Lessons from the Public-Private Partnerships in Surgical Care in Quebec

Yanick Labrie

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Introduction

Long wait times for surgical treatments have been a persistent issue in Canada and have worsened since the COVID-19 pandemic (Moir and Barua, 2022; Labrie, 2023). In an effort to tackle the long backlog of elective surgeries, various provincial governments have in recent months announced plans to partner with private surgical clinics (Daflos, 2023; Ferguson, 2023; Smith, 2023). Although such public-private collaborations have proven successful in the past (MacKinnon, 2016), debate rages in Canada about the potential to improve access to surgical care through increased partnerships with the private sector.

In this context the experience of Quebec is interesting to analyze, as such partnerships have existed there for more than 15 years.[1] Although it has a universal health care system that must comply with the principles of the Canada Health Act, Quebec has experimented with implementing specific public policies and programs that differ significantly from those of other provinces in several key respects. Since the Chaoulli judgment in 2006, private services for select procedures have been fairly commonplace. More recently, many more cases of publicly-funded day surgery have been outsourced to private medical centres, with the aim of alleviating the backlog created during the COVID-19 pandemic. At the beginning of April 2023, Quebec Health Minister Christian Dubé also announced the intention of his government to continue along this path and promote public-private partnerships in the health care system in the future (Vailles, 2023b).

This essay documents Quebec's relatively unique approach to health care in the Canadian landscape in order to show the compatibility—and potential benefits—of public-private partnerships within the framework of a universal health care system. After briefly describing the events surrounding the Chaoulli ruling and the subsequent government

1 This is all the more so since reports have compared Quebec's health care system favourably with those of other provinces (Barua, 2013; CHPI, 2016). Despite major challenges in waiting times for access to health care, Quebec has been historically among the three Canadian provinces where the waiting times are the shortest (Moir and Barua, 2022). At the dawn of the pandemic, Quebec was one of the two provinces with the highest percentages of patients operated on within the target wait times set for hip, knee and cataract surgeries (CIHI, 2023).

response, the report examines the factors underlying the expansion of private surgical centres in recent years. It concludes with the main lessons to be learned from the Quebec experience so far, and some conditions that would need to be met to take full advantage of the presence of entrepreneurs in this area of our health care systems.

The Chaoulli Ruling and the Creation of Specialized Medical Centres in Quebec

In 2005, the Supreme Court of Canada delivered a landmark ruling now known as the Chaoulli decision.[2] It was based on a case challenging the legality of two provisions in Quebec's health care laws that prohibited private health insurance for services that are covered by the public health care system.[3] The central element in the trial was the length of waiting lists and its consequences, as this symbolized the failure of the public health care monopoly. It also called into question the morality of prohibiting private medicine, insofar as patients who see their health and quality of life deteriorate under the monopoly system have no alternative. The court ultimately ruled that the prohibition was a violation of the right to life and security of patients and ran counter to the Quebec Charter of Human Rights and Freedoms (Labrie, 2015).

In response to the Chaoulli judgment, the Quebec government tabled Bill 33 in December 2006, amending the Act respecting health services and social services [the Act].[4] First, the amendments allowed Quebecers to purchase duplicate private insurance for a small number of treatments for which wait times were considered abnormally long, namely hip and knee replacements and cataract removals. However, no market for this kind of insurance has developed since then, given the limited number of admissible surgeries. The strict prohibition of mixed medical practice for doctors has also hampered the emergence of such an insurance market.

Second, the legislative changes contained new provisions to regulate the activities of private surgery clinics—from then on called Specialized Medical Centres (SMCs)—and allow them to consolidate their involvement in the public health care system. The

2 See Supreme Court (2005) (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2237/index.do).

3 See Section 11 of the Hospital Insurance Act < https://www.legisquebec.gouv.qc.ca/en/document/cs/a-28 > and Section 15 of the Health Insurance Act <https://www.legisquebec.gouv.qc.ca/en/document/cs/a-29 >, as of September 11, 2023.

