per capita pharmaceutical spending has been just 1.9%, compared to the average of 9% observed in the decades before.<sup>70</sup> Indeed, the policy was successful in reducing generic prices by approximately 40% between 2002 and 2005.<sup>71</sup> As for patients, their average

yearly co-payment for all prescribed pharmaceuticals in Sweden had fallen 5% by 2004.<sup>72</sup>

Finally, in 2009, the pharmaceutical industry was deregulated.<sup>73</sup> Previously, the distribution and purchasing of pharmaceutical products was managed by a state-owned pharmacy, Apoteket, that had a monopoly on retail pharmacy sales, including over-the-counter products. This meant that grocery stores or supermarkets in Sweden were prohibited from selling non-prescription drugs such as acne treatment or even headache medicine.<sup>74</sup> Apoteket operated approximately 900 retail pharmacies, which represented one per every 10,000 inhabitants,<sup>75</sup> a relatively low ratio when compared to their European counterparts at the time.<sup>76</sup> Many who were critical of the monopoly noted that the price of non-prescription medicine was high, likely due to lack of competition.<sup>77</sup> Since deregulation, two-thirds of the

68. *Ibid.*, p. 48.

69. Karolina Andersson et al., *Impact of a generic substitution reform on patients' and society's expenditure for pharmaceuticals*, *Health Policy*, Vol. 81, Nos. 2-3, 2007, pp. 377 and 380.

70. Author's calculations. OECD Data, *op cit.*, footnote 63.

71. A. Engström, J. Jacob, and D. Lundin, "Sharp drop in prices after the introduction of generic substitution," *Pharmaceutical Benefits Board, Solna*, 2006, as cited in Pierre Moïse and Elizabeth Docteur, *op. cit.*, footnote 67, p. 22.

72. Author's calculations. Karolina Andersson, et al., *op. cit.*, footnote 69, p. 380.

73. Amina Ahmed Ibrahim, Beatrice Yola Konlaan, and Carol Nakajugo Basudde, *Are competitors ready to take on a deregulated Apoteket AB?* Mälardalen University, 2008, p. 20.

74. *Ibid.*, p. 3.

75. *Idem.*

76. Pierre Moïse and Elizabeth Docteur, *op. cit.*, footnote 67, p. 43; Pelle Neroth, "Sweden's state pharmacies may lose hold over drug sales," *The Lancet*, Vol. 365, 2005, p. 2079.

77. *Ibid.*

Box 1-1

## Swedish High-Cost Protection Scheme: Pharmaceuticals

At the beginning of the year, Swedes pay the full cost of their medicines, until they have spent a cumulative amount of SEK 1,175 (about \$171 CAD). The public subsidy is then activated according to the “high-cost ladder” and the discount system begins.

When the full cumulative cost of medicine is between SEK 1,175 and SEK 2,243 (approximately \$171 CAD – \$326 CAD), the patient pays 50% of the bill until they have paid a total of SEK 1,709 (\$248 CAD).

When the full cumulative cost of medicine is between SEK 2,244 and SEK 4,167 (about \$326 CAD – \$605 CAD), the patient pays 25% of the bill until they have paid a total of SEK 2,190 (about \$318 CAD).

Finally, when the full cumulative cost of medicine is between SEK 4,168 and SEK 5,767 (approximately \$605 CAD - \$837 CAD), the patient pays 10% of the bill, until they have paid the maximum of SEK 2,350 (approximately \$341 CAD). After this point, any additional prescription medicine is paid in full by government subsidies until the end of the year.

**Note:** Costs are approximate and based on current currency conversion from SEK.

**Source:** Vardguiden, Treatment & aids, Treatment with drugs, Getting a prescription and buying medicines, What do prescription drugs cost? Consulted November 29, 2021.

government-owned pharmacies have been sold to private actors, and over-the-counter medicines can be sold outside pharmacies.<sup>78</sup> Furthermore, the number of pharmacies has increased by approximately 34%, and the number of pharmacy operators rose above ten, compared to the previous monopoly situation with one single state-owned pharmacy chain.<sup>79</sup>

1996, 2002, and 2009 – National Drug Reform	
Before	After
The distribution of all pharmaceuticals, including over-the-counter medicines, was monopolized by a single state-owned pharmacy chain. The reimbursement of prescription medicines was the responsibility of the national government.	County councils became responsible for managing the budget for reimbursing pharmaceutical products. Over-the-counter medicines could be sold by other retailers, and pharmacies were deregulated, allowing entrepreneurs to operate them.

78. Bearing Point, “Increased profitability, sales and efficiency by transforming store operations,” Apotek Hjärtat, 2013, p. 2.

79. *Idem*.

### 1999 – Dental Care Reform

The oral health care system in Sweden underwent one of the most important reforms regarding patient fees. Between 1974 and 1999, the dental system was characterized by a nationwide uniform patient fee system applied to both the public and private sectors.<sup>80</sup> Dentists were reimbursed for their services on a fee-for-service basis according to an established schedule: The dental insurance fund paid one-half of the cost of total charges up to SEK 1,000, or about \$145 CAD.<sup>81</sup> For charges exceeding this amount, patients were reimbursed for 75%.

With the demand for dental services surging, putting a strain on public finances, the state dental tariff was abolished in 1999. From that point on, private dentists could establish their own pricing, while public dental service prices were set by each county council.<sup>82</sup>

80. Raimo Pälvärinne, Downen Birkhed, and Eeva Widström, “The Public Dental Service in Sweden: An Interview Study of Chief Dental Officers,” *Journal of International Society and Community Dentistry*, May 17, 2018, p. 206.

81. Leif Haanes-Olsen, “Social Security Abroad, Dental Insurance in Sweden,” Social Security Administrators, December 1973, p. 21.

82. Raimo Pälvärinne, Downen Birkhed, and Eeva Widström, *op. cit.*, footnote 80, p. 206.



## Box 1-2

## Swedish High-Cost Protection Scheme: Dental Care

At the beginning of the high-cost period of one year, Swedes pay the full cost of their dental care, minus their yearly dental allowance, until they have spent a cumulative SEK 3,000, or about \$435 CAD, out-of-pocket. The public subsidy is then activated.

A dental treatment that exceeds the predefined threshold sees Swedes paying 50% of the additional costs. Once the cost exceeds SEK 15,000, or about \$2,176 CAD, they pay 15% of the cost.

**Source:** Forsakringskassan, Private person, Dental care, Dental care support, consulted November 9, 2021.

In 2008, the reimbursement scheme was modified once more.<sup>83</sup> With this latest reform, all adults over the age of 23 years<sup>84</sup> receive an annual subsidy called “general dental care allowance” to cover part of the cost of their dental care.<sup>85</sup> The amount of the annual allowance varies depending on the age of the patient:

- Between 23 and 29 years of age, the allowance is SEK 600, or about \$87 CAD.
- For those aged between 30 and 64, the subsidy amounts to SEK 300, or about 44\$ CAD.
- For those aged 65 and up, the dental care allowance is SEK 600, or about \$87 CAD.

It is possible to roll the allowance over to the following year. However, it is not possible to save it for longer than the allotted additional year.

To ensure accessibility, dental care in Sweden is also subject to a high-cost protection scheme which prevents any patient from paying the full amount of an additional treatment when they have already paid a cumulative SEK 3,000, or about \$435 CAD, over a period of 12 consecutive months<sup>86</sup> (see Box 1-2).

Dentists and dental hygienists can decide for themselves what price to charge for the various examinations

and treatments they provide. Prices therefore differ from clinic to clinic, but typical fees can be found in Table 1-2.

### 1990-2000 – Delegation of Hospital Management

In the late 1990s and early 2000s, the management of several hospitals was delegated to entrepreneurs. One of the most well-known hospitals whose management and operation was contracted out to entrepreneurs is the Saint Göran hospital in Stockholm.<sup>87</sup>

Like all hospitals in Canada, the Saint Göran hospital in Stockholm was financed and managed by the government. But in 1999, as the hospital was slated for closure, the county of Stockholm decided to turn to private enterprise, namely a company called Capio, for the management of the day-to-day operation of the Saint Göran hospital.<sup>88</sup> From the patient's point of view, Saint Göran is no different from any other public hospital. The cost of treatment is subject to the same fee schedule as any other public institution, with the hospital nearly entirely funded by the government.

St. Göran, like all other Swedish hospitals, was granted significant latitude in the management of its operations. However, this hospital had the added advantage of being infused with Capio's culture, with its core strategy aimed at providing patients with quality care, and doing

83. *Idem*.

84. Dental care in Sweden is free for everyone under 23 years old.

85. Informationsverige, I have been granted a residence permit, Civic orientation, The book “About Sweden,” Looking After Your Health in Sweden, Dental care, consulted November 9, 2021.

86. Forsakringskassan, Private person, Dental care, Dental care support, consulted November 9, 2021.

87. European Observatory on Health Systems and Policies, Health Systems in Transition (HiT) profile of Sweden, Principal health reforms, consulted November 29, 2021.

88. Schumpeter, “A hospital case,” *The Economist*, May 18, 2013.

Table 1-2

Typical cost of select dental services in Sweden	
Medical Item	Cost*
Examination performed by a dentist	\$128 CAD
Examination performed by a dental hygienist	\$97 CAD
Tooth filling (front or canine)	\$114 CAD
Tooth filling (molar or pre-molar)	\$142 CAD
Root canal	\$595 CAD

\*Costs are approximate and based on current currency conversion from SEK.

Source: Folk tandvården, Treatment and prices, Prices, Price list general dental care, consulted November 9, 2021.

so efficiently in order to generate profits.<sup>89</sup> A constant focus on internal and external performance indicators has ensured the achievement of this objective, and throughout the years, Capio's obsession with care quality and optimization has resulted in significant productivity gains at Saint Görän. The company even ended up offering its services to its county at a price that was 10% below its previous level and that of comparable Stockholm hospitals, so certain was it of its methods.<sup>90</sup> In 2013, the contract between the county and the hospital was renewed until 2021.<sup>91</sup>

The Saint Görän emergency room has also been noted for its exceptional efficiency. The average wait time to see a doctor in 2019 was just 31 minutes, the shortest wait of any emergency hospitals in Stockholm.<sup>92</sup> The hospital also scored highest among emergency hospitals on indicators of quality for the fifth year in a row, and was awarded the title "Best hospital 2019" in the small hospitals (without obstetrics) category.<sup>93</sup> As for its employees, their degree of satisfaction is greater than

that of their counterparts in other Stockholm hospitals, evidenced by a low rate of medical staff turnover and the low number of sick days taken.<sup>94</sup>

### 2010 – Duplicate Health Insurance

In 2010, Sweden made duplicate health insurance available.<sup>95</sup> As of 2017, roughly 13% of all employed individuals aged 16 to 64 years had duplicate health insurance.<sup>96</sup> Mostly purchased by employers, its purpose is to avoid wait lists for elective procedures and guarantee rapid access to ambulatory care.<sup>97</sup> While the price of plans vary, they typically come to about \$580 CAD annually for one person.<sup>98</sup>

The percentage of Swedes with duplicate health insurance can be viewed as quite low. While the reasons for this are not entirely clear, part of the explanation is likely that almost all doctors who practise in the parallel health system on a full-time basis do so within the government-run

89. The Swedish system is highly decentralized, which allows local authorities to choose funding methods and care providers in their region. This autonomy extends to hospitals, which are fully responsible for the management of care and staff, including doctors, whom they can hire and fire. See Jasmin Guénette, Johan Hjertqvist, and Germain Belzile, "Health Care in Sweden: Decentralized, Autonomous, Competitive, and Universal," Viewpoint, MEI, June 2017, p. 1.

90. Capio, *Capio Annual Review 2013, 2014*, pp. 3 and 32, as cited in Patrick Déry and Jasmin Guénette, "Saint Görän: A Competitive Hospital in a Universal System," Economic Note, MEI, October 2017.

91. Schumpeter, *op. cit.*, footnote 88.

92. Ramsay Santé Press Room, "Capio St Goran's Hospital in Stockholm Becomes a University Healthcare Unit," April 8, 2020.

93. *Idem.*

94. Hälso- och sjukvårdsförvaltningen, Benchmarking av akutsjukhusens effektivitet – Kärnverksamheterna på Danderyds sjukhus, Capio St Görans sjukhus och Södersjukhuset, Stockholm läns landsting, March 31, 2015, pp. 8, 31, and 32; Capio, *Capio Annual Report 2016, 2017*, p. 57; Capio, *Capio Annual Report 2015, 2016*, pp. 38-39. Data confirmed by the Stockholm County Council 2017, as cited in Patrick Déry and Jasmin Guénette, *op. cit.*, footnote 90, p. 3.

95. Anna Sharudenko, "10 Facts About Healthcare in Sweden," The Borgen Project, July 13, 2020.

96. Swedish Insurance Federation, [www.svenskforsakring.se](http://www.svenskforsakring.se); accessed April 16, 2018 as cited in Roosa Tikkanen, et al., (eds.) *2020 International Profiles of Health Care Systems*, December 2020, p. 183.

97. Roosa Tikkanen, et al., *Ibid*, p. 184.

98. The cost is SEK 4,000. Wise, Living Abroad, Life in Sweden, Getting health insurance in Sweden: A complete guide, consulted November 9, 2021.

system, and their services are paid for through public insurance. Thus, the market for duplicate insurance is small simply because the availability of health services outside of the government-run system is limited.

## 2010 – Patient Choice Reform

Despite the numerous liberalizing reforms, patients still lacked the ability to choose their provider, as those seeking primary care or hospital services were assigned to a facility based on place of residence.

The withdrawal of the *Family Doctor Act* and the *Act on Freedom to Establish Private Practice* when the Social Democratic Party came to power in 1995 was seen as an “unfinished structural reform” for the primary care system that needed to be addressed.<sup>99</sup> Patient choice and the liberalization of primary care returned to the political agenda in the latter half of the 2000s. To remedy the lack of choice, ten county councils took it upon themselves to reform their health care systems by introducing measures that expanded patient choice of provider. The movement led by the county councils ultimately inspired the national government that came into office in 2006 to take action.<sup>100</sup> Choice of primary care provider for residents together with freedom of establishment for accredited independent providers became mandatory in 2010 through the *Patient Choice Act*.<sup>101</sup> An important difference, when compared to the short-lived 1994 changes, is that the new reforms were initiated by individual county councils rather than imposed by the national government. This compelled the national government to allow for more flexibility in the implementation of its legislation, meaning different models could be adopted by different county councils.<sup>102</sup>

As of 2010, a county council could no longer prevent a practitioner from establishing a private practice.<sup>103</sup> The county council's regulatory power was revoked and it could no longer decide how many or which private practices were eligible to obtain public funding for their services. The requirements for funding were no longer centred around the location of services, but primarily focused on the minimum number of clinical services provided

by the primary care unit.<sup>104</sup> While private practitioners are now free to establish their practice, public funding is not guaranteed, since compensation is on a capitation basis, meaning it is contingent on the provider's ability to attract patients. In many county councils, as a means to prevent independent clinics from enlisting patients that are less-burdensome or that have low-maintenance health needs, the capitation payments were adjusted to reflect the age of the clinic's registered patients and other socioeconomic conditions.<sup>105</sup>

**In the late 1990s and early 2000s, the management of several hospitals was delegated to entrepreneurs. In 2010, Sweden made duplicate health insurance available, and choice of primary care provider through the Patient Choice Act.**

In just eight months, the number of new primary care centres increased by 23%, with some 223 new clinics being established across the country.<sup>106</sup> Of the total number of 1,200 primary care practices, 40% are now independently owned, either by national health care corporations or by practitioners themselves as a cooperative, with the remaining 60% belonging to the county councils.<sup>107</sup> With a greater number of providers, competition between units increased, creating an incentive to improve the quality of the services offered to patients. In many cases, primary care centres prolonged their office hours to accommodate their patients, expanding access to such services.<sup>108</sup>

An evaluation of the reform in Stockholm indicated that the use of primary care services<sup>109</sup> increased in all age groups, and even more so in low-income areas as well as in demanding patient groups (e.g., those with multiple

99. Anders Anell, Anna H. Glenngard, and Sherry Merkur, *op cit.*, footnote 10, p. 111.

100. *Idem.*

101. *Ibid.*, p. 44.

102. *Ibid.*, p. 111.

103. Prop. 2008/09:74 (2008) Vårdval i primärvården [Patient Choice in Primary Care]. Stockholm: Socialdepartementet as cited in Ulrika Winblad, David Isaksson, and Paula Blomqvist, “Preserving social equity in marketized primary care: strategies in Sweden,” Cambridge University Press, August 2020, pp. 219-220.

104. Ulrika Winblad, David Isaksson, and Paula Blomqvist, *Ibid.*, pp. 219-225.

105. *Ibid.*, pp. 222-224.

106. Swedish Competition Authority, *Uppföljning av vårdval i primärvården – Valfrihet, mångfald och etableringsförutsättningar. Slutrapport [Study of privatization and choice in primary care. Final report]*. Stockholm, Konkurrensverket, 2010 as cited in Anders Anell, Anna H. Glenngard, and Sherry Merkur, *op. cit.*, footnote 10, p. 111.

107. Roosa Tikkanen, *et al.*, *op. cit.*, footnote 96, p. 184.

108. Swedish Competition Authority, *Uppföljning av vårdval i primärvården – Valfrihet, mångfald och etableringsförutsättningar. Slutrapport [Study of privatization and choice in primary care. Final report]*. Stockholm, Konkurrensverket, 2010 as cited in Anders Anell, Anna H. Glenngard, and Sherry Merkur, *op. cit.*, footnote 10, p. 112.

109. Measured by weighted patient visits.

chronic illnesses).<sup>110</sup> This indicates that, contrary to the popular misconception that an independent or parallel sector favours access only to the more privileged and healthy population, the reforms in fact improved the distribution of services for those less socioeconomically advantaged areas, and in more complex and demanding patient groups.<sup>111</sup>

2010 – Patient Choice Reform	
Before	After
Until this reform, county councils had the authority to determine if and where private practices could establish themselves. Resources were therefore allocated by the government. Consequently, almost all primary care centres in Sweden were owned and operated exclusively by county councils.	As a result of the reform, private health care providers could establish themselves freely, effectively depriving county councils of their previous control over the number of independent primary care centres on their territory, and their location.

110. Anders Anell, Anna H. Glenngard, and Sherry Merkur, *op. cit.*, footnote 10, p. 112.

111. *Idem.*

## Box 1-3

## Sweden Reforms

### Before Liberalization

Sweden's health care system underwent a wave of nationalization and a rapid expansion of hospitals and primary health care, but had little room for private practitioners to operate in parallel to the public health care system. The "Seven Crowns" reform made private office practice less attractive to patients.

### Phase I: 1982-1991 – Decentralization and Cost Containment

**1982 – Health and Medical Services Act:** Made county councils responsible for the delivery and funding of all health care services in their respective jurisdictions.

**1985 – Dagmar Reform:** Reinforced the county councils' responsibility in the provision of care and changed the way private practitioners were remunerated. County councils were granted population-based sums to pay for privately produced care and were given the authority to decide which private practices were eligible for reimbursement and how many patients they could treat.

### Phase II: 1991-1995 – Focus on Accessibility and Populations with Specific Needs

**1992 – Patient Choice and Care Guarantee:** Patients gained the right to choose to be treated elsewhere if they have waited for longer than guaranteed by the national government.

**1992 – ADEL Reform:** Municipalities were made responsible for the provision of long-term care for the elderly and disabled.

**1994 – The Act on Freedom to Establish Private Practice:** Was withdrawn in 1995, but temporarily removed the county councils' ability to regulate the number of patients treated privately and could no longer refuse to fund private practices based on the location of their services.

**1994 – The Family Doctor Act:** Was withdrawn in 1995, but temporarily provided patients with the freedom to choose their family physician out of a list of government run and independent providers.

### Phase III: 1995-2010 – Reforms Targeting Patient Fees, Payment Mechanisms, and Patient Choice

**1995 – Hospital Funding Reform:** County councils adopted activity-based funding, namely a Diagnosis-Related Group scheme, for their hospital system, effectively forgoing block grants based on historical activity.

**1996, 2002, and 2009 – National Drug Reform:** Over the course of several years, the prescription drug program underwent numerous reforms. First, the responsibility for reimbursing prescription drugs was transferred to county councils and patients. Second, a new pricing and reimbursement scheme that took into consideration the cost-effectiveness and social value of new pharmaceuticals was introduced. Lastly, the distribution of prescription drugs was deregulated, meaning the state-owned pharmacy chain no longer had a monopoly on retail pharmacy sales, including over-the-counter products.

**1999 – Dental Care Reform:** Gave private dentists the ability to establish their own pricing. Adults over the age of 23 received an annual dental care allowance to cover part of their dental care.

**1990-2000 – Delegation of Hospital Management:** The management of several hospitals was delegated to entrepreneurs. These hospitals were henceforth managed by entrepreneurs. Care therefore remained free at point of service (aside from the nominal fees found in any public institution).

**2010 – Duplicate Health Insurance:** Sweden made duplicate health insurance available to its citizens. By 2017, approximately 13% of all employed individuals aged 16 to 64 years had duplicate health insurance.

