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Montreal Economic Institute

6418 Saint-Hubert Street
Montreal (Quebec)
H2S 2M2 Canada

Telephone: (514) 273-0969
Fax: (514) 273-0967

E-mail: info@iedm.org
Web Site: www.iedm.org

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J. Edwin Coffey
MD, FRCSC, FACOG
Retired Associate Professor
Faculty of Medicine, McGill University
Former President, Quebec Medical Association

Jacques Chaoulli
MD, MA Ed
General Practitioner

Universal Private Choice

A concept of health care with quality access and choice for all Canadians

Research Paper
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Montreal Economic Institute

Foreword

The inside cover of our research journals state, "The opinions of the authors of this study are not necessarily those of the Montreal Economic Institute or of its board of directors."

This formula is more than mere lip service. It expresses the very nature of the Institute: a forum where ideas are exchanged. Therefore we do not support, as such, the specific proposals that you will find in this research study more than any other proposal.

On the other hand, we do support the questioning of sacred cows, generally accepted ideas and sheep-like attitudes. On the question of health care, in particular, we believe that the debate must no longer be limited to how many million dollars are to be pumped into the system for the benefit of which regions or which professional bodies.

The two authors have worked extremely hard in producing this research study. Their proposal is the result of lengthy reflection. Their analysis does not take every detail into account, since guiding principles and a general orientation must first be agreed upon before a true reform of the health system can be undertaken. It is thus a question of modelling structures.

Those who might criticize this proposal should be rigorous in their criticism. If it is to be rejected, I hope that the rejection will be based on precise, well-founded arguments, not on superficial clichés or lack of courage.

Michel KELLY-GAGNON
Executive Director
Montreal Economic Institute

J. Edwin Coffey, Retired Associate Professor, Faculty of Medicine, McGill University
Former President, Quebec Medical Association

Jacques Chaouli, General Practitioner

Universal Private Choice : A concept of health care with quality, access and choice for all Canadians.

ABSTRACT

We are proposing a new approach to the financing, insuring and delivery of medical and hospital services. While retaining universal entitlement to Medicare insurance, as a core publicly funded service, we propose a new concept of universal private choice. This includes Medicare, as well as voluntary private medical, hospital and health insurance alternatives, as exist in all other OECD countries. Our aim is to improve quality, access and choice for all Canadians.

A government health system monopoly does not necessarily cost less than a mixed public-private health system, nor does it provide faster access to services. On the contrary, among 25 OECD countries with universal access, some like Sweden, with a universal public system alongside a parallel private one, actually spend less than Canada, with better access to medical services.

CONDENSÉ

Nous proposons une nouvelle approche du financement, de l'assurance et de la prestation des services médicaux et hospitaliers. Tout en maintenant le droit universel à l'assurance-maladie, en tant que service de base financé à même les fonds publics, nous proposons un nouveau concept de choix privé universel. Ce choix comprend, outre l'assurance-maladie d'État, des solutions de rechange en matière de soins médicaux, d'hospitalisation et d'assurances, comme on en trouve dans d'autres pays de l'OCDE. Notre objectif est d'améliorer la qualité et l'accessibilité des services ainsi que la liberté et le choix de tous les Canadiens.

Un système de santé monopolisé par l'État ne coûte pas forcément moins cher qu'un système mixte, pas plus qu'il ne procure forcément un accès plus rapide aux services. Bien au contraire, parmi 25 pays de l'OCDE qui donnent l'accès universel aux services de santé, certains, comme la Suède, où coexistent les systèmes public et privé, dépensent moins que le Canada tout en offrant un meilleur accès aux services médicaux.

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Executive Summary

Canada's universal government health insurance experiment, informally known as «medicare», and the medical and hospital services for which it was intended to provide, is now undergoing close scrutiny. Public confidence has waned and recent public opinion surveys call for fundamental changes or complete rebuilding of the health care system. Over the years, there has been a gradual decline in quality, access, and supply of medical and hospital services as well as modern medical technology. These problems have been aggravated by recent attempts to cut government health budgets and downsize infrastructure.

Canada's prohibition of voluntary parallel private health insurance and private medical services in hospitals, precludes any Canadian based comparison and control for the current experiment in provincial government health insurance monopolies. This reduces its value as a learning experience.

Of greater practical interest, however, are the lessons of other OECD countries, especially those in Europe and in particular, Sweden. Unlike Quebec and the rest of Canada, parallel public and private health systems have been permitted to compete, co-operate and contract out services in a manner which has brought results quite different than those of the Canadian medicare experiment.

With few exceptions, other OECD countries have avoided long waiting times for medical and hospital services and have often provided a higher percentage of government funding for public health services, even with a parallel private system. Through competitive markets, among the public and private sectors, they have preserved a variety of choices for patients and physicians.

Based on this study, the authors have put forward a proposal, referred to as Universal Private Choice: A concept of health care with quality, access and choice for all Canadians. It attempts to change the mind-set, language, and direction, of the ongoing public debate over health system reform in Quebec and the other provinces.

It is proposed that the current publicly funded, universal health insurance plan (medicare) continue as one of several voluntary options for all residents of Canada. It would be a basic insurance plan covering the comprehensive bundle of good quality medical and hospital services for all.

While retaining the present medicare insurance as a base to which all taxpayers would

Résumé

On examine ici de près l'expérience canadienne du régime de santé d'État universel et obligatoire, mieux connu sous le nom d'assurance-maladie, ainsi que les services médicaux et hospitaliers que ce régime est censé fournir. Les récents sondages révèlent que le public a perdu confiance et réclame une refonte du système de santé. D'année en année, on assiste à la dégradation de la qualité, de l'accessibilité et de la prestation des services médicaux et hospitaliers. Ces problèmes ont été aggravés par les récentes tentatives de couper dans les budgets gouvernementaux réservés à la santé et par la rationalisation de l'infrastructure.

L'interdiction de toute option privée, en matière d'assurance médicale et de soins hospitaliers, empêche toute comparaison des services de santé au Canada et prévient de la même façon tout contrôle de l'expérience en cours dans les monopoles d'État provinciaux, au chapitre de l'assurance-maladie.

On en apprend davantage en étudiant l'expérience des autres pays de l'OCDE, notamment les pays européens et, en particulier, la Suède. Dans ces pays, contrairement au Québec et au reste du Canada, des systèmes de santé publics et privés parallèles ont pu se faire concurrence, collaborer et impartir des services avec des résultats bien différents de ceux de l'assurance-maladie au Canada.

