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RESEARCH PAPERS

MARCH 2015

THE OTHER HEALTH CARE SYSTEM

FOUR AREAS WHERE THE PRIVATE SECTOR ANSWERS PATIENTS' NEEDS

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ISBN 978-2-922687-57-6

Legal deposit: 1st quarter 2015
Bibliothèque et Archives nationales du Québec
Library and Archives Canada
Printed in Canada

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EXECUTIVE SUMMARY

The recurring problems with which Canadian patients are faced, such as overcrowded emergency rooms and the inability of seeing a doctor when you need to, regularly occupy the front pages of our daily newspapers. In international rankings, Canada systematically finds itself at the bottom of the pack, among the countries where waiting times for health care are the longest.

Yet there exists another health care system, an essentially private one that works well but that does not always get the credit it deserves. This system provides services that are much more accessible and leaves very few people dissatisfied. This *Research Paper* provides a picture of four areas where the private sector responds promptly and effectively to the needs of Canadians: seniors' housing and care, pharmacy services, dental care, and eye care.

Quebec is the Canadian province with the highest number of private residential housing spaces for seniors. While the sector has received a lot of media attention in recent years, many of its successes have unfortunately gone unnoticed.

Of the seniors' housing spaces available in Quebec, around 70% are provided by private residences. These serve a clientele that is mostly made up of individuals who are autonomous or who have only slightly reduced autonomy. Yet experience shows that private facilities have the means to provide quality care for seniors with substantially reduced autonomy. A recent study found that the services provided by private facilities within this context were of a higher overall quality than those provided by public CHSLDs.

The pharmacy sector, contrary to the public hospital network that seems to be in a perpetual state of crisis, functions like a normal industry. We don't see headlines in the media referring to "lengthening wait times for pharmacy services" or to the inability of a substantial portion of the population to find a "family pharmacist." Canadian pharmacies distinguish themselves by their exceptional accessibility. Most pharmacies are open seven days a week, and some are open 24 hours a day.

This is not the case in all countries, however. For example, before liberalization, Sweden's government monopoly pharmacies offered clients very limited opening hours: from 10 a.m. to 6 p.m. Monday through Friday, and from 10 a.m. to 2 p.m. on Saturday. Not a single pharmacy was open on Sunday, and many even closed down completely for the summer.

We tend to take it for granted that pharmacies will continue to offer quality services that meet the needs of the population regardless of the governmental rules that are imposed upon them. The experiences of numerous European countries, however, reveal the dangers of excessive government regulation.

Dental care is also essentially a private sector matter in Canada, and once again, contrary to the public health care system, dental clinics are very accessible and waiting times to see a dentist are minimal to nonexistent. Canada is among the OECD countries with the highest proportion of private funding for dental care, and the vast majority of patients today, fully 85% of the population, consider their dental health to be good, very good or excellent.

Nonetheless, for the past few years, several interest groups have been calling for increased public funding for dental care in Canada. International examples show us, however, that more government funding does not necessarily improve the accessibility of services. On the contrary, we find the establishment of rationing policies and the appearance of long waiting lists to obtain required treatment.

In Finland, wait times in 2012 were over a month long in 85% of public dental centres. In Australia, waiting times for public dental services are often between two and five years in some areas, with up to 400,000 adults on waiting lists across the country. Canadians were 30% more likely to have visited a dentist in the past 12 months than Australians.

Finally, over 90% of total spending for eye and vision care in Canada comes from private sources. The optometry sector has become more and more competitive over the years, with the number of optometrists growing

by 67% between 1997 and 2012, far outpacing population growth. Manufacturers and retailers of lenses, frames and other vision devices also operate in a highly competitive, international market, which leads to improvements in product quality, and limits price increases.

Furthermore, over the past decade, laser surgery has improved the vision of hundreds of thousands of people in Canada. A growing number of clinics now compete to offer this service, and the results are convincing. Whereas in the early 2000s, a standard LASIK procedure cost around $5,000 for both eyes, the price now fluctuates between $1,000 and $2,000.

The lesson is clear: In those areas of health care where entrepreneurial initiatives are encouraged, we can see that the market is dynamic, innovations abound and the quality of services and treatments is constantly improving.

INTRODUCTION

In recent years, many studies and reports have highlighted the scope of our difficulties getting access to care in the public health system. The recurring problems with which Canadian patients are faced, such as overcrowded emergency rooms and the inability of seeing a doctor when you need to, regularly occupy the front pages of our daily newspapers.

Delays in receiving services in the public system have become a structural problem in all of the provinces over the years. In international rankings, Canada systematically finds itself at the bottom of the pack, among the countries where waiting times for health care are the longest.

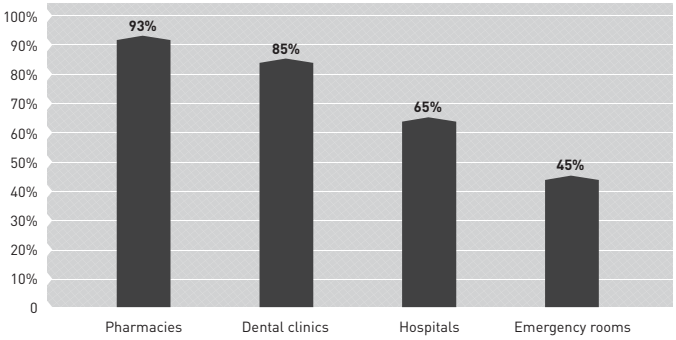
Patients, often running out of options, seem increasingly concerned by wait times for required treatments that are growing longer.[1] A majority of Canadians are of the opinion that major reforms are called for to improve the situation. According to a recent study on the population's health care perceptions and experiences, nearly two in three Canadians believe that the system requires fundamental changes or needs to be completely rebuilt.[2]

In the public system's shadow, however, there exists another health care system, an essentially private one that works well but that does not always get the credit it deserves. This system provides services that are much more accessible and leaves very few people dissatisfied. When polled, Canadians say they are much more satisfied by the services they receive in dental clinics and pharmacies than by those they receive in public hospitals. According to a survey carried out by Forum Research, the satisfaction rates of patients for services received from pharmacists (93%) or dentists (85%) are around twice as high as for services received in hospital emergency rooms (45%) (see Figure I).[3]

This *Research Paper* provides a picture of four health related areas where the private sector responds promptly and effectively to the needs of Canadians. These areas cover pharmacy services, dental care, eye care, and seniors' housing and care.

Figure I

Percentage of Canadians who say they are "very satisfied" or "somewhat satisfied" with services received in various areas of health care



Source: Forum Research, *Saskatchewan, Manitoba, New Brunswick Top Health Care Satisfaction Poll Overall*, June 2012, pp. 7-13.

We often mistakenly believe that these areas are fundamentally different from the rest of the health care system and that they just naturally work well, but this is not the case. As we shall see, the effectiveness and accessibility of the services provided in these areas in Canada result primarily from the market mechanisms that govern them: competition between providers, the profit motive, and patients' freedom of choice. In countries where these mechanisms are abandoned, we can witness the same access problems and waiting lists that afflict the public health care systems of each of the Canadian provinces.

1. See among others Nanos Research, *Wait Time Alliance - Wait Times Project Summary*, Poll commissioned by Wait Time Alliance, September 2014; Stuart N. Soroka, *Canadian Perceptions of the Health Care System*, A Report to the Health Council of Canada, February 2007, p. 3.
2. Mike Benigeri and Olivier Sossa, *Perceptions et expériences des soins de la population : le Québec comparé*, Results of a 2013 international study of health policies by the Commonwealth Fund, Health and Welfare Commissioner of Quebec, January 2014, p. 14.
3. Forum Research, *Saskatchewan, Manitoba, New Brunswick Top Health Care Satisfaction Poll Overall*, June 2012.

CHAPTER 1

Private Seniors' Housing and Care: The Quebec Example

Quebec is the Canadian province with the highest number of private residential housing spaces for seniors. In 2014, the Canada Mortgage and Housing Corporation estimated that there were nearly 220,000 Canadians aged 65 and over living in private seniors' residences, approximately half of whom were in Quebec.[4] In response to the aging of the population and the growing demand in this area, the number of rental units offered by private seniors' residences has jumped by nearly 30% since 2007.

While the seniors' housing and care sector has been at the centre of several controversies and received a lot of media attention in recent years, many of its successes have unfortunately gone unnoticed. As we shall see in this chapter, the growing reliance on the private sector has led to significant service quality improvements for seniors in Quebec.