**2010 – Patient Choice Act:** Choice of primary care provider for residents together with freedom of establishment for accredited private providers became mandatory. Patients were thereafter free to choose their provider of primary care, and private health care providers could establish themselves freely. County councils were effectively stripped of their previous control over the number and location of private primary care centres on their territory.

Box 1-4

## The Primary Care System in Sweden Today

There are two types of private health care in Sweden:

1. Health care services provided by a company under contract with the county council, local authority or municipality. In the event of such contract, the cost of private and public health care is the same and regulated according to a fee schedule established by each county council. Both government run and independent providers of primary care are thus funded through taxes, but the money ultimately follows the patient, since free choice of provider was made mandatory in 2010. Companies compete alongside public facilities for government funding and the right to provide health care to Swedish citizens.
2. Health care services provided by a private company under no contract with local government. Patients are then liable to pay for the full cost of any treatment and care received. Duplicate insurance is available to cover part of the cost of treatment.

As opposed to many provinces in Canada, there is no regulation prohibiting physicians, specialists, or other staff from also seeing patients outside the public hospital or primary care practice. Employers of health care professionals, however, may establish such rules for their employees.

While health care, whether government run or independent, is widely available and funded by taxes, there are small fees associated with many services (with the exception of those aged 20 years or younger and those qualified as a vulnerable person). County councils determine the prices for care in their region, but some typical fees for health services in Sweden are as follows:

Medical Item	Cost in Sweden
Hospitalization*	SEK 50 - 100 (approximately \$7.46 - \$14.92 CAD)
Primary care visit*	SEK 150 - 300 (approximately \$22.38 - \$44.76 CAD)
Outpatient specialist visit (ex: gynecologist, pediatrician)**	SEK 230 - 320 (approximately \$35.05 - \$48.76 CAD)
Emergency room visit***	SEK 300 (approximately \$45.60 CAD)

\*Data is from 2018 / \*\*Data is from 2011 / \*\*\*Data is from 2017

Among primary care centres, there is competition between providers (public and private) to attract patients to register with their facilities rather than another due to the patient choice reform. However, providers cannot compete through pricing because regions set patient fees. They therefore compete through quality of service, to the benefit of the patient.

Similar to the dental and pharmaceutical sectors, consultations with a specialist are subject to high-cost protection. The patient will therefore never pay a cumulative amount surpassing SEK 1,100 (about \$158.07 CAD) a year for services delivered by a medical specialist in a publicly funded health institution.

**Note:** Costs are approximate and based on average currency conversions from SEK for year indicated.

**Sources:** Socialstyrelsen, About us, Healthcare for visitors to Sweden, About the Swedish healthcare system, consulted November 12, 2021; Roosa Tikkanen, et. al., "2020 International Profiles of Health Care Systems," December 2020, pp. 184-185; Anders Anell, Anna H Glenngard, and Sherry Merkur, *Health Systems in Transition: Sweden Health system review*, European Observatory on Health Systems and Policies, Vol. 14, No. 5, 2012, pp. 62-63; Wise, Living Abroad, Life in Sweden, Healthcare in Sweden: A guide to the Swedish healthcare system, consulted November 26, 2021.

## UK Case Study

### Before Liberalization

Health coverage in the United Kingdom has been universal since the creation of the National Health Service (NHS) in 1948.<sup>112</sup> Much like in Canada, the fundamental principles underlying the creation of the NHS were that services would be funded predominantly through taxation and that they would be available to all, regardless of ability to pay. Contrary to Canada, though, a small but significant privately-funded health care system has always coexisted with the NHS.<sup>113</sup>

Similarly, roughly from the time of its founding, the NHS has allowed, and at times even encouraged, the development of a parallel insurance market.<sup>114</sup> In 2015, an estimated 10.5% of the UK population had duplicate health insurance.<sup>115</sup> While costs vary, the average premium for duplicate health insurance in the UK is approximately £1,155 (or just over \$1,900 CAD) a year.<sup>116</sup>

Prior to the liberalization of the NHS, and especially during the 1950s, hospitals were managed through directives passed down a chain of command from the central government to local hospital boards.<sup>117</sup> Hospital administrators' main tasks were to ensure that the institutions were clean and well-maintained, but did not include ensuring that the hospitals functioned efficiently.<sup>118</sup> Hospital funding was determined on the basis of historical budgets, which meant that a hospital received a set amount of money, typically a yearly budget. A hospital with a patient load that was "too high" could request extra funds, but there was no guarantee these would be granted because budgets had to be negotiated politically, as with all government budgets.<sup>119</sup> Hospitals there-

fore had an obvious incentive to reduce the number of patients they treated in order to save money. As we shall see below, however, in the early 2000s, the hospital funding mechanism in England was reformed in order to ensure that resources were distributed to hospitals in a way that matched the needs of the patients they treated.<sup>120</sup> Meanwhile in Canada, hospitals are still primarily funded through historical budgets to this day.<sup>121</sup>

**The NHS began investing in information management systems to improve the quality of hospital managers' decision-making, which sent a clear signal that a business-like approach was being introduced.**

By the 1970s, the health care system in the UK was being described as "a rigid organisation with too many layers of decision making."<sup>122</sup> Despite some reform efforts, health authorities did not account adequately for the numerous layers of management that existed within hospitals and community services. For instance, ward-level nurses<sup>123</sup> could have as many as four layers of management to climb through before reaching even the local health authorities.<sup>124</sup> Reducing excess bureaucracy and management costs therefore became a priority in the early 1980s. This was done by removing a tier of management and by involving practitioners in the process of deciding how to allocate resources, since doctors were the ones who actually spent the money for patient care.<sup>125</sup> The NHS also began investing in information management systems to improve the quality of hospital managers' decision-making, which sent a clear signal that a business-like approach was being introduced into the provision of hospital services.<sup>126</sup>

112. Konstantina Grosios, Peter B. Gahan, and Jane Burbidge, "Overview of healthcare in the UK," *EPMA Journal*, Vol. 1, No. 4, 2010, p. 1.

113. Peter Greengross, Ken Grant, and Elizabeth Collini, *The History and Development of the UK National Health Service 1948 – 1999*, DFID Health Systems Resource Centre, July 1999, p. 6.

114. Carl Emmerson, Christine Frayne, and Alissa Goodman, "Should private medical insurance be subsidised?" 2001, p. 52.

115. Roosa Tikkanen, et al., *op. cit.*, footnote 96, p. 60.

116. Irina Wells, "What does Private Health Insurance cost?" Bought By Many, November 11, 2021.

117. Peter Greengross, Ken Grant, and Elizabeth Collini, *op. cit.*, footnote 113, p. 7.

118. *Idem.*

119. Peter St. Onge, *For a Strong and Resilient Post-COVID Health Care System – Reforms to Expand Surge Capacity*, Research Paper, MEI, December 2020, p. 35.

120. Seán Boyle, *United Kingdom (England) Health system review*, Health Systems in Transition, European Observatory on Health Systems and Policies, Vol. 13, No. 1, 2011, p. 115.

121. Peter St. Onge, *op. cit.*, footnote 119, p. 35.

122. Peter Greengross, Ken Grant, and Elizabeth Collini, *op. cit.*, footnote 113, p. 9.

123. Ward-level nurses are without specialization, as opposed to nurse midwives or nurse practitioners. Their duties can include observing and recording patient outcomes, administering medication, etc. They can provide instruction and educate licensed vocational nurses and nurses' aides.

124. Peter Greengross, Ken Grant, and Elizabeth Collini, *op. cit.*, footnote 113, p. 9.

125. Department of Health and Social Security Steering Group on Health Services Information (Chaired by Edith Korner), reports from 1982 onward, HMSO, London, as cited in Peter Greengross, Ken Grant, and Elizabeth Collini, *op. cit.*, footnote 113, p. 11.

126. Peter Greengross, Ken Grant, and Elizabeth Collini, *op. cit.*, footnote 113, p. 11.

## Beginning of the Reforms

In the 1990s, there was an international political movement to use competition to reform inefficient and unresponsive public services.<sup>127</sup> Margaret Thatcher led the movement in the United Kingdom, implementing a profound structural reform of the social services sector. Her public-sector reforms applied business principles to the welfare state and prepared the National Health Service for its subsequent liberalization and privatization.

## Phase I: 1990-1997, Internal Markets and the Purchaser-Provider Split

### 1990 – National Health Service and Community Care Act

The *National Health Service and Community Care Act of 1990* was one of the most radical and significant reforms of the NHS since its inception. It introduced what was henceforth known as an “internal market,” within which the health care system would be structured around a novel separation of the roles of purchaser and provider of health services.<sup>128</sup> The purchasers, called district health authorities (DHA) at the time, received government funds on a capitation basis, meaning the amount of money they received would depend on the needs of the population served.<sup>129</sup> DHAs had the liberty to purchase hospital and community health services from any provider, whether government owned or independent. The providers, such as acute care hospitals or mental health facilities, had to compete for funds, and would become independent “trusts” practically free of DHA control and intervention if they were able to conclude an agreement with their DHA.<sup>130</sup> The legislation was intended to increase collaboration between entrepreneurs and government-run agencies and improve the efficiency and quality of services by drawing on the principles of a competitive market.

One of the most significant changes with regard to the purchaser-provider split was the introduction of General Practice (GP) fundholding, which allowed GP practices with 3,000 or more patients to apply for their own NHS budgets and keep any surplus they generated. The

budgets were used to cover their staff costs, prescribing, outpatient care, and a defined range of hospital services (mainly elective surgery).<sup>131</sup> To become a fundholder and benefit from the freedom it brought, practices were required to meet strict criteria, such as the demonstration of commitment, good management skills, and possession of a business plan.<sup>132</sup> By 1998, over 4,000 practices, representing 57% of primary care practices, had become fundholders,<sup>133</sup> up from the initial 300 practices that signed on in 1991.<sup>134</sup> Non-fundholder GPs had their services purchased for them by local health authorities, meaning these GPs could not refer a patient outside their local area, whereas GP fundholders became “purchasers” of services on behalf of their patient and could refer them to the hospital of their choosing, such as the one with shorter wait lists, for instance.<sup>135</sup>

**The National Health Service and Community Care Act of 1990 introduced an “internal market,” within which the health care system would be structured around a novel separation of the roles of purchaser and provider of health services.**

Despite their scope, the reforms preserved the principle of health care being free at point of use. However, the creation of the first “internal market” did not deliver the degree of measurable change that was anticipated, for several reasons. First, the internal market reforms were rolled out rapidly with very little guidance, making it difficult for existing medical service providers to adapt.<sup>136</sup> Guidance on how to navigate the internal market was only published a few years later, in 1994. The government also did not produce any pilot studies to determine the best method of implementation or to identify potential issues.<sup>137</sup> Similarly, groups such as the British

127. Alex Ingrams, Suzanne Piotrowski, and Daniel Berliner, “Learning from Our Mistakes: Public Management Reform and the Hope of Open Government,” *Perspectives on Public Management and Governance*, 2020, p. 259.

128. Nicholas Mays, Anna Dixon, and Lorelei Jones, “Return to the market: objectives and evolution of New Labour’s market reforms,” Kings Fund, 2011, pp. 1-3.

129. *Ibid.*, p. 3.

130. *Idem.*

131. *Idem.*; “National Health Service and Community Care Act 1990,” The Health Foundation, June 29, 1990.

132. Adrien Kay, “The abolition of the GP fundholding scheme: a lesson in evidence-based policy making,” *British Journal of General Practice*, February 2001, p. 141.

133. *Idem.*

134. Stephen Harrison and Nabila Choudhry, “General Practice Fundholding in the UK National Health Service: Evidence to Date,” *Journal of Public Health Policy*, Vol. 17, No. 3, 1996, p. 334.

135. Secretary of State for Health, *The NHS Plan: A plan for investment, A plan for reform*, National Health Service, July 2000, p. 89.

136. Peter Dragoonis, “Have new NHS market reforms learned from failings of old?” *London Journal of Primary Care*, Vol. 2, No. 2, December 2009, p. 153.

137. *Idem.*



Medical Association were not consulted prior to the changes.<sup>138</sup>

There were also some problematic operational features. For instance, contrary to what was intended with the purchaser-provider split, funds did not end up following the patient due to the absence of patient choice and the global funding mechanisms that were still in place for providers.<sup>139</sup> Another operational issue was the large amount of political involvement. Politicians were reluctant to delegate decision-making to managers and doctors, as their careers were on the line and depended on the success of the program.<sup>140</sup> Political intervention also diluted the incentive to compete due to the fact that, unlike in true markets, hospitals that underperformed relative to their competition were kept alive artificially.<sup>141</sup>

This unsuccessful attempt at introducing an internal market within a publicly funded health care system provides lessons for others wanting to incorporate an internal market. Whatever the *National Health Service and Community Care Act* might have failed to achieve, it nonetheless fundamentally changed the operations and even the culture of the NHS. For instance, providers had to become far more aware of the quality and cost of the care they gave their patients. As for purchasers, they came to question the traditional ways of delivering services and encouraged providers to think of new models of care that prioritized the needs of patients.

## Phase II: 1997-2012, Devolution of Political Power and a Second Attempt at Internal Markets

### 1997 – Creation of Independent Governments

The election of the Labour government in 1997 resulted in further reorganization of health services in the United Kingdom, but also led to the creation of autonomous, elected governments for England, Northern Ireland, Scotland, and Wales.<sup>142</sup> This devolution of political power has brought about increasingly diverse health

systems and distinct approaches to health care across the United Kingdom.

England, for its part, has made great efforts to decentralize its system, strengthen the internal market, and increase local control. Scotland and Wales, in contrast, have centralized their systems. Scotland contrasts most starkly with England in sticking to its strong tradition of public health care, whereas English health policy-makers have chosen to foster higher quality care through through partnerships with entrepreneurs and internal competition.<sup>143</sup>

**The Labour Party ensured that the money followed the patient by introducing patient choice and a reimagined funding mechanism for providers, namely Payment by Results.**

Given the nature of England's health care system and the fact that it represents nearly 85%<sup>144</sup> of the United Kingdom's population, the reforms presented hereafter will be those that were implemented in England.

### 1997 – Beginning of the Labour Party Health Reforms

The reforms introduced by the Labour Party upon its election shifted the focus from a competitive environment to cooperation between entrepreneurs and the public sector.<sup>145</sup> Yet while the newly elected government called for the abolishment of the internal market, it still did not systematically revert to the centralized approach of previous Labour governments. Indeed, the subsequent reforms shared the same objectives as those introduced previously—to create stronger incentives to improve performance—but attempted to correct the shortcomings of the first internal market. As such, market mechanisms and inter-institutional competition as a driver for improvement prevailed throughout the 1990s in the NHS.<sup>146</sup>

The new health reform program, unlike the previous attempt, underwent much longer planning and preparation. While initial plans were already being drawn up by

138. Jeremy Lee-Potter, *A Damn Bad Business: The NHS Deformed*, London: Trafalgar Square, 1997 as cited in Peter Dragoonis, *op. cit.*, footnote 136, p. 153.

139. Peter Dragoonis, *op. cit.*, footnote 136, p. 154.

140. Richard Q. Lewis, "Back to the future?" *BMJ*, 2004, as cited in Peter Dragoonis, *op. cit.*, footnote 136, p. 154.

141. Julian LeGrand, "Competition, cooperation, or control? Tales from the British National Health Service," *Health Affairs*, Vol. 18, No. 3, 1999, p. 33.

142. European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, Health Systems in Transition (HiT) profile of United Kingdom, consulted November 12, 2021.

143. *Idem.*

144. Author's calculations. Office for National Statistics, "Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2020," July 26, 2021, p. 14.

145. Labour Party, *New Labour Because Britain Deserves Better (1997 General Election Manifesto)*, Labour Party, 1997, as cited in Peter Dragoonis, *op. cit.*, footnote 136, p. 153.

146. Peter Dragoonis, *op. cit.*, footnote 136, p. 153.

2000, it was not until eight years later that the full effects and operations were in place.<sup>147</sup> The new reforms were implemented in a more controlled and gradual manner, with pilot studies undertaken across the country, especially to determine how introducing patient choice and new payment mechanisms could work in favour of all parties involved. Professionals from the health sector were also involved in the redesign and implementation of the reforms, along with expert management consultants.<sup>148</sup>

The Labour Party also addressed the operational features that were problematic during the Thatcher era.<sup>149</sup> They ensured that the money followed the patient by introducing patient choice and a reimagined funding mechanism for providers, namely Payment by Results. Hospitals henceforth only received payments for services they actually delivered, taking into account the complexity of patients' health care needs, thus creating an incentive to provide services not just for those with simpler health needs.<sup>150</sup> Hospitals therefore had to work to attract patients, who had a newfound ability to choose, in order to generate revenue. They could do so by making sure they provided key facilities that patients want, such as adequate meals, high success rates, and low infection rates. Competition between institutions was further reinforced by the use of entrepreneurs in the provision of clinical care, taking competition one step further than the prior internal market, which concentrated its outsourcing efforts on peripheral services such as cleaning.<sup>151</sup> In fact, between 1997 and 2009, total expenditures on the purchase of health care from non-government providers increased six-fold,<sup>152</sup> reflecting the government's decision to encourage greater use of the parallel health system.

In an attempt to reduce political involvement, a greater degree of managerialism was introduced into the NHS, putting expert managers in charge of health services. Decision-making was also decentralized to the best-performing hospitals. These were granted more freedom to operate as they saw fit, whereas the management of underperforming hospitals was assigned to outside teams. Lastly, greater efficiency was achieved by

expanding the roles of key medical professionals. For instance, in 2000, a set budget was established for training purposes, and by 2006, some 19,000 practising nurses had been trained as independent prescribers able to prescribe medicines.<sup>153</sup>

### 1998 – Abolishment of General Practice Fundholding

One of the first changes made by the Labour Party to the health care system in England was the removal of General Practice fundholding, seven years after its inception.<sup>154</sup> The idea was to restore choice of referrals to general practitioners, a privilege that had been removed from non-fundholding GPs. The GP fundholding scheme was replaced by nearly 500 Primary Care Groups (PCGs), each serving approximately 100,000 people and containing up to seven local general practices.<sup>155</sup> General practices therefore became providers of health care services rather than purchasers. Upon creation of the PCGs, their main responsibility was to advise health authorities on how best to commission health services for their population.

**Competition between institutions was reinforced by the use of entrepreneurs in the provision of clinical care, taking competition one step further than the prior internal market.**

The intention, however, was that these PCGs would develop over time and become Primary Care Trusts (PCTs) with additional responsibilities.<sup>156</sup> Once PCGs demonstrated they could manage budgets and services, they became PCTs and were considered freestanding bodies accountable to the health authority for commissioning care, with the responsibility for the provision of primary, secondary, and community-based health care. They could employ and manage staff as well as commission services from other providers.<sup>157</sup> Each PCT's budget from the Department of Health was calculated using a

147. Department of Health, *Delivering the NHS Plan*, The Stationery Office, 2002, as cited in Peter Dragoonis, *op. cit.*, footnote 136, p. 155.

148. Peter Dragoonis, *op. cit.*, footnote 136, p. 155.

149. *Ibid.*, pp. 155-156.

150. National Health Service, *A simple guide to Payment by Results*, Department of Health, November 2012, p. 8.

151. Peter Dragoonis, *op. cit.*, footnote 136, p. 156.

152. Seán Boyle, *op. cit.*, footnote 120, p. 113.

153. Secretary of State for Health, *op. cit.*, footnote 135, p. 12; National Institute for Health Research, "Nurses and pharmacists can prescribe as effectively as doctors," March 21, 2017.

154. Adrian Kay, "The abolition of the GP fundholding scheme: a lesson in evidence-based policy making," *British Journal of General Practice*, February 2002, p. 141.

155. David Wilkin and Anna Coleman, "From primary care groups to primary care trusts in the new NHS in England," Cambridge University Press, October 31, 2006, p. 216.

156. *Idem.*

157. *Idem.*

formula taking into account population and specific local needs.<sup>158</sup> The trusts would then sub-divide their allocations among local providers such as hospitals (also known as NHS Trusts), GPs, and private providers.<sup>159</sup> In fact, any provider that could deliver services to NHS standards at the NHS tariff could apply to be included in the list of choices of hospital offered to patients for elective referral.<sup>160</sup> By 2013, over 80% of funding for health services in England was allocated from the Department of Health to PCTs.<sup>161</sup> The purchaser-provider split was therefore maintained, but there were no longer two types of purchasers of primary care, as with fundholding and non-fundholding GPs where the funding was allocated on a practice-level only.

1998 – Primary Care Groups	
Before	After
General practices that became fundholders would obtain their own NHS budget and become purchasers as well as providers of primary care.	Primary care groups, later becoming primary care trusts, were responsible for the commissioning of primary, secondary, and community-based health care. General practices became providers of health care, rather than purchasers and providers at once. Each general practice was free to refer their patients to the secondary care provider of their choosing.