À quelques exceptions près, les autres pays de l'OCDE ont su éviter les longues listes d'attente des services médicaux et hospitaliers. Dans bien des cas, ils consacrent une plus grande partie du budget de l'État aux services de santé publics, malgré la coexistence d'un réseau privé. La concurrence entre le secteur privé et le secteur public leur a permis de préserver un éventail de choix tant pour les patients que pour les médecins.

Dans cette étude, les auteurs ont mis de l'avant une proposition, appelée le *choix privé universel* (ou CPU). C'est une vision des services de santé qui allie la qualité, l'accessibilité et la liberté de choix pour tous les Canadiens. Elle tente de modifier l'esprit, le vocabulaire et l'orientation du débat public actuel sur la réforme du système de santé au Québec et dans les autres provinces.

Les auteurs proposent que le régime public universel d'assurance des soins médicaux (l'assurance-maladie) soit maintenu pour former l'une des nombreuses options offertes à tous les résidents du Canada. L'assurance-maladie d'État servirait d'assurance de base, garantissant à tous un ensemble complet de

be obliged to contribute, whether they used the plan or not, new opportunities and incentives would be provided to encourage greater personal responsibility in health care matters.

It would encourage tax deductible options such as Medical Savings Plans for the funding of personal out-of-pocket health expenses and catastrophic health insurance.

It would provide wider choices in tax deductible private health insurance, either of a traditional type or in comprehensive health service plans formed by competitive regroupings of physicians, hospitals and health insurance providers.

It would provide for refundable tax credits or government vouchers for low-income individuals and families who prefer to invest in Medical Savings Plans or private insurance as alternatives to medicare.

Optional non-governmental Health Purchasing Agencies, mutually run by their members in professional, trade, or regional associations, would negotiate and arrange for large group purchasing of private insurance or health service plans on behalf of their members.

Hospitals would gradually relinquish their status as quasi-government facilities and regain their original status as private community-supported hospital facilities and university research and teaching hospital centres serving the public, and with options to form health service groups with other health service providers as above.

The decisional role of government would be reduced and much of the government funding would be passed through the patients as empowered consumers, and used by them for their choice of health services.

Before launching such a major health system reform, governments could consult the population through options such as a non-binding referendum. With any major health reform there should be a set time for evaluation, modification or termination.

An underlying principle of the Universal Private Choice proposal is its multiple choice policy of financing, insuring and delivery of health care services, instead of the single choice policy of the current medicare monopoly. Universal Private Choice aims to improve the quality, access and choice for all Canadians.

services médicaux et hospitaliers de bonne qualité.

Tous les contribuables continueraient de verser des cotisations à l'assurance-maladie, qu'ils se prévalent ou non de ses services. Tout en maintenant cette assurance, on offrirait aussi de nouvelles possibilités et de nouveaux encouragements pour promouvoir l'exercice d'une plus grande responsabilité personnelle en matière de soins de santé.

Cette proposition met aussi de l'avant des options déductibles du revenu imposable, notamment des régimes d'épargne-santé pour le règlement des frais médicaux directs ainsi qu'une assurance contre les maladies invalidantes.

Le choix privé universel créerait un vaste éventail d'assurances médicales privées, déductibles du revenu imposable, que ce soit sous forme de polices conventionnelles ou de régimes de soins intégrés, proposés par des alliances de médecins, d'hôpitaux et d'assureurs.

L'État accorderait des crédits fiscaux ou des bons d'échange aux particuliers et aux familles à faible revenu pour qu'ils puissent placer cet argent dans des régimes d'épargne-santé ou acheter des polices d'assurance privées, comme solutions de rechange à l'assurance-maladie gouvernementale.

De nouveaux groupes d'achat de services de santé, facultatifs, indépendants de l'État, négocieraient collectivement des achats d'assurance médicale privée ou de régimes de soins médicaux. Les membres de ces groupes d'achat se recruteraient au sein d'une profession, d'une industrie ou d'une région.

Les hôpitaux abandonneraient progressivement leur statut d'établissements paragouvernementaux et reprendraient leurs statuts initiaux de centres hospitaliers privés financés par leur milieu, de centres de recherche et d'hôpitaux universitaires au service du public. Les hôpitaux auraient aussi la possibilité de se joindre à d'autres prestateurs de soins pour former des groupes de services.

Le rôle décisionnel de l'État serait réduit, et une bonne partie du financement gouvernemental passerait par les mains des patients, ceux-ci exerçant alors leur pouvoir d'achat et de sélection des services comme de véritables clients.

Avant de lancer une telle refonte de la santé, les gouvernements pourraient consulter la population par des moyens tels qu'un plébiscite non décisionnel. Toute refonte des services de santé devrait aussi être assortie

d'échéances d'évaluation, d'amendement ou d'abrogation.

L'un des principes sous-jacents de cette proposition de choix privé universel consiste à rendre possibles des choix multiples en matière de financement, d'assurance et de prestation des soins de santé, plutôt que d'interdire ces choix comme on le fait en vertu du monopole actuel de l'assurance-maladie. Le choix privé universel a donc pour but d'améliorer la qualité, l'accessibilité et le choix pour tous les Canadiens.

Table of Contents

Chapter 1

Universal Access to Health Services: is government monopoly a prerequisite?

Difficulty of access to health services

In Canada, for persons with no private insurance, the introduction of the universal public health insurance system (medicare), in 1970, initially had the effect of improving access to medical services. However, it was soon unable to respond to all the needs. Emergency rooms have become more and more overcrowded and access to health services has become increasingly difficult. We have now reached the point where, in Quebec and elsewhere in Canada, patients are suffering — and sometimes dying — because they are unable to obtain medically necessary services when they are required. A recent report by the 'Collège des médecins du Québec' shows that difficulty of access to health care services is real and constitutes an important problem.[1] Also, reports by the government of Quebec confirm the important difficulties.[2]

Experience of other countries comparable to Canada

Other countries that have universal access to health care and are comparable to Canada, have not experienced waiting list problems, according to OECD reports on Belgium, Germany and France.[3] It is also worth noting that these three countries achieved better results even though their total health expenditure, as a proportion of GDP, was lower than Canada's (8% in Belgium) or about the same (9–10% in France and Germany). These countries also have, and have had for some time, health systems in which private hospitals and voluntary private insurance covering medically necessary services, co-exist with the public sector.

The World Health Organisation has also reported the advantages of partnership between the public and private sectors:[4]

> *There is a certain amount of evidence that tends to show that private providers manage to supply services at lower cost than the public sector… Public services have a tendency to provide a "product" without much regard to the consumer's preferences. This attitude is likely to be reflected in the range of services available, long waiting lists and inconvenient scheduling.*

In Quebec, the economist Pierre Fortin has shown[5] that, in the case of health-care institutions bound by service contracts with the state, operating costs are lower in private than in public institutions.

