Cambie vs Canadian Public Health Care

Summaries of Crown expert evidence
For BCHC & CDM
Prepared by Colleen Fuller

Timothy Besley
Reviewed

Timothy Besley is a professor economics and political science at the London School of Economics, a visiting professor at the Institute for Economic Studies, Stockholm University and a Fellow at the Canadian Institute for Advanced Research, Program on Institutions, Organizations and Growth. His research/writing focus has been on health economics.

Key Arguments in Affidavit
His affidavit is based on two papers he has co-authored with John Hall and Ian Preston. The first is entitled "Private and public health insurance in the UK" (1998) and the second is "The demand for private health insurance: do waiting lists matter?" These papers were not appended to the affidavit I reviewed, however, Besley summarized them in this way:

During the period covered in the first study, approximately 12% of households had members who were covered by private insurance, either through employers or individually. Based on data from the British Social Attitudes Survey and the NHS, he and his co-authors concluded that "regions in which many [individuals] are privately insured appear to put fewer resources into keeping waiting lists short".

The second paper indicated that between 14-17% of the population in the UK were covered by supplementary health insurance. They reached several conclusions regarding private health insurance and waiting times in the public system:

1. The demand for private health insurance was higher among high incomes groups;

2. Without lobbying pressure to shorten wait times in areas where a large number of individuals have private health insurance there appears to be a correlation between private insurance and longer waiting times for services in the public system.

3. Physicians may divert their time away from treating patients in the public system to treat their privately insured patients.

Gillian Booth
Reviewed

Gillian Booth has been an adjunct scientist at the Institute for Clinical Evaluative Sciences (ICES) since 2000. She is also an assistant professor in the Department of Medicine at the University of Toronto, and is a practicing endocrinologist at St. Michael's Hospital in Toronto. In addition to her research, Booth is actively involved in a number of committees and organizations, and was a member of the expert panel that developed the 2003 Canadian Diabetes Association Clinical Practice Guidelines.

Key Arguments in Affidavit
Booth's study looked at whether income disparities in diabetes-related morbidity or mortality declined after age 65 in a setting where much of health care is publicly funded but universal drug coverage starts only at age 65. She and her co-authors found that the incidence of cardiovascular disease (CVD) declined after age 65 when individuals became eligible for universal coverage for prescription drugs in Ontario.

The study found that mortality rates among people with diabetes (PWDs) fell substantially during the last 20 years, something that has been attributed mainly to medical advances in reducing CVD risk. There is evidence to suggest that more complex drug regimens, in combination with changes in behaviour (eg., diet and exercise), can prevent up to half of all cardiovascular events among high risk groups with diabetes. For this reason, access to complex (and costly) medications may be essential to optimum outcomes.

However, escalating drug costs may be having an adverse impact on people with diabetes (PWDs) who are low income with inadequate insurance coverage, a population more likely to restrict their use of prescription drugs because of high out of pocket costs. Lower income groups also are more likely to develop Type 2 diabetes, experience more complications from the condition and are far less likely to have private insurance coverage. Booth cites mounting evidence of the importance of health insurance in "closing the gap in health outcomes between groups of differing socioeconomic status".

In Canada, income-related differences in mortality fell substantially after the introduction of universal medicare. However, there are still social inequities in regard to health outcomes, including from coronary heart disease. The gap between richer and poorer PWDs has widened over the past decade. This study looks at whether income "would have a lesser impact on cardiovascular outcomes and mortality in the population with diabetes who were >65 years of age compared with younger-aged individuals". The study covered the period from April 2002 to March 2008 and looked only at Ontario.

The study found that "socially disadvantaged groups with diabetes have significantly higher risk of nonfatal [acute myocardial infarction], stroke or death compared with more affluent individuals, in a setting where much of health care is provided to all residents free of charge". The finding was "most marked" among patients under age 65 years who are much less likely to have private insurance coverage. In contrast, these disparities were

much less pronounced among those above age 65 years of age who are eligible for universal drug coverage, helping to close the gap in outcomes among this population. And the gaps are really significant: up to 5000 deaths and almost 2700 AMIs or strokes "could have been avoided among younger and middle-aged adults with diabetes if the gap between wealthier and poorer individuals had been identical to that seen among older groups" who were eligible for public drug coverage. Booth and her co-authors argue that "effective care may be becoming increasingly inaccessible for low-income people because of cost". Over the past decade, the number of PWDs who can't afford to buy prescribed medicines has increased in parallel with the rising cost and complexity of diabetes treatment strategies.

This is the only affidavits to look at the fact lower income Canadians are much less likely to have access to private insurance (a condition of employment circumstances) and that this lower level of coverage contributes to poorer health outcomes in this defined high-needs population.

Ivy Lynn Bourgeault
Reviewed

Ivy Lynn Bourgeault, is a Professor in the Faculty of Health Sciences at the University of Ottawa. She is also the Scientific Director of the pan-Ontario Population Health Improvement Research Network and the Ontario Health Human Resource Research Network both at the University of Ottawa with funding from the Ontario Ministry of Health and Long-term Care. She was recently awarded the Canadian Institutes of Health Research Chair in Health Human Resource Policy. Dr. Bourgeault has garnered an international reputation for her research on health professions, health policy and women's health. She has been a consultant to various provincial ministries of health in Canada, to Health Canada and to the World Health Organization. Her recent research focuses on the migration of health professionals with a particular focus on Canada, the U.S., the U.K., and Australia.

Key Arguments in Affidavit

Bourgeault's focus is on health human resource planning, specifically in regard to the (over) supply of physicians in certain specialty areas. Her affidavit is divided into four parts: 1) the likely causes of oversupply; 2) the rising supply of physicians in Canada and the implications for access and volume of services; 3) an overview of the literature on the mal-distribution of physicians; and 4) the role that the private provision of services has and will likely have on these complex and persistent problems if medicare laws are liberalized.

1. Physician Oversupply in Specialty Areas
A recent study by the Royal College of Physicians and Surgeons of Canada found that about 16% of residents in neurosurgery, cardiac surgery, plastic surgery, orthopaedic surgery and thoracic surgery, cardiology, gastroenterology, palliative medicine, urology, public health and preventive medicine, otolaryngology, nephrology and radiation oncology indicated they were unable to secure employment in Canada. The College cautioned that unemployment wasn't a simple case of "supply versus demand", but rather should be attributed to an "egregious failure in workforce planning", one that required "systemic solutions". There were three contributing factors found by the study's authors: lower retirement rates due to the economic downturn; increased inter-professional models of care in which non physicians were providing an increased range of services; and inadequate career counseling based on projected population health needs.

2. Rising Number of Physicians but Not of Supply of Physician Services
While the number of doctors across Canada has been rising, and they are making more money (30% higher incomes compared to a decade ago), they have not been providing a higher volume of services. This situation does not fully remedy access problems. Provinces are competing with each other to attract physicians (as well as non-physicians). Other changes include: fewer doctors are accepting new patients; younger doctors work less full-time hours; disparities exist among urban and rural doctors, with the latter group more likely to be accepting new patients.

3. Maldistribution of Physicians across Canada
This problem is not uncommon in developed countries, and Canada is no exception. A 2011 CIHI report indicated that only 9% of physicians were found in rural areas, compared to 18% of the Canadian population (six million people) who live in rural areas. This is one of four "distributional imbalances" found in Canada, the others being occupational imbalance, imbalance among specialties, and institutional imbalance.

Although there is general agreement that the present distribution of physicians is a problem, there is no consensus about what an acceptable distribution in Canada might look like or how it should be measured. "Strategies to address issues of distribution need to be multifaceted in nature because the causes of the problem are also multifaceted. Simply adding more doctors to the system overall does not address the problems with distribution that have left rural areas perpetually underserviced. Increasing physician supply…, however, significantly increase overall health care expenditures".

4. Private care worsens wait list/maldistribution problems
Provinces that contract private surgical clinics have done so in the belief that it will take pressure off the public system. However, what has happened instead is that private clinics have pulled health human resources out of the public system, exacerbating wait times in the public sector. Even though there may be under- and unemployment among physicians in certain specialty areas, there is not, overall, excess human resource capacity that can be pulled into the private sector without having an impact on the public system. This is especially true in regard to allied health professionals – and the work that such professionals are doing in inter-professional environments is what has contributed to physician underemployment in the first place.

When physicians are pulled into the private sector they tend to work at lower volumes because they can charge more and maintain or even enhance their incomes. "As a result, there is an overall decrease in total volume of services, which will be particularly constrained in the public sector. Indeed, the principal argument for permitting a second tier private alternative system, namely that this would cause better overall access to care and relieve pressure on the public system, is not supported by any data".

Bourgeault concludes her affidavit by warning that an increased migration of physicians from public to private systems where they can earn more at a reduced volume of services would cause an even greater decline in services overall. There would be a disproportionate negative impact on rural and remote populations, exacerbating problems related to maldistribution of physician resources. "Neither in the 2009 Cochrane Review nor in the 2010 WHO Report was the privatization of health care services mentioned as an evidence-based strategy to improve rural and remote access to services. This is largely because it would have the opposite effect…"

Damien Contandriopoulos
Reviewed

Damien Contandriopoulos is Associate Professor in the Faculty of Nursing at the Université de Montréal, as well as a researcher affiliated with the Research Institute of Public Health at the same university. His main research areas are in the field of public health policy, public decision-making, organizational theory and governance. During the last 10 years he has been a principal investigator or co-investigator in six peer-reviewed grants from the Canadian Institutes of Health Research to conduct research about health services financing, models of health care delivery and health policy-making processes.

Contandriopoulos has submitted two affidavits: the first one provides a description of the impact of the Chaouli decision on questions concerning access and equity. The second affidavit is based on a 2013 paper entitled "Fee Increases and Target Income Hypothesis: Data from Quebec on Physicians' Compensation and Service Volumes (co-authored with Melanie Perroux). This paper looks at what happened to the volume of services provided when physician fees were increased in Quebec.

Key Arguments in Affidavit #1
Contandriopoulos describes the response of the Quebec government to the decision of the Supreme Court of Canada in Chaoulli v Quebec (June 2005) and the effects that this decision and the government's response had on the public health care system in that province, including the effects on equitable access to health care services.

In December 2006, 18 months after the Chaoulli ruling, the Quebec government adopted Bill 33, based to some extent on an earlier white paper that highlighted the importance of the principles of equity, efficiency and quality in health care. The new law modified Quebec's existing health plan (Régie de l'assurance maladie du Quebec – RAMQ) in three ways: 1) it required hospitals to implement a centralized wait list management process and to offer alternative treatment options to patients that might wait longer than six months for knee or hip replacement and cataract surgery; 2) it allowed private duplicative insurance for those three specific surgical interventions, all of which are medically necessary in the public plan; and 3) it created a new regulatory framework for medical clinics interested in offering specific health services. In the view of Contandriopoulos, "these three modifications had limited effects on day-to-day financing or delivery of health services in Quebec".

Wait times
Bill 33 specified the options hospitals must offer to patients who may have a wait time of more than six months: 1) refer the patient to another surgeon in the same hospital; 2) refer the patient to another surgeon in another hospital in the same region; 3) refer the patient to another surgeon in a different region; and 4) refer the patient to a private facility with costs to be paid by RAMQ. The latest data (June 2013) show that 86% of patients waiting for hip surgery in Montreal waited less than six months for care, while 14% waited longer than six months. Of this latter group, only three patients were offered alternative treatment options and none of them accepted the offer. Contandropoulos says that none of

the patients were ever operated on in the private sector (option #4). The data show that the situation is similar for knee surgery and in other regions (excessive wait times for cataract surgery are less common). “This suggests that although the law now provides a centralized waiting list management system, the direct practical impact of Bill 33 on excessive waiting is limited”.

Private duplicative insurance

This element of Bill 33 was the most controversial and the one that was most directly related to the Supreme Court of Canada ruling. However, currently no insurer is offering coverage for the three designated interventions (knees, hips, cataracts), which may be related to issues around human resource availability, characteristics of the population that requires these types of surgeries and the technical requirements for providing these services.

Human resources: in order to bill RAMQ for services, physicians must opt in to the plan and once they are opted in they are prohibited from extra billing patients or charging private insurers for publicly insured services. They also, of course, may opt out and bill patients for services. Bill 33 now also allows opted out physicians to receive payment from private insurers for hip, knee and cataract surgery. However, opted out physicians can only practice in the fee-for-service private sector, a rule that has limited the number of opted out orthpaedic surgeons to six (out of ~336) and ophthalmologists to four (out of ~330). Contandropoulos suggests this is because the working conditions, including comfortable incomes, are better and more predictable in the public system. This, in turn, is a disincentive to private insurers who might want to offer coverage since the market is unlikely to be very large and surgeons may simply not be available in a timely fashion. “It should, however, be kept in mind that the scientific literature on the subject suggests that, once put in motion, the development of a private insurance market and the mass opting-out of physicians could have a mutual feed-back effect”.