4 See National Assembly (2006) < https://www.publicationsduquebec.gouv.qc.ca/fileadmin/Fichiers_client/lois_et_reglements/LoisAnnuelles/en/2006/2006C43A.PDF >, as of September 11, 2023.

implementation of SMCs regularized what was already being done by providing a regulatory framework with uniform safety and quality standards for interventions performed outside public hospital facilities.[5]

The new framework required SMCs to obtain a license from the government, follow an accreditation process comparable to that of public hospitals, and hire a medical director. SMCs were given three years to obtain the approval of Accreditation Canada, which would have to be maintained at all times thereafter. In addition, inspectors would have to visit SMCs to ensure compliance with safety and quality regulations. The regulatory standards required of private surgical centres by the Quebec government have become, arguably, the highest in the country (Allin, Sherar, Church Carson, Jamieson, McKay, Quesnel-Vallée, Marchildon, 2020).[6]

SMCs were initially authorized to perform only the three types of surgeries for which wait times were the most problematic; namely, hip or knee replacements and cataract removals. Since 2009, when a new regulation came into force, nearly fifty specialized medical treatments have been added to the list, the vast majority being cosmetic and ophthalmological surgeries.[7] These clinics must be majority-owned by Quebec physicians.[8] As dual practice is prohibited, physicians who operate in an SMC must either be exclusively participants or exclusively nonparticipants in the Quebec public health insurance plan.[9] The health services deemed medically required supplied by participants are covered by the government, while those offered by nonpartipants must be paid for

5 Historically, Quebec allowed private for-profit hospitals within its publicly funded health care system (Charles and Guérard, 2015; Geloso, 2017). Although the last private hospital closed in the mid-1990s due to budgetary constraints by the provincial government (Spurgeon, 1995), the government has always allowed private surgical clinics to operate in the province, mostly in the area of esthetic surgery.

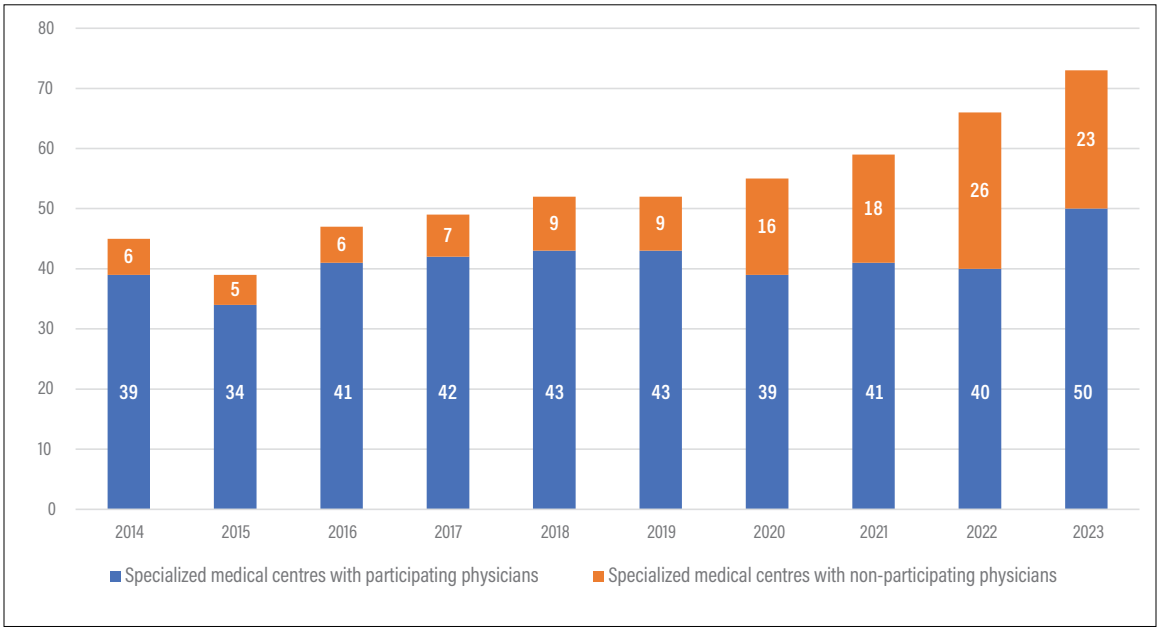
6 Private surgical centres in other provinces are not mandated to receive accreditation from Accreditation Canada, although some of them do on a voluntary basis: Opera MD (Alberta), Cambie Surgeries Corporation (British Columbia), Okanagan Health Surgical Centre (British Columbia), APEX Surgical (Newfoundland-and-Labrador), Jackman Eye Institute (Newfoundland and Labrador) (as of July 10, 2023).