Governments of many OECD countries have entered into service contracts with private hospitals, including for-profit hospitals, and pay them to take care of patients, including the poorest, who are exempted from making any contributory payment.

In France, 72% of health establishments are private, and for-profit establishments account for one-third of private hospitalizations.[6] In Germany, private hospitals constitute 38% of the total, of which 34% are non-profit and 4% for profit.[7] Moreover, Germany has a

The OECD indicates that in countries that have introduced market economics and competition, either within public services or between the public and private sectors, waiting lists have been reduced, sometimes dramatically. The OECD reports that this has been the case in Sweden,[10] Spain, Norway and the United Kingdom. In 1996, total health expenditure in these countries was lower than in Canada (between 6% and 8% of GDP), yet a universal public health care system, as in Quebec, was maintained.

private sector that does not have contracts with the state.[3] OECD reports show this is also the case in the United Kingdom, Norway, Denmark, Finland, Sweden, Belgium and the Netherlands.

In Japan, whose health-care system is based on the German model, there are multiple payers in a system of universal access to health care, and 81% of hospitals are private. As required by Japanese law, all private hospitals are non-profit.[8]

The Swedish example

◗ Sweden's situation is similar to Quebec's in several respects. The country is stretched out, from north to south, and population density is low, with the 8.6 million inhabitants largely concentrated in coastal regions and in the south. As in Quebec, the population is aging rapidly.

According to the OECD, all Swedish citizens are entitled to health care and to equal access to care, wherever they live and whatever their economic status.

As in Quebec and throughout Canada, the Swedish health-care system is based on a national medical insurance system. All citizens must support the public health-care system through general taxation.

Surprisingly, both in Sweden and in many other OECD countries, the range of services covered by public health insurance is considerably wider than in Canada. In these countries, unlike Canada, many services such as high-technology diagnostic services provided outside a hospital setting (magnetic resonance imaging, ultrasound, scanning), dental fees, physiotherapy and home care are covered by public health insurance. This is reflected in the statistical data: in 1991, the public portion of total health expenditure was 78% in Sweden, but only 73% in Quebec and Canada. Since then, according to the Canadian Institute for Health Information (CIHI), it has fallen to 62% in Canada.

Swedes can freely purchase voluntary private insurance for services already covered by the public plan. They can also consult "liberal" doctors, whose status is analogous to that of physicians here who do not participate in public medicare. A liberal physician may have a service agreement with a county council, so that part of his or her fee is paid by the patient and part by the council. Finally, while still having access to the public health insurance plan, patients can choose to pay for care in a private hospital.

In 1995, the Institute for Research on Public Policy (IRPP) stated that under the public plan, patients paid a nominal amount, ranging from $17 to $34, for each consultation, and that the rates were regulated by the central government. In the public system, a patient would thus pay no more than $280 per year, and the poorest were exempt from all payment. [9]

Overall, expenses paid directly by individuals account for only 10% of total health expenditures.

In 1992, total health expenditure amounted to 7.9% of GDP, and in 1996, to 7.2%. In Canada, by contrast, it hovers around 9.5% and has occasionally reached 10%.

As described in the IRPP report [9], the Swedish government decided to end the state monopoly in medical services in the late 1980s, in a period of major public finance crises, with hospital delays and waiting lists not unlike the recent and current situation in Quebec.

In 1994, the OECD reported that private physicians, private hospitals and private chronic care establishments accounted for 4% of total health expenditure, and that there was an emerging private hospital sector providing acute emergency care, either under service contracts with the state or without state contracts.[10]

In spite of the fact that private insurance premiums are not tax-deductible in Sweden, as they are in Canada, the Comité européen des assurances (CEA — European insurance committee) confirmed this private sector trend in 1997, when it reported that Swedes were showing more and more interest in voluntary private insurance in addition to the public health insurance plan.[11]

Nevertheless, the ending of the state monopoly over health care in the late 1980s was not of itself sufficient to solve the waiting list problem in Sweden. The Swedish government had authorized the establishment of private hospitals alongside the public system, and made it possible for municipalities, or county councils, to contract for services provided by private hospitals. Only after these service contracts had come into effect did access to health-care services improve for all, regardless of personal income.

While decentralization of health care in Quebec, was decentralization in name only, since the régies régionales de la santé (regional health boards) are not elected. In Sweden, however, health care was devolved to the municipalities, whose mayors are elected by universal suffrage and consequently are directly accountable to their electorate. In addition, again unlike Quebec, the county councils are empowered to levy a proportional income tax from their residents and have full authority to plan the health care services they provide, while in Quebec, the Act respecting health services and social services (section 431, paragraphs 1 and 2) specifies that planning authority is vested in the Ministère de la Santé et des Services sociaux (MSSS — the Quebec department of health): hospitals have no power to take initiatives and can only implement the decisions of the MSSS.

In 1992, in order to reduce patient waiting times at local hospitals or clinics for certain categories of services such as the diagnosis and treatment of coronary artery disease, hip and knee replacement, cataract surgery and others, the county councils established a Guarantee of Treatment rule. If patients had to wait more than three months for any of the above procedures at their local hospital, the county council would arrange to have it done in another public hospital or, if necessary, in a private hospital at the government's expense.

In 1995, the authors of the IRPP study[9] reported that this policy had resulted in a 27% reduction in waiting lists, mainly for surgical interventions.

In regard to Sweden, the OECD reported in particular:[12]

> *The number of operations performed has greatly increased, and the waiting lists have been very considerably shortened. There is no indication of an eviction effect, i.e., that patients who suffer from other ailments have to wait longer.*

In 1997, at a conference of the Standing Committee of the Hospitals of the European Union (HOPE), attended by delegates from 15,000 European hospitals, the Swedish representative Kai Essinger, director of the Federation of County Councils, spoke about the treatment guarantee initiative set up by the Swedish government, which guaranteed that patients would have their operations within fixed time limits, and, if necessary, would have their operations at state expense in private hospitals. He confirmed that this policy had brought the waiting lists under control, to the extent that all waiting lists had been shortened.

Sweden has thus taken action to promote the patients' freedom of choice, competition between health-care providers, and service contracts based on performance criteria. The fundamental principle is that, to restore the patients' freedom of choice, the money must follow the patient.

The OECD indicates that in countries that have introduced market economics and competition, either within public services or between the public and private sectors, waiting lists have been reduced, sometimes dramatically. The OECD reports that this has been the case in Sweden,[10] Spain, Norway and the United Kingdom. In 1996, total health expenditure in these countries was lower

than in Canada (between 6% and 8% of GDP), yet a universal public health care system, as in Quebec, was maintained.

