True North in
Canadian public policy

Injecting Some Healthy Competition Into Canadian Health Care

Mark Ronayne and Dr. Richard Audas

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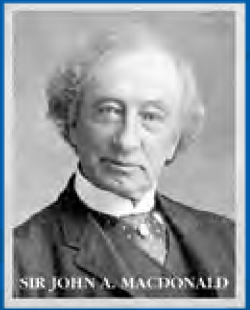
Canadian public policy



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Executive Summary

Competition may seem to Canadians like an abstract concept, of interest to economists and business people, but it plays an important role in our everyday lives. Every time we buy groceries, pump gas, or decide which television station to watch, competition is contributing to the range of choices, cost, and accessibility. Competition pushes us to be better, more innovative, and more responsive to clients or customers.

This is true in health care delivery as well, and with the strains on the Canadian health care system showing as much as ever, injecting a little healthy competition into medicare should be part of the conversation around needed reforms. As the federal health minister has stated, more money will not fix health care delivery in Canada.

While there are potential benefits to introducing greater competition throughout the health care system, this paper focuses on two main areas, hospitals and health professions, which combined account for 54 percent of health care expenditures in Canada.

Hospitals

Hospital funding may be a fruitful opportunity to realize the benefits of increased competition. And the UK hospital system presents a useful case study. In 2006, the Labour government implemented a system whereby all referrals to hospital had to be accompanied with a choice of five options where individuals could have the service performed with the full cost being borne by the National Health Service, and the funding for the procedure following the individual. Patients could examine key performance metrics, as well as how long it would take before the procedure could be conducted, before making a decision

So if you prefer a short wait time for example, but are prepared to travel farther, you can choose to do so. This also means that high performing hospitals are financially rewarded. And it creates transparent performance standards that each patient can assess and evaluate to determine the facility that will provide the best-suited care for them. And most importantly, studies found that mortality declined, without increasing costs.

Similar reforms have shown positive results in Norway and Denmark.

A shift toward greater reliance on activity-based funding (ABF) for hospital services, or funding by the number of procedures performed, would be another building block for competition. Canadians know little about the quality of service at their hospitals. That is to be expected given the current funding model with "global budgets" granted to hospitals based on past expenses. Under global budgeting, patients are seen as a cost, while activity-based funding rewards performance. The ABF model encourages hospitals to show their work.

Health care providers

Competition plays a limited role in the provision of physician services in Canada. There may be numerous areas where different professional groups could provide a competing service at significantly lower rates. Doctors make between 2.5 and 3.5 times what other highly trained medical professionals earn.

Many routine visits to doctors' offices could be handled by nurse practitioners just as effectively. Midwives have been found to perform as well or better than obstetricians in terms of outcomes and patient satisfaction. And physiotherapists and chiropractors can deliver certain kinds of care rather than GPs, again at lower cost. Allowing different professional groups a greater opportunity to compete would encourage innovation and should result in as-good-to-better outcomes at a considerable cost savings.

Ensuring that self-regulating professions cannot raise unnecessary barriers to competition could be a key to reform. Once again the UK provides an example. Reforms undertaken there in 2008 require all health profession regulatory boards to be made up of at least 50 percent lay members, ensuring the interests of the profession are balanced by the interests of society.

Another factor that can distort competition between professions is differences in the costs of services to patients. For example, while most physician services are publicly insured, services provided by many other health professions are not, even for treating the same condition. This creates an uneven playing field for competition that might be corrected by expanding public health insurance in certain areas.

Though limited, competition already plays a role in the performance of the above areas through patients' and doctors' choices of hospitals and health care professionals. However, this choice, especially for patients, is often constrained by a lack of access to information allowing competing providers to be effectively compared and providers to be selected based on the type and quality of care they provide. Efforts to develop this information and make it accessible to patients could go a long way toward empowering patients and improving competition in the health care system.

The evidence strongly suggests that there could be significant benefits to stoking competition in the two key areas studied here: competition between hospitals, and competition between professional groups. Patients should demand more information and greater choice in their care. And hospitals and providers shouldn't be afraid of a little healthy competition.

Sommaire

La concurrence pourrait bien être perçue par les Canadiens comme une notion abstraite qui concerne en particulier les économistes et le milieu des affaires, alors qu'elle joue en réalité un rôle crucial dans la vie de tous les jours. En effet, toutes les fois où nous achetons des aliments ou de l'essence, ou encore, décidons de regarder une chaîne de télévision, la concurrence nous permet de bénéficier d'un large éventail de choix, de prix et d'accès. La concurrence nous oblige à être meilleurs, à innover et à mieux répondre aux besoins des clients et des consommateurs.

Cela vaut également pour la prestation des soins de santé, et les pressions exercées sur le système canadien rendent plus que jamais pertinent d'inscrire l'injection d'un peu de saine concurrence à l'agenda des discussions sur les incontournables réformes à venir de l'assurance-maladie. Comme la ministre fédérale de la santé l'a affirmé, on ne réglera pas le problème de la prestation des soins de santé au Canada avec de nouveaux fonds.

Bien que l'introduction de la concurrence dans l'ensemble du système des soins de santé canadien présenterait des bénéfices potentiels, cette étude porte sur deux secteurs principaux, celui des hôpitaux et celui des services fournis par les professionnels de la santé. Ces secteurs représentent ensemble 54 pour cent des dépenses en soins de santé au Canada.

Les hôpitaux

Le financement des hôpitaux peut fournir une excellente occasion de tirer profit d'un accroissement de la concurrence. À ce titre, le système hospitalier britannique présente une étude de

cas utile. En 2006, le gouvernement travailliste a mis en place un système au sein duquel une personne qui est dirigée vers un hôpital se voit également proposer un choix entre cinq profils de services dont le coût est entièrement à la charge du Service national de santé, tandis que le financement est assuré relativement à toute intervention médicale choisie par la personne. Avant de prendre une décision, les patients peuvent examiner les principales mesures de rendement et les délais d'attente à l'égard des interventions.

Donc, si un patient souhaite écourter le délai d'attente par exemple, mais qu'il est prêt à se déplacer davantage, il peut choisir de le faire. Cet arrangement signifie également que les hôpitaux hautement performants sont récompensés financièrement. De plus, il permet l'élaboration de normes de performance transparentes que les patients peuvent analyser et évaluer pour choisir l'établissement fournissant les soins les mieux adaptés à leur situation. Mais plus important encore, des études ont révélé que la mortalité a diminué, sans augmenter les coûts.

Des réformes similaires ont donné de bons résultats en Norvège et au Danemark.

Une évolution en faveur du financement des hôpitaux fondé sur des critères d'activités (*activity-based funding* ou ABF) ou en faveur du financement basé sur le nombre d'interventions médicales effectuées renforcerait encore davantage la concurrence. Les Canadiens savent peu de choses de la qualité des services offerts dans leurs hôpitaux. Ce qui est normal, compte tenu du modèle de financement actuel axé sur les « budgets généraux » accordés aux hôpitaux en fonction des dépenses passées. Dans le cadre de la budgétisation globale, les patients sont considérés comme des coûts, alors que le financement par activité récompense le rendement. Le modèle ABF incite les hôpitaux à communiquer ce qu'ils font.

Les professionnels de la santé

Les services offerts par les médecins sont peu exposés à la concurrence au Canada. Dans de nombreux secteurs, différents groupes de professionnels pourraient fournir un service concurrent à des tarifs beaucoup plus bas que ceux des médecins. Ces derniers sont rémunérés à un taux de 2,5 à 3,5 fois supérieur à ceux d'autres professionnels de la santé hautement qualifiés.

Ainsi, les nombreux patients qui sont dirigés vers les cabinets de médecins pour leur examen de routine pourraient être traités aussi efficacement par des infirmières praticiennes. Sur le plan des résultats et de la satisfaction de leurs patientes, les sages-femmes ont un rendement qui s'avère égal ou supérieur à celui de leurs collègues obstétriciens. Enfin, les physiothérapeutes et les chiropraticiens peuvent remplacer les médecins généralistes pour certains types de soins, encore une fois à des coûts plus bas. Permettre aux différents groupes professionnels d'entrer en concurrence les uns avec les autres favoriserait l'innovation et se traduirait par des résultats au moins aussi bons à un coût considérablement plus bas.

Veiller à ce que les professions auto-réglementées ne soulèvent pas d'obstacles inutiles à la concurrence pourrait être un élément clé de la réforme. Une fois de plus, le Royaume Uni nous fournit un exemple. Grâce aux réformes entreprises en 2008, dans tous les organismes réglementant les professions du domaine de la santé, au moins 50 pour cent des membres doivent être des non-spécialistes, afin d'assurer l'équilibre entre les intérêts des professionnels et ceux de la société.

La différence dans les coûts des services qui sont à la charge des patients est un autre facteur qui peut fausser la concurrence entre les professions. Par exemple, alors que la plupart des services fournis par les médecins sont assurés par l'État, ceux qui sont fournis par de nombreux autres professionnels de la santé ne le sont pas, parfois pour soigner les mêmes maux. Cela engendre des conditions de concurrence inégales qui pourraient être corrigées en élargissant le régime d'assurance-maladie à certains secteurs.

La concurrence influe déjà, bien que de façon limitée, sur la performance des domaines ci-dessus au moyen des choix posés par les patients et les médecins en ce qui a trait aux hôpitaux et aux professionnels de la santé. Cependant, ces choix, surtout pour les patients, sont souvent limités par un manque d'accès à l'information qui permettrait aux fournisseurs concurrents d'être comparés efficacement les uns aux autres et donc d'être choisis en fonction du type et de la qualité de leurs services. Les efforts visant à développer cette information et à la rendre accessible aux

patients pourrait être extrêmement utile pour autonomiser les patients et améliorer la concurrence au sein du système de soins de santé.

