



UBC CENTRE FOR
HEALTH SERVICES AND
POLICY RESEARCH

Private Parts?

Finding the balance of public and private in health care

Conference Summary

July 2020

CHSPR 2020 HEALTH POLICY
CONFERENCE

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THE UNIVERSITY OF BRITISH COLUMBIA

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Contents

- 2 About CHSPR
- 2 CHSPR's Health Policy Conferences
- 3 About the Conference
- 4 Court Challenges to Canada's Health Care Laws
 - Understanding the current legal challenge to Medicare: *Cambie Surgeries et al. v. British Columbia*
Speaker: BJ Wray, Department of Justice Canada
 - What light does post-Chaoulli Quebec shed on the Cambie trial?
Speaker: Damien Contandriopoulos, University of Victoria School of Nursing
- 9 Public Policy in Light of the Charter
 - Cui Bono?* Legitimacy, policy-making capacity, and the Canadian Charter of Rights and Freedoms
Speaker: Steven Barrett, Goldblatt Partners LLP
- 10 International Evidence on Private Financing
 - The impact of parallel public and private finance on equity and access: What does the evidence say?
Speaker: Jeremiah Hurley, McMaster University Centre for Health Economics and Policy Analysis
- 13 International Experience and Design of Private Financing
 - Are carrots and sticks enough to keep private insurance viable in Australia?
Speaker: Anne-Marie Boxall, 2019-20 Australian Harkness Fellow, Columbia University
 - Hard work for government: Balancing public and private financing in Europe
Speaker: Sarah Thomson, WHO Barcelona Office for Health Systems Strengthening
- 16 Regulating Private Finance
 - What comes next? Analyzing the options for BC and Canada should Cambie succeed
Speaker: Colleen M. Flood, University of Ottawa Centre for Health Law, Policy and Ethics
- 18 Day I Closing Address
 - At the heart of it all: Are Canadians still bothered by inequity?
Speaker: Sarah de Leeuw, University of Northern BC
- 19 The Future of Financing for Prescription Drugs and Dental Care
 - National Pharmacare: Rolling stone or mossy boulder?
Speaker: Fiona Clement, University of Calgary O'Brien Institute for Public Health
 - Solving a mystery: A tale of two cities and loose ends
Speaker: Carlos Quiñonez, University of Toronto Faculty of Dentistry
- 22 Day II Closing Address
 - The Canada Health Act: Fold, hold, or raise?
Speaker: The Honourable Jane Philpott, P.C., Former Member of Parliament and Special Advisor on Health, Nishnawbe Aski Nation

About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity, and sustainability.

Our faculty are among Canada's leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

We receive core funding from the University of BC. Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies.

For more information about CHSPR, please visit <https://chspr.ubc.ca/>.

CHSPR's Health Policy Conferences

CHSPR's annual health policy conference is an opportunity for those interested in health policy issues to hear about emerging research and participate in interactive dialogues with experts in thematic areas shaping Canada's health system. This long-standing conference draws together leaders, researchers, policy-makers, academics, health care providers, and patients, from universities, governments, industry, health authorities, and national organizations across BC, the rest of Canada, and internationally. This document presents highlights from the 2020 conference. For summaries of past conferences, please visit <http://chspr.ubc.ca/conference/past-conferences/>.



About the Conference

CHSPR held its 32nd annual health policy conference on March 5–6, 2020 at the Pinnacle Hotel Vancouver Harbourfront.

The role of private financing for health care services has long been the subject of intense debate in Canada, leading to major court battles including *Chaoulli v. Quebec*, *Allen v. Alberta*, and *Cambie v. British Columbia*. The role of private financing is also part of ongoing discussions about the future of national pharmacare, dental care, mental health care, and long-term care.

At the 2020 CHSPR Conference, we delved into the evidence underpinning these debates. What evidence do we have on private financing? What remains to be known? What balance do other countries strike in deciding who pays for what?

Supporters and conference organization

This conference would not have been possible without the financial support of generous supporters, including the BC Academic Health Science Network, the BC Ministry of Health, the Institute for Health System Transformation & Sustainability, the Canadian Institute for Health Information, the Michael Smith Foundation for Health Research, the BC Patient Safety & Quality Council, the BC Primary Health Care Research Network, the Health Data Coalition, IQVIA, and the Canadian Institutes of Health Research. This report would not have been possible without support from Health Canada.

The conference program and planning committees were chaired by Dr. Michael Law of CHSPR and included a number of prominent health system and health policy leaders, as well as a patient partner. The conference was co-chaired by Dr. Law and Prof. Karen Palmer of Simon Fraser University. The conference planning committee was led by Dawn Mooney and Joyce Huang of CHSPR. Conference support was provided by Face2Face Events Management.

