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Montreal Economic Institute

Ideas for a More Prosperous Nation

MARCH 2014

FOR A UNIVERSAL AND EFFICIENT HEALTH CARE SYSTEM

SIX REFORM PROPOSALS

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Ideas for a More Prosperous Nation

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Summary

Quebec's public health care system is becoming increasingly costly for taxpayers. Since the early 1980s, health care spending has outpaced the growth of the economy. Taking inflation into account, public health care spending per capita in the province of Quebec has risen by more than 90% in 30 years, to reach nearly $4,000 in 2013.

Long waiting lists now seem to be a structural characteristic of the system. The median wait time between visiting a general practitioner and getting treatment by a specialist has more than doubled in the past twenty years, from 7.3 weeks in 1993 to 17.8 weeks in 2013. According to studies conducted by the Commonwealth Fund, Quebec has been dead last for several years in international rankings of a dozen developed countries in terms of wait times in the emergency room and to see a doctor.

These access problems are aggravated by the inability of a substantial segment of the population to find a family doctor. In 2012, nearly 25% of the Quebec population still had no regular doctor. As a result, many patients are forced to show up at an emergency room for health problems that could have been treated more effectively and less expensively in a doctor's office.

Since the beginning of the 2000s, several working groups and commissions have proposed reforms aiming, among other things, to make more room for the private sector and for competition in Quebec's health care system. Despite these recommendations, it is clear that patients still have very few options when it comes to health services. The provision of treatments considered "essential" remains largely monopolized by the public sector. As for the role of private health insurance, it is limited solely to the coverage of services that are not insured by the public plan.

No other industrialized OECD country imposes as many restrictions upon its citizens in the field of health care. In fact, the existence of a mixed public-private health care system is the norm in almost all OECD countries. It is apparent that countries that allow a lot of room for the for-profit private sector in the provision of care and that promote competition between the various care providers generally achieve better results than either Quebec or the rest of Canada in terms of accessibility and service quality.

There are some especially important lessons to be drawn from the experiences of Germany, England, Denmark, France and Italy, all countries whose health care systems are based on the principle of universal care.

In this publication, the MEI is proposing six concrete ideas for reforming Quebec's health care system that are inspired by the experience of these countries. These reform proposals, which are all interrelated, would likely lead to substantial improvements both to the quality of care provided to patients and to their access to that care.

1) Promote freedom of choice for patients and competition between care providers

2) Promote the emergence of a true private hospital market

3) Increase funding for health care through duplicate private health insurance

4) Allow mixed practice in order to increase the supply of medical specialists

5) Fund hospitals based on services rendered

6) Make the publication of hospital performance indicators mandatory

Contrary to certain beliefs, these reforms have in no way constituted a threat to the goals of universality and accessibility to care. On the other hand, they have provided substantial benefits to patients, especially in terms of improving wait times and service quality.

INTRODUCTION

It is no secret that Quebec's public health care system is becoming increasingly costly for taxpayers. Since the early 1980s, health care spending has outpaced the growth of the economy. Taking inflation into account, public health care spending per capita in the province of Quebec has risen by more than 90% in 30 years, to reach nearly $4,000 in 2013.[1] A recent study estimates that if its current rate of growth continues, it could actually take up almost 70% of the government's budgetary spending by the year 2030.[2]

Of course, not all sources of increased spending are problematic. New medical technologies, among other things, even if they are sometimes quite expensive, can provide valuable services,[3] and even reduce other costs. They can, for instance, replace surgical procedures or reduce the number of hospital visits, thereby leading to a decrease in total health care spending.

In an efficient industry, greater expenses are not necessarily cause for concern, especially if the quality of goods and services received is better. Moreover, there is nothing unusual about a population demanding more of a certain kind of service as its income grows. Rising standards of living are in fact one of the factors responsible for the growth of health care spending in recent decades.[4]

However, when increased expenses do not lead to better services, there is every reason to be concerned. In this regard, the results of Quebec's public health care system are far from satisfactory, despite the growing volume of resources devoted to the system over the years. The population is not getting its money's worth compared to the vast majority of OECD countries,[5] and the situation is not improving.

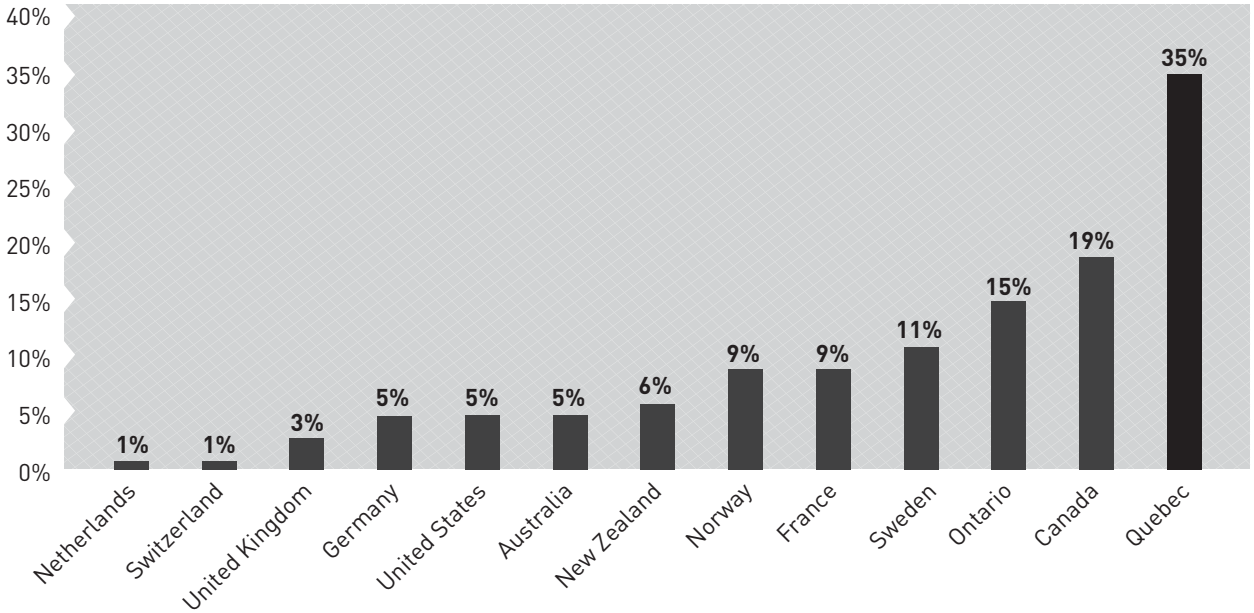
Long waiting lists now seem to be a structural characteristic of the system. The median wait time between visiting a general practitioner and getting treatment by a specialist has more than doubled in the past twenty years, from 7.3 weeks in 1993 to 17.8 weeks in 2013.[6] According to studies conducted by the Commonwealth Fund, Quebec has been dead last for several years in international rankings of a dozen developed countries in terms of wait times in the emergency room and to see a doctor (see Figures 1 to 3).[7]

"Given that traditional attempts to solve the problem of wait times have been unsuccessful, a majority of Quebecers wants government to explore private sector options."

Rarely a week goes by without some media outlet in Quebec taking stock of patients facing problems accessing primary care. According to a large study recently made public, nearly one Quebecer in five (and one in three among the poorest segment) reports having unmet needs when it comes to health care, primarily due to long wait times or the impossibility of seeing a doctor when needed (see Figure 4).[8] Despite increased amounts

1. Canadian Institute for Health Information, *National Health Expenditure Trends*, 1975 to 2013, p. 163. The data have been adjusted to account for inflation using the Consumer Price Index (CPI) for Quebec compiled by Statistics Canada, CANSIM Table No. 326-0020. In 1980, public health care spending in real terms was $1,992.47 (in 2012 dollars).
2. Nicolas-James Clavet, Jean-Yves Duclos, Bernard Fortin, Steeve Marchand and Pierre-Carl Michaud, *Les dépenses de santé du gouvernement du Québec 2013-2030 : projections et déterminants*, Research Report No. 2013s-45, Centre interuniversitaire de recherche en analyse des organisations (CIRANO), December 2013, p. 11.
3. See David M. Cutler, "The Lifetime Costs and Benefits of Medical Technology," *Journal of Health Economics*, Vol. 26, No. 6, 2007, pp. 1081-1100; William J. Baumol, *The cost disease: why computers get cheaper and health care doesn't*, Yale University Press, 2012, pp. 87-93.
4. Robert E. Hall and Charles I. Jones, "The Value of Life and the Rise of Health Spending," *Quarterly Journal of Economics*, Vol. 122, No. 1, 2007, pp. 39-72.
5. Brett J. Skinner and Mark Rovere, *Value for Money from Health Insurance Systems in Canada and the OECD*, Fraser Institute, October 2010; Jack Kitts *et al.*, *Better health, better care, better value for all: Refocusing health care reform in Canada*, Health Council of Canada, September 2013.
6. Bacchus Barua and Nadeem Esmail, *Waiting Your Turn: Wait Times for Health Care in Canada, 2013 Report*, Studies in Health Policy, Fraser Institute, October 2013, p. 37.
7. Jean-Frédéric Lévesque and Mike Benigeri, *L'expérience des soins des personnes représentant les plus grands besoins, le Québec comparé*, Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2011, Le Commissaire à la santé et au bien-être, Government of Quebec, 2012; Mike Benigeri and Olivier Sossa, *Perceptions et expériences de soins de la population: le Québec comparé*, Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2013, Le Commissaire à la santé et au bien-être, Government of Quebec, January 2014.
8. Jean-Frédéric Lévesque *et al.*, "Emerging organisational models of primary healthcare and unmet needs for care: insights from a population-based survey in Quebec province," *BMC Family Practice*, Vol. 13, No. 66, 2012.

Figure 1
Percentage of emergency room patients who had to wait 5 hours or more to be seen, 2013



Source: Mike Benigeri and Olivier Sossa, *Perceptions et expériences de soins de la population: le Québec comparé*, Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2013, Le Commissaire à la santé et au bien-être, Government of Quebec, January 2014, p. 84.

of money injected into the health care system in the past 25 years, it is undeniable that the problem of overcrowded emergency rooms remains as serious as ever.[9] In 2013, the average wait on a stretcher in emergency rooms stood at 17.6 hours, which is nearly two hours longer than a decade ago.[10]

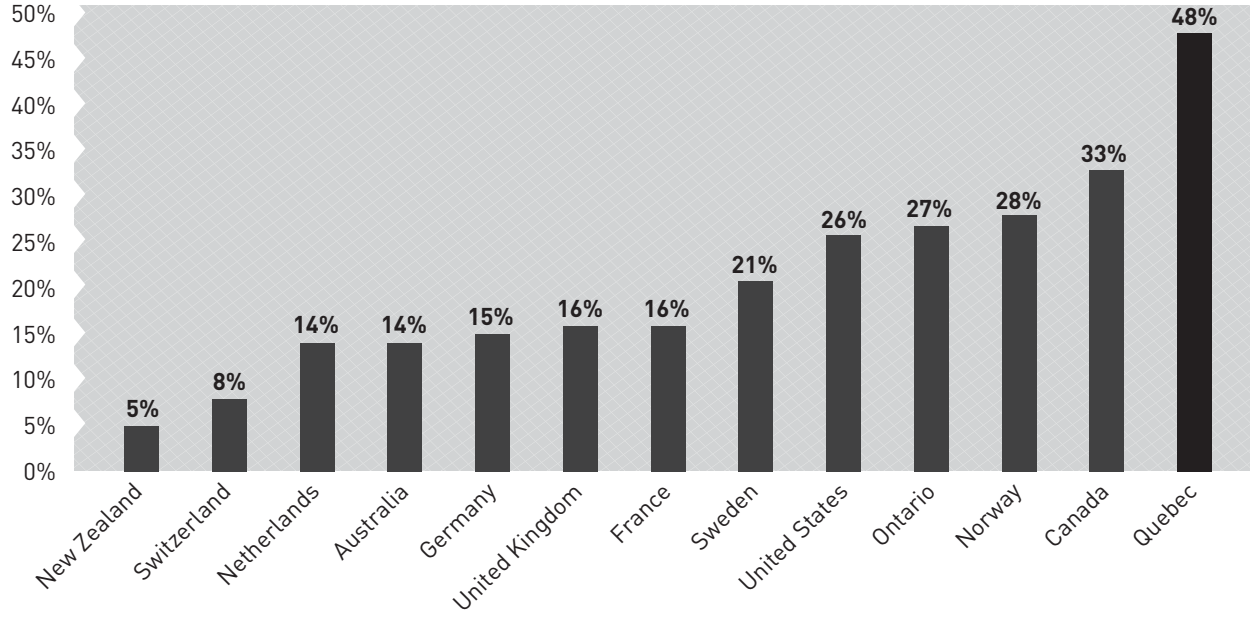
These access problems are aggravated by the inability of a substantial segment of the population to find a family doctor. In 2012, nearly 25% of the Quebec population still had no regular doctor.[11] As a result, many patients are forced to show up at an emergency room for health problems that could have been treated more effectively and less expensively in a doctor's office.[12]

All of these delays in the health care system are not only distressing for patients on a basic human level, but also very expensive from an economic standpoint. According to a report from the Fraser Institute, the 214,144 Quebec patients waiting for medical treatment in the public system in 2012 suffered combined losses of salaries amounting to some $200 million.[13]

Given that traditional attempts to solve the problem of wait times have been unsuccessful, a majority of Quebecers wants government to explore private sector options. According to a poll released in January 2013, two out of three Quebecers (66%) said they agreed that "[patients] should be given the right to buy private health care within Canada if they do not receive timely access to services in the public

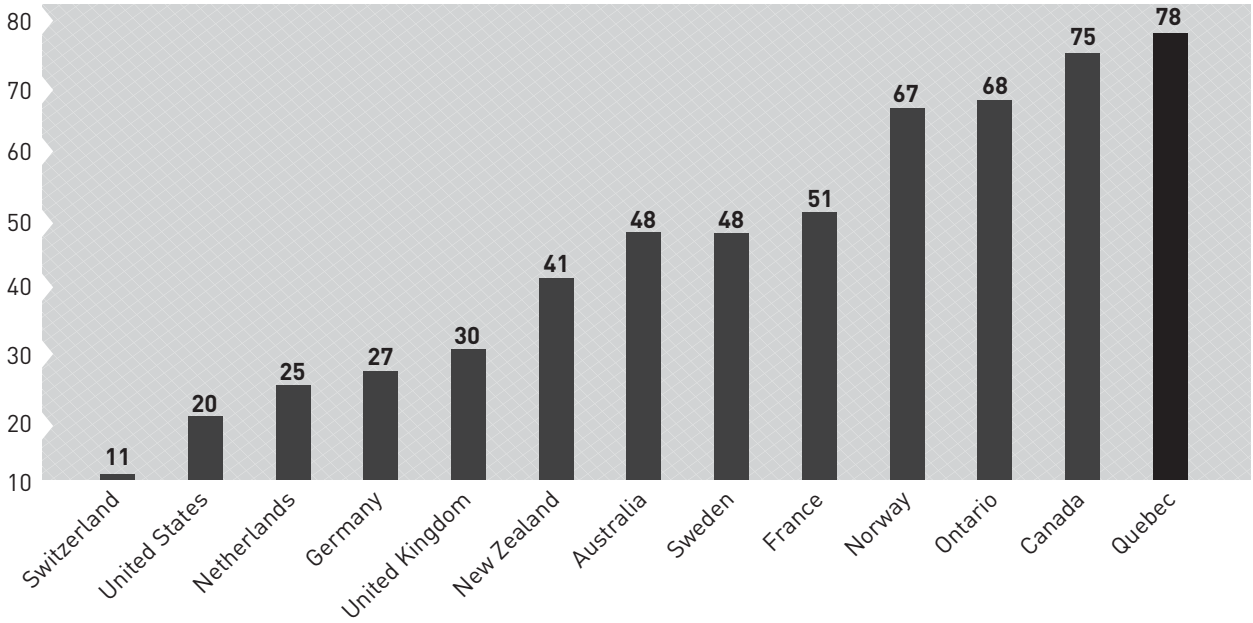
9. The problem of overcrowded emergency rooms is not a new one: It was already being observed in the 1980s. See Martha Gagnon, "Les omnipraticiens lancent un nouvel appel pour décongestionner les urgences," *La Presse*, December 7, 1988, p. A3.
10. Daphné Cameron, "Palmarès des urgences : toujours plus d'attente," *La Presse*, May 8, 2013; Pascale Breton, "Urgences : 'c'est clair que ça se détériore'," *La Presse*, February 7, 2007.
11. Statistics Canada, Table No. 105-0501, Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2012 boundaries) and peer groups. As part of another study, the Institut de la statistique du Québec estimates that 13% of Quebecers are unable to find a family doctor despite their efforts to do so and that another 8% of the population does not feel the need to have one. Institut de la statistique du Québec, *Enquête québécoise sur l'expérience des soins 2010-2011. Le médecin de famille et l'endroit habituel des soins : regard sur l'expérience vécue par les Québécois*, Vol. 2, March 2013, p. 35.
12. François-Pierre Gladu, "La pénurie réelle ou ressentie de médecins de famille au Québec : peut-on y remédier?" *Le Médecin de famille canadien*, Vol. 53, 2007, pp. 1871-1873.
13. Nadeem Esmail, "The private cost of public queues for medically necessary care," *Fraser Alert*, July 2013.

