VANCOUVER
AUG 14 2009
REGISTRY

R. Woollard #1
Sworn: August 13, 2009

No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CANADIAN INDEPENDENT MEDICAL CLINICS ASSOCIATION, CAMBIE SURGERIES CORPORATION, DELBROOK SURGICAL CENTRE INC., FALSE CREEK SURGICAL CENTRE INC., OKANAGAN HEALTH SURGICAL CENTRE INC. and ULTIMA MEDICAL SERVICES INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH SERVICES OF BRITISH COLUMBIA and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

AND:

SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

DEFENDANT BY COUNTERCLAIM

AFFIDAVIT

I, Robert Woollard, physician, 5804 Fairview Crescent, in the City of Vancouver, in the Province of British Columbia, AFFIRM AND SAY AS FOLLOWS:

1. I am a member of the College of Physicians and Surgeons of BC and have practiced medicine in the province for over 35 years. I have been actively involved in teaching medicine since 1974, first in family practice in rural Clearwater, BC., and for the past twenty years as a full time member of the faculty of the University of British Columbia. I have been a full tenured professor on the faculty since 1995, and served as the Royal Canadian Legion Professor and Head of the department of Family Practice there from 1998-2008. I am also have the Vice-Chair

of Canadian Doctors for Medicare – Médecins canadiens pour le régime public (hereafter referred to as "CDM-MCRP"). As such I have personal knowledge of the facts and matters hereinafter deposed to, save and except where same are stated to be made on information and belief, and where so stated, I verily believe them to be true.

2. CDM-MCRP is dedicated to providing a voice for Canadian doctors committed to preserving, strengthening and improving Canada's universal and publicly-funded health care system for the benefit of all Canadians. Founded in 2006 following the Supreme Court of Canada's decision in *Chaoulli* and in response to increasing concerns over challenges to Canada's publicly funded and delivered health care system, CDM-MCRP advocates for innovations in treatment and prevention services that improve access, quality, equity and sustainability within the public system. It is the only national physician organization advocating for reform within the fundamental tenets of Medicare and using the best available evidence as guides for public engagement. It is the only national physician organization advocating for reform within the fundamental tenets of Medicare, unequivocally opposed to the introduction of private funding and insurance for medically necessary services, and using the best available evidence as guides for public engagement.

3. CDM-MCRP's vision, mission and goals are as follows:

Vision

A high-quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another.

Mission

Our mission is to provide a voice for Canadian doctors who want to strengthen and improve Canada's universal publicly-funded health care system. We advocate for innovations in treatment and prevention services that are evidence-based and improve access, quality, equity and sustainability.

Our Goals

1. To continuously improve publicly-funded health care in Canada.

2. To assist in the education of doctors, policy makers, other health practitioners and the general public on the value, efficiency, quality and equity of publicly-funded health care and the reality of alternative systems.

3. To effectively collaborate with other organizations that share similar objectives.

4. Members of CDM-MCRP include high-profile and respected leaders in clinical medicine, research, policy and education; residents, medical students, retired physicians. CDM also has a "Friends" membership category that includes members of other health professions and the general public. Still growing after only three years in existence, CDM-MCRP currently counts approximately 2000 members and is led by a 19-member Board of Directors that is representative, on a geographic and specialty basis, of physicians across Canada. Attached hereto and marked as **Exhibit A** to this my affidavit are the condensed CVs of members of the Board of Directors which appear on the CDM-MCRP web page. CDM-MCRP has a partner association in Quebec, MQRP – Médecins québécois pour le regime public, which carries out independent but related activities in Quebec. All Quebec members of CDM are members of MQRP, and all members of MQRP are members of CDM). CDM-MCRP has also built a strong working alliance with Physicians for a National Health Program in the United States - an organization committed to bringing the best of the Canadian public-health care model to the U.S.

5. CDM-MCRP strives to make important contributions to the debate on Medicare in Canada. It has become Canada's recognized voice for physicians who support the preservation of our publicly funded and delivered health care system. Members of the CDM-MCRP Board participate in conferences, debates and forums, writes scholarly articles for peer-reviewed journals, and appears regularly on national television, on news programs and in print. CDM-MCRP also educates doctors, policy makers, other health practitioners and the general public on the value, efficiency, quality and equity of publicly-funded health care and the reality of alternative systems. "Grand Rounds," CDM-MCRP's comprehensive physician education program is presented in medical schools and conferences across Canada and the United States, and reviews the most current evidence respecting the value and effectiveness of public health

care and universal health insurance. A copy of our most recent grand rounds presentation is attached hereto and marked as **Exhibit B** to this my Affidavit.

6. CDM-MCRP has also prepared papers, which are referred to as backgrounders, on a number of subjects relevant to the funding and delivery of health care, and therefore to the issues raised in this litigation. These include backgrounders on health care sustainability, comparisons of the Canadian health care system with those in selected European countries, the practical and legal implications of the Chaoulli decision, and funding models for Canadian hospitals and surgical facilities. A true copy of each of these backgrounders are attached hereto as **Exhibits C, D, E and F**, respectively, to this my Affidavit.

7. In general terms, CDM-MCRP has significant concerns regarding the failure to enforce existing legislation safeguarding the public health care systems, and the potential adverse effect of introducing a parallel system of private insurance and delivery.

8. CDM-MCRP has consistently taken the position that advocating for Medicare does not mean that Canadian Doctors for Medicare supports the status quo in healthcare. We support the principles underlying Medicare because the evidence shows that publicly-funded systems deliver more effective care in a more economical and equitable manner than the alternatives. Nevertheless, Medicare requires intensive, continuous improvement to best serve the needs of Canadians today and in the future. Across Canada, there are dozens of innovative projects that are improving access, quality and cost-effectiveness while maintaining or even improving equity. In the view of CDM-MCRP, expanding these projects and continuing to innovate within Medicare represents the best future for the Canadian health care system. On its web page, CDM-MCRP maintains a catalogue of some of the evidence concerning innovations in medicare: http://www.canadiandoctorsformedicare.ca/medicaresuccesses.html.

9. From the perspective of CDM-MCRP, there would be significant adverse effects on the publicly funded health care system if the plaintiffs' constitutional challenge were successful and a parallel private health care system was introduced. This is because scarce human resources would be extracted from the publicly funded system, a particularly Canadian concern given the

current shortage of nurses and doctors in our country. In addition, CDM-MCRP is concerned that a parallel private system would decrease pressure from politically influential, privileged Canadians for maintaining the quality of publicly funded care. While physicians who work in privately funded for profit facilities and who value higher incomes over the delivery of equitable care might benefit from privatization (if they could put up with the increased bureaucracy and scrutiny of care that would accompany the introduction of private health insurance), many physicians (including members of CDM-MCRP) committed to practicing in the public system, would see conditions in the public system worsen; with two tiers of patients there would also be two tiers of physicians.

10. As a result, in my view, members of CDM-MCRP, who are committed to practicing medicine, engaging in research, and educating future generations of physicians within a publicly funded health care system, will be directly and vitally affected by this litigation.

11. As the national voice of physicians committed to preserving and strengthening the medicare system, CDM-MCRP as an organization has a demonstrated interest, and a genuine and substantial expertise, in the issues arising in this litigation, and in the outcome of this case. Given its mandate and expertise, CDM-MCRP can offer the Court an evidence-based physician perspective that will demonstrate the likely impact on the healthcare system of increased privatization, based both on our intimate knowledge of the Canadian health care system and expertise gained in respect of the health care models in place in other countries.

12. In addition, the CDM-MCRP Board is concerned with the potential effect of increased privatization on the medical education system, and the values of the physicians we are educating for future practice. As is apparent from my experience and qualifications, medical education is an area in which I have particular involvement and expertise, and there are several other CDM-MCRP Board members with similar commitment. In this respect, there is a very real concern that privatization may have direct, significant and adverse effects on medical education and on medical educators throughout Canada, including members of CDM-MCRP who work and learn in academic settings. Among the concerns are the following:

a) physicians practicing in private clinics and charging patients directly may be less willing to serve as clinical instructors, and to provide in-situ training for medical students and residents, reducing our capacity to provide needed education and training opportunities;

b) an increasing number of medical students and practicing physicians may be drawn to more affluent communities or specialties where an extra premium for care may be charged. This threatens to undo the progress that has been made by medical educators, including my own work, in meeting our obligations to ensure that all communities, and particularly those in rural areas, are adequately served by qualified physicians. Similarly, if specialists are able to earn even higher incomes by practicing privately, persuading medical students to become family doctors may become more difficult. Attracting new physicians to family practice has been a particular challenge for the past two decades; only through hard, concerted, national efforts have we seen these trends improve in recent years. Those gains could be seriously threatened as a result of increased privatization; and

c) increased privatization, with its focus on financial gain, may erode the values of professionalism, including the priority of doing useful and needed work, that medical educators seek to instill in medical students. As a result, a potential consequence of increasing privatization of medical care will be to make it far more difficult for me and other CDM members who teach in publicly funded medical schools to meet our mandate of equipping medical students with the values and skills needed to ensure that they attend to the medical service needs of all Canadians regardless of where they live, or their incomes.

13. I make this affidavit in support of CDM-MCRP's motion to be added as party or in the alternative an intervenor in these proceedings.

AFFIRMED BEFORE ME at the Town of Smithers, in the Province of British Columbia, this 13th day of August, 2009.

A Commissioner for taking Affidavits for British Columbia.

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Barrister & Solicitor
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Smithers BC Canada V0J 2N0
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ROBERT WOOLLARD

This is Exhibit A referred to in the affidavit of Robert Woolland sworn before me, this 13 day of August 2009.

A COMMISSIONER, ETC.

001

Canadian Doctors for Medicare

Médecins québécois pour le régime public

Bob Bortolussi, MD, FRCPC, Professor of Pediatrics, Pediatric Infectious Disease consultant at the IWK Health Centre at Dalhousie University, Halifax, NS

Bob Bortolussi is a Pediatric Infectious Disease consultant at the IWK Health Centre in Halifax where he also directs the AIDS treatment program for children across the Maritimes. Through the years he has worked within several health-care systems, from single payer ones in Canada and the Netherlands, to a patchwork of systems in the United States and the impoverished health care system in Uganda. Bob believes that the single payer, universal health care system of Canada should be guarded as a model for others.

Bob is also a researcher (host immunity in newborns) who has published over 100 original articles and book chapters on this subject. He was awarded the Research Award of the Canadian Paediatric Society in 2005 for contributions to research on newborn immunity. Bob's major interests also focus on mentoring physicians and clinician scientists. In 2008, he published a book, "The Handbook for Clinician Scientists" as a reference for clinician scientists on ethics, integrity, and research management and communication skills. The book is used in 17 Universities in Canada, and in the Netherlands, Uganda and China.

Bob is a first generation Canadian originally from Toronto. He is now a professor of Pediatrics at Dalhousie University in Halifax. Bob moved there after completing Medical School at the U of T in 1970 and clinical and research training in Montreal, Toronto and Minnesota. These years and sabbatical experiences in the Netherlands and Uganda have broadened his understanding of diverse health delivery systems and health care needs.

002

Canadian Doctors for Medicare

Médecins québécois pour le régime public

John Gillis, MD

Dr. John Gillis is a 32 year old emergency room physician and health care/ political activist in Halifax. John trained in family medicine at UWO but returned to Nova Scotia in 2001 to complete ER training and start his career.

As President of PAIRO and as a member of the OMA board, John gained significant exposure to the challenges faced by our current health system. After entering the work force and practicing in Ontario and Nova Scotia, and travelling extensively around the world, John became more convinced than ever of the comprehensive benefits of universal public health care from social justice, personal well being, and societal economic perspectives.

As a party political activist and medicare activist John has become increasingly concerned about the rightward change in direction of Canada's physician leadership in support of right wing political platforms. Without strong advocates to fight for our public system, it is clear that these forces will continue to erode the sanctity of our system at the expense of many who are unable to fight for it.

John currently resides with his wife, Jennifer, in Halifax where he works and dabbles in the media with the local cable medical talk show 'Doc Talk', a vehicle to bring important issues, like the threat to medicare into the public arena. He looks forward to helping CDM grow into a potent defender of our public system.

Canadian Doctors for Medicare

Médecins québécois pour le régime public

T. Jock Murray, OC, MD, FRCPC, FAAN, MACP, FRCP (Lond), LLD (Hon St FX), DSc (Hon Acadia) D.Litt (Hon St. Thomas) Professor Emeritus, Dalhousie University, Halifax, NS

T.J. "Jock" Murray is a Professor Emeritus of Medicine and founding director of the Dalhousie Multiple Sclerosis Research Unit. He is former Dean of Dalhousie Medical School, and while Dean he was elected President of the Association of Canadian Medical Colleges and Chairman of the Canadian Medical Forum. He was President of the Canadian Neurological Society and a founder and President of the Consortium of MS Centres, which awarded him the Dr. Labe Scheinberg Award for Lifetime Contributions to Multiple Sclerosis research. He served two terms as Vice President of the American Academy of Neurology, and is Chairman Emeritus of the American College of Physicians.

Dr. Murray has over 200 medical publications and 7 books, and has held 91 funded research grants.

He lectures widely on the history of the Canadian Health Care System and recently gave an address to the Taiwan Internal Medicine Association and to the American College of Physicians on this topic. He also recently was featured on an American on-line interview on a comparison of American and Canadian health care.

He has been the recipient of many awards, including Professor of the Year at Dalhousie University, honorary membership in the Canadian Radiological Society, Canadian College of Family Practice and London Osler Club, and awarded 3 honorary degrees. In 2002 he received a Mentor of the Year Award of the Royal College of Physicians and Surgeons of Canada.. He is an Officer of the Order of Canada and in 2008 inducted into the Order of Nova Scotia.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Adam Hofmann, MD, Internal Medicine Fellow, McGill University, Montréal

Dr. Adam Hofmann is an internal medicine fellow at McGill University, and a board member of the Medécins Québécois pour le Régime Public.

He has been vocal in the media, community and at his medical school about the dangers of privatization. He was the president of the "No Free Lunch" group at McGill, battling the adverse effects of pharmaceutical advertising to physicians and patients.

"The characteristic that divides a good doctor from a great doctor is the spirit that suffuses groups such as the Canadian Doctors for Medicare. It is the understanding that as physicians we cannot stand idly by while our shared values and well-being are threatened. Private for-profit medicine clearly threatens these values. It is imperative that physicians, and trainees, should unite to resist these threats, and work to build a stronger public system."

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Saideh Khadir, MD

Dr Khadir studied at Université de Montréal and obtained her degree in 1995. She is an emergency physician at Hôpital Saint-Luc, of the Centre hospitalier universitaire de Montréal (CHUM).

She also has a family medicine part-time practice and teaches at the Faculté de médecine of Université de Montréal.

She has been an active member of Médecins pour l'accès à la santé in Québec since its inception.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Simon Turcotte, MD, CDM Board Vice Chair

Simon Turcotte obtained his medical degree at Université de Montréal. He has been active in the medical student association at different levels and participated in international health projects. He is now completing a master's degree in immuno-oncology and his residency in general surgery.

The Chaoulli decision has prompted the creation of a new physician coalition in Québec, named "Médecins pour l'accès à la santé". Simon coordinates the activities of the group, whose goal is to propose concrete and equitable solutions to improve access to health care and to reduce waiting times within the public system. Two hundred physicians have supported the document presented by the group for the public consultation related to the Quebec government's response to the Chaoulli decision. The group will be heard at the Provincial Commission in mid-May 2006.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Irfan Dhalla, MD, FRCPC, General Internist, St. Michael's Hospital, Faculty member Departments of Medicine and Health Policy, Management and Evaluation, University of Toronto

Dr. Dhalla has been involved with CDM since its inception, initially serving a term as resident member of the board, and then continuing on in an advisory role after finishing his clinical training. He rejoined the board in 2009. He is a general internist at St. Michael's Hospital and holds faculty appointments in the Departments of Medicine and Health Policy, Management and Evaluation at the University of Toronto. After completing his clinical training at the University of Toronto, he received a Commonwealth Scholarship, which he used to study for a master's degree in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine.

Dr. Dhalla believes that the best available evidence not only highlights the strengths of publicly funded healthcare, but also provides a foundation from which we can innovate within Medicare to improve health care quality.

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Canadian Doctors for Medicare

Médecins canadiens pour le régime public

Nan Okun, MD, FRCSC

Dr. Okun specializes in Maternal Fetal Medicine. She is Associate Professor, Department of Obstetrics/Gynecology, University of Toronto and Director, Prenatal Screening Service, Mount Sinai Hospital.

She received her BScN in 1978 and her MD in 1983. She became a Fellow of the Royal College of Physicians and Surgeons of Canada in 1988; and in 1991 earned a Subspecialty Certificate in Maternal Fetal Medicine. She has been involved in numerous research projects and peer-reviewed publications.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Alan Katz, MD, CCFP

Dr Katz is an Associate Professor in the Departments of Community Health Sciences and Family Medicine at the University of Manitoba and is the Associate Director for Research at the Manitoba Centre for Health Policy. He received his medical training at the University of Cape Town.

The decision to settle in Canada was to a large extent based on the opportunity work in a universal coverage healthcare system. This commitment to Medicare has been enhanced by both his subsequent clinical experience as a family physician in Saskatchewan and then Manitoba, and his studies in Health Policy. He sees the opportunity to support Medicare and ensure its survival through active involvement with the Board of Canadian Doctors for Medicare as both an exciting opportunity and a huge honor.

Alan's research interests are focused on Primary Care and Quality of Care. He is the Principal Investigator of the CIHR/Cancercare Manitoba Team in Primary Care Oncology Research and currently holds the MMSF Clinical Professorship in Population Health. He is the Chair of the Primary Prevention Action Group of the Canadian Partnership Against Cancer.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Ryan Meili, MD

Ryan Meili is a Family Physician. He currently splits his clinical time between the Northern community of Ile a-la-Crosse and inner-city Saskatoon. He also works for the College of Medicine at the University of Saskatchewan as Chair of Social Accountability.

While in medical school Ryan helped to form Health Professionals for Medicare, an interdisciplinary group of students and professionals in the health sciences. Later, students from this group founded SWITCH, the Student Wellness Initiative Toward Community Health, a student-run interdisciplinary clinic in inner-city Saskatoon.

Ryan also runs a unique educational program called Making the Links that offers a multi-site experience for students to become familiar with the role that the social determinants of health play in multiple underserved contexts.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Khati Hendry, MD, CCFP, AAFP.

Dr. Khati Hendry is a family physician and fellow of both the CCFP and AAFP. She practices in Summerland, BC, and is the President of the Penticton Medical Staff Association. She has worked extensively with immigrant populations, and sits on the Board of the South Okanagan Immigrant and Community Services. She trained at UC San Francisco and moved to Canada in 2004.

She worked in community health centers the U.S. for equal access and quality care to all. She was the Medical Director of La Clinica de la Raza and of the Community Health Center Network based in the San Francisco East Bay. She also served as President of the Western Clinicians Network, physician champion of quality improvement programs through the National Health Disparities Collaborative, Associate Clinical Professor of Family and Community Medicine at UCSF, Fellow of the California Health Care Foundation Leadership program, and member of the Physicians for a National Health Program,

"Since moving to Canada, I have been impressed that many people don"t fully realize what they have in Canadian Medicare, and the perils of privatization. I have had in depth experience with the problems of the US system, and would like to help Canada avoid traveling that same wrong road."