### 2003 – Community Health and Standards Act

The *Community Health and Standards Act* provided for the establishment of NHS Foundation Trusts, a new type of NHS hospital that took decision-making away from the central government and gave it to local communities.<sup>162</sup> NHS Foundation Trusts are providers of secondary

care<sup>163</sup> (e.g., hospital care, emergency services, specialized care, home visits, mental health care, etc.) whose services are purchased by PCTs.<sup>164</sup>

NHS Trusts were designed to “reflect the spirit of public sector enterprise.”<sup>165</sup> NHS Foundation Trusts are part of the public system, but have greater financial and management liberty, including the ability to retain surpluses, invest in the delivery of new services, manage and reward their staff flexibly, and access a wider range of options for capital funding. NHS Foundation Trusts were given the authority to borrow to support their needs in terms of capacity and to improve services, as long as they could afford it, without needing to seek external approval.<sup>166</sup>

NHS Foundation Trusts were designed to establish stronger connections between hospitals and their local communities, which obtained social ownership of their NHS Foundation Trust. Those living in communities served by a hospital of an NHS Foundation Trust were invited to become a member. The intention was to ensure that hospital services more accurately reflect the needs and expectations of the local population.<sup>167</sup>

To become an NHS Foundation Trust, existing acute care or specialist hospitals had to meet strict criteria, including a three-star rating in the annual NHS performance ratings maintained throughout the application process, proof that the institution has strong leadership, and a commitment to modernizing services for patients and local communities.<sup>168</sup> Star ratings were launched in 2001 as part of a government initiative to provide patients with comprehensive information on the performance of their local hospitals.<sup>169</sup> Institutions with a three-star rating outperformed other hospitals with regard to key performance indicators, such as wait times, delayed discharges, staff opinions, re-admission rates, etc.<sup>170</sup>

158. Seán Boyle, *op. cit.*, footnote 120, p. 23.

159. *Ibid.*, p. 28.

160. *Ibid.*, p. 114.

161. Louise Marshall, Anita Charlesworth, and Jeremy Hurst, *The NHS payment system: evolving policy and emerging evidence*, Nuffield Trust, February 2014, p. 12.

162. Policy Navigator, “The Health and Social Care (Community Health and Standards) Act 2003,” The Health Foundation, November 20, 2003; Department of Health, “A Short Guide to NHS Foundation Trust,” NHS, 2005, p. 4.

163. NHS Data Dictionary, NHS Data Model and Dictionary, NHS Foundation Trusts, consulted December 6, 2021.

164. Department of Health, *op. cit.*, footnote 162, p. 11.

165. Policy Navigator, *op. cit.*, footnote 162.

166. Nuffield Trust, “A Short Guide to NHS Foundation Trusts,” Department of Health, November 2019, p. 7.

167. *Ibid.*, pp. 1-3.

168. *Ibid.*, p. 8.

169. Russell Mannion, Huw Davies, and Martin Marshall, “Impact of star performance ratings in English acute hospital trusts,” *Journal of Health Services Research & Policy*, February 2005, p. 18.

170. *Ibid.*, p. 19.

The first ten foundation trusts were established on April 1<sup>st</sup>, 2004. It was thought at the time that all eligible hospitals would become foundation trusts by 2008, but this did not materialize.<sup>171</sup> As of 2017, approximately 60% of government-owned secondary care providers in England were foundation trusts.<sup>172</sup>

2003 – Community Health and Standards Act	
Before	After
The single type of publicly funded hospital in England, called NHS Trusts, were centrally governed with little managerial flexibility.	Creation of a new form of publicly funded hospital called NHS Foundation Trust. Such hospitals have greater financial and managerial liberty than NHS Trusts and rely more on the guidance of the community in their decision-making. For NHS Trusts to become NHS Foundation Trusts, strict criteria must be met.

### 2003 – Consultant Contracts

The NHS updated the national framework governing the working conditions of its 26,000 consultants in 2003, the first such update since 1948.<sup>173</sup> Consultants are the most senior grade of doctor, most often in hospital or community settings, and are responsible for leading teams of junior and specialist doctors.<sup>174</sup> The vast majority work within the public system, whether employed by NHS Trusts, Foundation Trusts, or Primary Care Trusts.<sup>175</sup> Each Trust is entitled to determine its own part-time or full-time contracts and terms of service for its employees, including consultants, although in practice, very few NHS employers deviate significantly from the national agreement.

Under the pre-2003 consultant contract, full-time consultants had to limit their private earnings to the equivalent of 10% of their gross NHS income.<sup>176</sup> As for part-time senior doctors, they were free to earn an unlimited income from their private practice, as long as their NHS duties had been fulfilled, but received only 10/11<sup>ths</sup> of the salary of full-time consultants.<sup>177</sup>

The new contract changed the conditions that need to be met before consultants can undertake private practice. One of the main obligations is that NHS commitments should take precedence over private work.<sup>178</sup> Consultants wishing to undertake remunerated clinical work outside their main contract are expected to offer their spare professional capacity to the NHS first.<sup>179</sup>

For full-time consultant contracts, the senior doctor commits to ten “programmed activities” (PAs) per week, each having a timetable of three or four hours.<sup>180</sup> Programmed activities include responsibilities such as clinical diagnostic work, outpatient activities, ward rounds, training, etc.<sup>181</sup> Consultants are not required to do more than the standard ten PAs per week, although conditions for pay progression include that consultants should accept extra paid NHS work before doing private work.<sup>182</sup> When private activities are undertaken, there are no limitations on the amount that can be earned relative to NHS income.<sup>183</sup>

As for part-time consultant contracts, Trusts can offer between one and nine programmed activities. For those who wish to work in the NHS part-time specifically to undertake private work, contracts do not normally exceed six PAs.<sup>184</sup> If asked to perform an extra PA, however, part-time consultants are also expected to prioritize NHS work over their private activities.<sup>185</sup>

171. Policy Navigator, *op. cit.*, footnote 162.

172. Author's calculations. NHS Confederation, Publications, Key statistics on the NHS, consulted December 6, 2021.

173. Society Guardian, “Q&A: the consultant contract,” *The Guardian*, January 5, 2004.

174. British Medical Association, Advice and support, International doctors, Toolkit for doctors new to the UK, Doctor's titles explained, consulted November 15, 2021.

175. British Medical Association, *The Consultant Handbook*, BMA consultants, May 2009, p. 2.

176. *Ibid.*, p. 7.

177. *Ibid.*, pp. 7-8.

178. *Ibid.*, pp. 87-88.

179. *Ibid.*, pp. 25 and 87-88.

180. *Ibid.*, p. 18.

181. University of Bristol, Human Resources, Clinical Staff, Definitions and Principles of Job Planning, Definitions and Principles of Job Planning for Clinical Staff, consulted December 3, 2021.

182. British Medical Association, *op. cit.*, footnote 175, p. 25.

183. Stephen Morris, *et al.*, “Analysis of consultants’ NHS and private incomes in England in 2003/4,” *Journal of the Royal Society of Medicine*, Vol. 101, No. 7, 2008, p. 373.

184. British Medical Association, *op. cit.*, footnote 175, p. 30.

185. *Ibid.*, p. 89.

2003 – Consultant Contracts	
Before	After
Full-time consultants could not earn more than 10% of their gross NHS income in private practice. Consultant working part-time in the NHS were paid 10/11ths of the salary earned by full-time consultants, but could complement their income with private practice without limit, as long as their NHS duties were fulfilled.	Full-time consultants must commit to ten programmed activities per week. Consultants are free to engage in private practice outside their NHS schedule, but are incentivized to dedicate any additional time to extra PAs when asked. Those who work part-time in the NHS to be able to dedicate more time to their private practice are typically given contracts with no more than six PAs. There are no income limitations for either type of contract.

### 2003 – Creation of Independent Sector Treatment Centres (ISTCs)

Independent sector treatment centres (ISTCs) provide services to NHS patients but are owned and run by organizations outside the NHS. They were introduced in England in 2003, primarily to help the NHS reduce waiting times for planned operations and diagnostic tests.<sup>186</sup> At the time, resources in hospitals were being stretched thin by competing needs to provide both emergency care and perform planned tests and operations without delay or cancellation.<sup>187</sup>

Although the NHS has used services provided by the independent sector throughout its history, ISTCs are distinctive in two ways. First, ISTCs were deliberately created as a policy of central government, with a very clear goal of creating additional capacity and reducing wait times. Secondly, ISTCs provide services only to NHS patients even though they are privately owned and run, therefore increasing the role of the independent sector in the delivery of public health care.<sup>188</sup>

Besides reducing wait times, ISTCs provide patients with greater choice of providers, thus introducing competition between providers and encouraging other NHS

providers to improve their productivity. They are also meant to provide a more cost-effective way for the NHS to utilise capacity in the parallel system by purchasing services in bulk rather than through ad hoc spot purchasing<sup>189</sup> arrangements.<sup>190</sup>

In collaboration with key health authorities and Primary Care Trusts, the Department of Health targeted areas with low capacity and long wait times in which it opened 25 centers in 2003. By 2006, there were a total of 48 NHS treatment centres.<sup>191</sup> Primary Care Trusts were encouraged to send patients to these independent-sector providers.<sup>192</sup>

### 2003 – Hospital Funding Reform

Up until this point, hospital funding was predominantly transferred from commissioners to providers through block grants where the amount of money received by the hospital was fixed irrespective of the number of patients seen or the nature of the health issues that were being treated.<sup>193</sup> This provided little incentive to improve the quality or efficiency of care. In 2003, the government reformed the payment system by introducing the Payment by Results (PbR) tariff, an activity-based funding scheme (the equivalent of the DRG-based funding scheme introduced in Sweden in the mid-1990s) that provides incentives to improve performance.

With this form of funding, commissioners pay providers a fixed price for each patient seen or treated. The price does take into account the complexity of the patient's health care needs, and is also adjusted to reflect the fact that it is more expensive to provide services in some parts of the country than in others.<sup>194</sup> A payment system of this type ensures predictability and stability for hospitals,

189. Spot purchasing arrangements are one-time contracts between the purchaser (the NHS in this case) and the provider of health services whereby the funds received by the provider are meant to cover one single service, like an X-ray. Such spot contracts can occur multiple times for different health services over time. Purchasing service in bulk, on the other hand, covers an ensemble of medical services to be delivered across a period of time.

190. Chris Naylor and Sarah Gregory, *op. cit.*, footnote 186, p. 2.

191. Hansard, House of Commons Debates, February 2009, col 1768W, as cited in Chris Naylor and Sarah Gregory, *op. cit.*, footnote 186, p. 2; Department of Health, ISTC Manual, Department of Health, 2006, as cited in Chris Naylor and Sarah Gregory, *op. cit.*, footnote 186, p. 2; Department of Health, NHS Orthopaedic Schemes April-May 2006, as cited in Chris Naylor and Sarah Gregory, *op. cit.*, footnote 186, p. 2; Department of Health, NHS Ophthalmology TC Schemes April-May 2006, as cited in Chris Naylor and Sarah Gregory, *op. cit.*, footnote 186, p. 2.

192. House of Commons Select Committee on Health, Independent sector treatment centres, London, The Stationery Office (HC 934-1), 2006, as cited in Seán Boyle, *op. cit.*, footnote 120, p. 113.

193. *Ibid.*, p. 115.

194. National Health Service, *op. cit.*, footnote 150, p. 8.

186. Chris Naylor and Sarah Gregory, "Briefing – Independent sector treatment centres," The King's Fund, 2009, p. 1.

187. *Ibid.*, p. 2.

188. *Ibid.*, p. 1.

as they know in advance how much money they will receive in the event of an increase in activity. Providers can also retain any surpluses they generate if they are able to provide the covered medical service at a cost that is lower than the tariff they receive.<sup>195</sup> Payment by Results meant money would follow the patient, and because prices were fixed, competition for patients would be on the basis of quality rather than price. Competition between hospitals was limited, however, since patient choice of secondary care provider was still virtually non-existent.

PbR was introduced first for some elective inpatient procedures, and was then expanded to include much acute care, funding about 90% of hospital activity.<sup>196</sup> By 2008, non-government organizations supplying services to NHS patients came under the scope of the PbR as well.<sup>197</sup>

2003 – Payment by Results	
Before	After
Hospitals were funded through historical block grants without consideration for the type of health issues that were being treated.	Payment by Results was introduced as the new predominant form of funding for hospitals. Secondary care institutions received money based on volume of patients, the type of medical treatments they were providing, and the cost of providing medical services in their area.

### 2006 – Patient Choice Reform

For most of the seven decades since the inception of the NHS, GPs made referral decisions on behalf of their patients, and patient flows to hospitals reflected the referral behaviour of GPs rather than patient demand. This changed in 2006, when every patient in England was given the freedom to choose their hospital for secondary care.<sup>198</sup> One of the central aims of this policy was to

create financial incentives for providers to improve their clinical performance.<sup>199</sup>

In the initial stages of this reform, physicians were required to offer patients a choice of four or five hospitals if outpatient care was needed, of which at least one had to be a private provider.<sup>200</sup> By 2008, the policy was extended to include any provider on a national list, NHS or private, that had agreed to provide care to NHS standards.<sup>201</sup> Today, patients can make an informed decision regarding their choice of secondary care provider through the website “NHS Choices,” which provides information on certain aspects of hospital performance (e.g., mortality and waiting times).<sup>202</sup> With the Payment by Results tariff already implemented, all the pieces were now in place to encourage competition between hospitals based on service quality. Evidence from empirical studies have shown that the introduction of competition between institutions resulted in increased efficiency and led to cost savings for hospitals (see Figure 1-2).<sup>203</sup>

2006 – Patient Choice Reform	
Before	After
The flow of patients to hospitals reflected the referral behaviour of general practitioners. Patients had very little freedom to choose their secondary health care provider.	In 2006, patients were given the right to be offered a choice of at least four hospitals for elective care. Since 2008, patients have been allowed to choose any qualified provider.

### 2012 – Health and Social Care Act

The *Health and Social Care Act* provided the most extensive reorganization of the structure of the National Health Service in England to date.

The existing 152 PCTs were replaced by 211 Clinical Commissioning Groups (CCG), led by general practitioners.<sup>204</sup> These CCGs would include not only GPs, but

195. Department of Health, “Code of Conduct for Payment by Results,” January 2006, p. 8.

196. Westminster Health Forum, Payment systems and reimbursement in healthcare, 2020, as cited in Matthew Bell, Anita Charlesworth, and Richard Lewis, *REAL Centre Briefing: The future of the NHS hospital payment system in England*, The Health Foundation, July 2021, p. 4.

197. Seán Boyle, *op. cit.*, footnote 120, p. 116.

198. Anna Dixon and Ruth Robertson, *New Labour's market reforms Chapter 4: Patient choice of hospital*, The King's Fund, September 2011, p. 53.

199. Anna Dixon *et al.*, *Patient Choice: how patient choose and how providers respond*, The King's Fund, 2010, p. 47.

200. *Ibid.*, p. 53.

201. *Idem.*

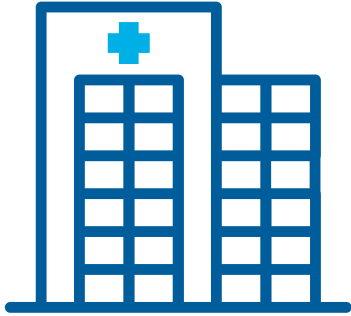
202. Francesco Longo *et al.*, “Does hospital competition improve efficiency? The effect of the patient choice reform in England,” *Health Economics*, November 19, 2018, p. 3.

203. *Ibid.*, pp. 7-11.

204. Policy Navigator, “Structural changes from Health and Social Care Act (2012),” The Health Foundation, April 1<sup>st</sup>, 2013.

Figure 1-2

## Hospital competition in England



### Hospital system with competition between institutions

- Greater number of admissions per hospital bed
- Greater number of admissions per doctor
- Cost savings for hospitals

**Source:** Francesco Longo *et al.*, "Does hospital competition improve efficiency? The effect of the patient choice reform in England," *Health Economics*, November 19, 2018, pp. 7-11.

also a range of other health care practitioners, which ensured the inclusion of other perspectives. The intention was to encourage clinicians to play a greater role in deciding how funds are spent in order to shape services efficiently and according to local needs.<sup>205</sup>

CCGs, armed with approximately 60% of the total Department of Health budget, were given two distinct responsibilities.<sup>206</sup> First, they were put in charge of commissioning of hospital services, community care, mental health services, maternity and newborn care, and rehabilitation services for their local population.<sup>207</sup> Such care could be purchased from public or independent sources (for-profit businesses or non-profit organizations). Second, they were legally required to support quality improvement in general practice. This second role is more challenging, since the responsibility for commissioning primary care services was transferred to a new organization, namely NHS England.<sup>208</sup>

NHS England acts as an independent organization that is less accountable to the central UK government. It was

made responsible for daily operations, for overseeing CCGs, as well as the commissioning of national contracts for specialized services, general practice, and other independent primary care contracts, including dentists and ophthalmologists.<sup>209</sup>

2012 – Health and Social Care Act	
Before	After
Primary Care Trusts were responsible for the purchasing of primary care for their population.	Clinical Commissioning Groups replaced PCTs and were made responsible for the provision and purchasing of secondary and community care. CCGs are led by general practitioners and are designed to be responsive to their local populations. NHS England, a new organization operating at arm's length of the central government, was made responsible for the oversight of CCGs and the commissioning of national primary care contracts, among other services.

205. Department of Health and Social Care, "The Health and Social Care Act 2012," April 30, 2012, p. 1.

206. Author's calculations. NHS England, "Understanding the New NHS," June 26, 2014, p. 11.

207. *Ibid.*, pp. 9-13.

208. Chris Naylor, *et al.*, "Clinical commissioning groups: Supporting improvement in general practice?" *The King's Fund*, 213, p. ix.

209. NHS England, *op. cit.*, footnote 206, pp. 8-9 and 12.

Box 1-5

## United Kingdom Reforms

### Before Liberalization

Hospital administrators were not tasked with ensuring that the hospitals functioned efficiently. Secondary care institutions were funded by historical budgets and the health system was described as “a rigid organisation with too many layers of decision making.”

### Phase I: 1990-1997 – Internal Markets and the Purchaser-Provider Split

**1990 – *National Health Service and Community Care Act*:** Introduced the “internal market,” which separated the roles of purchaser and provider of health services.

### Phase II: 1997-2012 – Devolution of Political Power and a Second Attempt at Internal Markets

**1997 – Creation of independent governments:** The devolution of political power and the creation of national administrations in England, Scotland, Wales, and Northern Ireland.

**1997 – Beginning of the Labour Party Health Reforms:** The Labour Party maintained the purchaser-provider split, but called for the abolishment of the internal market. Nonetheless, market mechanisms and inter-institutional competition as a driver for improvement prevailed throughout the 1990s in the NHS.

**1998 – Abolishment of General Practice Fundholding:** The GP fundholding scheme was replaced by Primary Care Groups (PCGs). Once PCGs demonstrated they could manage budgets and services, they became Primary Care Trusts and were considered freestanding bodies responsible for the provision of primary, secondary, and community-based health care. General practices became providers of health care services rather than purchasers.

**2003 – *Community Health and Standards Act*:** Creation of a new form of publicly funded hospital called NHS Foundation Trusts, which have greater financial and managerial liberty than NHS Trusts.

**2003 – Consultant Contracts:** Removed the limitations on income earned during private practice for consultants. Consultants are free to engage in private practice outside their NHS schedule, but are incentivized to dedicate any additional time to extra programmed activities when asked.

**2003 – Creation of Independent Sector Treatment Centres (ISTCs):** ISTCs were put in place with the objective of reducing wait times for planned operations and diagnostic tests. They are independently owned but provide NHS services.

**2003 – Hospital Funding Reform:** Introduced activity-based funding, namely the Payment by Results tariff, for the hospital system, effectively forgoing block grants based on historical activity.

**2006 – Patient Choice Reform:** Patients were given the right to be offered a choice of at least four hospitals for elective care. By 2008, patients were allowed to choose any qualified provider.

**2012 – *Health and Social Care Act*:** Replaced PCTs by Clinical Commissioning Groups (CCG), led by general practitioners who are responsible for commissioning hospital services and support quality improvement in general practice. It also erected a new independent organization, NHS England, responsible for overseeing daily operations.



## CHAPTER 2

### Enacting Meaningful Health Care Reform in Canada

#### The Regulatory Barriers Preventing Canadian Provinces from Liberalizing Their Health Systems

The timelines in the first chapter are rich in information and can serve as models for provincial politicians wanting to follow in the footsteps of Sweden or the UK. However, there are currently several legal components in each of Canada's provincial health systems that may impede forward momentum. As such, this chapter will start by identifying and analyzing the public policies and relevant legislation that represent the greatest obstacles to the liberalization of the provincial health care systems of Quebec and British Columbia.

These two provinces were chosen for the legal analysis for two reasons. First, they are among those with the greatest number of legal barriers to the adoption of liberalizing reforms, as we shall see. Second, and most importantly, the legislative frameworks in both provinces have been challenged in court due to the dire social consequences of the said barriers.

In Quebec, the 2005 Chaoulli case<sup>210</sup> is of particular importance as it was the first serious challenge to the Canadian public health system. The case challenged whether a province can forbid its residents from purchasing duplicate insurance to pay for services that are already covered by the public Medicare program. According to the plaintiffs, this practice actually endangered the right to life, liberty, and security of Quebec citizens as protected in the *Canadian Charter of Rights & Freedoms*.