Figure 2
Percentage of patients who had to wait 6 days or more before getting an appointment with a doctor the last time they needed to, 2013



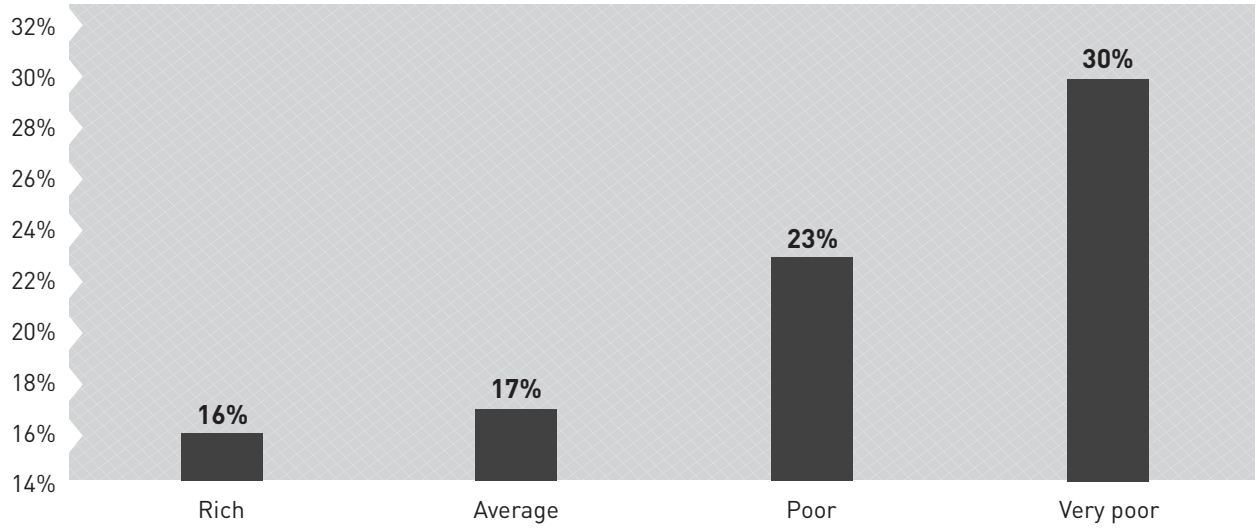
Source: Mike Benigeri and Olivier Sossa, *Perceptions et expériences de soins de la population: le Québec comparé*, Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2013, Le Commissaire à la santé et au bien-être, Government of Quebec, January 2014, p. 24.

Figure 3
Average number of days spent waiting for an appointment with a specialist, 2011



Source: Jean-Frédéric Lévesque and Mike Benigeri, *L'expérience des soins des personnes représentant les plus grands besoins, le Québec comparé*, Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2011, Le Commissaire à la santé et au bien-être, Government of Quebec, January 2012, p. 67.

Figure 4
Percentage of Quebecers who reported having unmet health care needs, by perceived wealth level, 2005



Source: Jean-Frédéric Lévesque *et al.*, "Emerging organisational models of primary healthcare and unmet needs for care: insights from a population-based survey in Quebec province," *BMC Family Practice*, Vol. 13, No. 66, 2012.

system," even if this might make access to care more unequal.[14]

An earlier poll commissioned by the MEI and conducted by Léger Marketing in September 2006 showed that a similar proportion of Quebecers (60%) would be in favour of the government allowing quicker access to health care for those willing to pay for it in the private sector, while maintaining the current free and universal health care system.[15] These polls suggest that there is a demand for health care financed and provided privately rather than exclusively by the public sector (as is currently the case for that basket of treatments considered to be medically required).

No excuse not to reform

Contrary to popular belief, it is not federal legislation but rather provincial laws that regulate almost all of the public health care system in Canada.[16] The *Canada Health Act* establishes the conditions that the provinces and territories must respect in order to receive the full amount of the federal government's financial contribution. These conditions are not binding. A provincial law that violates the *Canada Health Act* is therefore not invalid or illegal. The sanction is purely political and its repercussions are financial, not legal.

A provincial government thus has no excuse for keeping itself from reforming the health care system by incorporating market solutions, modelled after successful measures carried out in the vast majority of OECD countries. It can already, without any major changes to the legal rules that maintain the government's monopoly, integrate notions like flexibility and competition into the public system. It can also expand its recourse to the private sector for the provision of care, insofar as it continues to finance in full all insured treatments and that this larger place granted to the private sector does not infringe upon the condition that the system

14. Environics Institute, "What Canadians think about their health care system," January 2013.
15. Montreal Economic Institute, "The Opinion of Canadians on Access to Health Care," Results of a poll conducted by Léger Marketing, September 2006.
16. On this topic, see the MEI's *Economic Note* entitled "Health Care Reforms: Just How Far Can We Go?" April 2003; Gerard W. Boychuk, "The Regulation of Private Health Funding and Insurance in Alberta Under the Canada Health Act: A Comparative Cross-Provincial Perspective," The School of Policy Studies, SPS Research Papers, Vol. 1, No. 1, University of Calgary, December 2008.

be publically administered, as spelled out in the *Canada Health Act*.

It is the admixture of public and private financing that poses a problem. It would therefore be impossible to allow a patient to pay to obtain faster service provided by the public sector, or inversely to partially finance with public funds treatment provided in a parallel private system, without contravening the *Canada Health Act*. The Quebec government could, however, stop insuring certain services, or repeal certain articles of the *Health Insurance Act* and the *Hospital Insurance Act* in such a way as to allow the development of a private sector alongside the public sector in the province, where patients would be free to pay for all medically required services either directly or with private insurance.

Six reform ideas

In this publication, the MEI is proposing six concrete ideas for reforming Quebec's health care system. These reform proposals, which are all interrelated, would likely lead to substantial improvements both to the quality of care provided to patients and to their access to that care.

1) Promote freedom of choice for patients and competition between care providers

2) Promote the emergence of a true private hospital market

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4) Allow mixed practice in order to increase the supply of medical specialists

5) Fund hospitals based on services rendered

6) Make the publication of hospital performance indicators mandatory

These reform proposals are based on an exhaustive review of the literature: Over 250 books, studies and reports on health care policy were consulted and analyzed in depth in the context of this research project. The present *Paper* is also inspired by the work carried out by different MEI researchers in recent years.[17]

Since many countries have faced health care challenges similar to those now faced by Quebec—and others continue to face them—a thorough examination of the main reforms undertaken in several of these countries was carried out. There are some especially important lessons to be drawn from the experiences of Germany, England, Denmark, France and Italy, all countries whose health care systems are based on the principle of universal care.

"A provincial government has no excuse for keeping itself from reforming the health care system by incorporating market solutions, modelled after successful measures carried out in the vast majority of OECD countries."

Several observations arise from this broad analysis. First, the existence of a mixed public-private health care system is the norm in almost all OECD countries. It is apparent that countries that allow a lot of room for the for-profit private sector in the provision of care and that promote competition between the various care providers generally achieve better results than either Quebec or the rest of Canada in terms of accessibility and service quality.

Next, Canada is an exception in the industrialized world in limiting the role of private health insurance to the coverage of only those services that are not insured by the public system. And yet, many foreign experiments demonstrate that the instrument of duplicate private health insurance can help increase health care funding and relieve the pressure on the public system.

Finally, despite the fear of a certain portion of the population that greater reliance on the private sector

17. Numerous researchers have contributed to this work over the years, including Germain Belzile, Marcel Boyer, Julie Frappier, Norma Kozhaya, Mathieu Laberge, Valentin Petkantchin and Frederik Roeder.

will lead to a "two-tier" system, these international examples show that notions of freedom of choice, competition and profit are not incompatible with health care that is accessible to all.

"The existence of a mixed public-private health care system is the norm in almost all OECD countries."

CHAPTER 1

Promoting Freedom of Choice for Patients and Competition between Care Providers

Background

A fairly widespread opinion has it that the health care sector is not like other sectors, and that for this reason, the mechanisms of competition and choice are unlikely to produce the benefits we generally expect from them in the rest of the economy. This thesis, however, is increasingly being called into question.[18]

Over the past two decades, a large number of countries have undertaken reforms in order to improve the efficiency and productivity of their health care systems by decentralizing administration, by calling upon the private sector for the provision of care and by setting up competition mechanisms between different hospitals.

Within these health care systems, patients now have the freedom to choose not only their doctors but also the hospitals where they want to be treated, whether in the private or in the public sector. Contrary to certain beliefs, these reforms in no way constituted a threat to the goals of universality and accessibility of care. Rather, they led to substantial benefits, especially in terms of improvements in wait times and service quality.

This is in contrast to the situation in Quebec, where bureaucratic constraints place significant limits on patients' options.[19] In spite of similar kinds of recommendations having been made by various working groups and commissions since the early 2000s[20], most patients clearly still have very little real choice when it comes to hospital services, which remain largely monopolized by the public sector.

Today, very often the only option for patients who are dissatisfied with the services they receive is to file a complaint with the hospital ombudsman. As for those who are waiting for elective surgery, they generally have little alternative but to wait patiently with pain and discomfort.[21] The chance to opt for a medical institution outside the public sector for surgery is applicable only for three types of procedures, and only if the amount of time spent on the waiting list exceeds six months.[22]

Foreign experience

According to a recent OECD report, freedom to choose among providers is the measure that has had the most success in reducing wait times in countries that have adopted it over the past decade.[23] Among those countries are Germany, England, Denmark, Italy, Japan, Norway, the Netherlands, Portugal, Sweden and Switzerland, just to name a few.

In Japan, where freedom of choice of hospital has existed since the 1960s, competition among hospitals (nearly 80% of which are private[24]) has led not only to a general improvement in the quality of care in the network[25] but also to a reduction in the gap in quality between rural and urban regions. There are

18. See especially Amitabh Chandra, Amy Finkelstein, Adam Sacarny and Chad Syverson, "Healthcare exceptionalism? Productivity and allocation in the U.S. healthcare sector," Working paper No. 19200, National Bureau of Economic Research, July 2013; James C. Robinson, "The end of asymmetric information," *Journal of Health Politics*, Policy and Law, Vol. 26, No. 5, 2001, pp. 1045-1053.
19. Although the health services and social services law allows patients to choose the medical institution from which they want to receive their treatments, this freedom of choice is only theoretical, given the numerous administrative constraints that exist. See especially Karen Seidman, "University hospitals offering radiation therapy to face restrictions on who they can treat," *The Gazette*, February 12, 2014.
20. Michel Clair, "Refus de traitement," *La Presse*, February 23, 2008, p. A26.
21. The Quebec government recently announced its intention to set up regional waiting lists in the fall of 2014. As a result, patients would no longer be on the waiting list of the hospital closest to their residence, but rather on a list combining all the hospitals in their particular region. See Héloïse Archambault, "Vers des listes d'attente régionales," *Le Journal de Montréal*, February 15, 2014, p. 3.
22. Department of Health and Social Services, *Garantir l'accès : un défi d'équité, d'efficience et de qualité*, Document de consultation, Government of Quebec, 2006, p. 48.
23. Michael Borowitz, Valérie Moran and Luigi Siciliani, "A review of waiting times policies in 13 OECD countries," in *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies, 2013, p. 51.
24. Kozo Tatara and Etsuji Okamoto, "Japan: health system review," *Health Systems in Transition*, vol. 11, no 5, 2009, p. 84.
25. James H. Tiessen, "Hospital competition and quality in Japan: lessons for Canada," *Health Care Management*, Vol. 26, No. 28, 2005, pp. 49-59.

indications that these interregional disparities are less pronounced in Japan than in Europe.[26]

In Switzerland, where 46% of hospitals are private[27], people also have great liberty in choosing their care providers and are not required to receive treatment in the public hospitals closest to their homes.

England

Starting in 2002, a series of reforms were adopted in England whose aim was to give patients the freedom to choose the hospitals at which they wanted to receive their treatments. The primary goal of these reforms was to increase competition between hospitals in order to reduce waiting and improve the quality of services provided to patients. The government also hoped to reduce unequal access to care among different segments of the population. Indeed, at the moment when they went into effect, the Prime Minister of the day, Tony Blair of the Labour Party, said he wanted to "give poorer patients…the same range of choice the rich have always enjoyed."[28]

"According to a recent OECD report, freedom to choose among providers is the measure that has had the most success in reducing wait times in countries that have adopted it over the past decade."

The policy of freedom of choice initially took the form of pilot projects and applied only to patients suffering from heart disease who had been waiting for treatment for over six months. It is only as of 2004 that it was put into effect permanently. Doctors then had to present to their patients a minimum of four institutional options, including one from the private sector. In April 2008, choice was extended to patients needing non-urgent surgery, and that choice included any hospital in the country. One year later, freedom of choice was included in the constitution of the public health care system (the NHS) as one of "the rights of patients."[29]

In order to help with the choice of hospital, an information system tracking a variety of quality indicators that patients could consult online was also created (see Chapter 6). This option allows users to compare hospital performance. A wide range of data are now accessible to the population, in particular regarding quality of care, numbers of operations carried out, average wait times, average length of stay, readmission rates, survival rates after an operation, as well as patient experience. It is also possible to make an appointment directly online using the "Choose and Book" website.[30]

In conjunction with this, the government set up a network of so-called independent sector treatment centres specializing in elective surgeries, which expanded the choices offered to patients.[31] The number of these private centres has grown exponentially since the reform, from 10 in 2006 to 161 in 2011.[32] Independent analyses, including one carried out by the Royal College of Surgeons, have shown that these centres, far from selecting only the least complex cases as some had feared, instead raised the bar in terms of both efficiency[33] and quality of care.[34] Because all medical facilities are now remunerated based on the numbers of patients they attract, since the payment by results reform adopted in 2004, they are encouraged to try to distinguish themselves when it comes to service

26. Hiroshi Aiura, "Inter-regional competition and quality of hospital care," *European Journal of Health Economics*, Vol. 14, 2013, pp. 515-526.
27. Office fédérale de la statistique OFS, "Paysage hospitalier suisse en 2011," *Actualités OFS*, 14 santé, mai 2013, p. 2.
28. Zachary Cooper and Julian Le Grand, "Choice, competition and the political left," *Eurohealth*, Vol. 13, No. 4, 2007, p. 19.
29. Anna Dixon *et al.*, *Patient choice: How patients choose and providers respond*, The King's Fund, 2010, p. xiii.
30. Mirella Cacace, Stefanie Ettelt, Laura Brereton, Janice Pedersen and Ellen Nolte, *How health systems make available information on service providers: Experience in seven countries*, Rand Corporation Europe, 2011, p. 33.
31. Chris Naylor and Sarah Gregory, *Briefing: Independent Sector Treatment Centres*, The King's Fund, October 2009.
32. Elaine Kelly and Gemma Tetlow, *Choosing the place of care: The effect of patient choice on treatment location in England, 2003-2011*, The Nuffield Trust/Institute for Fiscal Studies, November 2012, p. 3.
33. Luigi Siciliani, Peter Sivey and Andrew Street, "Differences in length of stay for hip replacement between public hospitals, specialised treatment centres and private providers: selection or efficiency?" *Health Economics*, Vol. 22, No. 2, 2013, pp. 234-242.
34. J. Chard, M. Kuczawski, N. Black and J. Van der Meulen, "Outcomes of elective surgery undertaken in independent sector treatment centres and NHS providers in England: audit of patient outcomes in surgery," *BMJ*, Vol. 343:d6404, 2011; John Browne *et al.*, "Case-mix & patients' reports of outcomes in Independent Sector Treatment Centres: Comparison with NHS providers," *BMC Health Services Research*, Vol. 8, No. 78, 2008.

quality and treatments offered, tied as these are to their income (see Chapter 5).

The changes made to the English system have produced impressive results. By promoting freedom of choice and competition, the reforms have led to substantial improvements in hospital management[35] and quality of care provided to patients.[36] Competition between medical facilities has led to significant reductions in the risks of patient mortality, without increasing either costs or length of stay.[37] According to a group of British economists who looked into the effects of the reform, "Competition in the elective market in England likely prompted hospitals to take a number of steps to improve clinical performance, such as undertaking clinical audits, tightening clinical governance, making investments in new technology and improving hospital management."[38]

Finally, the reforms have fulfilled their promise in terms of wait times for elective surgeries, which have fallen on average by over 60% since 2002.[39] The introduction of freedom of choice and competition has also led to improvements in equality of access to treatment.[40] Patients from less privileged socioeconomic backgrounds have thus seen their wait times for a great number of surgical treatments fall more quickly than they did for more well-off patients.[41]

Many English patients want to take an active part in the decision regarding where treatment will happen. In a recent poll, 75% of respondents agreed that the choice of care provider was either "very important" or "important" to them.[42] It is unskilled workers and older people who say they place more importance on the choice of treatment location.[43] The data also show that patients' choices are guided more by the quality of care offered and the length of wait times than by the distance separating home and hospital.[44] Unsurprisingly, there has been a clear improvement in patients' satisfaction rates regarding their health care system since the launch of the reform.[45]

"Competition between medical facilities has led to significant reductions in the risks of patient mortality, without increasing either costs or length of stay."