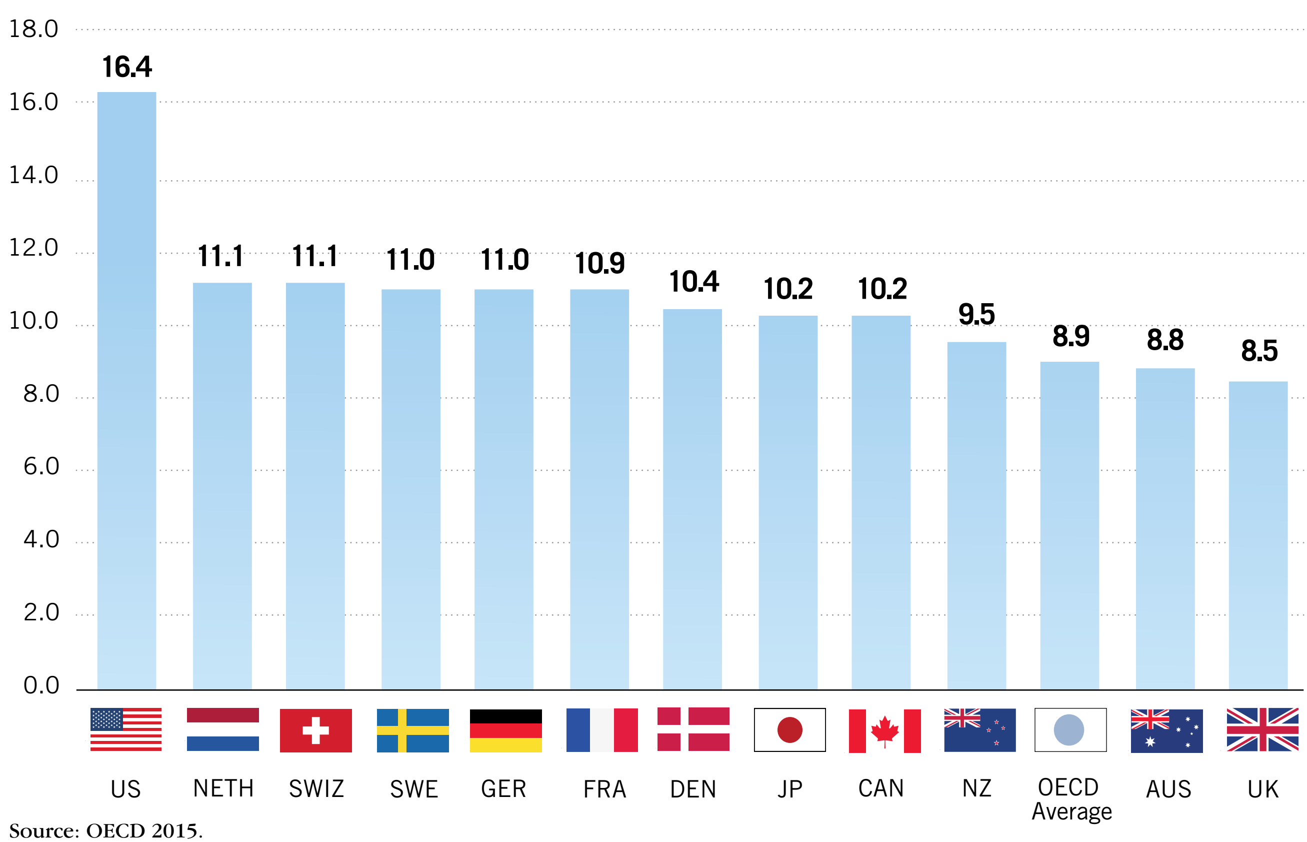
Les faits laissent fortement supposer qu'il serait avantageux de favoriser la concurrence au sein des deux domaines clés étudiés ici : soit entre les hôpitaux et entre les groupes professionnels. Les patients devraient exiger d'être mieux informés et d'avoir plus de choix relativement à leurs soins. Enfin, les hôpitaux et les fournisseurs ne devraient pas craindre un peu de saine concurrence.

Introduction

Canadians are among the highest spenders on health care in the world, with health expenditure in recent years accounting for more than 10 percent of GDP and expected to approach 11 percent in 2016 (Deloitte 2015). Chart 1 below compares the proportion of GDP spent on health care among a selection of Organisation for Economic Co-operation and Development (OECD) countries and demonstrates that Canada is considerably above the OECD average and well above the UK, Australia, and New Zealand, who have single-payer health care systems, similar to Canada.

Yet comparisons with other OECD countries indicate that it performs poorly in many areas compared to other countries which are spending comparably or less on health care. Wait times remain long for many diagnoses, procedures, and treatments. There are issues with quality of care, equity, and timeliness of access. Coverage for pharmaceuticals is variable and not universal and not nearly enough is being invested in preventive care. A report by the Commonwealth Fund (Davis et al. 2014) demonstrates that Can-

Chart 1 Health care spending as a percentage of GDP among OECD countries, 2013 comparison



Source: OECD 2015.

ada lags behind its peer OECD countries on a variety of key system indicators. The graphic is reproduced below as table 1.

The result is that we spend more on health care to get less than we ought to in terms of quality and services.

There are increasing levels of dissatisfaction with the performance of the health care system, as patients and providers have limited choice of treatment options (Romonow 2002). Despite the fact that chronic disease now exceeds acute disease in terms of economic burden, health care in Canada remains focused on treating the sick after the fact, rather than trying to limit the onset of preventable chronic conditions (CPHA). The Canadian health care system remains slow in becoming aware of and acting upon knowledge of new or better ways to prevent or treat ailments.[1] The result is that we spend more on health care to get less than we ought to in terms of quality and services.

The new federal government has recognized the need for reform. The federal Health Minister rightly observes that:

> Money isn't necessarily where the problem is . . . What we're looking at doing largely will be system reform. What

Table 1 Overall rankings of 11 health care systems, 2014

COUNTRY RANKINGS: Top 2* | Middle | Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/ Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

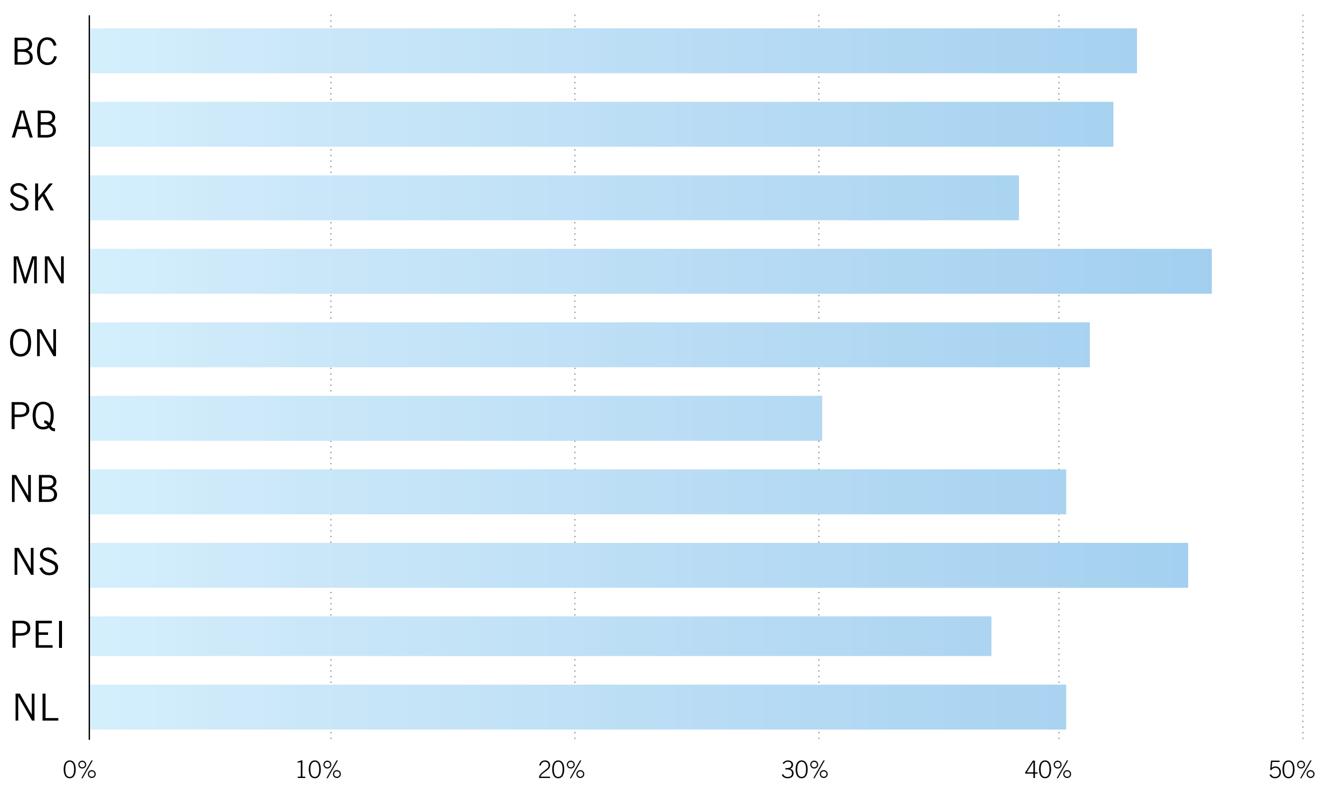
Source: Davis et al. 2014. Data from 2011 International Health Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; *OECD Health Data 2013*.

needs to be transformed in the way we deliver care. In the kind of incentives that are provided around care. . . . I'm hoping that we'll be able to do a lot of work without necessarily spending a lot more money, and, in fact, there's a lot of room for saving money. (Bourbeau 2015)

Health Minister Philpott held firm in her negotiations with provincial health ministers in October 2016. If no deal is reached, the rate of federal transfers to the provinces for health care will slow beginning in 2017/18 from the 6 percent annual increase negotiated in 2004, to a rate based on economic growth (Harris and Zimonjic 2016).

The evidence in favour of reform is compelling – the continuation of current demographic trends will place further strain on the Canadian health care system and this will lead to longer wait times, increasing numbers of negative outcomes for patients, and a failure for necessary health services to be delivered in a timely fashion. A recent report by Deloitte (2016) forecasts health expenditure to grow in Canada by 4.8 percent per year from 2015 to 2019, a figure that exceeds forecasted GDP growth over the same period and indicates that the share of health budgets consumed by health spending will grow. For provincial governments, health care is the single largest expenditure item, approaching or exceeding 40 percent of their total budgets. While most provinces have reduced the increase in health spending in recent years, without systemic reform health spending will further crowd out government investment in infrastructure, education, and other public goods (Bacchus, Palacios, and Emes 2016). Chart 2 below shows the proportion of provincial government budgets that are spent on health care.

Chart 2 Health care expenditure as a proportion of total government expenditure, by province, 2015



Sources: National Health Expenditure database; Canadian Institute for Health Information.

In short, the system is at risk. Disruptive change is needed, and we should look at all possible options to improve efficiency and quality. In this paper, we argue that the introduction of competitive mechanisms into Canadian health care finance and delivery should be part of this necessary transformation of the Canadian health care system.

Why competition?

Competition may seem like an abstract concept, of interest primarily to economists and business people, but it plays an important role in our everyday lives. Every time we buy groceries, pump gas, or decide which television station to watch, competition is contributing to the range of choices, their costs, and accessibility. Competition pushes us to be better, more innovative, and more responsive to clients or customers.

The key characteristic of a competitive market is that no single producer or group of producers and no single customer or group of customers can dictate how the market operates. Nor can they individually determine the price of goods and services, and how much will be exchanged. It involves multiple players competing in the marketplace without collusion or cooperation.

Canadians tend to be sceptical regarding the use of competition to improve the performance of the health care system. This view is largely based on inappropriate comparisons to the US health care system and fears that competition would necessarily mean the end of Canada's public health care system. As Senator Kirby and Dr. Keon state:

> The latest taboo in Canada's publicly funded health care system is . . . greater competition within the existing health care delivery system. Various groups in Canada have been largely successful in asserting — without any supporting argument or evidence — that competition among providers would put Canada on a slippery slope to an American-style system. The irony of this position is that without increased productivity, for which competition provides a powerful incentive, timely access to medically necessary treatment in Canada will be inhibited further. (2004, 9)

The truth is that competition, both directly and indirectly, already plays an important role in the delivery of health care in Canada. Competition is a primary driver of the development and supply of new and generic drugs, the location and supply of pharmacist services, the development and supply of diagnostic services and equipment, the supply of healthy lifestyle and homeopathic products and services, and the supply of non-medical services to hospitals.

Even in highly regulated and controlled sectors of the health care system, such as the supply of hospital and physician services, competition plays a significant role. Though often times with limited information and choice, patients seek out the most highly qualified physicians. Physicians compete for scarce space at hospital surgical facilities, and provinces compete amongst each other and with other jurisdictions to attract health care workers.

There is increasing evidence from other jurisdictions, including those that share the fundamental values of the Canadian health care system, that pro-competitive policies and approaches can provide major benefits. The Health Foundation (2011) conducted a comprehensive scan of the literature on the potential gains from making competitive reforms to health care delivery. These are:

- Improved clinical outcomes,
- improved patient choice,
- patient-centred care,
- access and responsiveness,
- equitable access to care,
- efficiency and productivity,
- flexibility in supply and capacity, and
- innovation and improvement.