Potential beneficiaries: most people with private supplementary insurance coverage in Quebec (and elsewhere in Canada) are employees, and once retired are much less likely to be covered under the employer-sponsored benefit plan. The average age of a patient who obtains hip replacement surgery is 70 years, and is similar for knee and cataract surgeries. Therefore, it is unlikely that most workers (or their employers) would want to pay additional premiums they are likely to require post-retirement and after the expiration of their supplementary benefit plans.

Technical requirements: Hip and knee surgery requires technically sophisticated surgical facilities and equipment as well as skilled physician and non-physician providers. This is particularly true when the surgery is performed on an elderly patient and if complications arise during the intervention. It takes a lot of money to invest in such facilities and equipment “which is unlikely in a market context where the demand for such procedures is quite low”. There is anecdotal evidence that only one orthopaedic surgeon is doing hips and knees in his clinic, while other surgeons “seem to specialize in less invasive surgeries for wealthy and healthy patients or surgeries for specific sub-populations such as athletes”.

New legal framework for medical clinics (Centres médicaux spécialisés or CMS)
A CMS is designated as such by the province and if it fails to meet the requirements is not able to offer hip, knee or cataract surgery. Bill 33 imposed new regulatory requirements on medical clinics but did not change their functioning or nature. Interestingly, under the new law it is the responsibility of the clinic to make sure all pre- and post-operative services, including rehabilitation and home care, are available in the clinic or through the clinic. It also prohibits opted in and opted out physicians to practise in the same CMS. Bill 33 also allows a medical clinic to contract with a hospital – but only if the physicians are opted in. By regulation, there are 50 interventions that may only be provided in a hospital or a CMS and not in an opted out clinic.

Contandriopoulos found Bill 33 had a "modest" direct impact on Quebec's health system. However, the Chaoulli decision had "a much more significant social and economic impact which, in turn, impacted the direction of the health care system". Quebec has seen a significant increase in private opted-out clinics (that is, clinics whose doctors have opted out of medicare) and of illegal billing practices by opted in physicians – practices that RAMQ has apparently done nothing to stem. The causes of privatization are "multifactoral", including "growing proportion of care to be offered in outpatient facilities or the globalization process that pushes toward uniformed social policies worldwide". This portion of his affidavit is based on a systematic review of 1330 stories in the media reporting on health policy issues and anecdotal evidence about private sector development.

Contandriopoulos identifies four trends that have developed post-Chaoulli: 1) the development of a significant opted-out private sector; 2) challenges associated with the delivery of publicly-insured specialty services and surgery in opted-in medical clinics; 3) the development of billing practices that may contravene legal restrictions; and 4) the increased proportion of opted-out private primary care.

Out of pocket fees (extra billing) in Quebec are known as accessory fees, which apply to both drugs and services. These user charges are extremely high – for example, RAMQ pays a physician $210 for a colonoscopy, but many clinics are charging between $400 and $500 for the procedure. Drugs that cost only a few dollars are being marked up by hundreds of dollars. In 2011, media reports prompted RAMQ to set up a kind of surveillance unit to monitor billing practices. The following year it was reported that, "only 20% of the opted-in medical clinics in Quebec had practices that were in conformity with legal requirements regarding patient billing for accessory fees".

Since the Chaoulli decision there also has been a significant increase in user fees for primary care, either in the form of membership fees to access services from opted-in physicians or payments made to opted-out family doctors. There also has been a "rapid and sustained development of opted out private primary care clinics staffed by opted out physicians" which are charging out of pocket user fees.

He affidavit concludes, “Overall, my opinion is that the *Chaoulli* ruling had a significant impact on the evolution of Quebec's health care sector. It fed a steady evolution toward the social acceptance and the development of a two-tier system that negatively impact the universal and equitable access of medical services. Moreover, the nature of the processes at stake also influence the overall allocation of resources in the healthcare sector and limit the collective capacity to implement policies aimed at maximizing appropriateness and equity”.

Key Arguments in Affidavit #2

This affidavit is based on a paper published in 2013 entitled “Fee Increases and Target Income Hypothesis: Data from Quebec on Physicians’ Compensation and Service Volumes”. Based on data from Quebec, he and his co-author (Melanie Perroux) assessed the impact of public funding of physician services across Canada on the volume of services provided to the public. The “Income Hypothesis” is a theory that people will spend money at a level consistent with what they expect to earn over the long term. Contandriopoulos and Perroux use the term to mean that, “people aim for a given level of income and will adjust their work practice to reach it”. What they found was that increasing physician compensation levels did not necessarily translate into a higher volume of services – in fact, the opposite was true. While compensation costs, average MD compensation and average unit cost per service all rose extremely quickly between 2007 and 2011, “the total number of services, number of services per capita, and average number of services per physician either stagnated or declined”. The only exception was a modest increase in the volume of specialized services, “although not when expressed as per capita or per physician”.

What the authors found so disturbing is that over the five years reviewed, an additional $1.5 billion was paid to Quebec doctors, but average volume of services declined. Even more worrisome, they write, “the decrease in the average volume of services per physician offsets most or all of the increase in the number of physicians”.

They write that this pattern “is compatible with the economic target income hypothesis: as the unit price of services rose, physicians adjusted their work practices and, overall, limited the number of services provided. The target income hypothesis suggests that physicians (and possibly others) have a target income (which need not be fixed over time) that their rate and style of work are adjusted to achieve.

Quebec physicians have pleaded with the government that their fees should be more in line with the rest of the country, otherwise, they argue, doctors will flee and there will be a decrease in the volume and availability of services. This argument flies in the face of evidence showing that Quebec has seen a net in-migration of physicians during the last several years.

“What our analysis shows, however, is that the increase in fee schedules recently implemented in Quebec – in part, to prevent a non-existing migratory trend – are likely to have a real negative impact on volumes of services provided”.

Carolyn DeCoster
Reviewed

Carolyn DeCoster is the Associate Director for the Western Regional Training Centre for Health Services Research at the University of Manitoba and the Executive Director of Clinical and Zone Analytics, Data Integration, Measurement & Reporting, Alberta Health Services. She is also an Adjunct Scientist at the Manitoba Centre for Health Policy, University of Manitoba. She has published extensively in the area of health service utilization and waiting times.

Key Arguments in Affidavit
DeCoster's affidavit is based on a study published in 2000 on coronary procedures, cataract surgery and eight routinely performed elective procedures. The cataract surgery was performed in Manitoba's public hospitals and private clinics from 1992 to 1999. The physicians who provided cataract surgery worked wholly in the public system or worked in both the public and private sectors (dual practice). The relevant findings for the Cambie Charter challenge are in regard to cataract surgery. The study notes that the "clinical relevance of shorter or longer waits is a subject of great controversy" – what is a *statistically* significant wait may not be *clinically* significant, but the evidence is not conclusive. "Therefore, the clinical significance of a change in waiting times is uncertain".

Until 1999, patients who went to a private clinic for cataract surgery were required to pay a tray or facility fee of about $1000. Since then, however, the province has covered all costs. The study found a 12-week difference in wait times between public and private sector surgery, with public wait times at 17 weeks, compared to 5 weeks for the private sector. There was a significant increase of 13 weeks public and 4 weeks private from the previous five-year medians that the authors had reviewed.

About 75% of cataract surgery was performed in the public sector; about two-thirds of the public sector surgeries were performed by surgeons who practised in both hospitals and private clinics. Waits for public sector surgery if the surgeon practised only in the public system were 10 weeks, but for those whose surgeons practised in both the public and private systems, wait times were 21 weeks in 1997/98 and 26 weeks in 1998/99. Median wait times were similar among regions and "neighbourhood income level". Almost 65% of cataract surgeries were performed on women – and women had median wait times about three weeks longer than men.

An interesting finding in the study was that about 20% of patients who went to private clinics (and therefore paid the facility fee prior to 2000) came from the lowest and lower-middle income neighbourhoods, compared to 32% who came from the highest-income neighbourhoods.

The study found that across all income groups, wait times among Manitobans were similar. For most procedures (except cataract surgery) wait times were less than 60 days and for several were about 30 days. The authors found that shortening wait times below

30 days “may in fact be inappropriate since patients should have sufficient time to weigh carefully the risks and benefits that accompany any surgical procedure”. Waits for coronary bypass surgery were declining during the period under review, with most patients receiving surgery within 90 days.

Despite this good news, the authors raised some concerns about an overall trend to increased waits for elective surgery and the complexity of trying to identify why this was happening. For example, while the rate of coronary artery bypass increased, the median wait time declined. But the increased rates of cataract and prostrate surgery were accompanied by increases in median wait times.

The authors conclude that, “The presence of a parallel private system… does not result in shorter waits in the public sector”. In fact, wait times for surgeons in the public sector were longest for those who maintained a dual practice. Importantly, these surgeons did not devote less time to their public sector patients “since they made maximum use of the public sector operating room time available to them”. The authors speculated that dual practice surgeons “might place their patients on wait lists earlier than others, knowing that with the anticipated wait, patients will be ready for surgery when called”.

PJ Devereaux
Reviewed

PJ Devereaux is the Cardiology Site Leader and the Leader of the Perioperative Cardiovascular Program at the Juravinski Hospital and Cancer Centre at the Hamilton Health Sciences Centre. He is also the Scientific Leader of the Perioperative Medicine and Surgical Research Group at the Population Health Research Institute, McMaster University. Most of his clinical research work is in perioperative vascular medicine in patients undergoing non-cardiac surgery. Devereaux is well known for a number of systematic reviews and meta-analyses showing that US patients treated in for-profit clinics, hospitals and long term care facilities experienced higher mortality rates and poorer overall health outcomes but paid higher fees for generally lower quality of care compared to those treated in similar not-for-profit facilities.

Key Arguments in Affidavit
Devereaux's affidavit is based on four studies he led:

1. "A systematic review and meta-analysis comparing mortality rates in private for-profit and private not-for-profit hospitals", CMAJ 2002;
2. "Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis", JAMA 2002;
3. "Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis"; CMAJ 2004; and
4. "Quality of care in for-profit and not-for-profit nursing homes: a systematic review and meta-analysis", BMJ 2009).

This summary is a very brief review of his four papers.

1. "A systematic review and meta-analysis comparing mortality rates in private for-profit and private not-for-profit hospitals"
This is a meta-analysis of 15 observational studies, involving more than 26,000 hospitals and 38 million patients, including one study in which the patients were infants. In the studies of adult populations, with adjustment for potential confounders, private for-profit hospitals were associated with an increased risk of death. The perinatal study reviewed also showed an increased risk of death in private for-profit hospitals.

Most Canadian studies have focused on the impact of private, for-profit hospitals on cost and on wait times. This is a focused look at whether who delivers has an impact on health and mortality outcomes, regardless of who is paying for the service. Devereaux and his co-authors also ask the question, "Why is there an increase in mortality in for-profit institutions?" They suggest that the 10-15% rate of return that investors expect on their investments has a lot to do with it. In addition, administrators are rewarded for matching or exceeding that profit margin. "In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face". Both for-profit (FP) and not-for-profit (NFP) facilities get the same cost

reimbursements from US Medicare, but FP institutions are unable to achieve the same outcomes as NFP institutions because they devote fewer resources to patient care and because they cut corners to achieve the 10-15% profit margin.

2. "Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis"

The majority of dialysis clinics in the United States are private for-profit and private not-for-profit clinics; about 75% of patients receive care in FP centres, a subject of extensive debate for many years. In 2002, Devereaux and colleagues conducted a systematic review of eight observational studies that included 500,000 patients treated in both FP and NFP facilities for the period 1973 to 1997. The study found that hemodialysis care in private not-for-profit centres was associated with a lower risk of mortality compared with care in private for-profit centres.

There were a number of reasons identified that may contribute to the higher mortality risk in for-profit centres. These include: FP clinics employ fewer personnel per dialysis run, and less highly skilled personnel overall; and patients have shorter durations of dialysis treatment in FP clinics (shorter duration is associated with higher mortality rates). Like hospitals, investors expect a 10-15% rate of return on investments. Since employees account for ~70% of total dialysis costs, FP clinics try to minimize staff and reduce the number of skilled technicians, nurses, etc. Devereaux, et.al., estimate that ~2500 deaths could be avoided each year if these patients were treated in not-for-profit dialysis centres. Together with his previous study on for-profit and not-for-profit hospitals, "these data provide compelling evidence that profit status can have an important impact on the outcomes of medical care".

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

After showing that patients in for-profit hospitals experience higher mortality rates and poorer health outcomes, Devereaux turned his attention to the comparative costs between these forms of health care delivery. In this study, Devereaux reviewed eight observational studies, involving more than 350,000 patients altogether and a median of 324 hospitals each. They found that 5 of 6 studies showed statistically significant higher payments for care at private for-profit hospitals; one study showed statistically significant higher payments for care at private not-for-profit hospitals. "The lone study demonstrating lower payments for care at private for-profit hospitals compared them with hospitals owned by private not-for-profit organizations but run by a private for-profit firm".