7 See the Regulation respecting the specialized medical treatments provided in a specialized medical centre (Chapter S-4.2, r. 25 of the Act respecting health services and social services) for the list of elective surgeries that can be performed in SMCs, which is available at: < https://www.legisquebec.gouv.qc.ca/en/document/cr/s-4.2,%20r.%2025 >, as of September 11, 2023.

8 Investors (including non-Quebecers) are allowed to own shares in an SMC as long as physicians who are members of the Collège des médecins hold the majority of the shares (50% + 1). A producer of goods or services related to health care cannot hold shares if these goods or services are required by the clients of the SMC.

9 Those who are participants in the public system practice in hospitals and in SMCs. They operate on patients who are on their waiting list in the public system in either a hospital or an SMC.

Figure 1: Number of Specialized Medical Centres in Quebec, Q1 2014-Q1 2023



Source: CSSS (2023), 2012-2013 to 2023-2024.

directly out of the patient's pocket. There cannot be a mix where both types of physicians (participants and nonparticipants) exercise their practice within the same SMC (Labrie, 2015). As shown in figure 1, the number of SMCs in the province has increased almost steadily over the last decade, going from 45 in the first quarter of 2014 to 73 in the first quarter of 2023.

With this legislative change, the Quebec government also wanted to open up new possibilities for the public system to improve access to certain specialized medical services by strengthening the complementarity between SMCs and hospital facilities through public-private partnership agreements. Since then, public hospitals have been authorized to contract out certain elective procedures to private medical clinics when the public system cannot meet its waiting time targets (Quesnel-Vallée, McKay, and Farmanara, 2020). These interventions remain government-funded, at no out-of-pocket cost for patients. Prior to the arrival of the COVID-19 pandemic, the few partnership agreements that had been signed significantly increased the number of elective surgeries performed each year, and they have considerably reduced waiting times in the hospitals concerned to well below Quebec average waiting times (Labrie, 2015; Vailles, 2019).[10]

10 As well, both government and independent evaluations have shown that operating costs were lower in private clinics than in hospitals (Boulenger and Castonguay, 2014; Bourque, Gingras and Paquin, 2014).

Although they have to comply with the relevant articles of the Act, public hospitals and SMCs are relatively free to negotiate the terms and conditions surrounding the signing of these partnership agreements,[11] which gives rise to a variety of funding models. Most often, the SMCs are reimbursed for the actual cost of the surgery plus a predefined profit margin (cost-plus model). Although this model has the advantage of transparency, it does not encourage SMCs to innovate and invest to improve productivity or reduce expenses, as the profit margin does not vary according to performance but to production costs. Another model sees the partners agree on a lump sum to be paid to the SMC for a certain pre-established volume of surgeries, without guaranteeing a profit margin (flat-rate model). The burden of making operations profitable then falls on the private provider to find ways to optimize the use of its medical staff and operating rooms. This type of agreement is generally of a longer contractual duration. Finally, the rental model (with long-term leases) involves a completely different mode of operation. In this business model, health care facilities deal directly with the private promoters/builders, who only offer operating room availability. They leave it up to the SMC to manage its own teams. This model allows SMCs to speed up access to recent and high-performance technical operating theatre equipment, an advantage compared with the classic construction of operating theatres (Benomar, Jobin, Fortin and Chênevert, 2021).

Regardless of the model used, the Act requires SMCs that have entered into a service agreement with a public hospital to offer patients undergoing surgery on their premises all the pre-operative, post-operative and rehabilitation services normally associated with treatments received in an hospital setting. If there are complications resulting from an intervention performed in an SMC, it must, where applicable, be treated in the infrastructures of the public system, at no cost to the patient or to the SMC.