At the same time, the use of competition in health care markets involves a complex mix of economic, health, and public policy concerns. For example, while competitive pricing of essential health care inherently raises concerns that it will prevent lower-income families and persons from getting the care they need, providing this care at

no cost inherently raises concerns that related services will be overused.[2] There is no shortage of examples of poorly designed pro-competitive measures having had undesired effects.[3] As indicated by the above-noted Commonwealth Fund study, the US health care system, which relies heavily on the competitive delivery of health care, falls at or near the bottom of a range of measures of overall health care performance in relation to comparator countries, and dead last in the overall ranking. The mixed evidence suggests that the introduction of competitive reform should be selective and determined by the best available evidence.

> *The introduction of competitive reform should be selective and determined by the best available evidence.*

Reform of the health care system must be consistent with the values and priorities of Canadians. Competitive reform should not be interpreted to mean the end of a publicly funded universal health care system. Quite the opposite. We believe that pro-competitive reform can strengthen the public system and with appropriate incentives can improve quality, equity, access, and efficiency in health care. The main objective of this paper is to explore ways that pro-competitive reform could be introduced to strengthen the current system.

The paper is organized as follows: Part 1 outlines a set of objectives for system reform in keeping with Canadians' values regarding health care financing and delivery, it examines how competition can promote the attainment of these objectives and values, and it sets out requirements for competition to accomplish this goal. Competition is not an end in itself. A first step in determining how best to use competition within the health care system is to define the objectives to be achieved.

Part 2 discusses ways that competition may be better used to improve the performance of the two largest sources of Canada's health care expenditures, hospital services, and health care provider services, including physicians as well as other providers. While important in their own right, these two areas of reform are only indicative of the full potential benefits from focusing on competition as a driver for the efficient and high quality supply of health care products and services.

Part 3 provides concluding remarks.

PART 1

Objectives of and Conditions for Reforms

Key objectives of health care reforms

Canadians have strongly held beliefs regarding the goals and objectives of their health care system on key issues such as access to and quality of care for all. These beliefs provide the essential background for any reforms to the health care system. The need to manage costs is a further essential consideration.

Given these considerations, any reforms should promote the following objectives:

1. **Increased access.**

   Support for access to medical care for all Canadians is reflected in the *Canada Health Act's* (CHA) principles of universality, portability, and accessibility.[4] However, the CHA is limited in scope in that it applies only to and supports funding for medical services that are deemed essential. Health care related goods and services that are not deemed to be essential medical services under the CHA are

neither subject to the principles of universality, portability, and accessibility, nor federally funded even though they may be necessary for the health and welfare of Canadians, and can help avoid the need for expensive and invasive "medically necessary services". These goods and services include, among other things, out-patient pharmaceuticals and pharmacist services, physiotherapy, dietetic services and optometric services, extended care homes, and dental services.[5] Ensuring that Canadians have effective health care access rightly concerns their access to all health-related products and services, not just hospital and physician services.

2. **Better quality health care.**

   Reforms should maintain or promote the population health of Canadians in terms of longer life expectancy and a better quality of life. Furthermore, system reform should promote better interactions within the health care system, including shorter length of stay, low rates of re-admission, fewer hospital-borne infections, and overall patient satisfaction. Innovation and evidence-based decision-making are key factors for promoting better health outcomes and need to be further encouraged through pro-competitive and other reforms.

3. **Efficient use of resources.**

   Resource efficiency means the delivery of equal or higher quality health care at lower cost. As noted, high quality health care outcomes may be achievable in a number of ways ranging from more and better preventative measures to better approaches for treating health care issues where they arise. Reforms should generally promote the use of prevention and/or treatment options that involve the lowest resource cost to the economy, taking into account not only the direct treatment costs, but also indirect costs such as lost work days due to illness and the intangible costs associated with pain and suffering.

4. **Increased choice.**

   The ability of patients and health care professionals to effectively choose among preventive and/or treatment options is essential not only for the selection of the best options for preventing or treating ailments but also for improving overall patient satisfaction with and welfare within the health care system. We are at a point in history when the average patient is better educated, better informed, and better able to access information than ever before. As patients become increasingly well informed, their ability to make good choices about their health care improves, and so should their ability to influence health care decisions directly affecting them.[6]

Other objectives are also often said to be fundamental for the Canadian health care system. Many consider public delivery of health care rather than private delivery to be a core principle of the Canadian health care system. In this regard, the CHA requires that "the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province." However, the CHA does not require that any goods or services obtained in support of, or supported under provincial insurance plans be publicly provided. Rather, plans are free to acquire the best available products, whether they are supplied by either public or private entities.[7]

In practice, most health care is already provided by private interests, including both not-for-profit institutions (NFPs), and for-profit providers (FPs). While their fees may be subject to regulation, the vast majority of physicians are self-employed, with many delivering services through profit-making physician practice management service providers.[8] All pharmaceuticals are developed and supplied by profit-seeking enterprises, as are most clinical tests and medical equipment. Most hospitals in Canada are also private, community-based NFPs. Private supply of health care has been and remains a key feature of the health care system.

While it is important to recognize that private, for-profit delivery of health care is neither antithetic to a well-functioning health care system nor prohibited under the CHA, it should also not be considered an end in itself. Rather, in determining the role for NFP, FP, and public de-

livery of health care services going forward, the key concern should not be the nature of the providers but rather which providers are likely to supply the best health care services at the lowest cost[9] within the relevant market and competitive or regulatory framework. Regardless of the provider, the key issue in obtaining the potential benefits from competition is putting in place the right conditions for it to achieve the above objectives.

Key conditions for effective competition in health care

We propose five key conditions required for competition to work effectively in health care markets.[10]

1. **The relevant market must be capable of supporting effective competition.**

   Markets may generally be considered effectively competitive if they have sufficient numbers and classes of competitors to impose strong competitive discipline on providers.[11] Attempts to apply competition in health care markets that are not effectively competitive have the potential to result in inefficient investment in duplicative facilities and the exercise of market power resulting in higher costs. Factors to consider in determining whether the potential for effective competition exists include the size of the market relative to the efficient scale of supply, barriers to supply entry and exit, and barriers to patient switching.

2. **Patient and health care practitioner freedom of choice.**

   Patients, by themselves, or working in conjunction with their physician or other health care provider, should have freedom to choose among competing options. The idea that one-size-fits-all does not apply well in the provision of health care. Care must be patient-centric. Patients and their providers need to be empowered to make choices regarding the health decisions that will directly impact patients' well-being.[12]

3. **Information must be made available supporting effective choice by patients and health care providers.**

   In order for markets to drive the most efficient and best choices among competing suppliers, parties acquiring or using health care products need access to information allowing them to effectively select products and suppliers based on their quality of care as well as price and other characteristics. However, access to information on the quality and effectiveness of health care procedures and treatments is often complicated by the technical nature of this information, difficulties in collecting and disseminating relevant information, and professional and other barriers to the release of information. As a consequence, competition can result in the undersupply of more difficult to measure quality aspects of health care and oversupply of more easily measured quality features such as nicer hospital or appointment rooms. A key challenge is often to make relevant information available in a manner allowing it to be effectively used by both health care practitioners and patients.[13]

4. **To the extent feasible, health care markets should incorporate incentives encouraging suppliers, buyers, and users to act efficiently.**

   Markets normally incentivize efficient behaviour by rewarding suppliers of higher quality or more desired products with higher prices and market shares. However, in health care this mechanism is restricted by the overlay of overriding public policy concerns, especially the desire for all Canadians to have affordable access to high quality health care. In addition, as noted, health care markets are potentially subject to market failure concerns that can distort the incentive for suppliers to act efficiently.

   The broad issue of provider and buyer incentives is one that plagues public health care systems like Canada's. For example, it is well recognized that different provider remuneration schemes, such as ones based on fee-for-service (where the doctor is paid by the procedure) or capitation (where the

doctor is paid by the patient), each create a different set of incentive concerns.[14] As well, the potential to use price or cost-based demand-side incentives, such as co-payments, is highly constrained by the overriding concern to ensure that all have necessary health care access.[15] An examination of this issue is outside of the scope of this paper. But in any case where competition applies, awareness of the underlying incentive structure is essential for understanding competition's effects and this structure should be designed to the extent feasible to promote efficient buyer, user, and supplier behaviour.

5. **Patients and related funds need to be contestable.**

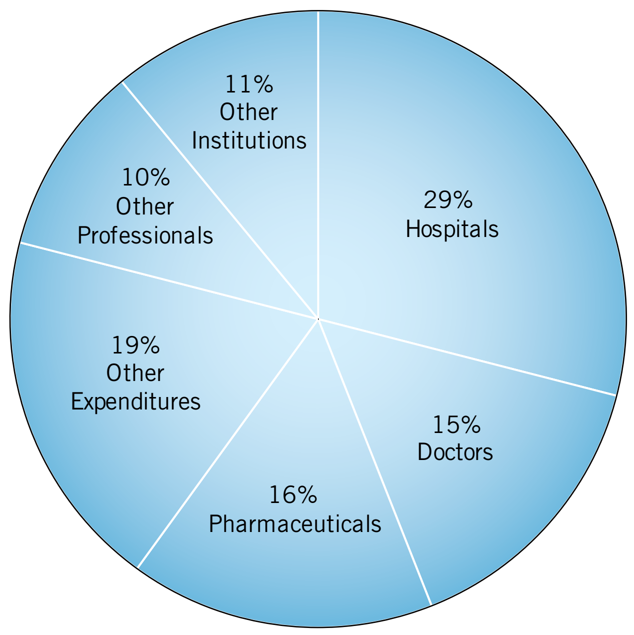
   The ability of patients and funds related to their care to be switched between providers is essential to encourage provider competition. To this end, barriers to patients' switching between providers should be kept to a minimum, taking into account any real costs associated with such switching. Furthermore, the decisions that patients make in terms of which services, therapies, and treatments they wish to use should have real financial impact. Services that are deemed to be more desirable should attract more resources, and those that are less desirable should attract less. This would have the natural effect of drawing more suppliers towards more favoured alternatives. Barriers to providers entering and exiting the system also should be kept to a minimum, as long as necessary quality and safety standards are met by new providers.

PART 2

Getting the Benefits from Competition in the Canadian Health Care Sector

This section considers the potential for better use of competition to improve the performance of the Canadian health care system in two main areas: hospitals and health professions. Chart 3 below details how health expenditure is allocated in Canada.

Chart 3 Allocations of health expenditures in Canada, 2015



Sources: Canadian Institute for Health Information; National Health Expenditure database.

Section 1 considers the potential for using competition to improve the performance of Canadian hospitals, which are, as indicated by chart 3, the largest single source of Canadian health care costs at 29 percent in 2015. Section 2 discusses competition issues pertaining to the supply of health care professional services, which collectively represent the second largest source of health care costs with physicians accounting for an estimated 15 percent of costs and other health care professionals accounting for about 10 percent.[16] As such, the areas where reform is being considered constitute 54 percent of all health care expenditure in Canada.

2.1: Competition between hospitals

While specifics can vary, hospitals in Canada are primarily supported through global budgeting. Under this approach, hospitals receive a lump sum, usually annually, to recover their costs. This amount is normally based on the hospital's historical costs so there is no direct incentive to serve more patients. Indeed, under global budgeting patients become a cost to the hospital, rather than an opportunity for additional income.