The policy of freedom of choice has worked so well that in the summer of 2012, the government amended the legislation once again in order to further increase the options offered to patients in terms of hospital services. The public health care system is now open to international competition. As a result, large private hospital groups, like Capio (Sweden), Ramsay Health Care (Australia), Netcare (South Africa), Apollo (India), Cinven/Spire (European holding company) and United Health (United States) have set up shop in England in order to offer a variety of services previously monopolized by the public sector.[46]

35. Nicholas Bloom, Carol Propper, Stephan Seiler and John Van Reenen, "The impact of competition on management quality: evidence from public hospitals," CEP Discussion Paper No. 983, Centre for Economic Performance, February 2013.
36. Martin Gaynor, Carol Propper and Stephan Seiler, "Free to choose? Reform and demand response in the English National Health Service," Working Paper No. 18574, National Bureau of Economic Research, November 2012.
37. Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper, "Death by market power: Reform, competition and patient outcomes in the National Health Service," *American Economic Journal: Economic Policy*, Vol. 5, No. 4, 2013, pp. 134-166.
38. Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire, "Does hospital competition save lives? Evidence from the English NHS patient choice reforms," *The Economic Journal*, Vol. 121, 2011, p. F251;
39. England Department of Health, Inpatient and Outpatient Waiting Times statistics, Historical Times Series, 1988-2010; Diane Dawson *et al.*, "The effects of expanding patient choice of provider on waiting times: Evidence from a policy experiment," *Health Economics*, Vol. 16, No. 2, 2007, pp. 113-128.
40. Anna Dixon and Julian Le Grand, "Is greater patient choice consistent with equity? The case of the English NHS," *Journal of Health Services Research & Policy*, Vol. 11, No. 3, 2006, pp. 162-166.
41. Zachary N. Cooper, Alistair McGuire, S. Jones, J. Le Grand and Richard Titmuss, "Equity, waiting times, and NHS reforms: retrospective study," *BMJ*, Vol. 339, 2009, p. b3264.
42. Anna Dixon *et al.*, *op. cit.*, note 29, p. xiii.
43. Ruth Robertson and Peter Burge, "The impact of patient choice on equity: Analysis of a patient survey," *Journal of Health Services Research & Policy*, Vol. 16, No. S1, 2011, pp. 22-28.
44. Walter Beckert, Mette Christensen and Kate Collyer, "Choice of NHS-funded hospital services in England," *The Economic Journal*, Vol. 122, 2012, pp. 400-417.
45. Ashley L. Grosso and Gregg G. Van Ryzin, "Public management reform and citizen perceptions of the UK health system," *International Review of Administrative Sciences*, Vol. 78, No. 3, 2012, pp. 494-513; John Appleby, *British social attitudes survey 2012: Public satisfaction with the NHS and its services*, The King's Fund, 2012.
46. Mark Dusheiko, "Patient choice and mobility in the UK health system: internal and external markets," in *Health care provision and patient mobility: Health Integration in the European Union*, Springer-Verlag, 2014, p. 118.

Denmark

The freedom to choose one's care provider constitutes one of the key pillars of Denmark's health care system. Beginning in 1993, a set of reforms focusing on patients' freedom of choice was gradually put in place with the goal of reinforcing competition and quality of health services. From that point on, patients were able to choose the hospital where they wanted to receive treatment among those in the public network.

In 2002, the government extended the reform by offering patients the option of treatment in private or foreign care centres paid for by the government if wait times in the public system exceeded two months. Since 2007, thanks to a waiting-time guarantee, a patient need not wait more than 30 days, once a diagnosis has been made, before receiving treatment. Beyond this limit, any patient can receive treatment in a private medical facility and have his or her expenses paid by the government.[47] Whether the patient chooses to receive his or her treatment in a public hospital or a private clinic, the medical facility in question will receive a predetermined amount under the country's activity-based funding system.

All Danes have access to a multitude of informational tools to help them in making their choices. In particular, an e-health Web portal (www.sundhed.dk) was created in 2001 in order to provide a single access point for available information on health care services in the country and to facilitate communication between doctors and the population.[48] The site gives Danish patients access to a wide range of data on the quality of care provided by hospitals (wait times, rates of complications and readmissions, hospital-acquired infection rates, etc.) and lets them compare hospitals. Patients can also make appointments with their doctors, who are available and remunerated for responding to patient questions by email.[49]

Contrary to a worry that is widespread in Canada, private sector medical facilities in Denmark do not select only the least complex, and therefore most profitable, cases. This is what a study of this question by the Danish Health Institute has shown[50]. Indeed, it really is patients who choose which hospitals will treat them and not the other way around. The managers of private clinics understand that rejecting the difficult cases would damage their reputation[51] and would affect their ability to attract patients in the future.

"All Danes have access to a multitude of informational tools to help them in making their choices."

The Danish hospital system has made impressive improvements since the early 2000s and now stands out internationally in terms of efficiency and quality of care.[52] Wait times for patients for elective surgeries have fallen considerably over the past decade and the patient choice policy has had a lot to do with it.[53] In a recent analysis of 16 countries, OECD researchers found that Denmark had the second shortest median wait times for elective surgeries, with wait times less than half as long as they are in Canada.[54]

Thanks in large part to the freedom granted to patients, the Danish health care system has been one of the top four most efficient in Europe for over five years, according to the independent Health Consumer Powerhouse organization.[55]

47. Those who have duplicate private insurance or who want to pay directly can of course choose a private clinic from day one (60% of cases treated in private clinics).
48. Mirella Cacace, Stefanie Ettelt, Laura Brereton, Janice Pedersen and Ellen Nolte, *op. cit*., note 30, pp. 23-31.
49. Denis Protti and Ib Johansen, *Widespread adoption of information technology in primary care physician offices in Denmark: A case study*, Issues in International Health Policy, the Commonwealth Fund, March 2010, p. 2.
50. Karolina Socha and Mikael Bech, "Extended free choice of hospital – waiting time," *Health Policy Monitor*, Survey No. 10, October 2007.
51. Lotte Bøgh Andersen and Mads Jakobsen, "Does ownership matter for the provision of professionalized services? Hip operations at publicly and privately owned clinics in Denmark," *Public Administration*, Vol. 89, No. 3, 2011, p. 967.
52. Organisation of Economic Co-operation and Development, *Denmark: Raising Standards*, OECD Reviews of Health Care Quality, pp. 114-118.
53. Terkel Christiansen and Mickael Bech, "Chapter 6: Denmark," in *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies, 2013, pp. 115-131.
54. Luigi Siciliani, Valérie Moran and Michael Borowitz, "Measuring and comparing health care waiting times in OECD countries," OECD Health Working Paper No. 67, November 2013.
55. Arne Bjornberg, *Euro Health Consumer Index 2013*, Health Consumer Powerhouse, November 2013.

The reform and its benefits

The Quebec government should adopt a consistent reform giving Quebec patients complete freedom to choose their care providers, whether from the public or the private sector, for their non-urgent surgical procedures. Greater freedom of choice, combined with a hospital funding system in which the money follows the patient (see Chapter 5), would likely increase competition among care providers and service quality throughout the system. For such a policy to be more effective, data on a series of quality indicators in health care institutions should be made available to the public through a Web portal, in addition to those on wait times,[56] in order to help patients make better choices of where to receive treatment (see Chapter 6).

The logic behind competition mechanisms is relatively simple. Insofar as patients are free to choose their care providers, they will be inclined to abandon institutions that offer mediocre services and to turn to those that provide better services. For a hospital that wants to generate profits, a patient constitutes a source of income. The more patients an institution attracts by the quality of care it provides, the greater the demand for its services will be, and the better business will be.

In a system in which patients can choose among care providers, hospitals pay more attention to the importance of maintaining quality services and preserving a good reputation. They also make sure to collect data and information on quality and patient satisfaction regarding the care provided. They adapt their practices in light of patients' expectations and preferences and are constantly on the lookout for new and better ways of responding adequately to their needs. It is in these ways that they can hope to turn a profit.

Some analysts think that patients are unable to make decisions when it comes to health care or that they simply do not have the time to decide on the location where they will receive treatment given the urgency of their situations.[57] For these reasons, according to these analysts, competition would not have a positive influence on efficiency or on the quality of services offered. Yet on the contrary, both experience and economic theory teach us that competition between hospitals pushes them to improve the overall quality of treatments, not only those that will allow them to attract patients.[58] Researchers have shown, for example, that in regions where there is more competition between hospitals, patients admitted to emergency rooms (those having suffered a heart attack, for instance) have significantly lower risks of dying, even if they did not choose their treatment location.[59]

"OECD researchers found that Denmark had the second shortest median wait times for elective surgeries, with wait times less than half as long as they are in Canada."

In a competitive situation, neither private institutions nor public hospitals have an interest in neglecting the quality of services offered in order to cut costs because, in the end, lower quality services will lead to fewer patients and therefore less revenue. Cost reduction does not happen through the rationing of services either, as is the case in a monopolistic system like the one currently in place in Quebec, but rather through the more efficient and judicious use of available resources. It is also necessary to maintain attractive salaries and pleasant work environments, or employees will go practice their professions elsewhere.

Finally, since they are its main beneficiaries, patients are generally ready to devote more time and effort to finding the best place for them (in terms of quality, wait times, etc.) than often very busy attending physicians would. A policy of freedom of choice can therefore help both to reduce overall wait

56. http://wpp01.msss.gouv.qc.ca/appl/g74web/.
57. Julia Belluz, "Why the markets can't run hospitals," *Science-ish* (a joint project of *Maclean's*, *The Medical Post* and the McMaster Health Forum), December 5, 2011.
58. Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper, *op. cit.*, note 37; Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire, *op. cit.*, note 38.
59. Daniel P. Kessler and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?" *Quarterly Journal of Economics*, Vol. 115, No. 2, 2000, pp. 577-615.

times in the hospital system and to shrink the gap between different institutions in this regard.[60]

60. Richard Cookson and Diane Dawson, "Hospital competition and patient choice in publicly funded healthcare," in *The Elgar Companion to Health Economics, second edition*, Edward Elgar, 2012, pp. 219-230.

CHAPTER 2

Promoting the Emergence of a True Private Hospital Market

Background

In most economic sectors, the multiple problems facing the health care system would be perceived as a set of opportunities for private entrepreneurs. However, since hospital and medical treatments considered "essential" are monopolized by the state in Quebec, these entrepreneurs are by definition excluded from a large part of the health care sector.

Even in areas in which the private sector provision of care is allowed, numerous regulations and obstacles handcuff entrepreneurs and undermine their drive to initiate new ventures.[61]

For example, laws were enacted by the National Assembly in the wake of the Supreme Court's 2005 *Chaoulli decision* in order to oversee the services provided by private surgery clinics—now called specialized medical centres (SMCs). First of all, an SMC must be majority owned by members of the Collège des médecins du Québec. Furthermore, an SMC must be operated either exclusively by doctors who are participating in Quebec's public health plan or exclusively by non-participating physicians.[62] These new constraints have had the effect of severely limiting these centres' chances of attracting capital and getting their businesses off the ground.

So even though private clinics have been growing in number since 2006, they remain marginal, both in number and in size, in the Quebec hospital landscape.[63] A study carried out by the MEI in the fall of 2013 found that of the 185 entirely private medical clinics registered in the province, only 13% are operated by 5 or 6 physicians not participating in the public plan. Only a minority of them provide health services considered to be medically required, and these do so almost solely within the context of partnership agreements with public hospitals.[64] And as for private for-profit hospitals, they simply do not exist.

Foreign experience

In many countries, especially in Europe where the public funding of health care is at least as significant as it is in Canada, the private sector plays an important role in the provision of hospital services.[65] Over one third of hospitals are private and for-profit in Germany, Australia, Spain, France and Italy, all countries whose health care systems are based on the principle of universality (see Table 1).

Several international examples, including those in Germany and France, show that the participation of the private sector and the profit motive, contrary to beliefs that are widespread in Canada, are associated with better quality care and help the health care system respond more adequately to the needs of the population.

France

France has stood out over the years as a world leader in the private hospital sector. In 2011, private hospitals as a group could count on the know-how of 40,000 doctors and 150,000 salaried employees,[66] and generated total sales revenue of over 13 billion euros.[67]

In 2011, there were 1,047 private for-profit medical facilities accounting for 39% of all health

61. See Yanick Labrie, "Health Care Entrepreneurship: Overcoming the Obstacles," *Economic Note*, Montreal Economic Institute, November 2011.
62. See especially Sylvie Bourdeau, "Bill 33 now in force… authorizing private clinics and private health insurance in Quebec," *Health Law Bulletin*, Fasken Martineau, February 2008.
63. See Jasmin Guénette and Julie Frappier, "Private Medicine in Quebec," *Economic Note*, Montreal Economic Institute, December 2013.
64. Even though these agreements have proven their value in reducing wait times for surgery, the government wants to put an end to them. See especially Harold Gagné, "Fin de l'entente entre le Sacré-Cœur et la clinique privée Rockland MD," Canoë.ca, October 11, 2011.
65. See Yanick Labrie and Marcel Boyer, "The private sector within a public health care system: The French example," *Economic Note*, Montreal Economic Institute, April 2008.
66. Fédération de l'hospitalisation privée, http://www.fhp.fr/1-fhp/3-la-fhp/1010-/2-1010-article.aspx.
67. Éric Thuaud, "La situation économique et financière des cliniques privées à but lucratif en 2011," Études et Résultats, No. 859, Direction de la recherche, des études, de l'évaluation et des statistiques, Government of France, November 2013.

Table 1
Distribution of hospitals in different OECD countries by type of ownership, 2011

Country	Public hospitals	Private non-profit hospitals	Private for-profit hospitals
Germany	26.1%	32.5%	41.4%
Australia (2010)	55.9%	8.6%	35.5%
Austria	56.8%	16.1%	27.1%
Canada (2010)	99.0%	1%	0%
Spain	45.7%	15.6%	38.7%
United States (2010)	26.5%	52.7%	20.8%
France	35.0%	26.5%	38.5%
Italy	43.1%	2.9%	54.1%
Japan (2004)	22.0%	68.7%	9.3%
New Zealand	52.2%	19.3%	28.6%
Portugal	54.0%	24.6%	21.4%

Sources: Organisation for Economic Co-operation and Development, Health Data 2013; Kozo Tatara and Etsuji Okamoto, "Japan: health system review," *Health Systems in Transition*, Vol. 11, No. 5, 2009, p. 84.

institutions with hospitalization capacity. They accounted for nearly 100,000 full hospital beds, or 24% of the total.[68] These proportions are almost double those found in the United States, where private for-profit institutions account for 18% of all hospitals and 13% of beds.[69]

Private for-profit hospitals are specialized first and foremost in areas of surgery and short-term care. In all, these institutions take care of some eight million patients a year and carry out 54% of surgeries. For example, the private for-profit sector performs around one in two digestive system operations, two of every five heart surgeries, three out of four cataract surgeries and nearly three in ten deliveries.[70] Private hospitals also play a non-negligible role in ensuring emergency services, as they run nearly 20% of institutions with emergency rooms and receive over 2.3 million emergency room visits a year.[71]

The reputations of numerous private groups, in terms of innovation and medical expertise as well as range and quality of services provided, are well-established. For example, the companies Générale de santé and Groupe CAPIO, majority owned by Italian and Swedish shareholders respectively, are significant players in the provision of hospital care in France which export their expertise across Europe.

"Over one third of hospitals are private and for-profit in Germany, Australia, Spain, France and Italy, all countries whose health care systems are based on the principle of universality."

The private sector in France also stands out when it comes to efficiency. It is approximately 27% less expensive than the public sector in treating the same conditions.[72] This does not means that private institutions skimp on quality of care in order to cut costs. While institutional size and quality of services provided vary appreciably from one hospital to another, a study has shown that the mortality rates in

68. The exact number is 98,522, which represents 23.7% of beds. Bénédicte Boisguérin and Gwennaëlle Brilhault (eds.), *Le Panorama des établissements de santé – édition 2013*, Direction de la recherche, des études, de l'évaluation et des statistiques, Government of France, January 2014, p. 75.
69. Private non-profit hospitals represent 50.5% of institutions and 59% of beds. National Center for Health Statistics, *Health, United States, 2012: With Special Feature on Emergency Care*, 2013, p. 314; OECD, Health Data, June 2013.
70. Bénédicte Boisguérin and Gwennaëlle Brilhault, *op. cit.*, note 68, pp. 102-103.
71. *Ibid*, p. 137.
72. [French] Ministère de la Santé et du Sport, *Rapport 2009 au Parlement sur la convergence tarifaire*.

private for-profit hospitals in France, after adjusting for severity of cases, are lower than those of other hospitals.[73]

Nor is access to the treatments provided by private for-profit medical institutions reserved only for those with the means to pay. All French citizens can choose to be treated in the private sector and treatments are covered by the public health insurance plan, one of the main branches of the country's social welfare system.[74]

The private sector is actually more present in the poorer regions of France, where the public sector has failed to respond adequately to the needs of the population. Whereas there is just a single clinic with more than 200 beds in Paris, and none at all in the neighbouring Hauts-de-Seine suburbs, the richest department (a sub-regional division) in France, there are seven medical institutions with at least 200 beds in Seine-Saint-Denis, the poorest department in the Paris region.[75]

The French hospital system not only ensures universal access to care for all citizens regardless of patients' financial means, but it does so without having to ration care through waiting lists, as is the case in Quebec. The French system succeeds less through the size of its medical workforce than through the mechanisms in place that incentivize institutions to make the best use of available medical resources to treat the greatest possible number of cases as quickly as possible.

These incentives are the result of the way in which French hospitals are financed. Since 2004, a new activity-based funding system (T2A, *tarification à l'activité*) has gradually replaced the former method of financing hospitals on a historical basis. The implementation of the T2A system now offers the advantage of allowing all hospitals to be reimbursed based on number and complexity of cases treated, contrary to the global budget funding method (see Chapter 5).

Since the hospital funding reform, there has been a marked increase in the productivity of public institutions because of the greater competition from private clinics.[76] The introduction of competition has also encouraged institutions to try to better control costs and reduce the length of hospital stays.[77] Given that the hospital funding method takes into account complications and the severity of cases treated, private clinics have taken on tough cases at a rate that is comparable to that of public hospitals.[78]

"The mortality rates in private for-profit hospitals in France, after adjusting for severity of cases, are lower than those of other hospitals."