Devereaux and his co-authors concluded that private FP hospitals "result in higher payments for care than private not-for-profit hospitals. Evidence strongly supports a policy of not-for-profit health care delivery at the hospital level". It is unlikely that the higher costs are due to higher quality of care since previous studies have shown for-profit facilities are associated with higher mortality rates and poorer health outcomes. Some of the reasons for higher costs may include: the need to satisfy investor expectations of a 10-15% return on investment; higher spending on administration in FP hospitals; 20% higher executive compensation in FP facilities; higher rates of inappropriate upcoding; and

fraud. If Canada chose to direct more spending towards for-profit care providers it would have increased spending by approximately $3.6 billion in 2002 when the total health bill was $120 billion.

4. "Quality of care in for-profit and not-for-profit nursing homes: a systematic review and meta-analysis"

The final study in the affidavit focuses on quality of care in nursing homes in the United States. The review included 82 papers that covered the years 1965 to 2003. In 40 studies all statistically significant comparisons favoured not-for-profit nursing homes; three studies favoured for-profit facilities. All four meta-analyses favoured not for profit providers. However, 37 studies were inconclusive. The authors concluded that, "on average, not-for profit nursing homes deliver higher quality care than do for-profit nursing homes. Many factors may, however, influence this relation in the case of individual institutions".

This analysis found that NFP facilities delivered higher quality care than did for-profit facilities for two of the four most frequently reported quality measures: more or higher quality staffing and lower pressure ulcer prevalence. Non-significant results favouring not-for-profit homes were found for the two other most frequently used measures: physical restraint use and fewer deficiencies in governmental regulatory assessments.

The authors acknowledge the review had some limitations related to the characteristics of the studies included. However, there are no randomized trials (the highest quality of study) comparing quality of care across nursing home ownership. Studies were also limited in that no standard of quality of care exists, even though the same quality measures were used. There is great variation in ownership within the sector, for example some FP facilities are owned by large corporations, while others are small businesses. None of these limitations, however, "explained the substantial heterogeneity of our results".

Governments provide much of the funding for services in the LTC sector at fixed rates to both FP and NFP facilities. FP nursing homes, therefore, have "a strong incentive to minimize expenditures", something that may lead to lower quality staffing and higher rates of adverse events. The results of the study are based on observational studies "which cannot demonstrate causality. Furthermore, given their variability the results do not imply a blanket judgment of all institutions.

Stephen Duckett
Reviewed

Stephen Duckett has held a number of top operational and policy leadership positions in health care in Australia and Canada, including as Secretary of what is now the Commonwealth Department of Health. He has worked to implement various reforms in areas ranging from the introduction of activity-based funding for hospitals to new systems of accountability for the safety of hospital care. Duckett was hired by the Alberta government in 2009 as President and CEO of the newly created Alberta Health Services Board, which was established to implement a radical reform agenda that included significant funding cuts. In 2010, however, Duckett and his employer came to an agreement that they would part company. He is currently the Health Program Director at the Grattan Institute (Victoria, Australia) and writes extensively on health policy and administration.

Key Arguments in Affidavit
Duckett's affidavit is based on several peer-reviewed papers he has written on the impact of privatization (both delivery and insurance) on wait times in public and private systems in Australia.

The two papers he attaches to his affidavit both challenge the assertion that an expanding private sector will reduce wait times in the public sector. In fact, he argues the exact opposite happens.

The first paper, Private Care and Public Waiting (Aust Health Rev 2005: 29(1): 87–93), is a study testing the hypothesis that an increased proportion of care being provided in Australia's private sector is associated with reduced public sector waiting times. Duckett describes the high levels of public concern about lengthy wait times in the Australian health care system that led to significant policy changes to support private health insurance. These changes were justified, in part, on the grounds of their capacity to address the wait list problem. Duckett argues that longer wait times in the public sector were closely linked to the expansion of hospital services provided in the private sector. He cites a "time series analysis of United Kingdom national data [that] found that a 1% increase in a waiting time variable (measured as cost of waiting) was associated with a 0.6% increase in demand for private care".

The Australian government has supported private health insurance by creating incentives to the public to purchase coverage, including a 30% rebate on the cost of premiums. Coupled with policies supporting a lifetime community rating system, this support helped boost the number of people with private coverage by 50% - but the rebate costs about AU$2.5 billion a year, money that is being siphoned out of the public health care system.

The government argued that the 30% rebate would encourage people the obtain private insurance and facilitate access to private hospitals – which, in turn, would reduce pressure on the public sector and reduce wait times. Duckett uses a similar time series model as the one from the UK, Duckett found that a 1% increase in the proportion of

patients using the public system was associated with a 46-day reduction in median waiting time. He concluded that, in Australia, “increased private sector activity is associated with increased public sector waiting times, the reverse of the rhetoric supporting policies to increase support for the private sector in order to 'take the burden off the public sector'.”

Duckett acknowledges a limitation of the study may be associated with “the nature of the available data”. Nonetheless, he concludes that despite these limitations, “this study suggests that policymakers should be cautious about pursuing policies based on expanding private access as a strategy for achieving reductions in public sector waiting times”.

The second paper used to support the affidavit is entitled “Living in the parallel universe in Australia: public Medicare and private hospitals” (CMAJ, Sept. 27, 2005; 173 (7)). Written post-Chaoulli it is a reflection on that court decision. The paper was published in the Canadian Medical Association Journal, and urges Canadians to take a look at Australia before deciding to go down the same path as that country.

At the time of writing, about 40% of all hospital admissions in Australia were to private hospitals, and 43% of Australians had private insurance. He writes that this has had “deleterious implications for the equity and efficiency of the health care system” and similar ill effects could occur in Canada, whose health care system served as a model for Australia in certain respects. Like Canada, Australia has a national, universal medicare scheme that is administered, in terms of hospital access and fees, at the State level within a national framework. When private insurance was introduced, the government introduced a 1% surcharge on taxable incomes among high-income earners that they could avoid if they purchased private coverage. Premiums for private insurance range between US$1000 and $2000 a year after taking account of the 30% rebate mentioned above. Lower cost packages have higher deductibles and therefore higher out of pocket costs for hospital care.

A contentious aspect of private insurance is that, not only does it open the door to private hospitals, but it also enables subscribers to access “alternative providers” in the public system: “patients are able to pay to bypass public waiting lists or to guarantee that their elective surgery shall be performed by the specialist rather than by a surgeon in training”. (Yates also found that English patients who rely on the public system were more likely to see surgeons in training.) Duckett also points out that public and private sectors in Australia are not necessarily “complementary”. Private hospitals specialize in elective procedures – for example, 50% of orthopaedic and urologic procedures are done in the private sector. This allows private hospitals to “sidestep” the scheduling problems associated with providing emergency care. Because the public system provides urgent and emergency care to rich and poor alike, there remain high levels of public support for medicare.

Duckett concludes this paper by saying that “consumers” welcomed the wider choices provided in the private sector, but “this choice has come at the expense of equity”. The

43% of Australians with private insurance have faster access to elective surgery than those – the majority – who do not. He also raises a concern that "those with private health insurance have become a group with political influence". Private insurers have mounted successful lobbying campaigns to secure financial support from government. In fact, the financial support to the private insurance industry now "is greater than subsidies to agriculture, manufacturing and mining combined. This support is inefficient, in that the government expenditure for each additional patient treated in the private sector is well over the contemporary price paid for treating additional patients in the public sector. The additional government support is also probably impeding the ability of government to expand the public sector".

Colleen Flood

Colleen Flood is a Canada Research Chair in Health Law and Policy. She was the Scientific Director of the Canadian Institutes of Health Research, Institute of Health Services and Policy Research, from 2006 to 2011. She is a Professor of Law at the University of Toronto and is cross-appointed into the Department of Health Policy, Management and Evaluation and the School of Public Policy.

Key Arguments in Affidavit

Flood provides an overview of New Zealand's parallel health system, wait times and conflict of interest (within a dual practice environment). Canada and New Zealand share many characteristics, including the "clustering" of populations in a few cities across the country, creating similar challenges in both countries regarding access in sparsely populated towns and villages. Both health systems are primarily tax funded and both spend similar levels of GDP on health care. Both systems provide universal coverage for hospital and physician services, but New Zealand also funds dental care for children and formulary-listed drugs (and, although this is off topic, they have one of the safest and most cost-effective drug plans in the OECD).

However, New Zealand has a two-tiered system in which patients are able to use private funds to jump the queue and access specialists and elective and other surgical procedures in private hospitals. About one-third of New Zealanders have private health insurance, which goes mainly to pay for co-payments (which are numerous), elective surgery in private hospitals and outpatient consultations with specialists. The public-private spending split is: 82.7% public; 6% private insurance; 10.9% out of pocket. Patients in New Zealand's health system allows co-payments for a range of services, including in primary care, long term care and dental care (for adults). Flood cites studies showing that co-payments have a negative impact on utilization among lower-income earners in New Zealand. This extra billing may also be responsible for a higher use of hospital specialist services, "despite the fact that general practitioners are less expensive and may be more appropriate in the circumstances".

GPs are able to charge co-payments except in certain circumstances (eg., the patient has a chronic condition or meets a low income test) and the the median co-pay for an adult is quite steep – about $26-$30 (in CDN$). As in Canada, studies show co-pays have a negative impact on utilization for certain groups.

Wait times

In the early 2000s, patients in both Canada and New Zealand had similar wait times, but now there are significant differences that suggest New Zealand has made considerable progress in reducing the length of time patients wait. However, as the bulk of her affidavit shows, this is likely attributable to how waits lists are managed and reported, making it "impossible to tell what the real differences are between Canada and New Zealand vis-à-vis patient wait times.

Flood provides some detail on how New Zealand's wait list is managed. When its wait times were similar to Canada's, New Zealand managed the list in a very similar way to how the list is managed in Canada today: after referral to a specialist by a GP, the specialist would categorize the patient as urgent, semi-urgent or routine. In the mid-1990s, the country introduced a standard set of criteria (called the Booking System) to assess a patient's need for surgery and its "anticipated benefits". Those who met the criteria would have a guarantee of surgery within a specific time period while those who didn't would be referred back to their GP until their condition deteriorated. Patients who are referred to a specialist have an appointment within six months, at which time they are assessed. Depending on the score in the "Clinical Priority Assessment Criteria" patients are either booked for surgery within six months or are placed under "active review" to monitor their conditions within six months.

This sounds great, but there are four problems with the Booking System:

1. Patients often don't understand how the Booking System works. In addition, "Even if the booking system does provide certainty, those who are unable to afford private options must continue to wait until their condition improves or deteriorates to the point that they meet the threshold score to qualify for surgery".

2. The Booking System cannot guarantee equity because of regional or local variations in assessment policies as well as the fact that some patients are able to privately purchase their first specialist assessment and thereby jump the queue.

3. There are concerns about the validity of the criteria used to assess patients. Many doctors don't believe the assessment tools are clinically relevant and acknowledge that "gaming of the system occurs".

4. The Booking System lacks transparency. No information is reported to the public about actual wait times or what happens to patients who don't meet the assessment criteria. In 2010, there were 6821 patients who had not received scheduled services that they should have received within six months.

As a consequence of how the system works, New Zealanders who are waiting to be added to the official wait lists for surgery are not captured by wait times data collected and reported by the government. In addition, while Canadians are placed on a wait list according to medical need, in New Zealand getting on the wait list is dependent on funding - that is, the wait lists are "established according to the number of patients who can be treated with the available funds".

Conflict of interest

The arguments in favour of dual practice in New Zealand will sound familiar to Canadians, including that it is necessary because in some regions there isn't enough work to support a volume of surgery that will maintain competency levels and that without that option "physicians may have few incentives to join the medical profession, remain in the jurisdiction in question, or to participate in the public system". And, of course, this will

benefit patients, improve the quality of care in the public sector and introduce innovation into the health system generally.

However, conflict of interest is characteristic of dual practice, which tends to undermine access by patients left in the public system, lower quality, and support supplier-induced demand for private pay services and cream-skimming. While regulation and monitoring may counter the problem with dual practice physicians shirking their responsibilities, in countries where such public oversight exists "there are significant monitoring and enforcement problems". Flood's affidavit complements those of several others, for example Marmur. While Marmur describes the absence of the "regulatory burden" in Canada's mainly not-for-profit, single payer system, Flood describes how this strength could quickly become a weakness. She points out that "governance structures in some countries would seem to have a better chance of this type of managerial control (e.g., under salaried models used in New Zealand and the UK) than is the case in Canada. In Canada physicians are not salaried employees but work as independent contractors, and are self-regulated. Thus the cost and legal complexities associated with micromanaging physicians' schedules, to correct for conflict of interest, may be formidable".