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Canadian Doctors for Medicare

Médecins qu´bécois pour le régime public

T. W. Noseworthy, MD, MSc, MPH, FRCPC, FACP, FCCP, FCCM, CHE

Dr Tom Noseworthy is Director, Centre for Health and Policy Studies, Professor (Health Policy and Management) and Head, Department of Community Health Sciences, University of Calgary. He is Chair of the Western Canada Waiting List Project.

Dr Noseworthy is the former Vice President, Medical Services, and CEO of the Royal Alexandra Hospitals, and Chair of the Department of Public Health Sciences, Faculty of Medicine and Dentistry, University of Alberta. He holds a Master of Science in Experimental Medicine from the University of Alberta, and a Master of Public Health - Health Policy and Management from Harvard University.

Dr Noseworthy is a physician with specialty certification in the Royal College of Physicians and Surgeons of Canada, and the American Colleges of Physicians, Chest Physicians, and Critical Care Medicine. Dr Noseworthy has been a member of the National Statistics Council since 1999, and is currently a member of the Advisory Committee on Information and Emerging Technologies (F/P/T Deputy Ministers of Health). He served as a member of the Prime Minister's National Forum on Health from 1994-1997, and chaired the Steering Committee; co-chaired the Advisory Council on Health Infostructure (Federal Minister) from 1997-1999, and chaired the Senior Reference Committee for Alberta Wellnet from 1997-2002. His research has been published in over 70 papers and book chapters and includes a focus on optimising clinical practice behaviours and patient outcomes, and improving quality management of waiting times for scheduled services.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Robert Woollard, MD, CCFP, Royal Canadian Legion Professor and Head, UBC Department of Family Practice

A Fellow of the College of Family Physicians of Canada, Dr Woollard received his MD from the University of Alberta. After 16 years of rural family practice and teaching undergraduate medicine, he joined the University of British Columbia in 1989 and has been Royal Canadian Legion Professor and Head of the Department of Family Practice since 1998.

Dr Woollard has extensive national and international experience in the field of medical education and development. He is Chair of the Committee on the Accreditation of Canadian Medical Schools and recently completed a feasibility study for a new medical school in Nepal. He is Chair of the Board of the Canadian Hunger Foundation and has completed a five-year, five-university project on localized poverty reduction in Vietnam. He chaired the initial development of the Canadian Medical Association (CMA) Ethical Guidelines on relationships with industry and the Task Force developing the response to Health Canada's major statement on Health Promotion, "Achieving Health for All".

He currently works in a number of venues at the local, national and international level on issues relevant to social responsibility of the medical profession. In 2005 Dr Woollard traveled to Uganda twice to chair workshops in this regard. His primary research focus is the study of complex adaptive systems as they apply to the intersection between human and environmental health. His book, "Fatal Consumption: Rethinking Sustainable Development" details some of his work in this regard.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Jonathan Ross, MD, CCFP

Photo of Dr. Ross

Dr. Jonathan Ross is a family/emergency physician in NWT. He attended medical school at the University of Calgary from 2001-2004 and did his residency in Sudbury via the University of Ottawa in Family Medicine (CCFP).

Prior to entering medical school, he studied philosophy and mathematics at McGill University and worked with Médecins Sans Frontières in France.

He is committed to social justice and has been involved in international health as well as working with disadvantaged populations in Canada. He is currently signed on in the NWT for two years and is committed to dividing his time between working in Canada and on international health issues.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Noor Ladhani, MD, Resident in Obstetrics and Gynaecology, University of Toronto

Noor Ladhani is completing her residency training at the University of Toronto in Obstetrics and Gynaecology. She recently received a Master's degree in Public Health, focussing on Health Policy and Management, from Harvard University.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

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Chris Mackie, MD, Public Health Physician

Chris Mackie is a public health physician with academic appointment working in Hamilton.

He has worked for several years to support the publicly funded healthcare system through such organizations as the Professional Association of Residents of British Columbia, the Canadian Association of Internes and Residents, and the Professional Association of Internes and Residents of Ontario. As a board member for each of these organizations, he used the evidence relating the value of the publicly funded system to ensure that policy statements and advocacy positions were aimed at developing the best possible healthcare system for all Canadians.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Ron Stewart, OC, MD, Professor and Director of Medical Humanities, Faculty of Medicine, Dalhousie University.

Dr. Ronald Stewart holds the position of Professor and Director of Medical Humanities, within the Faculty of Medicine of his alma mater Dalhousie University. He also currently holds joint appointments as Professor in the Departments of Emergency Medicine, Anaesthesia, and Community Health/Epidemiology, and in the Faculty of Health Professions at Dalhousie and Adjunct Professor in the Faculty of Health and Rehabilitation Sciences and the Medical School of the University of Pittsburgh. Dr. Stewart has received numerous awards and acknowledgements of his academic and life achievements.

Dr. Stewart is an Officer of the Order of Canada, a Member of the Order of Nova Scotia, a former Minister of Health for the Province of Nova Scotia and a member of the provincial parliament. He was born in North Sydney, on the island of Cape Breton, Nova Scotia.

Dr. Stewart continues in his role as a national advocate of Canada's health system and of health renewal in Canada and the Province of Nova Scotia.

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Canadian Doctors for Medicare

Médecins québécois pour le régime public

Danielle Martin, MD, CCFP, CDM Board Chair

Recognition of exemplary contributions.

At the 2006 Annual Scientific Assembly of the Ontario College of Family Physicians, Canadian Doctors for Medicare Board Chair, Dr. Danielle Martin, MD, CCFP was recognized as one of three Ontario young family physicians who have made significant contributions to both Family Medicine and Ontario's health system in general. The award congratulates Danielle for her "exemplary contribution in her first few years of practice".

Biography

Danielle is a comprehensive care family physician who works in downtown Toronto and in rural northern Ontario. She is on the Staff at Women's College Hospital and Lecturer in the Department of Family and Community Medicine at the University of Toronto.

Her policy expertise and passion for equity make her an emerging leader in the debate over the future of our healthcare system.

A recipient of the CMA Award for Young Leaders, Danielle sits on the Health Council of Canada and was a founding co-chair of the New Health Professionals Network.

Danielle believes strongly in Medicare as the most efficient, equitable and compassionate way to ensure access to high-quality healthcare services for all Canadians. She is honoured to be the founding Chair of the CDM Board of Directors.

More about Danielle Martin

019

This is Exhibit "B" referred to in the affidavit of Robert Woollatt sworn before me, this 13 day of August 2018
A COMMISSIONER ETC.

Beyond Headlines:

Hot Topics in Canadian Healthcare

Danielle Martin, MD, CCFP

Presentation Overview

1. Defining terms

2. Medicare Overview

3. Evidence of relevance
   a) Healthcare financing
   b) Healthcare delivery

4. Wait Times

5. Making Medicare Better

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Canadian Doctors for Medicare
CDM MCRP
Médecins canadiens pour le régime public

Challenges

- Aging population
- Health human resources shortages
- Wait times (linked to cuts in 1990s, staff shortages, demography)
- Rural communities
- Aboriginal and other populations
- Pharmaceutical/technology costs and differential access
- Concern that costs are growing

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Canadian Doctors for Medicare
CDM MCRP
Médecins canadiens pour le régime public

The Debate

- Should we allow private insurance/private payment for medically necessary physician and hospital services?
- What about the delivery of health care in Canada?
- Are these methods the best way to solve the challenges facing health care in Canada and around the world?

Health Care in Canada
Public/Private Financing Balance

What are the risks and benefits of this change?

Depends on what you are trying to accomplish

- Increase Public – universality, equity and total cost control
- Increase Private – more consumer choice, faster service for some and government cost control
- Who pays and how influences cost, quality, and outcomes

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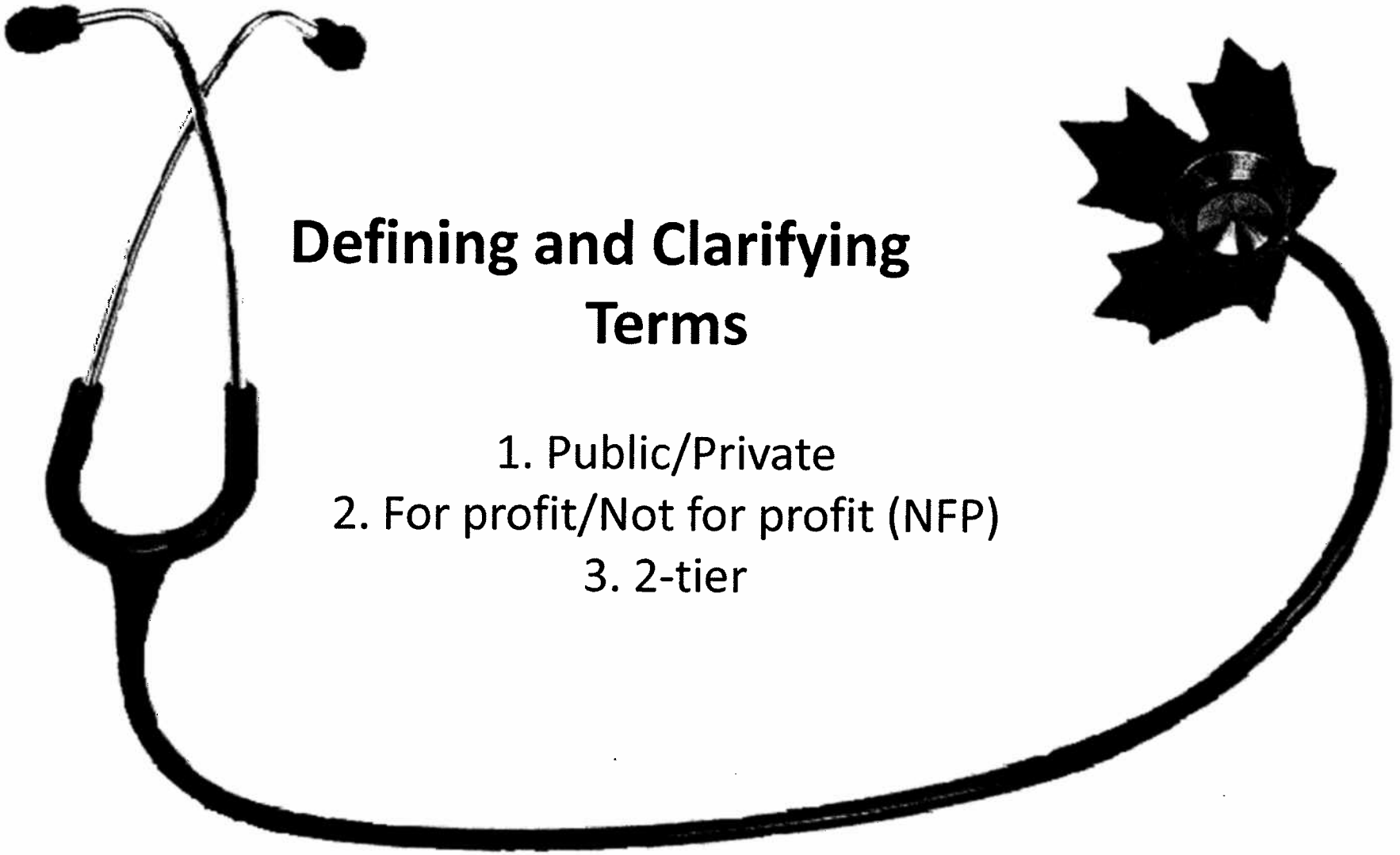

Defining and Clarifying Terms

1. Public/Private
2. For profit/Not for profit (NFP)
3. 2-tier

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Public/Private **Financing**

Who Pays?

- **Public $**
  - Government (through taxes)
- **Private $**
  - Out-of-Pocket
  - Insurance

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Public/Private **Delivery**

Who delivers the service?

- **Public (government) delivery**

- **Private delivery**
  - Not-for-profit
  - For-profit small business / provider owned
  - For-profit corporate / investor owned

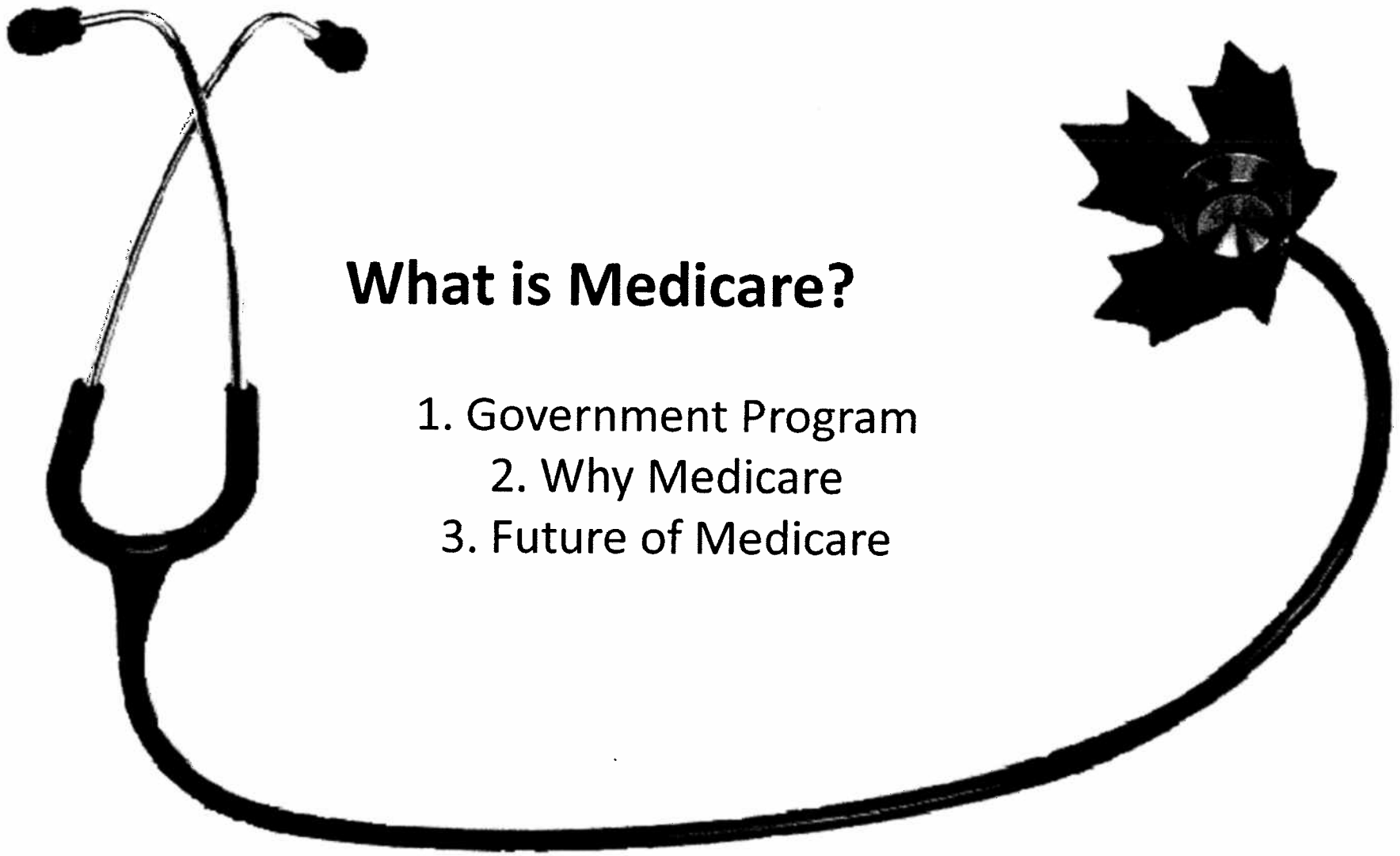
Defining Terms

2-Tier

- Confusing term – many meanings

- Focus on who is paying
  - Can I purchase publicly funded services?
  - Preferential access for private payment

028



What is Medicare?

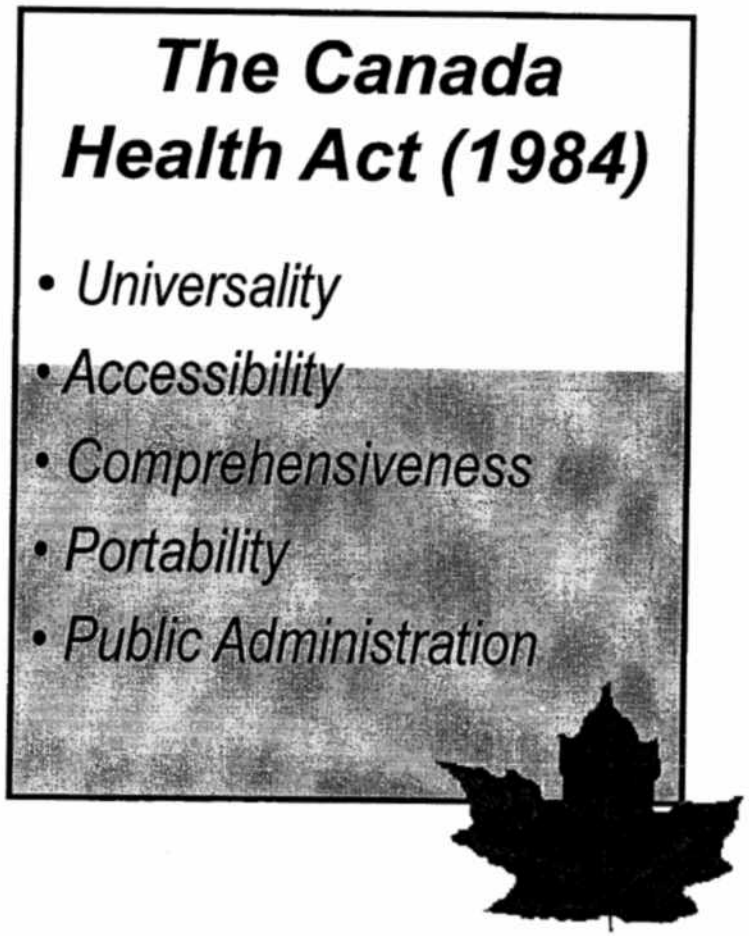
1. Government Program
2. Why Medicare
3. Future of Medicare

029

What is Medicare?