The OECD has also published health indicators for various countries, including statistics on "preventable mortality", in other words, deaths that could have been avoided by the application of medical knowledge. In this respect, the United Kingdom, Sweden and Norway obtain better results than Canada, with lower expenditures.[13] Among countries with a national health system, such as countries of North and South Europe, Canada is the country that spends the most per person on health care, according to the OECD[13].

Learning From Government Health Policy Experience

Before proposing a new direction and alternative arrangements for the financing, insuring and delivery of our medical and hospital services, it is essential that we take note of the lessons to be learned from Canada's health system experiment.

The role of the market process in health care and health insurance services

◗ There have been conflicting opinions as to the appropriateness of the market in health care and health insurance services. There are those who maintain that the personal qualities of sympathy and compassion, expected of a physician or other health professional, should not be equated with money or prices. Yet the value that patients, as consumers, put on such qualities, as well as the values they put on the skills and knowledge of the physician or nurse, may be quite different from the value set by the physician or nurse for the services provided. Similarly, the value placed by the indemnity insurer or managed care group on the package of health insurance products may be quite different than the value perceived by the patient. Again, the market process is the best generator of signals and information that helps both parties co-ordinate and satisfy their interests and needs.

It is remarkable that all OECD countries, except Canada, permit private and public health services to compete and provide alternative health services. In many of these European countries, except the UK, there is no serious problem with waiting times for hospital services.[14]

Other OECD countries permit private parallel health services and competition

◗ As previously mentioned, the OECD experience shows that health care and health insurance services, like most other personal services, can be successfully provided in a competitive market where consumers and providers benefit from the market process. In fact, market competition for price, quality and convenience is one method of allocating scarce resources.

Absence of market process means loss of discovery procedure for consumer and provider

◗ By eliminating the market for most health care and health insurance services in Canada, the state has prevented patients, physicians, hospitals and insurers, as consumers and providers of these services, from utilising the free market process as a discovery procedure [15]. The market process, with its signals of price, quality and convenience, brings either satisfaction or disappointment to consumers. They respond in turn, either by continued loyalty or by searching out alternative providers or services. This reaction supplies information to the provider regarding the value, quality, convenience, and suitability of the service in the eyes of the consumer. It allows the provider to make adjustments in these areas in order to retain and attract consumers, or to improve provider skills in the same or other fields, to meet the demands of the consumer.

Specific needs of patients, as consumers, best known by themselves

◗ The specific needs and preferences of patients, as consumers of medical, hospital, laboratory and related insurance services, are best known by those individual consumers. Often the help of a physician, nurse or health insurance advisor can assist the patient in better identifying their medical and insurance needs and preferences, and can advise them accordingly. Most medical, hospital and diagnostic services are covered by health insurance of one type or another. In the private sector, most of the economic decisions are made when an individual buys a package of health insurance services. This can be either a traditional indemnity policy that reimburses the patient or an enrolment in a managed care plan, such as a Health Maintenance Organization (HMO). The latter provides for all the medical and hospital needs of the patient much as the Canadian medicare insurance provides presently.

The market process allows consumers and providers of insurance plans, to discover information on price, access, quality of care, and convenience, regarding hospitals, clinics, and physicians. This information, together with other market produced data that may be abstract and barely comprehended, increases the overall knowledge of consumer and provider and allows for better decisions regarding insurance coverage. The competitive nature of the market tends to keep the cost, quality and access to medical and hospital services more attractive to consumers.[16]

Insured patients in USA get ready access. Insured patients in Canada wait

◗ Despite the difficulties in solving the problem of uninsured health care in the USA, when one examines the insured population, we find that their vibrant competitive market in private health services and insurance facilitates ready access to high quality diagnostic and treatment services. In Canada, on the other hand, private competitive markets in medical and hospital services are virtually prohibited and publicly insured patients experience long delays in access to services and technology of mediocre standards, in many instances [17]

Conclusions from Canada's medicare experiment, point health policy in new direction

◗ Before proposing a new direction and new alternatives for the health systems of Quebec and Canada, we should make certain that we understand the lessons learned from Canada's thirty-year experiment with a publicly funded health system. As pointed out previously, it is unfortunate for Canadians that the learning experience concerning a parallel private health system, in a Canadian context, has been limited. This is due to the fact that alternative models of private health insurance and private health care delivery, that normally test new competitive methods of financing, insuring and delivering health services, have been explicitly prohibited by coercive health legislation in Quebec, since 1970. These private voluntary alternatives have been virtually prohibited in the rest of Canada since 1984, by the Canada Health Act. No other OECD country has endured such prohibitions against the study and evaluation of alternative health system financing models.

In spite of the above limitations, much has been learned from the Canadian experiment, concerning the adverse effects of current federal and provincial health legislation on patients, hospitals, physicians, nurses and other health professionals.

Although there are different opinions as to the preferred direction that should be pursued, in correcting these problems with Canada's health care and health insurance experiment, there is a strong public sense that a major change in course must be undertaken.

Chapter 2

Universal Private Choice: a concept of health care with quality, access, and choice for all Canadians

Guiding principles for a new Canadian approach

We propose a new approach in the financing, insurance, and delivery of health services in Quebec and the other provinces and territories. We shall refer to this new concept and direction as Universal Private Choice (UPC).

The guiding principles of the Universal Private Choice concept are:

1. Medical, hospital, and insurance services can be provided in a competitive market where both consumers and providers benefit from the discovery of exclusive information generated by the market process.

2. In a free and tolerant society, the opportunity and responsibility for making vital decisions, concerning the private interests and health of individuals and families, are often left to private choices of those individuals and families rather than public choices of bureaucrats and politicians. This does not preclude government financing of various sorts.

Opted out individuals are still obliged to contribute, through taxes or premiums, to the government plan.

3. When governments attempt to solve health system problems such as physician scarcity in remote regions, by using expedient and short sighted legislation that forces regional quotas and economic penalties on new urban physicians, rather than following broad principles of equality of citizens under the Law, there is a risk that individuals will lose their freedom.[18]

4. In any health system arrangement there should be respect for private property, economic freedom, and the liberty of individuals to choose and take responsibilities in matters of health care, health financing and insurance.

5. A prepaid, government funded, core package of medical, hospital and diagnostic services, equivalent to current medicare, should be available to all residents of Canada. Patient cost sharing may be required above a certain income threshold, on a sliding but capped income scale.

6. Canadian consumers and health care providers should have choice as to health care setting, mode of delivery (type and location of practice) and method of health care financing [19].