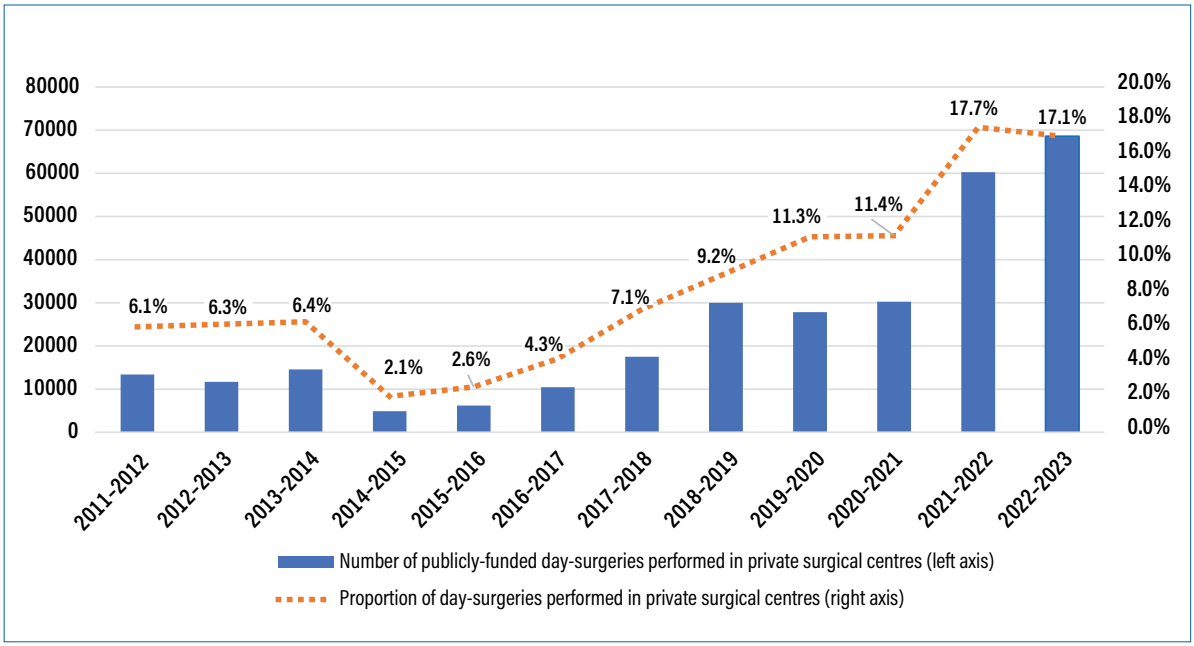
11 Specialized Medical Centres must comply with a set of rules and regulations related to these partnership agreements, notably with respect to the recruitment of employees. For instance, agreements must include a noncompete clause for employees of the public network before the end of a period of 90 days following the departure of an employee from a public institution (MSSS, 2023).

The Increasing Role of Specialized Medical Centres in Ambulatory Surgery

In May 2016, the Quebec government launched an experimental project allowing the transfer of a certain volume of publicly funded day surgeries to three private surgical clinics (RocklandMD, Chirurgie Dix30 and Opmedic). The objective of this project, renewed in 2019, was to assess the costs of procedures carried out in the private sector and compare them with the costs of those carried out in the public sector. While the Ministry of Health (MSSS) generally leaves the public hospitals to negotiate the funding model for such agreements with the private clinics, it was decided that within the framework of this pilot project the clinics would receive full public funding for the cost of the procedures plus a guaranteed profit margin of 10% (cost-plus model).

While the pandemic abruptly put an end to the experimental project, it gave new impetus to the negotiation of contractual agreements between establishments in the public network and private surgical clinics (Benomar, Jobin, Fortin and Chênevert, 2021). Indeed, faced with this large accumulation of patients waiting for surgery, the government decided to make greater use of SMCs in its strategy for alleviating the accumulated backlog of day surgeries. In various public outings the Minister of Health underlined the positive contribution of SMCs to the resolution of the long-waiting-list problem. The pandemic of COVID-19 also seems to have contributed to boosting public opinion in favour of an increased role for the private sector in the day surgery landscape. From March 2020 to April 2021, 28 agreements were signed between public hospitals and 13 SMCs to help decrease the waiting list of elective surgeries. As shown in figure 2, about 15% of day surgeries were performed in SMCs during the first two years of the pandemic, from 2020 to 2022, a proportion approximately three times higher than during the previous decade. The percentage of surgical cases outsourced to SMCs varies significantly from one region to another, and can exceed 40%, as is the case in Laval, one of the regions that best manages to reach its wait time targets (Archambault, 2022).