France's mixed health care system stands out globally in terms of excellence. It acquired a certain fame at the turn of the century by being ranked first among 191 countries by the World Health Organization.[79] Health indicators in France, such as measures of the population's satisfaction with the system itself,[80] are among the highest in the world. For example, in terms of life expectancy at age 65 and infant mortality, France is ahead of almost every other industrialized country, including Canada (and Quebec). Since 1997, the French health care system has been ranked first in the world in terms of avoidable mortality rates due to causes

73. Carine Milcent, "Hospital ownership, reimbursement system and mortality rates," *Health Economics*, Vol. 14, No. 11, 2005, pp. 1151-1168.
74. Karine Chevreul *et al.*, "France: health system review," *Health systems in transition*, Vol. 12, No. 6, 2010, European Observatory on Health Systems and Policies, World Health Organization, pp. 53-55.
75. Victor Mennessier, *La place du privé dans le système hospitalier français*, Speech delivered at a conference organized by the Montreal Economic Institute, October 16, 2008.
76. Zeynep Or, Julia Bonastre, Florence Journeau and Clément Nestrigue, *Activité, productivité et qualité des soins des hôpitaux avant et après la T2A*, Working Paper No. 56, Institut de recherche et de documentation en économie de la santé, April 2013; Philippe Choné, Franck Evain, Lionel Wilner and Engin Yilmaz, *Introducing activity-based payment in hospital industry : Evidence from French data*, Working Paper G2013/11, National Institute of Statistics and Economic Studies, November 2013.
77. Franck Evain, "Hospitalisation de court séjour – Évolution des parts de marché entre 2003 et 2011," Études & Résultats, No. 854, October 2013.
78. Olivier Guérin and Jocelyn Husser, "Les effets incitatifs de la T2A pour les établissements de soins: vers une nouvelle répartition des actes médicaux?" *Vie et Sciences de l'entreprise*, No. 189, 2011, pp. 12-22.
79. World Health Organization, *The world health report 2000 – Health systems: improving performance*, 2000.
80. European Commission, *Health and long-term care in the European Union*, Eurobarometer Special Survey 283, December 2007.

related to deficient health care.[81] In other words, the chance that a patient might die from an illness for which effective treatments exist, due to not having received the appropriate treatments in time, is lower in France than in any other country.

Germany

In Germany, hospitals are either public (generally municipal), private non-profit (often administered by a religious organization) or private for-profit institutions. There were a total of 2,064 hospitals providing short-term care in 2010, distributed more or less equally among the three categories.[82] Private hospitals are generally integrated into the public health care system and treat all patients, not just those who have purchased private insurance.

In the late 1980s and early 1990s, several public hospitals in Germany were faced with recurring deficits, and their infrastructure was gradually deteriorating. It was at this moment that, in several *länder*, the restrictions preventing the privatization of public hospitals were lifted.[83] The number of private for-profit hospitals jumped by 90% from 1991 to 2010, while the number of public hospitals fell by 43%.[84] This led to significant efficiency improvements in these hospitals.[85]

Private for-profit German hospitals provide higher quality care than that offered by public or non-profit hospitals.[86] Wait times before receiving treatment after having consulted a specialist are also shorter in these hospitals. They admit patients 16.4% faster than non-profit hospitals and 3.1% faster than public hospitals.[87] There is no difference between private for-profit hospitals and public hospitals in terms of access to or quality of emergency services.[88]

In comparisons between the public sector and the private sector, one often hears the stereotype that the private sector treats less "difficult" patients. According to this perception, private hospitals are found solely in urban areas with high population densities and above-average purchasing power. The German data show that this is not the case. Private for-profit companies seem to have developed the most appropriate solutions for rural regions, where only small hospital projects (fewer than 200 beds) are feasible and where the efficient use and allocation of resources are crucial to providing the local population with the care it needs.[89] In the early 2000s, it is the Rhön-Klinikum company, owner of a large chain of private hospitals, that took the lead in the development of telemedicine services aimed at better serving patients in remote regions.[90]

"Private hospitals are generally integrated into the public health care system and treat all patients, not just those who have purchased private insurance."

Access to extra capital from private markets puts for-profit hospitals in a better position when the time comes to make necessary investments, especially those that reduce operating costs (for example, by promoting energy conservation).[91] It is in private for-profit hospitals that the highest investments per number of cases are found (64% more than in public hospitals). These investments allow them to offer

81. Ellen Nolte and Martin McKee, "Variations in amenable mortality – Trends in 16 high-income nations," *Health Policy*, Vol. 103, No. 1, 2011, pp. 47-52; Juan J. Gay *et al.*, *Mortality Amenable to Health Care in 31 OECD Countries: Estimates and Methodological Issues*, OECD Health Working Papers, No. 55, 2011.
82. Economist Intelligence Unit, *Germany: Healthcare and Pharmaceuticals Report*, December 2011.
83. Patrick Jeurissen, *For-profit hospitals: A comparative and longitudinal study of the for-profit hospital sector in four Western countries*, Doctoral thesis, Erasmus University, Rotterdam, pp. 145-147.
84. Statistisches Bundesamt, *Grunddaten der Krankenhäuser*, Fachserie 12 Reihe 6.1.1, 2011, p. 13.
85. Oliver Tiemann and Jonas Schreyögg, "Changes in Hospital Efficiency after Privatization," *Health Care Management Science*, Vol. 15, No. 4, 2012, pp. 310-326.
86. Oliver Tiemann and Jonas Schreyögg, "Effects of Ownership on Hospital Efficiency in Germany," *Business Research*, Vol. 2, No. 2, 2009, pp. 115-145.
87. Björn A. Kuchinke, Dirk Sauerland and Ansgar Wübker, *Determinanten der Wartezeit auf einen Behandlungstermin in deutschen Krankenhäusern: Ergebnisse einer Auswertung neuer Daten*, Technische Universität Ilmenau, 2008.
88. Barbara Hogan and Ulrike Güssow, "Notfallmanagement im Krankenhaus Stellenwert einer Notaufnahmestation," *Klinikarzt*, Vol. 38, No. 1, 2009, pp. 16-20.
89. Boris Augurzky, Andreas Beivers, Günter Neubauer and Christoph Schwierz, *Bedeutung der Krankenhäuser in privater Trägerschaft*, RWI, 2009, p. 24.
90. Barrie Dowdeswell, "Rhön-Klinikum Group, Germany," in Bernd Rechel *et al.* (eds.), *Capital investment for health: case studies from Europe*, European Observatory on Health Systems and Policies, World Health Organization, 2009, pp. 143-157.
91. Christoph Schwierz, "Expansion in Markets with Decreasing Demand – For-Profits in the German Hospital Industry," *Health Economics*, Vol. 20, No. 6, 2011, pp. 675-687.

the latest treatments and to purchase cutting edge medical equipment.

Subject to very strict transparency and quality control mechanisms (see Chapter 6),[92] private for-profit hospitals cannot reduce treatment quality in order to increase profits. Such a strategy would be very harmful to a hospital's reputation and to its ability to attract patients, who are the source of its revenue. Quality checks have moreover determined that the number of problematic cases is 9% higher (per 100 hospitals) in public hospitals than in private for-profit hospitals.[93]

"Long wait times in emergency rooms, an omnipresent phenomenon in Quebec hospitals, are unheard of in Germany."

Contrary to most Quebec hospitals, German hospitals do not have global budgets, but are instead reimbursed based on the numbers and types of cases treated[94] (see Chapter 5). Since this new reimbursement system was put in place in 2004, hospitals' incentives have changed and efficiency has increased throughout the system.[95] Hospitals compete to attract patients, who are free to choose to be treated in any medical institution integrated into the public health care system. This way of doing things leads to health care provision that is more centred on the patient, and avoids problems of rationing by waiting list. Wait times for receiving treatment are therefore substantially shorter than they are in Quebec.[96] Long wait times in emergency rooms, an omnipresent phenomenon in Quebec hospitals, are also unheard of in Germany.

92. Reinhard Busse, Ulrike Nimptsch and Thomas Mansky, "Measuring, Monitoring, And Managing Quality In Germany's Hospitals," *Health Affairs*, Vol. 28, No. 2, 2009, pp. w294-w304.
93. Germany's Federal Office for Quality Assurance (BQS).
94. German Institute of Medical Documentation and Information, *Reimbursement System for German Hospitals*.
95. Wilm Quentin, Alexander Geissler, David Scheller-Kreinsen and Reinhard Busse, "DRG-type hospital payment in Germany: The G-DRG system," *Euro Observer*, Vol. 12, No. 3, 2010, pp. 4-6.
96. Jean-Frédéric Lévesque and Mike Benigeri, *L'expérience des soins des personnes représentant les plus grands besoins, le Québec comparé*, Results of the Commonwealth Fund's 2011 international study of health policies, Le Commissaire à la santé et au bien-être, Government of Quebec, 2012.

The reform and its benefits

Decision makers should promote the emergence of a true private hospital market in Quebec. As we have seen, the absence of private hospitals is a rare phenomenon among industrialized OECD member countries. Such a reform would increase competition and give patients more choice, two factors that can substantially raise the quality level of hospital services.

Economic studies show that private hospitals (for-profit or non-profit) generally surpass public hospitals in terms of efficiency and care quality.[97] The profit motive is at the root of the success of private for-profit hospitals. Since investors expect to receive an adequate return on the funds they have invested, hospital administrators have a strong incentive to be more efficient. Required reorganizations of hospital practices and restructuring plans are therefore put in place more quickly.

Private hospitals also focus on the central mission of their business: treating patients. As a result, secondary activities like the administration of food services and stocking or the management of the premises are often entrusted to other companies with expertise in these areas. Conversely, public hospitals tend to manage many secondary services themselves, which raises their operating costs and interferes with their primary function.

There exist certain concerns about the private sector that, upon closer reflection, are unfounded. For example, critics of opening the market to the private sector often claim that the diseases that are the least expensive to treat would be taken over by private for-profit hospitals, and that difficult and risky cases would be left to public hospitals.[98] However, in a context of competition and transparency where medical institutions are remunerated based on the severity of cases and the complexity of diseases,

97. See especially Paul H. Jensen, Elizabeth Webster and Julia Witt, "Hospital type and patient outcomes: An empirical examination using AMI readmission and mortality records," *Health Economics*, Vol. 18, 2009, pp. 1440-1460; Karen Eggleston *et al.*, "Hospital ownership and quality of care: what explains the different results in the literature?" *Health Economics*, Vol. 17, 2008, pp. 1345-1362.
98. Guillaume Hébert and Jean-François Landry, "Le Québec bénéficierait-il d'une présence accrue du privé en santé?" Note socio-économique, Institut de recherche et d'informations socio-économiques, February 2008.

this situation will not occur, as is shown by foreign experience.[99] Rejecting the serious cases can only harm a clinic's reputation and drive away potential clients, and hence, precious revenues.

Obviously, in a situation in which the only private hospitals are small ones, public hospitals (and university hospitals in particular) will often remain the best places to treat more complex cases given the scale of machinery and equipment that these require. Nonetheless, as Stanford University economists Daniel Kessler and Jeffrey Geppert have shown, this does not necessarily lead to decreased efficiency or quality of health services.[100]

"The advent of specialized private clinics in the hospital sector has generally been found to push other hospitals to improve their efficiency in the face of increased competition."

On the contrary, specialization is actually likely to lead to a beneficial sorting of patients among the different types of institutions based on the comparative advantages of each. Indeed, not being faced with the same imponderables as university hospitals, which often force them to delay elective surgeries, specialized centres can generally carry out a greater number of medical interventions with shorter delays. These centres therefore develop expertise that leads to improvements in the quality of care provided to patients, as numerous studies confirm.[101]

Furthermore, the advent of specialized private clinics in the hospital sector has generally been found to push other hospitals to improve their efficiency in the face of increased competition.[102] This translates into increased productivity throughout the hospital network, and more patients therefore manage to receive the care they need within a reasonable time frame.

Finally, some oppose the greater participation of the private sector by saying that it would drain precious medical resources from the public sector, entailing both a deterioration in the quality of services and the lengthening of wait times. This argument is questionable on several counts. First, we can reasonably assume that competent and ambitious doctors will still want to treat more complex cases, if only to obtain the recognition of their peers, and perhaps a certain degree of fame. Also, by helping to raise the productivity of the hospital sector, as we have just seen, private hospitals and clinics are on the contrary more likely to free up medical resources for the treatment of more patients in the public sector, and as a result, to reduce overall wait times.

99. Frank A. Sloan, Justin G. Trogdon, Lesley H. Curtis and Kevin Schulman, "Does the ownership of the admitting hospital make a difference? Outcomes and process of care of Medicare beneficiaries admitted with acute myocardial infarction," *Medical Care*, Vol. 41, No. 10, 2003, pp. 1193-1205; Bimal R. Shah *et al*., "The impact of for-profit hospital status on the care and outcomes of patients with Non-ST-Segment elevation myocardial infarction: Results from the CRUSADE initiative," *Journal of the American College of Cardiology*, Vol. 50, No. 15, 2007, pp. 1462-1468.

100. Daniel P. Kessler and Jeffrey J. Geppert, "The effect of competition on variation in the quality and cost of medical care," *Journal of Economics & Management Strategy*, Vol. 14, No. 3, 2005, pp. 575-589.

101. Peter Cram *et al*., "A comparison of total hip and knee replacement in specialty and general hospitals," *Journal of Bone and Joint Surgery*, Vol. 89, 2007, pp. 1675-1684; Jonathan R. Clark and Robert S. Huckman, "Broadening focus: spillovers, complementarities, and specialization in the hospital industry," *Management Science,* Vol. 58, No. 4, 2012, pp. 708-722; R. J. Critchley, P.N. Baker and D. J. Dechan, "Does surgical volume affect outcome after primary and revision knee arthroplasty? A systematic review of the literature," *The Knee*, Vol. 19, No. 5, 2012, pp. 513-518; Piet N. Post *et al*., "The relationship between volume and outcome of coronary interventions: A systematic review and meta-analysis," *European Heart Journal*, Vol. 31, 2010, pp. 1985-1992.

102. Daniel P. Kessler and Mark B. McClellan, "The effects of hospital ownership on medical productivity," *RAND Journal of Economics*, Vol. 33, No. 3, 2002, pp. 488-506; Philippe Choné, Franck Evain, Lionel Wilner and Engin Yilmaz, *op. cit*., note 76.

CHAPTER 3

Increasing Health Care Funding through Duplicate Private Health Insurance

Background

In a decision handed down in June 2005, the Supreme Court of Canada ruled that the prohibition on purchasing private health insurance violated patients' rights to life and security of person and runs counter to the *Quebec Charter of Human Rights and Freedoms*.[103] The judgment was based on the premise that wait times in the public health care system were causing irremediable harm and suffering to patients, and even premature deaths in certain cases.[104]

This Court decision struck down two provisions of Quebec health care law, namely section 11 of the *Hospital Insurance Act* and section 15 of the *Health Insurance Act*.

In principle, it is now possible for Quebecers, since the adoption of a bill tabled in the National Assembly in December 2006, to purchase duplicate private insurance for a certain number of medical and surgical treatments such as hip and knee replacements and cataract removals.

In practice, however, no real market for this kind of insurance has emerged yet, as the number of admissible surgeries remains too low for new insurance products to appear that would appeal to individuals and employers.[105] Currently, of the five categories of private health insurance, the only one available to Quebecers is supplementary insurance, which covers extras and services not insured by the public system (see Sidebar 1).

103. *Chaoulli* v. *Quebec (Attorney General)*, [2005] SCC 35.
104. Sylvie Bourdeau, "Bill 33 now in force… authorizing private clinics and private health insurance in Quebec," *Health Law Bulletin*, Fasken Martineau, February 2008.
105. Mathieu Perreault, "Pas encore d'assurances privées," *La Presse*, April 23, 2010; Colleen M. Flood and Bryan Thomas, "Blurring of the Public/Private divide: The Canadian chapter," *European Journal of Health Law*, Vol. 17, 2010, pp. 268-269.

Foreign experience

Duplicate health insurance, which allows one to be treated in private hospitals while still retaining the coverage offered by the public plan, is available in many OECD countries including England, Australia, Denmark, Spain, Finland, Greece, Ireland, Italy, Norway, New Zealand, Portugal and Sweden (see Table 2). It can even attract a sizable portion of the population, as it does in Australia and Ireland, where nearly half the population has such insurance.[106]

As was rightly pointed out by the OECD economists who exhaustively analyzed the different types of private insurance available internationally, "in countries where [private health insurance] plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive."[107]

Denmark

In the early 1990s, the problem of waiting lists in Denmark's public health care system was becoming more and more worrisome. At that point, duplicate private health insurance was allowed, but very few people had purchased it.[108]

This changed in 2002 when the government decided to make business expenses for the purchase of such insurance policies for employees tax deductible.[109] This launched a true private health insurance market in Denmark. Over the course of the following decade, the number of Danes with duplicate private insurance exploded. While in 2001, less than 1% of the population had private insurance

106. In Australia, the percentage is 46.9%. Private Health Insurance Administration Council, Quarterly Statistics, June 2013. In Ireland, 43% of the population has private health insurance. Millward Brown Lansdowne, *Report on the health insurance market*, Health Insurance Authority, 2012, p. 3.
107. Francesca Colombo and Nicole Tapay, *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems*, OECD Health Working Papers, No. 15, 2004, p. 4.
108. Jeppe Dørup Olesen, "Policymaking without Policy Choice: The Rise of Private Health Insurance in Denmark," *Journal of Public Policy*, Vol. 23, No. 3, 2009, p. 281.
109. Although various studies have established that the government was benefiting from this policy in terms of public finances, the government decided to remove this tax benefit in 2012. See Mia Amalie Holstein, *sundhedsforsikringer giver en svag forbedring af de offentlige finanser*, CEPOS, November 2010; Christina Gordon Stephansen, *Sundhedsforsikringer forkorter det langvarige syge-fravær på grund af hurtigere behandling*, Danish Insurance Association.