A Sector in Transition

The seniors' housing and care sector in Quebec has been profoundly transformed over the past two decades. Long-term care centres (or CHSLDs, for "centres d'hébergement et de soins de longue durée") are now reserved primarily for people with substantially reduced autonomy who require more extensive clinical services. At the same time, other forms of housing provided for the most part by the private sector have grown in number, as they are perceived to be less expensive alternatives offering services that are better adapted to the varied needs and preferences of the elderly (see Figure 1-1).

Table 1-1 sketches a general picture of the seniors' housing sector in Quebec in 2014. There are four broad categories of housing resources. Other than CHSLDs, there are intermediate resources, family-type resources and private seniors' residences.

Of the seniors' housing spaces available in Quebec, around 70% are provided by private residences. These serve a clientele that is mostly made up of individuals who are autonomous or who have only slightly reduced autonomy. Private residences determine their own admission criteria and receive no government subsidies. Since 2007, they must obtain certification from Quebec's Department of Health and Social Services (DHSS) in order to be allowed to house residents.

Public CHSLDs and private CHSLDs that are under contract from government represent one quarter of the overall supply of housing spaces. The admission criteria in these facilities are determined by the Department of Health and Social Services and rental prices are set by the Régie de l'assurance maladie du Québec, the province's public health insurer. The average annual cost of a space in a CHSLD is $77,522. A resident covers at most 28% of costs (related to lodging and meals), with the balance being financed by the government. In 2014, these facilities provided 41,815 housing spaces for people with substantially reduced autonomy.[5]

"Of the seniors' housing spaces available in Quebec, around 70% are provided by private residences."

As for intermediate resources and family-type resources from private organizations, they provided 8,860 spaces combined, representing a little more than 5% of the sector's total supply. Many of them have service agreements with their regional health and social services agencies. The people who reside there have moderately reduced autonomy.

Higher Quality Services

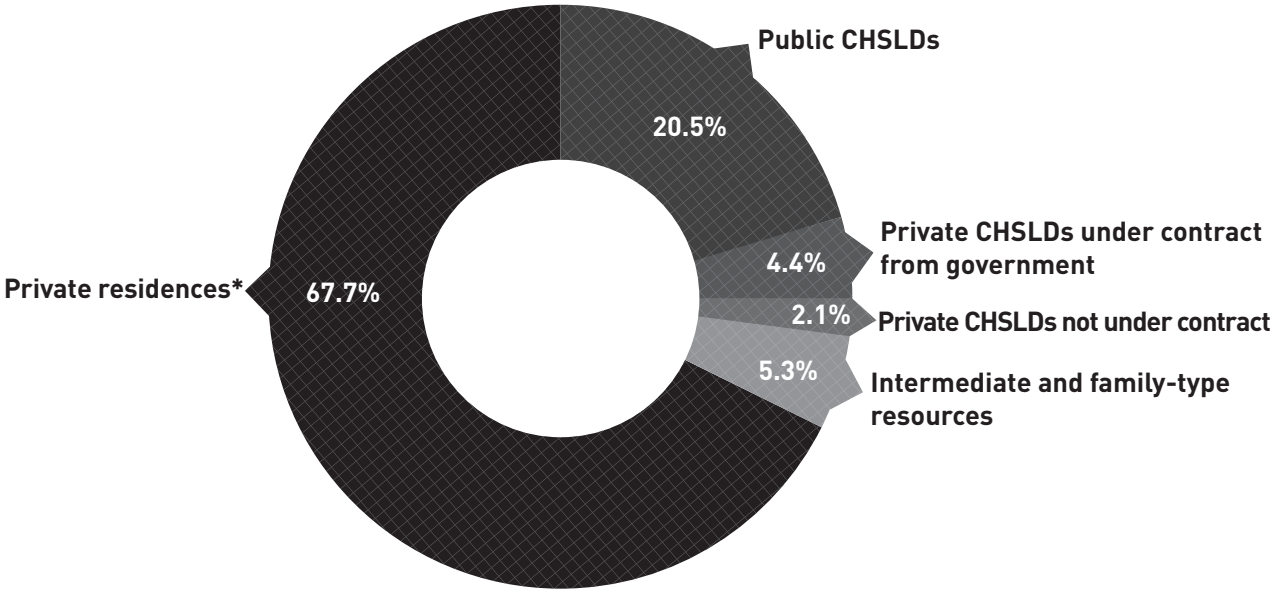
With the aging of the population, the subject of the living conditions of seniors residing in long-term care centres has been at the heart of numerous studies and commissions over the past few years.

In a wide-ranging study published in 2014, a group of researchers affiliated with the Université de Sherbrooke and the ÉNAP looked into the quality of care and services in private residences and in public CHSLDs by measuring 54 indicators spread across six key areas: residential environment, physical condition, medical

4. Canada Mortgage and Housing Corporation, *Seniors' Housing Report – Canada Highlights*, June 2014, p. 4.

5. Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Deuxième groupe d'opposition, Vol. 2, June 2014, pp. 216-226 and 257; Régie de l'assurance maladie du Québec, Accommodation in a public facility.

Figure 1-1
Distribution of spaces by seniors' housing type, Quebec, 2013-2014



Sources: Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Aile parlementaire du Parti québécois, Vol. 3, June 2014, pp. 164-167; Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Deuxième groupe d'opposition, Vol. 2, June 2014, pp. 216-226; Committee on Citizen Relations, *L'étude des crédits 2013-2014, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Volet aînés, March 2013, pp. 105-107; Institut de la statistique du Québec, *Québec population estimate, by age group and sex*, 2001-2013.
* Data from 2013.

management, psychosocial adaptation, financial burden, and human rights. The results of their research showed that, contrary to certain beliefs,[6] the quality of care in private seniors' residences is relatively high in Quebec, and has improved significantly over the past fifteen years.

> **"Researchers observed that private facilities offered greater comfort and privacy as well as a less restrictive environment than CHSLDs."**

By comparing the quality of care in private residences and in public facilities, the researchers also found notable differences. Indeed, the quality of care proved to be significantly better in private residences for each of the six care dimensions studied. In 2010-2012, the percentage of seniors receiving care deemed to be inadequate totalled just 7.9% in private residences, versus 33.2% in public nursing homes. Comparing these figures to data collected between 1995 and 2000, the private sector improved considerably, with a 12.4-percentage-point drop in inadequate care, while the public sector worsened with a 29-percentage-point increase. Moreover, 92% of private residence administrators said they felt they were offering the best possible care to their clientele, an 8.9-percentage-point increase compared to the 1995-2000 data. As for the public sector, the corresponding figure stagnated at around 64% over the same period.[7]

Obviously, in accordance with their mission, public CHSLDs receive a clientele with a greater loss of autonomy and whose needs are more complex than the clientele of private residences.[8] On the other hand, housing expenses per resident in publicly financed facilities have risen substantially in recent years. From 2006 to 2012, these expenditures per available bed in public CHSLDs and in private CHSLDs under contract from government

6. The Canadian Press, "Sondage – Les résidences privées pour aînés ont mauvaise réputation," *Le Devoir*, November 19, 2012.

7. Gina Bravo *et al.*, "Does Regulating Private Long-Term Care Facilities Lead to Better Care? A Study from Quebec, Canada," *International Journal of Quality in Health Care*, Vol. 26, No. 3, 2014, pp. 330-336.
8. Gina Bravo *et al.*, "Comparing the Resident Populations of Private and Public Long-Term Care Facilities over a 15-Year Period: A Study from Quebec, Canada," *Ageing & Society*, 2015 (forthcoming).