Figure 2: Number and proportion of publicly funded day surgeries performed in Specialized Medical Centres (SMCs) in Quebec, 2011-2012 to 2022-2023



Source: CSSS (2023) and MSS (2023).

The Quebec government recently announced the deployment of other pilot projects, this time allowing four SMCs in the Montreal and Quebec City regions to perform more complex surgeries that require short-stay hospitalization after surgery (Gentile and Boily, 2023). If these pilot projects prove successful, some patients throughout the province will eventually have the possibilty to be hospitalized in SMCs for up to 72 hours, which was not allowed before 2023. This initiative aims to alleviate the backlog created by the pandemic and speed up the operating times for patients who have been waiting for more than a year and who the public network has been unable to treat in a timely manner.

The increased reliance on the private sector to perform elective surgeries is not just the result of the pandemic, however. Other factors may have contributed to this upward trend observed in recent years (see table 1 for a summary of the comparative advantages of private surgical centres in the Quebec health care system and the barriers to their expansion).

Population support

First, support for the participation of the private sector in the supply of health services has always been higher among the Quebec population than among those of the other provinces, (Dufresne, Jeram, and Pelletier, 2014; Kurl, Shachi, and Korzinski, 2017;

Wright, 2023). This may seem counter-intuitive at first glance, as jurisdictions with a strong union presence are generally associated with less reliance on the private sector for the provision of public services (Potter, 2022).[12] However, for some academics, dedication to a government-run health care system is one of the main symbols of national identity and pride in English Canada, a characteristic that is presumably less pronounced in Quebec (Dufresne, Jeram, and Pelletier, 2014). Be that as it may, polls generally show that a large majority of Quebecers (between two-thirds and three-quarters) support the idea of giving private clinics a greater role in improving access to care, as long as it remains within the realm of a universal health system (Jobin, Parent, Fortin, Benomar, Vallières-Goulet, 2017; IPSOS/MEI, 2020).

Such support for outsourcing the provision of health care services to the private sector has also been expressed by several experts appointed by the Quebec government to various commissions and working groups over the years, even preceeding the Chaoulli judgment. In 1999, the report of the Task Force on the complementarity of the private sector in the pursuit of the fundamental objectives of the health system in Quebec, chaired by Rolland Arpin (MSSS, 1999), concluded that "the government would benefit from using private medical clinics, affiliated with hospitals, to perform day surgeries and to offer diagnostic examinations requiring expensive and state-of-the-art equipment" (quoted in Dutrisac, 1999: A1). Similar recommendations were also made in the Clair (CÉSSSS, 2001), Ménard (CTPSSSS, 2005), and Castonguay (GTFSS, 2008) commission reports.

Greater incentives to innovate

In the early 2000s, several studies and reports pointed to major efficiency shortcomings in public hospitals in Quebec (Bilodeau, Crémieux, and Ouellette, 2009; Ouellette, 2007). One particularly important study estimated the potential cost savings associated with improving efficiency at almost one-fifth of the health department's expenditures (Bilodeau, Crémieux and Ouellette, 2009). For instance, hospital managers are not able to allocate as much operating room time as surgeons would like. Many of them complain that they can operate only one day a week in the public health care system (Gentile, 2021). The problem is that identifying the proper solutions—at the establishment-level—to improve efficiency requires incentives that cannot be designed by state functionaries. These incentives can only exist thanks to competitive pressures among establishments

12 In 2022, the unionization rate stood at 37.3% in Quebec and at 28.7% in Canada as a whole (Morrissette, 2022).

and with a patient-based funding method that rewards greater efficiency (Esmail, 2021). In turn, more efficient (and cost-reducing) practices can be identified.