As for British Columbia, a case has been ongoing since 2009. Commonly referred to as the Cambie case, it represents an even greater challenge to the public system's legislative framework than the Chaoulli case. This is because the plaintiffs have asked the court to invalidate not only the prohibition on duplicate insurance, but every single legislative disposition of BC health law that has the effect of blocking the emergence and develop-

ment of a parallel decentralized and liberalized health care system.<sup>211</sup>

This chapter will thus also explore the content of both court cases, focusing specifically on the changes that the Chaoulli case brought about in Quebec and the opportunities that could result from a favourable ruling in the ongoing Cambie case.

Finally, we will present the reforms that would need to be introduced in Quebec and British Columbia in order to emulate the experience of Sweden and the UK. It should be noted that these reforms do not contravene the *Canada Health Act* (which sets out the framework for provincial operations), and in some cases would not even require amendments to existing provincial legislation.

#### The Role of the Federal Government in the Fundamentally Provincial Matter of Decentralizing and Liberalizing Public Health Care in Canada

Before diving into the details regarding the most restrictive legal components of Quebec and British Columbian health law, it is essential to understand the larger context in which all provincial governments evolve and exercise their competence in the regulation of health. Canadian health care policy—including decisions on what services will be provided under a universal plan, how these services will be funded and paid, who will be allowed to provide services, and whether these services can be partially or fully funded by the private sector—is determined exclusively by provincial governments in Canada. However, the federal government significantly influences provincial decision-making through the *Canada Health Act* (CHA).

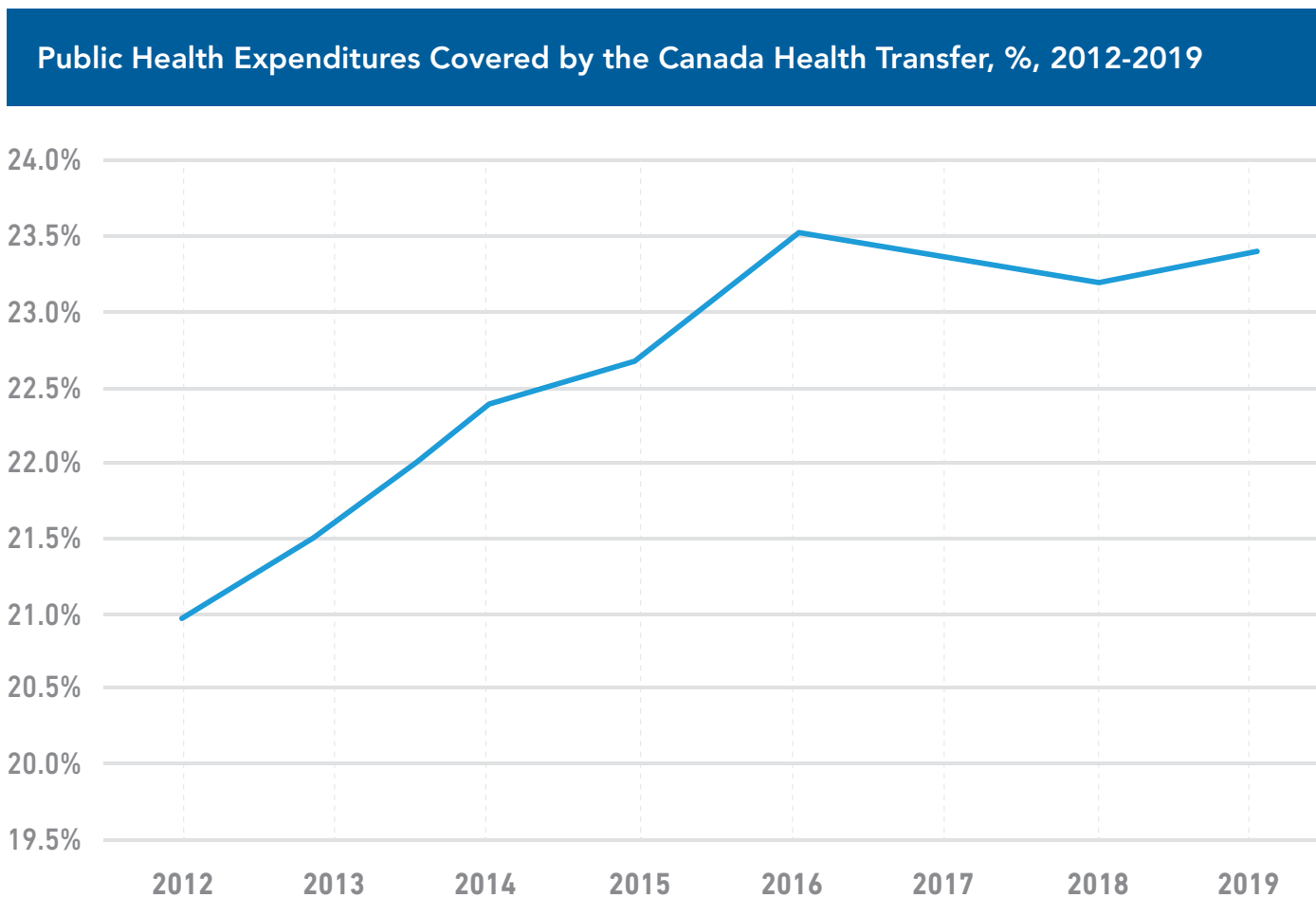
The CHA sets out the terms and conditions under which provincial governments will retain full access to the Canada Health Transfer (CHT), which represented approximately 23.5% of each province's total expenditure in 2019, up from 21.0% in 2012<sup>212</sup> (see Figure 2-1). Even though this law does not directly govern the activities of any individual or health care provider in Canada, the large federal cash transfers for compliance with the CHA most definitely influence provincial policy decisions.

210. Supreme Court of Canada, Cases, Decisions and Resources, Supreme Court Judgments, *Chaoulli v. Quebec (Attorney General)*, consulted November 16, 2021.

211. Colleen M. Flood and Bryan Thomas, *Is Two-Tier Health Care the Future?* University of Ottawa Press, 2020, pp. 40 & 84.

212. Sony Norris, "Federal Funding for Health Care," Library of Parliament, December 29, 2020, p. 4.

Figure 2-1



Source: Sony Norris, "Federal Funding for Health Care," Library of Parliament, December 29, 2020, p. 4.

Provinces lock in their eligibility for the full amount of their share of the CHT by ensuring that their health care systems respect the five pillars of the CHA: (a) public administration, (b) comprehensiveness, (c) universality, (d) portability, and (e) accessibility<sup>213</sup> (see Figure 2-2).

First, in order to be eligible to receive health transfers, a province's (or territory's) health insurance plan must be administered by a public institution.<sup>214</sup> This means the provinces' health insurance plans cannot be managed by a for-profit corporation. However, since this obligation only concerns the administration of health care insurance programs, it does not apply to the administration of health services themselves. Thus, the CHA does not prohibit the management of, say, hospitals by entrepreneurs or for-profit organizations. Canadian provinces are there-

fore well within their legislative rights to delegate the management of health care institutions to entrepreneurs, as was done in Sweden. The criterion of universality (outlined below) would be maintained since independently run hospitals would still be funded by provincial government health insurance plans.

Second, a province's (or territory's) health insurance plan must respect the criterion of comprehensiveness, which theoretically requires these plans to cover all medically required health services.<sup>215</sup> This principle allows flexibility in determining which services to cover. There is no one-size-fits-all list of medically necessary health services per the CHA, so provinces and territories make the call for their respective populations in conjunction with their respective physician colleges or groups.<sup>216</sup>

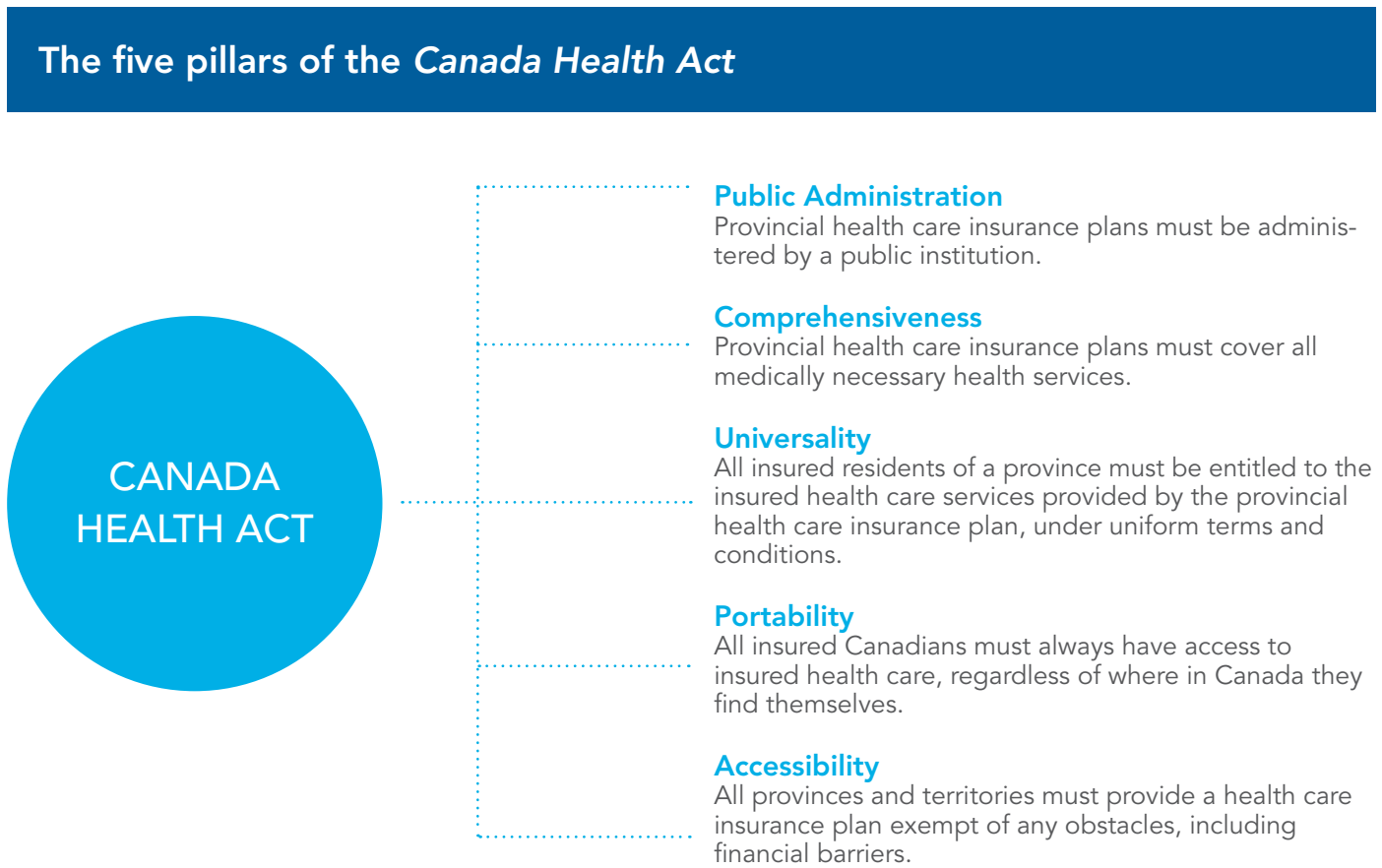
213. Government of Canada, "Canada Health Act," Minister of Justice, January 12, 2022, p. 5.

214. *Ibid.*, p. 6.

215. *Idem.*

216. Government of Canada, Canada.ca, Departments and agencies, Health Canada, Services, Reports and Publications – Health Care System, Canada's Health System, September 17, 2019.

Figure 2-2



Source: Government of Canada, *Canada Health Act*, Minister of Justice, January 12, 2022, pp. 6-8.

Third, provinces and territories must comply with the criterion of universality.<sup>217</sup> This requires that all insured residents be entitled to the insured health care services provided under their health insurance plan, under uniform terms and conditions. This principle, when combined with the accessibility criterion detailed below, promotes equitable access to health care.

Fourth, the government health insurance plans must allow portability.<sup>218</sup> This requires that all insured Canadians always have access to insured health care, regardless of where in Canada they find themselves. This allows insured persons to be protected under their province's insured plan, even when they move or travel from one Canadian province to another.

Finally, the fifth criterion of accessibility means that all provinces and territories must provide a health insurance plan that is exempt of any obstacles, including financial barriers.<sup>219</sup> Consequently, all persons who are covered under a provincial or territorial plan and who require medically insured services must have uniform access to those services, wherever they are being offered and on the same basis. In other words, this criterion, when combined with the principle of universality, implies that the only characteristic that can be considered by the government in its choice to serve one patient before another is the medical needs of the patient. As such, factors such as employment status, revenue, ability to pay, or insurability are irrelevant in determining the exercise of an insured citizen's access to health care.

It is this criterion of accessibility that prevents physicians practising inside the public system from extra-billing,

217. Government of Canada, *op. cit.*, footnote 213, p. 6.

218. *Ibid.*, p. 7.

219. *Ibid.*, p. 8.

whereby a publicly employed physician charges a patient an additional fee for services covered by the public plan.<sup>220</sup> The physician would thus receive not only the payment from the public plan, but also whatever extra he or she is able to bill the patient. The patient would have to pay that additional cost out-of-pocket (a user charge) because it is currently illegal in most Canadian provinces and territories to hold duplicate insurance that would cover additional costs. The appeal of extra-billing for physicians lies in the ability to set their own prices and have the public plan subsidize a portion of the chosen cost.<sup>221</sup>

**The CHA does not prohibit duplicate insurance that covers services similar to those provided by Medicare, nor does it explicitly prohibit mixed practice or delegating the management of public hospitals to entrepreneurs.**

Provinces can legally adopt legislation contrary to the five principles outlined in the CHA, but the determination of provincial non-compliance with a criterion is entirely at the discretion of the federal government. Failure or refusal to comply with any of these principles subjects a province or territory to sanctions from the federal government, such as withholding funds from the Canadian Health Transfer. For instance, if a province allows extra-billing, the federal government can “claw back,” dollar for dollar, the amounts charged by publicly-employed physicians through this practice, and may withhold further sums.<sup>222</sup> This has occurred on several occasions because of extra-billing practices in Alberta, Manitoba, Newfoundland, and Nova Scotia.<sup>223</sup>

At first glance, the requirements of the CHA may appear reasonable, but the vague definitions and discretionary nature of the penalties may discourage governments from considering certain policy options out of fear of losing a portion of the CHT on which they rely. For example, the

CHA does not prohibit for-profit hospitals<sup>224</sup> or the sale or purchase of duplicate insurance that covers services similar to those provided by a provincial Medicare plan,<sup>225</sup> nor does it explicitly prohibit mixed practice or delegating the management of public hospitals to entrepreneurs. And yet, almost all provinces have either prohibited most of these practices altogether or have implemented very strict rules that make it nearly impossible, or simply unprofitable, for such activities to occur. It is in fact these additional regulations, incorporated into each province's health laws, that represent the greatest obstacles to the liberalization and decentralization of any given provincial health system.

Specifically, there are three main regulatory measures commonly used to govern health care systems in Canada that restrain the development of a parallel health care system.<sup>226</sup> Provinces have implemented these measures to varying degrees, as we shall see below.

### Opting In and Opting Out

Before describing these three regulations, we must first clarify the concept of opting out. A Canadian physician may, at any time, choose to give up his or her rights to bill the public plan and take up practice in the private sector. Every provincial plan permits physicians to opt out.<sup>227</sup> However, there is little financial incentive to do so since provinces have various measures in place to prohibit the public sector from subsidizing the private sector. For example, in Manitoba, Nova Scotia, and Ontario, physicians who have opted out are prohibited from billing more than they would receive if they were working within the public plan.<sup>228</sup>

In all other provinces,<sup>229</sup> opted-out physicians can set their fees at any level, but are still disincentivized to opt out due to the prohibition of public subsidies to the private

224. Nadeem Esmail and Bacchus Barua, *Is the Canada Health Act a Barrier to Reform?* The Fraser Institute, 2018, p. 22.

225. Bruno Gagnon, “The Chaoulli Case and Its Impacts on Public and Private Health Insurance,” Canadian Institute of Actuaries, 2018, p. 3.

226. Marie-Claude Prémont and Cory Verbauwhede, “Canadian legislatures and the regulation of the private health-care industry,” *University of Toronto Law Journal*, Vol. 68, No. 2, 2018, pp. 237-241.

227. *Alberta Health Care Insurance Act*, RSA 1980, c. A-24, s. 5.11; *Medicare Protection Act*, RSBC 1996, c. 286, s. 13(8); *Health Services Insurance Act*, RSM 1987, c. H35, s. 91(1); *Medical Services Payment Act*, SNB 1973, c. M-7, s. 3(b)(iv); *General Regulation – Medical Services Payment Act*, NB Reg. 84-20, s. 12; *Medical Care Insurance Act*, RSN 1999, c. M-5.1, s. 7(3); *Health Services and Insurance Act*, RSNS 1989, c. 197, s. 27(2); *Health Insurance Act*, RSO 1990, c. H.6, s. 15(4); *Health Services Payment Act*, RSPEI 1988, c. H-2, s. 8; *Health Insurance Act*, RSQ, c. A-29, ss. 26, 30; *Saskatchewan Medical Care Insurance Act*, RSS 1978, c. S-29, ss. 18(2), 24(1), 24.1.

228. Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 826.

229. *Idem.*

220. Colleen M. Flood and Tom Archibald, “The illegality of private health care in Canada,” *Canadian Medical Association Journal*, Vol. 164, No. 6, March 20, 2001, p. 825.

221. *Ibid.*, p. 827.

222. *Idem.*

223. Colleen M. Flood, “The structure and dynamics of Canada's health care system,” in Jocelyn Downie and Timothy Caulfield (eds.), *Canadian Health Law and Policy*, Toronto, Butterworths, 1999, pp. 5-50, as cited in Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 827.

sector. In other words, patients that are treated by opted-out physicians are not entitled to any public funds to subsidize the cost of buying their services privately, whether the service is already covered by public insurance or not.<sup>230</sup> As such, even if a physician charges the same amount that would be charged in the public system, he or she will not receive payment from the government for the medically necessary services rendered.

Another measure used to disincentivize physicians from opting out of the public system is the administrative burden of doing so. In Quebec, for instance, a doctor who wishes to opt out of the public system must fill out and send the related form by mail<sup>231</sup> and then wait 30 days before being able to practise outside the public system.<sup>232</sup> An opted-out physician can opt-in at any moment by once again sending the form by mail and waiting but eight days before having the right to practise in the public scheme again. As for British Columbia, the commitment is much greater. In order to cancel their enrolment, they must provide a 30-day written notice to the commission,<sup>233</sup> and following that decision, if enrolment is cancelled, cannot re-enroll for at least 12 months unless the commission judges it in the public interest to make an exception.<sup>234</sup> This delay could be interpreted as an attempt to discourage enrolled physicians from leaving the public health care system.

### Three Main Regulatory Restrictions to Liberalizing Provincial Health Care Systems

#### Prohibition on Duplicate Insurance

The first regulatory measure that discourages the emergence of a parallel health care system is the prohibition on duplicate insurance, present in six out of the ten provinces.<sup>235</sup> When a province prohibits the purchase of private duplicate insurance, it forbids its population from purchasing health insurance that would provide coverage for services that are already insured by the public health care system.

As of now, the only type of parallel health insurance that is permitted, generally, is supplementary insurance, meaning the policy covers only services not insured by the public system such as dentistry,<sup>236</sup> optometry, and pharmaceutical drugs. Adherence to supplementary insurance is in fact very widespread across both Quebec and British Columbia, with population coverage of 66% and 55%, respectively.<sup>237</sup>

**The Canadian provinces that prohibit the purchase of duplicate insurance are among the only universal health systems in the world to do so.**

Surprisingly, the Canadian provinces that prohibit the purchase of duplicate insurance are among the only universal health systems in the world to do so. As seen in the first chapter, neither Sweden nor the United Kingdom prohibit their populations from purchasing such insurance, and the same can be said of France,<sup>238</sup> Israel,<sup>239</sup> and the Netherlands,<sup>240</sup> among others—all countries with high-performing universal health care systems that encourage plurality. Despite the prevalence of parallel insurance, these countries have prevented income levels and pre-existing health conditions from interfering with access to full coverage of basic health care, something which can be done through appropriate regulation.<sup>241</sup>

Opposition in Canada to duplicate health insurance markets for medically necessary services is deeply rooted. The main concern is that allowing individuals to purchase duplicate insurance will produce a “two-tier” system where patients with higher incomes obtain faster or “better” health care than those with lower incomes. Were it legal, duplicate insurance would most likely

230. Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 826.

231. Exceptionally during the COVID-19 pandemic, the form could be sent by email. Régie de l'assurance maladie du Québec, Médecins spécialistes, Événements de carrière, Je deviens professionnel non participant, consulted November 17, 2021.

232. Régie de l'assurance maladie du Québec, Manuel des médecins omnipraticiens Brochure no 1, Accord-cadre, consulted November 8, 2021.

233. *Medicare Protection Act*, ss. 13 (8).

234. *Medicare Protection Act*, ss. 13 (9).

235. British Columbia, Alberta, Manitoba, Ontario, Quebec, Prince Edward Island. Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 826.

236. Except for “surgical-dental services performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.” Health Canada, *Canada Health Act Annual Report 2019-2020*, Government of Canada, February 2021, p. 6.