Table 1-1
The various kinds of seniors' housing in Quebec, 2014

TYPE OF HOUSING	TYPE OF OWNERSHIP	PUBLIC FINANCING	NUMBER OF FACILITIES	NUMBER OF SPACES	TYPE OF CLIENTELE
Public CHSLDs	Public	DHSS annual budget	**359***	**34,367**	Substantial loss of autonomy
Private CHSLDs under contract from government	Private	DHSS subsidies based on a contract	**60**	**7,448**	
Private CHSLDs not under contract	Private	None	**45**	**3,477**	
Intermediate resources	Private	Daily price based on level of autonomy (under contract with public CHSLD)	**393**	**8,034**	Moderate to substantial loss of autonomy
Family-type resources	Private	Daily price based on level of autonomy (under contract with public CHSLD)	**130**	**826**	Slight to moderate loss of autonomy
Private seniors' residences*	Private	None	**2,106**	**113,281**	Autonomous and slightly reduced autonomy
Total			**3,093**	**167,433**	

Sources: Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Aile parlementaire du Parti québécois, Vol. 3, June 2014, pp. 164-167; Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Deuxième groupe d'opposition, Vol. 2, June 2014, pp. 216-226; Committee on Citizen Relations, *L'étude des crédits 2013-2014, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Volet aînés, March 2013, pp. 105-107; Committee on Health and Social Services, *The Living Conditions of Adults Living in Residential and Long-Term Care Centres*, Consultation document submitted to the National Assembly of Quebec, Parliamentary Proceedings Directorate, September 2013, p. 24.
* Data from 2013.

increased by 31%.[9] These spending increases should normally have led to service improvements for residents, but this was not the case.

Furthermore, experience shows that private facilities have the means to provide quality care for seniors with substantially reduced autonomy. The "alternate housing models" program is an eloquent example. Put in place in 2003 by the Department of Health and Social Services, this program consisted of entrusting to private for-profit or non-profit organizations[10] the responsibility of taking care of seniors with substantially reduced autonomy who would traditionally have been placed in public CHSLDs. The goal was to allow seniors to receive the

9. Department of Health and Social Services, *Contour financier des programmes*, from 2005-2006 to 2012-2013; Department of Health and Social Services, *Info-Hébergement*, September 2011, p. 14; Committee on Citizen Relations, *L'étude des crédits 2013-2014, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières – Volet aînés, March 2013, p. 73; author's calculations.

10. The partnership agreements within the context of these alternate housing models were concluded with private for-profit facilities in 44% of cases, with non-profit facilities in 30% of cases, and with HLMs (low-rent public housing) in 26% of cases. See Nicole Dubuc *et al.*, "Alternate Housing Models for Older People with Disabilities: Their Clientele, Structures and Resources in Relation to the Quality of and Satisfaction with Care Delivery," *Ageing & Society*, Vol. 34, No. 9, 2014, p. 1583.

same range of services as in a CHSLD, but in a more familial environment that corresponded more with their preferences.

A recent study found that the services provided within the context of these agreements with private facilities were of a higher overall quality than those provided by CHSLDs, and were better suited to adequately meeting residents' varied needs. The researchers observed that the private facilities offered greater comfort and privacy (larger rooms, private bathrooms, personal furniture and individual storage spaces, etc.), as well as a less restrictive environment (possibility of living closer to one's community or family and of cohabitation, more varied schedules and choices for activities and meals, etc.) than CHSLDs. Onsite evaluations also showed that all needs were satisfied in 93% of cases for alternate housing models involving the private sector, versus 86% in CHSLDs.[11]

The Market Mechanisms That Make the Difference

Both economic theory and experience teach us that the supply of services in a market adapts itself to demand, as long as prices are free to fluctuate and there are no artificial barriers to entry.[12] In the private sector for seniors' housing and long-term care in Quebec, we can see that this is indeed what happens.[13]

Conversely, when prices are set arbitrarily by public authorities and there is no possibility of freely entering the market, the volume of services supplied is generally insufficient to satisfy the demand. The pressure to maintain quality services also decreases in the absence of competition.[14] Once again, this is precisely what can be observed in the case of public long-term care centres in Quebec.

An ordinary citizen cannot make a direct request to obtain a space in a public CHSLD (or one under contract from government). It is bureaucrats from the Department of Health and Social Services who determine the admission criteria and who decide whether or not a particular person receives housing. Moreover, like the province's hospitals, CHSLDs receive fixed global budgets on a historical basis. Insofar as admissions are controlled by the government, revenues depend neither on the number of people housed nor on the quality of services provided. Services are therefore rationed through the use of waiting lists. The number of people waiting for spaces in CHSLDs totalled nearly 3,800 as of March 31, 2014.[15]

The wait time to obtain a space in a residential centre for people with reduced autonomy can drag on for many months in the public system, even up to a few years. According to data collected by the Auditor General of Quebec who led a widespread investigation of the matter, one has to wait 13 months on average before being admitted to a CHSLD in the Quebec City region and 7 months in the Montreal region.[16]

"The wait time to obtain a space in a residential centre for people with reduced autonomy can drag on for many months in the public system, even up to a few years."

In contrast, private residences operate in a competitive market and consumers have freedom of choice. In this context, the managers of these centres must make an effort to provide satisfactory services in the eyes of consumers, or else those consumers will take their business elsewhere. This is why we see private residences providing a broader and broader range of care and services that clients value. As shown in Table 1-2, the proportion of private residences providing personal assistance care increased from 53% in 2004 to 88% in 2014. Whereas only 24.6% of residences offered nursing services in 2004, this had risen to 52.1% in 2014. Moreover, according to the Canada Mortgage and Housing Corporation's annual study, 98.5% of Quebec residences are now equipped with a 24-hour emergency alert system.

The level of satisfaction of the clientele has increased in step with the expanding provision of services over the past fifteen or twenty years. Among other things, the proportion of residents of private centres who would

11. *Ibid.*, pp. 1584-1587.
12. See among others Keiko Yoshida and Kazuo Kawahara, "Impact of a Fixed Price System on the Supply of Institutional Long-Term Care: A Comparative Study of Japanese and German Metropolitan Areas," *BMC Health Services Research*, Vol. 14, No. 48, 2014.
13. Claude Turcotte, "Résidences pour personnes retraitées : l'offre suit la demande, en constante croissance," *Le Devoir*, November 7, 2011; Mylène Péthel, "Les résidences pour aînés en demande," *Argent*, June 19, 2014.
14. John A. Nyman, "Excess Demand, Consumer Rationality, and the Quality of Care in Regulated Nursing Homes," *Health Services Research*, Vol. 24, No. 1, 1989, pp. 105-127.
15. Committee on Health and Social Services, *L'étude des crédits 2014-2015, Ministère de la Santé et des Services sociaux*, Réponses aux questions particulières - Deuxième groupe d'opposition, Vol. 2, June 2014, p. 165.
16. Auditor General of Quebec, *Personnes âgées en perte d'autonomie – Services d'hébergement*, Rapport du Vérificateur général du Québec à l'Assemblée nationale pour l'année 2012-2013, Chapter 4, Spring 2012, p. 18.

Table 1-2
More and more private residences in Quebec provide a wide range of care and services

SERVICES	2004	2014
Meals included	62.0%	85.3%
Domestic help	n.a.	92.6%
Personal assistance care	53.1%	88.4%
Nursing services	24.6%	52.1%
Organized recreational services	52.9%	89.5%
24-hour call bell	n.a.	98.5%

Sources: Canada Mortgage and Housing Corporation, *Seniors' Housing Report – Quebec*, June 2014, pp. 25 and 52; François Aubry, *Les résidences privées à but lucratif pour personnes âgées : Un portrait sectoriel*, LAREPPS Research Papers No. 05-08, Laboratoire de recherche sur les pratiques et les politiques sociales, UQAM, July 2005, p. 37.

recommend their residence rose from 88% in 1995-2000 to 98.6% in 2010-2012. During the same period, this percentage decreased by 7 percentage points for public facilities.[17]

The most recent polling data show that seniors living in private residences appreciate the overall quality of services they receive. According to Léger polling firm, the percentage of residents who say they are "moderately satisfied" or "very satisfied" is particularly high when it comes to residential safety (97%), the respect, competence and availability of personnel (94%), the upkeep of the premises (94%), and their feeling of freedom, flourishing and well-being (97%).[18]

The reasons for this success are well summarized by a player in the field who is very much aware of the changes experienced by this sector in recent years:

> The key to success is choice. Not so long ago, the supply was such that you had to get on a waiting list, and once a space opened up, you had to take it or leave it. Since then, the supply has greatly improved, and it now takes into account a major transformation that has occurred in its clientele. Seniors now demand choice and want to decide what kinds of residences they will live in and what kinds of services they will receive. When people show up to visit one of my residences, I know that they've visited others, and it's great that they have. What makes and what will continue to make our sector improve is precisely this notion of choice.[19]