The Federal Government:

- Sets (and enforces?) national standards for insured health care services
- Provides $ through fiscal transfers
- Delivers direct health services to specific groups of Canadians



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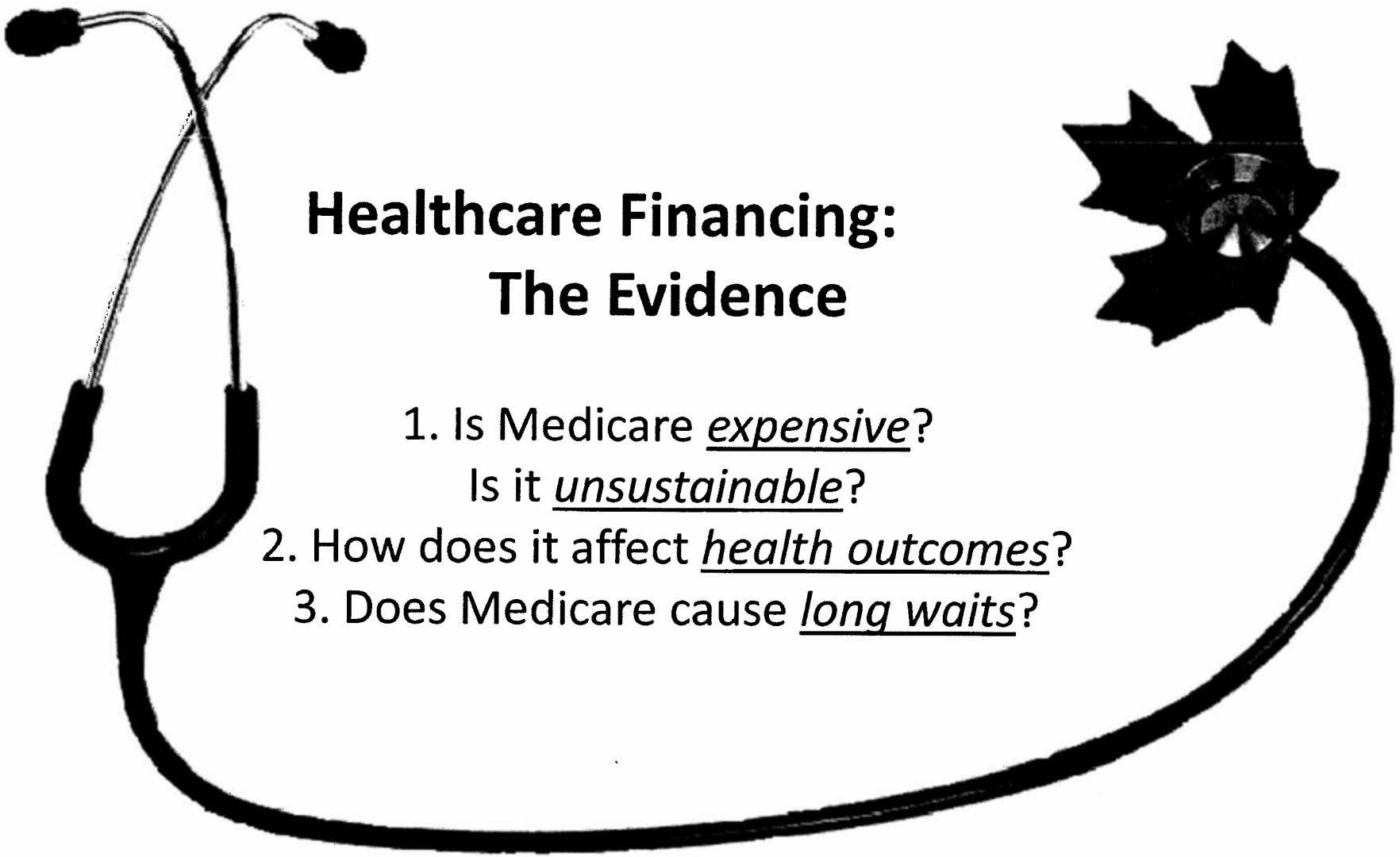
Medicare and the MD

- **Ban on Extra-Billing**
  - Physicians cannot charge beyond what the plan pays for medically necessary services
  - Clinical autonomy is preserved

- **Physicians can opt in or out**
  - Opt in
  - Opt out
  - Special case: Ontario

051

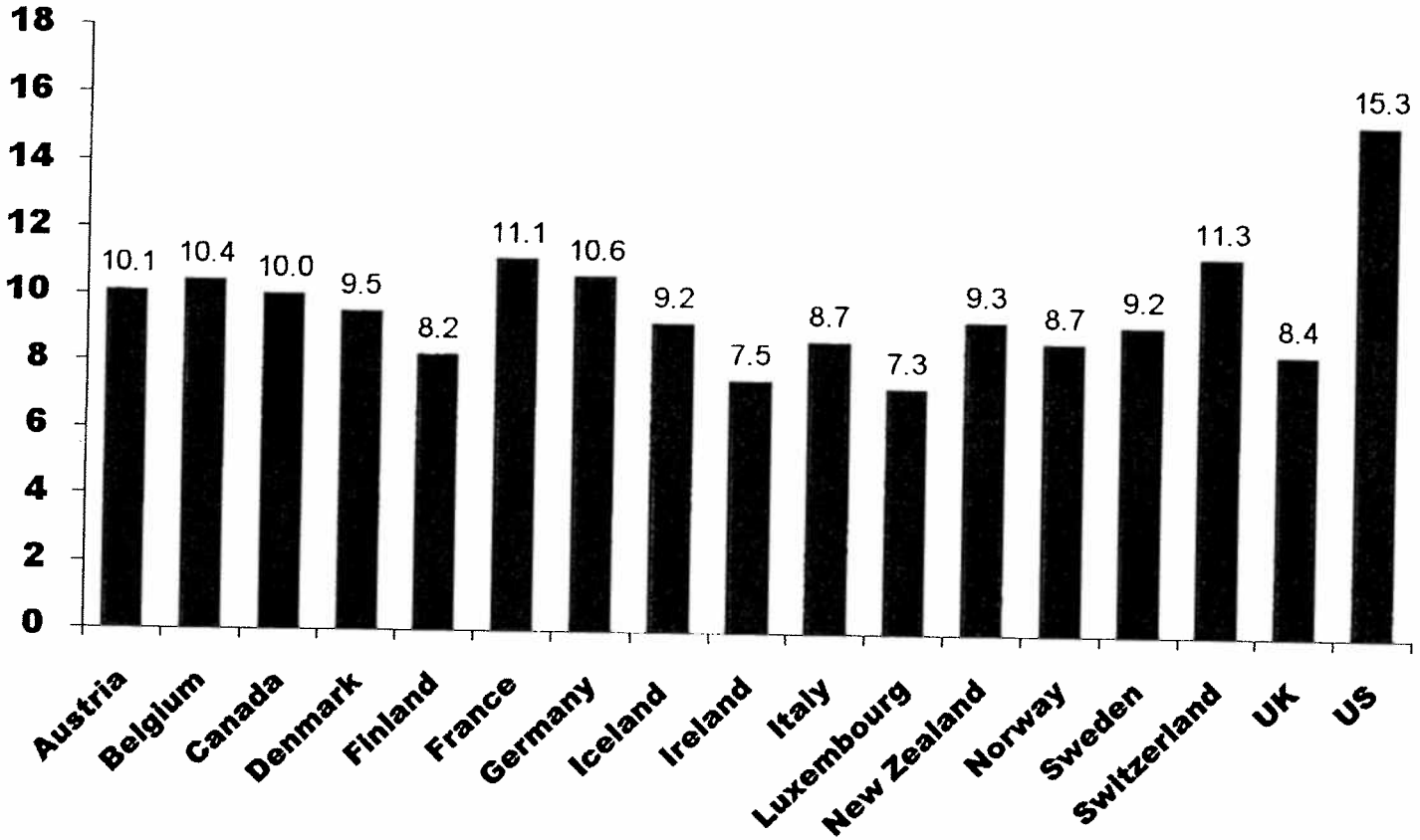


Healthcare Financing: The Evidence

1. Is Medicare *expensive*?
   Is it *unsustainable*?
2. How does it affect *health outcomes*?
3. Does Medicare cause *long waits*?

Is Medicare Expensive?

Health Spending as a % of GDP



OECD Health Expenditure Data (2008)

053

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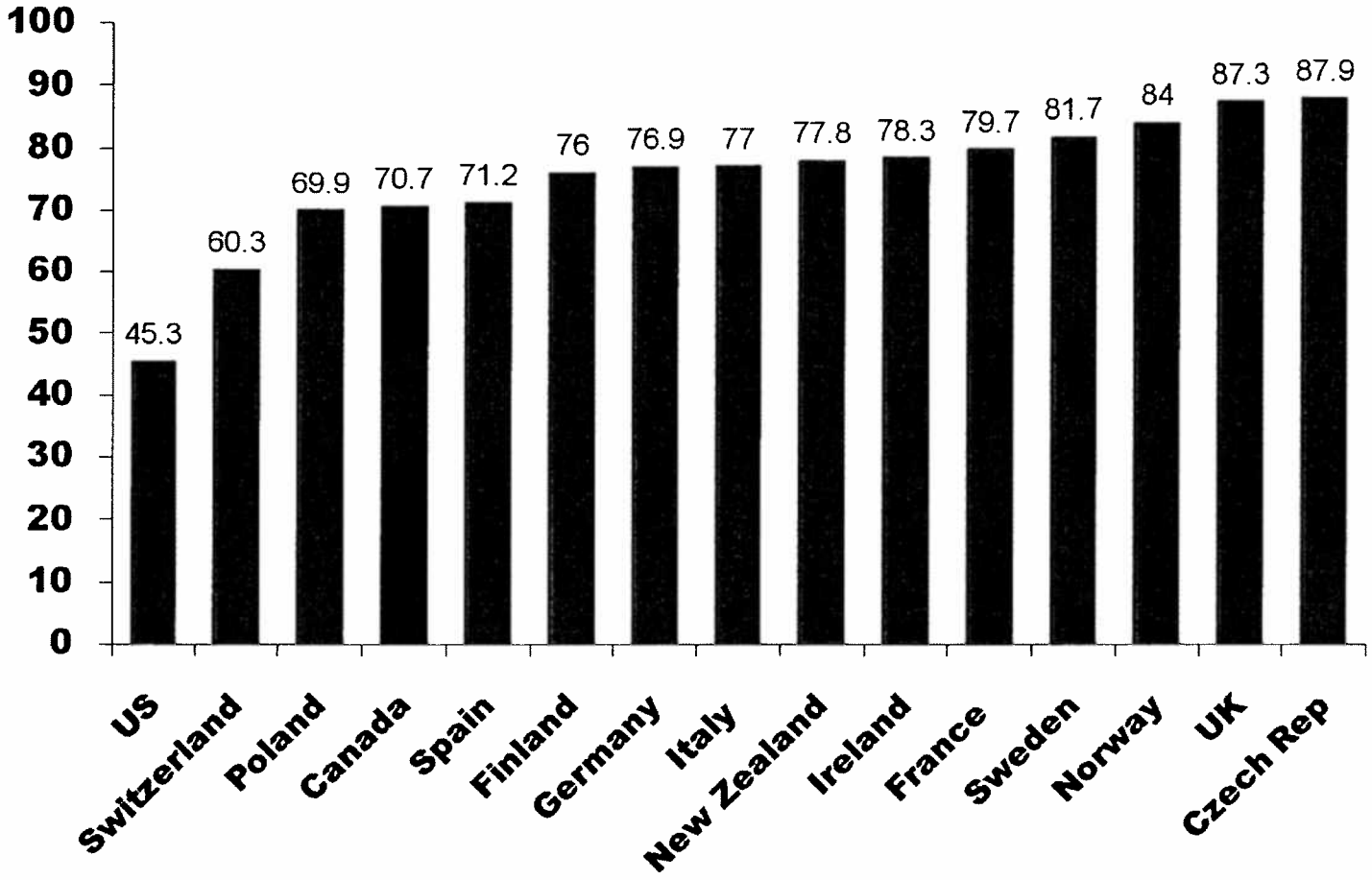
Is Medicare Expensive?

What % of Overall Health Spending is Public?



OECD Health Expenditure Data (2008)

Public Funding of Health Care: Canada and the World

% Public Funding of Services

PHYSICIAN SERVICES		***HOSPITALS***	
Canada	98%	France	94%
Germany	76%	Canada	91%
France	75%	Germany	88%

PHARMACEUTICALS		***DENTISTS***	
Germany	74%	Germany	61%
France	69%	France	37%
Canada	39%	Canada	5%

OECD Health Data (2007)

053

Administrative Costs

- The United States:
  - 31.0% of health care expenditures overall
- Canada:
  - 16.7% health care expenditures overall
  - 1.3% inside the provincial programs
  - 13.2% among private insurers

Woolhandler, S. et al. (2003). NEJM 349. 768-75.

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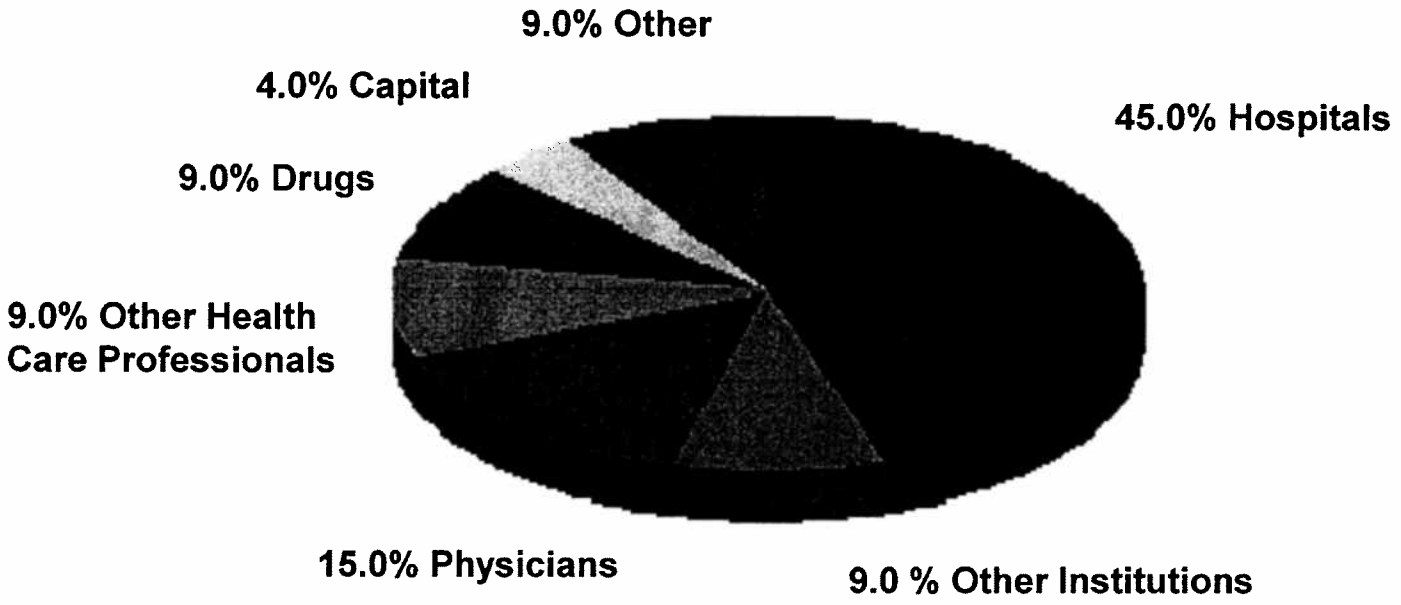
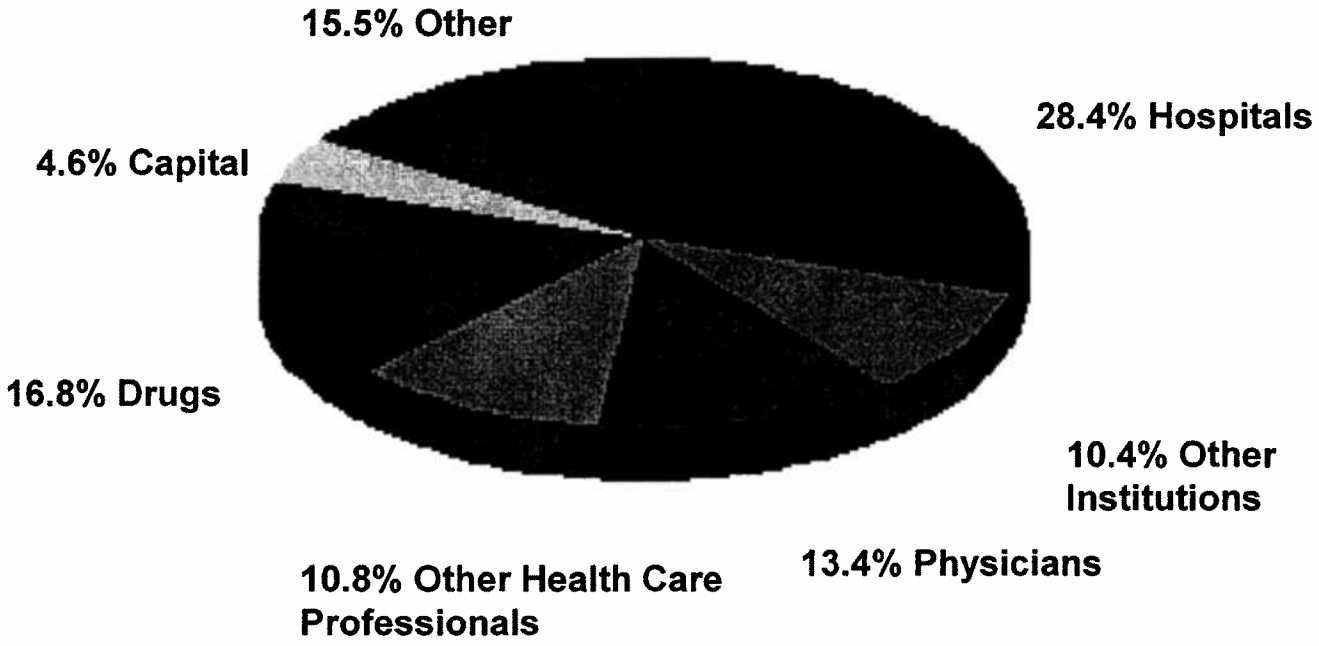
Is Medicare Sustainable?