We thank the students whose notes helped us write these proceedings, including Talshyn Bolatova, Celestin Hategeka, Richard Musoke, Andrea Stucchi, and Seraphine Zeitouny.

We gratefully acknowledge that this conference took place on the traditional and unceded territories of the Coast Salish peoples, and we thank Coast Salish Elder Roberta Price of the Snuneymuxw and Cowichan First Nations for the welcome she provided.



DAY 1 SESSION 1

Court Challenges to Canada's Health Care Laws

Understanding the current legal challenge to Medicare: *Cambie Surgeries et al. v. British Columbia*

Speaker: BJ Wray, Department of Justice Canada

Dr. Wray provided an overview of the ongoing constitutional challenge involving *Cambie Surgeries Corporation v. British Columbia*. Dr. Wray outlined the three main impugned provisions of the BC Medicare Protection Act (MPA), which the plaintiffs say infringe patients' rights under the Canadian Charter of Rights and Freedoms, including their Section 7 rights to life, liberty, and security of the person. Dr. Wray then discussed what the outcome of the case might mean for the future of health care in BC and Canada.

The Canada Health Act (CHA) sets out the primary objective of Canadian health care policy, which is to ensure and uphold universal access to health care services on the basis of need rather than the ability to pay. It establishes criteria and conditions related to medically necessary insured health services that the provinces and territories must fulfil to receive their full share of the federal cash transfer under the Canada Health Transfer. The BC MPA parallels the CHA.

The Cambie trial began September 6, 2016 and closed February 28, 2020, with evidence having been heard on both sides. Now, the court is deliberating and will provide a decision, likely in three to six months. This will most certainly be followed by appeals.

The plaintiffs in the case pursued action to strike down several provisions of the BC MPA, primarily to allow physicians to provide expedited medically necessary insured health care services to patients for a fee. The plaintiffs asked the Court to strike the following prohibitions:

1. The prohibition on **duplicative private insurance**, which does not allow individuals covered by the BC Medical Services Plan (MSP) to purchase private insurance to cover things that are already covered by MSP.
2. The prohibition on **extra billing and user charges**, which does not permit physicians to charge individuals who are covered by MSP for services covered on the plan. The Government of Canada requires provinces to enforce this prohibition, or face mandatory deductions from their share of the Canada Health Transfer.
3. The *de facto* prohibition on **dual practice**, which restricts physicians enrolled in MSP from providing insured services to both public pay and private pay patients. Physicians must choose to practice as enrolled doctors in the public system, or as un-enrolled doctors entirely outside the public system.



Who is leading the charge?

Plaintiffs

1. Corporate Plaintiffs: Cambie Surgeries Corporation, comprising Cambie Surgery Centre (whose physicians are all enrolled in the public plan, and currently provide both publicly-funded and private pay surgeries), and Specialist Referral Clinic (which offers consultations and referrals to Cambie Surgery Centre for a fee).
2. Patient Plaintiffs: A group of four individually named plaintiffs who testified that they faced excessively long wait times, which caused them physical and psychological harm.

Defendants

1. Named Defendant: Attorney General of BC.
2. Unnamed Defendant: Attorney General of Canada (not named as there is no federal legislation being challenged; however, constitutional challenges at the provincial level trigger the ability of the Federal Attorney General to intervene). Jane Philpott, Federal Minister of Health at the time, felt this was an important case which could have national implications and instructed the Attorney General to intervene.

Interveners

1. BC Anesthesiologists Society: Argued access is not reasonable.
2. Patient Interveners: Claim to have experienced harms from dual practice and extra billing, and sought to demonstrate inherent harms of some being able to buy their way to the front of the line.
3. Coalition of Interveners: BC Health Coalition and Canadian Doctors for Medicare, both strongly aligned with the defendants, held the position that it was necessary to maintain equitable access to essential services based on need rather than ability to pay.

Plaintiffs' position

Section 7 of the Canadian Charter of Rights and Freedoms

Plaintiffs allege the MPA causes harm because they say it prevents patients from accessing services in a timely fashion.

- Must show patients endured physical/psychological harm due to waitlists.
- Must show the prohibitions in the MPA were the cause of the harm.
- Must show the intended effect of the legislation is not connected to the objective of the law.

Section 15

- Plaintiffs allege the MPA privileges some groups over others.

Section 1

- Plaintiffs allege the MPA is not rationally connected to its objective.