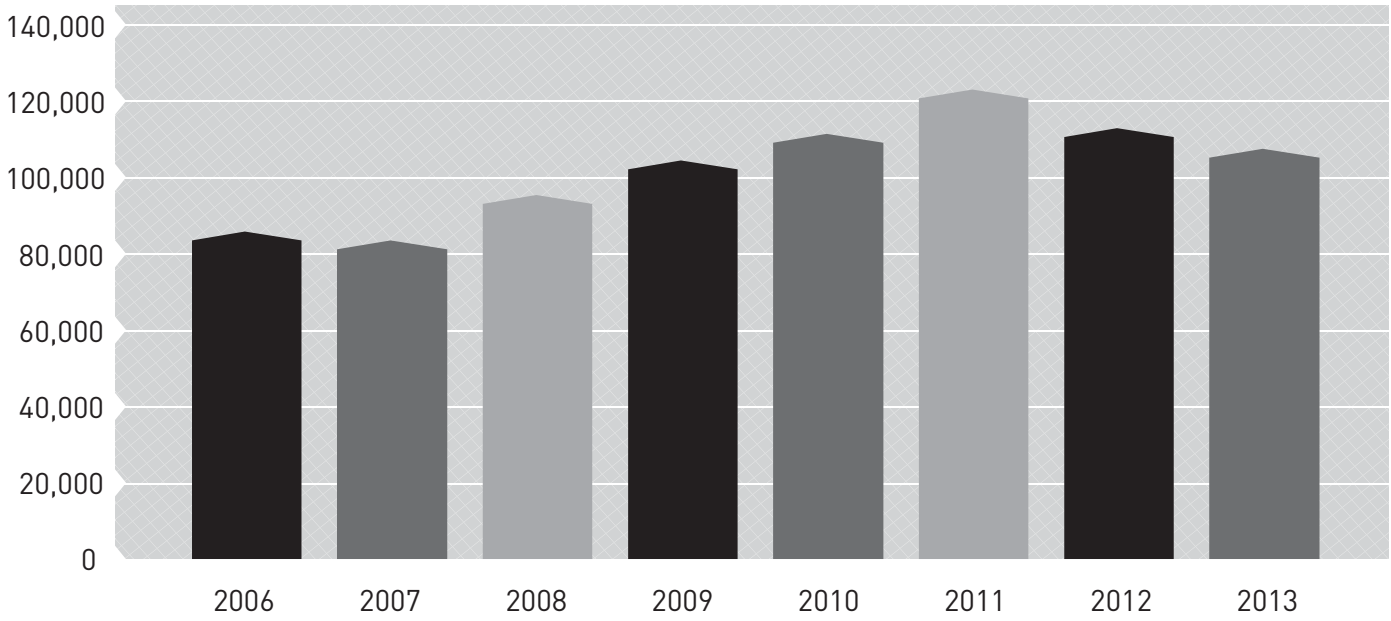
The Harmful Effects of Excessive Regulation

These past few years, several groups of stakeholders have pressured the Quebec government to tighten the regulation of private residences. This pressure has generally followed events that, although isolated, fueled so many headlines that some often mistakenly associate them with a lack of regulatory oversight in this industry.

Since 2007, seniors' residences must adhere to a series of rules in order to obtain the certification they require. Other rules were added in 2013, regarding for instance an emergency alert system in residence rooms, a minimum level of personnel to ensure 24-hour surveillance, and criminal background checks for employees and volunteers. Whereas the relevant regulations used to

17. Gina Bravo *et al.*, *op. cit.*, footnote 7, p. 332.
18. Léger, "Sondage auprès des personnes âgées des résidences membres de RQRA," Study of satisfaction levels carried out on behalf of the Regroupement québécois des résidences pour aînés, June 2014.
19. Pierre Vallée, "Groupe Maurice – Un réseau comptera bientôt 18 résidences pour personnes âgées," *Le Devoir*, October 8, 2011.

Figure 1-2
Number of dwelling units supplied by private seniors' residences in Quebec, 2006 to 2013



Sources: Department of Health and Social Services, *Info-Hébergement 2011*, September 2011; Auditor General of Quebec, *Personnes âgées en perte d'autonomie – Services d'hébergement*, Rapport du Vérificateur général du Québec à l'Assemblée nationale pour l'année 2012-2013, Chapter 4, Spring 2012, p. 6; Department of Health and Social Services cited in André Dubuc, "Des impacts sur le loyer des résidants," *La Presse*, May 6, 2014.

comprise 25 articles, there are now 53 articles regarding norms and conditions to be respected for autonomous residences and 63 for semi-autonomous ones.[20]

> **"The changes required in order to conform to the new rules imply substantial costs that imperil the financial viability of many facilities."**

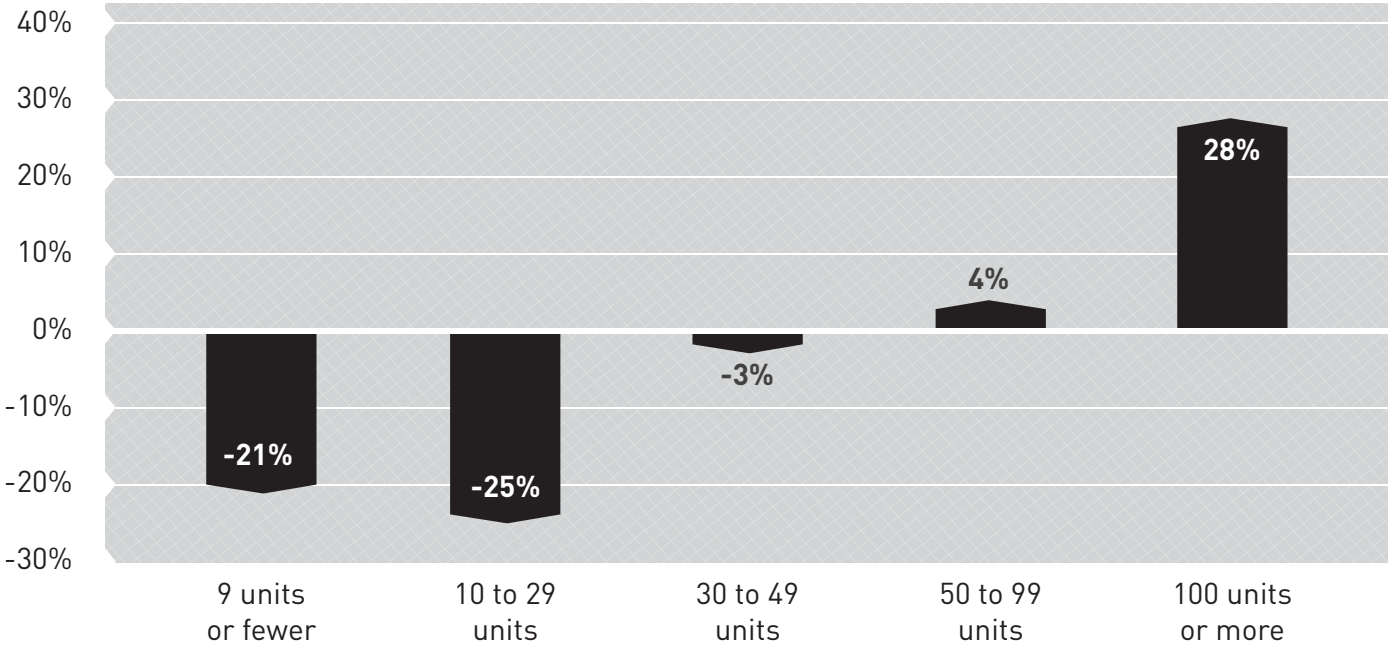
Even though it is commendable to want to increase the safety of residents, it is important to be aware of the harmful effects that excessive regulation can entail. Recent history demonstrates once again that these risks are very real. Indeed, the changes required in order to conform to the new rules imply substantial costs that imperil the financial viability of many facilities. In the year that followed the tightening of rules in 2013, 111 facilities had to shutter their doors in Quebec, which entailed a significant drop in the total number of spaces[21] (see Figure 1-2). Unable to afford the burden of expenses related to the new regulatory requirements, 85% of non-profit residences that were awaiting certification also had to withdraw from the process.[22]

Obviously, if the rules led to the closure of residences that are out-of-date or that offer mediocre quality services, everyone would agree that the regulatory policy was achieving its objective. However, if these closures end up reducing the availability of small residences providing a more familial environment, often located in remote regions, then the tightening of regulations could give rise to undesirable results for many seniors wanting to remain in their communities. Recent data for the Quebec City region demonstrate that these concerns are well-founded. Indeed, as shown in Figure 1-3, the number of residences housing fewer than 30 people fell by between 21% and 25% in this region since 2008, the year following the implementation of the reform.