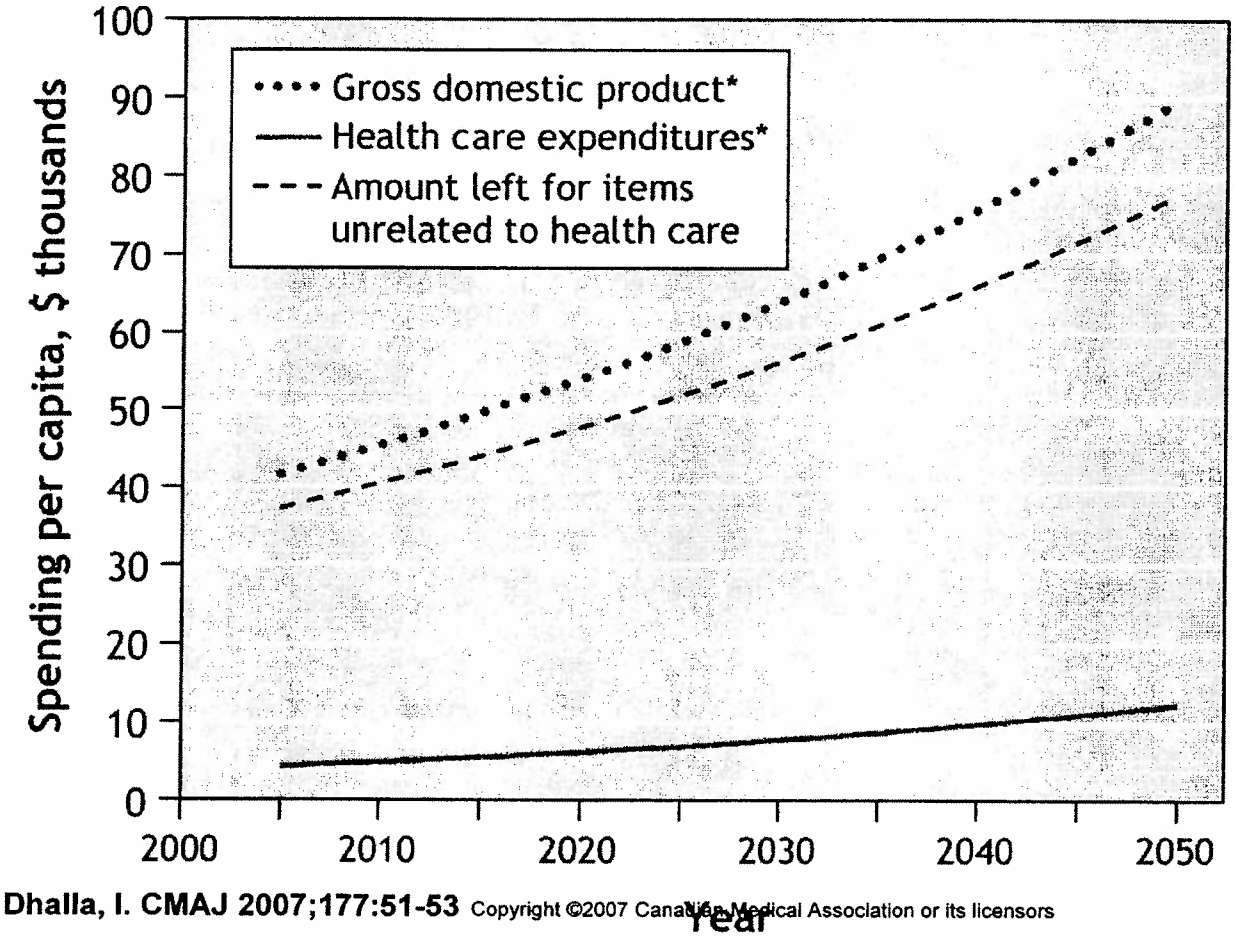
CIHI: Health Care Expenditures. (1975).

Is Medicare Sustainable?



CIHI: Health Care Expenditures Database (2007)

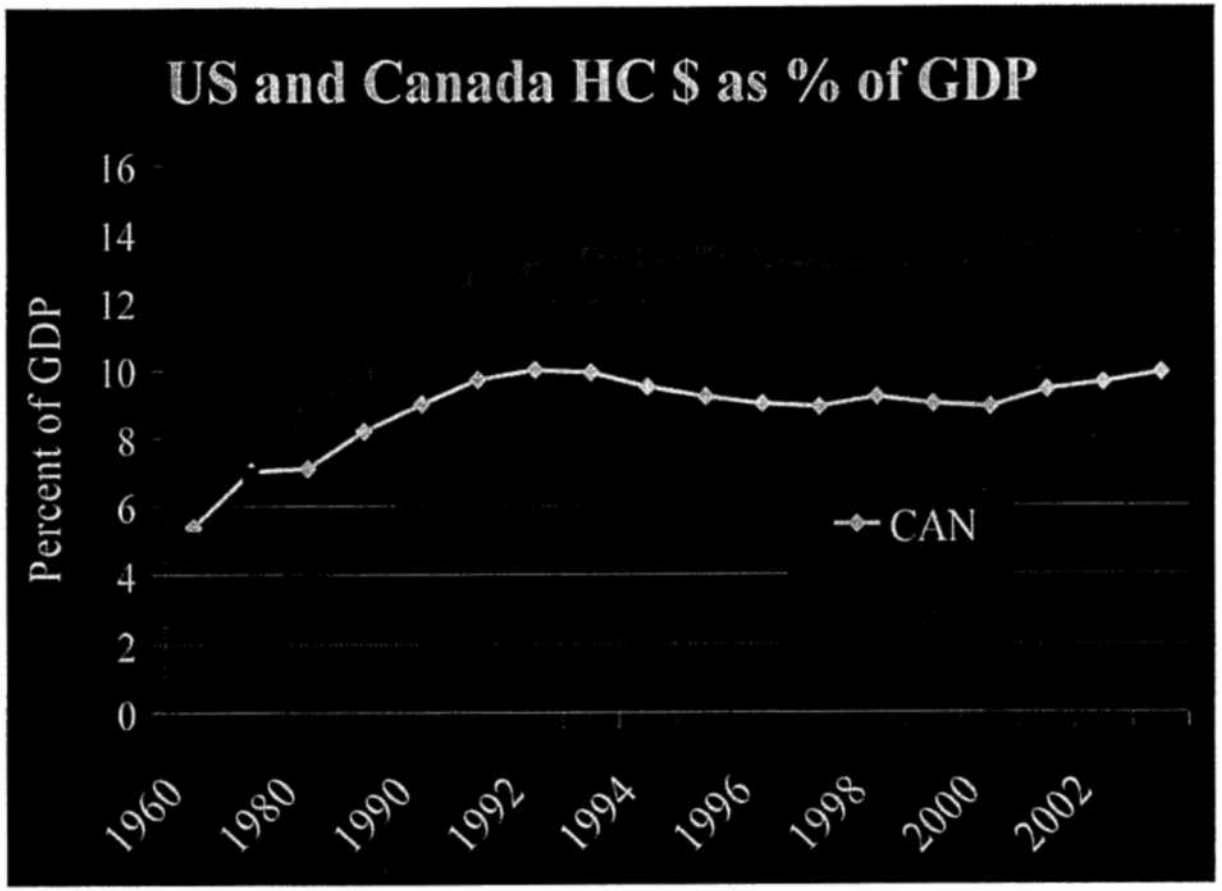
Long-term Projections for per Capita Spending on Healthcare and Other Non-health-related Items in Canada



Dhalla, I. CMAJ 2007;177:51-53 Copyright ©2007 Canadian Medical Association or its licensors

Is Medicare Sustainable?

(Compared to What)



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Does Medicare Deliver Quality?

PREVENTABLE MORTALITY RATES*
(deaths from treatable conditions)
in 2002-2003

Rank	Country	Rate
1	France	64.79
2	Japan	71.17
3	Australia	71.32
6	Canada	76.83
7	Norway	79.79
19	U.S.	109.65

* WHO data: Health Affairs, 2008;27:58-71

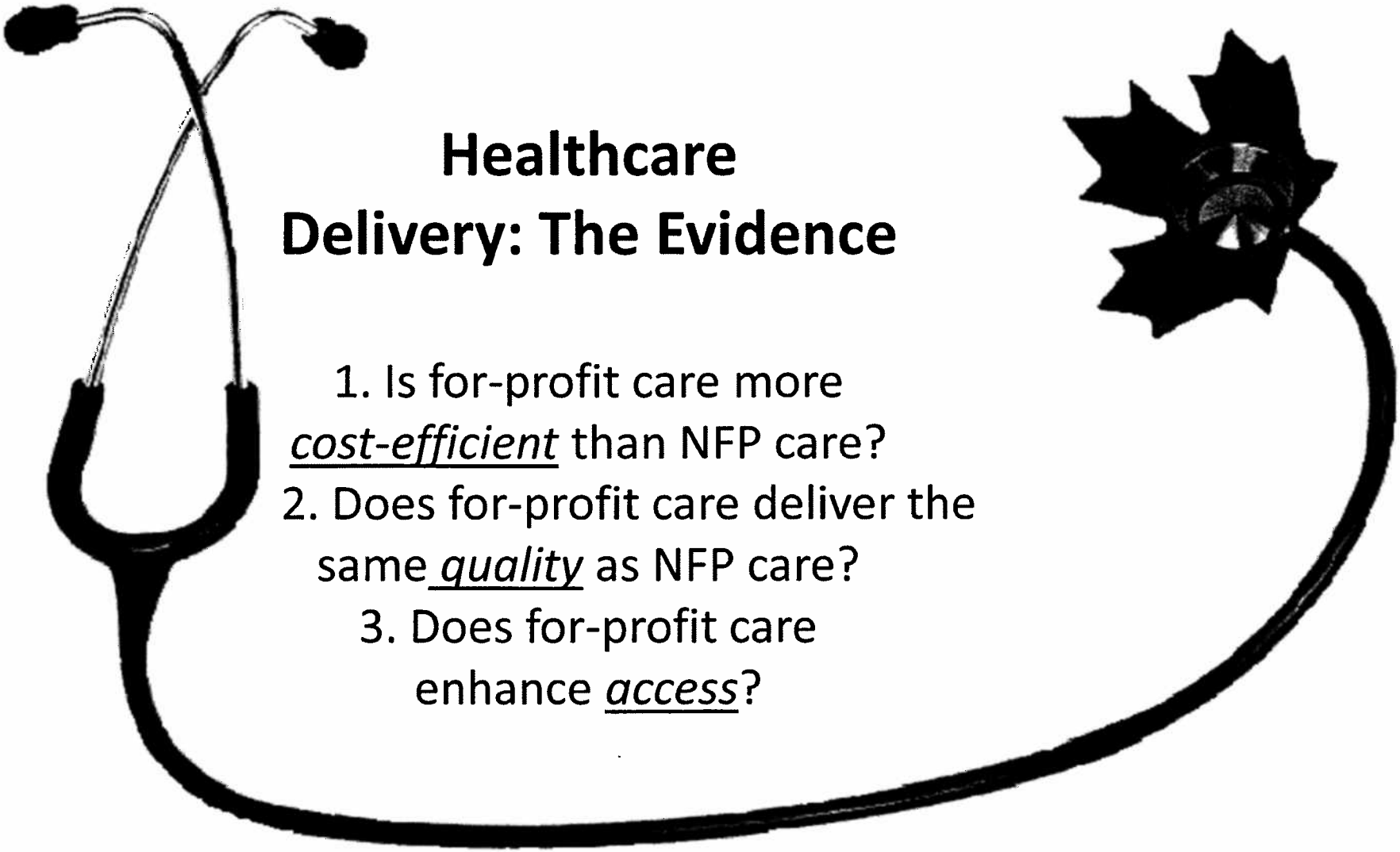
04

Private Financing – Conclusion?

"Although private health insurance can provide greater choice and access to services for those who can afford it, it has not been found to improve access to publicly insured services, lower costs or improve quality."

- It's About Access! Canadian Medical Association, 2006

042



Healthcare Delivery: The Evidence

1. Is for-profit care more *cost-efficient* than NFP care?
2. Does for-profit care deliver the same *quality* as NFP care?
3. Does for-profit care enhance *access*?

045

Cost

Is private for-profit delivery as *cost-efficient* as not-for-profit delivery?

044

Cost

Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis

Results: private for-profit hospitals result in 19% higher payments for care than private not-for-profit hospitals.

Devereaux et al, CMAJ • June 8, 2004; 170 (12)

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Quality

Does private for-profit delivery deliver the same quality of care as non-profit delivery?

047

Quality

A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals

Results: For-profit owned hospitals associated with ~2% more deaths

Devereaux et al. Can Med Assoc J 2004; 170: 1817

047

Quality

Even without aggregation of the data, there are three compelling reasons to believe the overall result…

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Quality

1. The finding of excessive mortality associated with for-profit hospitals recurs in one study after another in the meta-analysis. It also recurs in most of the studies that were excluded.

Quality

2. These studies are not clustered in one time or place. Excess mortality associated with for-profit hospitals is evident in separate comparisons covering most of the United States, over more than a decade in which the US health care system underwent a major transformation in finance and organization.

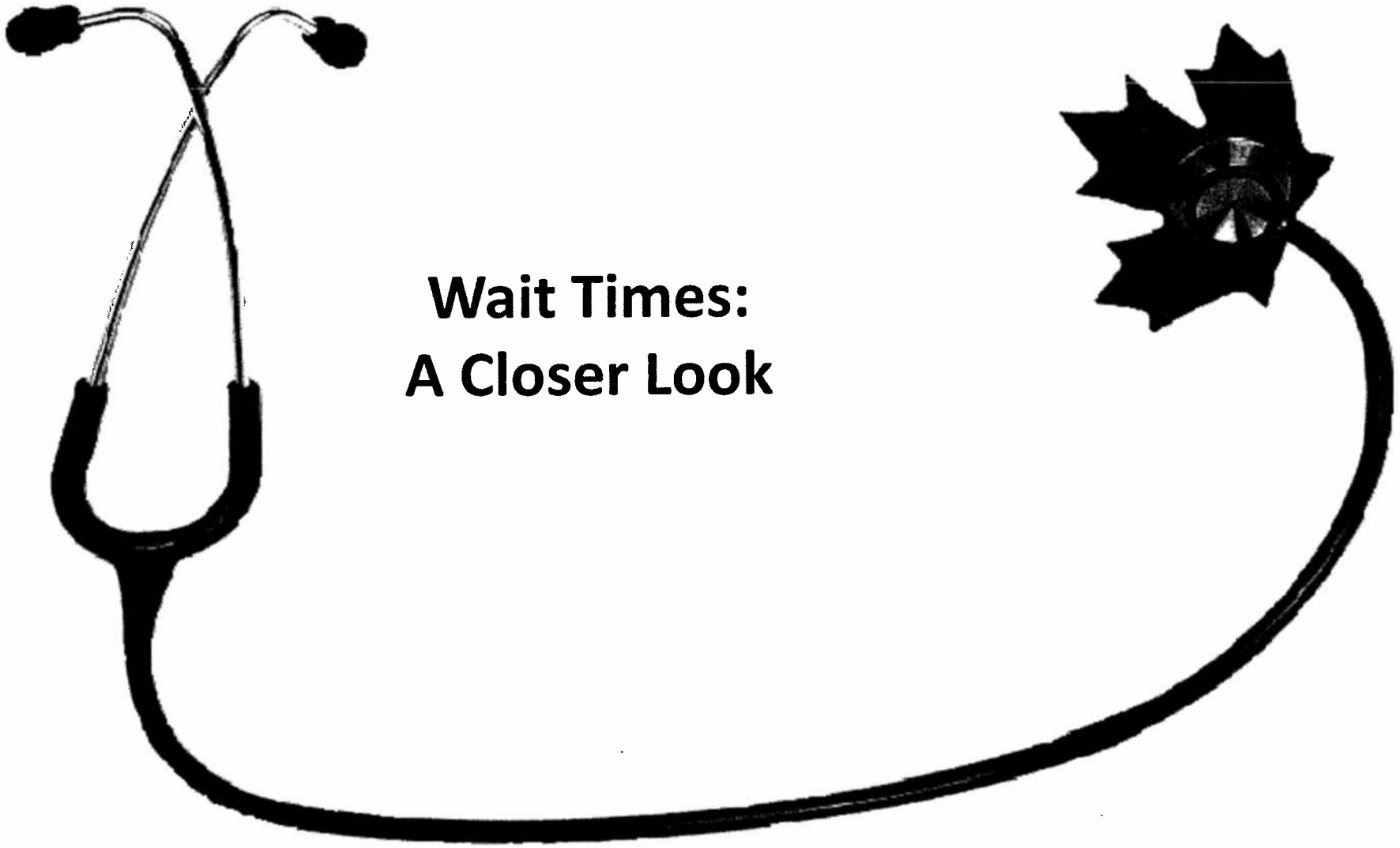
Quality

3. The authors' secondary findings lend strong plausibility to the overall conclusion. For example, individual study findings are consistent with the literature showing outcome advantages for teaching hospitals.

Access

Would increased private for-profit delivery improve access to care in Canada?

052



Wait Times:
A Closer Look

Primary Health Care

- Proportion of people who had difficulty getting care for a minor health problem:
  - 24%
- % of Canadians could get a same-day or next-day appointment with a doctor when they last needed care:
  - 36% (compared to 58% in the UK and 75% in New Zealand)

" Adopting team-based care continues to be a challenge for a number of reasons, including misgivings and misconceptions among the different professions about one another's roles and responsibilities"

– Health Council of Canada

Primary Care Wait Times

Challenges

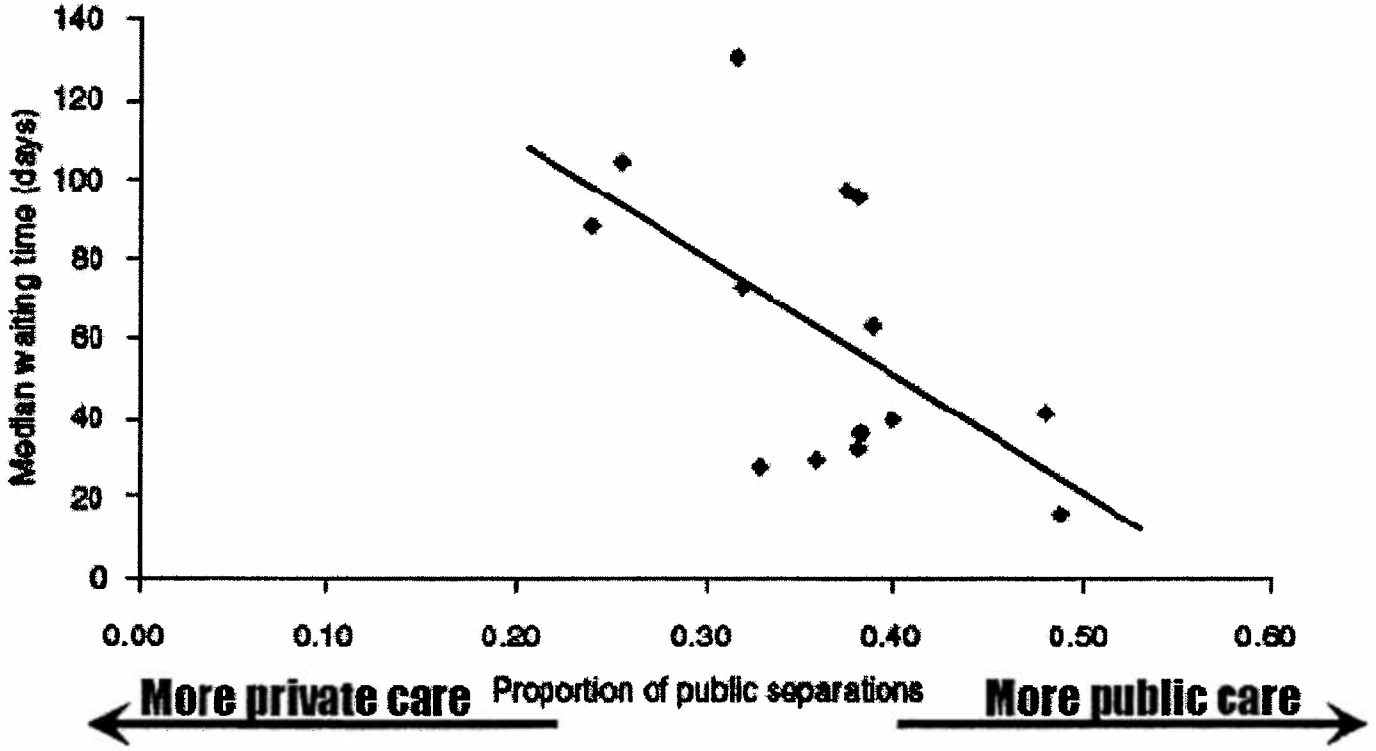
Restricting capacity:

- closed practices
- looming retirements
- changing practice patterns
- payment methods

Tom Bailey 2008

Access: Effect of Private Funding on Wait Times

Relationship between level of public activity and median waiting times by procedure, 2000–01



Duckett. (2005). Australian Health Review 29. 87.