Defendant's position

Section 7

- Plaintiffs failed to demonstrate the impugned provisions of the MPA caused harms.
- Plaintiffs did not understand the provisions, since physicians have the choice to un-enroll from MSP and operate in the private pay system if they so choose.

Section 15

- No true discrimination between groups was demonstrated.

Section 1

- Any rights that may have been infringed could be justified in a free and democratic society.



What light does post-Chaoulli Quebec shed on the Cambie trial?

Speaker: Damien Contandriopoulos, University of Victoria School of Nursing

Dr. Contandriopoulos provided an overview of the Supreme Court of Canada's ruling in *Chaoulli v. Quebec*, which found that prohibitions on the sale of private health insurance violated the Quebec Charter of Human Rights and Freedoms. He explained the details of the case, the subsequent passing of Bill 33 which legalized the sale of private health insurance for three specific surgical services in Quebec (i.e. hip and knee replacements and cataract surgery), and the lessons BC can learn from Quebec's experience.

Dr. Jacques Chaoulli and a patient, Mr. Zeliotis, sought to strike down the prohibitions imposed by the Quebec Health Insurance Act and the Hospital Insurance Act which prevented the sale of private health insurance in Quebec. In a narrow 4-3 decision, the Supreme Court ruled in the plaintiffs' favour and found the Act violates the rights to life and security of person in the Quebec Charter of Human Rights and Freedoms. The ruling is binding only in Quebec.

The outcome of the ruling was the passage of Bill 33 in 2006, *An Act to amend the Act respecting health services and social services and other legislative provisions*. This bill had several important components:

- Legalized the sale of private insurance to cover knee, hip, and cataract surgeries performed by non-enrolled doctors.
- Imposed guidelines on the maximum amount of time a person would have to wait for one of the above procedures, and implemented a monitoring system.
- Allowed for the possibility of publicly-funded procedures in private for-profit clinics should the wait times surpass the imposed maximum time.

Ironically, although it has been legal to sell duplicative insurance for the above surgeries for nearly 15 years, no health insurance companies actually sell the insurance. Wait times are monitored; however, nothing is done with the data, and no patient has ever gone to the private pay sector for one of the allowable procedures if the publicly-funded wait has been too long.

There were three main implications of Bill 33:

1. Private investors got the message that for-profit health care delivery markets were worth investing in (many private companies bought up land around hospitals to build for-profit clinics).
2. Many family practitioners decided to jump ship and un-enroll from the public system.
3. Many un-enrolled doctors started opening private pay, fee-for-service, clinics in which they charge fees. This dramatically shaped the collective mentality of the public, as patients came to expect fees and to pay out-of-pocket for certain services.

Other serious concerns have been raised in post-Chaoulli Quebec, such as the practice of physicians temporarily un-enrolling from the provincial medical plan, performing surgeries in the private system, and then immediately re-enrolling to recruit more patients from the public pay to the private pay system. This loophole allows physicians to treat private pay patients, and then immediately go back to the main pool of publicly-funded patients to recruit more business.

It also causes issues with physician retention in certain fields. The ruling did not impact all specialities in the health care sector in the same way, with most specialties being unaffected by un-enrollments; however some specialties, like dermatology, lost a significant number of practitioners. In practice, there are tiny pockets of medically necessary services that are moving out of the public system. This is where we see the implication of private demand on the public system.

Most concerning of all has been the collective mind change towards fees, or *frais accessoires*. Post-Chaoulli, the collective mindset of the public seems to have permanently changed. No one questions the additional fees they were charged, even though there is nothing to suggest the fees were legal. Despite the provincial government's efforts to prohibit double billing and extra user fees, doctors, clinics, and investors continue to find ways to circumvent the rules and the public does not appear to care. The main take away is that once the infrastructure is there, once investors have sunk the money into building the clinics and purchasing the equipment, they will find a way to pay for it.

Dr. Contandriopoulos then discussed how he believes Chaoulli affects BC's case:

1. Whatever the outcome of the case, the ruling is not the end of the story—likely many areas of the health care system will be impacted, far beyond just what the Cambie Clinic is seeking to change.
2. When/if the market develops, it is going to be difficult to slow or change it. It is a lot more difficult to undo something than to not do it at all. If Cambie wins, those changes will likely shape the future of health care permanently.
3. The overall impact from the court's decision in Cambie may be a mix of market forces (demand, supply, investment decisions) and post-ruling legislation.

A big take away from Cambie and Chaoulli is that the public and private arguments are totally opposite, with public arguments focusing on equity, and private arguments focusing on the rights of individuals/performance. The question of how to find a balance between these competing demands remains.