That point is the strongest in her comments on conflict of interest. She reiterates many of the arguments made by other affidavits, including the negative impact on quality, the shift of resources (both human and material) out of the public to the private system, the concentration of services in areas of higher population density, the possibility of poorer patient outcomes, referrals from public to private practice, cream-skimming, etc.

She provides a very stark warning about the impact of extra billing in a country like Canada with a self-regulated medical profession and which has a comparatively low percentage of physicians working on salary. She says if doctors could extra bill whatever they want there would be strong financial incentives for them to practice in the private sector and "there would not necessarily be any residual public sector with salaried physicians as there is in New Zealand".

Cy Frank
Reviewed

Cy Frank is a co-founder of the Alberta Bone and Joint Health Institute (2004) and was its Executive Director from 2010 to 2013. He is an orthopaedic surgeon with a strong research interest in knees, ligaments, osteoarthritis and health service improvements in Canada (specifically, wait times for hip and knee arthroplasty). From 2000-06, Dr Frank served as the first Scientific Director of the National CIHR Institute of Musculoskeletal Health and Arthritis. Currently he is the CEO of Alberta Innovates Health Solutions (formerly the Alberta Heritage Foundation for Medical Research), administering and allocating >$100M/year of funding for research and innovations in health and health care in Alberta.

Key Arguments in Affidavit
Frank's affidavit is in response to statements made in Paragraphs 47, 48, 54, 59, 60 and 62-66 of the Medical Service Commission's Response to Further Amended Claim, January 11, 2013.

Paragraph 47 states: "Wait lists occur in every health system, regardless of the mix of public and private financing or delivery". Frank agrees with this and expands upon it.

Wait times are one of six dimensions of quality (accessibility, acceptability, appropriateness, efficiency, effectiveness and safety), all of which are equally important. In all systems, people wait their turn for surgery and sometimes during that wait they undergo further investigation and may try various (and safer) non-surgical interventions. Even those needing urgent care are queued based on the physician's assessment of need.

Not all wait times are managed or reported in the same way. For example, some systems report "mean wait times" while others report "median wait times", and still others report on the "90th percentile". Even among those who agree on one of these options, "there can still be significant differences between them in when the clock actually starts and stops". For example, the clock can start ticking when the GP refers a patient to a surgeon or when an informed surgical consent is given by the patient. Most of the public focus is on the latter category; but the date of patient consent can be manipulated – some patients may sign the form with no intention to undergo surgery. More than 50% of referrals to most orthopaedic surgeons in Canada are for elective "non-surgical" treatment.

Not surprisingly, given how complex the subject is, reported wait times in Canada are flawed. A study done by the Alberta Bone & Joint Institute several years ago found that 25.5% of patients on surgeons' wait lists were not waiting for surgery for a variety of reasons – most because they had already received the surgery. Of those who had been referred to a surgeon but not yet seen, 27.1% were not actually waiting; again most because they already had received the surgery. "Perhaps most importantly, the fact that patient wait numbers (and thus calculated times) were not accurate in their practices was not known by the surgeons involved (who didn't know that these patients would not show up for appointments) nor by the staff of the clinics, since they would never collect such

information from patients unless they are calling to remind patients immediately prior to the event". Thus, external audits or surveys of surgeons (such as are conducted annually by the Fraser Institute) are unable to substantiate actual wait times.

Other problems with wait lists include:

- The definition of "list" itself is variable, let alone who is on the list and why.
- The "patient journey" is poorly defined and understood (eg., some patients are not "medically optimized" for surgery or are on a list voluntarily waiting for the "next available" surgeon.
- The choice of surgeon based on "reputations" and the choice of surgeon with the longest wait times (assuming they must be the "best"); these patients are, in effect, "choosing to wait". The ABJH found that at least 35% of current wait times in Alberta are attributable to voluntary delays for elective surgery.

Frank discusses a number of related issues raised in the MSC January 2013 amended claim, including the impact of patients on surgical waits. He says the evidence on whether diseases and conditions predictably progress while patients are on a wait list is mixed, and it is not possible to predict disease progression accurately. This is one reason there are not standard definitions of "appropriate wait times" or "maximal acceptable wait times" for any given patient. Doctors make "educated guesses" in some cases regarding disease progression but some research shows that some patients (definitely not a majority) actually improve while waiting so they can either defer or avoid surgery entirely. Faster is not always better and faster does not always equate to better outcomes. Science also shows that 50-70% of patients progress to osteoarthritis with or without arthroscopic surgery.

Frank points out that, "contrary to what is claimed by advocates for private systems - who generally claim a 'benefit to the public system because a private system will decrease wait lists', evidence suggests the contrary. In fact, health systems with private health systems in which 'lists' are determined by a patients' ability to pay and not their medical need, do have significant and increasing 'waiting lists' for publicly delivered elective services". For example, "despite having a large and expanding private system for elective orthopaedic surgical care [in Australia], public patients waiting for knee replacement surgery suffered the longest delays of any surgical discipline in their country.

Paragraph 48 in the MSC claim says that, "A functioning health care system must prioritize differently for elective conditions than for urgent, emergency, or high priority conditions. The prioritization process takes into account the fact that no risk of death arises with respect to elective surgery". Frank generally agrees with the statement, but says, "there is some (very remote but not negligible) risk of death due to elective surgery". The three types of surgery – elective, urgent, emergency – need to be prioritized but it is a complicated system: "Emergent, by definition, always trumps urgent and urgent, by definition, always trumps elective. It is important to note that any patient can switch categories within minutes/hours depending on their condition (and test results) – making this a very time-dependent definition".

Regarding Paragraphs 54, 59, 60 and 62-66: Frank is in agreement with #54; #59; and #60. Regarding Paragraph 62 (MDs earn more money in the private sector), Frank says in

Canada there is no evidence showing this is or isn't the case, but it is certainly true in the US. Private clinics "by definition" attract patients who not only can afford the price but are known to be better educated, healthier and with fewer co-morbitities, thereby making them easier and safer to treat. This predisposes private clinics to report slightly better outcomes (not risk adjusted).

He is in agreement with Paragraphs 63 but feels the statement in Paragraph 64 ("The inevitable result of encouraging a truly parallel private system is to increase wait times experienced by beneficiaries who cannot afford treatment in that system") depends on what policies exist to prevent doctors from practising in both public and private systems.

Paragraph 65 ("There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems to encourage their patients to seek treatment from them privately by: a) maintaining long wait lists; b) failing to provide beneficiaries with accurate information regarding wait times for treatment in the public system; and c) withholding from beneficiaries information regarding options available to them in the public system"): Frank concurs with part (a) and thinks that (b) and (c) may be true with some individuals, "but this is more likely to happen because of a void in information regarding wait times and other options, than it is due to withholding 'known' information". Frank says there is anecdotal evidence to suggest, whether consciously or not, surgeons tend to provide preferred access to more "lucrative" patients over public patients. For example, after the introduction of a higher fee schedule by the WCB, injured workers were provided with faster access. In other countries there is evidence showing that patients who can pay and who have fewer co-morbidities and less risk are given preferred and much more rapid access over WCB-funded patients. He believes the likelihood of this type of behaviour "would probably rise in a very competitive environment (where physician per population ratios are high)".

Paragraph 66 states, "There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems, and who have an ownership interest in a private clinic, to refer beneficiaries to the private clinic for care and treatment that is no appropriate". Frank endorses this statement with some qualification. He states that there is evidence in existing literature that this is the case – citing studies that suggest there are "significant differences between public and private practices, with an overuse of diagnostics and therapies in private facilities, "particularly in the medical disciplines in which the risk of such potentially 'unnecessary interventions' are relatively low – eg., diagnostic imaging and radiation therapy". However, he is not familiar with any documentation that physicians who work in both public and private sectors "actively block or delay access in their public practice and actively divert these patients to their private practices". Nonetheless, he cites conflict of interest among physicians practicing in both sectors as "a major source of current concern".

Regarding referrals to private clinics for inappropriate care, Frank expressed some scepticism: "Deflecting patients from a public practice to a private practice for medically appropriate care… seems far more likely to me".

John Horne
Reviewed

John Horne is an Adjunct Professor in the Faculty of Social and Applied Sciences at Royal Roads University in Victoria. He is a consulting health economist and hospital administrator, the former CEO at Winnipeg's Health Sciences Centre and a former Professor in the Department of Community Health Sciences at the University of Manitoba. He has published widely and was a founding co-editor (2005 to 2010) of Healthcare Policy. He is a Director and Treasurer of the Canadian Association for Health Services and Policy Research and a member of the Editorial Advisory Committee of the Community for Excellence in Health Governance.

Key Arguments in Affidavit
Horne is the co-author of a paper published in 1980 (Beck RG, Horne JM. Utilization of Publicly Insured Health Services in Saskatchewan before, during and after Copayment. Medical Care 1980;18: 787-806) that looked at the impact of copayments (extra billing by physicians and user charges by hospitals) on patient utilization of medical and hospital services, 1968-1971. During the period, Saskatchewan allowed user fees of ~33% on medical services and 6% on hospital services. The authors found that copayments reduced utilization of medical services over the entire period by 3.83% to 5.66%. They also found that user fees did not reduce the rate of hospital admissions or length of stay and "thus did not reduce total health care costs. Instead, user fees shifted costs from public budgets to private individuals, with the burden of such transfers falling disproportionately on the sicker members of the population".

Horne states in his affidavit that, "the introduction of user fees would be likely to reduce access to physician services, especially among the poor and the elderly. [However], the introduction of user fees would not be likely to control costs by reducing either hospital admissions or lengths of stay. Instead, these fees would shift costs from public budgets to private individuals, which would disproportionately affect the poor and the elderly".

Jeremiah Hurley
Reviewed

Jeremiah Hurley is Professor and Chair in McMaster's Department of Economics. His current work includes an examination of public and private roles in health care financing, resource allocation and health care funding models, the use of incentives in health care, and the application of experimental methods in health economics. He has focused much of his past work on the relationship between workers' compensation payers and health care providers.

Key Arguments in Affidavit
Hurley focuses on paragraphs 70(a), (b), (c), (d), (e), (i), and (j), and 72-76 of the *Response to further Amended Civil Claim*, paragraphs 121-126 of the *Further Amended Civil Claim.* He also comments on how the impact of user charges and extra-billing varies depending on income.

Hurley, like other experts involved with the case, points to overwhelming evidence, both in Canada and internationally, showing that the demand for duplicative private insurance is strongest among those with higher socio-economic status, and income and education in particular. The demand is not influenced as much by perceived differences in quality of clinical care between public and private sectors, but rather by lower performance in the public system as reflected in long wait times. The main reason individuals seek private insurance is to avoid long waits in the public system.

Private insurers exclude coverage for pre-existing conditions and generally exclude coverage for chronic conditions, focusing instead on short-term, acute conditions. Typically, private plans do not offer catastrophic coverage. Where policies prohibit discrimination or require community-rated premiums, risk-rated premiums can be prohibitively expensive for many who are chronically ill. Private duplicative insurance concentrates coverage primarily (and in some places exclusively) on a small set of acute care services for relatively uncomplicated conditions provided on an elective basis, like those provided by Cambie and SRC.

The evidence shows that those with private duplicative insurance have better access to care than those without insurance and that providers give priority access to this group because private insurers pay higher rates than public payers. Although the evidence is somewhat limited, it is consistent in showing that wealthier individuals have private insurance and thus enjoy better access than those without, with preferential access on the basis of ability to pay in systems with large duplicative insurance sectors.

Although there is little direct evidence of what impact parallel private finance has on wait times in the public system, what does exist shows that such systems do not reduce wait times or increase access to services for those who rely on the public system; and there is a high probability that systems which allow dual practice increase wait times and reduce access for those who rely on the public system. A parallel private system of financing would compete with the public sector for health human resources, exerting upward pressure on costs. This would lead to real increases in the cost of services in the public system. Without duplicative private insurance, "only a small parallel private system for a limited set of services is financially viable".

Finally, "The introduction of duplicative private insurance would lead to an increase in the overall demand for health care and it will change the composition of those who receive health care services".

Hurley comments on the impact of extra billing and user charges: The vast literature on the subject shows they reduce utilization, especially among low-income individuals; they reduce utilization of both necessary and unnecessary services, especially for low income earners; reductions in necessary utilization, in particular, lead to adverse health effects, especially among low-income and vulnerable populations; they can cause costs to increase, in part because of adverse health events that could have been avoided. Hurley also says that user charges/extra billing "often end up generating small net fiscal gains" because of reduced utilization of services for which an extra charge is applied – however, this is much smaller than anticipated by those who believe such charges will save the system money due to reductions in utilization.