7. Residents should be able to opt out of the benefits provided by the government health insurance plan (medicare), either totally or for selective components such as hospital, physician, laboratory and drug services. They would receive a refundable tax credit or voucher valued at the average per capita public health expenditure for those respective components. This refundable tax credit or voucher can only be used towards the financing of an alternative health insurance, a combined medical savings plan plus catastrophic insurance, or other health service plan that must, at least, provide for the core services of the public medicare plan. Opted out individuals are still obliged to contribute, through

taxes or premiums, to the government plan.

8. In order for individuals to make informed choices among different health insurance and medical savings plans and other health plans, they should have adequate information regarding the plans' advantages, disadvantages and price, relative to the individual's needs. Since the medicare experiment began 30 years ago, Canadians have been denied any personal experience in competitive market pricing of health services and health insurance and relating the price to the value received. This valuable market information and the discipline thereby engendered for most non-emergency medical, hospital, and health insurance services, should be made available through a market option. (See number 1)

It is important, therefore, to permit the establishment, on an optional basis, of a member-directed purchasing agency or co-operative for consumers. This agency would be independent of government and private insurers. It could be funded by mutual occupational, professional, or geographic groups of at least 10,000 members each. They would provide all the necessary information and advice for consumers about the various types of health insurance and health plans offered. Each year they would call for a standard package of core services to be offered by all insurers or health plans, to allow for price competition and meaningful price/value comparisons by the consumers. This is an essential part of the Managed Competition concept, introduced by Alain Enthoven in the USA and Europe, to enable health service consumers to receive the maximum advantage from the market, as an informed consumer[20]. Consumers and providers should be encouraged, but not forced, to form mutual associations of this nature, for group purchasing and group provision of health care and health insurance services, if the advantages of quality, price, access and choice can be enhanced.

9. Because of the special nature of long stay patients, this Universal Private Choice concept would not apply to chronic care for the elderly, mentally ill, mentally handicapped nor physically handicapped. These individuals, as well as many community services, would continue to be supported by the present combination of private and government funding.

Since the medicare experiment began 30 years ago, Canadians have been denied any personal experience in competitive market pricing of health services and health insurance and relating the price to the value received.

The Concept of Universal Private Choice

Universal access

◗ This proposal is based on the above principles and is called Universal Private Choice (UPC): A concept to provide health care quality, access and choice for all Canadians. It is a new approach and a new direction for Canadians in the financing, insuring and delivery of medical and hospital services. The policy objective is to ensure that no one will be denied access to core medical and hospital services because of financial difficulty.

Because of the special nature of long stay patients, this Universal Private Choice concept would not apply to chronic care for the elderly, mentally ill, mentally handicapped nor physically handicapped.

Patient choice, price competition, and money follows patient

◗ It retains some useful features of medicare and incorporates others that aim to correct the deficiencies that have come to light during the medicare experience. The key elements that are missing in Canada's present system are price competition and market choices for patients, physicians and other health system providers. This proposal incorporates these elements among others.

The key elements that are missing in Canada's present system are price competition and market choices for patients, physicians and other health system providers.

Universal Private Choice draws extensively on the work of Alain Enthoven,[20] John Goodman and Gerald Musgrave,[21] David C Green,[22] Friedrich Hayek,[23] Arthur Seldom,[24] the Canadian Medical Association's Report of the Working Group on Health System Financing in Canada,[25] and many others.

Creates free environment for initiative, innovation, referendums on health care issues

◗ This proposal does not attempt to lay down detailed plans for the transition, implementation and operation of unknown numbers of health care and health financing arrangements that already exist or are yet to be discovered. Instead, it offers certain principles and general directions for reform that will create an environment better adapted to the patients' needs. It will facilitate the emergence of future arrangements in health care insurance and health care delivery, that are voluntarily chosen by an optional non-binding referendum of the population, rather than coercively imposed.

This proposal is based on the above principles and is called "Universal Private Choice (UPC) : A concept to provide health care quality, access and choice for all Canadians".

Universal Private Choice is a consumer sovereignty model of health financing

◗ Universal Private Choice is an example of the Private Choice and Consumer Sovereignty Models, described in the Report of the Working Group on Health System Financing in Canada.[122] This alternative proposal follows the world-wide political and economic movement away from the concept of central economic planning and control.

UPC assumes that in the near future there will be a revision of current legislation that now prohibits competition by private insurers, that restricts individual freedom of patients and physicians in matters of private contract, and that erodes personal and family responsibility in health care matters.

Private non-profit and commercial health insurance and health plans permitted

◗ UPC will allow the emergence of private (non-profit and commercial) health care insurance, and encourage the evolution of superior health care arrangements, yet to be discovered in a competitive market.