A big take away from Cambie and Chaoulli is that the public and private arguments are totally opposite, with public arguments focusing on equity, and private arguments focusing on the rights of individuals/performance. The question of how to find a balance between these competing demands remains.

DAY I SESSION II

Public Policy in Light of the Charter

Cui Bono? Legitimacy, policy-making capacity, and the Canadian Charter of Rights and Freedoms

Speaker: Steven Barrett, Goldblatt Partners LLP

Mr. Barrett provided thoughtful commentary on the Canadian Charter of Rights and Freedoms, its legitimacy and role in public policy, and he considered *cui bono*, “who benefits”.

He introduced the Charter and discussed its effects on government powers and decision-making. He considered whether or not the Charter, with its judicial power, risks over-protecting vested interests at the expense of the disadvantaged and oppressed, and whether there are, or should be, limits to the promise of constitutional rights. Drawing from case law, he explored the tension in some landmark Supreme Court trials involving individual rights and those of the collective, reflecting on our societal notions of justice. He described previous decisions involving Section 7 challenges, such as *Canada v Bedford* (in which the law was found to deprive sex workers of their right to security by forcing them to work secretly), *Canada v Carter* (overturning the law that denied a right to medical assistance in dying), and he considered their relevance in *Cambie v British Columbia*. He reflected on whether it is possible or desirable to “charter-proof” public policy choices and laws, as some have suggested, such as those related to health care policy.

He opined that irrespective of the outcome of the trial, long wait times should be addressed. If *Cambie* wins at trial, several risks should be considered, including the possibility of physicians switching to the private pay sector, and the potential for increasing health care costs in the public pay sector.

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DAY I SESSION III

International Evidence on Private Financing

The impact of parallel public and private finance on equity and access: What does the evidence say?

Speaker: Jeremiah Hurley, McMaster University Centre for Health Economics and Policy Analysis

Dr. Hurley spoke about the economics of private health financing, reviewing evidence and analytics on parallel duplicative insurance, dual practice, and deregulated private fees. This is a complicated question that needs to draw from empirical evidence, including from Australia and the UK, to determine what the outcomes in Canada might be. There is not a lot of evidence regarding some of the impacts, it is contested, and there are often counterfactuals that one cannot adjust for. It is almost impossible to look at outcomes in isolation of other factors. The overall conclusion from studies to date, however, is that parallel private financing reduces health system equity and, on balance, it likely reduces access to care in the publicly-funded system.

Private health care financing thrives on the uniqueness of services, and their particularity in terms of amenities, choices, and shorter waits. To be viable, health care providers need to have incentives to offer these services and private insurance needs to defray the high costs of care.

Duplicative private financing affects three different types of equity in health care systems:

1. Equity of use and access

- Calls for services to be allocated according to need. There is both horizontal equity (those in equal need receive equal treatment) and vertical equity (those with differing needs receive appropriately different treatment).
- Private funding unequivocally reduces distributional equity with respect to use and access. It compromises allocation based on need by disproportionately increasing use/access for those of high socioeconomic status, prioritizes those who seek private pay care and require uncomplicated elective procedures, and excludes some users, such as those with more complicated conditions, or seniors.
- Overall, parallel private payment compromises allocation according to need.

2. Equity in finance

- The dominant criterion is monetary contribution is according to ability to pay. There is both horizontal equity (those with equal ability to pay contribute equal amounts) and vertical equity (those with differing ability to pay contribute appropriately different amounts).
- The impact of private finance on equity has less evidence, but duplicative private finance will in general increase the correlation between amount of contribution and ability to pay (income), increasing measures of distributional equity in financing if no tax subsidies are applied.

3. Net distributional incidence

- This measures equity with respect to the difference between the value of services received and contributions made.
- Private funding reduces distributional equity with respect to net benefit.

Both demand and supply must be considered in assessing the impacts of parallel private finance on access to the publicly-funded system. The impact on access in the public system depends on supply and demand responses in each of the public and private health care sectors. Dr. Hurley illustrated this with the following examples:

Case 1: Equal supply and demand responses

- Total system demand stays constant but A units of demand shift from public pay to private pay.
- Total system supply stays constant but A units of supply shift from public pay to private pay.
- This will result in everyone getting treated, but access worsens for public pay patients because of differential prioritization.

Case 2: Differential demand and supply responses

- Total demand stays constant but A units of demand shift from public pay to private pay.
- Total supply grows by 1 unit (new supply goes to private pay sector) and $(A-1)$ supply units shift from public pay to private pay.
- This will result in everyone getting treated, additional patients treated in public pay, and ambiguous impact on wait times in public sector.