Sidebar 1
Categories of private health insurance

Primary principal: Covers the medical care of persons who do not have legal access to the public system.

(Not applicable in Quebec)

Primary substitute: Covers the medical care of persons who have the choice of substituting private insurance for public coverage.

(Illegal in Quebec)

Duplicate: Covers the medical care of persons who continue to have access to the public system (and who are obliged to contribute to it through taxes) but who wish to be treated in a parallel private sector.

(Legal in Quebec since 2006 for a limited number of non-urgent surgeries, although no market has yet emerged)

Complementary: Covers the portion under the responsibility of the insured person (copayments or coinsurance) in the public health insurance system.

(Not available in Quebec insofar as copayments and coinsurance are not allowed)

Supplementary: Covers extras or services not insured by the public system.

(Legally permitted in Quebec)

Source: Organisation for Economic Co-operation and Development, "Private health insurance in OECD countries," *OECD Observer*, November 2004.

covering treatments offered in private hospitals and clinics,[110] this percentage climbed to over 30% by 2011.[111]

From the start, duplicate private insurance quickly enjoyed significant support from the population, and not only among the better-off. Already in 2002, a poll indicated that nearly two out of three unskilled workers were very interested in this type of social benefit. Today, three quarters of Danes have a positive view of the role played by private health insurance in their health care system.[112] Unions are no longer opposed to it, given the appeal that it holds for their members, including low-wage earners.[113] Some public sector unions have even negotiated this type of benefit for their members (police officers, teachers, etc.).[114]

According to a recent study, duplicate private insurance has significantly reduced the pressure on the public hospital network and improved access to care.[115] Even though spending related to private health insurance remains modest, it has led to an annual reduction of 10% in the use of public hospital services, according to Danish researchers who evaluated its impact. This policy has therefore played a role in the substantial reductions in wait times for elective surgery throughout the health care system, which fell from an average of 90 days in 2001 to 52 days in 2012, a 42% drop.[116]

110. Jeppe Dørup Olesen, *op. cit*., note 108, p. 264.
111. This estimate is based on a simple calculation: 21% of the population has duplicate private insurance from a private for-profit company. See Statistics Denmark, *Table BEF5: Population – 1 January, by sex, age and country of birth*; Forsikiring & Pension, *Sundhedsforikring Antal forsikede, praemier og erstatninger*. The estimated percentage of Danes with duplicate insurance from the non-profit company Sygeforsikringen danmark is 11.38%. See Astrid Kiil and Kjell Møller Pedersen, *The Danish Survey on Voluntary Health Insurance 2009: Data documentation: Population, Design, and Descriptive Statistics*. Research Document, University of Southern Denmark, 2009, p. 23.
112. Forsikring & Pension, *Danskernes syn på sundhedsforsikringer*, June 2009.
113. Jeppe Dørup Olesen, *op. cit*., note 108, p. 281.
114. Karsten Vrangbaek, "Privatization via PHI and waiting time guarantee," *Health Policy Monitor*, Survey No. 11, April 2008.
115. Rikke Søgaard, Morten Saaby Pedersen and Mickael Bech, "To what extent does employer-paid health insurance reduce the use of public hospitals?" *Health Policy*, Vol. 113, 2013, pp. 61-68.
116. Danish Ministry of Health, *Udviklingen I gennemsnitlige erfaret*

Table 2
Percentage of the population holding duplicate private health insurance, various OECD countries

COUNTRY	PERCENTAGE INSURED	TAX TREATMENT
England (2012)	**16%**	**Tax incentives for the insured who are 60 years of age and older (1990-1997). Health care services are not subject to sales tax.**
Australia (2013)	**47%**	**Tax credit of up to 40% of insurance premiums, varying as a function of income and age of the insured; extra tax contribution of at most 1.5% for high-income earners who have not purchased private insurance; lower premiums for life for those signing on to a private insurance plan before the age of 30.**
Denmark (2012)	**32%**	**Business expenses devoted to the purchase of private insurance policies tax deductible if all employees are covered (2002-2012).**
Spain (2011)	**18%**	**Private insurance policies offered by employers are not taxable benefits for employees and their dependants.**
Ireland (2011)	**43%**	**Tax credit of 20% on insurance premiums up to a maximum of 1,000 euros a year.**
Italy (2001)	**21%**	**19% of expenses devoted to the purchase of private insurance policies tax deductible up to a maximum of 1,250 euros a year.**
Norway (2011)	**Over 5%**	**No specific tax incentives.**
New Zealand (2013)	**30%**	**No specific tax incentives. Bill proposing a 25% tax credit on the purchase of insurance policies tabled in September 2013.**
Portugal (2006)	**20%**	**Tax credit of 10% on insurance premiums up to a maximum of 100 euros (varying according to income).**
Sweden (2011)	**4-5%**	**No specific tax incentives.**

Sources (percentage insured): ENG: Mark Dusheiko, "Patient choice and mobility in the UK health system: internal and external markets," in Rosella Levaggi and Marcello Montefiori (eds.), *Health care provision and patient mobility: Health Integration in the European Union*, Springer-Verlag, 2014, p. 83; Ian W. H. Parry, "Comparing the welfare effects of public and private health care subsidies in the United Kingdom," *Journal of Health Economics*, Vol. 24, 2005, pp. 1191-1209. **AUS:** Private Health Insurance Administration Council, Quarterly Statistics, March 2013. **DEN:** Astrid Kiil and Kjell Møller Pedersen, *The Danish Survey on Voluntary Health Insurance 2009: Data documentation: Population, Design, and Descriptive Statistics*, Research document, University of Southern Denmark, 2009, p. 23; Statistics Denmark, Table BEF5: Population – 1 January, by sex, age and country of birth; Forsikring & Pension, *Sundhedsforsikring Antal forsikrede, praemier og erstatninge*. **SPA:** Lourdes Lostao, David Blane, David Gimeno, Gopalakrishnan Netuveli and Enrique Regidor, "Socioeconomic patterns in use of private and public health services in Spain and Britain: implications for equity in healthcare," *Health & Place*, Vol. 25, No. 1, 2014, p. 23. **IRE:** Millward Brown Lansdowne, *Report on the health insurance market*, Health Insurance Authority, 2012, p. 3. **ITA:** Daniele Fabbri and Chiara Monfardini, *Opt out or top up? Voluntary healthcare insurance and the public vs. Private substitution*, Working Paper No. 5952, Institute for the Study of Labor (IZA), September 2011. **NOR:** Commonwealth Fund, "The Norwegian Health Care System," *International Profiles of Health Care Systems 2013*, The Commonwealth Fund, 2013, p. 105. **NZ:** Health Funds Association of New Zealand, "Health insurers fund record level of treatments," *Cover Stories: Health insurance news*, Vol. 7, No. 2, September 2013, p. 4. **POR:** Pedro Pita Barros, Rita Cristovão and Pedro Andrade Gomes, "Portugal," in Luigi Siciliani, Michael Borowitz and Valérie Moran (eds.), *Waiting Time Policies in the Health Sector: What Works?,* OECD Health Policy Studies, 2013, p. 238. **SWE:** Anders Anell, Anna H. Glenngard and Sherry Merkur, "Sweden: Health system review," *Health Systems in Transition*, Vol. 14, No. 5, 2012.

Sources (tax incentives): AUS: Australian government, Private Health Insurance Ombudsman. **EUR:** Sarah Thompson and Elias Mossialos, *Private health insurance in the European Union*, Final report prepared for the European Commission, LSE Health and Social Care, London School of Economics and Political Science, June 2009, pp. 71-74. **NZ:** New Zealand Parliament, *Affordable Healthcare Bill*, September 2013.

Holders of private insurance policies, by choosing to be treated in the private sector while continuing to contribute to the funding of the public system, allow those who opt for the public system to receive their treatments more quickly. Far from being penalized, low-income people instead are better off. According to data compiled by the European Commission, barely 0.4% of Danes belonging to the bottom income quintile (the poorest 20%) reported having unsatisfied needs for care in 2012, one of the lowest proportions in Europe.[117]

"Currently, of the five categories of private health insurance, the only one available to Quebecers is supplementary insurance."

Nor has the presence of a duplicate private insurance market led to greater inequality when it comes to access to medical services. In a recent analysis of 19 countries, OECD researchers found that Denmark was the most egalitarian country in this regard, followed by the United Kingdom. In fact, among the countries analyzed, Denmark is the only one where the probability of consulting a doctor is higher among low-income people (bottom quintile) than among high-income people (top quintile).[118] The data also show that wait times for elective surgery throughout the system do not vary as a function of patients' incomes.[119]

Despite the keen interest of many, and contrary to certain fears, the emergence of a private insurance market in Denmark has not eroded the population's general support for the public health care system.[120] Contrary to the argument often put forward by those who favour maintaining the government monopoly, the existence of a private insurance market does not necessarily lead to funding reductions for the public health care system, nor to its deterioration. Rather, public health care spending per capita is higher in Denmark (US$3,827 at purchasing power parity) than in Canada (US$3,146 at purchasing power parity), and it has continued to increase over the past decade.[121]

The reform and its benefits

Duplicate private insurance should be legally permitted to cover the hospitalization costs of all elective surgeries in private health care facilities (not just hip and knee replacements, cataract removal and a few other minor surgeries, as is currently the case).

In order to facilitate the emergence of such an insurance market, the government should, through the tax system, aim to reduce the premiums to be paid by the insured.[122] Currently, a taxpayer can request a non-refundable tax credit corresponding to 20% of medical expenses (including expenses related to private insurance) that exceed 3% of his or her net income.[123] At this threshold, however, most Quebecers must spend hundreds or even thousands of dollars before being able to get a reimbursement.

The reform should instead make private insurance premiums for treatments that are normally covered by the public plan admissible from the first dollar spent. The tax credit proposed here could be varied in order to be more beneficial for the least well-off, as is currently done in Australia, where this credit can represent up to 40% of insurance premiums for those who earn less than a certain income threshold.[124]

ventedid til operation, 2001-2009 [Changing average wait times experienced for surgery, 2001-2009], May 2010; Statens Serum Institut, *Erfaret ventetid for alle opererede patienter*, 2005-2012.

117. Eurostat, Self-reported unmet need for medical examination or treatment, by income quintile.
118. As for Canada, it was the fifth least egalitarian country (after the United States, Estonia, Finland and Poland). Marion Devaux and Michael de Looper, *Income-Related Inequalities in Health Service Utilisation in 19 OECD Countries, 2008-2009*, OECD Health Working Papers No. 58, 2012, p. 17.
119. Luigi Siciliani and Rossella Verzulli, "Waiting times and socioeconomic status among elderly Europeans: Evidence from SHARE," *Health Economics*, Vol. 18, 2009, pp. 1295-1306.
120. Jeppe Dørup Olesen, *op. cit*., note 108, p. 282.
121. Organisation for Economic Co-operation and Development, *Health at a Glance 2013: OECD Indicators*, 2013, p. 155.
122. The data show that Canadians are sensitive to these incentives. See Michael Smart and Mark Stabile, "Tax credits, insurance, and the use of medical care," *Canadian Journal of Economics*, Vol. 38, No. 2, 2005, pp. 345-365; Amy Finkelstein, "The effect of tax subsidies to employer-provided supplementary insurance: evidence from Canada," *Journal of Public Economics*, Vol. 84, 2002, pp. 305-339.
123. Quebec Department of Finance and the Economy, *Dépenses fiscales,* Édition *2012*, 2013, p. B.75. A similar tax credit exists at the federal level.
124. Private Health Ombudsman, Australian Government Private Health Insurance Rebate, Government of Australia, applicable rates from July 1, 2013 to June 30, 2014.

Studies have shown that partially subsidizing private insurance coverage is a less expensive and more effective way of reducing delays in the health care system than simply increasing public funding.[125] Far from constituting a net "tax expenditure," the proposed measure would actually reduce spending by the public treasury since only a small proportion of the cost of premiums would be financed by the government, whereas 100% of the cost of care in the public health care system is paid for by taxpayers.

"In countries where [private health insurance] plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive."

Contrary to a certain belief, duplicate private insurance would promote greater equity in the funding of health care, as shown by economists Adam Wagstaff and Eddy Van Doorslaer in widely cited studies.[126] In England, Spain and Italy, where duplicate private insurance covers 16%, 18% and 21% of the population respectively, it turns out that public health care services are used first and foremost by the people with the lowest income levels.[127] Conversely, the data show that it is the richest in Canada who generally enjoy a privileged access to the public health care system,[128] if only through personal relationships allowing them to jump the queue.[129]

Currently, only the very rich (or those who are ready to make substantial financial sacrifices) can afford to pay the costs of elective surgery in the private sector in Quebec out of their own pockets. Private health insurance would allow people with more modest incomes to have access to the same range of services that is now reserved for a minority.

Insofar as those covered by duplicate insurance policies would use the private system while continuing to contribute to the funding of the public system through their taxes, more resources could be devoted to each patient in the public system. Access to care in the public system would therefore improve. This benefit is not theoretical; it is the conclusion reached by different researchers who have looked into the matter in recent years, especially in Denmark[130] and Australia.[131]

Although certain critics maintain that private insurance would lead the insured to neglect their health more and thereby to increase the overall demand for care in the end,[132] the facts tend to show just the opposite. Indeed, foreign experience

125. Ian W. H. Parry, "Comparing the welfare effects of public and private health care subsidies in the United Kingdom," *Journal of Health Economics*, Vol. 24, 2005, pp. 1191-1209; H.E. Frech III and Sandra Hopkins, "Why subsidise private health insurance?" *The Australian Economic Review*, Vol. 37, No. 3, 2004, pp. 243-256.
126. Adam Wagstaff and Eddy Van Doorslaer, "Equity in health care finance and delivery," *Handbook of Health Economics*, Vol. 1, 2000, part B, p. 1826; Adam Wagstaff *et al.*, "Equity in the finance of healthcare: some further comparisons," *Journal of Health Economics*, Vol. 18, 1999, pp. 263-290.
127. Lourdes Lostao, David Blane, David Gimeno, Gopalakrishnan Netuveli and Enrique Regidor, "Socioeconomic patterns in use of private and public health services in Spain and Britain: implications for equity in healthcare," *Health & Place*, Vol. 25, No. 1, 2014, pp. 19-25; Daniele Fabbri and Chiara Monfardini, *Opt Out or Top Up? Voluntary Healthcare Insurance and the Public vs. Private Substitution*, Discussion Paper No. 5952, Institute for the Study of Labor (IZA), September 2011; Mark Dusheiko, "Patient Choice and Mobility in the UK Health System: Internal and External Markets," in Rossella Levaggi and Marcello Montefiori (eds.), *Health Care Provision and Patient Mobility: Health Integration in the European Union*, Springer-Verlag, 2014, p. 83.
128. Louise Pilote *et al.*, "Universal health insurance coverage does not eliminate inequities in access to cardiac procedures after acute myocardial infarction," *American Heart Journal*, Vol. 146, 2003, pp. 1030-1037; Lori J. Curtis and William J. MacMinn, "Health Care Utilization in Canada: Twenty-five Years of Evidence," *Canadian Public Policy*, Vol. 34, No. 1, 2008, pp. 65-87; Kimberlyn M. McGrail, "Income-related inequities: Cross sectional analysis of Medicare services in British Columbia in 1992 and 2002," *Open Medicine*, Vol. 2, No. 4, 2008, pp. E91-E98.
129. David A. Alter, Antoni S.H. Basinski and C. David Naylor, "A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada," *Annals of Internal Medicine*, Vol. 129, No. 7, 1998, pp. 567-572.
130. Rikke Søgaard, Morten Saaby Pedersen and Mickael Bech, *op. cit*, note 115.
131. See Brian Hanning, "Has the increase in private health insurance uptake affected the Victorian public hospital surgical waiting list?" *Australian Health Review*, Vol. 25, No. 6, 2002, pp. 64-71; Agnes E. Walker *et al.*, "Public policy and private health insurance: distributional impact on public and private hospital usage," *Australian Health Review*, Vol. 31, No. 2, 2007, pp. 305-314; Ian R. Harper, "Health Sense: when spending money saves money," *Policy*, Vol. 19, No. 3, 2003, pp. 19-24; Luigi Siciliani and Jeremy Hurst, "Tackling excessive wait times for elective surgery: a comparative analysis of policies in 12 OECD countries," *Health Policy*, Vol. 72, 2005, pp. 201-215. Other researchers, for their part, maintain that private insurance has not had as much of a beneficial effect on wait times. This model is less relevant to Quebec, however, as Australian patients can use their private insurance to be operated on in public hospitals, which Quebec patients could not be allowed to do without violating the *Canada Health Act*.
132. Odette Madore, *Duplicate Private Health Care Insurance: Potential Implications for Quebec and Canada*, Research Document PRB 05-71E, Library of Parliament, March 2006.

demonstrates that people covered by private insurance are just as concerned as others, if not more so, with maintaining healthy habits like doing sports or not smoking,[133] and that they do not tend to make more frequent use of the hospital system as a whole.[134] Private insurance policy holders generally demonstrate a greater aversion to risks, and simply want to avoid the high costs associated with the inability to work.

"In order to facilitate the emergence of such an insurance market, the government should, through the tax system, aim to reduce the premiums to be paid by the insured."