237. Author's calculations, based on 2017 private insurance enrollment and population data. Statista, Health, Pharma & Medtech, Health System, Number of Canadians that are enrolled in private health insurance in 2017, by province, consulted November 9, 2021; Statistics Canada, Table 17-10-0009-01: Population estimates, quarterly, 2017.

238. Colleen M. Flood and Bryan Thomas, *op. cit.*, footnote 211, p. 240.

239. Roosa Tikkanen, *et al.*, *op. cit.*, footnote 96, p. 107.

240. Hans Maarse and Patrick Jeurissen, “Private health insurance in the Netherlands,” in Sarah Thomson, Anna Sagan, and Elias Mossialos (eds.), *Private Health Insurance: History, Politics and Performance*, European Observatory on Health Systems and Policies, Cambridge University Press, 2020, p. 349.

241. Colleen M. Flood and Bryan Thomas, *op. cit.*, footnote 211, p. 87.

enable faster access to medical services for those who hold it. At the same time, though, it would also likely shorten delays for those who rely on public insurance alone, as the patients who have contracted duplicate insurance will favour resources funded by said insurance over publicly provided care, thus liberating public resources for others.

### Prohibition on Mixed Practice

The prohibition on mixed practice is another significant barrier to the development of an independent health care sector. And once again, it is a regulation that is virtually nonexistent among other high-income countries with universal health care systems,<sup>242</sup> mostly because when health systems have the capacity to enforce regulations that protect public services that are free at point of service, as Canadian provinces do, dual practice can be beneficial.<sup>243</sup>

**Doctors practising in countries that allow mixed practice, such as Australia and Denmark, do not spend any less time caring for patients in the public system.**

There are six provinces<sup>244</sup> that have erected legislative barriers to prevent physicians and other health care professionals normally paid by taxpayer funds from providing publicly covered services within the public system and the independent sector simultaneously. This means that physicians must formally opt out of the public system to be able to bill patients for publicly covered services. While there are no limitations as to the number of times a practitioner can opt in or out of the public system, the process of doing so is cumbersome and typically takes several weeks.<sup>245</sup>

One often raised objection to allowing for dual practice is that it would result in a decrease in the number of hours worked in the public system. Yet evidence has shown that doctors practising in countries that allow

mixed practice, such as Australia<sup>246</sup> and Denmark,<sup>247</sup> do not spend any less time caring for patients in the public system than their single-practice counterparts. At any rate, the fear of exodus could be addressed by instituting a realistic minimum number of hours to be worked in the public system, as has been done in England through the reformed consultant contracts introduced in 2003.

### Capping of Private Fees at the Level of Public Fee Schedules

Lastly, the capping of private fees at the public fee schedule level greatly disincentivizes any health care professional from practising outside the public scheme. This regulation prohibits opted-out physicians from offering publicly funded services at prices above what they would receive in the public sector. Their only incentive to opt-out would therefore reside in greater freedom in scheduling and possibly better working conditions, depending on the context. The seven provinces that do allow doctors to charge fees above the public schedule have instead instituted and enforced other disincentives which rule out the possibility of the public sector subsidizing the private services provided by opted-out physicians, regardless of the price they may charge.<sup>248</sup> And because duplicate insurance is prohibited in most provinces, the patients must pay the fees entirely out-of-pocket, thus limiting access to medically necessary services provided by opted-out physicians to those who can support the full cost.

Table 2-1 illustrates a basic overview of the differences between the provinces' respective use of the three principal regulatory measures which limit the liberalization of their health care systems. The current regulatory frameworks in Canada reflect different levels of openness towards the emergence of a parallel market for the entrepreneurial provision of health services. On the one hand, the regulatory measures restraining the liberalization of health care in Canada can be found in almost every province's legislation, with Ontario having adopted all three of the restrictive measures and four others having adopted at least two. Overall, approximately 90% of the Canadian population is subjected to at least

242. Kiwanuka SN, et al., *Dual practice regulatory mechanisms in the health sector A systematic review of approaches and implementation*, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, March 2011, pp. 2-3.

243. Barbara McPake, et al., "Implications of dual practice for universal health coverage," *Bulletin of the World Health Organization*, 2016, p. 143.

244. British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and New Brunswick.

245. *Medicare Protection Act*, ss. 13 (8); Régie de l'assurance maladie du Québec, *op. cit.*, footnote 232.

246. Terence Chai Cheng, Catherine M. Joyce, and Anthony Scott, "An Empirical Analysis of Public and Private Medical Practice in Australia," *Health Policy*, Vol. 111, No. 1, 2013, p. 48.

247. Karolina Socha and Mickael Bech, "Dual practitioners are as engaged in their primary job as their senior colleagues," *Danish Medical Journal*, Vol. 59, No. 2, 2012, p. 5.

248. Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 826.

Table 2-1

The three main regulatory measures preventing the liberalization of health care in Canada, by province			
Province	Prohibition on duplicate insurance	Prohibition on mixed practice	Capping of private fees at the level of public fee schedules
British Columbia	Yes*	Yes	No, except in hospitals and community-care facilities
Alberta	Yes	Yes	No
Saskatchewan	No	Yes	No
Manitoba	Yes	No	Yes
Ontario	Yes	Yes	Yes
Quebec	Yes**	Yes	No, except when opted-out physicians provide services to insured persons in an emergency.
New Brunswick	No	Yes	No
Nova Scotia	No	No	Yes
Prince Edward Island	Yes	No	No
Newfoundland and Labrador	No	No	No

\* In British Columbia, the prohibition has been interpreted as being limited to enrolled physicians.

\*\* Quebec is categorized as prohibiting duplicate private insurance even though it has been allowed since 2008 for three specific surgeries; apart from these three exceptions, the prohibition still applies.

**Sources:** Marie-Claude Prémont and Cory Verbauwede, "Canadian legislatures and the regulation of the private health-care industry," *University of Toronto Law Journal*, Vol. 68, No. 2, 2018, p. 244; Colleen M. Flood and Tom Archibald, "The illegality of private health care in Canada," *Canadian Medical Association Journal*, Vol. 164, No. 6, March 20, 2001, p. 826.

two of the three measures.<sup>249</sup> This shows that Canadian provinces maintain control and impose a certain restraint on the potential for the development of a parallel health care system. Interestingly, the provinces that have adopted only one or none of the three measures are not considered to be in violation of the CHA, demonstrating that the public system's integrity can be maintained despite the absence of strong barriers to the liberalization of health care.

249. Author's calculations. Québec, Ontario, Manitoba, Alberta, and British Columbia each hold two or more of the three regulatory prohibitions. This amounts to approximately 33,817,504 persons, which represents 90% of Canada's total population of 37,540,203 in 2019. Statistics Canada, "Table 17-10-0009-01: Population estimates, quarterly," September 29, 2021.

On the other hand, a certain degree of openness can be observed in the fact that each province allows its physicians to practise outside of the government-run system, and thus to provide health care services in independent health facilities.<sup>250</sup> This shows two things. First, it proves that while these measures may restrict the liberalization of health care, they do not preclude it. Next, it illustrates that even the provinces with the most restrictive regulatory measures are not completely closed to the existence of a parallel health care system.

The diversity of provincial approaches also reflects the CHA's flexibility toward provinces' discretionary power

250. Colleen M. Flood and Tom Archibald, *op. cit.*, footnote 220, p. 825.

to legislate on their own terms regarding the liberalization of their health care systems. Importantly, this shows that while provinces can restrict the flexibility of their health care systems, they can also choose to expand it.

## Challenges to the *Canada Health Act* – The Chaoulli and Cambie Cases

In recent years, the debate surrounding the liberalization of Canada's provincial health care systems has been spurred on by their less-than-satisfactory performance—especially in terms of timeliness and quality—caused, in part, by frameworks of restrictive regulatory measures. The public system's inability to treat patients within a reasonable time frame is in fact what prompted one of the first major judicial challenges to provincial health care law, namely the Chaoulli case, and also what is fueling the ongoing Cambie case in British Columbia.

### Chaoulli vs. Quebec

In 2005, appellants Jacques Chaoulli and George Zeliotis challenged the constitutional validity of Quebec legislation prohibiting duplicate insurance for publicly insured services, versus the Attorney General of Quebec and Attorney General of Canada.<sup>251</sup> Jacques Chaoulli, a physician originally from France, had tried unsuccessfully to obtain a license to operate an independent clinic, while George Zeliotis was a patient who had suffered from a number of health problems and who had had to wait nine months for a hip operation.<sup>252</sup> The lengthy delay was what prompted him to speak out against waiting times in Quebec's public health care system.

The appellants contested the validity of section 11 of the *Hospital Insurance Act* (HOIA) and section 15 of the *Health Insurance Act* (HEIA), claiming that the prohibition of duplicate insurance instituted by these two laws deprived Quebec residents of access to health care services and infringed on the constitutional right to life, liberty, and security of person.<sup>253</sup> Specifically, they argued that this prohibition was in violation of the right to life guaranteed by both the *Canadian Charter of Rights and Freedoms* and the *Quebec Charter of Human Rights and Freedoms* because it can induce physical and psychological harm as a result of the public system's chronic inability to provide care within a reasonable

timeframe.<sup>254</sup> Were it not for this restriction, they argued, patients facing lengthy waits for medically necessary procedures in the public system could obtain faster care in the private sector, paid for with their duplicate insurance.

While the case was dismissed by the Superior Court of Quebec and the Quebec Court of Appeal, the Supreme Court of Canada finally ruled in favour of the appellants. Indeed, the Supreme Court of Canada made one of its most controversial decisions with this case by ruling that Quebec's ban on duplicate health insurance was unconstitutional. Specifically, the majority of the court ruled that the prohibition on duplicate insurance was a contributor to the lengthy waiting lists for some procedures in Quebec, and that those lists were consistently so long that they caused physical and psychological harm. As such, the ban on duplicate health insurance in Quebec was ruled as void and unenforceable because it violated both the Quebec and Canadian Charters. In the words of then-Chief Justice Beverley McLaughlin, "Access to a waiting list is not access to health care."<sup>255</sup>

**In the words of then-Chief Justice Beverley McLaughlin, "Access to a waiting list is not access to health care."**

Lawyers for the Quebec and Canadian governments had argued that restrictions on duplicate insurance were necessary to ensure the integrity and quality of the system.<sup>256</sup> The majority of the justices did not agree. Indeed, based on evidence from other developed countries with public systems that permit access to private health care, the Court found that there was "no real connection in fact between prohibition of health insurance and the goal of a quality public health system."<sup>257</sup> The international evidence focused on the fact that most Western European countries manage to maintain high-performing public systems while permitting duplicate insurance. With this, the court declared that "[Even] if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity."<sup>258</sup>

251. Supreme Court of Canada, *op cit.*, footnote 210.

252. Bruno Gagnon, *op. cit.*, footnote 225, p. 3; Colleen M Flood and Sujith Xavier, "Health Care Rights in Canada: The Chaoulli Legacy," *Medicine and Law*, Vol. 27, No. 3, 2008, p. 617.

253. Supreme Court of Canada, *op cit.*, footnote 210.

254. *Idem.*

255. Supreme Court of Canada, *op cit.*, footnote 210.

256. Colleen M. Flood and Bryan Thomas, *op. cit.*, footnote 211, pp. 4-5.

257. Supreme Court of Canada, *op cit.*, footnote 210, para. 139.

258. *Ibid.*, para. 74.



Although successful, the Chaoulli decision unfortunately did not lead to the runaway liberalization of health care in Canada that the applicants had hoped for, due to a number of factors. First, the law overturned the prohibition on duplicate health insurance, which as we saw above is only one of several laws restricting the liberalization of health care in Quebec and other provinces.

Second, the majority decision rested upon the *Quebec Charter of Human Rights and Freedoms* as opposed to the *Canadian Charter of Rights and Freedoms*, and thus technically applied only to Quebec—necessitating re-litigation in other provinces to diffuse the Chaoulli precedent nationwide. Consequently, the impact of Chaoulli in liberalizing the Canadian health system was not as dramatic as one might have imagined.

The third factor explaining the underwhelming result of the Chaoulli case was the Quebec National Assembly's actual response to the Supreme Court ruling. In fact, the new section 11 of the HOIA, as adopted in 2006, remained quite similar to the one that was invalidated by the Supreme Court, since it still completely prohibits the purchase of contracts offering coverage of health care services provided in institutions. The main difference is the considerable increase in the amount of the fine imposed on an insurer found guilty of a contravention to the prohibition. The current section 11 of the HOIA imposes fines that vary between \$50,000 and \$200,000,<sup>259</sup> while previously, the maximal fine was equivalent to \$100.<sup>260</sup> On that basis, according to the Minister of Health and Social Services at the time, this section constitutes the most severe way of preventing the emergence of private institutions providing the same services and accomplishing the same mission as hospital centres in Quebec.<sup>261</sup>

As for section 15 of the HEIA, which was also found to be unconstitutional, it was amended to allow a patient to purchase private duplicate insurance for three specific procedures: hip replacement, knee replacement, and cataract extraction.<sup>262</sup> Such insurance cannot be used in just any health establishment, however. Private insurance contracts can only be used if the treatment is provided by a non-participating Specialized Medical Centre (SMC), of which there are but 25 in the province (see

Box 2-1).<sup>263</sup> Quebec's National Assembly therefore did not completely strike down the ban on duplicate insurance, as would seem to have been required by the Supreme Court's decision.

Admittedly, the new section 15 of the HEIA does allow the government to expand the list of eligible specialized procedures that could be insured with a duplicate insurance policy. In other words, with the *Collège des médecins du Québec's* approval, the health minister could allow Quebec citizens to purchase duplicate insurance for other publicly insured medical procedures. But as of now, these restrictive rules create a regulatory environment that is unfavourable to the emergence of a duplicate insurance market. Indeed, with only three procedures that can be covered by such an insurance policy, and a total of just 25 SMCs, it is no wonder that it has not caught on.

**Quebec's National Assembly did not completely strike down the ban on duplicate insurance, as would seem to have been required by the Supreme Court's decision.**

In light of the changes made to the HOIA and the HEIA, overall, the judgement of the Supreme Court in Chaoulli can be interpreted in the following manner: As long as the Quebec government resolves the issue of unreasonable waiting times to access health care, it is not legally obliged to lift the prohibition on private duplicate insurance.<sup>264</sup>

Although the Chaoulli case did not ring in a new era of liberalized health care across Canada, or even in Quebec, it did help popularize the idea of delegating the provision of insured services to non-participating physicians. It also made private duplicate health insurance a legitimate policy option—and even a constitutionally required one—when monopolistic government systems fail to deliver timely care.

259. *Hospital Insurance Act*, Chapter A-28, Section 11.

260. Marie-Claude Prémont, *La garantie d'accès aux services de santé : analyse de la proposition québécoise*, *Les Cahiers de droit*, Vol. 47, No. 3, 2006, p. 576.

261. Assemblée Nationale du Québec, "Travaux parlementaires, Travaux des commissions," *Journal des débats de la Commission des affaires sociales*, Vol. 39, No. 70, 2006.

262. *Health Insurance Act* s 15(1).

263. Author's calculation. Ministry of Health and Social Services, Professionnels, Permis, Obtention d'un permis de centre medical spécialisé (CMS), Liste des centres médicaux spécialisés ayant reçu un permis en date du 22 novembre 2021, consulted December 7, 2021.

264. Marie-Claude Prémont, *op. cit.*, footnote 260, p. 575; Marie-Claude Prémont, "L'affaire Chaoulli et le système de santé du Québec : cherchez l'erreur, cherchez la raison," *McGill Law Journal*, 2006, pp. 191-192.

2005 – Changes to Quebec parallel health insurance laws following the Chaoulli ruling	
Before	After
The provision of duplicate insurance was prohibited, with no exceptions. The fine imposed on an insurer found guilty of a contravention to the prohibition was \$100.	Creation of two types of Specialized Medical Centres (SMCs), either participating or non-participating. The purchase of duplicate insurance is now permitted for three specific procedures (total hip or knee replacement and cataract extraction). If one was to purchase such insurance, it could only be used in non-participating SMCs to cover the total cost of one of the three treatments. The fine imposed for contravening the new law on duplicate insurance can now vary between \$50,000 and \$200,000.

Source: Marie-Claude Prémont, "La garantie d'accès aux services de santé : analyse de la proposition québécoise," *Les Cahiers de droit*, Vol. 47, No. 3, 2006, p. 576.

Box 2-1

## Specialized Medical Centres (SMCs)

SMCs were created through Bill 33 following the Chaoulli case as a way to shorten wait lists for elective surgery and to facilitate access to certain specialized services. The Bill defines a "specialized medical centre" as a place, outside a hospital, that is equipped to provide all medical services necessary for a total hip or knee replacement, or a cataract extraction or implantation. These and only these medically necessary treatments are performed in an SMC and correspond exactly to the specialized services covered by the opening made in parallel health insurance.

There are two types of SMCs:

1. One in which the practising doctors are opted in to the public insurance plan (known as participating SMCs). The medically necessary services provided in these centres are covered by the public insurance plan. Public hospitals may also enter into agreements with these SMCs to reduce wait list backlogs, conditional on obtaining approval from the Minister of Health and Social Services. If approved, the SMC then becomes an Associated SMC (ASMC). This agreement allows the hospital to delegate the provision of determined specialized medical services to the ASMC, for a maximum duration of five years.
2. One in which the practising doctors have opted out of the public insurance plan (known as non-participating SMCs). The medically necessary services provided in these centres are not covered by the public insurance scheme. Duplicate insurance can cover the cost of a total hip or knee replacement, or a cataract extraction or implantation. These SMCs cannot enter into agreements with public hospitals, limiting the extent to which opted-out physicians can lend a hand to help reduce the length of public system wait lists.

Given the prohibition on mixed practice, a specialized medical centre cannot be operated in part by doctors participating in the public plan and by others who are non-participating.

If an established clinic wishes to become an SMC, it must first obtain a permit from the Minister of Health. This means that contrary to the situation in Sweden or England, the number of SMCs, whether participating or non-participating, can be limited by the government's willingness to deliver permits.

Sources: Sylvie Bourdeau, "After 'Chaoulli'... Bill 33 opens the door to private clinics and private insurance in Quebec," *Mondaq*, July 28, 2006; Vos droits en santé, Organismes du système de santé, Les ressources privées du système de santé, Les cabinets privés de professionnels, Les centres médicaux spécialisés (CMS), consulted November 18, 2021; Sara Veilleux, La sous-traitance des services médicaux spécialisés : les motifs de recours, le processus et son évaluation au Québec, en Ontario, en Alberta et au Royaume-Uni, Ministère de la Santé et des Services sociaux, August 13, 2010, p. 18; Government of Quebec, *Act respecting health services and social services*, October 2021, section 107.1., p. 48.

## Cambie Surgeries vs. British Columbia

Building on Chaoulli, interest groups that want to benefit from the expansion of privately financed care in the Canadian system, as well as patients distressed by increasing wait times, have launched lawsuits in other provinces (Ontario,<sup>265</sup> Alberta,<sup>266</sup> and British Columbia<sup>267</sup>). Of most significance is an ongoing case that was launched against the British Columbia government in 2009, known as the Cambie case.<sup>268</sup>

Initiated by Cambie Surgeries Corporation (a private for-profit clinic) and led by its owner, Dr. Brian Day, the case challenges the constitutionality of every legislative disposition of British Columbia health law that has the effect of blocking the emergence and the development of a parallel decentralized and liberalized health care system. More specifically, the plaintiffs asked the court to invalidate the laws in British Columbia that:

1. Ban duplicate health insurance for medically necessary hospital and physician services (as in Chaoulli) [section 45 (1) of the *Medicare Protection Act* (MPA)];
2. Ban extra-billing so that doctors cannot charge patients above what they would receive from the public insurance scheme [section 17 (1) of the MPA]; and
3. Ban dual practice so that doctors must choose to bill exclusively to the public system or bill exclusively to private payers [combination of sections 13, 14, and 18 (3) of the MPA].<sup>269</sup>

The reasoning behind the challenge to these laws is that by preventing the emergence and development of a decentralized and liberalized health care system in British Columbia, these provisions violate the fundamental rights to life and security as provided in section 7 of the *Canadian Charter of Rights and Freedoms*,<sup>270</sup> because these provisions impose barriers making it more difficult, or impossible, for patients to have access to private health care when the government-run system is

deficient.<sup>271</sup> To escape an unfavourable ruling, the provincial government was required to demonstrate either that wait times in BC are reasonable or that there are measures in place to ensure that the right to life, liberty, and security of the person, as protected by section 7 of *Canadian Charter of Rights and Freedoms*, are not infringed.

The Cambie case, then, is a much broader challenge than the Chaoulli case. It recognizes that in order to have a flourishing independent health sector in Canada—that is, to make it much more economically viable for doctors to provide services outside the public system—it is necessary not only to overturn the restriction on the purchase of duplicate health insurance, but also to strike down restrictions on dual practice and extra-billing.

**The case challenges the constitutionality of every disposition of British Columbia health law that has the effect of blocking the emergence and development of a parallel decentralized and liberalized health care system.**

In the province of British Columbia, patients treated by unenrolled physicians offering medical services covered by public insurance will not be reimbursed by the government, even if the total fee that is charged does not exceed the amount determined by the public fee schedule.<sup>272</sup> If the ban on extra-billing were struck down altogether, then all enrolled or non-enrolled physicians would be entitled to bill what they wanted to the patient or insurer on top of what they already bill the public system.