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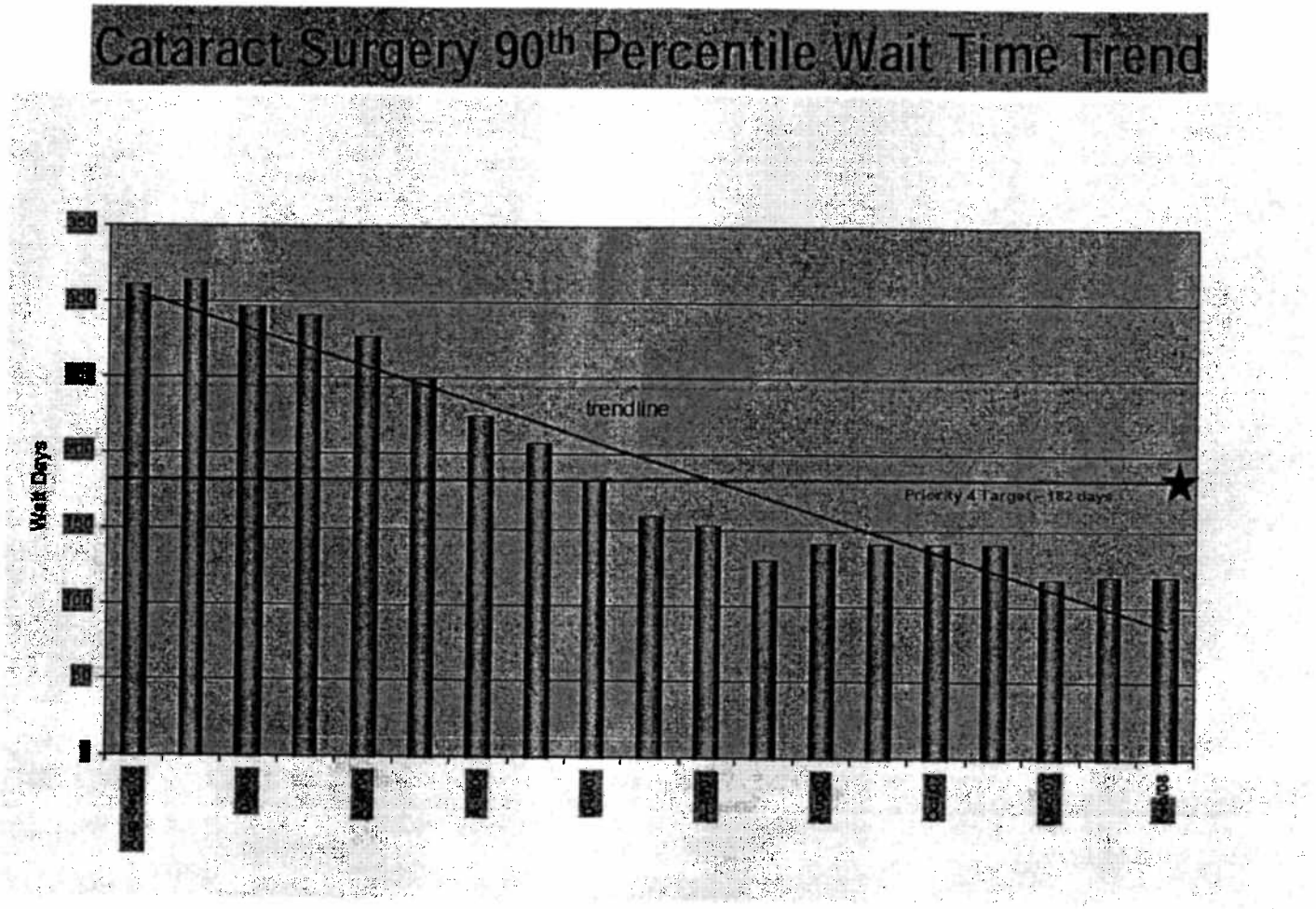
Building on Success in Ontario



Alan R. Hudson 2008

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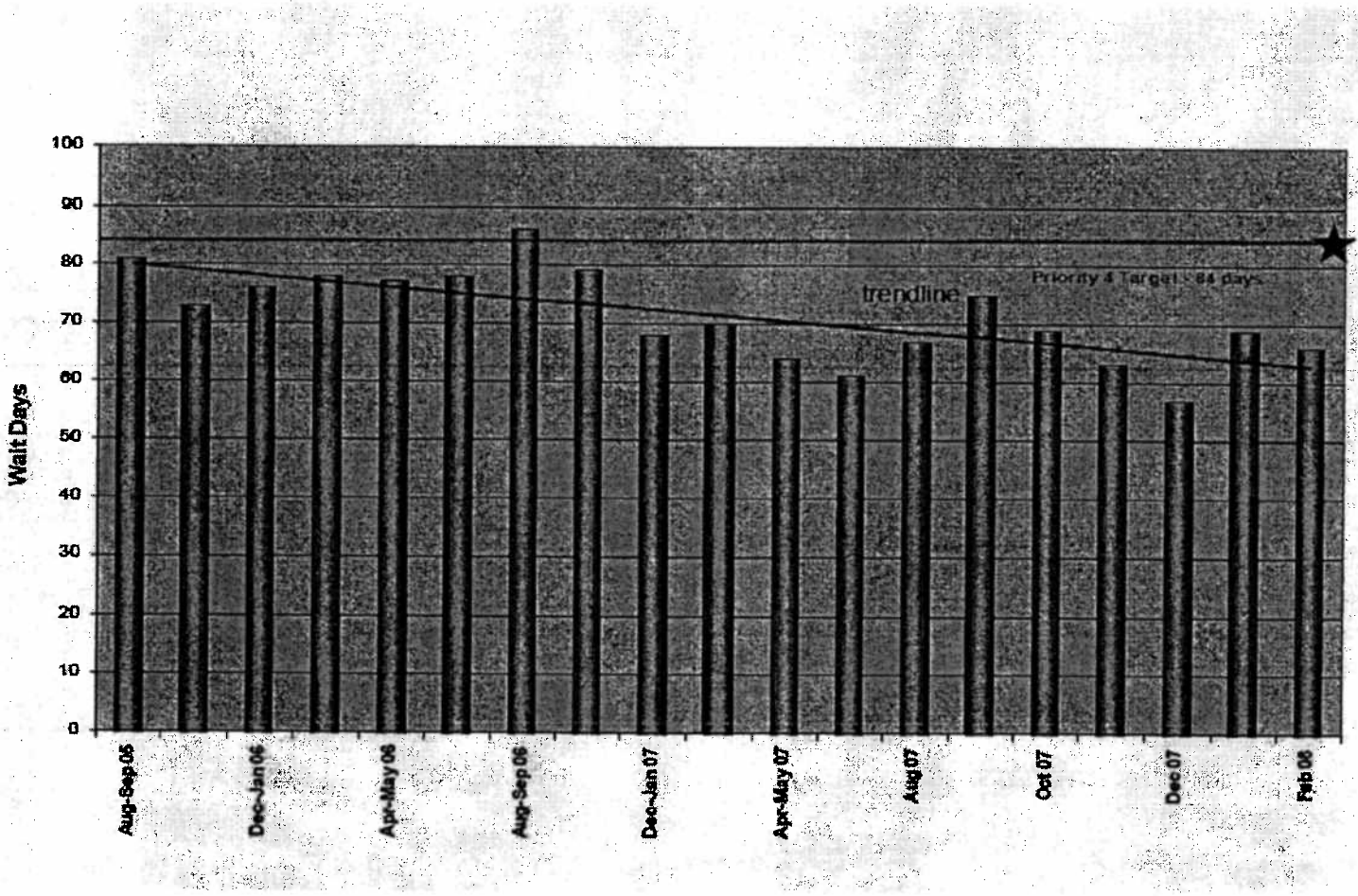
Cancer Surgery 90th Percentile Wait Time Trend



Alan R. Hudson 2008

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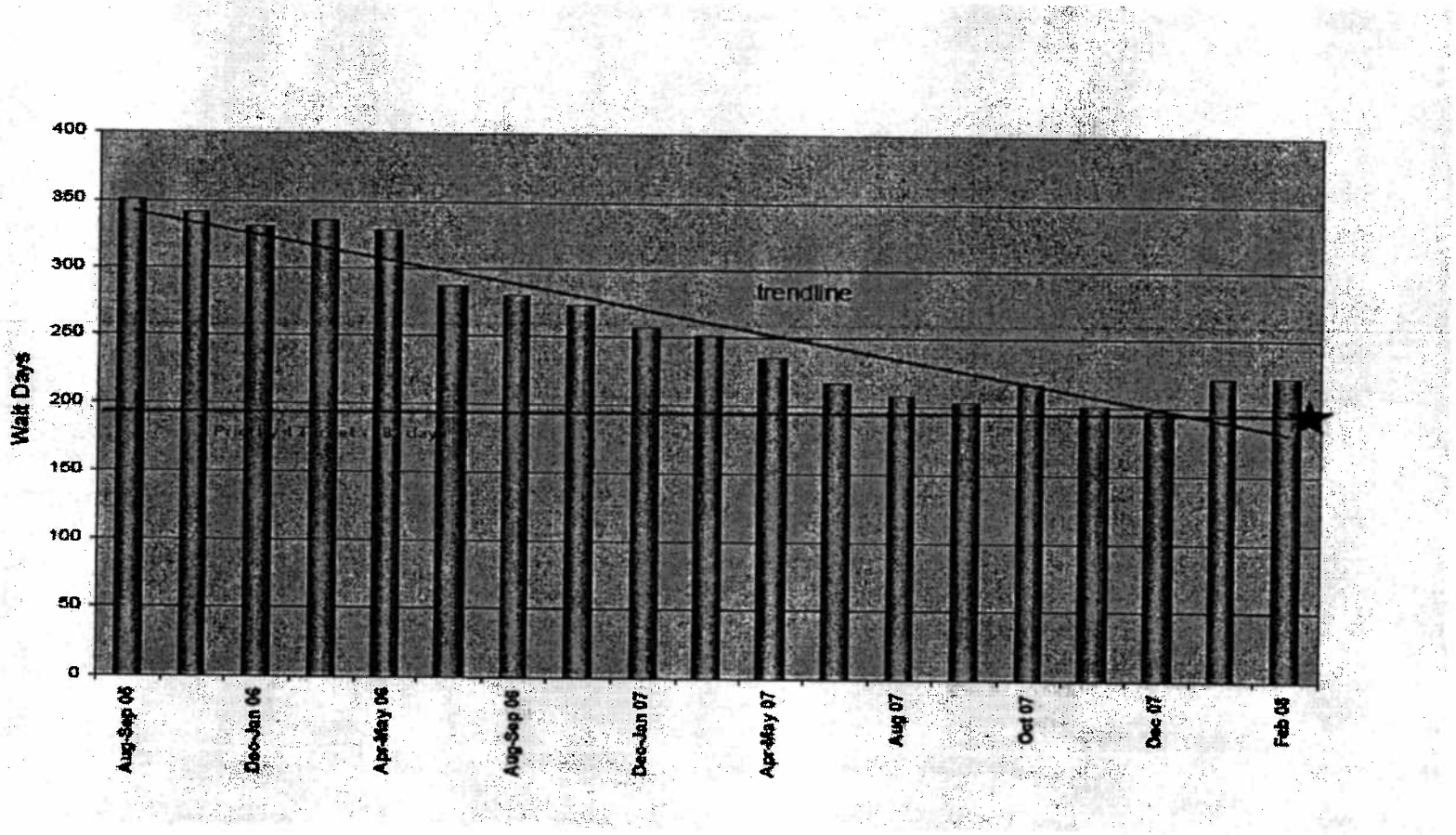
Hip Replacement 90th Percentile Wait Time Trend



Alan R. Hudson 2008

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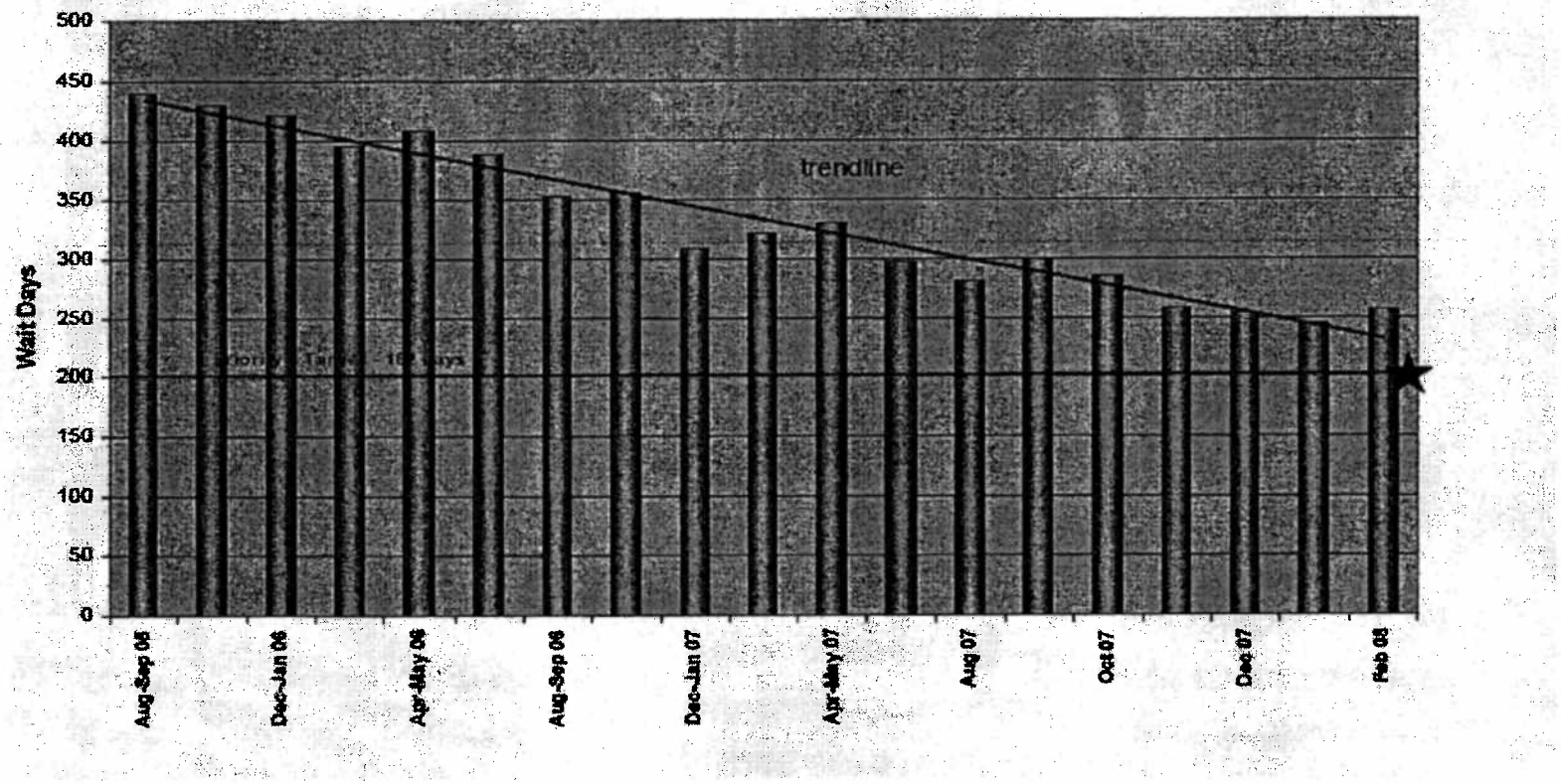
Knee Replacement 90th Percentile Wait Time Trend



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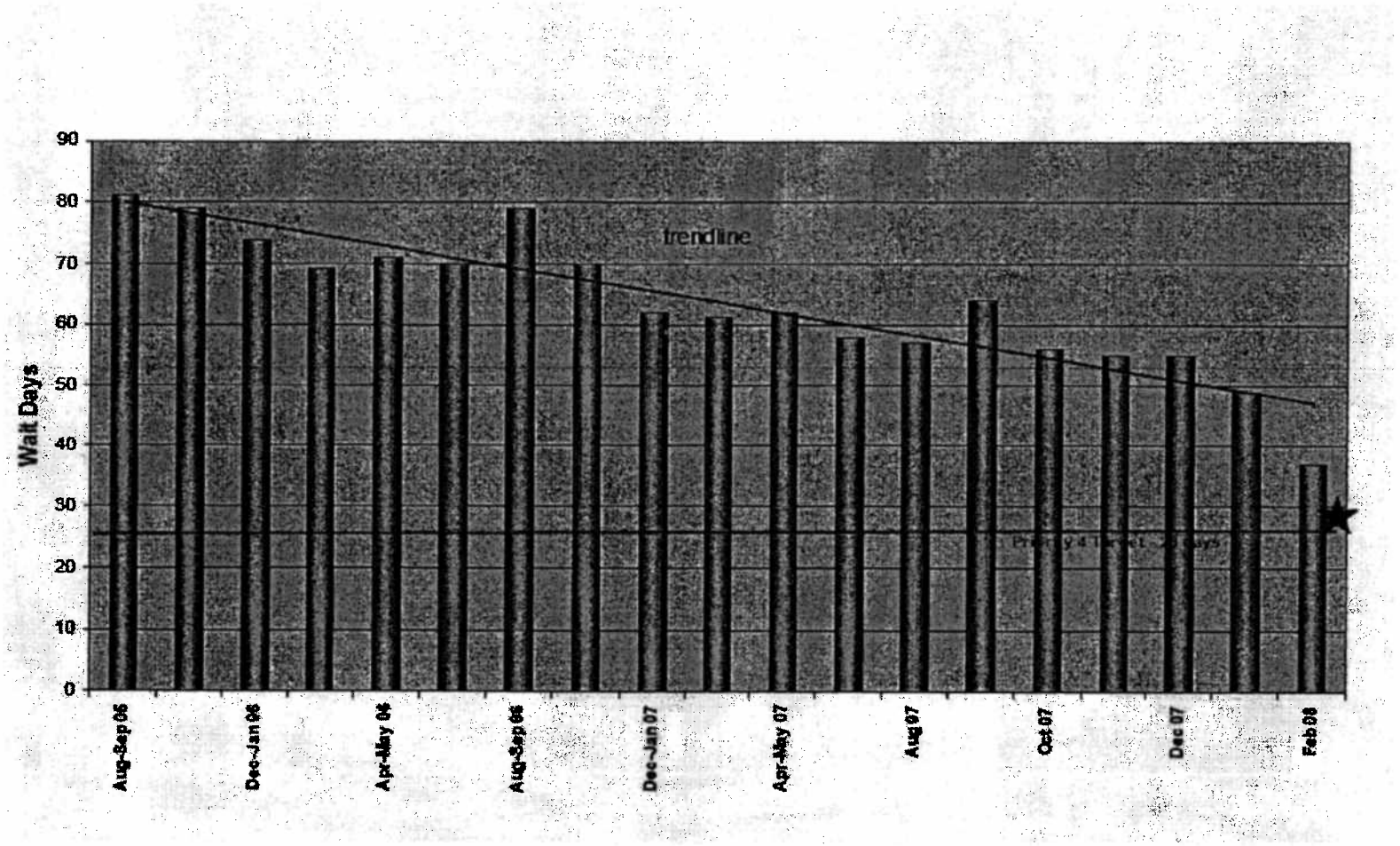
CT 90th Percentile Wait Time Trend



Alan R. Hudson 2008

Effective Waiting List Strategies

- A single common waiting list
- A wait-time champion
- Queuing strategies to improve current organizational processes
- Team-based care that enables providers such as nurses to assume broader clinical tasks
- Practices that ensure the right patient has the right procedure
- Pre-surgical programs that prepare patients for surgery

Postl, Brian. 2006. Final Report of the Federal Advisor on Wait Times. Health Canada. June.