20. Éric Gourde, "Une dizaine de fermetures depuis deux ans," *Courrier Frontenac*, May 22, 2014; Department of Health and Social Services, *Manuel d'application : Règlement sur les conditions d'obtention d'un certificat de conformité et les normes d'exploitation d'une résidence privée pour aînés*, March 2013, p. 8.

21. Mylène Péthel, *op. cit.*, footnote 13.
22. Ariane Lacoursière, "Résidences privées pour personnes âgées : les effets pervers de la certification," *La Presse*, August 20, 2013.

Figure 1-3
Change in the number of private residences by size of facilities, Quebec City region, 2008 to 2014



Source : Louis Demers, "La certification des résidences privées pour aînés et la situation de la région de la Capitale-nationale," Presentation at the regional forum *Habiter, vivre et vieillir dans la région de la Capitale-nationale : de la réflexion vers l'action*, October 8, 2014.

Before 2007, only a certain number of facilities had to be duly certified by the government of Quebec. The requirements dealt primarily with minimum levels of personnel needed and on the safety of residents. Residences were periodically inspected to ensure that norms were respected and to specify the measures to be taken to resolve problems that were identified. Conversely, non-certified facilities were only inspected if a formal complaint was filed by a resident or a family member.

At the time, studies had attempted to compare the quality of care provided in the two types of facilities. None of them was able to demonstrate that the quality of care was inferior in residences not subject to government regulation.

In one of these studies, involving residents from 88 seniors' homes in Quebec, the authors found rather that there was no greater risk of dying in facilities without regulatory certification than in centres possessing such certification. While quality of care unsurprisingly had an impact, the researchers showed that regulation had no direct effect on seniors' risk of death, other factors being equal (age, comorbidities, cognitive skills, functional autonomy, etc.).[23]

These results agree with those obtained through another study of this matter carried out around the same time. The authors' conclusion is once again revealing:

> The most unexpected finding in [our] study was the ability of unlicensed homes to deliver care of relatively good quality under these unfavourable conditions [heavy care needs and smaller numbers of personnel]. In many respects, the care provided was of comparable quality to that observed in the licensed facilities.[24]

Conclusion

Certain groups maintain that the government abandons its responsibilities when it entrusts the care and housing of the elderly to the private sector. According to them,

23. Gina Bravo *et al.*, "Relationship between Regulatory Status, Quality of Care, and Three-Year Mortality in Canadian Residential Care Facilities: A Longitudinal Study," *Health Services Research*, Vol. 37, No. 5, 2002, pp. 1181-1196.
24. Gina Bravo *et al.*, "Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec," *Canadian Medical Association Journal*, Vol. 160, No. 10, 1999, p. 1444.

seniors with reduced autonomy simply do not have the capacity to make enlightened decisions with regard to their housing options. This allows private providers to exploit their vulnerability by offering lower quality services in order to reduce their costs.

According to other analysts, regulation is not enough, or is too expensive to implement, and we should therefore rely solely on public or non-profit organizations for the provision of housing and long-term care to seniors.[25] This point of view echoes that of the CSQ which, like other labour unions in Quebec, affirmed last year in the context of the consultation on the living conditions of adults housed in CHSLDs that "in the future, only public housing and non-profit private housing should be considered."[26] In their opinion, governments should reverse their tendency of increasingly relying on the private sector that began in the mid-1990s, since services in such facilities are of lower quality.[27]

"Relying on the private sector becomes an indispensable element for dealing with the challenges posed by the aging of the population, which will in all likelihood entail an increasing demand for long-term care and seniors' housing."

Yet as we have seen, this argument stands up neither to analysis, nor to the bare facts. Moreover, the tendency to rely increasingly on the private sector is not unique to Quebec.[28] Indeed, there is a converging tendency among a large number of industrialized countries, especially in Europe, to liberalize the long-term care sector and to put in place reforms making room for freedom of choice and competition in the supply of services for seniors.[29] The studies that were carried out in some of these countries, including Sweden, demonstrate that liberalizing the long-term care sector led to significant improvements in service quality.[30]

The population of Quebec, like those of industrialized countries around the world, is aging rapidly. While around 16% of Quebecers are currently aged 65 years and over, it is estimated that this proportion will climb to 26% by 2036. According to the likeliest scenario established by the Institut de la Statistique du Québec, the number of people aged 65 years and over should almost double between 2011 and 2036, growing from 1.26 million to 2.44 million.[31]

In this context, relying on the private sector becomes an indispensable element for dealing with the challenges posed by the aging of the population, which will in all likelihood entail an increasing demand for long-term care and seniors' housing. As the 1999 Arpin report concluded: "Whatever the adjustments to public services that the government could make in the coming years, a majority of the needs of seniors in terms of housing and home care will be filled by the private sector."[32] More than fifteen years later, this conclusion remains as relevant as ever.

25. Margaret J. McGregor and Lisa A. Ronald, *Residential Long-Term Care for Canadian Seniors: Nonprofit, For-Profit or Does It Matter?* IRPP Study No. 14, Institute for Research on Public Policy, January 2011.
26. Centrale des Syndicats du Québec and Fédération de la santé du Québec, *Conditions de vie des adultes hébergés en CHSLD : L'urgence d'agir de façon cohérente*, Notice presented to the Committee on Health and Social Services as part of its consultation on the living conditions of adults living in long-term care and housing centres, February 2014, p. 10.
27. Louise-Maude Rioux Soucy, "En CHSLD, qualité rime d'abord avec public," *Le Devoir*, January 25, 2011.
28. When it comes to home care specifically, Quebec does however stand out by relying very little on the private sector for the provision of services. See in this regard Oscar E. Firbank, "Framing Home-Care Policy: A Case Study of Reforms in a Canadian Jurisdiction," *Journal of Aging Studies*, Vol. 25, 2011, pp. 34-44.
29. Emmanuele Pavolini and Constanzo Ranci, "Restructuring the Welfare State: Reforms in Long-Term Care in Western European Countries," *Journal of European Social Policy*, Vol. 18, No. 3, 2008, pp. 246-259.
30. Ragnar Stolt, Paula Blomqvist and Ulrika Winblad, "Privatization of Social Services: Quality Differences in Swedish Elderly Care," *Social Science & Medicine*, Vol. 72, 2011, pp. 560-567.
31. Institut de la Statistique du Québec, *Perspectives démographiques du Québec et des régions*, 2011-2061, September 2014, p. 44.
32. Roland Arpin *et al.*, *La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec*, Working group report submitted to the Department of Health and Social Services, September 1999, p. 76.

CHAPTER 2

Pharmacies in Canada: Accessible Private Health Care Services

Pharmacies play an important role in the provision of health care services in Canada that often goes unnoticed. Contrary to the public hospital network that seems to be in a perpetual state of crisis, the pharmacy sector functions like a normal industry. We don't see headlines in the media referring to "lengthening wait times for pharmacy services," to a "crisis in the system" or to the inability of a substantial portion of the population to find a "family pharmacist."[33] In contrast, reports on the shortcomings of the public health care system and on patients' difficulties accessing treatment are a dime a dozen.[34]

Although it operates in a context that is characterized by a high degree of government intervention, the pharmacy sector is based in large part on market mechanisms that have proven themselves time and again: entrepreneurship, competition and freedom of choice for consumers. All pharmacies in Canada are for-profit businesses, which almost nobody complains about. The reason is very simple: Pharmacies respond efficiently and promptly to the needs of the population.

This is not the case in all countries, however. Indeed, several European countries impose excessive regulations on pharmacies, thereby discouraging competition and seriously penalizing consumers. As we shall see in this chapter, there are particularly important lessons to draw from the case of Sweden, where a nearly four-decade public monopoly experiment in the pharmacy sector proved to be a resounding failure.

An Overview of the Pharmacy Sector in Canada

There are a little over 9,000 private pharmacies in Canada. The majority of these (about two thirds) are associated with a chain or banner (see Figure 2-1). The remaining third are independent pharmacies and supermarkets and big-box stores that also sell medications and natural health products.

The number of pharmacies in Canada has been growing rapidly over the past ten years, as shown in Figure 2-2. It is in the Atlantic provinces that we find the largest number of pharmacies per capita. In Newfoundland and Labrador, there are no fewer than 3.61 pharmacies per 10,000 inhabitants, by far the most in the country. Quebec, on the contrary, is the province with the fewest, at 2.22 pharmacies per 10,000 inhabitants (see Figure 2-3).