There is also little competition between hospitals. Rather, any changes to the hospital sector are made through a centralized decision-making processes taking place at the provincial or regional level (University of British Columbia).

This centralized decision-making and funding approach is not well-designed for promoting the supply of high-quality, low-cost hospital services. As stated in a paper by Kirby and Keon (2004), *Why Competition Is Essential in the Delivery of Publicly Funded Health Care Services*, under this basic approach:

> hospitals have little incentive to enhance the quality and/or accessibility of their services, to contain or reduce costs, to improve their efficiency or to improve their productivity. This is largely because their annual budgets are not based directly on the volume and type of procedures performed in a given year, nor do they reflect the actual cost of providing these services. . . . In a system as complex and multifaceted as health care, a top-down command and control strategy will almost certainly lead to compounding existing inefficiencies. (4)

Kirby and Keon go on to conclude that using "market forces" is the only effective way to make the health care delivery system more efficient and its providers more productive.

The introduction of competition among hospitals potentially raises a range of well-recognized concerns. For example, where the quality of outcomes is not easily measured, competition can lead to a focus on easily observed hospital quality characteristics, such as nicer rooms and meals, rather than the quality of care, leading, in turn to inferior health care outcomes. Competition can also limit access to health care for persons having more complicated health issues, as hospitals attempt to "cherry-pick" or "cream-skim" patients that they will likely be able to serve at a lower cost and higher net return.[17]

While recognizing these important concerns, there is increasing evidence from other jurisdictions that well-designed competition can provide an effective means to improve the performance of hospitals and drive the more efficient, innovative, and higher quality supply of hospital services. Moreover, this evidence indicates that achieving these benefits does not require the abandonment of publicly funded health care.

As outlined in the OECD 2012 Roundtable on Competition in Hospital Services, an increasing number of countries are looking to competition as a way to improve the performance of their hospital systems and have embraced reforms enhancing patient choice (9). These jurisdictions include not only the US, but also others with universal health care systems such as the UK, the Netherlands, Finland, and Sweden – all countries with reputations for strong social safety nets and publicly financed health care.

This trend reflects the limited effectiveness that regulation alone has had not only in controlling costs, but equally or more important, promoting the quality of hospital services. While greater use of competition has been largely incited by the desire to control hospital costs, international

experience is showing that it can also be highly effective for improving the quality of hospital services and patient satisfaction.

Hospital competition in the UK

The potential benefits of hospital service competition and choice are illustrated by developments that have taken place in the UK hospital system. In 2006, the Labour government implemented a system whereby all referrals to hospital had to be accompanied with a choice of five options where individuals could have the service performed with the full cost being borne by the National Health Service, and the funding for the procedure following the individual. Patients could examine key performance metrics as well as how long it would take before the procedure could be conducted before making a decision as to where to book a procedure.

Choice allows people to prioritize the aspects of care that matter most to them.

This created numerous benefits. First, it allowed people to weigh up and prioritize the key aspects of care that matter most to them. So if you prefer a short wait time, but are prepared to travel farther to get the procedure performed, you can choose to do so. Alternatively, if you would prefer to have the procedure close to home but are happy to wait longer for it, this is acceptable as well. Furthermore, patients can choose to weight various attributes of performance as they see fit. So if they place a high value on getting back home quickly, they can choose a hospital that has a short length of stay. If they value low re-admission rates or low rates of medical error, then they can choose hospitals that perform well on these metrics.

Second, it means that high performing hospitals are financially rewarded for their superior performance and low performing ones are not. It is an effective mechanism to allow governments to channel more resources to the effective and efficient, and fewer to those who are not performing up to standards. Hospitals have been given autonomy to expand and raise capital so they can build on success. Poor performing hospitals face the financial realities of declining income and the need to reorganize to compete with more successful hospitals.

Third, it creates transparent performance standards that each patient can assess and evaluate to determine the facility that will provide the best-suited care for them.

This innovative reform was widely studied to examine the impact of introducing a competitive element into the provision of publicly funded health services. The findings are highlighted below.

Gaynor, Moreno-Serra, and Propper (2013) conducted a study examining discharge data from the English National Health Service, and they found that an increase in competition between hospitals had the effect of reducing deaths without increasing costs. They conclude that increased competition has resulted in a better performing health system. They note that "economic theory suggest that competition will increase quality in markets with regulated prices" (2). They further note that "the established literature suggests that an increase in the elasticity of demand combined with a fixed price regime should lead to an improvement in hospital quality where hospitals face competition and a larger increase in quality when hospitals face greater competition".

Based on their findings, which are broadly consistent with that found in previous studies, Gaynor et al. conclude:[18] "These results suggest that competition is an important mechanism for enhancing the quality of care that patients receive. Monopoly power is directly harmful to patients in the worst way possible – it increases their risk of death. The adoption of pro-market policies in European countries as well as policies directed at increasing or maintaining competition such as antitrust enforcement, appear to have an important role to play in the functioning of the health sector and assuring patients' well-being."

Dixon et al. (2010) examined the initiatives to promote choice for patients in the NHS in En-

gland. Their review suggested that uptake of choice was not as high as expected and that general practitioners were often an obstacle to choice – most often recommending referral to their local hospital. However, this review also suggested that patients valued choice and that if their local provider fell short of other competitors, then travel to access treatment and services would be considered. The authors also argued that the information needs for patients were not being met and that more timely information relating more closely to the procedures being sought would facilitate more competition. Furthermore, they argue that "[competition] still represents a threat to providers that can keep them focused in what is important to patients."

Pilot tests in England show that 60 percent of patients would choose care outside their local provider if it would reduce wait times.

Jones and Mays (2009) reviewed a series of pilot studies carried out in England prior to the wider implementation of a choice-based system. The evidence from these pilots showed that if offered a choice that would reduce wait times, approximately 60 percent of patients would choose care outside their local provider. Jones and Mays also believe that competition will improve the quality of care as organizations are increasingly concerned about the perceived quality of care offered and the patient experience. Their review also suggested that choice was not more likely to be exhibited by any particular socio-demographic or socio-economic group, but they do argue that high quality and accessible information is required to support good choices, particularly by those less familiar with the NHS or with lower levels of education.

Cooper et al. (2011) examined the impact of choice on mortality in the English NHS. They found that in areas where there was greater choice, mortality declined. Gaynor and Town (2011) review the evidence from the UK and the US and find that, by and large, the evidence supports increased competition leading to improved hospital quality.

Furthermore, Cookson, Laudicella, and Li Donni (2013) echoed the conclusion that the choice-based reform of the English NHS improved quality and reduced cost, and furthermore did so without compromising equity of access across socio-economic groups. In total, this is an important body of empirical evidence that demonstrates that pro-competitive reform that increases choice for patients can improve quality, potentially reduce cost, and do so without unfairly disadvantaging those who are worse off.[19]

Creating competition among hospitals in Canada

Increased competition has the potential to provide a wide range of benefits for the supply of hospital services in Canada including:

- More efficient use of existing hospitals by reallocation of procedures across institutions according to their ability to provide them at lower cost;[20]
- promoting greater specialization in the supply of procedures across hospitals and clinics, in turn promoting the higher quality and lower-cost supply of procedures;[21]
- promoting greater innovation in the supply of hospital services by promoting entry by new classes of facilities;
- promoting greater efficiency in the use of health care workers in hospitals by providing incentive to abandon unnecessary and inefficient work rules and restrictions or allowing entry by new competitors not bound by such restrictions; and
- spreading risks and costs associated with fluctuations in demand for hospital services.[22]

A consideration often raised as a limit on the potential for hospital competition in Canada is that the country's relatively low population density, with a portion of the population being located in relatively small and remote communities, is incapable of supporting effective competition. While this should be a consideration in determining

whether real competition is possible in all areas of the country, competition should be promoted where it is feasible. Canada has 35 census metropolitan areas (CMAs) with more than 100,000 people and six with more than one million people – Canada is a very urban country. Many smaller communities are close enough to large CMAs or other communities to make choice viable. For those living in rural and remote locations, it is likely that any in-patient procedure will require travel to access services, meaning increased competition and choice would likely benefit them as well. For instance, a patient living in Sussex, New Brunswick could choose to receive care in Fredericton, Saint John, or Moncton. A patient in Northern Ontario could choose to receive treatment in Thunder Bay, Sudbury, Ottawa, or Toronto.

Larger population centres in Canada contain a number of hospitals and clinics that are capable of competing across a range of hospital services. In less densely populated or more remote areas, it may be possible to promote competition and patient choice through targeted subsidies. For example, Norwegian health care legislation provides patients with a right to obtain service at a hospital of their choice within a designated health care region so that all can have access to the best available health care. In support of this right, patients' travel, food, and accommodation costs associated with their choice of hospital are funded by the public health care system.[23]

To obtain the benefits from hospital competition, where it is feasible, patients, physicians, and health authorities will require access to information allowing them to effectively compare hospitals' costs of providing services, and the quality of these services. The Canadian Institute for Health Information (CIHI) is a world leader in collecting, collating, and reporting on health system performance. To promote better hospital performance, its role should be expanded to provide greater, and timelier information on the performance of hospitals. Most of the necessary data collection and reporting infrastructure is largely in place at CIHI. However, there would be a requirement for information to be made available on a more disaggregated level than is currently provided.[24]

Better mechanisms and more freedom are also needed for patients and health care professionals to select among hospitals with funding tied to the efficiency and quality with which the hospitals deliver services. Unnecessary barriers to the provision of services by competing suppliers, whether they be FPs, NFPs or public institutions, must be removed. That these may be difficult tasks should not be a reason to maintain the status quo or move slowly toward pro-competitive reforms.

A shift toward activity-based funding for hospital services would be another building block for competition.

A shift toward greater reliance on activity-based funding (ABF) for hospital services would be another building block for competition. The global budget funding approach that dominates hospital funding in Canada involves lump-sum transfers from the government to hospitals based on historic spending. The ABF model involves a hospital receiving all or a large portion of its funding based on its actual supply of services with amounts provided based on the quantity and nature of services provided.[25] ABF is the primary hospital funding mechanism used by other OECD countries, such as the UK, Switzerland, France, and Germany. This model creates a price signal to hospitals to be more efficient in the supply of services.[26] This aligns well with a reimbursement model based on patient choice, wherein the resources follow the choices of the individual seeking care or treatment.

The ABF model has contributed to a greater focus on hospital-level information with respect to cost and quality in the jurisdictions in which it has been adopted. For instance, Socha and Bech (2007) examined the impact of enabling choice and amending payment structures to an activity-based system in Denmark. They find that this increase in competition resulted in a one-third reduction in wait times across most of the health-system. In addition Gravelle at al. (2014)

suggest that there are positive spillovers from competition (such as the ABF funding model), with improvement in one hospital being found to be positively correlated with improvement in nearby competitors. The key takeaway is that competition can contribute to service quality improvements that can be widely distributed.

This stands in stark contrast to Canada, where only limited information is available at the institutional level. This should be expected. It is reflective of the incentives inherent in the funding model. The ABF model encourages hospitals to show their work. The global budgeting model, at best, is neutral and at worst actually encourages hospitals to obfuscate.

These examples highlight how other countries have introduced competition into the provision of health care services to improve outcomes in publicly funded health care systems.[27] The results are a compelling insight into the positive role that competition can play in encouraging efficiencies, producing better services, and lowering costs. The key is empowering the choices of patients through financing reforms – in particular adopting an activity-based reimbursement mechanism for hospitals and better, more accessible information for patients, providers, and governments to make good choices about who should be providing health care.