However, the plaintiffs in the Cambie case are not seeking to fully strike down the ban on extra-billing. In fact, they are of the opinion that enrolled physicians should not be entitled to add private fees to Medicare services, as this would create a financial barrier to accessing a public service.<sup>273</sup> However, they insist that enrolled physicians should also be allowed to treat patients when taxpayer funding is not involved, “leaving it to government to respond with more tailored legislation that bans

265. *McCreith and Holmes v. Ontario* (5 September 2007) (Statement of Claim filed at ONSC).

266. *Allen v Alberta*, 2015 ABCA 277.

267. *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2020 BCSC 1310. Vancouver S090663 (BCSC) [Cambie].

268. Maria Weisgarber, “Appeal planned after B.C. court rules against private health care constitutional challenge,” CTV News, September 11, 2020.

269. *Medicare Protection Act*, RSBC 1996, Ch. 286, ss. 14, 17, 18 and 45 [Medicare Protection Act].

270. *Canadian Charter of Rights and Freedoms, part I of the Constitutional Act of 1982* [annex B of the *Canada Act 1982*, 1982, c. 11 (U.-K.)], s. 7 [Canadian Charter].

271. *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, paras. 73-74.

272. Government of British Columbia, Health, Practitioner & Professional Resources, MSP Physicians, Enrolment, consulted December 7, 2021.

273. Colleen M. Flood and Bryan Thomas, *op. cit.*, footnote 211, p. 8.

extra-billing while allowing wholly private billing by enrolled physicians.”<sup>274</sup>

In September 2020, the BC Supreme Court dismissed the Cambie case, claiming that the emergence of a parallel health care system would have negative impacts on the public system. The evidence on this point, however, is far from universally accepted. Supporters of the plaintiffs in this case have argued, for instance, that there is no evidence that the introduction of private clinics in BC in the 1990s did any damage to the public system.<sup>275</sup>

**The Cambie case, if successful in whole or in part before the Supreme Court of Canada, has the potential to rapidly accelerate the development of a parallel health care system across Canada.**

Despite this unfavourable ruling, the Cambie case is still ongoing. The plaintiffs have indicated that they will be appealing the decision to the BC Court of Appeal, and regardless of what is decided there, it seems likely that the case will be brought to the Supreme Court of Canada.<sup>276</sup>

The Cambie case, if successful in whole or in part before the Supreme Court of Canada, has the potential to rapidly accelerate the development of a parallel health care system across Canada. Unlike in the Chaoulli case, a favourable Supreme Court ruling would indirectly apply to other provinces' similar legislative provisions. In this case, other Canadian provinces would have the opportunity to pass alternative laws and policies that are constitutionally compliant with the CHA, but that leave room in their universal health systems for a parallel sector.<sup>277</sup>

## Lessons Quebec and BC Can Learn from Sweden and the UK

The first chapter of this paper presented the paths followed by Sweden and the UK in decentralizing and liberalizing their respective health care systems. In both

cases, the health reforms involved expanding access to health services by including practitioners and institutions operating outside the public system. In other words, the independent sector was not seen as a threat to the integrity of their health care systems, but rather as a network of additional resources that could be used to complement the public system and ultimately benefit patients. The support of the independent sector is reflected in the fact that dual practice (while still regulated in England for consultants) and duplicate private insurance are permitted, as opposed to most Canadian provinces.<sup>278</sup> Additionally, both Sweden and the UK place greater importance on patient choice, further enforced by the implementation of payment mechanisms and hospital funding schemes that were designed to ensure that the money would follow the patient.

There are features of the Swedish and British health care systems that, given current provincial regulations, rule out the possibility of seeing them as comprehensive models for reformed provincial Canadian systems. For example, user fees for physician visits<sup>279</sup> would likely be considered unacceptable in Canada. And to the Canadian medical profession, a system of mainly salaried doctors<sup>280</sup> may seem unattractive, given that they are currently remunerated on a fee-for-service basis.<sup>281</sup>

In many other respects, though, there are lessons that can be learned from the experiences of these systems that, with some amendments to the current regulatory system, could be applied to Canadian provinces as a way to expand the participation of entrepreneurs in the provision of health care. Indeed, despite the limiting effects of the CHA on provinces' ability to reform their health systems, there are nonetheless a number of potential reforms that are not explicitly prohibited by federal law that should be considered.

The reforms presented in this section are thus included based on their compliance with the CHA and their real-world use and success in other countries with universal health care, as seen in the first chapter. What's more, the order in which these reforms are applied is arguably just as important as the reforms themselves. As such, they are presented in an order that, if respected, would maximize the chances of reaching the best possible outcome, that is to say, a health system that is patient-oriented and

274. *Idem*.

275. Ian Mulgrew, "Ian Mulgrew: Plaintiffs will appeal landmark court challenge of universal Medicare," *Vancouver Sun*, September 11, 2020.

276. Tracey M Bailey, et al., "Cambie Surgeries Corporation V. British Columbia (Attorney General): Case Comment," Miller Thomson, December 10, 2020.

277. *Idem*.

278. British Medical Association, *op. cit.*, footnote 175, pp. 87-88; Carl Emmerson, Christine Frayne and Alissa Goodman, *op. cit.*, footnote 114, p. 52.

279. Roosa Tikkanen et al., *op. cit.*, footnote 96, pp. 184-185.

280. *Idem*.

281. Canadian Institute for Health Information, *Physicians in Canada, 2019, 2020*, p. 35.

equipped with the tools and partnerships that allow it to better respond to the needs of the population.

## 1- Adopt Electronic Patient Records and Expand Access to Health Data

Before any single adjustment is made to a provincial health system or the laws regulating it, it is imperative that the use of electronic health records (EHRs) be widespread, that health data be readily accessible, and that operational administrative duties be performed electronically. In other words, handwritten records and fax-based communication between institutions, archaic practices still present across the country, must make way for the technologies of the present.<sup>282</sup> At the very least, the digitization of health data and patient records would greatly facilitate a province's ability to monitor the implementation of reforms and their efficiency.

While adopting EHRs and expanding access to health data is not a reform per se, it remains a crucial step in the transformation and liberalization of a health care system, for several reasons. For one thing, if a province wishes to reform hospital funding, moving from historical (global) budgets to activity-based funding mechanisms such as Payment by Results or DRGs, it will be essential to first be able to collect the relevant data pertaining to a hospital's activity and its patients. This is especially true for Payment by Results schemes, since remuneration is based on patient outcomes—information that can be most easily accessed through electronic records. Moreover, making certain hospital and physician performance indicators accessible to the public can strengthen a patient's ability to make an informed decision when choosing a health care provider.

The lack of sound health data on everything from population health to human resources means there can be little evidence-based health care planning, including planning of services, delivery mechanisms, or recruitment needs. This hinders effective policy-making, and without such information, government policies or reforms regarding health care will never adequately respond to the population's needs.

Health records in electronic form are not only more legible and more easily retrieved than paper-based health records, but they provide patients and their health care providers with complete and up-to-date details about

the individual's health profile. This offers many potential benefits, such as decreased risk of a patient being sent for duplicate tests, being prescribed an inappropriate medication, or receiving delayed service. Overall, by enabling better health care planning, monitoring of health outcomes, and health research support, EHRs offer citizens long-term benefits such as safer and more effective health services.<sup>283</sup>

Such benefits are most likely to occur if two conditions are met, however. First, citizens need to fully understand how their data are used in health research with the help of transparent and effective explanations from their health care providers. And second, to fully benefit from digital health care, "e-health" competencies must be integrated into the medical school curriculum and be part of our health care professionals' continued professional development. All health care professionals must be well versed in the use of the virtual tools and platforms at their disposal. Such training is key to accelerating acceptance of the collection of health care data.

**These reforms are presented in an order that, if respected, would maximize the chances of reaching the best possible outcome: a health system that is patient-oriented and equipped to better respond to the needs of the population.**

Initiatives involving electronic patient records began decades ago in England. Already by 1996, 96% of general practices has computerized their activities.<sup>284</sup> Today, a computerized clinical system records nearly every primary care consultation in the UK.<sup>285</sup> The collected information is then anonymized and shared with the research divisions of various institutions. Patient-level data is, however, only shared if the patient agrees. Otherwise, the data remains available to the practice only, and patients maintain the right to opt out of their data being shared for purposes other than direct care.<sup>286</sup>

282. Laura Osman, "Archaic paper records submitted by fax hold up real-time COVID-19 data," CTV News, May 12, 2020; François Thibeault, "Are there alternatives to fax in Canada's health care systems?" GRISS, June 26, 2020.

283. Nir Menachemi and Taleah H. Collum, "Benefits and drawbacks of electronic health record systems," *Risk Management and Healthcare Policy*, May 11, 2011, pp. 49-50.

284. Royal College of General Practitioners, RCGP information sheet, October 2000, No. 7, General practice computerisation, London: RCGP, 2000 as cited in Tim Benson, "Why general practitioners use computers and hospital doctors do not—Part 1: incentives." *BMJ*, Vol. 325, 2002, p. 1086.

285. Stephen H. Bradley, Neil R. Lawrence, and Paul Carder, "Using primary care data for health research in England – an overview," *Future Healthcare Journal*, Vol. 5, No. 3, 2018, p. 207.

286. *Ibid.*, p. 208.

As for Sweden, the use of electronic health records has been implemented for several years. In 1997, the government created an EHR for prescription drugs, which reduced the need to use paper written prescriptions.<sup>287</sup> This initiative resulted in 95% of all pharmaceutical prescriptions being issued and transferred electronically by 2012.<sup>288</sup> That same year, the use of EHRs in primary health care, hospitals, and psychiatry reached 100% coverage.<sup>289</sup>

## 2- Remove the Prohibition on Duplicate Health Insurance

### *Legality with regard to the CHA*

Contrary to popular belief, the CHA does not specifically preclude parallel or independent health insurance for medically necessary services. In other words, the CHA does not explicitly prevent provinces from introducing reforms that would allow for the emergence of a duplicate insurance market for services deemed medically necessary by their Medicare programs. However, policies contracted with duplicate insurers could only cover services rendered outside the public health care system: The CHA unambiguously prohibits private insurance providers from sharing the cost of publicly insured medically necessary services.<sup>290</sup>

### *Experience in Sweden and the United Kingdom*

In both Sweden and the United Kingdom, a person can purchase duplicate insurance. This means their insurance plan can cover the cost of medical services received in a private facility, even if those same services are already offered in the public system. Sweden's private insurance market is relatively new, having only been legalized in 2010, whereas citizens of the United Kingdom have had the freedom to purchase duplicate private insurance since the 1950s.<sup>291</sup> Still, in both countries, the proportion of the population with such insurance has

not surpassed 15%.<sup>292</sup> The reasons behind the low adherence to duplicate insurance are two-fold.

First, as explained in Chapter 1, in Sweden's case, duplicate insurance is not purchased by many because most independent physicians operate within the public system. This means their services are covered by the public insurance scheme, limiting the need to buy additional coverage. Moreover, even though there are patient fees associated with visiting a primary or secondary care physician, these are quite minimal, are subject to a yearly cap, and are regionally pre-determined so as to limit any potential adverse effects of extra fees.

**Handwritten records and fax-based communication between institutions, archaic practices still present across the country, must make way for the technologies of the present.**

Second, since duplicate insurance is often purchased in order to receive treatments more rapidly, if a health care system becomes more efficient and significantly reduces wait times for procedures, the demand for duplicate health insurance is likely to fall, as the population may no longer see the need to purchase duplicate insurance.

***The reform: Allow duplicate private insurance to cover the costs of all medical procedures, whether or not these are already insured by the public system.***

The prohibition on duplicate insurance severely limits the number of options available to patients who are seeking private services for publicly funded care, especially in a context where waiting lists are unreasonably long, as is the case in many provincial health care systems. It also dampens the demand for care offered by opted-out physicians who extra-bill, by limiting patients' ability to pay for those services. As of now, in Quebec and British Columbia, neither public nor parallel insurance covers services provided by opted-out physicians if they extra-bill. The market for those physicians' services is restricted to patients who can afford to pay the full cost out-of-pocket. As such, removing this prohibition would allow patients to gain access to care in a timely manner when the public system fails to provide it. Considering the impacts of the COVID-19 pandemic on scheduled surgeries and wait lists, it is a safe bet that

287. Paolo Nicola Barbieri and Kristian Bolin, "Digitalizing and collecting health data in Sweden," *Pharmaceuticals Policy and Law*, Vol. 19, Nos. 3-4, 2018, pp. 236-237.

288. L. Jervall and T. Pehrsson, eHealth in Swedish County Councils 2013, as cited in Paolo Nicola Barbieri and Kristian Bolin, *ibid*, p. 237.

289. Action plan 2013-2018 eHealth collaboration among counties, regions and municipalities, 2012, pp. 1-24 as cited in Paolo Nicola Barbieri and Kristian Bolin, *idem*.

290. Bacchus Barua, Jason Clemens, and Taylor Jackson, *Health Care Reform Options for Alberta*, Fraser Institute, 2019, p. 24.

291. Anna Sharudenko, *op. cit.*, footnote 95; Carl Emmerson, Christine Frayne, and Alissa Goodman, *op. cit.*, footnote 114, p. 52.

292. Roosa Tikkanen, *et al.*, *op. cit.*, footnote 96, pp. 61 and 183.

the pressures on the public system will not be relieved anytime soon.<sup>293</sup>

### **What would need to be done in Quebec**

Removing the ban on duplicate insurance in the province of Quebec would involve amending section 11 of the *Hospital Insurance Act* and section 15 of the *Health Insurance Act*. More concretely, the government could expand the current list of medically necessary procedures that can be covered by duplicate insurance. Indeed, Quebec currently allows the purchase of additional insurance to cover the cost of three treatments (total hip or knee replacement and cataract surgery), as long as they are provided in a non-participating SMC. But Quebec health authorities could expand the list to include other medically necessary procedures.<sup>294</sup>

### **What would need to be done in British Columbia**

The ban on duplicate health insurance for medically necessary hospital and physician services in British Columbian health law is in section 45 (1) of the *Medicare Protection Act*. An amendment to this section would therefore be required to allow medically necessary services to be covered by duplicate insurance.

While amending the appropriate health laws represents one of the crucial first steps toward a more liberalized health system, it will not by itself encourage the emergence of a parallel health insurance market. Indeed, in Quebec, even after permitting certain procedures to be covered by duplicate insurance, the market for such products remains practically non-existent. As such, this reform must be accompanied by other market-oriented health system transformations.

## **3- Remove the Prohibition on Dual Practice**

### **Legality with regard to the CHA**

Dual practice by physicians is another policy option that is not expressly outlawed by the *Canada Health Act* (CHA). This means that under the CHA, Canadian physicians are allowed to practice both in the public system and in a parallel system simultaneously. It is the provinces themselves that impose such a restriction on their health professionals. Specifically, doctors must first opt out of the public system before being allowed to practise in a private setting.

293. Maciej J. K. Simon and William D. Regan, "COVID-19 pandemic effects on orthopaedic surgeons in British Columbia," *Journal of Orthopaedic Surgery and Research*, Vol. 16, No. 161, pp. 2-4.

294. Government of Quebec, *Health Insurance Act*, sections 15 and 15.1.

### **Experience in Sweden and the United Kingdom**

Mixed practice is permitted in both Sweden and England. In the latter, though, there is a stricter framework in place governing the dual practice of consultants, allowing them to practise privately only after having devoted a certain number of hours to the public system.<sup>295</sup> Such restrictions do not apply to medical professionals who are not consultants, such as nurses or general practitioners, who are free to divide their time as they see fit.

**Quebec currently allows the purchase of additional insurance to cover the cost of three treatments (total hip or knee replacement and cataract surgery), but health authorities could expand the list to include other procedures.**

### **The reform: Allow mixed practice for all health care professionals.**

Allowing health practitioners to operate in both the public and private sectors simultaneously without having to opt in or out would provide several benefits for both the patient and the physician, as well as for government health authorities. For instance, permitting dual practice can serve as an attractive tool for recruiting and retaining health workers in public facilities, and even in rural and remote areas, without inducing an extra budgetary burden. Also, working in the independent sector can enhance doctors' technical knowledge and skills, thereby boosting the quality of care delivered.<sup>296</sup> Similarly, dual practitioners will have an added incentive to perform as well as possible during their public working hours in order to build up a good reputation for their parallel practice. Furthermore, public funding could become more effectively targeted toward lower-income populations, as physicians would have an incentive to refer higher-income patients from the public to the private sector, thereby reducing public wait lists and increasing access for both groups.

### **What would need to be done in Quebec**

Because of section 22 of Quebec's *Health Insurance Act*, doctors participating in the public system are not allowed

295. British Medical Association, *op. cit.*, footnote 175, pp. 87-89.

296. Peter Berman and Dexter Cuizon, *Multiple public-private jobholding of health care providers in developing countries, An exploration of theory and evidence*, Department for International Development Health Systems Resource Centre, March 2004, pp. 6-7.

to work outside of it when it comes to medically necessary insured services.<sup>297</sup> This section of the law must be amended in such a way as to allow doctors the freedom to work in the private and public sectors simultaneously.

### **What would need to be done in British Columbia**

The ban on dual practice in British Columbia is found in sections 14, 17, and 18 (3) of the *Medicare Protection Act*.<sup>298</sup>

The prohibition on dual practice in both of these provinces is the result of the accumulation of restrictions on physicians' billing practices and beneficiaries' ability to obtain public reimbursement if billed directly by a physician for a covered service. More specifically, to be able to bill patients directly for publicly covered services, a doctor must first completely opt out of the public system. Then, an opted-out physician providing medically necessary services can bill their patients directly for an amount superior to public fees, but the patient will not be refunded for any part of this amount. Unless duplicate insurance is permitted, as recommended above, the patient must simply pay out-of-pocket.

Permitting dual practice would require amending or striking out these laws altogether. The concept of opting out of the public system would then no longer exist, alleviating the administrative burden for health professionals who wish to dedicate their time to both sectors, thereby reducing red tape. In British Columbia, physicians would no longer have to wait a full year before working for the public sector again after having done some work in private practice.

## **4- Increase the Supply of Medical Professionals: Three Reforms**

### **Legality with regard to the CHA for all three reforms**

There are no legal restrictions in the CHA to enlarging the pool of medical professionals.

### **The reform: Use three different methods to increase the number of available medical professionals.**

Some worry that the removal of the prohibition on dual practice could reduce the available resources in the public system due to an exodus of physicians toward the entrepreneurial sector, or that there would be a lack of medical professionals to fill the positions in any new

institutions that opened in order to expand access to health care. Such concerns arise because the supply of physicians is limited. But there are ways to increase the number of available medical professionals. Both Sweden and the UK were faced with this very concern, but ultimately overcame this challenge using several different methods.

**Dual practice by physicians is not expressly outlawed by the *Canada Health Act (CHA)*. It is the provinces that impose such a restriction on their health professionals.**

### **4.1 - Recognize Skills Learned Abroad and Launch an International Recruitment Campaign**

#### **Experience in Sweden and the United Kingdom**

In the UK, when independent specialized treatment centres (ISTCs) were first being staffed, there were concerns that staff would be "poached" from the NHS.<sup>299</sup> As such, in the first wave of hiring, ISTCs were not permitted to recruit staff who had been employed within the public system in the previous six months. Many medical professionals were therefore recruited from other countries. This condition was relaxed in the second wave of hiring, at which point ISTCs were allowed to hire NHS staff. However, professionals working in fields determined to be in shortage were only permitted to work in ISTCs outside of their contracted NHS hours.<sup>300</sup>

In the early 2000s, northern Sweden was facing a worsening shortage of doctors and nurses, which led regional governments to turn to entrepreneurs and agencies to fill open positions.<sup>301</sup> For-hire companies have become key operators in many parts of Sweden since then, which is all the more impressive given that such agencies were still illegal in the early 1990s. These professionals play a significant role in the health system, and when one of the county councils declared a halt to the hiring of doctors and nurses through these agencies,

297. Government of Quebec, *Health Insurance Act*, section 22.

298. Government of British Columbia, *Medicare Protection Act*, sections 14, 17, and 18(3).

299. Chris Naylor, "Briefing Independent sector treatment centres," The King's Fund, October 2009, p. 4.

300. NHS Employers, "Human Resources Framework. To support independent sector elective and diagnostic schemes," August 2007 as cited in Chris Naylor, *idem*.