Generally speaking, even though there are differences between Canadian provinces, it is clear that pharmacies operate in a highly competitive market.[35] This competition occurs on several fronts: 1) geographic location and opening hours; 2) the prices of products and services;[36] 3) the range of products offered; 4) the quality of services provided; and 5) marketing tools.[37]

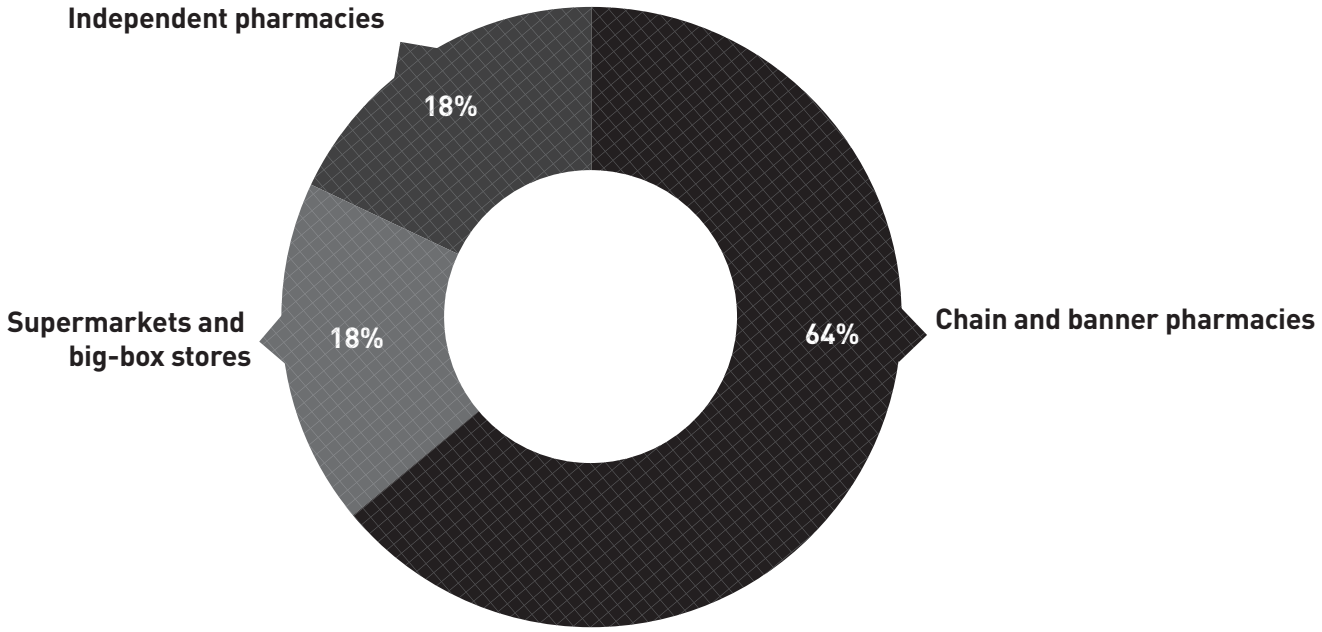
"The pharmacy sector is based in large part on market mechanisms that have proven themselves time and again: entrepreneurship, competition and freedom of choice for consumers."

Whereas a public hospital in the current system does not gain anything in particular if patients choose it over another hospital, it is quite a different story in the pharmacy sector. A pharmacy has every reason to offer its clients the best possible service, because if it doesn't, they will go elsewhere. Competition encourages them to offer a wide range of products and services valued by the population.

More and more, pharmacists are also being granted the right to prescribe certain medications, renew prescriptions and set up vaccination clinics, among other services. Indeed, conscious of the advantages of pharmacy services in terms of access to frontline care, the governments of several provinces have begun to

33. We occasionally see reports dealing essentially with price comparisons between pharmacies. See in this regard Éric Yvan Lemay, "Chaque pilule coûte 10¢ de plus ici," *Journal de Montréal*, February 16, 2015.
34. See among others Héloïse Archambault, "Entre 10h et 26h d'attente à l'urgence selon l'hôpital," *Journal de Montréal*, May 6, 2014; Amélie Daoust-Boisvert, "L'attente toujours trop longue au Canada," *Le Devoir*, June 3, 2014.
35. Jason Perepelkin and David Di Zhang, "Quality Alone Is Not Enough to Be Trustworthy: The Mediating Role of Sincerity Perception," *International Journal of Pharmaceutical and Healthcare Marketing*, Vol. 8, No. 2, 2014, p. 226.
36. Note that prescription drug prices are heavily regulated in Canada, as are the fees that pharmacists can charge those insured by public plans. This has the effect of limiting competition in this regard.
37. Paul Grootendorst, Marie Rocchi and Harold Segal, *An Economic Analysis of the Impact of Reductions in Generic Drug Rebates on Community Pharmacy in Canada*, Working paper, Leslie Dan Faculty of Pharmacy, University of Toronto, November 2008, pp. 11-17.

Figure 2-1
Distribution of pharmacies in Canada by category, 2013



Source: IMS Brogan, *Pharmaceutical Trends: Retail Pharmacies by Outlet Type, Canada, 2002-2008* and *2007-2013*.

delegate certain tasks to pharmacists that were traditionally the responsibility of doctors or other health professionals.[38]

Canadian pharmacies distinguish themselves by their exceptional accessibility. Most pharmacies are open seven days a week, and some are open 24 hours a day. They are found in almost every city in the country. In Ontario, for example, researchers calculated that 85% of the population lives within two kilometres of a pharmacy, and 91% live within five kilometres.[39]

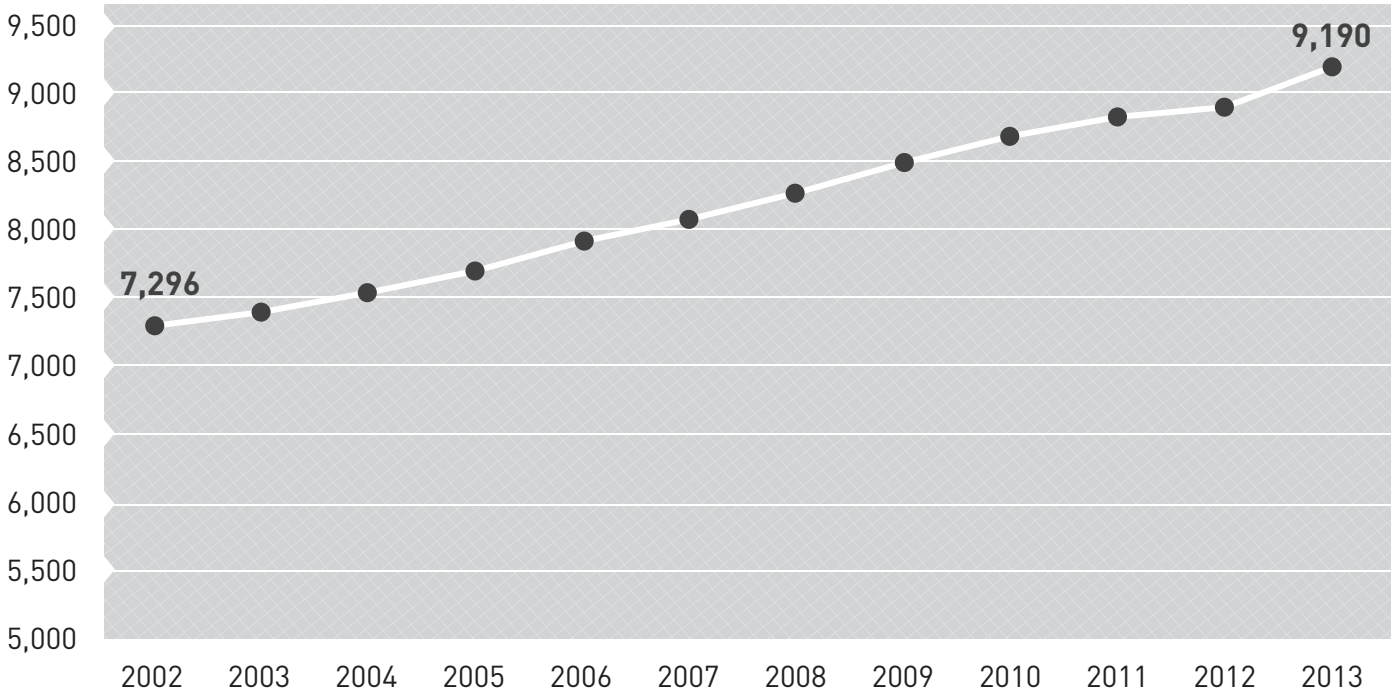
Some 55% of Canadians visit a pharmacy every week—in the vast majority of cases, without having to make an appointment beforehand.[40] Waiting lists for consultations don't exist either. Practically all clients are able to receive their prescriptions within a very short time. There is little available data on average pharmacy wait times, though, precisely because there is no waiting time problem. As part of a study carried out in Alberta, researchers did however poll a sample of clients to find out how long they waited for their prescriptions to be filled. A very large majority of them waited less than 15 minutes.[41]