Case 3: Differential demand and supply responses (the more realistic scenario)

- Total demand grows, with A units of demand shifting from public pay to private pay, B units of new demand.
- Total supply remains constant and $(A+B)$ units of supply shift from public pay to private pay.
- This will mean that those who rely on the publicly-funded system are unambiguously worse off (fewer patients treated, wait times increase).

Most probable demand-side scenario: Total demand will increase.

On the supply side, impact will depend on the work decisions of health care professionals, and physicians in particular. Competition for health care professionals will drive up wages, resulting in reduced real value of the public budget and, therefore, reduced volume of services that can be publicly-funded. Current evidence is that provider labour supply is highly inelastic, so total work hours are unlikely to increase, but some of that labour supply will shift from public to the private sector.

Most probable supply-side scenario: Reduced supply to the public pay sector.

Finally, Dr. Hurley considered whether detrimental effects be mitigated. He suggested that might be possible through a series of interventions:

- Limit size of parallel private pay sector;
- Remove employers' tax subsidy for, and tax purchase of, parallel private insurance; and,
- Prohibit public facilities from providing privately financed care.

...parallel private financing reduces health system equity and, on balance, it likely reduces access to care in the publicly-funded system.

DAY I SESSION IV

International Experience and Design of Private Financing

Are carrots and sticks enough to keep private insurance viable in Australia?

Speaker: Anne-Marie Boxall, 2019-20 Australian Harkness Fellow, Columbia University

Dr. Boxall compared the Canadian and Australian health care systems, outlining similarities between the two countries. Both countries have federations with provinces, parliamentary democracies, similar population size, similar proportion of Indigenous peoples, similar proportions of people born “overseas”, universal health care coverage, and similar percent of GDP spent on health care. One main difference between the health care coverage of the two countries is that in Australia, Medicare is a federal government program, while in Canada it is the responsibility of provincial and territorial governments. In Australia, national Medicare covers hospital stays, physician visits, and prescription drugs. In Australia, co-payments (extra billing) are allowed, and, consequently, dual practice is allowed. In Canada, Medicare does not cover prescription drugs, and neither extra billing nor dual private nor private duplicative insurance are allowed.

Australia did not intentionally design a mixed payment system. In the 1950s, private health insurance covered 80% of the population. Government subsidized voluntary insurance was introduced, eventually followed by Medicare in 1984 due to high rates of un-insurance. Over time, Australia has added layers of private insurance coverage—incentivized by various policy levers involving carrots (rebates on premiums, tax incentives) and sticks (tax penalties, premium penalties, reduced rebates on premiums)—on top of publicly-funded Medicare, consistent with conservative and liberal governments swapping places. Private insurance premiums and out-of-pocket costs are increasing and benefits are shrinking. This mix of public and private coverage has resulted in a system in which young people are purchasing private health insurance (now with the encouragement of government through taxes and penalties for those do not enroll before the age of 30), but people outside of those age groups are relying solely on the public plan. Some are dropping out of private insurance plans due to rising costs of insurance premiums, reduced coverage, and, consequently, increased out-of-pocket spending.

Lessons for Canada from the Australian experience suggest not following Australia's lead on duplicative private insurance, fighting to keep only a supplementary rather than duplicative role for private health insurance, making it clear that prioritizing "choice" has implications for equity, and recognizing that concessions that appear small at the time can have major impacts on the health care system.



Hard work for government: Balancing public and private financing in Europe

Speaker: Sarah Thomson, WHO Barcelona Office for Health Systems Strengthening

Dr. Thomson outlined the gaps in public coverage in EU countries, considered whether private health insurance fills them in, explored why this is hard work for government, and offered lessons for Canada.

In the EU, gaps are most significant for dental care and outpatient medicines, with the poorest households spending the most out-of-pocket. The percent of households with catastrophic health spending and unmet need is consistently highest in the poorest income quintile. These gaps have several causes, including the exclusion of migrants, entitlement being linked to payment of contributions, narrow benefit packages, and user charges. This results in unmet need and financial hardship for both rich and poor.

Private health insurance (PHI) can fill these gaps in health care provision in the EU. However, PHI does not fill these gaps very well in most cases, and provision of voluntary private insurance is "hard work" for governments. In the EU, PHI may offer "choice" and faster access where waits are long (e.g. Poland, UK, Italy, Greece, Spain, Portugal, Ireland, Belgium). PHI may cover user charges (e.g. Finland, Latvia, Denmark, Slovenia, and France). It may cover some excluded services (e.g. Germany and the Netherlands). It does not fill gaps in dental care or medicines in most countries.