Hurley also refutes the claim by Brian Day, et.al., that exceptions to the Medicare Protection Act's restrictions "demonstrate the arbitrary nature of the impugned provisions as they do not apply on a uniform basis." This is an oft-repeated reference to workers who incur an illness or injury in the workplace and are thus covered by the workers' compensation system. The exception is rooted in the Canada Health Act and reflects a rationale "central to the design of the workers' compensation system and is consistent with longstanding principles governing the relationship between the workers' compensation system and broader social policy". There are three principles that guide workers' compensation policy in Canada:

1. It is a longstanding principle that employers should bear the cost of accidents that occur in workplaces they own and control. In return for workers fore-going the right to sue employers, they (workers) are able to receive, in exchange, compensation covering lost wages and medical costs. This predates medicare. Participation in the workers' compensation system "is mandatory for all eligible workers and employers – there is no choice".

2. Equally important, "workers' compensation health benefits are part of the overall system of public financing for health care". Hurley describes this as part of the public policy vision for public financing for services included in medicare. In addition, injured workers who obtained surgery at Cambie could only have done so according to the rules and policies of the WCB – it is not solely the prerogative of the worker to get such surgery in a private facility.

3. The Canadian social policy framework has treated the workers' compensation system as distinct from broader social policy arrangements across a number of policy spheres – health is not an exception.

Hurley concludes with this: "The above points do not imply that the treatment of workers' compensation in Canada's health and social policy framework is, in some sense, optimal. There is scope for considerable debate on this matter. They do document, however, that the exclusion from the public system of health care services required to treat workplace injuries and illnesses covered by workers' compensation legislation is not arbitrary. It is part of a long-standing principle and a consistent policy framework that has guided the development of social policies in Canada".

Tor Iversen
Reviewed: This reviewed copy is still difficult because of the remarks I made on the original summary. I'm not sure we should circulate it anywhere.

Tor Iversen is a health economist based in Oslo. He was one of the initiators of the Health Economics Research Programme at the University of Oslo (HERO) and has been its research director since 2006. He is also the Associate Editor of Health Economics, serves on the Editorial Board of the International Journal of Health Care Finance and is a member of the International Health Economics Association and the Scientific Committee for the World Congress on Health Economics. He has authored and co-authored a number of papers for international of journals and for the OECD, many of them looking at wait times and wait times policies.

Key Arguments in Affidavit
Iversen bases his affidavit on his previously published work, including a paper entitled "The effect of a private sector on the waiting time in a national health service" (1997) in which he constructed an economic model to examine wait times. The conclusions he reached were that when surgeons practise in both public and private facilities, wait times in the public system will increase if those wait list admissions are rationed. Rationing occurs when not everyone on the wait list is there by choice. Iversen writes that "if, as is presently the case in Canada, different specialists work in the public sector than those who work in the private sector the private sector will not have any effect on the [public sector] waiting time when waiting list admissions are rationed. In the economic model he developed, when waiting list admissions are not rationed (no pre-existing criteria for a patient to be added to the wait list) public wait times will grow longer when patients are able to switch to private care.

The 1997 paper he attached to his affidavit challenges the claim that private options will relieve pressure on the public system and thereby improve quality and access in the public system. Iversen looks at factors that may influence a patient's decision to go the private sector for services, concluding, "The waiting time, a patient's income and the price of a private treatment influence the choice".

The paper notes that, "The literature about the interaction between the private sector and the waiting time in a national health service is rather scanty". This was true in 1997, but is no longer the case.

This is a very complicated paper using a variety of mathematical equations to calculate whether the impact of private sector providers is positive or negative.

Dr. Dennis Kendel
Reviewed

Dennis Kendel is a past Registrar of the College of Physicians and Surgeons of Saskatchewan. He is a member of the Board of Trustees of the Canadian Health Services Research Foundation and Chair of the Finance Committee on the Medical Council of Canada. Dr. Kendel also participates on the Board of Directors of the Saskatchewan Health Quality Council, focusing on improved patient care and safety by reducing medical errors and introducing improved practices.

Key Arguments in Affidavit
Kendel focuses on the assertions by patients who have joined Cambie/SRC that they were unable to access the care they needed in a timely fashion. He argues that, at the time the care was needed, there was ample capacity both within BC and within Canada to assure their needs were met within the public health care system. Unfortunately, it appears that the patients were unaware of how best to access all of the options available to them. The only options they were able to exercise were the ones offered them by the physicians treating them. In fact, each of the physicians treating these patients had a duty to inform them of all the options available within the public system but, "They failed to do so".

While some of the patients relied on the internet to seek out care in the private system, it doesn't appear that any of them exercised "comparable due diligence" in exploring the options within the public system. "However, that is largely irrelevant to their principal claim, which is that the public system lacked capacity to meet their needs in a timely manner".

Kendel's affidavit includes a fairly detailed review of the guidance provided to physicians regarding "Duty of Care" – in particular to patients who are on wait lists for consultation or surgery – by medical and professional organizations. In his view, the treating physicians failed in their duty of care towards all five of the patient-plaintiffs. In regard to Chris Chiavatti, Mandy Martens, Krystiana Corrado, and Erma Krahn, there were adequate resources within BC's public system; in regard to Walid Khalfallah, there were adequate resources within Canada. He argues that it wasn't the BC health care system, or the health system in Canada, that failed these patients – but rather the physicians treating them who failed "to take into account all of the available resources in the public system that could have been brought into play for their patients, failed to disclose all of those options to their patients, failed to assist their patients in making fully informed choices from all of the available options, and failed to adequately assist their patients in getting access to the most timely available care options".

Using the analogy of a house with many rooms, Kendel says the gatekeepers (doctors) directed their patients into only one room even though "the wait times for care in that room were longer than options available in other rooms". Unfortunately, the patients concluded that the government was responsible for what they perceived as the limited options available to them. Furthermore, "some of the physicians involved in the

professional care of these five patients aided and abetted these patients in making woefully uniformed choices. Some physicians in the public system did so simply by their failure to access and share with them information that would have enabled them to make much better informed care choices. Some physicians in the private system did so because it is in their interest to have patients believe the public system has inadequate capacity to meet their needs".

This is the focus of most of Kendel's affidavit. However, he also contributes a description of some of the motives that might have been involved on the part of physicians. He points out that the medical profession, through the BCMA, is in control of how resources are allocated across the spectrum of physician services. Doctors "can derive more income from a daily schedule that allows them to perform ten relatively simple procedures as opposed to two complex procedures". He also argues that the performance of these relatively routine procedures is more lucrative than doctor-patient consultations. "While some doctors work more hours per day than others, variance in earning capacity is driven more by the number of visits crammed into each working hour". Furthermore, it is not unlawful for doctors to focus on highly selective scopes of practice to maximize income.

There can be a broad variance in income between doctors in the same medical discipline (eg., orthopedic surgery), with similar overhead costs, who devote the same amount of time to practise, and who are compensated on a fee-for-service basis. Two key variables contribute to income variance: 1) scope of practice is limited to the most lucrative work (cherry-picking); and 2) high volume practice (more billable services per hour). The degree of autonomy accorded to physicians makes 'cherry picking' entirely lawful. "Also, regrettably, there is tolerance in the MSP rules for high volume practice until it reaches a threshold that is utterly inconsistent with safe high-quality patient".

Importantly, Kendel cites the WCB as a major revenue stream for private, for-profit surgical facilities in BC. The WCB not only contracted the facilities to provide services for injured workers, it also paid doctors at a higher rate for the same services in the MSP payment schedule. However, in recent years, this lucrative source of profit has changed for two main reasons: 1) there has been increased attention to workplace safety and - more significantly – 2) the fact there is more competition among private clinics for the simple reason that there are many more of them. "So, any business person who becomes concerned about diminishing revenue from one business line will automatically strive to grow revenue from other business lines". The new business line is publicly insured services.

Eike-Henner Kluge
Reviewed

Eike-Henner Kluge is a professor of philosophy at the University of Victoria. In 1989 he was asked by the Canadian Medical Association to establish the Department of Ethics and Legal Affairs, and was its first Director. He was the first expert witness in medical ethics recognized by Canadian courts, and has acted in that capacity in Alberta, British Columbia and Ontario. Kluge is widely respected as a bioethicist and has been an outspoken supporter of a woman's right to choose an abortion and of the right to die. He is a strong advocate of what he calls three "ethical principles", namely: "the principle of autonomy and respect for persons; the principle of equality and justice; and the principle of beneficence."

Key Arguments in Affidavit
Kluge focuses on fair and just resource allocation, and the ethics that support this approach to health care funding and provision. He argues that the question of how to allocate resources in a just and equitable fashion has been hindered by a lack of scrutiny of the central role and nature of the medical profession, which acts as the gatekeeper. He describes health care as a "service provider monopoly" in which physician practice is based on different – and sometimes conflicting – "conceptualizations": the Hippocratic model, the social service model and the business model. Each of these, in turn, has different implications for the health care system. He argues that the "business model cannot be an appropriate model for the ethics of healthcare resource allocation, because it ignores the ethical implications of medicine as a service-provider monopoly (and the social nature of some healthcare goods), although it can provide some useful tools for restructuring the *means* of delivery once *allocation* has been settled" (emphasis in original).

Since Kluge is an ethicist, his affidavit focuses on key ethical issues within the context of the Canadian social and legal system. He suggests that health care is an ethical, as opposed to legal, right. When resources are scarce, the right to access health care is naturally limited and society may confront conflicts that arise between competing claims. He argues that health resources are finite ("and there is nothing anyone can do about that"), a reality that underlies the reason for macro-allocation. When demand exceeds supply, micro-allocation decisions have to be made. No society is able to ensure the necessary health resources are ready and waiting for each citizen when and if they need them. A two-tier system ignores the fact the private system would compete with the public system for resources – and that the private "track" cannot function (except in a very limited way) without access to public goods.

Craig Knight
Reviewed

Craig Knight is the Assistant Deputy Minister in the Corprorate Policy, Legislation and Intergovernmental Relations Branch, Ministry of Health. He was present at a meeting on September 14, 2009, with Gordon Macatee (Deputy) and Brian Day.

Key Arguments in Affidavit
The purpose of Knight's affidavit is to refute Day's description of what happened at a meeting on September 14, 2009 at which he was present, along with Gordon Macatee (Deputy) and Brian Day. The meeting, which was convened to discuss the complaints the Ministry had received and referred to the Medical Services Commission about extra billing by Cambie and the audit the MSC intended to conduct. Knight's statement is very short and focused on Para. 8 in Day's affidavit (see Affidavit #1 filed by Dr. Brian Day with exhibits (Sept 14, 2009)) in which Day told Knight and Macatee that the principles of the Chaoulli decision applied to all provinces in Canada and suggested that they obtain a legal opinion on the issue. Day was advised that this was not the case.

According to Knight, Day expressed concerns that auditors would want to look at the records of patients who had not complained about extra billing, as well as records of those who had complained. When he was reassured this was not the intention of the audit, Day agreed to reconsider the Commission's request to audit the clinic. In his September 14 affidavit, Day says that "at the conclusion of this meeting, …Mr. Macatee agreed that there seemed to be no purpose in carrying out an audit of Cambie to determine whether it extra billed British Columbia residents when this was not in dispute".

Sara Kreindler
Reviewed

Sara Kreindler is a recipient of the Canadian Harkness Fellowship in Healthcare Policy and Practice. She is a researcher in the research and evaluation unit at the Winnipeg Regional Health Authority and assistant professor in the department of community health sciences at the University of Manitoba. She has previously served as a research consultant for the Manitoba Institute for Patient Safety and as an instructor at the University of Manitoba as well as at Oxford University. A strong theme in her work is patient access to health services and her current research looks at challenges to improving patient access and flow in the Winnipeg Health Region.

Key Arguments in Affidavit
Kreindler's affidavit is based largely on a paper she wrote in 2010 on the international evidence regarding wait time reductions for elective care. The international evidence she found shows that a proactive, targeted investment in public sector capacity is an effective long-term strategy to control wait times. Funding treatment activity, buying capacity locally and providing strong incentives for organizations to meet wait time targets have been shown to work in reducing wait times.

The evidence also shows that what Kreindler refers to as "indirect strategies" – such as depending on internal markets or increased private financing, providing wait time information to help patients "redistribute themselves", or unenforced wait time guarantees – have a poor record. Private for-profit delivery is not more efficient; rather these providers choose the type of services that can be run most efficiently (and thus profitably). She also warns that companies that must deliver profits to shareholders/investors pose "genuine risks" to health care systems. One tactic employed in this kind of environment is skimping on quality in order to cut costs and to divert resources from patient care to profits. These tendencies are especially difficult to prevent in complex systems such as hospitals and long-term care homes.

Kreindler discusses evidence showing that duplicative* private insurance is associated with longer wait times in the public system. This private financing of access does not necessarily increase overall capacity, but when it does that capacity may not be used to bring down wait lists. In addition, the new capacity is distributed on the basis of ability to pay rather than on the basis of clinical need. She is critical of private health insurance (PHI) because it is "an indirect, inequitable and potentially very expensive way to increase the supply of treatment – something that can be achieved much more efficiently through other means".