> **"Practically all clients are able to receive their prescriptions within a very short time."**

In this context, it is not surprising to find that the rate of satisfaction among the population with regard to pharmacy services is very high in Canada, as indicated by

38. Alberta was the first province to allow pharmacists to prescribe medications in 2007. Several other provinces have since followed suit. For several years, the MedsCheck program in Ontario has offered certain patients suffering from chronic illnesses the opportunity to consult with their pharmacists once a year in order to promote adherence and optimize the effectiveness of their medication. See among others Cara Tannenbaum and Ross T. Tsuyuki, "The Expanding Scope of Pharmacists' Practice: Implications for Physicians," *Canadian Medical Association Journal*, Vol. 185, No. 14, October 2013, pp. 1228-1232; Ministry of Health and Long-Term Care, Government of Ontario, "Improving Access to Drugs and Pharmacy Services," Press release, June 7, 2011.
39. Michael R. Law *et al.*, "Geographic Accessibility of Community Pharmacies in Ontario," *Healthcare Policy*, Vol.6, No. 3, 2011, p. 39.
40. Chantal Sauvageau *et al.*, "Immunization Services Offered in Québec (Canada) Pharmacies," *Human Vaccines & Immunotherapeutics*, Vol. 9, No. 9, September 2013, p. 1943.
41. See Suliman A. AlGhurair, Scot H. Simpson and Lisa M. Guirguis, "What Elements of the Patient-Pharmacist Relationship Are Associated with Patient Satisfaction?" *Patient Preference and Adherence*, No. 6, 2012, p. 667.

Figure 2-2
Evolution of the number of pharmacies in Canada, 2002 to 2013



Source: IMS Brogan, *Pharmaceutical Trends: Retail Pharmacies by Outlet Type, Canada, 2002-2008* and *2007-2013*.

several surveys.[42] Even though they work in for-profit organizations, pharmacists remain the health professionals that Canadians trust the most.[43]

Excessive Regulation: The Lessons from Europe

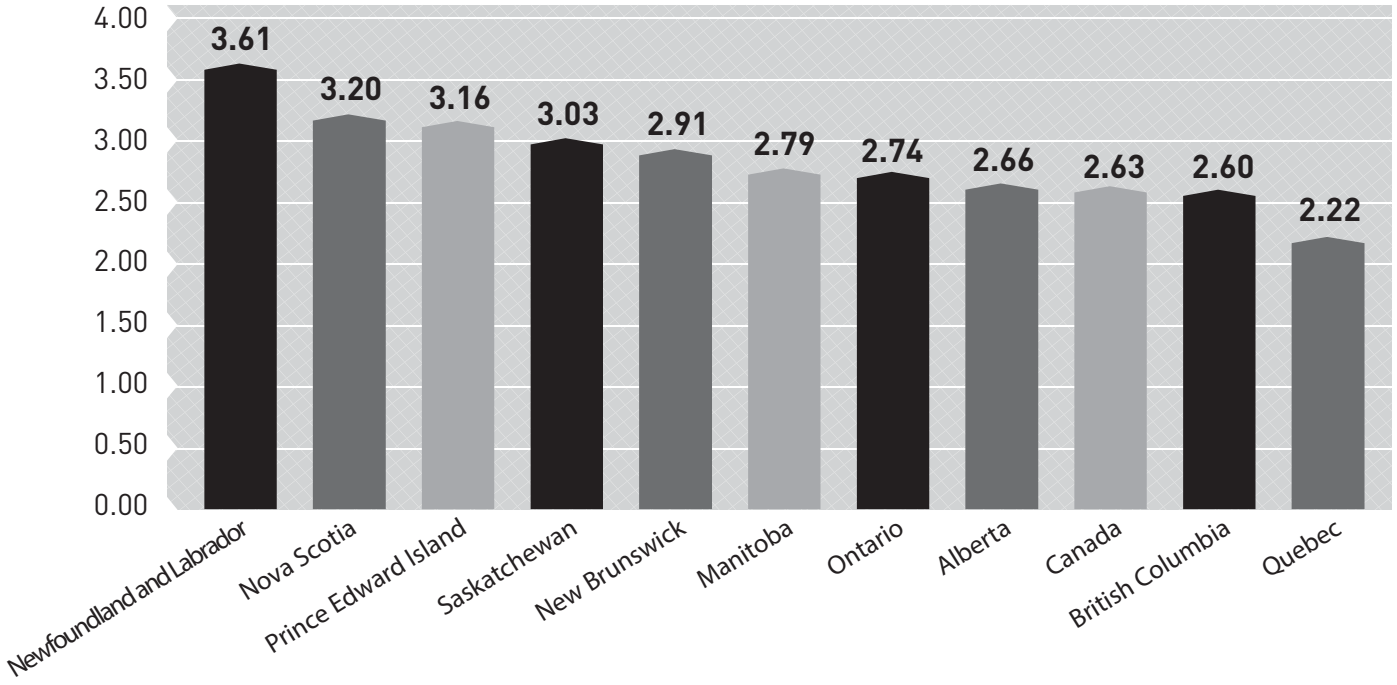
In most countries, the pharmacy sector is heavily regulated. In addition to regulating admission to university faculties and the awarding of diplomas to pharmacists, governments determine rules about opening, owning and operating a pharmacy. The rates that pharmacists are paid for the provision of various services are set by the public authorities. Medications, both patented and generic, are subject to more price controls than practically any other product or service in the economy.

In Canada too, the pharmacy sector is subject to many of these rules (see Table 2-1). However, there are far fewer barriers to entry into the market and to ownership than in most other industrialized countries. For example, over half of European Union (EU) countries do not allow individual pharmacists to own more than one independent pharmacy. Pharmacy chains are legal in only a little over one third of EU countries. In around two thirds of them, there exist restrictions on the entry of new pharmacies into the market that take the form of zoning laws, rules regarding the distances that separate pharmacies, or regional quotas based on the size of the population.[44]

Several studies have shown that such restrictions greatly reduce patients' access to pharmacy services. In Belgium, for example, economists have estimated that government-imposed pharmacy quotas based on population size had the effect of reducing the number of pharmacies in the country by 50% and seriously penalizing consumers.[45] In Ireland, where similar barriers to entry were erected between 1996 and 2002, a comparable

42. See among others Ipsos-Reid, "With Inter-Provincial Working Group Seeking Transformative and Innovative Healthcare Sustainability, Majority of Canadians Support Private Sector Pharmacies Extending Products and Services into Avenues of Healthcare," Poll results, June 25, 2012.
43. See Ordre des pharmaciens du Québec, "Le pharmacien : un professionnel de confiance selon les Canadiens," Press release, February 2, 2012.
44. J. R. Borrell and C. Casso, "Pharmacies," in Anthony J. Culyer (ed.) *Encyclopedia of Health Economics*, Elsevier, Vol. 3, 2014, pp. 51-52.
45. Catherine Schaumans and Frank Verboven, "Entry and Regulation: Evidence from Health Care Professions," *RAND Journal of Economics*, Vol. 39, No. 4, 2008, pp. 949-972.