PHI systematically favours richer and more educated people living in cities. PHI in the EU mainly uses risk rated premiums and excludes pre-existing conditions, often has no open enrolment, has waiting periods, and is not sold to older people.

In France, for example, more than 90% have PHI to cover heavy user charges. It is heavily regulated with subsidies for the poor, but inequalities persist and many (mainly poor) people still lack PHI due to financial and administrative barriers. PHI covering user charges must be affordable for everyone needing protection, but it's hard to ensure this for the poorer among us.

In Ireland, 45% have private voluntary insurance for faster access to hospitals. This has resulted in complicated arrangements, including PHI using private beds in public hospitals, which encouraged providers to prioritize PHI patients. Forty percent of PHI-financed care takes place in public hospitals. In 2014, the government introduced a levy on the use of private beds in public hospitals. Alternatively, the public sector has bought care from private hospitals, which encourages hospitals to use these private beds. Poor people are subsidizing faster access for richer people and there has been a steady increase in the numbers of patients waiting for inpatient care. Indiscriminate tax subsidies, perverse incentives, and blurred boundaries have skewed resources away from need. This complicated arrangement of both PHI and public payment is messy and has led to legal challenges in 2003 and 2007.

The lesson from Europe to Canada is that PHI is predictably challenging for governments and patients. PHI increases complexity and inequality, with spillover effects that undermine publicly financed coverage. It is also a moving target politically that requires constant energy and resources for monitoring, regulation, and oversight. So is it worth it? Dr. Thomson suggested not letting the tail wag the dog and focusing instead on improving publicly financed care.

[Private health insurance is] ...a moving target politically that requires constant energy and resources for monitoring, regulation, and oversight. So is it worth it? Dr. Thomson suggested not letting the tail wag the dog and focusing instead on improving publicly financed care.

DAY 1 SESSION V

Regulating Private Finance

What comes next? Analyzing the options for BC and Canada should Cambie succeed

Speaker: Colleen M. Flood, University of Ottawa Centre for Health Law, Policy and Ethics

Dr. Flood described the different laws being attacked in the Cambie case (BC laws banning dual practice, extra-billing, and private health insurance for Medicare services) and noted these laws are similar across all provinces. She then described what happens in other jurisdictions that have two-tier systems, so as to lay out options for after the Cambie trial ruling, regardless of the outcome.

If Cambie wins and one or more of the laws discussed are overturned, then the BC government will need to be concerned about the following effects:

1. Siphoning of health care professionals from the public pay to the private pay sector;
2. Incentives for physicians to increase demand for private pay services by permitting wait times to lengthen in the publicly-funded system;
3. Further difficulties with the maldistribution of medical labour, with it being easier to set up lucrative practices in large urban centres;
4. Health care spending rising due to paying higher prices to maintain labour in a flourishing private pay sector, thus driving up labour prices in the publicly-funded system;
5. Access issues for those unable to pay for either timely care or high-quality care; and
6. Possible diminished political support for publicly-funded Medicare services, over time resulting in lower public investments and knock-on problems with quality and access.

What is not known is whether the court will overturn some or all of the challenged laws. If the BC government is required by the court to revisit existing laws banning, for example, dual practice or private health insurance, then the BC government (and other provincial governments) could look to a range of possible strategies:

1. Increase spending to reduce waiting lists within existing system arrangements (i.e. increase taxation or reallocate government spending to wait times).
2. Eliminate wait times through centralization of wait lists and following evidence-based guidelines for triaging patients to the first available specialist/surgeon.



3. Create a wait time guarantee (a law that no one waits more than, for example, eight weeks for a specialist appointment without recourse) with a system of targets and incentives (for example, penalties and rewards for hospital management) to realize those wait time targets within the public system.
4. Subsidize the purchase of private duplicative insurance through tax breaks or other means.
5. Disincentivize private duplicative insurance by having national fee schedules beyond which providers are not allowed to charge.
6. Set contractual or regulatory limits on the number of physicians, or on physician time spent in private pay practice, to ensure sufficient physicians in the public system.

Although all these options can be explored, in Dr. Flood's view the best set of options should be for the court to overturn one or more laws of the BC government (and other provincial/territorial governments with the support of the federal government) to address the problem of wait times. This would mean the BC government would not have to accept that the laws themselves are unconstitutional and must be repealed. In other words, the unconstitutionality of the laws (if so found) is only because of the fact of long waiting times; if waiting times are tamed then the laws themselves need not be overturned. Thus, in her view, it is critical for provincial governments to address wait times through measures discussed in 1-3 above.