Private surgical clinics do not face the same constraints and, under proper funding conditions, they have greater incentives to innovate and use their available resources as judiciously as possible in order to make their activities profitable (Munnich and Parente, 2018; Vailles, 2019). When surveyed, the vast majority of surgeons and anesthesiologists in Quebec believe that they are able to perform many more cases in one day in a Specialized Medical Centre than in one working day at the hospital where they usually practice. Analyses have shown that surgeons' and anaesthelogists' productivity is between 20% and more than 40% higher when they operate in the private sector (Touzin, 2019).

Lower disruption from unforeseen events

SMCs are able to increase the volume of elective surgeries performed in the health care system, as they are better positioned to optimize the use of operating rooms, as well as being at less risk of having to cancel or postpone surgeries due to unforeseen events, which is frequently the case in public hospitals (Bélair-Cirino, 2009). For example, one of the factors that motivated one of the first public hospitals—Sacré-Cœur Hospital—to contract out day surgeries to the private sector was the high cancellation rate for surgeries at the time, which fluctuated between 8% and 12% annually. This represented more than 400 interventions postponed in this one hospital, year after year (Bourque, Gingras and Paquin, 2014).

Very often, planned surgeries in public hospitals cannot be performed in a timely manner due to administrative or organizational factors: employee absences, equipment failures, poor scheduling of operating rooms, lack of available beds, etc. At the end of April 2023, 12% of hospitalized patients in Quebec no longer required acute care, but were nevertheless occupying beds while awaiting transfer to another rehabilitation or long-term care facility (Cousineau, 2023). In other contexts, patients come to the emergency room with health conditions that become priorities and occupy operating rooms, forcing the postponement of elective surgeries (Duval, 2016). Surgical procedures are also frequently cancelled due to the contagion of nosocomial (i.e., hospital-acquired) infections, which are more prevalent in hospitals than in ambulatory surgery centres. The economists Boulenger and Castonguay (2014), who analyzed in detail the service agreement between Sacré-Cœur Hospital and the private surgical centre RocklandMD a few years ago, stated that "performing more surgeries outside hospital walls is a way to reduce the incidence of hospital-acquired infections as well as the impacts associated

with them (own translation) (p. 9)." Hence, performing surgeries on an outpatient basis in SMCs and segmenting patients into low- and high-complexity care pathways generates efficiency gains from both economic and clinical standpoints (Iweala, Uchi, et al., 2019; Uppal, 2019).

Fewer labour constraints and greater organizational flexibility

Efficiency gains can also be obtained through improved management of human resources in private clinics, compared with the public health care system. Labour relations and employment conditions in the public network are governed by collective agreements that leave little room for flexibility and provide little incentive for efficiency (Ouellette, 2007). These rules have been criticized for stifling innovation (Benomar, Castonguay, Jobin, and Lespérance, 2016) and amplifying problems of recruitment and retention, as well as causing shortages of medical staff (Vailles, 2023a; Boudreau, 2023). They also likely contribute to higher absenteeism rates. According to a report by the Health and Welfare Commissioner, the overall absence rate of staff in the public health network averaged 22.5% in the five years preceding the arrival of the COVID-19 pandemic (CSBE, 2022). These numerous absences may not only lead to higher costs,[13] but also contribute to accentuating the labour shortage and lengthening waiting times in the public health care system.

In contrast, private clinics have more managerial autonomy than public institutions and have to deal with fewer constraints related to work organization and compliance with collective bargaining agreements (Blomqvist, 2023). Even if they have to deal with the ban on dual practice for doctors, less rigidity in employment contracts generally allows SMCs to make better use of their medical staff and maintain low absenteeism rates. The better management of available human resources, combined with greater efficiency, thus invalidates the argument that increased private sector involvement in the delivery of surgical care contributes to worsening labour shortages and access to care in the public network. Rather, evidence tends to point in the opposite direction (Vailles, 2019).