Kreindler also cites inefficiencies in the public system that can create long wait times even when there is sufficient capacity. These include unduly complex booking processes, "traffic jams", unnecessary steps, avoidable delays and the poor use of human and/or physical resources. Although reviews have concluded that increased efficiency contributes to wait time reductions, it has been difficult to identify which interventions have what impacts. It is important to ensure that organizations undertake a "thorough,

whole-system analysis" in order to correctly identify the problem and, thereby, the solution.

* Other experts are using different terms, for example, Stabile uses the term "supplementary" to describe duplicative private insurance.

William Lahey
Reviewed

Bill Lahey is a Rhodes Scholar and an Associate Professor at the Schulich School of Law, Dalhousie University. His research spans the fields of health systems law and policy; administrative law; environmental regulation; professional regulation; and legal history. He is Vice-Chair of the Board of Directors of the Nova Scotia Health Research Foundation and Chair of the Board of Directors of Efficiency Nova Scotia Corporation. From 2007-2011, Lahey was Director of the Dalhousie Health Law Institute and has acted as a consultant in law and policy in the field of health (as well as other fields).

Key Arguments in Affidavit
Lahey's affidavit is based on a report to the Health Services Preferential Access Inquiry in the Province of Alberta last year (2013). The report examined the legal entitlement to health services enjoyed by Canadians, and how such entitlements ensure access on the basis of relative need rather than on the basis of relative wealth. Lahey provides a legal interpretation of the *Canada Health Act* and the arrangements between provinces and the federal government – compliance with the five criteria of the Act (public administration, comprehensiveness, universality, accessibility and portability) in exchange for federal cash transfers. In addition to the five criteria, extra-billing and user charges must not be permitted under provincial health insurance plans. The clear exceptions to medicare legislation are in regard to the provision of medically necessary care provided to injured workers under workers' compensation laws, Canadian Forces, federal inmates and to those who have not met the residency requirements.

Similar to British Columbia, designated surgical clinics provide insured services under a "minister-approved agreement with Alberta Health Services", with the cost of the services paid for by the public system. Such clinics may also provide non-insured services or "enhanced medical goods and services" paid for by the client or a third-party payer.

Although there are variations across the country in the range and type of services included in provincial health plans, the commonality among them is that medicare makes most of the services provided by doctors and hospitals available to residents without personal expense. Lahey notes that there is "more extensive variation among provinces and territories on their funding of health services not included in Medicare", including home care, long-term care, dental care, outpatient therapies, and drugs accessed outside of hospital.

Interestingly, and a thought that is echoed in some of the other affidavits (eg, Marmor), Lahey comments that "the prohibition of extra-billing and user fees that the *Canada Health Act* indirectly imposes on physicians and hospitals constitutes the truly unique element of Canada's approach to the public funding of essential services".

Lahey's affidavit doesn't comment specifically about British Columbia – the document attached to the affidavit is about Alberta. He goes into some detail in examining each of

the criteria provinces must meet in order to receive federal cash transfers. One area he describes as not clearly within the scope of the *Canada Health Act* is outpatient diagnostic services. He also emphasizes that the Act does not deal with the delivery of services, but only their funding, thus when services are delivered by private providers it does not constitute a violation of the national criteria.

Unfortunately, Lahey seems not to have seen some of Health Canada's internal documents on the subject. For example, a strategic overview by the department included an examination of "Options re Private Delivery". This document states: "The role of private, for-profit providers in the delivery of insured health services is an increasingly prominent issue in Canada. Although not a CHA issue *per se*, private delivery of CHA insured services can have CHA implications if providers of such services charge patients for insured health services and/or allow them to jump the queue. Notwithstanding the federal government cannot control private delivery, the federal government is free to say, in policy terms, it is concerned about the CHA risks. Similarly, it is free to point out that there is no evidence to suggest private delivery is more cost-effective, of higher quality or more efficient than public delivery".

Lahey provides a very thorough overview of the requirements of and rationale underpinning the *Canada Health Act*.

Joel Lexchin
Reviewed

Joel Lexchin is an emergency physician at The University Health Network. He is currently a Professor in the School of Health Policy and Management at York University and an Associate Professor in the Department of Family and Community Medicine at the University of Toronto. He is one of the most prolific writers on the subject of prescription drug safety and public policy.

Key Arguments in Affidavit

Lexchin's affidavit is based on a systematic review of the international literature he undertook (with Paul Grootendorst) that looked at the effects of cost sharing on vulnerable populations. Specifically, they looked at the effects of cost-sharing on drug use, physician prescribing patterns, patient health status, individual and drug plan expenditures and use, and expenditures on physician and hospital-based services among the poor and those with chronic health problems. The review found that the introduction of user fees by both public and private drug programs has been a common tactic to reduce expenditures. User fees take many forms, including: copayments, deductibles, the removal of drugs from formularies, and reimbursement ceilings. User fees have shifted the cost burden to consumers.

User fees have had an impact on both drug use and related outcomes among vulnerable groups. The authors argue that, since "user fee sensitivity" is higher among those who spend a large share of their income on drugs (the poor and frequent drug users), the adverse effects of such user fees are concentrated in this group. Studies that focus on the impact of user fees among healthy individuals who likely spend less on drugs will "mask the responses of vulnerable individuals".

Another important factor that makes this group vulnerable is the lack of knowledge – general among all consumers – about which drugs are essential and which are not, thereby undermining their ability to discriminate. Thus, while user fees might be effective at reducing drug program costs, they may also inadvertently result in poorer health outcomes. When health status declines, there is greater use of the public health system (physician and hospital services). The increases in public spending for physician and hospital services may offset the cost savings on drugs.

The review found that the use of prescription drugs by the poor and by those in poor health with insurance had higher usage. These results came from both the US and Canada. Almost all of the studies under review found that drug user fees decreased drug use in vulnerable groups. "Even relatively small copayments…reduced drug use by 26 percent among low-income drug users". Lack of drug coverage among poor people and those with five or more chronic conditions led to significantly higher out-of-pocket spending on medications.

The paper concludes that spending a larger percentage of income on prescription drugs is associated with greater sensitivity to price increases. Copayments (and other user fees) do lower drug costs for the payer, but lead patients to forego needed medicines, thereby increasing the use of emergency services, nursing home admissions and serious adverse events. Conversely, easing access to prescription medicines for the poor lowers hospital costs.

Greg Marchildon
Reviewed

Greg Marchildon is a Canadian historian, economist and lawyer who has taught and lectured across Canada and the United States. In 2000/01 he was the executive director of the Royal Commission on the Future of Health Care in Canada (the Romanow Commission). He served currently is a Tier 1 Canada Research Chair at the Johnson-Shoyama Graduate School of Public Policy, an interdisciplinary centre for public policy research, teaching, outreach and training with campuses at the University of Regina and the University of Saskatchewan. He has written extensively on health policy in Canada.

Key Arguments in Affidavit

Marchildon reviews the history of both hospital insurance and medicare in Canada and British Columbia. His particular focus is on the right of physicians to opt out of provincial health insurance plans; the prohibition on private health insurance for publicly covered services; first-dollar coverage and the rules that have been developed to discourage or prohibit extra billing; and universal coverage provided to all Canadians on uniform terms and conditions. His affidavit begins in Saskatchewan, broadens to focus on the national picture and ends in British Columbia.

Doctors (who struck for 23 days) won significant concessions from the government of Saskatchewan when medical care insurance was introduced in 1961, including the right to opt out (and thereby extra bill) and the right of physicians to maintain private practice. Part of the compromise with physicians also allowed private (non-profit) insurers to co-exist with the public plan. In the end, however, very few patients chose opted out physicians or private insurers. In the end, Saskatchewan physicians themselves supported medicare, in part because their annual incomes increased by 35% in the plan's first three years.

The Hall Commission rejected extra billing and user charges, as well as means-testing – all three conditions were heavily promoted by the Chambers of Commerce, the insurance industry and the medical profession, in particular the BC Medical Association which became one of the most outspoken critics of the Hall report. The BCMA said the philosophy of the Commission was out of sync with that of the medical profession and was "so far out of step with Canadian thinking that only a small segment of the population [would] go along with report." This, of course, turned out to be flat out wrong. The Medical Care Insurance Act was passed unanimously in the House of Commons in 1968 with very high levels of public support.

In 1979, because extra billing and user fees were commonplace in many parts of the country, the federal government appointed Emmett Hall to report on the issue. He recommended that such charges be eliminated. Consequently, the then-Liberal government moved to introduce the *Canada Health Act*. Marchildon writes that physicians argued a ban on extra billing would have "a deleterious impact on their independence and power relative to provincial governments". As a gesture of goodwill towards the profession, a clause was inserted in the CHA guaranteeing "reasonable compensation" to physicians obtained, if necessary, through conciliation or binding arbitration.

The BCMA and the BC government had already reached an agreement on such a ban, and as a result extra billing was almost non-existent in the province. Although the practice was illegal in Ontario, the province had the highest incidence of extra billing at $49 million in 1983 (compared to $14 million in Alberta, which had the second-highest rate in the country). Although Marchildon doesn't mention it, this may have been because doctors with hospital appointments – who were "opted in" to the public health plan and paid by the government – were allowed to run a separate opted-out practice using a different payment model. According to the Heiber, Deber study cited by Marchildon in his affidavit, this arrangement allowed physicians "to 'stream' their more affluent patients to the opted-out practice and send the others to an opted-in office" located in the hospital system.

British Columbia

Marchildon describes the events that led to the ban on extra billing in BC, which was the second province to introduce hospital insurance. It was also the second to introduce medicare, or at least a version that took from both the Saskatchewan and Alberta plans. After the Hall report was published, the Bennett government was heavily lobbied by physicians and the commercial insurance industry – both promoted Alberta's Manningcare as a preferable alternative to universal medicare because it was voluntary and allowed user charges. But in 1964, Bennett signaled the commitment of the province to "the principle of a national health program and its willingness to take part in such a program." But in 1965, the Social Credit government agreed to a provision in the five-year "Master Agreement" with the BCMA that gave physicians the right to extra bill.

To ensure BCMA support, the Bennett government offered to subsidize high-risk patients so they could obtain coverage from the non-profit, physician-sponsored MSA medical plan (predecessor to Pacific Blue Cross). But MSA rejected the idea because "the inclusion of such individuals through government subsidy would threaten its independence". Nonetheless, the province established the BC Medical Plan as a non-profit corporation with a six-member board, including three from the BCMA. But Ottawa warned BC it was not eligible for federal funding because the plan was not universal, the insurance plan was not publicly administered and the plan lacked universality – that is, it was not offered on "uniform terms and conditions". To meet the criteria of the federal legislation, BC would have to put its plan under a single public authority in order to meet the requirement of public administration. In response, the province in 1968 passed *Medical Services Act*, the law that established the Medical Services Commission (MSC).

The BC law didn't explicitly ban extra billing. In 1980, the BCMA demanded a 30% fee hike, threatening to extra bill patients 40% if they didn't get it. The government offered 15.19%, an offer that was rejected by 93.7% of BCMA members, who also voted 86.5% in favour of extra billing. The government, in response, passed Bill 16, banning extra billing and ensuring that any future governments would be unable to include that right in agreements with the BCMA. However, this came at a significant price: the government agreed to a 40% fee hike.

Today, six provinces, including BC, prohibit parallel private health insurance. In BC extra billing was first restricted and then banned (in 1981).

Ted Marmor
Reviewed

Ted Marmor is Professor Emeritus of Public Policy and Political Science at Yale and has a long and distinguished career as an academic researcher, writer and commentator on international health care systems. His many areas of expertise include comparative policy analysis and the risks and benefits of efforts to import policy lessons across borders. He is an expert in Canadian health policy and has written a number of papers assessing Canada's overall performance in universal health insurance. He has written extensively about Canada's health care system (including as a consulted to Roy Romanow during the Royal Commission on the Future of Medicare). From 1994 to 2003, he was a member of the steering committee of the annual Four-Country Conference on Health Reforms and Health Care Policies in the United States, Canada, Germany and the Netherlands, a 50-person group set up to discuss issues in health policy.

Key Arguments in Affidavit
This affidavit addresses what Marmor refers to as Brian Day's (et.al.) "drive-by analysis" of parallel systems in Europe, specifically in regard to wait times and cost-effectiveness.

Marmor provides a broad description of the Canadian health care system, including the accommodation reached with physicians to protect clinical and professional autonomy. He suggests that it's precisely that high level of autonomy which has enabled doctors to use evidence-based strategies to reduce wait times – for example, Cy Frank in Alberta and the Ontario Cardiac Care Network.

The *Canada Health Act*'s ban on extra billing and user charges, and the prohibition on private insurance for publicly insured medical and hospital services, virtually precluded the need to develop regulations for the private provision of health services as so many other countries have done. Many European countries have long-established parallel public and private health systems and, as a consequence, have sophisticated regulatory regimes in place to protect citizens. By contrast, Canada "is not burdened by the level of regulatory intrusion that marks many other health systems". In a public system this is a positive, but it also means that we are probably not equipped to deal with "the inevitable complications of hybrid systems like those the plaintiff would have this Court approve".