133. Christophe Courbage and Augustin de Coulon, "Prevention and Private Health Insurance in the U.K.," *The Geneva Papers on Risk and Insurance*, Vol. 29, No. 4, 2004, pp. 719-727; Reza Rezayatmand, Milena Pavlova and Wim Groot, "Health Insurance and the Decision to Change Health-Related Lifestyle—A Case Study from the Netherlands," *Health and Ageing*, No. 27, 2012, pp. 12-15. Furthermore, the risk of adopting behaviours that are harmful to one's health would be larger in the case of people covered by a public plan than by a private one. See in this regard Jay Bhattacharya, M. Kate Bundorf, Noemi Pace and Neeraj Sood, "Does Health Insurance Make You Fat?" in Michael Grossman and Naci H. Mocan (eds.), *Economic Aspects of Obesity*, University of Chicago Press, 2011, pp. 35-64.

134. Thomas C. Buchmueller, Denzil G. Fiebig, Glenn Jones and Elizabeth Savage, "Preference heterogeneity and selection in private health insurance: The case of Australia," *Journal of Health Economics*, Vol. 32, 2013, pp. 757-767; Damien S. Eldridge, Ilke Onur, Malathi Velamuri and Catagay Koç, *The impact of private hospital insurance on the utilization of hospital care in Australia*, Research Document, La Trobe University, June 2013.

CHAPTER 4

Allowing Mixed Practice in Order to Increase the Supply of Medical Specialists

Background

Health policy analysts often mistakenly bring up the shortage of doctors as being responsible for lengthening wait times in the public system. Yet as a team of researchers has recently pointed out, most of the countries where delays are not a concern rely on a proportion of doctors that is lower than the average for OECD countries.[135] In Quebec, despite the number of doctors having risen twice as fast as the population over the past twenty years,[136] wait times have continued to worsen.

This result is not as counterintuitive as it seems. Several indicators suggest that the main cause of long wait times is the poor allocation of available medical resources in the public system. Currently, the workloads of many Quebec doctors are limited by quotas and rules whose purpose is to contain costs. For example, rationing of operating times in hospitals has the effect of limiting the number of medical interventions that medical specialists can carry out, which in turn makes wait times longer. Given these constraints, numerous specialists are unable to operate as much as they would like to, and much to their chagrin, they find themselves on forced holiday several weeks a year.[137]

If certain doctors are limited in their practices because of wage ceilings or hospital budgetary constraints, this means that some of them would surely be ready to work more if this work was well-paid.

The MEI carried out a survey in the spring of 2009 in order to determine whether medical specialists in Quebec would be prepared to provide more services beyond their commitments within the public system, and if so, to quantify this reserve supply.[138] The study revealed that nearly half of specialists (43.6%) would be ready to put in some hours in the private sector during the week, above and beyond their commitments to the public system. Moreover, 38.6% said they were ready to work weekday evenings and 30.4% said they would be willing to work weekends.

"The main cause of long wait times is the poor allocation of available medical resources in the public system."

The MEI also carried out a quantitative evaluation of the reserve hours of medical specialists. These specialists said they were ready to work on average 3.98 hours a week during weekdays, 3.77 hours during weekday evenings and 3.88 hours over the weekend. Assuming they work 40-hour weeks, these hours of availability are equivalent to the addition of 790 full-time specialists on weekdays in the daytime, 740 during weekday evenings and 1,924 over the weekend.

The evidence is clear: There really is a reserve supply of work from medical specialists that the province of Quebec is currently foregoing.

Foreign experience

Canada is the exception among industrialized countries in prohibiting specialists from practicing in both the public sector and the private sector when

135. Michael Borowitz, Valérie Moran and Luigi Siciliani, "Waiting times for health care: A conceptual framework," in Luigi Siciliani, Michael Borowitz and Valérie Moran (eds.), *Waiting Time Policies in the Health Sector: What Works?* OECD Health Policy Studies, 2013, p. 25.
136. Canadian Institute for Health Information, *Supply, Distribution and Migration of Canadian Physicians, 2012,* September 2013, p. 93; Institut de la statistique du Québec, *Le bilan démographique du Québec,* édition *2013*, p. 21.
137. On the limited use of operating blocks in Quebec hospitals, see Julie Frappier and Mathieu Laberge, "An overview of operating room use in Quebec hospitals," Economic Note, Montreal Economic Institute, December 2007. See also "Attente en chirurgie : méchant mal de blocs," *Le Spécialiste*, Vol. 14, No. HS-1, 2012, pp. 6-8; Ariane Lacoursière, "Des salles vides et des listes pleines," *La Presse*, May 26, 2008, pp. A2-A3; Johanne Roy, "Des salles d'opération trop peu accessibles," *Le Journal de Québec*, August 2, 2010, p. 6.
138. Marcel Boyer and Julie Frappier, "Medical specialists in Quebec: How to unlock the reserve supply," Economic Note, Montreal Economic Institute, April 2009.

Table 3
Characteristics of dual physician practice in various OECD countries

Country	Percentage of doctors practicing in both the public and private sectors	Number of doctors per 1,000 inhabitants (2011)
Australia	**48% (2008)**	**3.3**
Austria	**Nearly 100%**	**4.8**
Denmark	**15% (2008)**	**3.5**
Spain	**20% (2006)**	**3.8**
France	**30% (2005)**	**3.3**
Finland	**33% (2005)**	**2.7 (2009)**
Ireland	**Over 90%**	**2.7**
Norway	**29% (2005)**	**3.7**
New Zealand	**50% (2009)**	**2.6**
England	**39% (2012)**	**2.4**
Other OECD countries allowing doctors to practice in both the public sector and the private sector: **Germany, Belgium, United States, Greece, Italy, Japan, Netherlands, Portugal, Sweden, Switzerland**		

Sources (dual practice): ENG: National Audit Office, *Managing NHS Hospital Consultants*, HC 885, Session 2012-13, February 6, 2013, p. 21. **AUSTRALIA:** Terence Chai Cheng, Catherine M. Joyce and Anthony Scott, "An Empirical Analysis of Public and Private Medical Practice in Australia," *Health Policy*, Vol. 101, 2013, pp. 43-51. **AUSTRIA:** Ariadna García-Prado and Paula González, "Whom do physicians work for? An analysis of dual practice in the health sector," *Journal of Health Politics, Policy and Law*, Vol. 36, No. 2, 2011, p. 273. **DEN:** 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. **SPA:** Ariadna García-Prado and Paula González, "Whom do physicians work for? An analysis of dual practice in the health sector," *Journal of Health Politics, Policy and Law*, Vol. 36, No. 2, 2011, p. 273. **FRA:** Ketty Attal-Toubert, Hélène Fréchou and François Guillaumat-Tailliet, "Le revenu global d'activité des médecins ayant une pratique libérale," in *Les revenus d'activité des indépendants, édition 2009*, Institut national de la statistique et des études économiques, September 2009, p. 63. **FIN:** Terhi Kankaanranta *et al*., "The role of job satisfaction, job dissatisfaction and demographic factors on physicians' intentions to switch work sector from public to private," *Health Policy*, Vol. 83, 2007, p. 51. **IRE:** Miriam M. Wiley, "The Irish health system: Development and strategy, structure, funding and delivery since 1980," *Health Economics*, Vol. 14, 2005, p. S177. **NOR:** Linda Midttun, "Private or public? An empirical analysis of the importance of work values for work sector choice among Norwegian medical specialists," *Social Science & Medicine*, Vol. 64, 2007, p. 1268. **NZ:** Toni Ashton *et al*., "Sources of satisfaction and dissatisfaction among specialists within the public and private health sectors," *New Zealand Medical Journal*, Vol. 126, No. 1383, 2013, pp. 9-19.
Source (doctor population density): OECD, *Health at a Glance 2013: OECD Indicators*, 2013.

it comes to medically required care.[139] Only the provinces of New Brunswick, Newfoundland and Labrador and Prince Edward Island authorize dual practice, although even in these provinces it is not widespread.[140]

In almost all OECD countries, dual physician practice is allowed, although generally regulated (see Table 3). In England, specialists are obliged to work 44 hours in the public system (NHS) before being allowed to practice in the private sector, which 39% of them do.[141] In Ireland, doctors have an agreement to work 33 hours in the public system, after which they can practice in the private sector. Over 90% of Irish doctors have mixed practices[142] and many of them rent public sector facilities in which to treat their private patients (as is also done in France, Germany, Italy, Australia and Austria).[143]

In other countries, including Australia, New Zealand, Norway and Sweden, the conditions of dual practice are subject to no particular regulations and

139. Ariadna García-Prado and Paula González, "Policy and regulatory responses to dual practice in the health sector," *Health Policy*, Vol. 84, 2007, pp. 142-152; Ariadna García-Prado and Paula González, "Whom do physicians work for? An analysis of dual practice in the health sector," *Journal of Health Politics, Policy and Law*, Vol. 36, No. 2, 2011, pp. 265-294.
140. Gerard W. Boychuk, *The Regulation of Private Health Funding and Insurance in Alberta under the Canada Health Act: A Comparative Cross-Provincial Perspective*, SPS Research Papers, Vol. 1, No. 1, December 2008, pp. 16-17.
141. National Audit Office, *Managing NHS Hospital Consultants*, HC 885, Session 2012-13, February 6, 2013, p. 21.
142. Miriam M. Wiley, "The Irish health system: Development in strategy, structure, funding, and delivery since 1980," *Health Economics*, Vol.14, No. S1, 2005, p. S177.
143. Ariadna García-Prado and Paula González, *op. cit*., note 139. Moreover, this is also the case in Quebec, but only for specialists who offer treatments not covered by the public insurance plan, like cosmetic surgery. See "Des chirurgies esthétiques au privé effectuées au CHUM," *Le Devoir*, April 25, 2013.

are instead determined by contractual arrangements between hospitals and doctors.[144]

In England,[145] in Australia[146] and in Denmark,[147] studies have shown that doctors who have mixed practices increase the total number of hours allocated to the treatment of patients, and do so without reducing the supply of services they devote to the public system. This is also the case in Norway, where specialists with dual practices (28.9%) and those who practice exclusively in private hospitals (23%) devote more time to seeing patients than their colleagues working in the public sector alone (48.1%),[148] being less encumbered by administrative tasks of various kinds.[149]

Japan, where mixed practice is allowed, manages to avoid rationing health care services with waiting lists,[150] despite a relatively older population,[151] and even with a lower number of doctors per thousand inhabitants (2.2)[152] than the vast majority of OECD countries (including Canada and Quebec, with 2.4 doctors per thousand inhabitants).[153]

Denmark

Mixed practice, which is legally permitted in Denmark, has been the subject of intense public debate over the past decade. Indeed, many were worried that doctors with dual practices would reduce the number of hours they worked in the public system, which is to say that they would work only part-time or that they would avoid overtime hours, in order to spend more hours practicing in the private sector.[154]

These fears proved to be unfounded. A recent study has shown that Danish doctors with mixed practices worked more hours a week (50 hours) in total than their colleagues working exclusively in the public system (47.2 hours).[155] The number of hours worked in the public sector by the two kinds of doctors is very comparable: 44.8 hours for doctors practicing in both sectors versus 47.2 hours for doctors practicing only in the public sector. As a matter of fact, the vast majority of private surgery clinics employ doctors with full-time positions in public hospitals.[156]

"The evidence is clear: There really is a reserve supply of work from medical specialists that the province of Quebec is currently foregoing."

There is no observable difference between dual practitioners and those who work exclusively in the public sector when it comes to numbers of research projects or numbers of studies published in scientific journals. Moreover, the numbers of on-call duties accomplished outside of normal work hours are the same for both types of doctors. However, doctors with dual practices are generally quicker to accept to work extra hours in order to perform duties they have been entrusted with on a short notice than their colleagues working solely in the public sector.[157]

Just like Canada (and Quebec), Denmark has among the fewest medical specialists as a proportion of the population of any OECD country.[158] The fact that dual practice is allowed in Denmark has the effect of increasing the overall workload of medical

144. Ariadna García-Prado and Paula González, *ibid.*
145. Karen Bloor *et al.*, "Variation in activity rates of consultant surgeons and the influence of reward structures in the English NHS," *Journal of Health Services Research and Policy*, Vol. 9, No. 2, 2004, p. 82.
146. 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, pp. 43-51.
147. 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.
148. Linda Midttun, "Private or public? An empirical analysis of the importance of work values for work sector choice among Norwegian medical specialists," *Social Science & Medecine,* Vol. 64, 2007, pp. 1267-1268.
149. Linda Midttun, "Medical specialists' allocation of working time," *Health Policy*, Vol. 83, 2007, p. 119.
150. Naoki Ikegami and Gerard F. Anderson, "In Japan, All-Payer Rate Setting under Tight Government Control Has Proved an Effective Approach to Containing Costs," *Health Affairs*, Vol. 31, No. 5, 2012, pp. 1049-1056.
151. Organisation for Economic Co-operation and Development, *Health at a Glance 2013: OECD Indicators*, OECD Publishing, 2013, p. 171.
152. *Ibid*, p. 65.
153. Canadian Institute for Health Information, *op. cit.*, note 136, p. 69.
154. Karolina Socha, "Physician Dual Practice and Shortages of Providers," *Health Policy Monitor*, No. 15, 2010.
155. Karolina Socha and Mickael Bech, *op. cit.*, note 147.
156. Lotte Bøgh Andersen and Mads Jakobsen, *op. cit.*, note 51.
157. Karolina Socha and Mickael Bech, *op. cit.*, note 147.
158. Canada and Denmark have ratios of 1.3 and 1.4 specialists per 1,000 inhabitants, respectively. Organisation for Economic Co-operation and Development, *OECD Reviews of Health Care Quality, Denmark 2013: Raising Standards*, OECD Publishing, 2013, p. 114. Note that this is not the case for general practitioners, who are significantly more numerous as a proportion of the population in Denmark than in Canada (or Quebec).

specialists and therefore of compensating for this lower ratio. Practicing in the private sector allows many Danish surgeons to operate on more patients than if they worked solely in public hospitals. Patients therefore have better access to hospital care.

Australia

In Australia, medical specialists are legally authorized to practice both in the public sector and in the private sector, and it is estimated that nearly half of them have dual practices.[159]

The number of hours that a doctor can devote to private practice depends on the contractual agreement he or she has with a public hospital. In certain cases, only consultation in the private sector is allowed, and only outside of regular practice hours in the hospital that employs him or her.[160] In other cases, specialists are granted the right to practice privately even within the public hospitals where they work. Even though only half of specialists choose to take advantage of them, these various rights to practice privately are perceived by hospital administrators as means of recruiting and retaining renowned, high-quality candidates.

"Japan, where mixed practice is allowed, manages to avoid rationing health care services with waiting lists."

Australian doctors with mixed practices work approximately 11% more hours a week (47.9) than those who practice solely in the public system (43.2).[161] Doctors with dual practices—just like those who work exclusively in the private sector—miss work less often in order to take various holidays.[162] Furthermore, there is no observable difference between dual practitioners and those who work only in the public sector in terms of qualifications or years of postdoctoral study.

Doctors with mixed practices work just as much in remote regions as their colleagues practicing exclusively in the public sector or the private sector.[163] This fact contradicts the thesis of detractors of the private sector according to which dual practice encourages doctors to leave remote regions and move to more densely populated urban areas.

The reform and its benefits

As we have seen in the preceding chapters, the province of Quebec would benefit from the expansion of patient choice by allowing the emergence of a true private hospital market. One of the arguments frequently raised against such a reform is that there are presently too few doctors in the public system to allow greater scope to the private sector.[164] It is also argued, not without reason, that it can take up to a decade to train a new doctor.

However, it would be possible, in the near term, to increase the capacity of the health care system when it comes to its workforce. One of the immediate solutions would be to allow existing medical personnel, largely underutilized, to work more.[165]

Because of section 22 of Quebec's *Health Insurance Act*, doctors participating in the public system are not allowed to offer their services outside of it when it comes to insured services. This section of the law should be amended in such a way as to allow doctors to work in the private sector after having practiced in the public system for a number of hours equivalent to a full-time job (40 hours).

By allowing them to do privately remunerated work as a complement to their commitment to the

159. Terence Chai Cheng, Catherine M. Joyce and Anthony Scott, *op. cit*., note 146.
160. *Ibid.*
161. *Ibid.*
162. *Ibid.*
163. *Ibid.*
164. Colleen M. Flood, Mark Stabile and Sasha Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying, and Two-Tier Systems," in Colleen M. Flood, Kent Roach and Lorne Sossin (eds.), *Access to Care, Access to Justice: The Debate over Private Health Insurance in Canada*, University of Toronto Press, 2005, pp. 309-311.
165. Another avenue recently suggested by economists is to rely more on doctors trained abroad. See David R. Henderson, "The Inefficiency of Health Care Rationing—and a Solution," in Steven Globerman (ed.), *Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Evidence*, Fraser Institute, October 2013, pp. 88-90. Whereas one in four doctors in Canada (30% excluding Quebec) obtained his or her diploma abroad, this proportion plummets to 11% in Quebec. See Canadian Institute for Health Information, *op. cit*, note 136, p. 31.

public insurance plan, doctors could treat more patients and increase their incomes. By significantly raising the total number of hours devoted to the health care system, dual practice is likely to alleviate our long waiting list problems.

"Practicing in the private sector allows many Danish surgeons to operate on more patients than if they worked solely in public hospitals."

Contrary to what certain groups would have us believe, legalizing mixed practice would not reduce the supply of services in the public system since a minimum number of hours would be required before practicing in the private sector would be allowed. The ability of doctors to maintain longer waiting lists in the public system in order to attract patients to their private clinics would be greatly diminished in a competitive context in which patients would enjoy several options regarding where to receive treatment.