301. Johan Hjertqvist, "Swedish Healthcare in Transition," Frontier Centre for Public Policy, February 1<sup>st</sup>, 2001.



waiting lists began to grow, resulting in cancer patients being sent home due to a lack of nurses.<sup>302</sup>

Sweden and the UK also offer accreditation programs to foreign-trained doctors to allow them to conform to local standards and be able to practise.<sup>303</sup> While Canadian provinces offer similar programs,<sup>304</sup> there is greater participation of foreign-trained doctors in Sweden and the UK. Indeed, between 2003 and 2018, Sweden issued more medical licenses to people having obtained medical training outside the country than to those educated in Sweden.<sup>305</sup> In 2015, the Swedish National Board of Health and Welfare (SNBH) granted 1,509 licenses to foreign-educated medical students, compared to 1,070 for Swedish graduates.<sup>306</sup> A growing number of licenses have been issued to International Educated Nurses (IENs) as well in recent years, with 672 licenses granted to IENs in 2015, up from 229 in 2009.<sup>307</sup> The proportion of foreign-trained doctors has been on an upward slope since the early 2000s at least, with the most recent numbers indicating that internationally-trained doctors account for 29% of all physicians in Sweden.<sup>308</sup>

Similarly in England, the difference between the number of foreign-trained doctors and home-grown British physicians beginning their career in the United Kingdom more than doubled in recent years. Approximately 9,100 internationally-trained medical professionals received a license to practise in the United Kingdom in 2019, compared to the 7,100 permits that were issued to British-trained doctors.<sup>309</sup> Overall, non-UK graduates comprised 31% of the total number of doctors in 2020.<sup>310</sup> By contrast, just 24% of practicing physicians in Canada in

2019 graduated from a foreign medical school.<sup>311</sup> This percentage varies greatly from one province to the next, however, with a lower concentration of foreign medical graduates in Quebec (15%) than in provinces such as Saskatchewan (52%) and Newfoundland and Labrador (32%)<sup>312</sup> (see Figure 2-3). Even during the pandemic, with a dire need for medical staff, Quebec refused to retain the help of over 20 French-speaking “overqualified” nurses who were ready to move to the province to practise their profession.<sup>313</sup> This speaks volumes as to the lack of openness toward foreign-trained health professionals.

**Out of 1,435 internationally educated doctors who live in Canada and applied for residency positions in 2020, only 29% got placements. Over 1,000 qualified physicians willing and able to work in Canada in 2020 were left unable to practise.**

The low proportion of foreign-trained doctors in Canada in general can also be partially explained by the allotment of mandatory residency positions that are reserved for Canadian graduates by the Canadian Resident Matching Service. Indeed, for the past eight years, 90% of positions have been reserved for students who attended Canadian or American universities, leaving only 10% to be filled by foreign-trained doctors. And it is not from a lack of foreign-trained applicants.<sup>314</sup> Out of 1,435 internationally educated doctors who now live in Canada and applied for those residency positions in 2020, only 29% got placements.<sup>315</sup> This means that over 1,000 qualified physicians who were willing and able to work in Canada in 2020 were left unable to practise.

### **What would need to be done in Quebec**

Quebec currently has an agreement with France that mutually recognizes the educational and professional qualifications of 81 professions, including that of nurses and doctors, with its main objective being to facilitate

302. *Idem.*

303. Socialstyrelsen, Obtaining a licence if you are educated outside EU and EEA, consulted December 22, 2021; NHS Employers, Working and training in the NHS – a guide for international medical graduates, May 19, 2021.

304. Royal College of Physicians and Surgeons of Canada, Exams Home, Eligibility, International medical graduates, consulted in December 17, 2021.

305. Swedish National Board of Health and Welfare, “National Planning Support’s (NPS) register,” Stockholm, Swedish National Board of Health and Welfare, 2016 as cited in Elisabeth Eriksson, Soren Berg, and Maria Engstrom, “Internationally educated nurses’ and medical graduates’ experiences of getting a license and practicing in Sweden – a qualitative interview study,” *BMC Medical Education*, 2018, Vol. 18, No. 296, p. 1.

306. Elisabeth Eriksson, Soren Berg, and Maria Engstrom, *Idem.*

307. Swedish National Board of Health and Welfare, *op. cit.*, footnote 305, p. 2.

308. OECD. Stat, Health Workforce Migration: Foreign-trained doctors by country of origin - % of foreign-trained doctors, consulted January 31, 2022.

309. Henry Bodkin, “Gap between number of foreign doctors and UK trained doctors doubles in a year, new figures from GMC show,” *The Telegraph*, October 24, 2019.

310. OECD. Stat, *op. cit.*, footnote 308.

311. *Idem.*

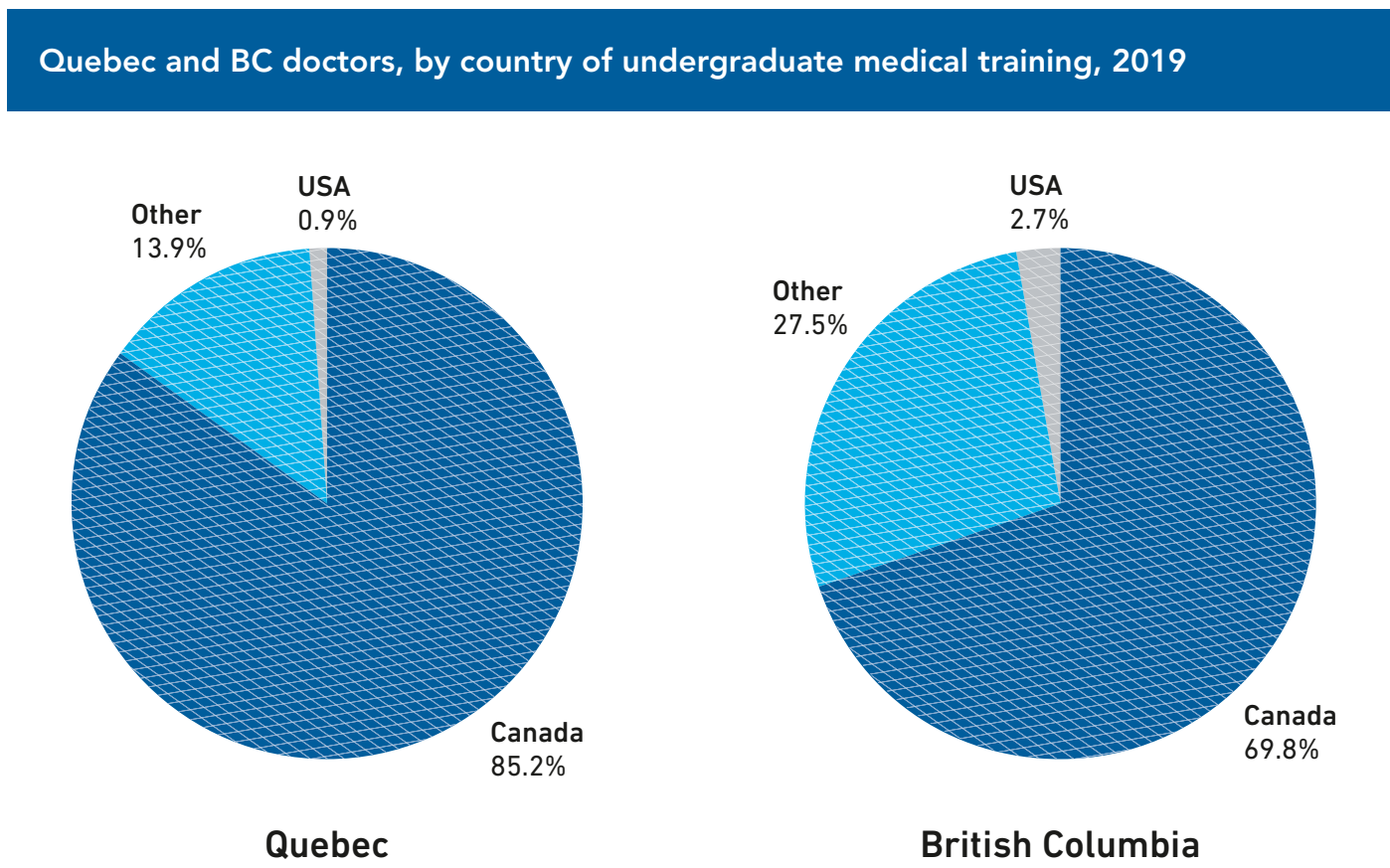
312. Canadian Medical Association, “CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory,” 2019, p. 2.

313. Lisa-Marie Gervais, “Les agences privées écartées du recrutement à l'étranger,” *Le Devoir*, October 15, 2021.

314. Lori Culbert, “Physician mission: B.C. pressed to recognize qualifications of foreign-trained doctors,” *Vancouver Sun*, August 20, 2021.

315. *Canadian Resident Matching Service, 2020 CaRMS Forum*, 2020, p. 5 as cited in Lori Culbert, *Idem.*

Figure 2-3



Source: Canadian Medical Association, “CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory,” 2019, p. 2.

the mobility of workers.<sup>316</sup> Despite this agreement, hundreds of applications are denied. In 2016, for instance, 56% percent of the French doctors who applied for a license were not granted one, closing the door to 194 additional doctors.<sup>317</sup> One study found that the impact of the Quebec-France agreement was severely limited by the legislative, regulatory, and administrative provisions in force in Quebec.<sup>318</sup> In France, the agreement allows Quebec doctors to obtain a permit and work in France in less than two months, whereas for French doctors, the procedures in Quebec often take more than two years, and they do not always succeed.<sup>319</sup>

316. Government of Quebec, Immigration, Francisation et Intégration, Entente France-Québec sur la reconnaissance mutuelle des qualifications professionnelles, consulted December 22, 2021; Antoine Dumas-Martin, *L’Entente Québec-France et ses limites : le cas des médecins de famille*, École de politique appliquée Faculté des lettres et sciences humaines, Université de Sherbrooke, 2014, p. 9.

317. Author’s calculations. Sophie Langlois, “Le Québec ferme la porte à près de 200 médecins français,” Radio-Canada, April 5, 2020.

318. Antoine Dumas-Martin, *op. cit.*, footnote 316, p. 50.

319. Sophie Langlois, *op. cit.*, footnote 317.

As such, expanding the health care workforce with foreign-trained doctors can be achieved by easing the regulatory barriers to entering the Quebec workforce. Therefore, it would be in Quebec’s best interest to streamline the applications of French doctors, just as France has done for Quebec applications. Going further, the integration process must also be improved for doctors and nurses who have been trained in other countries.

### What would need to be done in British Columbia

The issue regarding the accreditation of internationally trained doctors in British Columbia is of particular importance since the province of over 5 million people has a very limited capacity to train its own doctors, with only one medical school.<sup>320</sup>

320. Practice in BC, Canadian Medical Schools, consulted November 23, 2021.

Despite a significant doctor shortage in British Columbia, foreign-trained doctors are unable to get approved to work as physicians in the province. This is not a new issue. Many permanent residents, and even Canadians, who have obtained their medical degree in another country have for years been pushing the provincial government to change the discriminatory rules that prohibit the vast majority of them from getting residencies in hospitals.<sup>321</sup> These rules and regulations have made it nearly impossible for foreign-trained doctors to get resident positions in 86% of specialties in order to be certified in British Columbia.<sup>322</sup>

The issue is related to the strict regulatory framework for obtaining a license to practise in the province, much like in Quebec. More specifically, foreign-trained doctors, after having passed multiple qualifying exams and a language test, must complete a residency program before being able to practise on their own. This is true even if the internationally trained doctor has practised for several years before immigrating to Canada and has already practised under supervision elsewhere in Canada.<sup>323</sup>

A step in the right direction would be to adapt the current accreditation process for internationally trained doctors by taking into account their individual experience, and streamlining the process accordingly. An agreement with other countries could also be drawn up, similarly to the Quebec-France initiative, but with fewer regulatory hurdles. Additionally, more residency positions are needed for international medical graduates.

## 4.2 - Increase the Number of Home-Grown Doctors by Eliminating Medical School Quotas

### *Experience in Sweden and the United Kingdom*

While it is unclear whether Sweden imposes a quota on the number of medical graduates, the United Kingdom does limit the places available in medical schools.<sup>324</sup> Nonetheless, these countries still manage to have a greater number of medical graduates every year, compared to the Canadian average. Indeed, there were fewer than 8 newly graduated medical students per

100,000 population in Canada in 2019, compared to over 13 in both Sweden and the UK.<sup>325</sup>

This gap has been persistent for decades, with Canada's figures showing only modest expansion since 2000 (see Figure 2-4). This can be explained by the fact that Canadian provinces impose a quota on the number of students that may be admitted into university medical programs. One of the motivations behind this admissions limit in the past was to make sure no doctors found themselves unemployed once they graduated.<sup>326</sup> Given the current doctor shortage in both Quebec<sup>327</sup> and British Columbia,<sup>328</sup> there would be room for a lot more of them after having completed their studies.

**There were fewer than 8 newly graduated medical students per 100,000 population in Canada in 2019, compared to over 13 in both Sweden and the UK.**

### *What would need to be done in Quebec*

The government of Quebec has recently decided to raise the quota on the number of medical school admissions, and by 2023, an additional 139 students will be permitted to study medicine in the province's medical programs, a 16.7% increase over 2020 admissions.<sup>329</sup> Quebec would still refuse far more students than it admits (see Figure 2-5), but at least it is therefore making strides in bolstering its supply of physicians. This increase would potentially bring the number of medical graduates per 100,000 population in Quebec to 11.3 by 2023,<sup>330</sup> a ratio approaching that of Sweden and the United Kingdom. However, this alone will not sufficiently increase the supply of doctors to an optimal level, especially given the rapidly aging population of the province. The best course of action would be to eliminate these

321. Neetu Garcha, "Foreign-trained doctors file B.C. human rights complaint, claiming systemic discrimination," *Global News*, June 26, 2020.

322. Author's calculations. *Idem*.

323. *Idem*.

324. Sean Coughlan, "UK students excluded from UK medicine degree," *BBC News*, September 22, 2015.

325. Health Care Resources: Graduates, consulted November 23, 2021.

326. Hugo Duchaine, "Gaétan Barrette coupe le nombre de futurs médecins," *Le Journal de Montréal*, July 8, 2017.

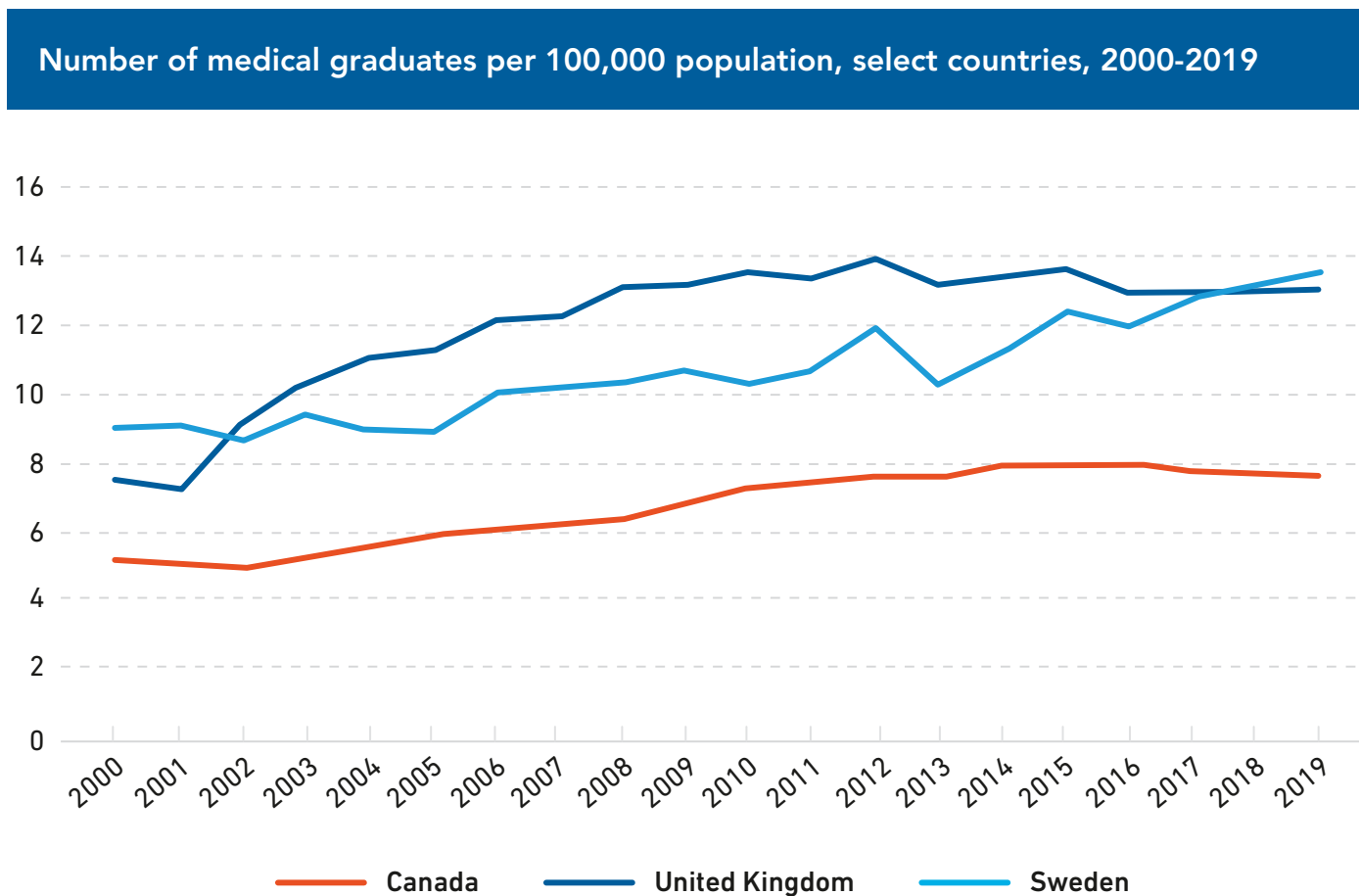
327. Brian Gore, "Opinion: Don't blame family doctors for shortage in Quebec," *Montreal Gazette*, November 3, 2021.

328. Penny Daflos, "B.C. family doctor shortage impacting 911 service and ambulance waits," *CTV News*, November 9, 2021.

329. Author's calculations. Vincent Larin, "Québec augmente les admissions en médecine," *TVA Nouvelles*, May 22, 2020.

330. Author's calculations, assuming that every single student admitted in the first year of the program will graduate. *Idem*; Statistics Canada, Table 17-10-0009-01: Population estimates, quarterly, 2021.

Figure 2-4



Source: OECD.Stat, Health Care Resources: Graduates.

quotas altogether, in conjunction with the other reforms in this section.

**What would need to be done in British Columbia**

As of 2020, the number of medical students currently being admitted into British Columbia's single medical school has been 288 since 2011,<sup>331</sup> and the province has only 5.6 medical graduates per 100,000 population per year. With an acceptance rate of just 10% in 2021, over 2,000 applicants have been refused annually since 2017<sup>332</sup> (see Figure 2-6). In order to reach a number of medical graduates similar to Sweden and the UK, BC would have to increase its number of medical school

admissions to 677 per year,<sup>333</sup> a daunting challenge, especially with just one medical school. The best course of action for this province would therefore certainly be to complement any efforts to increase medical school admissions with the other reforms in this section.

**4.3 - Eliminate Interprovincial Barriers to Medical Licensing**

**Experience in Sweden and the United Kingdom**

Doctors having completed their studies in Sweden have no jurisdictional limitations on their place of practice one they have obtained a medical license from the National Board of Health and Welfare.<sup>334</sup>

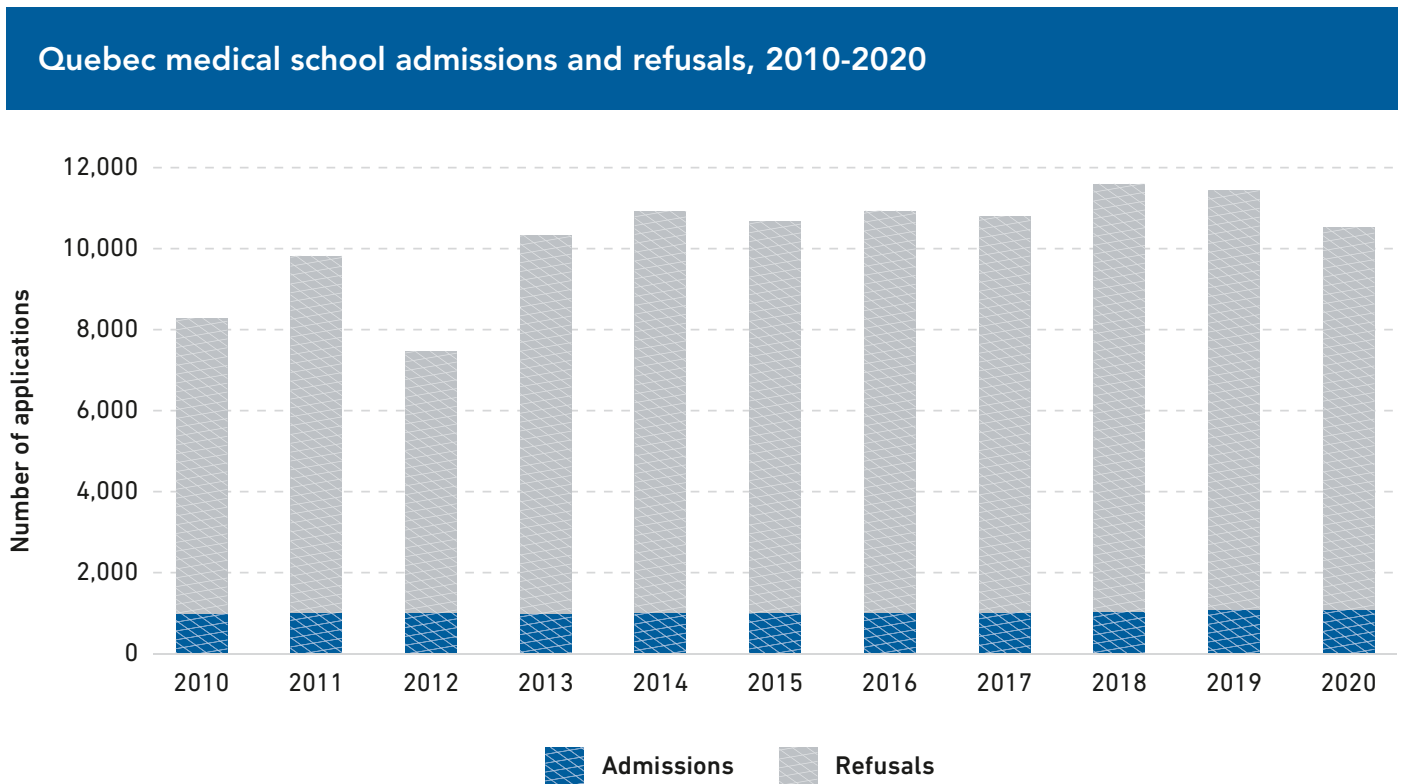
331. The University of British Columbia, "Statistical data on application and admissions – 2012 (med 2016) with comparative figures for 2010 & 2011," 2012, p. 1.