Canada's ban on extra billing and user charges is unique and expresses a deep commitment among Canadians to equitable access and equitable sharing of the burden of illness. This also underpins the broad support medicare receives across virtually all classes (with, obviously, some exceptions among individuals).

The major focus of Marmor's paper is the methodology (or lack of it) employed by Day & Co. in comparing Canada's health care system to the systems in place in other countries. He describes in some detail what is needed to develop a sophisticated comparative analysis, including the purpose of such a comparison, the selection of countries whose policies one wants to learn from and the identification of common experiences across the range of comparator countries. He also describes problems with Days' analysis, which is based on anecdotes and observations rather than on a

comparative methodology that examines health care financing systems and assesses their effects. "There is no suggestion that he – or his supporters – have seriously studied cross-national findings in medical care". He points out that the claims made in Day's affidavit "are inaccurate and unsupported", and his conclusions are empirically false and unsupported "by any methodologically sound comparative analysis".

For example, Marmor points out that in comparable countries with parallel systems private health insurance is not purchased by "ordinary" citizens, but by mainly by the wealthy; thus, weakening the rules against extra billing and private insurance likely will not benefit ordinary Canadians. Without stringent regulations in place, private insurance becomes more expensive and increasingly exclusionary for the elderly and those with pre-existing medical conditions. (Although Marmor doesn't comment, the *Canadian Human Rights Act* allows "certain distinctions" to be made that exempt insurers from penalties if they discriminate against people based on their age, sex and/or disability where the basis of discrimination can be justified by actuarial calculations. So the existing regulatory regime is already weak in this regard.)

A private tier of health care in Canada would undermine equity and increase the cost and burden of regulation and administration. Extra billing would create perverse incentives and erode public support for medicare, and increase the overall cost of health insurance and provision. Marmor argues that the link between extra billing and reduced wait times is a false one. He points out that parallel private systems in Europe were not established to reduce wait times and that, in fact, 3 of the 7 countries Day points to have wait time problems similar to Canada's. The one common feature in all countries is the "regulatory burdens to constrain the distributive effects of extra billing, queue-jumping or channeling patients into private practice for financial gain". Marmor cautions that Canada has avoided most of those costs "and there is no reason to suppose that where long wait lists are a problem, reforming Medicare's rules is the solution".

Charles Normand
Reviewed

Charles Normand is the Edward Kennedy Chair in Health Policy and Management at Trinity College, Dublin. A health economist, Normand is the Chair of the European Observatory on Health Systems and Policies. His research focus is on the funding and organization of health services and the evaluation of treatments and services.

Key Arguments in Affidavit
Normand's affidavit focuses on four themes within the Irish health system:

- Equity – What is the effect of privately funded health care on the overall patterns of equity in access to care?
- Level of resources – To what extent does the private funding of services increase total health care resources and take burden off the state funding of care?
- Efficiency – To what extent does the existence of privately funded care lead to innovation and more efficient provision across the health sector?
- Impact of a parallel market – what are the effects of the parallel system on the capacity and operation of the state funded health system?

About 80% of the Irish health system is publicly funded, 8% is funded by private insurance, with 12% out of pocket. Public hospital care is nearly free for the entire resident population, but most of the out of pocket payment goes to GPs since the majority of people aren't covered for physician services. Private insurance and out of pocket spending are both heavily subsidized through the tax system.

Equity
People covered by private insurance have greater – and quicker – access to medical care than those who depend on public funding. Normand describes how parallel private funding in the Irish health system undermines equity and is associated with delayed access to care for people on low and middle incomes.

Level of resources
In Ireland's two-tier system, private insurers play a significant role. Although half of the population is covered by private insurance, it only contributes about 8% of total health funding. There are those who assert that private insurers and services increase the overall capacity across the health system, enabling public resources to be focused on those who cannot afford private care. However, Normand points out that the government pays about 20% of the total of both out of pocket and private insurance, therefore "the value is reduced by 20% and the cost of government funding increased by the same sum". Private services cost more than equivalent services in the public system and some of those private sector services are not included in the public benefit package because they are not considered to be of "sufficient value". Taking all of these factors into consideration, there is a modest net contribution by private funding but it is "much lower than the 'headline' figure of 8%" that many assert in Ireland.

Efficiency

It is difficult to compare the efficiency of public and private systems because the private sector doesn't provide data. However, where there is evidence, it suggests that there is significant overtreatment in the private sector, for example radiation treatment. Private providers/payers offer more limited services to respond to problems and adverse events. "When private treatment encounters problems some patients have to be transferred to public facilities that have the full range of intensive care and critical care facilities".

Impact of a parallel market

The biggest problems with a parallel private sector have to do with the resources required to regulate both payers and providers. There is evidence "of significant time being devoted in government to the regulation of public and private parallel practice". There is also evidence that when doctors practise in both the public and private sectors "cheating on the rules is observed", for example they may encourage patients with long waits to obtain a referral to their private practice to access needed services.

Normand points to a number of problems with private funding and provision of health care in Ireland. These include inequities that have emerged in Ireland, the limited contribution of private "additional resources" to reducing the burden on the state, and there growing evidence of decreased efficiency. "Finally, private service provision in Ireland has led to serious problems in regulating and controlling the sector, and has led to some harmful effects on the capacity of the public system to deliver services".

Adam Oliver
Reviewed

Adam Oliver is a Reader in Health Economics and Policy, LSE Health, London School of Economics and lecturer in health economics and policy in the Department of Social Policy. He is also founding co-editor of the journal, Health Economics, Policy and Law. Oliver has published widely in the areas of health equity, economic evaluation, risk and uncertainty, and the economics and policy of European health care reform. His current principal research interests focus on the interface between economics and political science in health care policy analysis.

Key Arguments in Affidavit
Oliver focuses on strategies employed in England (but not Ireland, Scotland or Wales) to reduce wait times that were viewed as unacceptably long. One successful strategy was a "star system" that rated the performance of hospitals. At the heart of this system was what he calls the concept of "naming and shaming". The star system was strengthened by large annual increases in NHS funding which enabled the NHS to increase capacity in the public system as well as to commission private sector providers "to aid the effort to reduce waiting times". Between 1997 and 2011, spending across the public and private sectors rose in parallel to each other.

In 2005, the Labour government introduced "patient choice" into the equation, so that GPs could offer a choice of hospital at the point of referral. A system of national tariffs for hospital procedures (similar to activity based funding) was introduced at the same time, "and thus the idea was that since prices are fixed, hospitals will want to compete for patients on the basis of quality, including low waiting times, in order to maximize revenue, believing that patients would be motivated to search for the best service". Although some people have attributed the fall in wait times to the patient choice policy, Oliver asserts that at most it was a partial driver since wait times had been falling for some time previous to the policy being introduced: "No respectable scholar would attribute the fall in NHS waiting times to any aspect of the private health care insurance market". Instead, the fall was attributable to a combination of waiting time targets, the "naming and shaming" strategy (which also included threats to employment among hospital managers if targets weren't met), high increases in health care spending and, to a lesser extent, patient choice.

Very few doctors work exclusively in the private sector. Those who work in both private and public systems are required by law to work 40 hours in the NHS. Because earnings are higher in the private sector, doctors have perverse incentives to diagnose and treat patients with private insurance in a timely manner. Easy-to-treat patients who are able to afford paying for their own treatment are sometimes encouraged by dual practice doctors to do so. Having said that, Oliver says that the relatively small size of the private insurance market, the lack of hard (as opposed to anecdotal) evidence of conflict of interest and the fact that most UK doctors are highly committed to the NHS, means that "any claim that these conflicts of interest represent a significant problem does not stand up to academic scrutiny".

Regarding private insurance, the patterns in the UK are similar to those in Canada. That is, "income, socioeconomic class and better health are significantly correlated with the demand for private health care insurance: the relatively wealthy and healthy, and those in professional, managerial and technical occupations are more likely to purchase such insurance than the relatively poor (in money and health terms) and those in unskilled jobs".[1] If private insurance was more common – currently it covers only about 10% of residents – there would be greater challenges to protect equity and social justice in relation to health care access. His conclusion is "Queue jumping and better hoteling services that are on offer with private insurance coverage could of course be perceived as distinctly inequitable, but this is probably not considered a big enough problem in the UK to cause much concern, particularly in the current era of historically short NHS waiting times. Moreover, it can plausibly be argued that so long as those with private insurance still pay their taxes, any care that they receive outside of the NHS might reduce some pressure on the public system".

Oliver concludes his affidavit by suggesting that, "features of the UK health care system do not apply to Canada". The public/private split in expenditures in the UK is 80/20, compared to Canada's 70/30. In Canada most non-hospital and non-physician services are not covered by public insurance, meaning that, "Canadians might be more ready to perceive an extension of private insurance as competitive rather than supplementary to the public system". Moreover, the FFS system provides incentives for Canadian doctors that do not exist for most NHS doctors who are on salary. He concludes by writing, "The threat of possible conflicts of interest, and to equity and social justice, of lifting the ban on extra-billing in the Canadian context therefore seem much more stark than those presented by the parallel private tier operating within the institutional structure of UK health care".

[1] In Canada, unionized workers are more likely to be covered by employer-sponsored benefit plans, although roughly 60% of the costs associated with such plans go to pharmaceuticals. The rate of unionization in Canada is higher than the UK.

Robert Reid
Reviewed

Robert Reid is a senior investigator at Group Health Research Institute in Seattle and associate medical director of research translation at Group Health Physicians (part of Group Health Cooperative). He is an adjunct professor at UBC's School of Population & Public Health, an affiliate associate professor in the Department of Health Services in the School of Public Health and Community Medicine at the University of Washington. He has also been a faculty member at the Centre for Health Services & Policy Research (CHSPR) and an assistant professor in the Department of Health Care & Epidemiology, the latter two both at UBC.

Key Arguments in Affidavit
Reid's main focus is based on a 2003 paper he co-authored, published in the Journal of Health Services Research & Policy entitled "Conspicuous consumption: characterizing high users of physician services in one Canadian province." The paper used physician claims, hospital discharge summaries, and vital statistics data to compare characteristics of high users, other users and non-users of physician services in BC. Reid and his co-authors found that the top 5% of users – characterized by multiple and complex health problems – consumed a disproportionate 30% of spending on physician services. For this population of high users, deterrence strategies such as cost-sharing are unlikely to have much impact on their costs and will likely do considerable harm to their health by adding financial burden to their health burden.

Ian Rongve
Reviewed

At the time the affidavit was written, Ian Rongve was the Executive Director of the Planning Analysis Branch, BC Ministry of Health. He was responsible for ensuring that strategic and operational planning is based on the best available analytical work. Rongve was formerly an assistant professor at the University of Regina.

Key Arguments in Affidavit
Rongve describes the complexities involved in measuring and tracking wait times in BC and, to a lesser extent, across Canada and across several fields: statistics, economics and health services. A key problem is the fact that there is little consensus within the medical community as to what is an appropriate wait time as opposed to an excessive wait time. Brian Day and the Fraser Institute are among many commentators who "are prone to ideas that have little or no support from the academic research". (For example, neither seems to realize that the quality of the data collected has significantly changed and improved since Cambie opened in 1996.)

The Fraser Institute's methodology in measuring wait times is based on a physician survey with a very low response rate and therefore its conclusions are seriously flawed. The average number of surgeries performed per surgeon cannot be accurately calculated (as the FI and Brian Day assert) by dividing the number of patients on that surgeon's wait list by the median wait time. Furthermore, median wait times in Canada cannot be used to draw conclusions about median wait times for elective surgery in BC because every province uses a different methodology to collect and report on wait times. (There is also a growing body of literature about the very similar problems comparing wait times among different countries within the OECD.)

Rongve challenges a number of assumptions made by Day in his affidavit, including the notion that there is a "government wait list". The Ministry of Health maintains two registries: the Surgical Patient Registry (SPR) and the Surgical Wait Times Registry (SWT). The public cannot access the former registry as it contains personal patient information. The Wait Times Registry is posted on the ministry website and updated monthly based on data in the SPR, which tracks all patients in BC who are having surgery in a public facility, including both elective and urgent (scheduled and unscheduled).

The SPR only collects data after the surgeon makes a clinical decision that surgery is required. There is very little delay in entering patient information in the SPR or transferring appropriate data to the publicly accessible wait times registry. Only surgeons (and not the province or health authority) decide which patients will receive surgery, when they will receive surgery and in what order. Neither hospital staff, health authorities, or the province moves patients between surgeons. Whether surgery is urgent or elective is solely the decision of the surgeon.