Debate is More Than A vs. B

- The media typically portrays the options as two-tier vs. status quo, but there is a third option . . .

063

Access:
The Canadian Experience

1. Linking insured to uninsured services

   - Primary Care Clinics (e.g. Copeman)

   - Colonoscopy Clinics

2. Self-referral and cream skimming

   - Surgical Centres (e.g. Don Mills, Cambie, RocklandMD)

3. Queue-jumping

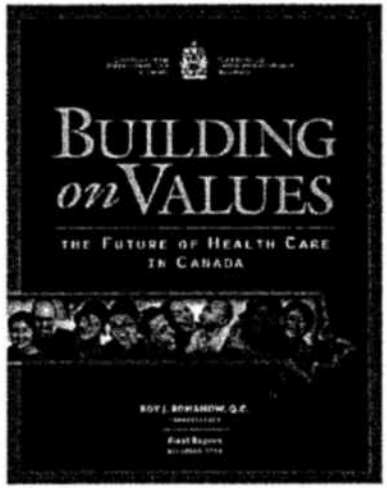
   - Surgical Centres

   - Urgent care centres (e.g. False Creek)

The Commission on the Future of Health Care in Canada

- Publicly funded, not-for-profit health care
  - Can better meet our needs than alternatives
  - Can be as sustainable as Canadians want it to be

- 47 renewal recommendations including:
  - Restoration of funding
  - Increased efficiency and innovation
  - Effective governance: balance between services, needs and resources
  - Creation of Health Council of Canada (www.healthcouncilcanada.ca)



Building on Values, The Final Report of the Commission on the Future of Health Care in Canada, November 2002 - Building on Values, Roy J. Romanow, Q.C., Commissioner

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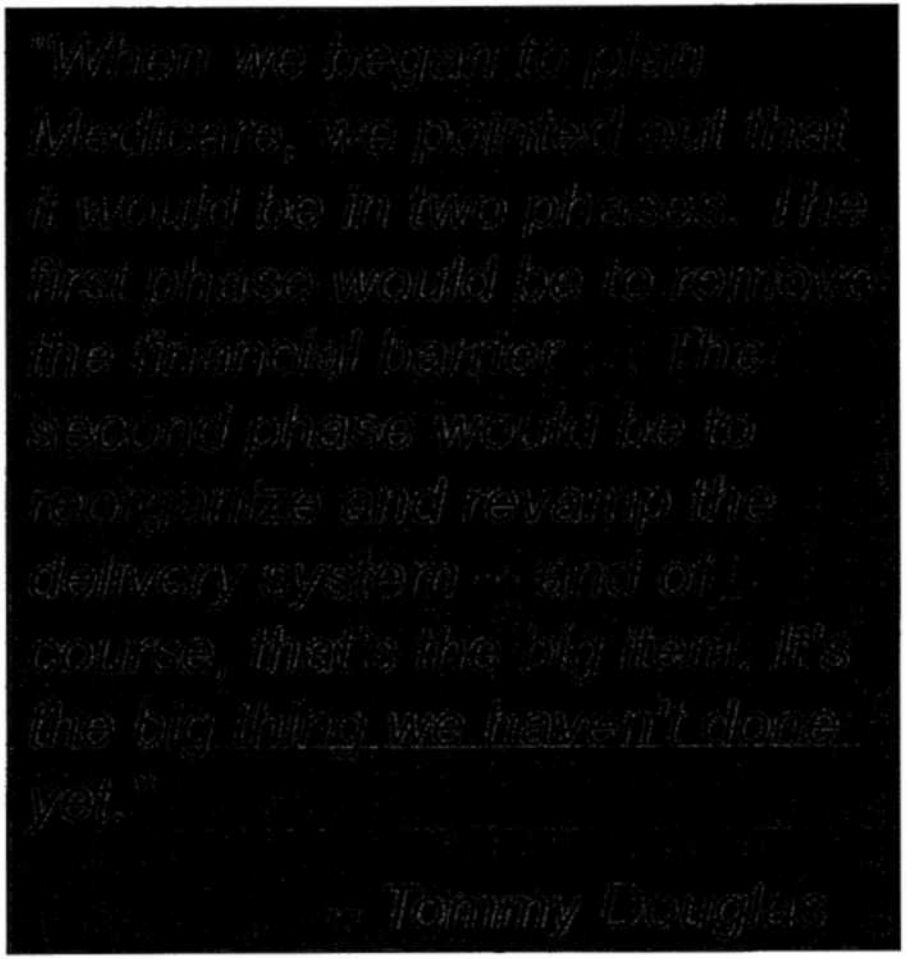
The 2nd Stage of Medicare



066

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The 2nd Stage of Medicare

- **Wait time initiatives**
  - Centralization of lists
  - Integration of care
- **Interprofessional Care**
  - Right provider, right place, right time
- **Illness prevention**
  - Obesity, immunization
- **Chronic Disease Management**
  - Self-care pathways
  - Home care and community-based care
- **Electronic Health Record**
  - Duplication minimization
  - Safety and quality

067

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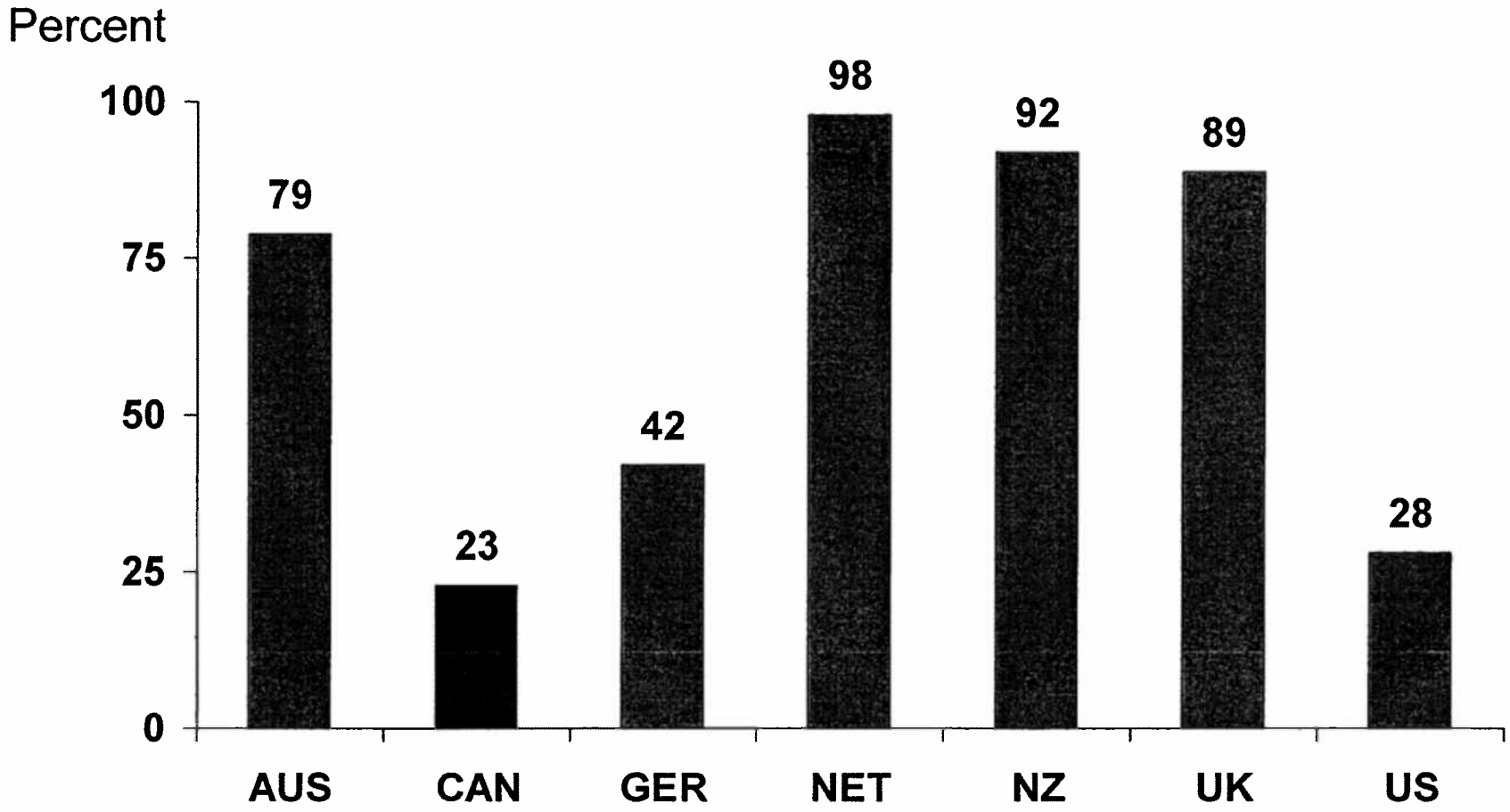
Primary Care Doctors Use of Electronic Patient Medical Records



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

Examples of Success

- Hamilton
  - –70% decrease in referrals to psychiatrists
- Alberta
  - Reduced wait times for hip and knee replacements from 19 months to 11 weeks
- Sault Ste. Marie
  - –50% reduction in readmissions of heart failure patients
- Nova Scotia South Shore
  - No ventilator associated pneumonias in 14 months…


A responsive, sustainable public
funded healthcare system exis
the highest expression of
Canadians caring for one another.
www.canadiandoctorsformedicare.ca

CDM MCRP

MQRP

This is Exhibit C referred to in the affidavit of Robert Woollard sworn before me, this 13 day of August 2009
A COMMISSIONER, ETC.

Backgrounder

Simply shifting costs from governments to individuals does not make a healthcare system sustainable, even if it helps governments "control" spending. It simply downloads the cost of health care to individuals.

THE SUSTAINABILITY OF MEDICARE

Why is there a debate about the sustainability of Canadian health care?

Some government, business and physician leaders have said we should expand the role of the private sector in the financing and delivery of health care, arguing that our current system of Medicare is not sustainable because of increasing costs; in particular prescription drugs, new technologies and pressures from an aging population.

However, there is strong evidence that a shift from our publicly funded system to private for-profit funding and delivery of health care would *not* improve sustainability, and would adversely affect overall health care system cost, efficiency, equity and accessibility.

What is sustainability?

A sustainable health care system is one that we as a society can afford now and in the future, and that provides good value for the money we spend on it. It means being able to ensure that Canadians receive high-quality care for a full range of health needs based on need and not ability to pay, within an agreed-upon framework of medically necessary insured services.

The argument that shifting more of the costs of health care from governments to individuals will make the system more sustainable is false. A shift may help governments "control" their spending, but it would have negative impacts on health care in terms of overall costs, quality and accessibility.

In this sense, the sustainability debate is really about *how* we should pay for health care, *how* services are allocated, and whether service should be provided through public funding based on need -- or private financing based on the ability to pay, which would benefit the wealthy, some physicians, insurance companies and investors.

Health care costs in Canada are not spiraling out of control

It is true that we spend more on health care today than in the past, but the claim that health care is taking over the government budget is misleading. Spending is increasing as a proportion of government spending but this is because of decisions governments made in the late 1990s to cut taxes and to reduce spending in other areas like education and social services, and does not represent a true increase.[i] In other words, health care appears to represent a bigger part of the pie because the pie has been shrunk. It would not be dominating budgets if tax rates had been maintained and spending on education and social services strengthened.

In terms of real spending based on national wealth, between 1970 and 2006, total spending on health care from private and public sources rose from 7% to 9.8% of GDP, with similar or larger increases occurring in all high income countries. It is estimated that this rate of growth is affordable for decades to come.[ii]

What about adding more private funding and insurance and reducing public spending?

In Canada, 70% of health care comes from the public purse; the remaining 30% from private health insurance or 'out of pocket' payments for services like prescription medicines, dental services and home care. Most OECD countries cover services such as these, *and* publicly fund *more* than 70% of overall health care costs.

Supporters of increased private funding argue that if we allow private insurance for medically necessary hospital and physician services, wealthier patients will be able to pay for care in private clinics, freeing up the public system for the rest of us. However, the evidence suggests otherwise:

- Australian data shows that establishing a parallel private insurance system increases wait times in the public system as nurses and doctors move to the private system.[iii] This is especially true in places like Canada with a shortage of health care professionals.
- Numerous studies show that privatization introduces *inefficiency* because of the heavy administrative costs associated with complicated accounting and billing schemes. The U.S., a country with a huge number of payors for health care, spends 30 cents of every health care dollar on administration.
- Leaving patients to pick up the tab does not control health care costs, it simply downloads costs to citizens. This might make Medicare more affordable for the government, but it would be less affordable for average Canadians and would thus threaten the principle of equity on which our system is founded.

Does this mean we should not be concerned about health care costs increasing?

It would be foolish to think that our publicly funded health care system does not need improvement simply because it is affordable for the foreseeable future. While most people who use the system report excellent service, there are significant inefficiencies and long-term challenges that must be addressed. Furthermore, regardless of how much we spend, or can

afford to spend, if we are not getting appropriate access to high quality care that actually improves the health of our population, we need to do better.

To improve value for money, increase cost efficiency and thus enhance the sustainability of Medicare, governments should:

1. Develop a public prescription drug program so that governments can negotiate with pharmaceutical companies for reasonable drug costs
2. Shift the focus from expensive hospital-based care to primary care, health promotion, disease prevention, and the social and economic determinants of health
3. Optimize the use of - and collaboration between - highly trained health professionals
4. Accelerate information technology solutions such as integrated electronic health records
5. Make strategic capital investments in equipment and buildings
6. Use health technology assessment to channel funding toward true innovation rather than well marketed gimmicks and me-too technologies with no added value
7. Address the shortage of health professionals
8. Improve physician and hospital funding mechanisms to encourage more appropriate delivery of care

Conclusion

Both the Canadian Medical Association[iv] and the Romanow Commission[v] concluded that private insurance would not improve access to publicly insured services, lower costs, or improve quality of care. Demographic changes and other cost pressures mean that we need to look seriously at health care in Canada. But increased privatization would mean that Canadians would pay more overall, and would likely see reduced access and poorer quality care. Canadians have expressed a strong desire to maintain the fundamental aspect of Medicare - providing care based on need, and not ability to pay. Thus based on the evidence, and Canadians' attachment to Medicare, our focus should be on how to get the most efficient and highest quality health care value for our public dollars.

---

[i] Dhalla, I. Canada's Health Care System and the Sustainability Paradox. CMAJ, July 3, 2007; 177

[ii] Dhalla

[iii] Duckett, S.J. Living in the parallel universe in Australia: public Medicare and private hospitals, CMAJ 2005; 173:745-747

[iv] Canadian Medical Association, It's about access! Informing the debate on public and private health care, June 2006

[v] Building on Values. The Future of Health Care in Canada, November 2002. (The Romanow Report)

This is Exhibit....D.....referred to in the
affidavit of .Robert Woollard...
sworn before me, this ...13.....
day of ..August.....2009...
A COMMISSIONER, ETC.

Backgrounder

INTERNATIONAL HEALTH SYSTEMS

What Canadian Health Care Can Really Learn from Europe and Beyond

Some participants in Canada's ongoing debate about the organization and financing of health care have argued that additional private funding will improve health care outcomes in Canada. The most common claim is that we should model our financing system on the ones currently used in Europe. However, the idea that changing to the European financing model would solve our health care problems is a vast oversimplification.

There is no such thing as the "European financing model." Each country in Europe has its own unique health care system, which evolved on a particular historical path due to the institutions, interests and needs specific to that country. In addition, every country, both in Europe and elsewhere, faces its own health care policy challenges. No country has developed a perfect way to finance, organize and deliver health care.

While Canadian health care policies should be informed by successful policy ideas and programs from around the world, none of the policies worth emulating require a shift toward private financing. In fact, many of the most high-performing European health care systems have substantially more public funding than Canada.[i] Below, we briefly review several health care systems from around the world and consider which features Canada should study more closely and which features we would be wise to ignore.

Australia

Overview - Most of Australia's health care is funded through taxation, much like Canada. However, unlike Canada, Australia currently uses a two-tier model of health care, with a large portion of the population purchasing additional and duplicative coverage through private insurance, despite public coverage available for all. Individuals purchase private insurance to get care more quickly and with more add-ons than are available through the public system.[ii] The government encourages the purchase of private insurance by subsidizing premiums.[iii] Another important distinction between Australia and Canada is that in Australia the federal government uses public funds to subsidize pharmaceuticals.

What We Can Learn - The government has had to spend billions of dollars supporting the private health insurance industry.[iv] Waiting lists remain long for publicly funded patients, especially in areas where more private care is available.[v] Private hospitals generally treat the healthier, more profitable patients—a typical feature of two-tier systems often referred to as "cream skimming."

In a recent report on public hospitals, the Australian Medical Association raised serious concerns about equity. They determined that after years of two-tiered medicine, the public hospitals "are in bad shape and are desperately in need of urgent recurrent and capital funding increases."[vi] And after a fact finding trip to Australia, two prominent Canadian hospital administrators came to the following conclusion:

> "We believe both Australia and New Zealand expanded their original small private hospital system as a quick fix, political solution but failed to appreciate the potential for this new system to negatively impact the future sustainability of their public hospital system."[vii]

In contrast, Australia's current pharmaceuticals plan offers a positive lesson for Canada. Australia grants citizens equitable access to drugs through subsidized government purchases and a national plan. Most individuals pay a co-payment of approximately AU$30 per prescription, but the cost is much lower for concessional card holders (the elderly and the poor). There are also patient/family limits on out-of-pocket pharmaceutical expenditure. After reaching a specific amount, most individuals pay for further prescriptions at the concessional co-payment rate, while concessional cardholders receive all further prescriptions free.[viii] Australia also uses reference-based pricing more widely than Canada. Modeling Australia's approach to pharmaceuticals could help Canada have more buying power and contain drug costs, one of the main reasons for the increasing cost of health care.

Germany

Overview – Most health care in Germany is funded through social insurance—employees and employers pay into non-profit 'sickness funds'. Because contribution rates do not depend on an individual's risk of needing health care, the system functions more like Canada's public insurance system than a private insurance model. Only the wealthiest Germans are permitted to purchase private insurance, and if they do they cannot subsequently revert to the sickness funds. Currently, a small number of citizens can choose to have no health coverage at all, but this option is being phased out by 2009, at which point Germany will have total universal coverage.

What we can learn - There is evidence from Germany, as well as from other European countries with similar systems, that preferential treatment for those with private insurance creates inequity.[ix] This makes sense, because in order to be more attractive than the public options, commercial insurers must provide care options that *appear* superior. According to the OECD, private health insurance members are both healthier and wealthier on average than social insurance members, and this leads to less efficient risk pooling.[x] These inefficiencies eventually increase overall societal costs.