Finally, dual practice could even prove to be a valuable tool for the public system to use in recruiting and retaining medical personnel, as foreign experience suggests.[166]

166. Ariadna García-Prado and Paula González (2011), *op. cit.*, note 139.

CHAPTER 5

Funding Hospitals Based on Services Rendered

Background

Currently, almost all hospitals in Quebec—as in the rest of Canada—receive their funding in the form of global budgets based essentially on the amounts of expenditures made in the past.[167] These expenditures are increased each year to take into account the rising costs of labour, prescription drugs, technology and medical supplies.

This funding method has always been perceived by decision makers as easy to administer and useful for reining in rising costs.[168] However, this controlling of costs—which has not actually prevented expenses from climbing—has historically been accomplished through the rationing of services: given constantly growing demand, hospitals have had no choice but to limit admissions in order to stay within budgets.[169] The chronic problem of waiting lists in Quebec and in the rest of Canada is therefore rooted in part in the way hospitals are funded.

Furthermore, lump-sum funding offers no incentive to hospital administrators to innovate in order to reduce spending and improve access and wait times. Under the current funding model, an administrator who devoted time and resources to putting innovative measures in place in order to improve care quality and reduce waiting in his or her hospital would not be rewarded for this initiative.[170] On the contrary, an innovation that led to spending reductions would be translated into an equivalent drop in the hospital's next budget.

Similarly, an innovation allowing wait times to be reduced and more patients to be treated would entail increased pressure on a hospital's fixed budget. In either case, since patients represent a source of additional expenses for hospitals, there is no benefit to be found in trying to improve efficiency.

Foreign experience

The United States led the way, in 1983, becoming the first country to fund hospitals on the basis of services provided in the treatment of patients who were admissible for the public Medicare program. Since then, practically all industrialized countries have followed suit, opting for activity-based hospital funding to varying degrees[171] (see Table 4).

"The chronic problem of waiting lists in Quebec and in the rest of Canada is rooted in part in the way hospitals are funded."

While the details of the different activity-based funding systems vary from one country to the next, the central operating principle is basically the same. Hospitals receive a fixed payment for each medical procedure (for example, a hip replacement), usually equivalent to the average cost of providing this treatment within the hospital network. In most countries, this payment is adjusted to take into account a series of factors specific to the medical institutions and the patients they serve: geographic location, severity of cases and complexity of diseases, characteristics of each particular patient, etc.

In countries where the activity-based funding model is widely used, there is generally more competition between medical facilities and quicker access to care within the hospital network. Marked

167. In March 2012, the Quebec government put together a group of experts whose mandate was to evaluate the feasibility of an activity-based funding pilot project in the hospital network. Sara Champagne, "Budget en santé : le gouvernement ouvre la porte au financement à l'acte," *La Presse*, March 20, 2012. On February 20, 2014, the group published its report: http://www.santefinancementactivite.gouv.qc.ca/en/.
168. Jason M. Sutherland, *Hospital payment mechanisms: An overview and options for Canada*, Canadian Health Services Research Foundation, March 2011, p. 4.
169. Roger Feldman and Felix Lobo, "Global budgets and excess demand for hospital care," *Health Economics*, Vol. 6, 1997, pp. 187-196; see also Gérard Bélanger, *L'économique de la santé et l'État providence*, Éditions Varia, 2005, pp. 185-187.
170. Pierre Ouellette, *Efficience et budgétisation des hôpitaux et autres institutions de santé au Québec*, Document submitted to the Task Force on the Funding of the Health System, November 2007, p. 13.
171. David Scheller-Kreinsen, Alexander Geissler and Reinhard Busse, "The ABC of DRGs," *Euro Observer*, Vol. 11, No. 4, 2009, p. 1.

Table 4
Statistics on hospital activities and expenditures, selected OECD countries

OECD country	Year activity-based funding was introduced	Number of patients released from hospital per 1,000 inhabitants, 2011	Average hospital expenditures per patient discharged, 2011**
Australia	1993	159*	US$9,611*
Canada	Pilot projects in Alberta (2012), British Columbia (2011) and Ontario (2012)	82*	US$15,433*
Denmark	2002	172*	US$11,295*
France	2004	169	US$8,049
Germany	2004	244	US$5,192
Japan	1997	111	US$12,650 (2008)
Norway	1997	175	US$11,306*
New Zealand	1993	147	US$7,856
Netherlands	2005	122	US$13,025
Sweden	1995	163*	US$9,990*
Switzerland	2012	170	US$11,219
United States	1983	125*	US$21,018*

Others among the 25 richest OECD countries having adopted a hospital funding method based on cases treated (and date introduced): England (2003), Austria (1997), Belgium, South Korea (2012), Spain (1999), Estonia (2003), Finland (1995), Greece (2011), Ireland (1993), Iceland, Italy (1995), Poland (2008), Portugal (1984).

*Data from 2010 **Adjusted to account for cost of living differences between countries.
Source: David Squires, Multinational comparisons of health systems data, The Commonwealth Fund, November 2012 and November 2013 editions.

improvements in this regard have been observed in many countries, especially in Europe.

In Norway, hospital funding reform was enacted in 1997. Hospital activities and efficiency grew significantly from the first years of the reform, while the portion of hospital budgets provided by activity-based funding gradually increased from 30% in 1997 to 60% in 2003.[172] The new funding method not only improved the efficiency of Norwegian hospitals, but its implementation also coincided with a significant reduction in wait times. From 2002 to 2006, hospital admissions jumped 24% and the average wait time for elective surgeries fell 30%.[173]

In the Netherlands, hospital funding reform came about following a 1999 court decision stipulating that the government rationing of hospital services violated the right of patients to receive timely access to the health care they need. Activity-based funding, adopted a few years later to replace global budgets, contributed to substantial wait time reductions throughout the hospital network. Delays before undergoing elective surgery have been cut in half since the year 2000 and now fluctuate between two and six weeks.[174] According to Dutch researchers, the large increase in activity due to

172. This percentage has since dropped back to 40%. See Erik Biorn *et al.*, "How different are hospitals' responses to a financial reform? The impact on efficiency of activity-based financing," *Health Care Management Science*, Vol. 13, 2010, pp. 1-16.
173. Pål E. Martinussen and Jon Magnussen, "Health care reform: the Nordic experience," in Jon Magnussen, Karsten Vrangbaek and Richard B. Saltman (eds.), *Nordic Health Care Systems: Recent Reforms and Current Policy Challenges*, Open University Press, 2009, pp. 21-52.
174. Frederik T. Schut and Marco Varkevisser, "Tackling hospital waiting times: the impact of past and current policies in the Netherlands," *Health Policy*, Vol. 113, 2013, pp. 127-133.

the reform also helped accelerate increasing life expectancy in the population starting in 2002.[175]

Activity-based funding, then, does not lead medical institutions to skimp on service quality in order to reduce costs, contrary to certain fears. Insofar as hospitals' incomes depend on the number of patients they are able to attract, it is essential for them to offer high quality services and to maintain a good reputation. In Australia, for example, activity-based funding has pushed hospitals to improve treatment quality in order to avoid complications and the high costs associated with extended stays.[176]

Italy

The Italian health care system has been substantially transformed over the past twenty years. In the early 1990s, wait times in the public system were getting longer and the quality of services was gradually deteriorating. Only private hospitals were reimbursed based on numbers of cases treated. Public hospitals had very little incentive to optimize resource use since they received guaranteed funding, based primarily on past expenditures, and all deficits were covered by the government.

In 1992, the law was amended in such a way as to promote competition between institutions and thereby to improve the quality of services provided to the population. More specifically, the system was reformed so as to allow a) freedom of choice for patients in terms of care providers; b) reimbursement of hospital expenditures based on services provided; and c) parity between public and private hospitals' funding models.[177]

Starting in 1995, all Italian hospitals began receiving funding as a function of cases treated rather than on the basis of past expenditures. In this newly decentralized system, each region was free to determine the details of its own method of reimbursing hospital expenses. Five of the 21 regions adopted their own activity-based system while the 16 others opted for a common approach designed at the national level.

The funding reform on the whole generated substantial positive effects for the Italian hospital network. Those regions where activity-based reimbursement accounted for a larger portion of hospital budgets saw quality of care improve more. A recent study has shown that mortality and readmission rates for hospitalized patients are significantly lower in these regions.[178] The explanation of this result is quite simple and stems from the incentives created by the new funding model: Medical institutions that offer better services and attract more patients are rewarded with more funds.

"Hospitals receive a fixed payment for each medical procedure, usually equivalent to the average cost of providing this treatment within the hospital network."

The Lombardy region, the most populous and one of the more prosperous in Italy, is the one that pushed the use of activity-based reimbursement the furthest, and also the one that stands out in terms of the efficiency of its health care system.[179] Patients have the freedom to choose where they want to receive their treatments, and hospitals, whether public or private, compete with one another to attract them. The revenues that institutions get are higher for more complex cases and for emergency services, and are cut back in the case of readmissions within 45 days. The government has succeeded in limiting fraudulent reimbursement requests (known as upcoding) in a simple way: by accepting to pay out higher fees meant for complex cases only if the patient's length of stay is longer than the threshold

175. Johan Pieter Mackenbach *et al.*, "Sharp upturn of life expectancy in the Netherlands: effect of more health care for the elderly?" *European Journal of Epidemiology*, Vol. 26, No. 12, 2011, pp. 903–14.
176. Anurag Sharma, "Inter-DRG resource dynamics in a prospective payment system: a stochastic kernel approach," *Health Care Management Science*, Vol. 12, 2009, pp. 38-55.
177. Giovanni Fattore and Aleksandra Torbica, "Inpatient reimbursement system in Italy: How do tariffs relate to costs?" *Health Care Management Science*, Vol. 9, 2006, pp. 251-258.
178. Marina Cavalieri, Lara Gitto and Calogero Guccio, "Reimbursement systems and quality of hospital care: an empirical analysis for Italy," *Health Policy*, Vol. 111, No. 3, 2013, pp. 273-289.
179. Ariana De Nicola, Simone Gitto, Paolo Mancuso and Vivian Valdmanis, "Healthcare reform in Italy: an analysis of efficiency based on nonparametric methods," *International Journal of Health Planning and Management* (forthcoming).

considered medically necessary for each particular kind of procedure.[180]

Additionally, private hospitals have made massive investments in order to offer a wider range of services, and many have equipped themselves with emergency rooms in order to increase their revenues. Despite the increasing number of services and new investments, Lombardy has managed to contain rising health care spending better than any other region.[181] Wait times have fallen significantly in the region and it now attracts a large number of patients from everywhere else in Italy.[182]

England

In England, hospitals before 2003 were funded primarily by global budgets and, similarly to Canada's current situation, the population seemed resigned to long wait times before receiving treatment.[183] Since then, practically all hospital care is reimbursed using an activity-based funding system, including ambulatory care and emergency services.[184] Hospitals that offer better services and attract more patients now receive more income, which encourages them to maintain high performance levels. Inversely, those who do not manage to do so are incentivized to modify their way of operating in order to become more efficient.

It did not take long for results to be seen. Average length of stay fell rapidly after the reform came into effect.[185] Hospitals made better use of their resources, allowing more patients to be treated without sacrificing care quality.[186] Indeed, a portion of payments made to English hospitals varies based on meeting certain objectives related to treatment quality.[187]

The hospital funding model reform also paved the way for other changes within the English health care system that have had beneficial effects. Patients now have the opportunity to choose the medical facilities where they want to receive treatment, and hospitals compete to attract them. This increased competition, which stems directly from the funding reform, has played a key role in improving hospital management and the quality of care provided to patients (see Chapter 1).

"Insofar as hospitals' incomes depend on the number of patients they are able to attract, it is essential for them to offer high quality services and to maintain a good reputation."

Median wait times for elective surgery in England plummeted over the course of the past decade, from 13 weeks in 2002 to 4 weeks in 2010.[188] Moreover, according to a recent study examining changes in wait times for hip and knee replacements as well as cataract removals, this reduction was even more pronounced for patients from underprivileged areas.[189]

Thanks to activity-based funding and other incentives given to hospitals, the speed with which patients are admitted in the emergency room has also experienced clear improvements without other aspects of care having suffered.[190] The most recent

180. Giorgio Vittadini, Paolo Berta, Gianmaria Martini and Giuditta Callea, "The effect of a law limiting upcoding on hospital admissions: evidence from Italy," *Empirical Economics*, Vol. 42, 2012, pp. 563-582.
181. Margherita Stancati, "Competitive care," *Wall Street Journal*, April 13, 2010.
182. Elenka Brenna, "Quasi-market and cost-containment in Beveridge systems: The Lombardy model of Italy," *Health Policy*, Vol. 103, 2011, pp. 216-217; Silvia Balia, Rinaldo Brau and Emanuela Marrocu, "What Drives Patient Mobility Across Italian Regions? Evidence from Hospital Discharge Data," in Rosella Levaggi and Marcello Montefiori (eds.), *Health care provision and patient mobility: Health integration in the European Union*, Springer-Verlag, 2014, pp. 133-154.
183. See especially Christian Rioux, "La Grande-Bretagne, royaume des files d'attente," *Le Devoir*, May 2, 2000; John Carvel, "Extra cash fails to halt rise in NHS waiting lists," *The Guardian*, October 6, 2001.
184. Anne Mason, Padraic Ward and Andrew Street, "England: The Healthcare Resource Group system," in Reinhard Busse, Alexander Geissler, Wilm Quentin and Miriam Wiley (eds.), *Diagnosis-Related Groups in Europe: Moving towards Transparency, Efficiency and Quality in Hospitals*, Open University Press, 2011, pp. 197-220.
185. National Audit Office, *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*, Report by the comptroller and auditor general ordered by the House of Commons, HC 192, Session 2012-13, June 29, 2012, p. 32.
186. Shelley Farrar, Deokhee Yi, Matt Sutton, Martin Chalkley, Jon Sussex and Anthony Scott, "Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis," *BMJ*, Vol. 339, 2009, p. b3047.
187. Wilm Quentin *et al*., "Hospital payment based on diagnosis-related groups differs in Europe and holds lessons for the United States," *Health Affairs*, Vol. 32, No. 4, 2013, p. 719.
188. English Department of Health, *Inpatient and Outpatient Waiting Times Statistics,* Historical Times Series, 1988-2010.
189. Zachary N. Cooper, Alistair McGuire, S. Jones, J. Le Grand and Richard Titmuss, *op. cit*., note 41.
190. Steven Kelman and John N. Friedman, "Performance Improvement and Performance Dysfunction: An Empirical Examination of

data compiled indicate that 96% of patients who show up in emergency rooms receive a diagnosis from a doctor within the wait-time target of four hours.[191]

In addition, concerns that activity-based funding might encourage hospitals, in particular those in the private sector, to select the least complex cases have proven to be largely unfounded.[192] Like most countries having adopted this type of funding, mechanisms were developed in England to identify atypical cases and to take into account the extra costs involved in treating such patients, when determining payments to hospitals.[193]

"This increased competition, which stems directly from the funding reform, has played a key role in improving hospital management and the quality of care provided to patients."

Contrary to what certain analysts have led us to believe,[194] activity-based funding reform has not led to an unusual multiplication of administrators in the health care system in England. From 2002 to 2012, the number of administrators grew just half as quickly as the number of doctors (full-time equivalent).[195] This growth was also comparable to that seen in Scotland,[196] a part of the United Kingdom that has not adopted activity-based hospital funding. In sum, there are far fewer managers and administrative staff per thousand inhabitants in England than in any other region of the United Kingdom—only half as many as in Scotland and Northern Ireland.[197]

It is also interesting to note the progress that has taken place in England compared to that in the rest of the United Kingdom, which has kept funding hospitals through the use of global budgets. Over the course of the past decade, England has done a better job of improving its health results, all while also containing health care spending increases better than elsewhere.[198] England now has better results than Scotland, Northern Ireland and Wales in terms of wait times and access to care, yet also has lower health care spending levels, a smaller medical workforce and fewer hospital beds per capita.[199]

The reform and its benefits

The Quebec government recently announced its intention to reform its anachronistic method of funding hospitals using global budgets so that the money will follow the patient within the health care system.[200] This is without a doubt a step in the right direction.[201]

Far from starting off from a disadvantage, the province of Quebec has had a structure in place, since the merger of institutions for the creation of the Health and Social Services Centres (CSSSs), which should facilitate the adoption of hospital funding according to services provided. Furthermore, hospitals are not all in the dark when it comes to data on the medical interventions they carry out. Costs per patient are known in some twenty Quebec hospitals, and will soon be known in many others.[202]

The new activity-based funding model should be adjusted to take into account the severity of cases

Distortionary Impacts of the Emergency Room Wait-Time Target in the English National Health Service," *Journal of Public Administration Research*, Vol. 19, 2009, pp. 917-946; Carol Propper, Matt Sutton, Carolyn Whitnall and Frank Windmeijer, "Incentives and Targets in Hospital Care: Evidence from a Natural Experiment," *Journal of Public Economics*, Vol. 94, 2010, pp. 318-335.