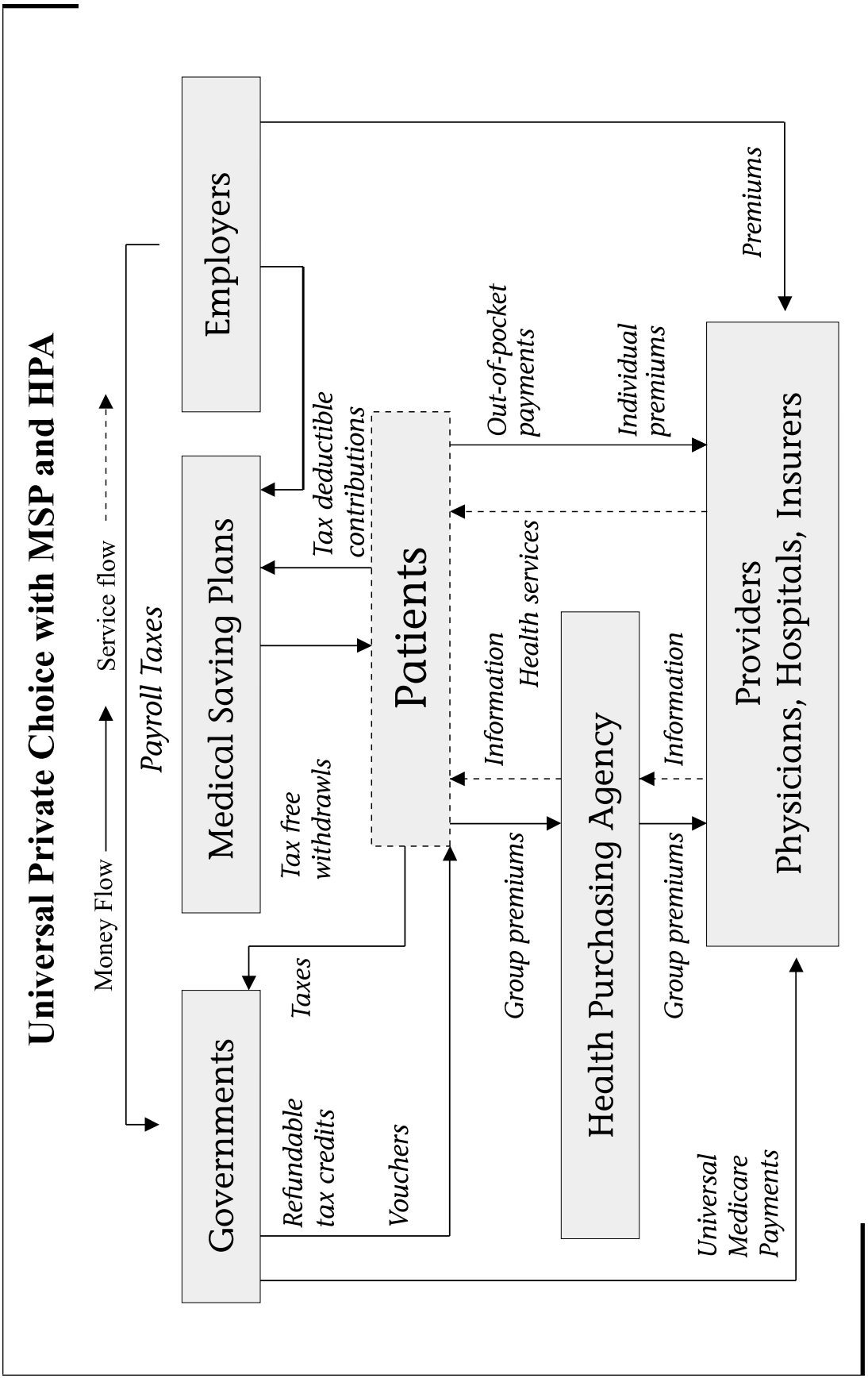
How Would Universal Private Choice Work?

The stakeholders in Universal Private Choice concept

(see Flow chart, page 15)

◗ The Universal Private Choice concept involves four sets of stakeholders, each with a special interest in the success of the plan. Their health services and financial interests are co-ordinated within the market process. The stakeholders are as follows:

- **Health Care Purchasing Agency (Optional)**
  - ▷ Educator, advocate, negotiator, buyer for patients
- **Patients**
- **Providers**
  - ▷ Individual physicians, etc
  - ▷ Individual insurers or underwriting firms
  - ▷ Combined providers—MD's, hospitals, clinics, laboratories, pharmacies
  - ▷ MD/Hospital alliances, Managed Care, Managed Competition, HMO, PPO,


Universal Private Choice with MSP and HPA
Money Flow
Service flow
Payroll Taxes
Employers
Premiums
Medical Saving Plans
Tax deductible contributions
Patients
Out-of-pocket payments
Individual premiums
Information
Health services
Tax free withdrawls
Health Purchasing Agency
Providers
Physicians, Hospitals, Insurers
Information
Group premiums
Group premiums
Taxes
Governments
Refundable tax credits
Vouchers
Universal Medicare Payments

To avoid the possibility of individuals being turned down for health insurance, because of existing disease or high risk, there would be a wide period of unrestricted open enrolment each year, by the local health purchasing agency.

- ▷ Insurance underwriters and providers

- **Payers**
  - ▷ Government (Refundable Tax Credits, Vouchers, medicare payments)
  - ▷ Patients (Personal Savings, Medical Savings Plans, Out-of-pocket)
  - ▷ Employers (Payroll taxes, premiums for employee plans)
  - ▷ Insurers (Reimbursement to patients or providers for health costs)

Optional Health Care Purchasing Agency (HPA)

A concern has been raised that consumers of health services and insurance lack adequate information to make prudent decisions in the competitive market for these services. Enthoven, who has pioneered the concept of Managed Competition in health care, recommends the setting up of a non-governmental health care purchasing agency or co-operative, to deal with competing health plans and insurers on behalf of consumers and to act as an agent, negotiator, and educator.[20] This agency would be optional, in order to give as much flexibility as possible to consumers, to initiate a variety of group purchasing arrangements within the Universal Private Choice concept.

The health-purchasing agency would demand at least one standard core health insurance package from all insurers, to be priced and submitted to the agency. This would give price competition for a set of similar products and would ease the decision making of consumers. The purchasing agency, after receiving the money from the fully informed patient, would make the transactions with the health plans or insurers on behalf of consumers. The agency's purchasing clout would make it an effective advocate of the individual consumer.

The agency, when directed by the respective patients, could receive the refundable tax credits from governments, to purchase health insurance or health plans on their behalf. The agency could also receive the voucher funds from government, valued at the annual provincial per capita government health expenditure, and refunded to consumers who opt out of the government medicare plan benefits. This opting out may be total, or selective for hospital, medical, drugs or laboratory services.

Other vouchers may be issued to patients by the government, in order to procure designated health services outside of medicare, as a result of long waiting times or unreasonable access to government hospitals, etc. The agency would also act on behalf of consumers regarding poor service and suggested improvements. The agency does not sell a competing insurance plan of its own.

To avoid the possibility of individuals being turned down for health insurance, because of existing disease or high risk, there would be a wide period of unrestricted open enrolment each year, by the local health purchasing agency. At this time everyone could be informed and could enrol in, or change, their health plan of choice for the coming year.

Community rating or equal premiums for all, would generally apply. However, if an HPA found an abnormally high cost group within its membership it might negotiate differential fees for demographic purposes. Of course that would

Funding would come from a combination of public and private sources. Current medicare funding would continue. Employer sponsored plans could continue but employees would have the choice of plan to which the employer would direct their contribution. Tax incentives or government subsidies, to encourage individuals to take greater personal and family responsibility in health insurance matters, would include refundable tax credits, tax deductions and government issued health insurance vouchers, depending on the preferences and financial capacity of individuals.

risk losing members to a competing HPA and thus, market discipline would play a role in the consumer's favour.

Patients

◗ The individual or family purchases directly, or through the Health Purchasing Agency, a traditional health insurance that reimburses the cost or portion of cost of medical, hospital, laboratory and drug services, or a health plan that insures and provides all the medical, hospital, laboratory and drug services

Providers

◗ Providers may be separate entities such as physicians, hospitals, clinics, laboratories and pharmacies, etc. They either contract with insurance plans, managed care, or managed competition groups, or practice without contracts and bill patients on a fee-for-service or annual capitation fee basis. Insurance providers may sell traditional indemnity insurance coverage that reimburses a percentage of the medical or hospital bill, leaving a portion of co-payment, often 20%, to be paid by the insured.