Like Australia, Germany has more equitable coverage for drugs, and it also offers much better eye care through its public financing than is currently offered by Canadian provinces.

France

Overview – France has universal coverage, funded mostly through social insurance. Social insurance contributions come from employers, general tax revenues and employees. Patients are charged co-payments on most visits, although these are reimbursed either through complementary private insurance or via a government-subsidized scheme for those with lower incomes.

What we can learn – France is often considered to have one the best health care systems in the world. However, largely because of co-payments that must be paid up front, many studies have shown access to health care in France is inequitable – not all citizens are getting the benefits of its successes.[xi] Also, for

many years France's social insurance funds accrued large deficits, although more recently the financial situations of the funds have improved.

Since 1990, France has shifted its source of health care financing from employee contributions to taxes. In 1990, employee contributions accounted for 32.2% of financing; by 2000, the number had dropped to 3.4%. In addition, the government has begun to play a larger role in influencing health care delivery.[xii] Though the financing methods are still quite different, the fact that France has been moving closer to the Canadian funding model over the last 18 years while reducing its deficit suggests that our model of financing is worth keeping and helps keep costs more manageable.

France also has many more physicians than does Canada—3.4 per 1000 compared to 2.1 per 1000.[xiii] One reason why France can afford more physicians is that doctors are paid less in France than in Canada. For a number of important reasons, including the proximity of the United States, reducing wages in Canada would likely not lead to improved physician supply. While increasing medical school enrolment in Canada is helping to alleviate the physician shortage, it is clear that we must achieve and maintain a higher physician-to-population ratio. This is likely to prove more expensive in Canada than in Europe.

Japan

Overview – Japan offers its citizens a public health insurance system with two methods of payment. Corporate employees pay through employer-based insurance, while the National Health Insurance plan offers coverage for self-employed individuals and students. The gatekeeper model of using primary care physicians does not exist in Japan. Patients do not need to make appointments and can see any specialist at any time. In Japan, physician fees are strictly regulated by the national Medical Fee Schedule.

What We Can Learn – Because Japan has no gatekeepers, it probably spends too much on unnecessary treatments and unnecessary tests. This suggests that Canada's current model, where family doctors perform a gate keeping function, is wise. It limits the overuse of specialists and prevents the system from wasting money on unnecessarily expensive care.

Despite the lack of gatekeepers, Japan has very low cost health insurance due to strict price controls. But fewer limitations on fee-for-service care than in Canada have probably led to excessive testing and prescribing by physicians to make additional income.[xiv] Historically, Japanese physicians have also been able to increase their incomes by dispensing medications, and this may be one reason why the Japanese are among the highest users of prescription drugs in the world.

Singapore

Overview – Singapore has a health care model that emphasizes individual responsibility. Citizens pay into Medisave, a compulsory savings account administered by the government. Every person is required to put 6-8% of their income into these medical savings accounts, which they then use to pay for some but not all medical expenses. Individuals are also encouraged to purchase insurance from the government's MediShield program, which offers citizens coverage for catastrophic illness.

What We Can Learn – Singapore's health care financing arrangements have been closely studied because of the extensive use of medical savings accounts (MSAs) and because of its relatively low health care costs. Medical savings accounts have also become increasingly popular in the United States, particularly

among individuals who believe the best way to contain health care costs is by enhancing "consumer choice."

Although MSAs do meet the needs of young, affluent and healthy people who need little care in the present, they are ineffective for everyone else, especially the poor, the elderly and the sick.[xv] Comprehensive data which would enable one to adequately assess the effects of MSAs in Singapore on equity, efficiency and quality are unavailable. However, most experts believe that the financing arrangements function only because the government contains costs by limiting the provision of health care. For example, Singapore has strongly restricted access to new technologies and has strictly limited the percentage of specialists allowed in the overall physician workforce.[xvi]

Sweden

Overview - Sweden offers universal coverage to its citizens, funded through local and federal taxation. Local governments have considerable freedom to determine the best way to deliver health services to their populations. Sweden allows supplementary private health insurance for faster access to care, but only about 2.5% of the population takes advantage of this.[xvii] Although residents pay fees for all visits to doctors in the public system, these co-payments are very small (usually a few dollars per visit) and annual caps are low (about $15 dollars for doctor visits and $30 for medications).

What We Can Learn – Despite the opportunity to use private health care insurance and providers, most Swedes prefer to use the public system. Attempts at privatization in some of the local counties have led to resistance.

Sweden has been stressing integrated care in its health care system. This involves a variety of care providers, such as local hospitals, health centers, and social services, which coordinate their services in order to meet patients' needs.[xviii] Canada has been working toward this model recently as well, but we can and should do more. From a practical standpoint, public health care makes instituting successful integrated care much easier than disjointed and competitive commercialized care.

In areas where Sweden has implemented activity-based funding, payments fall once a specified volume of activity has been reached. This limits a hospital's ability to unnecessarily increase activity just to increase its revenues.[xix] If Canada should increase its activity-based funding, a similar policy could be considered.

United Kingdom

Overview – The National Health System is funded almost entirely through taxation. Almost all services are free at the point of use. Prescription drugs are also covered, without co-payments for most residents. Residents may also purchase private insurance, which can be used to expedite care at private hospitals.

What We Can Learn – Primary care doctors in the United Kingdom are much more likely than in Canada to work in teams. Moreover, 89% of medical records used by primary care doctors in the UK are electronic. In Canada, the comparable figure is 23%. Electronic medical records can help limit duplication, over prescribing, and make overall patient management easier.[xx] A publicly funded but independent agency, the National Institute for Health and Clinical Excellence, was established almost 10 years ago to provide national guidance on promoting good health and preventing and treating ill health. This guidance has been used to establish standards, monitor progress and reduce inequities in care.

Increased public funding and the establishment of national wait time targets, combined with clear lines of accountability and incentives, have also led to sharp reductions in wait times for all diagnostic tests, outpatient specialist visits and elective surgery. Though provinces like Ontario have been very successful in reducing wait times in select priority areas[xxi], we may find more success if provincial governments were to review the British example for more opportunities to excel.

Canada should also consider following the British example when it comes to paying for drugs and influencing physician prescribing. Pharmaceutical spending in the NHS grew at 1.7 per cent last year, compared with 7.2 per cent in Canada.

United States

Overview – Health care in the United States is funded mainly through tax revenue, private insurance and out-of-pocket payments. Further complicating this mix is the extensive use of tax incentives. Private insurance is prohibitively expensive if purchased individually, so it is available primarily through employment. Publicly funded health care is available for people who are 65 and over and for those who are very poor, along with some children, people with disabilities and pregnant women. The U.S. currently spends more on health care per capita and as a portion of GDP than any other country in the world, and is the only industrialized nation where a substantial portion of the population lacks health insurance.

What We Can Learn – Though it may be surprising, we can learn several positive things from the U.S. health care system. Medicare, the publicly funded program for the elderly, illustrates clearly how administrative costs can be reduced with publicly-financed health care. A study revealed administration costs for traditional fee-for-service U.S. Medicare were 3.5% of total costs, while for commercial carriers, administration was 19.9% of costs.[xxii]

The Veterans Health Administration in the U.S. offers compelling evidence of the success of publicly funded health care within the most corporate health care system in the world. Once thought of as an example of bloated bureaucracy, the VA has turned itself around in the last fifteen years by looking for solutions outside the competitive market approach. Its outcomes have improved such that it is outperforming the private sector in several areas, including patient satisfaction.[xxiii] These results have come from a central health administration that emphasizes preventative primary care, has a successful national electronic patient record system and offers veterans an affordable, evidence-based prescription plan.[xxiv]

Conclusion

Our around-the-world tour illustrates the unique features of several health care systems, and explains that private funding does not lead to improved quality, equity or efficiency internationally. It is important to point out that no nation has achieved equity in health care, let alone equity in health. All countries should be working to improve equity as well as quality and efficiency in the health care sector. Canadian health care could be improved if we spent more time and energy studying some of the successful innovations in promoting access and efficiency from other countries and from within our provinces. These innovations can and should be incorporated within Canadian Medicare. We currently waste too much energy debating commercial solutions. Doctors should know better than to continue to debate solutions unsupported by evidence. We can continue to improve on a good health care system; we just need to prescribe the right solutions to the challenges that face us.

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This is Exhibit E referred to in the affidavit of Robert Woollard sworn before me, this 13 day of August 2009

A COMMISSIONER, ETC.

CDM BULLETIN: THE CHAOULLI DECISION

What the Supreme Court said and what it means for Canadian healthcare

What is the "Chaoulli case"?

Chaoulli v. Quebec (Attorney General) involved a patient who had to wait several months for hip replacement surgery. Together with his physician, Dr. Jacques Chaoulli, the two challenged the Quebec law that prohibited private health care insurance for publicly insured health services. They argued that these provisions offended rights guaranteed by the Canadian Charter of Rights and Freedoms and its Quebec equivalent. Although the case was dismissed by both the trial court and the Quebec appeal court, the Supreme Court agreed to allow an appeal, which it heard on June 8, 2004.

On June 9, 2005, by a majority of 4-3, the Supreme Court of Canada ruled that Quebec's ban on private insurance for publicly insured health care services violates the Quebec Charter of human rights and freedoms. Three of the same four judges also concluded that the ban violated the Canadian Charter, while three judges held that it did not, with the seventh judge not voicing an opinion on the matter. As a result, while the Court ruled that there was a violation of the Quebec Charter, it did not rule that there was a violation of the Canadian Charter.

What does the decision mean?

While the decision has been trumpeted as a victory by advocates of privatization and two-tiered health care, this is not the case. The direct consequences of the Court's ruling are, in strict legal terms, limited to the application of the Quebec Charter and to the province of Quebec.

In addition, the judges allowed the Quebec government considerable latitude to address the Court's concerns about waiting lists and the timeliness of treatment, while maintaining a single-tier publicly funded health care system.

The 4 judges merely concluded that the Quebec Charter guarantees a right to private insurance **where the public system is inadequate.** Thus, the Court's decision was explicitly based on the failure of Quebec's public health care system to provide reasonably timely access to health care in the mid-1990s, before government reinvestments into the public healthcare system. It did not rule that a parallel private insurance system is constitutionally guaranteed, nor did it hold that a single-tier publicly insured system is unlawful. It merely stated that under the Quebec Charter, if the public system fails to deliver care within a

reasonable time (including through publicly funded wait time guarantees), individuals have the legal right to purchase private insurance.

> It is important to understand that even the judges who ruled there was a violation of the Quebec Charter did not conclude that citizens had a freestanding right to private insurance.

If not the end of Medicare, then what?

As a result, and contrary to the claims of the pro-privatization lobby, the decision is not the end of Medicare. In fact all of the justices of the Court acknowledged the importance and validity of the Canada Health Act, and at least four of the seven judges explicitly recognized the right of governments to enact laws and policies which favour the public over the private system and preserve the integrity of the public system. This includes limiting the number of physicians who can opt out of the public system, preventing physicians from practicing in both the public and private systems, and ensuring that the price for services provided privately do not exceed the publicly insured amount.

In fact it is arguable that Quebec (and other provinces) already satisfy (or are well on their way to satisfying) "reasonable" expectations about the delivery of timely care. This is because the foundation for Chaoulli's case arose from the circumstances of Quebec's health care system in 1997, before the Quebec government began to address the issue of waiting times. However, the situation in Quebec today, as well as in other provinces, is different than it was in Quebec in 1997. Furthermore, since 1997, the Romanow and Kirby Reports, as well as several federal-provincial health accords and provincial strategies have begun to seriously address the question of waiting times.

It is also important to recognize that the Court 's reliance on health care systems in European countries has been widely criticized, as a result of its failure to recognize the comparative evidence that wait times in the public system are actually longer in those countries with parallel private insurance. As well, the majority decision has been criticized for misunderstanding the relationship between private and public insurance in the majority of European countries that permit private insurance, since in those countries, private insurance does not allow those who can afford it to jump the queue and obtain preferential treatment.

> "In a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status ... Patients who are in greater need of health care are prioritized and treated before those with a lesser need...
>
> For all these reasons ... it is not "arbitrary" for Quebec to discourage the growth of private sector health care. Prohibition of private health insurance is directly related to Quebec's interest in promoting a need-based system and in ensuring its viability and efficiency.
>
> - Justices Binnie, Lebel and Fish (dissenting justices), Chaoulli decision

Canadian Doctors for Medicare Position on Activity-based funding in Canadian Hospitals and other Surgical Facilities

1. Introduction

In recent months there has been advocacy by some in Canada, including the leadership of the Canadian Medical Association, to shift away from hospital block grants and other budgeting mechanisms, and to instead fund hospitals through an "activity-based" or "patient-focused" method, linked to the number and type of patients seen. As Canadians consider the best mechanism for funding hospitals, it is useful to review how this type of "à la carte" or "fee-for-service" funding works in other nations, and what the positive and negative consequences of such a transition might be.

Hospital funding mechanisms should be consistent with the following four goals:

1. promote appropriate and rapid **access** to medically necessary hospital care
2. facilitate and ensure the highest **quality** of care possible
3. ensure **equity** of access as much as possible across the population
4. ensure that **costs** to our publicly funded health care system are not inflated by profit-making at the expense of the public good.

There appear to be inconsistencies in our collective understanding of what activity-based funding is, how it works, and how it doesn't. This position paper attempts to foster enlightened discussions amongst Canadians, informed by a common knowledge base. It describes the current design of Canadian hospital funding, briefly reviews activity-based funding in selected countries, and outlines the position of Canadian Doctors for Medicare (CDM) on activity-based funding.

2. What is activity-based funding?

Widespread confusion exists around the jargon used to describe different ways of funding hospitals. **Activity-based funding** (ABF) is also known in the UK as **payment-by-results** (PbR), as **patient-focused funding** (PFF) by the Canadian Medical Association, as **service-based funding** or **case-mix funding** by the Kirby Commission, as **prospective payment system** (PPS) in the US, and elsewhere as **payment-for-volume**, or **volume-based funding**. We use the relatively neutral term of activity-based funding, because the focus is not necessarily on the patient, but rather on the type and volume of service delivered.

Under ABF, the services that patients receive in hospitals for a particular illness are classified into clinically meaningful groups that use similar levels of hospital resources. These groups are known in the US as diagnosis-related groups (DRGs). DRGs are analogous to health-resource groups (HRGs) in the UK. Both DRGs and HRGs use complex algorithms to classify patients into groups that are homogeneous in their use of resources. Hospitals receive a fixed amount for treating patients diagnosed with a given illness to whom a specific bundle of grouped services is delivered (on average), regardless of the length of stay or type of care received. The money follows the patient to the facility that provides the service, with the amount paid to the hospital based on the specific "activity" or service bundle provided per patient. Thus, hospitals do not receive a budget from the government

This is Exhibit F referred to in the affidavit of Robert Woollard sworn before me, this 13 day of August 2009

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based on what was spent last year, but instead receive money based on the numbers of patients seen with a given medical problem and DRG classification.

3. Pay-for-performance (P4P) is *not* Activity-based funding (ABF)
Pay-for-performance (P4P) is ***not*** the same as Activity-based funding (ABF) but it is being confused with P4P by contributors to the debate.[1, 2] P4P is simply an incentive program that provides extra funding to hospitals that meet certain efficiency targets or to physicians whose patients achieve certain health outcomes. In other words, whereas P4P links money to specific *health outcomes or efficiency targets,* ABF links money to the *volume* of activity.

These two concepts — activity-based funding and pay-for-performance — should not be confused.

The following examples of P4P are provided to illustrate the point that P4P is about achieving outcomes and targets, not about activity or volume:
In 2003, the Centers for Medicare and Medicaid Services (CMS) launched the largest P4P pilot project in the US. The objective of the study was to determine whether P4P was associated with improved processes of care and outcomes or with unintended consequences for acute myocardial infarction.[3]

In the UK, P4P has had mixed results, and has led, in some cases, to manipulation of facility and physician performance data through "creative accounting" techniques such as gaming of clinical and non-clinical data, and fraudulent reimbursement claims.[4]

In Canada, the Emergency Department Decongestion Pay for Performance pilot project (in Vancouver) is an example of a P4P initiative that rewards four hospitals with financial incentives if they meet or exceed specific time targets for moving emergency department patients into hospital beds or back to the community.

4. Who owns Canadian hospitals and how are they currently funded?
Canadian hospitals are mostly not-for-profit entities owned by community-based organizations, by religious orders, or rarely by universities or municipal/provincial governments. Except for some psychiatric hospitals, provincial and federal governments rarely own hospitals. Most hospitals, however, are funded by the provincial/territorial department of health.[5]

Capital projects (the bricks and mortar of hospitals) function on a project-based model for funding across Canada. By contract, hospital *operating* costs are funded through a variety of budgeting methods summarized below and outlined in Table 1 (adapted from Kirby, 2003). In some cases, hospitals rely on a primary funding method, supplemented through a number of secondary methods to apportion lesser amounts. Population-based, ministerial discretion, and global budget approaches are the most common primary funding methods.

1. ***Line item***: involves negotiating amounts for specific line items in a budget. The sum of all line items equals the total hospital budget. Line item budgeting allows a ministry to link specific policy objectives with the amount of funding allocated to a

particular objective, and has the benefit of allowing for predictable budgets. The limitations of line item budgeting include inflexibility to move funds from one line to another thus reducing the link between activity and community need, a lack of efficiency because the focus is not on performance or volume, and the amount of effort required to scrutinize line-by-line budget detail.

2. ***Ministerial discretion***: decisions are made by the provincial minister in response to specific requests. This method allows the greatest flexibility and has the fewest constraints, but it is also the most subjective, lacks transparency, and places funding at risk of being politicized by interest groups.

3. ***Population-based***: uses demographic data to forecast demand for services. Demand for services based on patient characteristics is matched to average service costs, and a budget is derived. Individual hospitals or regional health authorities (RHAs) with different demographic characteristics are funded differently, but equally.

4. ***Global budgets***: use the previous year as the cost-basis, and then for the upcoming year use a multiplier or add a lump sum amount. Global budgets are straightforward to calculate, and allow hospitals maximum discretion in the efficient use of funds. The downside of global budgets is that there is no direct link between budgets and services, inequities across budgetary categories may be perpetuated, and efficiency is not necessarily rewarded. Most significant is that there is a loss over time of true cost basis for services because hospitals rely on the original, and possibly inaccurate or outdated, cost calculations as the starting point for annual changes to the budget. This absence of data is important in any consideration of shifting to activity-based funding because in many cases, depending on the type of budgeting currently in place, there is no solid cost basis for deciding what a DRG should be "worth" either provincially or nationally.

5. ***Policy-based***: funding is distributed to achieve certain policy objectives, such as minimum length of stay. This supported the implementation of health policy-based standards in hospitals, but also can be unpredictable if policies change from year to year, or from government to government.

6. ***Facility-based***: uses hospital characteristics, such as size, level of care, rural vs urban, teaching vs non-teaching, or occupancy to determine budgets. This method accommodates certain features of hospitals, but doesn't account for demography or disease patterns.

7. ***Project-based***: distributes funds to various hospitals to implement government-initiated policy, typically for a one-time need.

8. ***Service- or activity-based***: described in detail throughout this paper.