Access to additional capital on favourable terms

Investments to update hospital facilities have not kept up with the needs of the Canadian population in recent years, and our health care systems are left with obsolete

13 These absent employees remain on the payroll of the public hospitals, but must be replaced by other workers during their absences. Along with depreciation costs of installation and equipment (Vailles, 2023b), this is a source of additional hidden costs that is generally not taken into account when cost comparisons are made between public and private sector care providers.

technologies and operating theatres in several provinces, including Quebec (Teja, Daniel, Pink, Brown and Klein, 2020; Archambault, 2019). Specialized Medical Centres have an incentive to invest in newer technologies to the extent that they enhance efficiency, increase throughput, and attract top-level surgeons. They can also bring in additional funds from their access to private capital markets, which allows them to invest in the acquisition of state-of-the-art equipment and to build modern operating theaters more tailored to specific subspecialties (Scholl and Bhandari, 2022).

Traditional accounting practices mislead many people into believing that government borrowing is always cheaper than private borrowing. This is because governments are considered less likely to default and therefore have a lower risk premium, which translates into lower interest rates. However, these comparisons focus only on the accounting cost rather than the full economic cost of borrowing. Indeed, accounting practices ignore the cost of government borrowing to taxpayers. At a lower interest rate governments can undertake more projects than the private sector. If these projects fail, governments can simply seize more of taxpayers' assets and income. Thus, there is a risk for taxpayers that more bad or unprofitable investment projects will be undertaken. When public sector costs to taxpayers are taken into account, it becomes clear that private developers can access capital at all-inclusive borrowing costs as favourable as those the public sector can access (Boyer, 2022).

Table 1: Public-private partnerships (PPPs) for elective surgeries: The comparative advantages of Specialized Medical Centres and the barriers to their expansion in the Quebec health care system

Comparative advantages of Specialized Medical Centres	Barriers to the expansion of public-private partnerships in elective surgery
▪ Efficiency gains from specialization: lower staff requirement and resources due to specialization in a narrower range of procedures result in larger throughput and lower cost ▪ Less disruption due to unforeseen events: fewer surgery cancellations and postponements mean faster access to needed surgical care ▪ Access to additional capital from private markets: higher capacity to acquire new cutting-edge technologies and equipment ▪ Technological advancement: less invasive new surgical techniques mean lower operation time and lead to faster patient recovery ▪ Labour market flexibility (no collective bargaining agreements/unionization) ▪ High population support	▪ Uncertainty of rules/regulations: Changes in government could alter legislative and regulatory arrangements and discourage new entry of SMCs into the market ▪ State dominance in funding elective surgeries ▪ Top-down price and volume determination by the government ▪ Hiring restrictions for SMCs: noncompete and nonsolicitation clauses in agreements with the public sector ▪ Moratorium on new licenses for SMCs creates barriers to entry in the market ▪ Politicization of health care: antiprivatization campaigns by interest groups and negative or sensational reports in the media

Discussion and Conclusion

The increased use of public-private partnerships in the delivery of surgical care in recent years has brought undeniable benefits for patients and the public health care system in Quebec. Far from being a zero-sum game, these partnerships benefit all parties involved: all patients are operated on more efficiently in SMCs, even if they are low-risk, leaving more resources devoted to more complex cases in the public system (Ruseski, 2009). While the proportion of elective day surgeries entrusted to private clinics is growing in Quebec, it still remains relatively modest in comparison with those European countries that have more accessible universal health systems. In France, for example, more than 60% of patients (56% for those in the bottom income quintile) choose to receive their elective surgery in private for-profit clinics, and the costs are reimbursed by their health insurance (Milcent, 2023). In fact, the European experience in general shows us that there are still a number of conditions to be met for public-private partnerships to be consolidated and continue to benefit Quebec's population.

First, public funding given to Specialized Medical Centres must be the same as that granted to public hospitals for the same procedure and adjusted for case mix, so that all care providers operate on a level playing field. The funding rule during the experimental project between May 2016 and March 2020 provided few incentives to control costs in the private sector. During this time, the rule stated the estimated cost of the procedures in the public sector in the year of the agreement, and then added a fixed proportion on tariffs by private firms that could go up to 15%. As such, private clinics were given a guaranteed profit margin for most procedures. This attenuated incentives to cut down costs and seek efficiency gains. More generally, higher public spending alone will not have a significant effect on the volume of surgery or on waiting times, without a mode of financing hospitals and clinics that rewards efficiency (Brindley, Lomas and Siciliani, forthcoming). The Quebec government is in the process of correcting the situation: activity-based funding has gradually been put into place since April 2023.