332. Author's calculations. The University of British Columbia, Faculty of Medicine, Home, Admissions, Before you apply, Past Admissions Statistics, consulted January 31, 2022; Statistics Canada, *op. cit.*, footnote 330.

333. Author's calculations. Statistics Canada, *Idem.*

334. Unican Immigration, Sweden Residency for Medical Staff, consulted December 20, 2021.

Figure 2-5



\*2012 data missing for one medical school. Number of refusals are therefore underestimated.

Source: Author's calculations. The Association of Faculties of Medicine of Canada, *Canadian Medical Education Statistics 2020*, 2020, pp. 66 and 150.

Similarly, in the United Kingdom, medical graduates from any school within one of the four administrations (England, Northern Ireland, Scotland, and Wales) who obtain a license from the General Medical Council can practise throughout the NHS, without additional licensing.<sup>335</sup>

In Canada, a physician practising medicine in an office or in a health establishment in a given province or territory must be licensed in said jurisdiction. This means that a physician who wishes to practise across the country will need to be licensed by each of the thirteen provinces and territories. Obtaining these permits will be subject to compliance with eligibility criteria, production of several documents, and payment of fees which will total a few thousand dollars per year.<sup>336</sup> For example, if a Quebec doctor wishes to practise in neighboring Ontario as well, he or she would need to provide upward

of 40 documents<sup>337</sup> for the application process and pay the annual medical license application fee of \$1,725 for the Ontario license, on top of the \$1,660 fee to retain the Quebec license.<sup>338</sup>

From a patient's perspective, easing the regulation of licenses to practise, for example through mutual recognition of provincial licenses, could help increase the availability of care and facilitate access since the administrative burden of practising in multiple regions would be lighter, thereby making it easier for medical professionals to work across the country. If a doctor or nurse has a valid license to practise in one province, health authorities in other provinces should consider this valid as well. A major obstacle to labour mobility would thus be removed, and provincial public health systems would also benefit. Indeed, the mutual recognition of permits

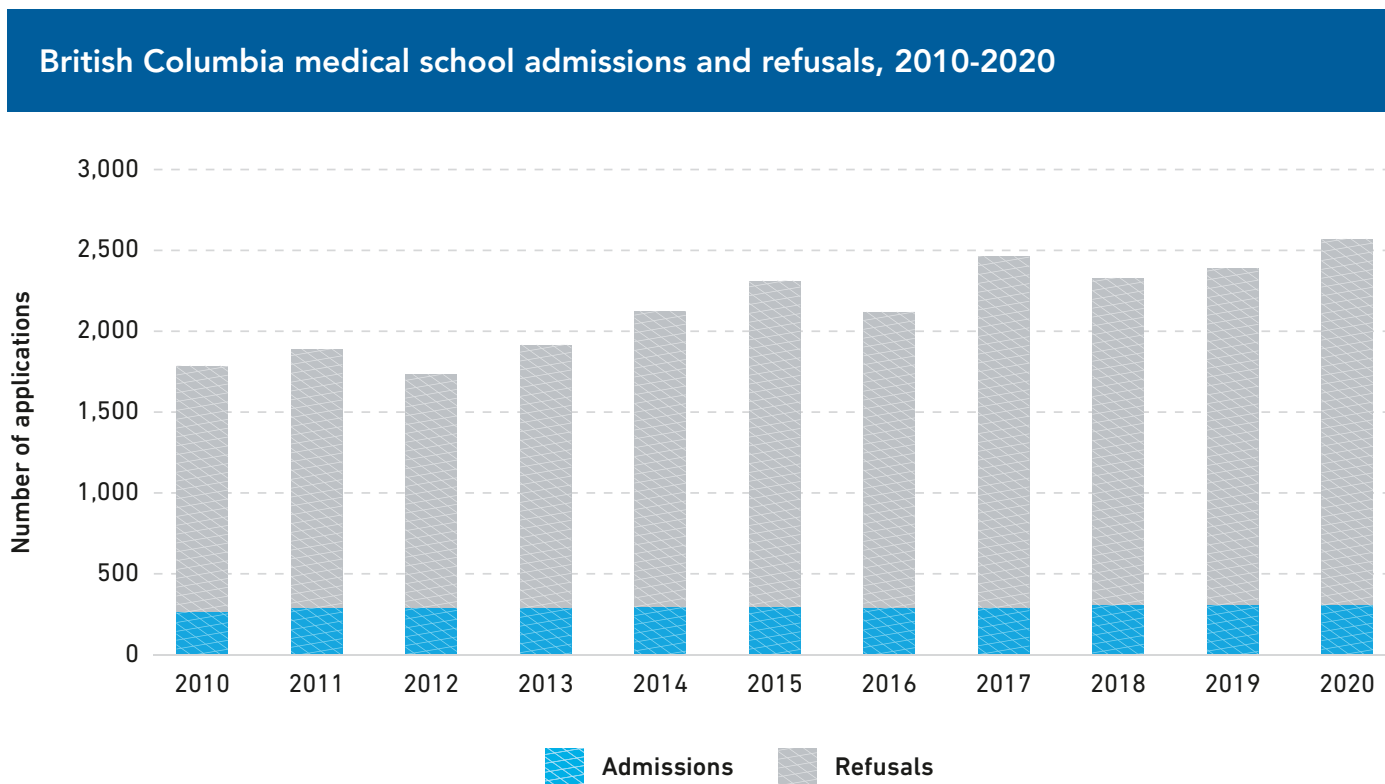
335. NHS, Explore roles, Doctors, Information for overseas doctors, consulted December 20, 2021.

336. Joshua Tepper, Ryan Hinds, and Bernard Ho, "Is it time to implement one national license for Canadian doctors?" *Healthy Debate*, March 18, 2020.

337. Andre Picard, "Why isn't there a single medical license for all doctors in Canada?" *The Globe and Mail*, January 4, 2019.

338. The College of Physicians and Surgeons of Ontario, Physicians, Your Practice, Membership Services, Fee Schedule, March 2020; Collège des médecins du Québec, Professional practices, Managing my file, First registration, First registration on the membership roll, April 6, 2021.

Figure 2-6



Source: Author's calculations. The Association of Faculties of Medicine of Canada, *Canadian Medical Education Statistics 2020*, 2020, pp. 66 and 150.

would allow doctors to practise where they are needed most, either in person or through telemedicine.

**What would need to be done in Quebec and British Columbia**

Mutual recognition of medical licenses is a long overdue reform that would have the support of virtually the entire medical workforce. In 2019, nine in ten physicians were in favour of national licensure that would enable them to practise anywhere in the country.<sup>339</sup> Additionally, 74% of medical professionals agree that a national licence would improve access to care for Canadians<sup>340</sup> (see Figure 2-7). In fact, according to then-CMA President Dr. Sandy Buchman, without these barriers, many physicians would

be willing to provide virtual care in other parts of the country where they are not licensed.<sup>341</sup>

The regulation of medical licensing is a responsibility of the provinces and their respective colleges of physicians and surgeons. The hands of medical authorities are therefore not necessarily tied by Canadian law, and so the elimination of the barriers to the mobility of health care workers will depend on nationwide collaboration between provinces.<sup>342</sup> Quebec and British Columbia must engage in strategic partnerships with their fellow provinces in order to further expand access to health care in their own provinces.

339. Canadian Medical Association, "CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory – Q11. How supportive would you be of the implementation of national licensure that would enable practice in all Canadian provinces/territories?" 2019, p. 1.

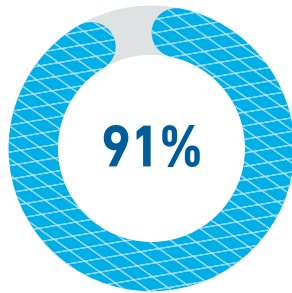
340. Canadian Medical Association, "CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory – Q13. To what extent do you agree that national licensure will improve access to care for Canadians," 2019, p. 1.

341. Lauren Vogel, "What's the hold up on national licensing for doctors?" *CMAJ News*, October 29, 2019.

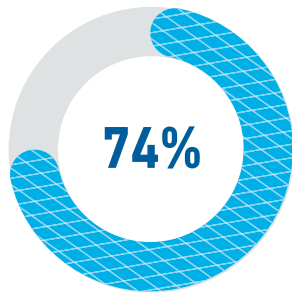
342. Joshua Tepper, Ryan Hinds, and Bernard Ho, *op. cit.*, footnote 336.

Figure 2-7

## Opinion of Canadian physicians regarding national licensure, 2019



**91%** of physicians are supportive of a nationally recognized medical licence



**74%** of physicians agree that a national medical licence would improve access to care for Canadians

**Sources:** Canadian Medical Association, "CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory - Q11. How supportive would you be of the implementation of national licensure that would enable practice in all Canadian provinces/territories?" 2019, p. 1; Canadian Medical Association, "CMA Physician Workforce Survey, 2019. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory - Q13. To what extent do you agree that national licensure will improve access to care for Canadians," 2019, p. 1.

### 5- Adopt Funding and Payment Mechanisms Conducive to Performance, Efficiency, and Productivity

#### *Legality with regard to the CHA*

Provinces must respect the five criteria established within the CHA in order to receive their share of the Canadian Health Transfer. However, the mechanism used to finance health care institutions is entirely at the discretion of the province, provided it does not jeopardize the integrity of the health care system.

#### *Experience in Sweden and the United Kingdom*

Much like Canadian provinces, health institutions in Sweden and the UK were initially funded by historical budgets, by which hospitals receive fixed amounts of money regardless of the number of patients seen or the types of health issues treated. This provides little incentive

to innovate or to improve the quality or efficiency of care. Like most countries with universal health systems, Sweden and the UK have moved away from historical budget allocations and adopted activity-based hospital funding mechanisms such as Payment by Results and DRGs. By 2014, the UK had adopted activity-based funding for about 60% of the activity in an average hospital,<sup>343</sup> whereas Sweden had applied it to 75% of all in-patient care by 2012.<sup>344</sup>

As mentioned in the first chapter, activity-based funding remunerates hospitals on a per-case basis that is adjusted according to the treatment performed, the severity of the condition, and even differences in operating costs

343. Department of Health, *A Simple Guide to Payment by Results*, 2012 as cited in Louise Marshall, Anita Charlesworth and Jeremy Hurst, *op. cit.*, footnote 161, p. 17.

344. Clas Rehnberg, *op. cit.*, footnote 55, p. 6.

between hospitals.<sup>345</sup> The reforms in these countries were introduced as part of a package of reforms favouring patient choice, with such funding enabling the money to follow the patient.

**The reform: Adopt activity-based funding mechanisms for the majority of hospital activity.**

Physicians in most Canadian provinces are paid on a fee-for-service basis, but the hospitals they work for are funded through fixed historical budgets. And so, while doctors have an incentive to care for more patients, hospitals may not be able to keep up and fund all of their activities. The combination of activity-based funding and remuneration based on the act of service aligns the efforts of institutions and the labour force. This allows the health system to function efficiently and without fear of lacking funds, effectively removing the need for rationing through long waiting lists.

**Like most countries with universal health systems, Sweden and the UK have moved away from historical budget allocations and adopted activity-based hospital funding mechanisms.**

Furthermore, standardizing the cost received per treatment provided, and then sharing this information, will increase the transparency of the system and the accountability of institutions. Indeed, hospitals may need to adapt and become more efficient if their operating costs are higher than the public funds they receive for the treatments they deliver. Otherwise, the hospital will be accountable for the difference. But if they are able to provide a service at a lower cost than what is financed by the government, they could keep the surpluses and redistribute them toward other activities, therefore encouraging the emergence of innovative ideas. It must be noted, however, that in order for this reform to reach its full potential, hospitals that are unable to perform their duties within the price range established by the government must be subject to real-world market rules. In other words, the government must not proceed to bail out a hospital that is simply unable to provide care at the pre-determined cost or that is unable to compensate for the losses incurred. This condition was not met during the first round of market-oriented reforms in

England, and was one of the reasons the internal market initially did not perform as well as expected.<sup>346</sup>

With Canadian hospitals unaccustomed to detailed scrutiny of what services are provided to whom, and with what results, the move to activity-based funding would be significant. This is where detailed electronic record-keeping of hospital activity would come in handy. Determining the price that best reflects the actual cost of providing a specific treatment can only be achieved if health authorities have access to patient-level cost data that is routinely collected and managed through EHRs.

**What would need to be done in Quebec**

The Quebec government first contemplated the move to activity-based funding in the early 2010s as “the way to solve, once and for all, the funding disparities between the regions,” according to then-Health Minister Gaétan Barrette.<sup>347</sup> However, Quebec hospitals are still funded by global historical budgets to this day. The province must not just contemplate, but wholeheartedly embrace the shift to activity-based funding.

**What would need to be done in British Columbia**

While British Columbia experimented with activity-based funding in 23 hospitals between 2010 and 2013, this did not lead to a meaningful transition away from global budgets.<sup>348</sup> In order to emulate the positive experience seen in Sweden and the UK, British Columbia will need to fully commit to increasing the proportion of hospital activity that is funded using activity-based funding mechanisms in hospitals across the province.

**6- Transfer the Management of Some Hospitals to Entrepreneurs and Expand Private Care Provision**

**Legality with regard to the CHA**

The CHA does not prohibit the management of hospitals by entrepreneurs or for-profit organizations. Canadian provinces are therefore well within their rights to delegate the management of health care institutions to entrepreneurs.

346. P. West, *Understanding the NHS Reforms: The Creation of incentives?* Buckingham: Open University Press, 1997, as cited in Peter Dragoonis, *op. cit.*, footnote 136, p. 154.

347. CBC News, “Quebec health reform to standardize medical treatment costs,” February 3, 2016.

348. Nadeem Esmail, *Understanding Universal Health Care Reform Options, Activity-Based Funding*, Fraser Institute, 2021, p. 13.

345. *Ibid*, p. 7.



### **Experience in Sweden and the United Kingdom**

Sweden currently has six independently run but publicly funded hospitals, of which three are not-for-profit.<sup>349</sup> These hospitals receive activity-based funding from county councils to fund most of their activities, and care remains free at point of access, to the exception of the nominal fees which are universally applied at any hospital in Sweden. These hospitals have the possibility of selling some of their spare capacity to other hospitals, which helps cut down on wait times in those other institutions.<sup>350</sup> A more detailed account of the successful experience observed in one of Sweden's best-known privately run hospitals, Saint Göran, can be found in the first chapter of this paper.

**Delegating the management of tax-funded hospitals to non-public entities would not undermine the universality of the system. Rather, it would increase the efficiency of operations, to the benefit of patients.**

As for England, there currently aren't any independently run but publicly funded hospitals. Partnerships with the private sector are common, however, and have been since the NHS's inception. Indeed, public hospitals can even outsource certain procedures to private clinics or facilities.<sup>351</sup>

#### **The reform: Allow entrepreneurs to manage hospitals, all while maintaining public funding.**

Just like their Swedish and British counterparts, most Canadians are in favour of a primarily tax-financed health care system. But public financing does not necessarily mean that providers have to be government-owned and operated. Delegating the management of tax-funded hospitals to non-public entities would not undermine the universality of the system. Rather, as has been observed in Sweden, it would increase the efficiency of operations, to the benefit of patients.

A reform of this type can only be successfully implemented if entrepreneurs have enough human capital for the hospitals' operations, which is why the resource-increasing reforms presented above are crucial prerequisites in the transformation of a province's health system. Moreover, with activity-based funding, hospital managers will have clear incentives to maintain operating costs at the level provided by government financing, if not lower. Lastly, quality of care would be maintained and even increased through competition between institutions, since with activity-based funding mechanisms, the funding follows the patient.

#### **What would need to be done in Quebec and British Columbia**

For at least ten years, Sweden has allowed the delegation of hospital management to companies. It is time that Quebec and British Columbia follow suit by allowing entrepreneurs to enter the health care market, introducing competition into what has been a mostly monopolistic, inefficient medical system for the past several decades. Even today, without any of the previously-mentioned reforms, there are no specific laws standing in their way. It thus comes down to a matter of courage and political willingness to improve the health system.

349. Bob Bell and Stefan Superina, "Swedish health care: An expensive publicly funded model," April 7, 2019; Roosa Tikkanen, *et al.*, *op. cit.*, footnote 96, p. 185.

350. David Rae, *Getting Better Value for Money from Sweden's Healthcare System*, OECD Economics Department Working Papers, September 20, 2005, p. 16.

351. The Centre for Health and the Public Interest, "The contracting NHS – can the NHS handle the outsourcing of clinical services?" March 2015, p. 8.

Box 2-2

## **Lessons Quebec and BC Can Learn from Sweden and the UK**

**1 – Adopt Electronic Patient Records and Expand Access to Health Data**

**2 – Remove the Prohibition on Duplicate Health Insurance**

**3 – Remove the Prohibition on Dual Practice**

**4 – Increase the Supply of Medical Professionals with Three Reforms**

4.1 – Recognize Skills Learned Abroad and Launch an International Recruitment Campaign

4.2 – Increase the Number of Home-Grown Doctors by Eliminating Medical School Quotas

4.3 – Eliminate Interprovincial Barriers to Medical Licensing

**5 – Adopt Funding and Payment Mechanisms Conducive to Performance, Efficiency, and Productivity**

**6 – Transfer the Management of Some Hospitals to Entrepreneurs and Expand Private Care Provision**

## CONCLUSION

No matter how profoundly the reforms that were adopted in Sweden and the United Kingdom have transformed health care in those countries, the universality of their health systems was maintained. Indeed, all citizens have access to health care—whether primary, hospital, or community-based—that is free of charge at point of access.<sup>352</sup> This is all the more important to mention given the major role that the independent health care sector played in the shaping of the reformed health care systems in both countries. These systems, therefore, are models that Canadian politicians can use to show that the growth of entrepreneurial involvement in the provision of care need not be done at the expense of the principle of equality of access.

**Now is the time for policy-makers to acknowledge the benefits of a liberalized health care system by looking beyond the current legislation and taking note of what has been accomplished elsewhere.**

The performance of the health care systems in Sweden and the UK was not achieved overnight. It took several sequences of trial and error, and as it turns out, it is a mixed health care system embracing partnerships between the public and independent health sectors that has proven to be the best approach, rather than the monopolistic provision of care. Luckily, Quebec and British Columbia, and other provinces as well, can learn from these experiences and apply here what suits Canadians best.

It must be emphasized that the absence of a parallel entrepreneurial system here is not due to the illegality of private health care at the federal level. Rather, the lack of a flourishing entrepreneurial sector in Canada is mostly attributable to a combination of multiple laws implemented by the provinces themselves, a shortage of human capital, and unresponsive hospital funding, among other factors.

With a constitutional challenge underway in British Columbia, now is the time for policy-makers to acknowledge the benefits of a liberalized health care system that allows for the entrepreneurial provision, and also the parallel private financing, of medically necessary care by looking beyond the current legislation and

taking note of what has been accomplished elsewhere. Provinces have the political power to proceed with confidence in implementing market-oriented reforms; all that is missing is the political will to do so.

352. Except for low co-payments in Sweden.

# ABOUT THE AUTHOR



## MARIA LILY SHAW

Maria Lily conducts research using government websites, among other sources, and ensures the accuracy and integrity of the data contained in our work. She is always on the lookout for new data and information that could be of interest to the general public and enhance our publications. Besides the free coffee and her wonderful coworkers, what Maria likes the most about her work is collaborating with professionals and experts in various fields who share their views about what's happening on the ground.

Maria Lily holds a master's degree in economics from McGill University. Prior to her graduate studies, she studied at the Université de Montréal and graduated with a bachelor's degree in economics. She completed the honors program and earned a mention of excellence, in addition to being involved in the Economics Students' Association at the Université de Montréal (AÉÉSÉUM). She joined the MEI team in September 2020.



Montreal Economic Institute

910 Peel Street, Suite 600, Montreal QC H3C 2H8

T 514.273.0969 [iedm.org](http://iedm.org)

ISBN 978-2-925043-17-1