Providers may also combine their services to form a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO) or a physician/hospital alliance. These combinations may take various forms and generally include physicians, hospitals, clinics and laboratories and insurance underwriters. Some combinations contract with an insurance company for a discounted fee schedule or an arrangement for deductibles and co-payments by the patient. PPOs provide contracted discount medical services by solo or group physicians outside an HMO.

Other physicians may be interested in exploring an internal market arrangement within the government-funded system, known in the UK as GP fundholding. The government allocates the annual capitation allowance or voucher to a patient registered with a group of physician fundholders or targeted medical agency. This agency's staff cares for the patient and purchases all the necessary additional services such as speciality consultations, diagnostic and hospital services.[26]

Individuals and families with an income below a certain threshold, would receive a government subsidy to provide full coverage of basic core health services.

Payers

◗ The payers may be the government, through medicare payments to providers, as in the present Canadian system, or through refundable tax credits, or vouchers as refunds from government to patients, with a value equal to the per capita annual health expenditures of the province or Canada. Other payers include employers, who contribute to government health insurance by way of payroll tax or to private health insurance plans or medical savings plans of employees, the insurance companies, the Medical Savings Plans, and patients who pay providers out-of- pocket.

Pluralistic Financing and Insuring for all Canadians: Money follows empowered consumers and service is patient centred

Variety, options, and choice in health insurance, medical savings plans, managed care and managed competition

◗ All individuals and families would be empowered through a variety of government tax or cash subsidies and personal savings, to purchase prepaid coverage for basic core medical and hospital services to be provided by a variety of plans. These might include traditional indemnity health insurance, medical savings plans or accounts, managed care and managed competition plans, and others. There will be several optional plans from which to choose, beyond the core plan,

To avoid the danger of under insuring, all insurers and health plans would be required to include in their various plans, a standard package of core services and coverage for catastrophic illness.

but they will require funding mainly from the consumer and a reducing level of government subsidy.

Mixed funding from public and private sources, refundable tax credits, medical savings plan

◗ Funding would come from a combination of public and private sources. Current medicare funding would continue. Employer sponsored plans could continue but employees would have the choice of plan to which the employer would direct their contribution. Tax incentives or government subsidies, to encourage individuals to take greater personal and family responsibility in health insurance matters, would include refundable tax credits, tax deductions and government issued health insurance vouchers, depending on the preferences and financial capacity of individuals.

Low-income individuals entitled to full government subsidy for core services and catastrophic plan

Individuals whose income falls below the taxable threshold, would also have the privilege of opting out and taking the same health care dollars with them to purchase the respective services, medical savings plans or private hospital and medical insurance.

◗ Individuals and families with an income below a certain threshold, would receive a government subsidy to provide full coverage of basic core health services. This could be through a refundable tax credit, transferred once a year or monthly from government to the purchasing agency or the consumer. To avoid the danger of under insuring, all insurers and health plans would be required to include in their various plans, a standard package of core services and coverage for catastrophic illness.

Medicare continues as core service with optional opt out for benefits, but not for taxation

◗ The present taxation based government insurance system, medicare, would continue in a modified form to cover core services that were cost effective and of proven value. It would be one of the core packages of services offered and would be universally available, but individuals would be allowed to opt out of the hospital, medical, laboratory, or drug coverage and take the average annual per capita cost of these respective services in equivalent dollars with them. This would be in the form of a government-issued voucher, a refundable tax credit or equivalent financial instrument, to be exclusively used towards those services in kind or for the purchase of private hospital or medical insurance, medical savings plan, managed care or managed competition plan, etc. Consumers are not permitted to opt out of their tax or premium obligations required by government for medicare, hospital and drug insurance.

Individuals who did not opt out of the government plan (medicare) would still be permitted to buy private health insurance and use it when desired as an alternative to medicare. In Europe this practice is called *doublon*.

Low-income individuals can opt out of medicare and choose private core plan fully covered

◗ Individuals whose income falls below the taxable threshold, would also have the privilege of opting out and taking the same health care dollars with them to purchase the respective services, medical savings plans or private hospital and medical insurance. The voucher or refundable tax credit would always guarantee

the purchase of a basic or core insurance plan.

Individuals who remain in medicare would have the option, if they required surgery or hospital treatment that was unreasonably delayed on a waiting list, to obtain a voucher for treatment elsewhere.

Medical Savings Plan combined with mandatory catastrophic insurance : a concept similar to Canadian RRSPs

◗ To encourage individual and family responsibility in financing routine health expenses, UPC would encourage the use of Medical Savings Plans (MSP) or Accounts (MSA), to provide tax-sheltered savings similar to the Registered Retirement Savings Plan. Individuals could contribute savings, government refundable tax credits and opt-out vouchers, and employees and employers could contribute to the plan up to an annual maximum amount of say, $3000 to $4000 per year. Contributions to the MSP would be tax deductible like the RRSP's. No limit would be placed on after-tax contributions.

The MSP/MSAs would belong to the individuals and would be administered by financial institutions, insurance companies, mutual fund organizations, union and professional associations, etc. Coverage by a catastrophic high deductible, low premium, health insurance plan would be mandatory along with the MSP.

A debit type card could be issued to the individual, by the MSP/MSA institution, and used to pay for health services when received, much like the present medicare card. If the premium for the catastrophic health insurance plan was higher than the government's refundable tax credit or voucher, the individual would pay the difference out of his MSP/MSA or could buy private «gap» insurance to cover this risk. Individuals below a certain income threshold would receive a refundable tax credit adequate to fully purchase an MSP and catastrophic insurance.

The Medical Savings Plan would be used to pay for routine health costs up to say, $2000 per year, after which a compulsory high deductible catastrophic insurance plan would kick in for the remainder of the medical and hospital costs. The unused savings would accumulate tax-free and could be used after retirement to help pay premiums on high deductible health insurance if the individual preferred private insurance. If the individual wished to use the funds for non-health care purposes he would be taxed and a 10% penalty would be charged on the amount withdrawn. Money from the MSP could be rolled over into the Registered Retirement Savings Plan tax-free.[21, 27, 28]

In summary

◗ The Universal Private Choice concept is based on the assumption that patients, physicians, hospitals, insurers and other health care providers will be freed from prohibitive legislation that now severely limits access to private health insurance and private medical services in hospitals.[29]

It frees up the innovative and competitive capacities of all, in the service of health care consumers.

It eliminates the government monopoly on planning and co-ordination of most health care services and takes advantage of market competition and individual planning.