Second, it is crucial to allow diversification of revenue sources for Specialized Medical Centres if we are to consolidate their contribution to the health network. Indeed, the

SMCs operating in the field of day surgery are largely dependent on the public insurance system (RAMQ) for their financing. For instance, work or road accident victims who are covered by other types of public insurance (CNESST or SAAQ) should be able to be operated on in SMCs that have excess capacity, in order to accelerate their return to work and avoid the deterioration of their health condition, as is done regularly in other provinces (Hurley, Pasic, Lavis, Cuyler, Mustard, and Gnam, 2008). The government should also promote the emergence of a true duplicate insurance market, in accordance with the Chaoulli judgment, covering the same range of health services as the public insurance plan (Shaw, 2023). Varied sources of revenue would reduce uncertainty for private clinics and strengthen their ability to assist the public health system in its goal of improving access to surgical care.

Third, increased private sector participation in the field of elective surgery will only be fully beneficial if it is accompanied by mechanisms promoting competition between institutions (Labrie, 2023). The current government says it is committed to promoting competition between public hospitals and private clinics, but only time will tell if this intention will indeed become a reality. During the COVID-19 pandemic, Quebec spent approximately $200 million to perform 162,000 surgeries under over-the-counter contracts with the private sector. However, the government has announced that future contracts will be awarded following competitive bidding proposals, in order to obtain a better price (Vailles, 2023). Competitive bidding for blocks of procedures is expected to provide far stronger incentives to lower costs and improve efficiency (Vining and Globerman, 1999). This is in line with international experience, notably in Europe (Andersen and Jacobsen, 2011; Hagen, Holom, and Amayu, 2018).

Finally, the government should eventually introduce a policy of free choice whereby patients can decide where they wish to receive their treatment, among various options in the public or private sectors. Currently, the government decides on the volume of operations that will be contracted out to the private sector, and patients have little say in the decision with regard to their treatment location. The quality of the services delivered by private health care providers and their general performance do not influence their ability to attract more patients and generate more revenue, as the volume is determined by contract, and not by patient choice as in many European countries (Andersen and Jacobsen, 2011; Wholin, Fischer, Carlsson, Korlén, Mazzocato, Savage et al., 2021; Cooper, Gibbons, Jones, McGuire, 2011; Fernández-Pérez, Jiménez-Rubio, and Robone, 2022; Milcent, 2023). This feature essentially prevents private providers from operating at their most efficient scale (where average costs are lowest per unit of care). Finding the most

efficient scale is impossible for state functionaries, and it is not their role. However, if competitive mechanisms where public funding follows the patients are encouraged, then provider and patient market decisions would identify the most efficient scale of surgical care delivery. This would generate cost savings for the health care system and sustained benefits for patients in terms of improved access and welfare.

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About the Authors

Yanick Labrie is a senior fellow of the Fraser Institute. He is a health economist and public-policy consultant living in Montreal. He currently serves as an adjunct economist at HEC Montreal's Healthcare Management Hub. Mr. Labrie's career in health policy spans more than fifteen years. He has worked as an economist at the Montreal Economic Institute, the Center for Interuniversity Research and Analysis on Organizations (CIRANO), and was a lecturer at HEC Montréal's Institute of Applied Economics. He authored or co-authored more than 40 research papers and studies related to health care and pharmaceutical policies. Many of his articles have appeared in the *Globe and Mail*, *National Post*, *Ottawa Citizen*, *Montreal Gazette*, *La Presse*, and *Le Devoir*, among other newspapers. He is frequently invited to participate in conferences and debates, and to comment on economic affairs in the media. He has been invited to give testimonies at numerous parliamentary commissions and working groups on a wide range of topics and in court cases as an expert witness. Yanick Labrie holds a master's degree in economics from the Université de Montréal.

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