There have been significant increases in the number of certain surgeries performed in BC between 2000/1 and 2007/08: knee replacements (118%); hip replacements (58%); cataract (42%); and angioplasties (55%). There also have been significant decreases in wait times: open heart surgery (15.1 to 6.9 weeks); hips (18.7 to 10.1) and knees (25.4 to 13.1).

Mark Stabile
Reviewed

Mark Stabile is the Director, School of Public Policy and Governance at the University of Toronto and Professor of Business Economics and Public Policy at the Rotman School of Management. His research focus includes the economics of health care and health insurance, and tax policy and health insurance.

Key Arguments in Affidavit:
Stabile's main argument is that the international evidence suggests supplementary private insurance does not reduce pressures on public health care systems. In fact, in a study to be published in the April 2014 edition of *Encyclopedia of Health Economics*, Stabile and his co-author Matthew Townsend found that the opposite occurs: private health insurance has a negative impact on the public supply of health services.

Stabile will look at the impact of two different types of private health insurance on national publicly funded medical services. He uses the term "supplementary" to describe insurance that "generally provides access to services that are already within the publicly financed health insurance scheme (presumably affording faster access, greater choice, and other amenities)". Complementary insurance covers services not already covered by the public system, for example (in Canada) prescription drugs.

Stabile says that the international literature on the impact of private health insurance on a public health system is ambiguous. However, despite this shortcoming, the weight of the "limited evidence" suggests that introducing private insurance "may result in a decline in the supply of medical services in the public system" partly because doctors will shift to private practice. In addition, governments tend to pay less attention to public wait times if there are privately financed providers providing duplicative services. These two factors combined result in potentially longer waiting lists for patients who remain in the public system.

There is also evidence that a private health insurance system leads to a more complex case-load in the public sector, resulting in either higher public costs or longer public wait lists. The experience in most jurisdictions suggests that education and income is a stronger predictor of who is covered by private insurance than health status. There is little evidence "that supplemental private insurance is able to achieve an often-stated goal of reducing pressure on the public system and reducing public sector costs".

Stabile suggests that complementary insurance increases demand for both privately insured services as well as those that are publicly covered, thereby increasing costs in the public system through increased utilization and a reduction in the types of incentives characteristic of a system based on cost sharing.

Jeffrey Turnbull
Reviewed

Dr. Jeff Turnbull is Ottawa Hospital Chief of Staff and a past president of the Canadian Medical Association. He has also worked extensively in community health, and is a co-founder and medical director of the Ottawa Inner City Health Project which provides care to the homeless population.

Key Arguments in Affidavit
Turnbull summarizes the case brought to the courts by the plaintiffs: wait times in British Columbia are unacceptably long; for-profit facilities are able to assess and treat (paying) patients more quickly than the public system; for-profit facilities cannot survive unless they are able to charge fees to patients and/or to private insurers. The plaintiffs assert that allowing patients to pay for health care would help those who are paying, reduce wait times and improve the quality of the health system. He says that "plaintiffs have not, to date, provided evidence in support of this last claim" and his affidavit provides evidence to the contrary.

Turnbull focuses on 6 points to refute the claims made by the plaintiffs:

1. When physicians receive higher fees in the private sector, public sector wait times are longer.
To support this, Turnbull cites two important studies by DeCoster, et.al., which showed patients whose surgeons worked only in the public system waited a median of 10 weeks in 1997/98 and 1998/99, while those whose doctors worked in both public and private sectors waited a median of 21 weeks. Because of certain public policy steps taken by the Manitoba government, median wait times in the public system are now shorter than they were during the period studied (4-16 weeks). He also cites a paper by Charles Wright which noted that physicians in the UK were spending less time than required in the public system while working longer to expand the scope of their private practice. "The fact that this incentive does not exist within the present Canadian system is a fundamental strength, not a weakness to be eliminated".

While a few studies do support the plaintiffs' view that privately funded care provides spin off benefits to the public system, the "mountains" of "evidence in its totality" does not.

2. When facilities can charge fees, or where private health insurance is permitted, the result is access to care based on wealth rather than need.
The evidence that private insurance and out-of-pocket charges result in access being undermined is so voluminous it can't be easily summarized in the affidavit. Turnbull uses the experience of Australia to illustrate what much of the evidence shows. In Australia private insurance became available in the 1990s; by 2001 data showed the 69% of Australians in the wealthiest decile had insurance compared to 28% of those in lowest decile.

3. Care provided in for-profit facilities tends to be of lower quality than care provided in non-profit facilities.
The expansion of private insurance / out of pocket payments for surgeries would likely increase the share of health care services being provided in for-profit clinics. Several systematic reviews show that non-profits provide better quality care than for-profits in dialysis facilities, acute care hospitals and nursing homes in the United States. Studies also show an increase in unnecessary tests that can increase exposure unnecessarily to radiation; increase costs; and can lead to an increase in false positive tests.

4. Complications that arise in private clinics are frequently referred to the public health care system. This reduces access for those who rely exclusively on the public system.
There is evidence that wider access to privately funded care will divert public resources away from those who rely exclusively on the public system. To prevent this from happening would require additional scarce resources to be allocated to a regulatory infrastructure instead of being allocated to improving the public system.

5. The total cost of privately funded care is likely to be higher than publicly funded care.
A large private sector may result in lower public spending, but likely would increase total spending (both public and private).

6. Regulation of the private sector will be expensive.
Turnbull argues that proponents of privatization say increased regulation will allow fair co-existence of private firms (both providers and insurers). Whether such regulation is even possible "remains a matter of debate". He cites the example of Ontario which has provided the College of Physicians & Surgeons with regulatory authority on quality assurance in so-called "independent health facilities". The facilities are charged an annual fee of between $1000 and $2000 to support the quality assurance program, but these fees are passed on to the patients. The higher costs of regulation are not outweighed by lower costs in the private sector since evidence in other jurisdictions show that care is more costly in the private sector.

Aidan Vining
Reviewed

Aidan Vining is a professor of Business and Government Relations in the Beedie School of Business, Simon Fraser University, in Vancouver. He has been at SFU since 1984. Most of his work has focused on the areas of public policy, policy analysis, institutional analysis and business strategy. His current public policy research focuses on privatization, corporatization, contracting out and public-private partnerships.

Key Arguments in Affidavit

Vining's affidavit is based entirely on a paper he co-authored with Michael Epp entitled *The impact of direct and extra billing for medical services: evidence from a natural experiment in British Columbia* (2000). The paper is based on a study that looks at the characteristics of opted in and opted out physicians, as well as those of their patients. It brings both a class and gender lens to the discussion not often seen.

It should be noted that British Columbia allows physicians enrolled in the Medical Services Plan to opt out. In these cases, their patients are able to submit a claim to MSP for reimbursement. Doctors can unenroll from MSP altogether; in these cases they directly bill their patients who are unable to seek a reimbursement from either a public or private insurer.

The period reviewed in Vining's study is September 1992 to July 1993 when negotiations between the government and the BCMA reached an impasse; 81 physicians (out of about 7000) opted out of the Medical Services Plan and began billing patients directly. The authors compared the billing patterns of 73 opted out and 73 opted in doctors in 14 communities across the province. Interestingly, 100% of opted out specialists were male, compared with 88% of those who were opted in. During the two-year period, both groups treated nearly 140,000 patients. The study does not look at the impact of user fees on health status. The opted out physicians remained enrolled so that their patients were able to submit a claim to MSP for reimbursement.

The study found that the number of patients visiting a specialist dropped "significantly" – by about 6% – after the doctors opted out. The impact of use fees reduced utilization of GP services among female patients by 9%, while males were unaffected by the user fee. However, payments for opted GPs increased by about 10%. Lower income patients reduced their utilization of specialists' services as a result of DE billing. The drop in the number of patient visits did not affect the amount of money the doctors earned in billings. This is because specialists were billing MSP 7% more after opting out. Specialists and GPs both extra-billed based on their estimate of "patients' willingness and ability to pay". The average GP charged an additional $5 per visit, while specialists charged $10. Both also charged up to a 15% premium for other services.

This is a fairly complicated study that found reduced utilization of opted out physicians, especially among female and lower income patients, in response to relatively small user fees. There is evidence that shows patients switched from opted-out to opted-in specialists and that, in response to reduced demand, extra and direct billing patterns change.

Michael Wolfson
Reviewed

Michael Wolfson was (until 2009) the Assistant Chief Statistician, Analysis and Development, at Statistics Canada, with a focus on health program evaluation and determinants of health. Currently he is a professor in the Institute of Population Health at the University of Ottawa, where he was also awarded a Canada Research Chair in Population Health Modeling / Populomics in the Faculty of Medicine in 2010. His major writings have been in the areas of health program review and evaluation, and social determinants of health.

Key Arguments in Affidavit:
Wolfson argues that if BC allows a parallel private system, the private portion will grow, resulting in less distribution of wealth across income groups. If Canada follows the lead of other countries with growing private sector involvement, income disparities will be exacerbated and public support for tax dollars going to medicare would also erode. This is because different groups pay for health care through a variety of mechanisms – taxes being a key method – but how much they receive back in terms of health care services varies depending on a number of factors, including age and health.

Much of Wolfson's affidavit is drawn from a 2013 study he undertook with Michael Grignon entitled *Lifetime Distributional Effects of Publicly Financed Health Care in Canada*. The study concluded that an important (and often overlooked) characteristic of medicare is the way it acts to redistribute wealth across different socio-economic groups in society. Conversely, private health care increases disparities.

His study shows that the top 20% of Canadians earn 5.1 times the bottom fifth (after taxes and other deductions). "When the value of publicly financed health care is added, this disparity falls to 4.3 times". When people are at their highest earning power (middle age) they tend to use the health system the least. However, when their incomes are at their lowest, they are less healthy and thus their use of the health system increases.

In his affidavit, Wolfson shows that while taxes are higher among higher-income groups, the differences between income groups are less pronounced when measured over a lifetime. This same principle holds true for health care costs: these costs are higher for low-income groups, but the differences are not as pronounced when estimated over a lifetime instead of a single year. That is because higher income earners live longer than those at the bottom of the income ladder and thus use services for a longer period of time. Lower income people use health services more in their younger years but have a shorter lifespan than their higher-income counterparts. Over a lifetime, the lowest income earners pay 6% of their income toward publicly funded health care, compared to the highest earners who pay just below 8%.

As an expert witness Wolfson will show that health costs increase substantially with age and so the amount spent by higher income earners is offset by their higher use as they age. Conversely, there is generally a pattern of higher costs associated with lower income groups in their younger years, but their lifetime use declines relative to higher income earners. Therefore, the use of health care services across income groups evens out over a lifetime.

John Michael Yates
Reviewed

In 1978, John Yates was seconded from a senior NHS management position to the Health Services Management Centre (HSMC) at the University of Birmingham, and there he remained until his retirement in 2003. HSMC was set up in 1972 to provide a combination of research, teaching, professional development and consultancy to health and social care agencies in the UK. Under Yates leadership, it established the Inter Authority Comparisons and Consultancy (IACC), which developed some of the first indicators within the NHS to measure quality. Since wait times is a key quality indicator, this became his main focus. He developed a critical analysis of the interface between public and private physician practices (including conflict of interest). This is likely to be the focus of his expert testimony.

Key Arguments in Affidavit
Yates' affidavit argues that "public patients" (ie., patients in the NHS) wait longer than private patients. In a pivotal 1995 study, he found that private patients saw an orthopaedic surgeon within two weeks of referral, compared to a 25-week wait by patients in the NHS. Public patients also received fewer operations, compared to private patients who received more – as well as more unnecessary surgeries. The same study found that although only 9% of the population in Britain had private insurance in 1989, 28% of all hip surgeries were done on private-pay patients.

Yates effectively describes why this is inequitable. In Britain, public patients suffer greater levels of illness than their counterparts in the private system, but wait longer for treatment and receive fewer surgeries. He also provides a breakdown of the geographic distribution of private practitioners and shows that the regions with the most private beds have the worst waiting times. Specialties with the longest wait times have the highest earnings from private practice. The medical conditions with the longest wait times in the NHS appear to be the mainstay of the private sector and the surgeons who work in both the public and private systems appear to have the longest wait lists.

Yates argues that if Canada permits private insurance (or private pay) for publicly-insured services, private payers will likely get faster care in spite of the fact that patients who rely on the public system are sicker. Private pay patients would receive a higher volume of services, some of which would likely be unnecessary. Because of conflict of interest, dual practice physicians have an incentive to ensure their public patients are waiting longer so they will want to go private. Furthermore, it would be very costly to monitor this.

Yates was instrumental in developing a system to reduce wait times in the NHS. These steps were necessary to achieve significant reductions:

- Wait lists had to be accurately measured
- Inefficiencies were reduced
- Hospitals were adequately resourced
- NICE was established to study the efficacy of drugs and surgical interventions

If Canada wants to reduce wait times it should follow the example of the (old?) NHS, not introduce conflict of interest in dual practice, which is likely to increase, not decrease, wait times.