Table 1. Methods of hospital funding, by province

Province	Basis for Hospital funding	
	Primary funding	**Secondary funding**
British Columbia	line item	policy-based
Alberta	population-based	policy-based
Saskatchewan	population-based	none
Manitoba	ministerial discretion	none
Ontario	global budget	policy-based population-based service-based facility-based
Quebec	global budget	policy-based population-based
New Brunswick	line item	none
Nova Scotia	ministerial discretion	none
PEI	ministerial discretion	none
Newfoundland	ministerial discretion	none
Territories	unknown	unknown

5. Why is activity-based funding now being considered in Canada?
Some argue that ABF would provide an incentive to improve productivity, thereby decreasing waiting times and costs. The argument goes that if hospitals rely on high volumes of "activity" to get their funding, then they will perform more procedures and see more patients, thereby reducing waiting times.

This argument assumes, of course, that hospitals are not currently performing at their maximum volume (in other words, that there are both underutilized human resources and facility space), and that if volumes increase, there will be adequate funding available from governments to pay for those increased volumes. Theoretically, it is certainly true that if governments increase available funding and then give it to hospitals *per procedure* or *per patient treated*, waiting times could be reduced – as long as the money available is sufficient and there are clinicians and space available to treat those patients.

Promoters of ABF in Canada, however, often have a second component to their argument. They advocate for an increase in the number of private for-profit clinics and surgical centres, that would "compete" with hospitals for government activity-based funding, thus forcing hospitals to improve their productivity. The basis for this argument is not so much grounded in actual evidence, but more in a belief in the primacy of the market and the principle of competition. It also assumes that there are sufficient doctors, nurses, and other healthcare providers to staff both private for-profit clinics/surgical centres *and* public not-for-profit hospitals, and to service an increase in the volume of patients. It further assumes that private for-profit facilities will be able or willing to provide services at the same cost as public hospitals, while still managing to skim off a profit.

Thus, when analyzing a move towards ABF, one must ask whether it is only ABF that is being promoted, or ABF *plus* increased private for-profit clinics and surgical centres, and the impact of each of these changes needs to be considered.

6. Where is activity-based funding used, and what impact has it had on waiting times and costs?

Most countries use a mix of various payment systems, similar to those outlined above. Activity-based funding, either alone or as part of a mixed funding strategy, is used to greater or lesser degrees in the US (where it was first developed and implemented) and in several European countries.

6a. Activity-based funding in Western Europe and Australia

In ***France***, public hospitals are budgeted globally, with activity-based funding used mostly in private hospitals. French hospitals have been collecting case-mix information for 20 years, and are now considering a move toward more activity-based funding, but it is likely the overall organization of France's health care system that accounts for the lack of waits, not just the relatively small proportion of activity-based funding.

Denmark began to experiment in 1997 with activity-based funding in some counties. In 2000, the national government formally introduced a system combining global budgets, activity-based funding, and performance targets. The Danish model is a blended innovation in that it uses the DRG rates in determining global budgets, and then funds hospitals globally to 90% of the DRG rate, with the remaining 10% only allocated according to the actual activity performed. Hospitals that provide more volume than their negotiated target receive the extra funds, and there are plans to shift more to activity-based funding if efficiencies are realized. ***Norway*** has a similar blend of global budgets and activity-based funding.

Australia introduced activity-based funding in 1995 as part of a broader strategy to reduce waiting times.[6] This included centralized waiting lists, additional funding for complex procedures, performance bonuses for hospitals that met access targets (P4P), optimization of the OR schedule, electronic patient data, and more day surgeries. Yet, in 2008, Australia is still one of the OECD countries that continues to have wait-time problems for scheduled elective surgeries.

Sweden has also introduce some activity-based funding, but, again, this was part of a broader strategy that included a new national treatment guarantee, the 0-7-90-90 rule wherein initial contact with the health care system is instantaneous (0 delay), contact with a general practitioner takes no more than 7 days, contact with a consultant takes no more than 90 days, and treatment takes place no more than 90 days after that[7]. Together, these and other initiatives, have improved waiting times.

6b. Activity-based funding and the English NHS experience: PbR mixed with For-Profit Delivery

Because the discussions in Canada seem to focus on **English**-style ABF, known in the NHS as PbR, a more thorough analysis of this experiment is presented.

The English health care system has implemented a number of strategies to reduce waiting times, including financial rewards for hospital trusts and primary care trusts that meet targets, dedicated elective surgery and diagnostic testing centres, significant cash infusions, commissioning of publicly funded services in privately owned facilities, and, in 2003/4, activity-based funding (known in the UK as payment-by-results or PbR).

Under the PbR system, care is grouped into HRGs (the equivalent of DRGs), and public hospitals compete for patients (and, therefore, funding) with private, investor-owned Independent Sector Treatment Centres (ISTCs) that contract to the English National Health Service (NHS). This inclusion of private facilities is not always part of the design in other European countries experimenting with activity-based funding. Unlike in other countries where activity-based funding has been experimented with only on a controlled and small scale, PbR is expected to be implemented extensively, eventually covering all outpatients and ambulatory health care.

Evidence on cost in England

On the cost front, services delivered by investor-owned facilities but financed by England's NHS through PbR (the UK term for ABF) have cost more than the equivalent services performed in public facilities. In 2006, the Department of Health reported that procedures purchased by ISTCs cost, on average, 11.2% more than the public hospital equivalent. A British House of Commons committee concluded in 2006 that the ISTCs had not improved capacity and did not offer more efficiency or better "value for money" than the public sector[8].

Similarly, "HRG drift" occurred in the form of up-coding diagnoses, resulting in higher payments to hospitals and higher overall costs to the system. In one study of PbR in England, the proportion of lobar, atypical, or viral pneumonia episodes for treatment of patients under 70 years with complicating conditions rose significantly for some trusts using the new PbR system, but not for others still using block grant contracts.[9] A similar pattern of up-coding diagnoses was found in the US when DRGs were first introduced.[10]

Primary care trusts and hospital trusts have seen their administrative costs increase dramatically because of PbR. The main cost driver has been the increased information-collecting demands of moving to an activity-based payment system.[11] Other administrative costs include higher data collection costs, higher monitoring costs to track activity, and higher enforcment costs.[12]

The PbR system was temporarily withdrawn in 2005 because the Department of Health miscalculated the amount to be paid per HRG. The tariffs for specialist children's hospitals, for example, were undercalculated, resulting in the need for a cash injection.[13] Part of the problem with calculating accurate tariffs has been that, "since fixed tariffs are based on national average costs, 50% of acute providers will have costs below and 50% will have costs above the tariff."[14] The risk is that hospitals with costs that exceed the tariffs for certain procedures may stop doing those procedures rather than improve efficiency. Establishing accurate DRGs/HRGs is difficult for some services, such as mental health care and critical care.

Evidence on access to care in England

Numbers of short-stay hospital admissions in England escalated disproportionately within foundation trusts implementing PbR as compared to other trusts, presumably because hospital payment is based on volume. In one study, the numbers of short-stay inpatients admitted through accident and emergency (the ER) increased by between 16% and 17% in some hospitals, 24% in others, and by a whopping 54% in one hospital.[15]

The move towards more investor-owned private for-profit delivery is highly controversial, in part because the private sector was enticed to participate through preferential treatment in the form of income guarantees. By developing a "rigged market", a playing field was created that disadvantaged the public sector and advantaged the investor-owned private sector. This has led to the closure of some public facilities, thereby limiting access to care and increasing waiting times, and to high profits for the private sector. ISTCs were meant to provide extra capacity and staff, "but 23,000 NHS beds in England have closed and many NHS clinical staff have transferred to the private sector since their introduction."[16]

Evidence on quality of care in England

The British Medical Association (BMA) voted to oppose PbR, in part because it "creates profitable and unprofitable patients and services. The result is overdiagnosis and overtreatment of some patients, and neglect and undertreatment of others. Particularly vulnerable are people who have chronic care or physical and/or learning disabilities." [17] The BMA unanimously passed a motion saying that "more emphasis should be placed on collaboration as opposed to competition..."[18]

Evidence on benefits of English-style PbR

Payment-by-results is no panacea for controlling costs or for improving access. In the English experience, there have been some benefits such as enhanced, albeit costly, data collections, and a perhaps more sensible distribution of resources to providers as an incentive to increase capacity and to reduce waiting lists.[19] However, a comprehensive analysis of what is working, and what is not, has yet to be done.

6c. Activity-based funding and the U.S experience: Prospective Payment System (PPS)

In the **United States**, Medicare, enacted in 1965, is the largest publicly-financed component of the healthcare complex, providing coverage for all people age 65 years and older. It was Medicare's transition in 1983 to a Prospective Payment System (PPS, the US version of ABF) that triggered the economic restructuring of the U.S. health care system. This model was first introduced to reimburse hospitals for inpatient expenses only, and then, nearly 20 years later, it was expanded in 2000 to include some ambulatory payments.

Under this activity-based system Medicare prospectively sets the payment amount (DRG rates) that providers who service the Medicare population will receive for most covered products and services. These DRGs are based on complicated formulae and clinical information including principal diagnosis, complications, comorbidities, surgical procedures, age, gender, and discharge disposition. Providers agree to accept those pre-determined rates

as payment in full for their Medicare patients.[20] Diagnoses and procedures are documented by the attending physician, and coded by hospital personnel using ICD-9/10 nomenclature.[21]

The result of the PPS has been reasonable cost containment in Medicare (as compared to the privately funded sector), but the savings have been derived through aggressive regulation, not because of competition.[22] The discovery of rampant Medicare fraud and abuse in the 1990s was dealt with by a federal government crackdown. Legislation that increased financing for investigation and prosecution[23], coupled with laws delivering harsh civil penalties[24], and particularly visible prosecutions of large health care providers[25], appear to have had the desired effect of containing the most obvious kinds of fraud and abuse uncovered in the publicly financed portion of Medicare. In response to the antifraud initiative, "DRG creep"—the phenomenon in which more and more admissions were classified as more complex and costly diagnoses—suddenly stopped in 1997 (U.S. CBO 1999).[26]

Table 2. Evidence on reduction in waiting times, reduction in costs, benefits, and unintended consequences associated with activity-based funding (ABF), by Country

	Extent to which ABF is used	Effect on waiting times	Effect on costs	Other positive effects	Other negative effects
France	Minor, mostly in private hospitals	Overall organization of health care system accounts for few waits, not ABF alone	No evidence that ABF, alone, has reduced costs	Undocumented	Undocumented
Denmark	Blended with global budgets, as of 2000	Little effect on reducing waits for elective surgeries, effect on other waits unknown	No evidence that ABF, alone, has reduced costs	Undocumented	Undocumented
Australia	Nationally (in 1995) as part of a broader strategy to reduce waits	Little effect on reducing waits for scheduled elective surgeries, effect on other waits unknown	No evidence that ABF, alone, has reduced costs	Undocumented	Undocumented
Sweden/Norway	Nationally as part of a broader strategy to reduce waits	Effect of ABF, per se, unknown	No evidence that ABF, alone, has reduced costs	Undocumented	Undocumented
England (PbR)	Incrementally beginning in 2003	Some reduction in wait times, but the effect of PbR, per se, on wait times is unknown because it was simultaneously introduced with increased system capacity through more public funding	Costs have escalated, but no data show whether this is due to PbR, to increased use of private facilities introduced concurrently with PbR, or to other causes	Enhanced data collection	HRG drift; increasing administrative costs for data collection, for monitoring, and for enforcement; inaccurate DRG rates initially due to lack of cost basis data.
USA (PPS)	In single- payer publicly funded Medicare population since 1983, expanded to about 80% of all hospitals	Wait times unchanged by PPS	Generally unkown. Cost escalation may have been limited with PPS in heavily regulated publicly funded system. Regulation, not competition, is controlling costs.	None	DRG creep, inaccurate DRG rates initially due to lack of cost basis data, rampant fraud, increased administrative costs, premature hospital discharge, increased legislation to counteract negative externalities

The belief that activity-based funding, alone, will reduce waiting times is not borne out by the experience in Western European health care systems, or in Australia. In all Western European systems and in Australia where surgical waiting times have decreased, the use of some activity-based funding is only one part of a broader, multi-faceted strategy that includes everything from improved surgical capacity resulting from more ambulatory surgeries (Germany), to high availability of equipment, physicians, and acute care beds (Switzerland), to new funding for surgical activity (Denmark, France), to private delivery coupled with public financing (France). It appears that it is the synergy of various financing and delivery strategies that reduce waiting times and/or contribute to cost control in some European countries, not necessarily activity-based funding, *per se*. We do not know, therefore, what, if anything, activity-based funding contributes to reducing waiting times or to controlling cost in most countries where it has been studied.

7. What lessons can Canada learn from other countries?

There is little, if any, evidence that activity-based funding, by itself, is a cure for waiting times, and under some conditions it may lead to increased healthcare costs. If not implemented carefully, ABF can lead to hospital closures in rural communities and provide a disincentive for hospitals to provide low-volume but needed care. If linked to increased investor-owned for-profit delivery then it can also threaten coordination of care, increase the unit cost of healthcare, and threaten care quality.

If Canada is to explore activity-based hospital funding, we should do so with our eyes wide open to the risks and benefits. We are poised to learn from each of the countries currently experimenting with activity-based funding and to create a uniquely Canadian version of activity-based funding that, hopefully, avoids the pitfalls. If, therefore, adequate funding and human resources are available and governments wish to experiment with ABF to increase the volumes of some services, then there are a few lessons we can learn from the experience of other nations.

Lesson 1: If governments decide to study ABF, then restrict the implementation of ABF to a carefully controlled, discrete experiment in the financing of care.

We don't know whether activity-based funding, alone, is the solution to reducing waiting times or to controlling costs. Nowhere in the world has this been shown to be the case. In all countries where activity-based funding has been implemented, it has been part of a broader strategy aimed at increasing efficiency and quality, and at reducing costs. Little evaluation research, therefore, has been done to measure the efficacy of this intervention alone. If Canada wishes to contribute to the international evidence on this front, we should choose to carefully introduce activity-based funding, on a small scale, in a carefully controlled, methodologically rigorous experiment, to measure its efficacy on reducing waiting times and on controlling costs. Introduction of activity-based funding should not be complicated by simultaneously allowing public financing of private investor-owned for-profit facilities, if the goal is to test whether activity-based funding, *per se*, is an effective intervention for reducing waiting times and costs. Equally important to a well-designed study is the imperative that Lessons 2-6 be undertaken *prior* to commencing the experiment.

Lesson 2: Start with services that are under-provided.
If an intent of ABF is to reduce surgical waitlists, then begin the experiment with under-provided services where waiting times are judged to be excessive.

Lesson 3: Take the time to get accurate cost data for the DRGs/HRGs.
The Kirby Commission concluded that "after years of global budgets in a number of provinces, no one knows how much anything costs anymore and that, as a result, it is difficult to know even approximately what the public is getting for its spending on hospitals."[27] The OECD (2004), citing Kirby (2003) similarly noted that with these funding methods, decisions are not usually based on detailed cost information, since funding is either decided politically or based on historical trends, neither of which encourages efficiency. Establishing the true unit cost of health services is complicated, and detailed data needed to correctly allocate direct and indirect costs to the units of services are not always available, especially where global budgets have been used for a long period of time. Without accurate cost data, any move toward the use of DRGs is sure to fail because hospital reimbursement depends on the coding assigned to each patient. The rush to implement activity-based funding too fast, and too extensively, will result in chronic "tinkering" with the costing in an effort to get it right. This has been one of the ongoing defects in England's adoption of PbR.

Lesson 4: Account for more than just "activity" in the DRG algorithms.
The DRGs/HRGs must account for "quality" endpoints, such as post-operative outcomes, complications, and relapses. Confounding factors that affect both cost and outcome measures, such as acuity and diagnostic co-morbidities, must also be considered. Simply paying a flat fee based on primary diagnosis and treatment will result in incentives for some facilities to offer care to the healthiest and least complicated patients (i.e. cherry picking), while rejecting the sickest, most complicated, and most expensive patients. If private, investor-owned for-profit surgical facilities, with only outpatient capacity, were allowed to compete for patients, they undoubtedly would win the volume selection game, and public hospitals would have no choice but to accept the more complicated patients, thereby reducing their volume and undermining the financing of the public sector in favour of the private, investor-owned sector. An alternative to accounting for more than just "activity" in the DRGs/HRGs would be to only allow ABF for procedures that are largely independent of confounding factors and of patient characteristics, and that are unlikely to have unavoidable complications. This alternative would limit the kinds of procedures that could be funded through ABF to include, for example, surgeries that don't involve general anesthetic.

Lesson 5: Develop a strategy to deal with the unique costs of teaching, rural, small town, and other types of non-typical hospitals.
Under activity-based funding, hospitals and other surgical facilities would compete with each other for patients. However, although activity-based funding may work well in urban community hospitals, other unique facilities, such as teaching hospitals, high acuity centres caring for patients with complex diagnoses, and rural or remote hospitals may need to be treated differently as it is not possible to create a market for many of the services they provide. "Extra or alternative funding arrangements, therefore, may have to be negotiated

with these unique hospitals that do not have significant patient volumes but where it is deemed appropriate that such facilities should continue to provide certain services."[28]

Lesson 6: Develop robust policies to monitor coding practices that protect against DRG creep/HRG drift and other forms of fraud and abuse.
Evaluation of activity-based funding has shown a propensity toward what amounts to "gaming", fraud, and abuse through deliberate manipulation of the system for financial gain. Gaming techniques include discharging and readmitting the same patient to attract additional payment, creatively up-coding complexity of care by billing for a more expensive DRG (DRG "creep") to gain greater reimbursement, over-admitting patients from ERs to increase hospital revenue, undertreating of some patients (e.g. chronically ill whose treatment is more labour and time-intensive) and overtreating of others (those with less complex "bread and butter" conditions that are quick and easy to treat), increasing hospital service charges *prior* to the development of DRGs so as to elevate the baseline costs from which the DRG rates are to be derived, and shortening lengths of stay for some DRGs to the point of being dangerous for unstable patients (e.g. mandatory discharge of all maternity patients and newborns in less than 24 hours).

Lesson 7: Unless governments intend to increase the total amount of available funding, limits will need to be set on the total amount of activity allowed.
Without the "rate limiting step" of global budgets, there is a risk that activity will be increased at such a pace that it exceeds the capacity of governments to pay. There must be a mechanism to prioritize and limit activity to control expenditure; thus far, this has been the global budget, but without global budgets other mechanisms will need to be developed, or Canadians will need to prepare for, and consent to, increases in healthcare costs.

8. Conclusion
There is little, if any, evidence that activity-based funding alone contributes to improved access to health care by shortening waiting times. At best, data from other countries are unclear because ABF has largely been part of a potpourri of interventions aimed at improving health. We don't yet know, for example, whether ABF improves quality, reduces (or at least stabilizes) overall health system costs, or ensures equitable care — and equal access to that care — across the population. We can, however, support an experiment to study ABF, but only under the strict conditions outlined in this paper, to learn whether this approach to hospital funding is any more successful than other funding mechanism currently in use. If ABF proves, over the course of a sustained period of time, to improve access to high quality, equitable care, for less money than other financing systems, then we would be inclined to support wider implementation.

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IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CANADIAN INDEPENDENT MEDICAL CLINICS ASSOCIATION ET AL.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA ET AL.

DEFENDANTS

AND

SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

DEFENDANT BY COUNTERCLAIM

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