2.2: Competition between health service providers

Although the Canadian health care system incorporates a wide range of health care professions, physicians play the most important role and account for the majority of related expenditures on health professionals (CIHI 2015, 15). Spending on physicians accounts for more than 15 percent of all Canadian health care costs and is just below estimated expenditures on pharmaceuticals. Other health care professions, including dentists, vision care providers, nurses and nurse practitioners, pharmacists, and others play essential roles in providing various health care services that complement or, increasingly, provide a substitute for physician-provided services.

Competition plays a limited role in the provision of physician services in Canada. Over 95 percent of physician services are publicly remunerated, mostly on a fee-for-service (FFS) basis, with fee levels negotiated between physician groups and provincial governments (CIHI 2014, 43).[28] Entry into the profession and the conduct of physicians is regulated by provincial physician colleges. Physicians have no incentive to compete on price for the supply of publicly funded services since patients do not directly bear any of the associated costs.

> *Spending on physicians accounts for more than 15 percent of all Canadian health care costs.*

The central role and function of physicians in the health care system and collective bargaining places them in a particularly strong position to extract high fees in negotiations with the provinces.[29] Self-regulation by physicians also provides them with a high degree of control over the requirements for entry into the profession as well as the qualifications determining which health care services can be supplied by physicians.[30]

Physicians may compete to a limited extent on non-price dimensions, such as location, reputation, availability, and patient friendliness. However, there is limited objective information available that would allow patients to compare the quality of services provided by physicians.

Further, professional self-regulation by physicians generally sets strict standards for the advertising of professional qualifications and prevents physicians from using comparative advertising or financial or free service promotions. These standards require that advertising meet vaguely defined criteria: for example, it must be professional, in good taste, and not demean the profession.[31]

Moreover, limits on the availability of particular classes of physicians and associated delays can result in patients simply opting for physicians

that they are able to see within a reasonable time frame rather than basing their choice on the quality of care they can be expected to receive.[32]

Unlike many other countries with universal access health care models, there is limited parallel private supply of physician services in Canada as a potential competitive alternative to publicly financed services. While parallel private supply of physician services is not prohibited under the CHA, provinces have adopted a range of measures to prevent or restrict the supply of physician services outside of the public health care system. These measures include, for example, requirements for patients to pay the full costs of any privately supplied services, caps on the amount that physicians can charge for private services, and restrictions against private health insurance.[33] As a result, privately-paid physician services are a negligible part of most provinces' health care systems (Blomqvist and Busby 2015, 4).

Competition among other health care providers such as dentists, pharmacists, and nurses is similarly limited by entry and other restrictions imposed by self-regulatory regimes. However, private financing of supply of these services, particularly dentists and pharmacists, plays a much more important role than in the case of physicians. While public funding of pharmacists provides a portion of their total revenues, private payments account for significantly more than 50 percent. Other health care professionals, such as physiotherapists, occupational therapists, optometrists, and audiologists obtain more than 90 percent of their revenues from private payers (CIHI 2014, 43).[34]

Prices for health care services that are not publicly reimbursed are generally determined by market forces. A full examination of the effectiveness of these market forces for the low-priced and efficient supply of high quality services competition is beyond the scope of this report. However, competition advocacy work performed by the Canadian Competition Bureau in regard to the regulation of pharmacists, optometrists, and dentists, discussed further below, provides reason to be concerned regarding the impact of self-regulatory regimes in these professions.

The potential for competition to take place between health care professions is determined by legislation and regulations defining each profession's scope of practice. All provinces maintain legislation broadly indicating services that can be provided by specific professions and defining the scope for overlap between professions. There may be numerous areas where different professional groups could provide a competing service.

As professions have evolved and practice standards have become entrenched, the monopoly of one profession's hold on offering a particular service should reduce. And as technology expands and plays a greater role in the provision of health care, the ability of different professions to offer the same service should increase. In short, different professional groups should be equally competent to provide the same services, although they may work at very different wages. There are numerous areas where competition between professions could serve to increase access, encourage innovation, and lower cost without harming (and quite likely improving) the quality of care offered to patients.

Table 2 provides a comparison of salaries among health professionals.

Table 2 Average income by professional group, most recently-available data

Profession	Average Income
Medical Doctors	$225,000[1]
Nurse	$70,400[2]
Midwife	$75,200[3]
Nurse Practitioner	$87,100[4]
Physiotherapist	$69,300[5]
Chiropractor	$65,100[6]
Pharmacist	$87,400[7]

1 André Picard, 23 January 2013, "How Much Are Canadian Doctors Paid?" *Globe and Mail*, available at http://www.theglobeandmail.com/life/health-and-fitness/health/how-much-are-canadian-doctors-paid/article7750697/.

2 Registered Nurses' Association of Ontario, n.d, "Dollars and Sense: What are nurses paid?" Available at http://careersinnursing.ca/new-grads-and-job-seekers/find-nursing-job/dollars-and-sense-what-are-nurses-paid.

3 Living in Canada, 2016, "Midwife Salary Canada," available at http://www.livingin-canada.com/salaries-for-midwives-and-practitioners-of-natural-healing-jobs.html (based on 1950 hours

at $38.56, which is the average midwife wage in Manitoba. The Manitoba average wage is the highest reported in Canada).

4 PayScale, 2016, "Nurse Practitioner (NP) Salary (Canada)," available at http://www.payscale.com/research/CA/Job=Nurse_Practitioner_%28NP%29/Salary.

5 PayScale, 2016, "Physiotherapist Salary (Canada)," available at http://www.payscale.com/research/CA/Job=Physiotherapist/Hourly_Rate (based on an hourly wage of $35.53 and 1950 hours per year).

6 PayScale, 2016, "Chiropractor Salary (Canada)," available at http://www.payscale.com/research/CA/Job=Chiropractor/Salary.

7 PayScale, 2016, "Pharmacist Salary (Canada)," available at http://www.payscale.com/research/CA/Job=Pharmacist/Hourly_Rate (based on an hourly rate of $44.82 and 1950 hours per year).

On average, family physicians earn between 2.5 and 3.5 times more than other, highly-trained health professionals. As such, it is worthwhile to consider if there are areas where a professional other than a doctor could provide a comparable service.

We highlight three areas where competition has been allowed between professional groups.

1. **Nurse practitioners versus general practitioners in the provision of routine care**

   As the burden of disease has shifted from acute to chronic conditions, patients require more routine and ongoing care. However, many of the GP visits for those with chronic diseases are a simple check-in to ensure that a situation has not deteriorated and that their condition continues to be well-managed. These routine visits, while necessary, do not require consultation with a physician.

   Furthermore, many individuals with relatively simple conditions could be seen by a professional other than a doctor. Dierick-van Daele et al. (2010) conducted an economic evaluation comparing nurse practitioners to general practitioners in the treatment of common conditions in Holland. They concluded that substantial economic benefits could be gained by providing a comparable level of care and substantial cost savings, which they attribute to comparatively lower nurse practitioner salaries. These findings are echoed by Laurant et al. (2005) who conducted a systematic review of the evidence comparing GPs and nurse practitioners and conclude that: "appropriately trained nurses can produce as high quality care as primary care physicians and achieve as good health outcomes for patients." And they go on to state: "doctor-nurse substitution has the potential to reduce doctors' workload and direct health care costs." Kilpatrick et al. (2014) also conclude that nurses practising in an out-patient setting could provide comparable care to physicians at a lower cost. Martin-Misener et al. (2015) find that nurse practitioners "have equivalent or better patient outcomes than comparators [normally GPs] and are potentially cost-saving."

   In total, there is an impressive body of literature that suggests that there are many areas where nurse practitioners can provide care equal to or better than physicians offering the same service, at a lower cost. If providers were allowed to compete, and if patients were given a choice of provider, new innovations in the delivery of care for routine conditions could be achieved. This could increase access to services and potentially allow physicians to focus on more complex cases.

2. **Midwives versus obstetricians**

   Sandall et al. (2013) conducted a systematic review of the randomized control trial evidence comparing midwives to physicians in the provision of care up to and immediately following the delivery of a baby. The evidence largely favoured midwives in terms of most clinical outcomes and patient satisfaction. Furthermore, the authors note "a trend towards a cost-savings effect for midwife led continuity of care in comparison with medical-led care." This finding is supported by Sutcliffe et al. (2013) who conclude: "For low-risk women, health and other benefits can result from having their maternity care led by midwifes rather than physicians." Moreover, there appear to be no negative impacts on mothers and infants receiving midwife-led care. There are numerous other studies that arrive at the same basic conclusion: midwives are at least as effective, and generally less expensive, than physicians who provide maternity care.

3. **Physiotherapists and chiropractors versus general practitioners**

   Scholten-Peeters et al. (2013) compared the effectiveness of GPs and physiotherapists in the treatment of patients with whiplash-associated disorders. Their study revealed that both groups were roughly equal in terms of patient outcomes. However, it is quite likely that physiotherapy treatment would be considerably less expensive than that provided by GPs, resulting in better value for money from physiotherapy. Korthals-de Bos et al. (2003) compared chiropractors, physiotherapists, and GPs in the treatment of neck pain and found that chiropractors offered quicker recovery for roughly one-third of the cost of GP care.

These are three examples where the evidence supports multiple professional groups providing competing services. It is likely that there are many more, and if given the opportunity, different professional groups would come up with many different alternatives to physician-provided services. In a health system that requires an injection of innovative practices, we need to look beyond traditional ways of doing things and embrace alternatives to care by physicians.

Getting the benefits from competition between providers

Obtaining the potential benefits from competition within and between health care professions will require both the removal of unnecessary regulatory barriers to the supply of services, and enhancements to the mechanisms for competition between provider groups that are qualified to provide the same health care services.

1. **Removing regulatory barriers to competition**

A high level of regulation of health care professionals is clearly necessary to protect the interests of patients and the public. The establishment of minimum entry qualifications and scope of practice regulations is particularly important in the health care sectors. The delivery of poor quality health services by unqualified providers potentially poses serious risks to the health and welfare of patients. Oversight of professions can play a valuable role in helping to detect and prevent malpractice, the ongoing supply of inferior quality service, and other inappropriate behaviour by members of professions.

Self-regulation must remain focused on the protection of the public interest rather than the interests of the members of the relevant profession.