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DAY I SESSION VI

Day I Closing Address

At the heart of it all: Are Canadians still bothered by inequity?

Speaker: Sarah de Leeuw, University of Northern BC

Dr. de Leeuw used storytelling techniques to emphasize how justice, injustice, resistance, coloniality, power, geography, and uninvited occupation of traditional Indigenous territories all relate to the stark health inequities that exist in Canada. Through prose and poetry, she explored why some people, in some places, live better lives than others, and asked if equity fundamentally matters to Canadians. She shared stories of Indigenous populations in the North who do not have access to health care services at the same level as their southern counterparts, and of poor health arising from intergenerational trauma.

She reminded the audience that 95% of Canada's geography is inhabited by less than 5% of the country's population, and happens to be where some of our worst health outcomes persist: much lower life expectancies, much higher rates of complex comorbidities, the presences of illnesses found essentially nowhere in urban southern geographies (tuberculosis, for instance), much higher rates (when measured as a percentage of the overall population) of alcohol, drug, and tobacco consumption, and higher rates of illnesses tethered directly to poverty.

She also shared aspects of her personal story growing up in rural and Northern BC and why equity still matters there, as everywhere. She questioned how a "right" to pay privately for health care to jump the queue would ever improve equitable access to care for those living in the far North. She reminded us that if we are committed to equity, our commitment must be ubiquitous. We can't pick and choose when equity matters.

...if we are committed to equity, our commitment must be ubiquitous. We can't pick and choose when equity matters.



DAY II SESSION I

The Future of Financing for Prescription Drugs and Dental Care

National Pharmacare: Rolling stone or mossy boulder?

Speaker: Fiona Clement, University of Calgary O'Brien Institute for Public Health

Dr. Clement discussed approaches to implementing national pharmacare in Canada. She started by discussing the major changes to medical and hospital services in Canada, and how outpatient pharmaceuticals were omitted from both the Medical Care Act of 1966 and the Canada Health Act of 1984.

Absent universal coverage, this has left Canada with a highly variable patchwork of 19 public coverage programs, each with several different sub-plans, and thousands of private plans that are largely a benefit of employment. The result has been that spending for prescription drugs is 42.7% publicly-funded (in comparison to rates in the 90%+ range for hospital and medical services). A significant portion of this is from out-of-pocket charges to patients, resulting in 5.5% of Canadians reporting being unable to afford their medicines.

Dr. Clement then discussed national pharmacare in Canada, highlighting the Advisory Council on the Implementation of National Pharmacare and the 2019 mandate letter to the Minister of Health. She highlighted that the letter did not commit the Minister to pursuing a particular model of national pharmacare, which leaves open the question of what those models are and their respective advantages and shortcomings. In particular, she noted the trade-offs that need to be made between a particular budget, who is covered, what drugs are included, and how much patients are charged.

She then compared five different models with which Canada could approach national pharmacare coverage:

1. Comprehensive first-dollar coverage
2. Essential medicines
3. An income-based drug program
4. An individual mandate that would include private insurance
5. Targeted public coverage plans to “fill gaps”

This drew on her recent report published by the Conference Board of Canada. She specifically noted the differences in the drugs that would be covered for the different fully public options, and also noted their relative costs.

Several areas deserve special consideration when designing national pharmacare: the role of co-payments (if any); who would be covered; and inclusion of Indigenous peoples and other historically under-represented communities in the conversation. Concerns around over-prescribing, over-treatment, and rising costs will also need to be incorporated to assemble a comprehensive plan. There is no perfect method to implementing national pharmacare, but thoughtfulness is critical to evaluating the likely impact of the various policy options given a particular budget being available.



Solving a mystery: A tale of two cities and loose ends

Speaker: Carlos Quiñonez, University of Toronto Faculty of Dentistry

Dr. Quiñonez considered the desire among the Canadian public to move dentistry toward the same values and principles as exist for our health care system. International health policy analysts are often surprised when they learn how relatively little attention and funding the Canadian state provides for dental care. Dentistry is a tale of “two cities”, in which a complicated tension exists between dentistry as a private enterprise and dentistry as a public good.

Dental caries and periodontal disease can have serious oral and systemic health implications, with a crushing burden on some individuals and families. Yet, these conditions and their implications are almost wholly ignored by our health care system. Globally, “untreated caries of permanent teeth” ranks first in prevalence of health conditions, and dental conditions are among the top 35 causes of Years Lived with Disability. In Canada, about 40 million hours are lost from school, work, or normal activities due to oral diseases, which is comparable to musculoskeletal issues.