191. NHS England, *A&E Activity and Performance Time series*.
192. Luigi Siciliani, Peter Sivey and Andrew Street, *op. cit*., note 33.
193. Wilm Quentin *et al*., *op. cit*., note 187; Francesc Cots, Pietro Chiarello, Xavier Salvador, Xavier Castells and Wilm Quentin, "DRG-based hospital payment: Intended and unintended consequences," in Reinhard Busse *et al*., *op. cit*., note 184, p. 87.
194. Sarah Champagne, "Hôpitaux: le financement à l'activité, une 'avenue risquée'," *La Presse*, June 21, 2012; Jeanne Corriveau, "Mise en garde contre le financement des hôpitaux à l'activité," *Le Devoir*, November 5, 2012.
195. Health and Social Care Information Centre, *NHS Staff – 2002-2012, Overview: workforce census bulletin*, March 2013, p. 30.
196. ISD Scotland, NHS *Scotland Workforce Statistics, Overall Trend*.
197. Sheelah Connolly, Gwyn Bevan and Nicholas Mays, *Funding and performance in the four countries of the UK after devolution*, The Nuffield Trust, 2010, p. 44.
198. National Audit Office, *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*, HC 192, Session 2012-13, June 29, 2012, p. 15.
199. *Ibid*, p. 41 (wait times), p. 26 (workforce), p. 36 (hospital beds).
200. Guillaume Bourgault-Côté, "Le gouvernement veut que 'l'argent suive le patient'," *Le Devoir*, February 21, 2014.
201. The MEI was already proposing such a reform in the spring of 2012. See Yanick Labrie, "Activity-Based Hospital Funding: We've Waited Long Enough," *Economic Note*, Montreal Economic Institute, May 2012.
202. Martin Beauséjour, "La solution MED-GPS s'implante dans les hôpitaux," *La Presse*, September 28, 2012.

and the complexity of different diseases. By setting all hospitals on equal footing in terms of funding, none will find themselves in an unjustifiably delicate financial situation because of a range of cases that are more difficult and therefore more expensive to treat. Also, payments to hospitals should be cut back in cases of readmissions within a certain interval (45 days, for example).

"Far from starting off from a disadvantage, the province of Quebec has had a structure in place which should facilitate the adoption of hospital funding according to services provided."

Thanks to this funding method, hospitals will be encouraged to increase their activities in order to obtain more revenue. This formula will moreover encourage them to reduce useless costs and lengths of stay, thus freeing up resources to treat more patients. The increasing activity stemming from such an approach also means that patients will be treated more quickly, which is likely to substantially improve access to health care for those on waiting lists.

CHAPTER 6

Make the Publication of Hospital Performance Indicators Mandatory

Background

In most sectors of our economy, consumers need not be fully informed in order to make wise purchasing decisions. On average, consumers know very little about most products or services before acquiring them. Yet these markets function relatively well because people get rewarded for seeking the necessary information prior to purchase—by obtaining a better and more satisfying product or service—while choice and competition ensure that no systematic abuses occur.

The health care sector has always been perceived as different in this regard, since prices cannot influence the decisions of patients, and choice and easily accessible information have rarely been available to them. This is changing, however. Indeed, in the Internet era, the barriers to information acquisition in the field of health care are falling. More and more patients are coming into the doctor's office extremely knowledgeable about the characteristics of particular diseases and the treatment options available to them.[203] Although they still face an information disadvantage in some respects, the gap has narrowed in recent decades and most patients are now able to find valuable information at relatively little cost.[204] A growing number of patients also want to take an active part in decisions about their health.

Policymakers in many countries have come to realize that competition is probably the best way of improving the quality of service in the health care system, and that this competition cannot be fostered without making indicators of quality publicly available. In these countries, hospitals are now mandated to collect and make publicly available a series of performance indicators. These are generally accessible to the general public via a Web portal that provides easy reference for users looking for information.

More transparency of information, all else being equal, should allow patients to make better decisions and push service providers to seek excellence in quality when choice and competition exist. The more that data on facilities, and the range and quality of care they give are openly available, the more patients and referrers are empowered to choose the right facility for treatment. This is what most developed countries have understood.

In contrast, the situation in Quebec and across Canada in this regard is moving at a snail's pace. Only a few initiatives of hospital quality data collection have recently begun to emerge.[205] In most cases, however, this information remains largely inaccessible to the general public.

Foreign experience

Germany

Since 2003, German hospitals have been obliged to publish annual structured quality reports in an easily accessible data format (PDF) on the Internet.[206] These quality reports are meant to empower patients to learn about the level of quality of each hospital and enable them to compare these quality levels with each other. Medical doctors can furthermore base their referral decisions on transparent quality reports.[207] Health insurance companies use the quality data in making recommendations to their patients. A joint committee consisting of insurers and providers sets the framework for the quality reports and decides on the scope of those reports.

203. James C. Robinson, *op. cit.*, note 18; Liette D'Amours, "Santé 2.0: des Québécois bien plus avisés," *La Presse*, April 23, 2008, p. LPA8.
204. D. Eric Schansberg, "The Economics of Health Care and Health Insurance," *The Independent Review*, Vol. 18, No. 3, 2014, pp. 401-420.
205. See for instance the newly available website launched by the Canadian Institute for Health Information: http://ourhealthsystem.ca/.
206. Mirella Cacace, Stefanie Ettelt, Laura Brereton, Janice Pedersen and Ellen Nolte, *op. cit*, note 30, p. 42.
207. Federal Joint Committee: Vereinbarung gemaess §137 Abs. 1 Satz 3 Nr. 6 SGB V ueber Inhalt und Umfang eines strukturierten Qualitaetsberichts fuer nach §108 SGB V zugelassene Krankenhaeuser. *BAnz. 22.12.2005* 242:16896.

The German hospital quality reports are divided into two parts. The first part contains information on the scope and volume of services provided by each hospital. The second part contains information on hospital quality management systems.

Each report lists the medical and non-medical services a hospital provides and how accessible the facilities are to disabled people. The total number of inpatient beds per medical department and patient cases can also be found in the reports. Patients can moreover find information on the number of medical, nursing, and auxiliary staff and their levels of education.

The quality reports also include statistics on numbers of diagnosed indications (ICD) and quantities for each procedure (OPS) and their corresponding complication rates. Furthermore, one can find all the information broken down by medical department. A good indicator of quality is how often a procedure has been conducted during a given year. The more often it occurs in a given department, the higher the likelihood that this department has a high level of expertise when it comes to this procedure. The number of complications and infection rates are also very tangible decision parameters for patients.

"More transparency of information should allow patients to make better decisions and push service providers to seek excellence in quality."

Quality reports allow more transparency and patient choice in the inpatient sector. Furthermore, hospitals can use their quality reports as marketing tools, and most of them usually publish their quality reports on their websites. Since they are competing to attract patients, they use quality reports as a means of promoting their services and quality levels. Hospitals offering a higher level of quality will likely be able to attract more patients.

The quality reporting system is a work in progress that is continually evolving. This means that experts from the insurance industry and hospital providers are constantly reviewing the relevancy of quality indicators and evaluating the application of further indicators in order to allow more transparency in the quality of hospital care. Indicators can also be removed if the expert committee assesses them as misleading or irrelevant for inter-hospital comparisons. The longer this learning process continues, the better the quality of information that becomes available to patients. Reviews and surveys make it possible to rank the relevance of indicators for patients and thus to modify the list.

Over the course of the last eight years, the Joint Committee decided to gradually raise the number of hospital quality indicators included in the reports from a mere 28 to a much more comprehensive 289 indicators. Some of the recently added indicators concern the mobility of patients after knee surgery, infection rates after implant replacements, and the number of newborns with complications.

A Bertelsmann Foundation survey has shown that more than 70% of patients would read quality reports if they could before choosing a hospital for an elective treatment. Seventy percent of those who had already used quality reports said that it was easy to find the relevant information within those reports. In addition, 75% of the sample of patients surveyed agreed with the statement that the reports contain the information they need in order to make an informed decision.[208]

In order to make the reports easier for patients to understand and use, the health insurer AOK offers an easy search and quality comparison tool on the Internet called Health Navi.[209] Health Navi contains all the data hospitals must include in their quality reports, which allows patients to quickly compare the quality levels of different hospitals for any given treatment.

But it is not only patients who benefit from such quality reports. Four out of five hospital administrators and medical doctors agree on the importance of comprehensive quality reports. Structured quality reports help hospital administrators and doctors better understand the levels of quality in their own hospitals and compare

208. Max Geraedts, Qualitätsberichte deutscher Krankenhäuser und Qualitätsvergleiche von Einrichtungen des Gesundheitswesens aus Versichertensicht.
209. See their website at www.aok-gesundheitsnavi.de.

their performance to that of other hospitals.

Patients and medical doctors find it very relevant to know about the level of specialization of a medical department, the number of cases performed per procedure and the quality of different treatments. The qualification levels of doctors and nurses are also one of the most valuable indicators for patients.[210] In a study published in 2007, researchers showed that German patients base their choices between providers primarily on quality of care, waiting times and staff continuity, rather than on location of care *per se*. Providers' specialization and expertise in dealing with complex and unexpected clinical situations, risk and complications were found to be the most important characteristics for patients' choices.[211]

"Structured quality reports help hospital administrators and doctors better understand the levels of quality in their own hospitals and compare their performance to that of other hospitals."

More transparency and competition on quality have likely led to an increase in measured overall quality in German hospitals. The AQUA Quality Institute, the German institute that conducts the external hospital quality audits, found 21 quality indicators with alarmingly low results in the German hospital system in 2009. For 2012, the Institute found merely one indicator that had alarming quality issues.[212]

According to a recent study, following the introduction of mandatory quality reports, hospitals that were initially underperforming managed to increase their quality levels more than other hospitals. In addition, those that showed the best performance, in terms of outcome quality measures, experienced the largest increases in numbers of patients.[213] Again, this fact indicates that patients are aware of the usefulness of disclosed quality reports when making their choices of care providers.

The reform and its benefits

The Quebec government should set up a mandatory quality reporting system for all hospitals in the province. It would be a meaningful step in the direction of empowering patients and fostering patient choice and competition among health providers.

More transparency of information would allow patients to act as consumers and to make better decisions. Patients would be able to follow the best quality and "vote with their feet," which would therefore gradually lead to enhanced quality of care in the health system. Indeed, such a reporting system would push service providers to seek new ways of improving their performance, not only with respect to quality but also in terms of efficiency.

Even in a context in which hospitals are paid according to global budgets and competition and patient choice do not play a significant role, simply mandating the publication of quality indicators may incentivize administrators to improve their performance in order to avoid the shame of a bad report. In Ontario for instance, hospitals have been subject to mandatory public reporting of *C. difficile* infection rates on a monthly basis since September 2008[214]. Results of a recent study show that infection rates declined by 26% in the two years following the introduction of public reporting, which represents over 1,900 averted cases annually.[215] Lowered

210. Max Geraedts, David Schwartze and Tanja Molzahn, "Hospital quality reports in Germany: patient and physician opinion of the reported quality indicators," *BMC Health Services Research*, Vol. 7, 2007, p. 57.
211. David L. B. Schwappach and Thomas J. Strasmann, "Does location matter? A study of the public's preference for surgical care provision," *Journal of Evaluation in Clinical Practice*, Vol. 13, 2007, pp. 259-264.
212. Institute for Applied Quality Improvement and Research in Health Care GmbH, *German Hospital Quality Report 2012 (in German)*, AQUA Zukunft Durch Qualität, 2013.
213. Lapo Filistrucchi and Fatih Cemil Ozbugday, "Mandatory Quality Disclosure and Quality Supply: Evidence from German Hospitals," Working Paper No. 2012-070, Tilburg Law and Economics Center, Tilburg University, June 2012.
214. Since September 2008, the government of Ontario requires hospitals to publicly disclose information on a range of indicators related to the quality and safety of care. https://www.oha.com/CurrentIssues/keyinitiatives/PatientSafety/Pages/PatientSafetyIndicatorsandPublicReporting.aspx.
215. Nick Daneman *et al.*, "Reduction in *Clostridium difficile* Infection Rates after Mandatory Hospital Public Reporting: Findings from a Longitudinal Cohort Study in Canada," *PLOS Medicine*, Vol. 9, No. 7, 2012.

infection rates in turn likely translated into reduced spending on malpractice, complications, and long hospital stays due to hospital-acquired infections.

One often-heard argument against the publication of quality indicators is that it may encourage hospitals to focus on the visible and measured aspects of care and to overlook other, unassessed aspects. Although this is possible, it must be recognized that it would still be an improvement over the current situation in Quebec where very few indicators are measured and so, according to the same line of reasoning, almost every aspect of care is at risk of being neglected.

"Results of a recent study show that infection rates declined by 26% in the two years following the introduction of public reporting."

A more convincing argument concerns the incentives hospitals might have to avoid riskier and more complex cases in order to maintain good quality scores.[216] However, this problem can be addressed by adjusting the various measures of performance to take into account differences in patient age and gender, and in the presence of co-morbidities and complications. When these risk adjustments are made, the empirical evidence shows that the incentives for hospitals or physicians to avoid treating more severe cases disappear.[217] We must also recognize that in a context of greater competition and transparency, it would become much more difficult for providers, be they public or private, to successfully cheat the system.

Finally, a good number of studies demonstrate that mandatory public reporting of hospital performance indicators improves the quality of care.[218] Moreover, when hospital funding is partly linked to performance, as is the case in a few countries like England, we observe that quality of care improves even more.[219]

216. Rachel M. Werner and David A. Asch, "The Unintended Consequences of Publicly Reporting Quality Information," *Journal of the American Medical Association*, Vol. 293, No. 10, 2005, pp. 1239-1244.
217. See Jonathan T. Kolstad, "Information and Quality when Motivation is Intrinsic: Evidence from Surgeon Report Cards," *American Economic Review*, Vol. 103, No. 7, 2013, pp. 2875-2910; David M. Cutler, Robert S. Huckman and Mary Beth Landrum, "The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery," *American Economic Review*, Vol. 94, No. 2, 2004, pp. 342-346.
218. David M. Cutler, Robert S. Huckman and Mary Beth Landrum, *ibid.*; Shin-Yi Chou *et al.*, "Competition and the impact of online hospital report cards," *Journal of Health Economics*, 2014 (to be published); Christopher S. Hollenbeak *et al.*, "Reductions in Mortality Associated with Intensive Public Reporting of Hospital Outcomes," *American Journal of Medical Quality*, Vol. 23, No. 4, July-August 2008, pp. 279-286; Judith H. Hibbard, Jean Stockard, and Martin Tulser, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?," *Health Affairs*, Vol. 22, No. 2, 2003, pp. 84-94; David E. Ikkersheim and Xander Koolman, "Dutch healthcare reform: did it result in better patient experiences in hospitals? A comparison of the consumer quality index over time," *BMC Health Services Research*, Vol. 12, No. 76, 2012.
219. Peter K. Lindenauer *et al.*, "Public Reporting and Pay for Performance in Hospital Quality Improvement," *New England Journal of Medicine*, Vol. 356, 2007, pp. 486-496; Matt Sutton *et al.*, "Reduced Mortality with Hospitals Pay for Performance in England," *New England Journal of Medicine*, Vol. 367, 2012, pp. 1821-1828.

CONCLUSION

Since the beginning of the 2000s, several working groups and commissions have proposed reforms aiming, among other things, to make more room for the private sector and for competition in Quebec's health care system. Despite these recommendations, patients still have very few options when it comes to health services. The provision of treatments considered "essential" remains largely monopolized by the public sector. As for the role of private health insurance, it is limited solely to the coverage of services that are not insured by the public plan.

No other industrialized OECD country imposes as many restrictions upon its citizens in the field of health care. Do these constraints give rise to better results in terms of access and quality of services offered? Judging by foreign experience, the answer is a resounding "no."

"The government of Quebec no longer has any excuse not to reform the health care system and incorporate market solutions, just like other industrialized countries have successfully done."

Compared to the vast majority of OECD countries, the results of Quebec's public health care system are far from satisfactory, and the situation is not improving. In international rankings, Quebec at best finds itself in the middle of the pack when comparing quality of care indicators, while its health care expenditures are among the highest.[220]

With regard to wait times for required care, the province of Quebec, like the rest of Canada, has been at the bottom of the list for many years. Overcrowded emergency rooms are just as worrisome a problem as they were thirty years ago. The government monopoly and its associated restrictions lead to inefficiency and the rationing of services, such that the better-off and those with personal connections often enjoy privileged access to treatment in our health care system.

Given how ineffective traditional solutions have been when it comes to solving the problem of wait times, a large majority of Quebecers favour change. According to the latest report of the Commissaire à la santé et au bien-être on the population's perceptions of and experiences with medical care, 77% of Quebecers think that the health care system needs fundamental changes or needs to be rebuilt from the ground up.[221] Other polls carried out in recent years also indicate that a growing proportion of Quebecers want the government to explore the private sector option.

In this regard, there are numerous models to follow. As we have seen, the vast majority of industrialized countries, faced with challenges similar to our own, have undertaken reforms in recent decades by decentralizing administration, by calling upon the private sector for the provision of care and by putting in place mechanisms of competition between hospitals. Within these health care systems, patients now have the freedom to choose not only their doctors but also the medical facilities where they want to be treated, whether in the private or the public sector. Thanks to hospital funding based on cases treated, institutions that manage to attract more patients with the quality of their services are rewarded by receiving more funds.

Contrary to certain beliefs, these reforms have in no way constituted a threat to the goals of universality and accessibility to care. On the other hand, they have provided substantial benefits to patients, especially in terms of improving wait times and service quality.

The government of Quebec therefore no longer has any excuse not to reform the health care system and incorporate market solutions, just like other industrialized countries have successfully done. It is in this way that it will succeed in solving the province's most pressing problem, namely waiting lists.

220. See in this regard the Canadian Institute for Health Information's interactive online tool: http://www.cihi.ca/cihi-ext-portal/internet/en/documentfull/health+system+performance/indicators/international/oecd_etool_results.

221. Mike Benigeri and Olivier Sossa, *op. cit.*, note 7, p. 14.

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