However, in health care, as other professions, a key concern regarding self-regulation is that it remain focused on the protection of the public interest rather than the interests of the members of the relevant profession. Self-regulation can promote the interests of members of a profession rather than the public in a range of ways. They include, for example:

- The creation of excessive educational, experiential, or other entry barriers, limiting the number of members of a profession;
- creating scope of practice restrictions limiting the ability of other qualified professionals to supply services;
- restricting the release of information and advertising that might otherwise promote more effective competition between members of a profession;
- requiring members of a profession to use non- or anti-competitive business practices; and
- restricting the use of innovative business and professional practices that can result in lower returns to the profession.[35]

The potential for professional self-regulation to impede the efficient supply of services is a long-recognized concern pertaining to the Canadian primary health care system. In this regard, Kirby and Keon (2004) state:

> In addition to retaining a monopoly over the supply of services, professional associations determine the scope-of-practice rules that set out what each type of

> health professional is allowed to do. … There is clear evidence that the Canadian health care system could be made significantly more productive through the better utilization of providers. Much would be accomplished if health care professionals of all kinds were allowed to use their full range of skills and knowledge rather than being limited by rigid scope-of-practice rules. (14)

Continuing concern in this area is indicated by the 2014 Canadian Academy of Health Sciences 2014 report, *Optimizing Scopes of Practice: New Models of Care for a New Health Care System,* which states:

> One of the key problems in the way health care is delivered in Canada today is that health professional scopes of practice and associated models of care tend to be organized on the basis of tradition and politics rather than in relation to the evidence of how best to meet contemporary population health needs[.] (Nelson et al. 2014, 19)

And, while not specifically focused on primary care, the Competition Bureau's 2007 report, *Self-Regulated Professions – Balancing Competition and Regulation*, examines whether unnecessary regulatory barriers to competition may exist in regard to two health care professions: pharmacists and optometrists (see chapters 5 and 6). Related concerns identified in the report include excessive restrictions on advertising and promotion, the prevalence of common fee guidelines, limits on the quantity of training opportunities for new entrants, business model restrictions, and scope of practice issues. Several Bureau interventions have also been made in support of the removal of regulations requiring dental hygienists to be overseen by dentists.[36]

Ensuring that self-regulating professions cannot raise unnecessary barriers to competition requires that underlying legislation be drafted that creates the potential for all professions to provide services for which they are adequately qualified, and that professional self-regulation be subject to effective independent oversight ensuring that it does not create unnecessary barriers to competition.[37]

Progress on the first of these requirements is being made in Canada through the trend by provinces toward a common legislative framework encompassing all health professions rather than a separate legislative framework for each. Under this "umbrella approach" to health profession legislation, scope of practice statements include non-exclusive descriptions of activities that may be provided by regulated professions and restricted or controlled practices tend to be more narrowly defined (Nelson et al. 2014, 47). As a consequence, greater potential is being created for overlap between the roles for and competition between different professions.[38] However, given the dynamic and evolving nature of health care approaches and technologies, ongoing attention is required to ensure that any remaining legislative barriers to inter-profession competition are removed as soon as possible.

Professional self-regulation can impede the efficient supply of services.

Progress toward effective independent oversight of regulated health professions in Canada is generally limited. Health professionals tend to claim that lay persons do not have the necessary training and knowledge. However, the experience of the UK in dealing with this issue indicates that this is not the case. Reforms undertaken there in 2008 require all health profession regulatory boards to be made up of at least 50 percent lay members. Moreover, all board members must be appointed, rather than elected by the professions themselves, as is generally the case in Canada. These reforms, which received all-party support, are considered essential for ensuring public, professional, and parliamentary confidence in the regulators, reducing perceptions that they are acting in the interests of the professions they regulate, and have been strongly endorsed in subsequent reviews.[39]

Various initiatives have been taken in Canada to provide independent input into health profes-

sion self-regulation. Ontario has been a leader in this area through the creation of the Health Professions Regulatory Advisory Council (HPRAC) under Ontario's *Regulated Health Professions Act* (1991) (RHPA) to provide independent advice to the Ontario Minister of Health on health care profession regulation in the province.[40] HPRAC board members must be independent of the minister and Ministry of Health and Long-Term Care, regulated health colleges, regulated health professional and provider associations, and stakeholders who have an interest in issues on which it provides advice.

> *Pharmacists remain underutilized as an alternative resource for prescribing or modifying medications.*

Independent input into health care regulatory decisions is also promoted in Ontario through the appointment of independent members to the boards or councils of health profession regulatory bodies. For example, the Ontario Royal College of Physicians and Surgeons Council must consist of 13 to 15 independent government appointed members out of a total of 31 to 34 members.[41] Decisions made by health professions' regulatory boards are also subject to review by an independent body, the Health Professions Appeal and Review Board.[42]

While such measures are a welcome step, they still leave control over the regulation of health care professions primarily in the hands of the professions themselves. While the HPRAC is independent, its role is as an adviser to government only. Members of the relevant professions continue to dominate regulatory decision-making, creating the potential for actions and decisions to be taken based on the interests of the professions rather than the public interest in inter- and intra-profession competition.

The suggestion that the current regulatory framework is not working as well as it should is supported by the often slow pace of change in scopes of practice of health care professions in Canada. Despite the potential benefits, advanced practice nurses remain an underutilized part of the Canadian primary health care system.[43] Although their role has increased significantly over the past several years, pharmacists remain underutilized as a resource for prescribing or modifying medications as a substitute for or complement to physicians (Law et al. 2012).[44] Midwives are not used as extensively as would be justified by the evidence.

To ensure that health profession regulation does not restrict competition unnecessarily and otherwise operates in the broader public interest, all provinces should consider adopting measures to ensure that it is subject to ongoing review and effective public input. The creation of a fully independent advisory body by all provinces would be a significant step. However, to ensure that health profession regulation remains focused on the broader public interest not only in regard to competition, but also patient welfare and safety, consideration should be given to requiring all regulatory bodies not be composed of a majority of members of the relevant profession.

2. Service provider relative costs

The deep but narrow coverage of public health insurance schemes in Canada creates an uneven playing field between insured and uninsured professional services. Full public insurance of physician services deemed to be essential makes them available to patients at no financial cost. Provincial insurance of pharmaceuticals also provides subsidized access to pharmacist services and drugs although only to targeted populations and often involves co-payments.[45] Those fortunate enough to have work-related insurance covering some of these services may not be required to pay for them out-of-pocket outside of applicable co-payments. Others either must directly bear the costs of these services or acquire related private health insurance.

The competitive bias this situation creates can have major implications for health care costs. Although available to patients at no financial cost, essential health care services that are publicly insured, such as visits to physicians and hospital emergency departments are often a much more

costly way to treat patients than uncovered alternative approaches that patients are required to cover themselves. For example, relatively inexpensive physiotherapy to treat back or other muscle pain may reduce the frequency of higher cost visits to physicians.

> *Relatively inexpensive physiotherapy to treat back or other muscle pain may reduce the frequency of higher cost visits to physicians.*

A more even playing field might be promoted through the imposition of co-payment or other financial costs on patients in applicable cases. However, any such scheme would have to be carefully designed to ensure that it maintains easily affordable access to all, and could require amendments to the CHA.[46] A preferable alternative might be to expand the scope of public insurance schemes to cover competing services in appropriate cases. While this could increase the overall costs of public insurance to the provinces, it should promote more efficient use of Canada's overall health care resources.

3. Patient choice of provider

Though limited in scope, the current health care system contains two principal mechanisms for competition within and between primary health care providers: patients' choice of provider and the option to obtain services outside of the publicly-funded system.

Patient choice of their provider is a potentially powerful mechanism for enhancing the quality of services provided within the publicly-insured health care system. Because funding follows patients, they have the potential to provide a strong financial incentive for physicians to provide services meeting patients' needs and preferences. However, the effectiveness of this mechanism is dependent on the type and quality of information available to patients, and patients' access to competing providers. In order for patient choice to drive higher quality and more responsive service, patients must have effective access to information required for them to compare and select from a number of competing providers.

Advances in electronic data tracking, gathering, and analysis are unlocking increasing potential for the collection of information regarding the practices and performance of health care professions, particularly physicians. The development and release of comparative information regarding physicians' performance could greatly increase the effectiveness of the competition that currently exists within the health care system. Such information could be used by patients alone or in cooperation with their general practitioner to better choose providers based on the characteristics and quality of their service, in turn incenting all providers to perform better. For physicians, access to such information could allow them to more effectively compete, allowing them to gauge their performance against their peers and identify areas where they may be able to perform better.

However, a 2012 Commonwealth Fund survey (Schoen et al.) of the use of information technology by primary care doctors indicates that Canada lags well behind leading countries in the collection and dissemination of information on physicians' performance. Compared to the UK, the leading country in this area, in 2012 the percentages of Canadian physicians reporting that they routinely receive and review information on their practice's clinical outcomes, patient satisfaction, frequency of ordering diagnostic tests and their clinical performance compared to other practices, were 23 versus 84 percent, 15 versus 84 percent, 16 versus 56 percent and 15 versus 78 respectively (Schoen et al. 2012, 2811). Canadian physicians also lagged well behind all other countries surveyed, except Switzerland, in the use of electronic medical records (2809).[47]

Although the use of electronic record-keeping is continuing to expand, this has not yet translated into the systemic development and distribution of information on physician performance. Rather, patients continue to have limited information allowing them to effectively drive competition between service providers. Reversing this situation should be a key priority of further health care reform. [48]

The collection, analysis, and dissemination of comparative information on physicians is another area where CIHI could play a central role. However, it would require access to new information on the performance of practitioners and performance indicators would have to be developed around access, wait-times, and outcomes, and made publicly available in a manner enabling patients making informed choices.

> *A return to a better balance between the supply of and demand for physicians would provide welcome choice for patients.*

4. Removing barriers to new entrants

Even if better comparative information were available on physician performance, competition will not be effective unless patients are able to effectively choose between multiple competing providers. While there may be structural reasons for a lack of choice, such as low population density in rural areas, Canadians' choice of physicians has often been limited for other reasons. During the 1990s and into the 2000s the supply of physicians in Canada, particularly of family and general practitioners, switched from a perceived surplus to a severe shortage.[49] The emergence of shortages was due to a number of developments, including efforts by the provinces to restrict the number of physicians as a cost control measure.[50] A clear effect of the shortages has been to limit the ability of patients to shop among competing physicians to find preferred providers.

More recent evidence suggests that the state of physician supply versus demand is shifting back toward a possible surplus. The number of physicians in Canada has increased by significantly more than Canadian population growth over the past eight years, with this trend expected to continue over the next several years.[51] In addition, expanded use of health care teams and broadened scopes of practice for other health care professions are resulting in more health care services being provided by other professions that, in the past, would have been provided by physicians (Fréchette et al. 2013). A return to a better balance between the supply of and demand for physicians would provide welcome choice for patients, enabling the existing competitive elements of the health care system to operate more effectively.

Counting numbers of physicians qualified in a field of practice may not be a good indicator of their availability and patients' ability to choose. Barriers to entry into practice can also be an important consideration. For physicians providing surgery, their ability to practise depends on their access to operating facilities. Diagnostic imaging can be a barrier to receiving treatment as many specialist physicians cannot provide care without a detailed image. Where these facilities are scarce or controlled by incumbent physicians, this can prevent effective entry into the supply of services by qualified providers, in turn, limiting patient choice and competition.

That the barriers to entry into practice are important to consider is indicated by a 2013 employment study conducted by the Royal College of Physicians and Surgeons (Fréchette et al.). Among new specialist and sub-specialist respondents to the College's 2011 and 2012 employment surveys, 16 percent reported being unable to secure employment. A further 31.2 percent chose not to enter the job market, opting instead to pursue further subspecialty or fellowship training to make them more employable (2). Lack of new entrant access to clinics and hospitals, especially operating rooms, was cited as a major factor for these observations. In addition to an undersupply of such facilities, new entrant access was also reported to be limited due to incumbent physicians' control over available operating room spaces (45–46).

All of this creates a rather perverse co-existence of long wait times and underemployed physicians. For example, there are long wait times for procedures by orthopaedic surgeons and opthamologists, and large numbers of qualified physicians not currently practising in these areas of specialty.[52]

The measures discussed earlier in the paper for promoting greater hospital and clinic efficiency would likely help open up surgical facilities for new doctors. For example, greater use of activity based funding could incent hospitals to make better use of operating rooms, increasing the numbers of operations that can be performed.[53] By reducing costs to the health care system, competitive contracting for day surgery space could make it possible to fund more capacity.

Physicians need better access to scarce surgical facilities.