It puts purchasing power in the hands of all consumers of health services, rich and poor alike, and encourages patient participation in the market place for health services. It assists them in making informed choices among health insurance options.

It allows for a voluntary shift from the predominance of health care financing and monopoly control by government, as insurer, payer and provider, towards a pluralistic approach of financing, insuring, paying, and providing, mainly controlled by the patient.

Chapter 3

The transition: from public monopoly to private choice

Referendum on health system reform is optional

Since the evolution of the Canadian health system is a question of such importance, we are proposing that one option would be a provincial or a national non-binding referendum among the population, and that individuals should reply ***yes*** or ***no*** to the following question : *Do you wish the state to stop being the only source of payment for services provided by physicians, and to remit a portion of the health-care budget to every citizen, which would allow citizens to choose, on each occasion, to consult either a private-sector or a public-sector physician, while maintaining the guarantee of universal access to health care funded from general taxation ?*

If the majority says no, the status quo monopoly problem remains

◗ If the answer is *no* then the status quo remains and any reforms would have to take place within existing health legislation. Feeding more money into the present system, without making important structural changes, is likely to be insufficient.

Do you wish the state to stop being the only source of payment for services provided by physicians, and to remit a portion of the health-care budget to every citizen, which would allow citizens to choose, on each occasion, to consult either a private-sector or a public-sector physician, while maintaining the guarantee of universal access to health care funded from general taxation ?

If the majority says yes, Universal Private Choice would be one option for testing and evaluation

◗ If the answer is *yes*, then the Universal Private Choice alternative would be one option to try as a pilot project for a number of years, possibly five years. At that time an evaluation should be carried out to see if the plan was meeting the needs and expectations of the consumers.

From monopoly to competition, gradually

◗ Following a decision to make fundamental changes in the health system, there would be a gradual and voluntary transition from the government insurance system, that is mainly taxation based, to a voluntary government and private mix of mainly private insurance with graduated levels of public and private funding. The degree and pace towards a privatized system, open to all, will depend on the interest shown, and the satisfaction experienced, by patients who opt for the private plans. The decisive factors will be ready access to medical, hospital, laboratory, and specialized ambulatory clinic services, of high quality. These would include emergency medical services provided at home or in a public place. The present government plan (medicare) would continue, with necessary reforms, for those who preferred it. For those who opt out of medicare and continue to pay into medicare through taxes, and invest in a Medical Savings Plan, medicare could be one option for

the required catastrophic insurance, if the individual paid the required premium.

Medical Savings Plan, Refundable Tax Credit, Voucher

◗ Initially, everyone who opts out of medicare benefits would receive a voucher or equivalent instrument such as a refundable tax credit, for the average annual per capita expenditure on publicly insured health services, for instance $2815 projected for 1999.[30] This could only be used for purchasing private health insurance, a health plan of a managed care or managed competition type, or invested in a Medical Savings Plan along with the mandatory purchase of a high deductible, low premium catastrophic health insurance plan.

Gradually, individuals would become more financially responsible for their hospital and medical insurance. They could opt for an employer/employee plan, a group plan available through the new health insurance purchasing agencies that would form, or they could stay with a reformed medicare plan.

Will medicare still be available?

◗ What will happen to the present medicare system if people continue to opt out but are still obliged to pay through taxation? There will be need for continued reform in medicare to make it more attractive for consumers. Local managers in institutions will be given more responsibility for their revenue and expense budget.

What about the hospitals?

◗ As patients become more financially empowered to exercise greater choice as to the preferred type of health insurance, they will be more discriminating in their choice of hospitals, laboratories and diagnostic and treatment centres. These institutions should become denationalized and resume their original status, not only as private property corporations, but as private non-profit hospital centres. Health care money will follow the patient and thus the status of the patient changes from that of a cost burden on the hospital to that of a welcome bonus. Hospitals will compete for patients, insurers and physician alliances and will be compensated according to how well they satisfy these stakeholders. Comparative studies of quality control and efficacy of treatment outcomes in hospitals will become available to patients and referring doctors. Teaching hospitals will have special status because of their educational role and are likely to draw more financial support from governments and philanthropic organizations.

Teaching hospitals will have special status because of their educational role and are likely to draw more financial support from governments and philanthropic organizations.

If disappointed in the market for health services, vote with your feet

◗ With increasing use of the market process in health insurance services there will be disappointments along with success. However, when compared to the current disappointments in a health care system controlled by the political process, failures in a market process are much easier to correct. Consumers need only to vote with their feet to express dissatisfaction.

Improved health service quality, choice, access and freedom

◗ As competitive forces develop in the health insurance and health care system, there is likely to be improvement in quality, access and availability of modern technology for patients and physicians.

By introducing private sector forces and an opportunity for personal responsibility in economic decisions, an improved and more sustainable health care and health insurance system is likely to emerge. The most valued aspect, of this

proposed redirection of the health systems in Quebec and the other provinces and territories, is the enhanced choice that will be felt by all Canadians, including patients and physicians.

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◗ (Several extracts are from *Pour une question de vies ou de morts*, Guérin, éditeur © 1998)

Biographical notes

After a busy career in Gynecology and Obstetrics at the Montreal General and Royal Victoria Hospitals in Montreal, and as Associate Professor at McGill's Faculty of Medicine, Dr J Edwin Coffey has recently exchanged his scalpel for the pen. A graduate in Arts from Mount Allison and in Medicine from McGill, he took his speciality training at the Johns Hopkins Hospital in Baltimore. He has had a longstanding interest in political, economic and legal philosophy and has been a provocative leader in the councils of Quebec and Canadian Medicine. He is a former President of the Quebec Medical Association and has served on the Board of the Canadian Medical Association and its Working Group on Health Care Financing in Canada. In his writing and discourse, he has consistently defended the values of individual freedom and responsibility. Over the years, he has attempted to demonstrate the inherent human flaws that creep into the systems of financing and delivery of health services, when too much responsibility is transferred from individuals and voluntary organizations to the state.

Jacques Chaoulli was born in France in 1952. After obtaining his medical doctorate from Université de Paris VII, he immigrated to Quebec in 1978 and undertook research in medical education at Laval University's faculty of medicine. He received a master's degree in education from Laval University in 1982. He has practiced medicine in Quebec since 1986. As a first-hand observer of the difficulties of access to health services, he began, in 1996, to make a particular examination of the consequences patients suffer as a result of difficulty in obtaining health services, notably by analyzing the health systems of countries comparable to Canada. Since 1997, he has studied the legal frameworks governing health-care systems in Quebec and Canada..