Dr. Quiñonez noted that dentistry in Canada is dominated by the private sector. The great majority of dental care (94%) is financed through employer- and individually-sponsored dental plans and out-of-pocket spending, and almost all care is delivered in private dental offices on a fee-for-service basis. Among OECD countries, Canada is one of the lowest public spenders on dental

care. Public care is limited to some surgical-dental services delivered in-hospital per the Canada Health Act, and targeted and often variable programs within the provinces/territories. Sometimes these programs are legislated, and sometimes they are not, and though all provinces/territories have these programs, not all have services for children, those living with disability, or the elderly. It's more a sieve than a safety-net.

Why wasn't dental care included in Medicare? At the time Medicare was enacted an epidemiological transition was underway, meaning that severity of dental disease was rapidly decreasing, as was its prevalence early in life. The 1964 Royal Commission on Health Services estimated 25,000 dentists would be needed, but we only had 6,000. There were other spending priorities and demands. As an alternative to national dental insurance, the dental profession and some legislators stressed fluoridation, education on oral hygiene, and better eating habits, focusing on dentistry as an individual responsibility, rather than a social good. As a result, private employer-sponsored dental plans expanded rapidly, in part due to favourable tax treatment from governments.

Relatively small public investments in dental care came from the Canada Assistance Plan, peaking in the early 1980s, then declining in the subsequent recessions later that decade and in the 1990s, and rebounding slightly since then. The Royal Commission of 2002 ignored dentistry, but advocacy coalitions formed asking for more focus on oral health, arguing that dental care is an essential component of overall health care. As a result, a new federal Chief Dental Officer was appointed in 2005, and public investments began to expand for children and seniors, eventually resulting in broader calls across the political spectrum for improvements and more public funding. To move forward, Dr. Quiñonez suggests that we should consider clarifying what medically necessary dentistry might mean, and investing more in publicly-funded dental programs as part of a mixed-model of financing and delivery.

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DAY II SESSION II

Day II Closing Address

The Canada Health Act: Fold, hold, or raise?

Speaker: The Honourable Jane Philpott, P.C., Former Member of Parliament and Special Advisor on Health, Nishnawbe Aski Nation

Dr. Philpott shared her journey as Federal Minister of Health, offering conference attendees a “behind the scenes” perspective.

Experiences as a physician convinced her that the success of Canada’s health systems relies on maintaining its principles about access to care based on need, not ability or willingness to pay. She acknowledged Mme Monique Bégin’s wisdom in helping to enact the Canada Health Act into law in 1984, and Dr. Philpott felt a huge burden to ensure that under her tenure it would be administered in its fullness and not weakened through ignorance or neglect (willful or otherwise).

She argued that the beauty of the CHA lies in its simplicity, with criteria and conditions for how services must be provided by provinces, and a simple enforcement mechanism (in theory). The Canada Health Act Division of Health Canada is responsible for monitoring compliance. They inform the Minister about possible non-compliance and recommend potential action. Monitoring is not easy, as it relies on the Division scanning media and following up on public complaints, as they have no authority under the Act to investigate directly. They try to resolve issues behind the scenes to avoid deductions. Provinces and territories are expected to provide annual financial statements to Health Canada, itemizing extra-billing and user charges they have discovered. If the Minister has reason to believe this information is incomplete or inaccurate, the Minister is expected to estimate the potential deduction, following consultation with the province/territory. Non-compliance—especially in BC, Saskatchewan, and Quebec—were of concern during her tenure. She has reason to believe that the magnitude of non-compliance (in at least BC and Quebec) was greater than that being reported by the provinces. One of her first actions on this file was to speak with the federal Attorney General (Jody Wilson-Raybould) about the need for government to intervene in the Cambie case.

Dr. Philpott discussed other instances of enforcement of the CHA, including maneuvering to abolish illegal accessory fees in Quebec, extra billing for MRIs in Saskatchewan, and extra billing and user fees at private for-profit clinics in BC. She discussed amounts withheld from the Canada Health Transfer, including in BC (\$15.6 million in 2018 and \$16.2 million in 2019, related to violations by 11 clinics).

Dr. Philpott encouraged additional statutory obligations to include coverage for comprehensive primary care, pharmacare, mental health care, and home care. She closed by suggesting that political action and advocacy by health policy experts, clinicians, academics, teachers, and researchers is needed and wanted to help shape our health care system's future.

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