5. Alternatives to the public system

The ability of patients to obtain physician and other health care services outside of the public health care system has the potential to have a significant pro-competitive and beneficial impact on the Canadian health care system, although its effects have been limited to date. This competition may be provided either by travelling to the US or another country, or by the provision of health care services in Canada outside of the public health insurance system.

The extent to which Canadians seek care beyond our borders is unknown, and the issue continues to generate controversy. But it is generally recognized that some Canadians go to other countries to obtain health care services for which they are insured by their provincial health insurance plan. This may occur due to a desire to avoid treatment delays under the Canadian public system or possible concerns regarding the quality of care that would be provided in Canada versus a foreign provider.

However, the effectiveness of foreign providers as a competitive alternative to the supply of health care services in Canada is generally limited by the requirement that, with few exceptions, patients fund their foreign health care entirely out of pocket.[54] As a consequence, only persons having adequate resources to fully fund travel and health care services in other countries are able to take advantage of this competitive opportunity.

Because this option is only available to a small number of patients, it creates limited competitive pressure on the Canadian health care system to improve wait times and performance. Making this option more affordable for more patients potentially provides a way to exert additional competitive pressure on provincial public health systems to be more efficient and responsive to patient needs and improve overall health care access. This might be done, for example, by providing vouchers to patients to have procedures performed in another country when waiting time standards are not being met within the provincial system.[55] To prevent this approach from imposing excessive costs on the province, amounts made available might be capped at or tied to the cost of providing the treatment in Canada.

The CHA itself does not contain any restrictions against the supply of health care in Canada outside of the public health care system. Rather, it only determines conditions under which public insurance schemes must operate in order for provinces to qualify for federal health care funds. However, the provinces themselves have adopted a range of measures preventing physicians from operating outside of the public health care system or preventing them from providing both publicly insured and non-insured services, capping amounts that opted out physicians can charge patients, and bans against private insurance schemes.[56]

Canada is not getting its money's worth with regard to health care outcomes.

As a consequence of the above restrictions and the need for non-insured care to be paid for out-of-pocket, parallel supply of uninsured health

care has had a limited competitive impact in Canada. Removal of the above types of restrictions could increase the choices available to Canadians and the competitive impact of parallel supply on the publicly funded health care system. However, depending on how a parallel supply of health care is permitted, it can also have serious negative effects on the public health care system, in particular the quality and quantity of resources available with the system. While there are high performing universal health care systems that have substantial parallel private health care supply and insurance, the evidence on the overall effect on the public health care system and the accessibility of care is mixed.[57] Any efforts to promote parallel supply would have to be carefully implemented to insure that they enhance Canada's public health care system.

PART 3

Concluding Remarks

Canada's public health-care system is in need of reform. A growing body of evidence shows that Canada is not getting its money's worth with regard to health care outcomes. Canada spends more than most of our peers, and yet it performs poorly on a wide range of measures, including wait times and quality. The Federal Minister of Health has acknowledged that we need "system reform."

This study examines how a focus on competition has brought greater choice, better services, and lower costs to jurisdictions such as the United Kingdom. It also sets out recommendations for how Canada can incorporate greater competition in our own health care system to decentralize decision-making and empower patients.

The evidence strongly suggests that there could be significant benefits to stoking competition in two key areas: competition between hospitals, and competition between professional groups. On both fronts, the evidence points to increased efficiency, lower costs, and improved outcomes. In both cases, a key requirement will be developing and releasing better information on the quality and characteristics of specific health care service providers, allowing patients alone, or in cooperation with their GPs, to better choose their providers.

In the case of hospitals, an initial step toward getting more of the potential benefits from competition would be to apply activity-based funding, or ABF, to hospital budgets. Beyond this step, consideration should be given to measures giving patients real choices. This might eventually entail the adoption of a patient-based voucher system, as is currently employed in the UK.

Competition between health care professionals in Canada continues to be constrained by regulatory bodies, comparative patient cost, and a lack of effective mechanisms and conditions for

competition. This report has outlined a range of measures that may be considered to extend and improve both inter and intra-profession competition as a way to both improve the quality of care provided and reduce the cost. One key measure is the inclusion of lay people on professional regulatory bodies to keep doctors, for example, from raising unnecessary barriers to other well-trained professionals supplying services that they are qualified to provide at lower cost.

We believe six conditions must be met to allow competitive reform to deliver better outcomes.

1. Patients must have an effective choice of providers.

2. Patients must have good information on competing providers. This information must be timely and relate to key outcomes that will influence patient choice such as quality and wait times.

3. There must be financial implications for patients' choices. The funding must follow the patient, and, to the extent feasible, patients and their physicians should be accountable for the choices they make.

4. There needs to be oversight and regulation to ensure competing providers are not risking patient safety and that health profession regulators operate in the interests of the public, not the profession.

5. Pro-competitive initiatives should focus on the most routine of services. Highly specialized treatments are not good candidates for pro-competitive reform due to a limited demand and few opportunities for gains due to economies of scale or scope.

6. A requirement for making competition and choice work is timely, accurate, and pertinent performance information. The Canadian Institute for Health Information currently coordinates reporting by regional health authorities and is in the best position to expand their reporting to the institutional level and to extend to reporting on individual practitioners. We believe the provision of this information is a public good and should be funded by government.

While they are indicative of the potential benefits of better health care competition, the supply of hospital and health care professional services that are the focus of this paper are not the only areas where major benefits from competition can be anticipated. In particular, competition also remains highly underutilized as a possible means for reducing pharmaceutical costs in Canada (Competition Bureau Canada 2008; Gagnon 2014). Competitive contracting of clinic space potentially provides a low-cost alternative to increased primary hospital capacity for relatively standardized procedures such as knee, hip, dental, cataract, hernia, plastic, and gall bladder surgeries, dialysis, medical imaging, colonoscopies, and ear, nose, and throat procedures.[58] Diagnostic services is a further area where better use of the competitive mechanism could reduce costs and improve the quality of service.[59]

Without reform, Canadian health care is doomed to increasing costs, longer wait times, and a decline in quality.

The current demographic and expenditure trends in health care are not sustainable. To continue to offer high quality service in a timely fashion, new approaches to health care funding and delivery must be explored, and we believe the evidence provided in this paper provides significant justification for pursuing pro-competitive reform. Allowing competition between professional groups and between hospitals are possible mechanisms that can deliver disruptive change. Without such change, Canadian health care is doomed to increasing costs, longer wait times, and a decline in quality. Patients deserve to be able to make an informed choice about their care, and hospitals and doctors shouldn't be afraid of a little healthy competition.

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Endnotes

1 Straus, Tetroe, and Graham (2011) report that uptake of best practice in health care is haphazard with mechanisms for changing health care delivery not well established. This means that potentially more efficient treatments are being foregone for treatments that are less effective, more costly, or both. Lavis et al. (2002) studied eight health policy-making processes in Canada and found them to be poor in the use of published evidence to facilitate decision-making. Thus, even though the use of evidence in decision-making has improved, obstacles to change remain within the health care system. Grimshaw et al. (2012) confirm that knowledge uptake in Canada remains lacking.

2 For a general discussion of economic issues and concerns pertaining to the use of competition in health care, see Penelope Dash and David Meredith, 2010, *When and How Provider Competition Can Improve Health Care Delivery.* However, health care markets are not alone in being subject to these types of concerns. Rather, they also apply to some extent to many other products that are nevertheless provided competitively and there is a range of measures that can be used to mitigate them in order to get the benefits that competition can provide.

3 Goddard (2015) offers an excellent review of situations where competition has been useful, and when it has not. Mays (2011) suggests the evidence on competition in health care is mixed. It seems safe to conclude that not all aspects of health care would benefit from pro-competitive reform, but there is potential for targeted introduction of competitive mechanisms to improve health system performance.

4 See the Program Criteria section of the *Canada Health Act*, R.S.C., 1985, c. C-6.

5 The various components of the Canadian health care system and costs associated with their supply are outlined in Canadian Institute for Health Information, 2014, *National Health Expenditure Trends, 1975 to 2014*.

6 These objectives are not always complementary. For example, mechanisms for achieving more efficient use of health care resources, such as user fees, may limit some patients' access to health care. Where such trade-offs arise, it is essential that they be clearly understood.

7 For discussion see Michael Watts, 2013, *Debunking the Myths: A Broader Perspective of the* Canada Health Act, pages 14–15.

8 These groups may provide a range of practice management, financial, and electronic records services to physicians. See for example, the physician services offered by Appletree Medical Group (2016), Physiomed (2016), Abelmed (2016), TELUS Health (2016), and Lanier Healthcare Canada (2016).

9 This is consistent with the value-based competition approach advocated by Porter and Tiesberg (2006) in their book *Redefining Health Care*.

10 For a description of the conditions where market reforms may and may not be effective in health care see Dash and Meredith (2010) and Hsiao (1995).

11 For discussion of this issue and how to assess the effectiveness of competition in markets, see the Canadian Competition Bureau, 2011, *Merger Enforcement Guidelines*.

12 The idea of patient choice is advocated by Alain Enthoven (1988) in *Theory and Practice of Managed Competition in Health Care Finance*.

13 As stated in Dash and Meredith (2010), there is clear evidence that simply measuring data on health outcomes and organizational performance and then making the results publicly available improves the results achieved.

14 For discussion of the various payment options available see, for example, Pierre Thomas Léger, 2011, *Physician Payment Mechanisms: An overview of policy options for Canada*; and Åke Blomqvist and Colin Busby, 2012, *How to Pay Family Doctors: Why "pay per patient" is better than fee for service*.

15 For discussion of a way that patient-based incentives may be implemented through the tax system that incorporates a means-based approach to mitigate access issues and may be permitted under the CHA, see Shay Aba, Wolfe D. Goodman, and Jack M. Mintz, 2002, *Funding Public Provision of Private Health: The case for a copayment contribution through the tax system*. A version of this approach was considered by the Quebec government as part of its 2010/11 budget but eventually rejected. Whether the federal government would consider such a scheme to be a violation of the CHA access provisions remains an open question. In this regard, see Gerard W. Boychuk, 2012, *Grey Zones: Emerging Issues at the Boundaries of the* Canada Health Act, at pages 10–12.

16 Numbers are taken from Canadian Institute for Health Information, 2014, *National Health Expenditure Trends, 1975–2014*.

17 For a more fulsome discussion of the potential concerns from hospital competition see, OECD, 2012, *Competition in Hospital Services*, at pages 195–211, and Standing Senate Committee on Social Affairs, Science and Technology, 2002, *The Health of Canadians – The Federal Role*, Chapter 2.

18 For instance, Kessler and McClellan (2000) use US Medicare data to examine the impact of market concentration on health outcomes. They find that in markets where there is more competition, risk of mortality is lower. Similarly Kessler and Geppert (2005), also using US Medicare data, find that high-risk patients have greater mortality in markets where there is less competition.

19 Furthermore, Gravelle, Moscelli, Santos, and Siciliani (2014) suggest that there are positive spillovers from competition, with improvement in one hospital positively correlated with improvement in nearby competitors. This suggests that quality gains coming from competition are likely to be widely distributed.

20 For example, more relatively uncomplicated procedures might be shifted to community hospitals having relatively low overhead costs from teaching or tertiary hospitals having higher overhead costs.

21 Frequency of procedures performed at a facility is a well-recognized indicator of the quality of procedures.

22 For further discussion see Michael J. L. Kirby and Wilbert Keon (2004) at pages 18–21.

23 The service must be medically required and the hospital must be under the regional authority's health care umbrella. For a description of this and other competitive features of the Norway hospital sector, see OECD (2012) at pages 195–211.

24 Most CIHI data is reported at the Regional Health Authority level.

25 For a description, see Sutherland et al., 2013, "Paying for Hospital Services: A hard look at the options." This is a good report, offering a clear analysis of ABF.

26 There have been some attempts to introduce ABF for hospitals but, to date, they have been limited in scope. For discussion, see Sutherland et al. (2013) and Ontario Ministry of Health and Long-term Care (2014).

27 Hospitals would not have to be entirely funded on an ABF basis. However, a sufficient amount of their budget should be ABF-based to encourage them to compete for patients. For a discussion of mixed funding approaches see Sutherland et al. (2013).

28 Canadian Institute for Health Information reports, *National Health Expenditure Trends, 1975 to 2014*, ibid, p.43. For a further breakdown, see Åke Blomqvist and Colin Busby, 2012, *How to Pay Family Doctors: Why "pay-per-patient" is better than fee for service*.

29 This is supported by the 2012 Canadian Institute for Health Information report, *Health Care Cost Drivers: Physician Expenditure—Technical Report*, pages 53–54, which found that physician fees increased faster than wages for other health and social workers from between 1998 and 2008 and were the main driver of higher public health care costs over the period. A Ontario-based Institute for Competitiveness and Prosperity (2014) paper*, Building Better Health Care Policy: Opportunities for Ontario*, finds that physician wages increased 51 percent from 2002 to 2012 while other health care professionals and all occupations experienced wage increases of 29 percent.

30 The provinces also play an important role in determining entry by physicians through their support for related education and training opportunities.

31 See for example, College of Physicians and Surgeons of British Columbia (2012); College of Physicians and Surgeons of Alberta (2015); and Ontario Regulation 114/94, Part II.

32 Note that such shortages may not be due to a lack of qualified physicians, but rather, due to limited access to clinical and practice resources, especially operating room time. This issue is further discussed later in the paper.

33 For a description of these measures see Gerard W. Boychuk, 2008, *The Regulation of Private Health Funding and Insurance in Alberta Under the Canada Health Act: A Comparative Cross-Provincial Perspective*.

34 Primary care nurses are publicly funded, with additional public funding also being provided for various services provided in the community.

35 For further discussion of the potential anti-competitive effects of self-regulation, see Competition Bureau Canada, 2007, *Self-Regulated Professions – Balancing Competition and Regulation*.

36 See, for example, Sheridan Scott, 2015, "RE*: Dental Hygienists' Act - An Act Respecting the Regulation of the Profession of Dental Hygiene*."

37 Effective independent oversight is important not only on competition grounds but also to ensure that disciplinary and other decisions made by profession regulators are based on the broader public interest.

38 For a description of this approach as applied in Ontario, see HPRAC, 2009, *Critical Links: Transforming and Supporting Patient Care,* pages 10–11.

39 See, for example, the Department of Health's 2011 Report to Parliament, *Enabling Excellence: Autonomy and accountability for health care workers, social workers and social care workers*, and a 2015 report by the same, *Regulation of Health Care Professionals Regulation of Social Care Professionals in England: The Government's response to Law Commission report 345, Scottish Law Commission report 237 and Northern Ireland Law Commission report 18 (2014) Cm 8839 SG/2014/26*, at page 18.

40 Information on the structure roles and work of the HPRAC is available at their website, hprac.org. While health professions regulation advisory bodies may exist in other provinces, none is fully independent. For example, BC requires only that a majority of the members of advisory panels be independent, (see *Health Professions Act* [RSBC 1996] Chapter 183 s. 6.2 ff.). Alberta requires that at least 25 percent of its advisory board be drawn from regulated health care profession members (see *Health Professions Act*, Revised Statutes of Alberta 2000 Chapter H-7, Current as of September 15, 2016. s. 22 ff.).

41 See the *Ontario Medicine Act*, *1991*, S.O. 1991, c. 30, s. 6. The comparative portions of independent Council members for the Ontario College of Dental Surgeons of Ontario and College of Nurses of Ontario are 9 to 11 out of 23 to 25 and 14 to 18 out of 35 to 39 members, respectively.

42 It may be noted that a number of related initiatives have been taken by other provinces. For example, one-third of B.C. health care professions boards must consists of government appointed members that are not required to be registrants of the relevant profession. See section 17 of the *Health Professions Act* [RSBC 1996] Chapter 183. Alberta requires that at 25 percent of the voting members of a professions council be made up of members of the public appointed by the provincial government. See section 12 of the *Health Professions Act*, Revised Statutes of Alberta 2000 Chapter H-7.

43 See, for example, R. Martin-Misener and D. Bryant-Lukosius, 2014, *Optimizing the Role of Nurses in Primary Care in Canada* and Faith Donald et al. 2010, "The Primary Healthcare Nurse Practitioner Role in Canada." It is recognized that expanded roles for other health care professions should not be at the expense of beneficial collaboration between professions. However, where a health care professional is qualified to provide a service independently they should be permitted to do so and where care is provided collaboratively competition should be promoted between collaboratives.

44 For an example of the potential benefits from expanded roles for pharmacists, see James Gallagher et al., 2014, "Cost-outcome Description of Clinical Pharmacist Interventions in a University Teaching Hospital."

45 For a description of the coverage of public pharmaceutical insurance schemes, see Competition Bureau Canada, 2007, *Canadian Generic Drug Sector Study*, at pages 36–38.

46 It may be noted, however, that the potential for applying a suitably designed income co-payment scheme under the CHA remains an open question. For discussion see Shay Aba, Wolfe D. Goodman, and Jack M. Mintz, 2002, "Funding Public Provision of Private Health: The case for a copayment contribution through the tax system." A related approach was considered by the Quebec government as part of its 2010/11 budget but eventually rejected. Whether the federal government would consider such a scheme to be a violation of the CHA access provisions remains an open question. In this regard, see Gerard W. Boychuk, 2012, "Grey Zones: Emerging issues at the boundaries of the *Canada Health Act*," at pages 10–12.

47 While there has been substantial progress more recently in this area, more than 25 percent of Canadian doctors still do not generate electronic medical records. See CIHI 2016a.

48 As stated in Institute for Competitiveness and Prosperity (2014) at page 51, "Peer performance data within a care setting can help stimulate healthy competition that could drive change . . . Physicians respond to evidence, and if benchmark data show that their practice varies from the norm, they will be incentivized to improve . . . benchmark reports encourage healthy competition that pushes people ahead."

49 See, for example, Benjamin Chan, 2002, *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?*

50 See, for example, Thomas F. Crossley, Jeremiah Hurley, and Sung-Hee Jeon, 2006, *Physician Labour Supply in Canada: A Cohort Analysis*.

51 In 2014 alone, the number of physicians entering the Canadian health care system exceeded population growth by 2.9 percent (Crossley, Hurley, and Jeon 2006, 7).

52 For a survey of wait times, see, Canadian Institute for Health Information, 2016, *Wait Times for Priority Procedures in Canada, 2016*.

53 Under global budgeting, hospitals may have a disincentive to maximize use of their operating rooms as it may increase their costs without providing any additional income to them.

54 For example, coverage may be provided for emergency services or services for which a physician can make the case that supply outside of the country is required. See for example restrictions on Ontario foreign coverage of health care costs available at Ontario Ministry of Health and Long-term Care 2012 and 2015.

55 A potential concern in funding patients to have procedures performed in other jurisdictions is that medical costs due to complications following poorly performed procedures may eventually have to be covered under the relevant provincial plan. While patients would in any event have an interest in ensuring that they receive high quality services, to address this concern, patients might be required to use approved or qualified foreign providers.

56 For a review of these restrictions, see Gerard W. Boychuk, 2008, "The Regulation of Private Health Funding and Insurance in Alberta Under the *Canada Health Act*: A comparative cross-provincial perspective."

57 Analysis of this issue has generally centred around the impact of having private insurance schemes operating in countries in competition with public insurance schemes. For a survey of potential benefits and concerns pertaining to parallel supply of health care, see Odette Madore, 2006, *Duplicate Private Health Care Insurance: Potential implications for Quebec and Canada*.

58 See, for example, All Points West, 28 August 2015, "Island Health Partners with Private Contractor to Reduce Surgical Wait Times," *CBC News*.

59 See, for example, Wendy Glauser, Jill Konkin, and Andrew Remfry, 12 February 2015, "Ontario's Private Outpatient Lab Sector Needs Overhaul, Say Critics."

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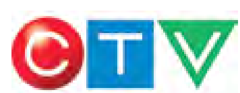

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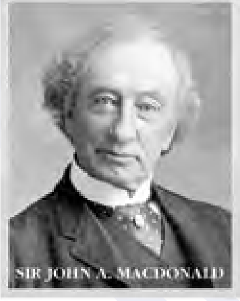
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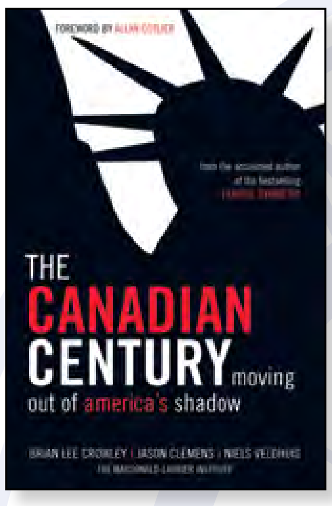

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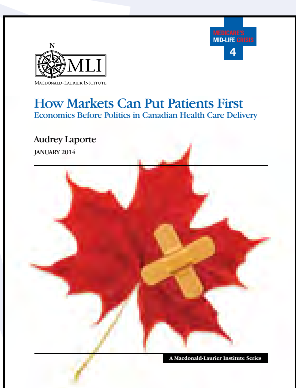

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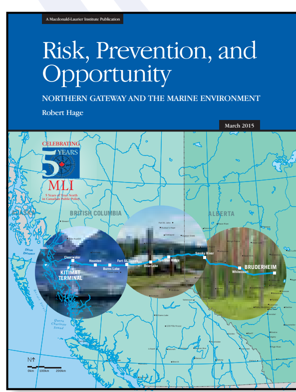
Sean Speer and Ian Lee



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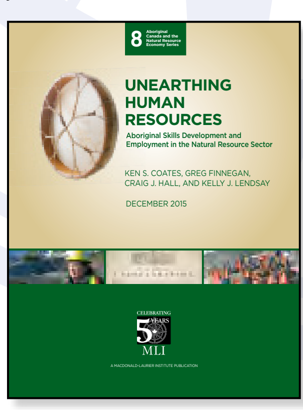
Robert Hage



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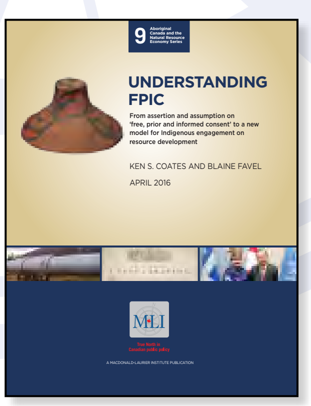

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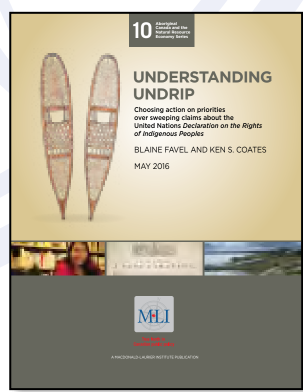

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True North in Canadian public policy

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