Figure 2-3
Number of pharmacies per 10,000 inhabitants, Canadian provinces, January 2014



Sources: National Association of Pharmacy Regulation Authorities, *National Statistics*, January 2014; Statistics Canada, *Estimates of population, Canada, provinces and territories, quarterly (persons)*, CANSIM Table No. 051-0005; author's calculations.

effect was observed: The rate at which new pharmacies appeared on the market plummeted by 50% compared to the preceding period from 1991 to 1995.[46]

Given the costs entailed by excessive regulation in terms of owning and operating a pharmacy, several governments, notably in Scandinavia and the United Kingdom, decided to liberalize the sector (see Table 2-2). Consumers in Iceland (1996) and Norway (2002) quickly reaped the benefits of the reforms undertaken, the number of pharmacies jumping by 41% and 34% respectively in these two countries in the space of just a few years.[47]

In England also, pharmacies became increasingly accessible after the reforms adopted in 2005. A recent evaluation showed that 89% of the population (98% in urban centres) lives within a radius of 1.6 kilometres from a pharmacy. Access is even greater in regions where average incomes are lower.[48] Moreover, the increased competition coincided with a 30% drop in prices of non-prescription drugs sold in supermarkets and big-box stores.[49]

"From 1971 to 2009, the retailing and distribution of pharmaceutical products in Sweden was kept hermetically sealed by a government monopoly."

Sweden also profoundly reformed its pharmacy sector a few years ago. No other country had gone as far in terms of state control of this economic sector. Indeed, from 1971 to 2009, the retailing and distribution of pharmaceutical products in Sweden was kept hermetically sealed by a government monopoly. There were no private pharmacies, and no health food stores or

46. Paul K. Gorecki, "Do You Believe in Magic? Improving the Quality of Pharmacy Services through Restricting Entry and Aspirational Contracts, the Irish Experience," *European Journal of Health Economics*, Vol. 12, 2011, pp. 521-531.
47. Niklas Rudholm, "Entry of New Pharmacies in the Deregulated Norwegian Pharmaceuticals Market – Consequences for Costs and Availability," *Health Policy*, Vol. 87, 2008, pp. 259-260.
48. Adam Todd *et al.*, "The Positive Pharmacy Care Law: An Area-Level Analysis of the Relationship between Community Pharmacy Distribution, Urbanity and Social Deprivation in England," *BMJ Open*, Vol. 4, No. 8, 2014.
49. Maria Lluch and Panos Kanavos, "Impact of Regulation of Community Pharmacies on Efficiency, Access and Equity. Evidence from the UK and Spain," *Health Policy*, Vol. 95, 2010, p. 250.

Table 2-1
Restrictions regarding the operational structure of pharmacies in Canadian provinces

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
A pharmacy must be managed by a pharmacist	x	x	x		x	x	x	x	x	x
A pharmacy must be owned by a pharmacist or pharmacist partnership					x	x				
A doctor may not own or operate a pharmacy	x				x					
A pharmacist may only manage one pharmacy								x		
A majority of shareholders or directors in a corporation must be pharmacists	x		x		x	x				

Source: Competition Bureau of Canada, *Self-Regulated Professions — Balancing Competition and Regulation*, 2007, p. 113.

supermarkets were allowed to offer drugs on their shelves, prescription or non-prescription—not even simple pain relief tablets for headaches.

As a result, for nearly four decades, Sweden was among the countries with the lowest number of pharmacies in the world, by population. Before liberalization, there was barely one branch per 10,000 inhabitants, which is about a third as many as in most Canadian provinces.[50] Furthermore, the government monopoly's branches offered clients very limited opening hours: from 10 a.m. to 6 p.m. Monday through Friday, and from 10 a.m. to 2 p.m. on Saturday. Not a single pharmacy was open on Sunday, and many even closed down completely for the summer.[51]

An article appearing in *The Lancet* medical journal in 2005 illustrates just how difficult it sometimes was to access the services of a pharmacist during the government monopoly period:

> In parts [of the country], even getting the medicine over the counter requires a complex, organised expedition to the nearest town where a pharmacy is located, which could be a fair drive away. In some towns, the local pharmacy is closed down all summer.
>
> Even in the big cities, if you want to buy medicine in the evening, life is difficult: the state pharmacies usually operate short opening hours. One Swede working for the European institutions in Brussels told a Swedish newspaper recently how he wanted to buy medicine for his asthma attack one evening in Malmo, Sweden's third largest city with a population of nearly 300,000. He went to the pharmacy website and was told the nearest open outlet was in Stockholm, 450 miles away.[52]

"Increased competition not only improved Swedes' access to required medications; it also encouraged retailers to expand the range of products and services offered and to innovate in order to reduce costs and wait times at the pharmacy."

Since the liberalization of the sector, the number of pharmacies has skyrocketed, increasing by 46% from 2009 to 2013. In the space of just four years, the growth in the number of pharmacies surpassed that observed

50. Ron Sapsford, *Delivering World Class Value for Money in Provincial Drug System: A Case for Change*, Ministry of Health and Long-Term Care, Government of Ontario, July 2009, p. 10.
51. Kajsa Lindberg and Petra Adolfsson, *The Evolution of Swedish Pharmacies and Recent Reforms*, Gothenburg Research Institute, School of Business, Economics and Law, Göteborg University, No. 5, 2007, p. 15; Pelle Neroth, "Sweden's State Pharmacies May Lose Hold over Drug Sales," *The Lancet*, Vol. 365, No. 9477, June 2005, p. 2079.
52. Pelle Neroth, *ibid.*

Table 2-2
Deregulation experiences of four European countries

COUNTRY (YEAR)	REFORMS	ADVANTAGES
Iceland (1996)	• Liberalization of rules regarding opening and ownership*	• 41% increase in the number of pharmacies in the country and 67% increase in Reykjavik in the two years following deregulation
Norway (2001)	• Liberalization of rules regarding opening and ownership* • Authorization of non-prescription drug sales elsewhere than in pharmacies	• 34% increase in the number of pharmacies from the year 2000 to June 2004, which went from 392 to 524 (compared to an increase of just 71 from 1991 to 2000)
England (2005)	• Abolition of nearly all rules restricting entry of new pharmacies into the market	• 30% drop in prices of non-prescription drugs sold in supermarkets and big-box stores • Better access to neighbourhood pharmacies for populations in depressed areas • Improved efficiency of pharmacy sector
Sweden (2009)	• Privatization of some 615 pharmacies belonging to the government monopoly Apoketet AB • Liberalization of rules regarding opening, ownership* and sales of non-prescription drugs elsewhere than in pharmacies	• 46% increase in the number of pharmacies from 2009 to 2013 • 76% increase in total number of opening hours from 2009 to 2013 • Contributed to a 19% drop in retail prices and 35% drop in wholesale prices (per dose of medicine provided)

Sources: Iceland and Norway: Niklas Rudholm, "Entry of New Pharmacies in the Deregulated Norwegian Pharmaceuticals Market – Consequences for Costs and Availability," *Health Policy*, Vol. 87, 2008, pp. 259-260; Sabine Vogler, "Concurrence dans la distribution de produits pharmaceutiques," Forum mondial sur la concurrence, Organisation de coopération et de développement économique, March 2014, p. 8. **England:** Maria Lluch and Panos Kanavos, "Impact of Regulation of Community Pharmacies on Efficiency, Access and Equity. Evidence from the UK and Spain," *Health Policy*, Vol. 95, 2010, pp. 245-254; Adam Todd *et al.*, "The Positive Pharmacy Care Law: An Area-Level Analysis of the Relationship between Community Pharmacy Distribution, Urbanity and Social Deprivation in England," *BMJ Open*, Vol. 4, No. 8, 2014, pp. 3-5. **Sweden:** LIF, *FAKTA 2012: Swedish Pharmaceutical Market and Health Care*, p. 64; Sveriges Apoteksförening, *Branschrapport 2013*, p. 2; Anders Anell *et al.*, *Sweden – Health system review 2012*, Health Systems in Transition, Vol. 14, No. 5, 2012, p. 113; Mats A. Bergman *et al.*, "Reforming the Swedish Pharmaceutical Market – Consequences for Costs per Defined Daily Dose," HUI Working papers, No. 105, June 2014, p. 3.
***** Only doctors and pharmaceutical companies are forbidden from owning pharmacies in Iceland, Norway and Sweden. See Karin Svensberg, Sofia Kälvemark Sporrong and Ingunn Björnsdottir, "A Review of Countries' Pharmacist-Patient Communication Legal Requirements on Prescription Medications and Alignment with Practice: Comparison of Nordic Countries," *Research in Social and Administrative Pharmacy*, forthcoming, 2015.

over the previous thirty years (see Figure 2-4). As for the extent of opening hours, there was an overall increase of 76% after the sector was opened up to competition. In addition to the hundreds that were privatized, 374 new private pharmacies entered the market, thereby improving access for the inhabitants of all regions. Today, nearly 90% of the population lives within a ten-minute car ride from a pharmacy.[53]

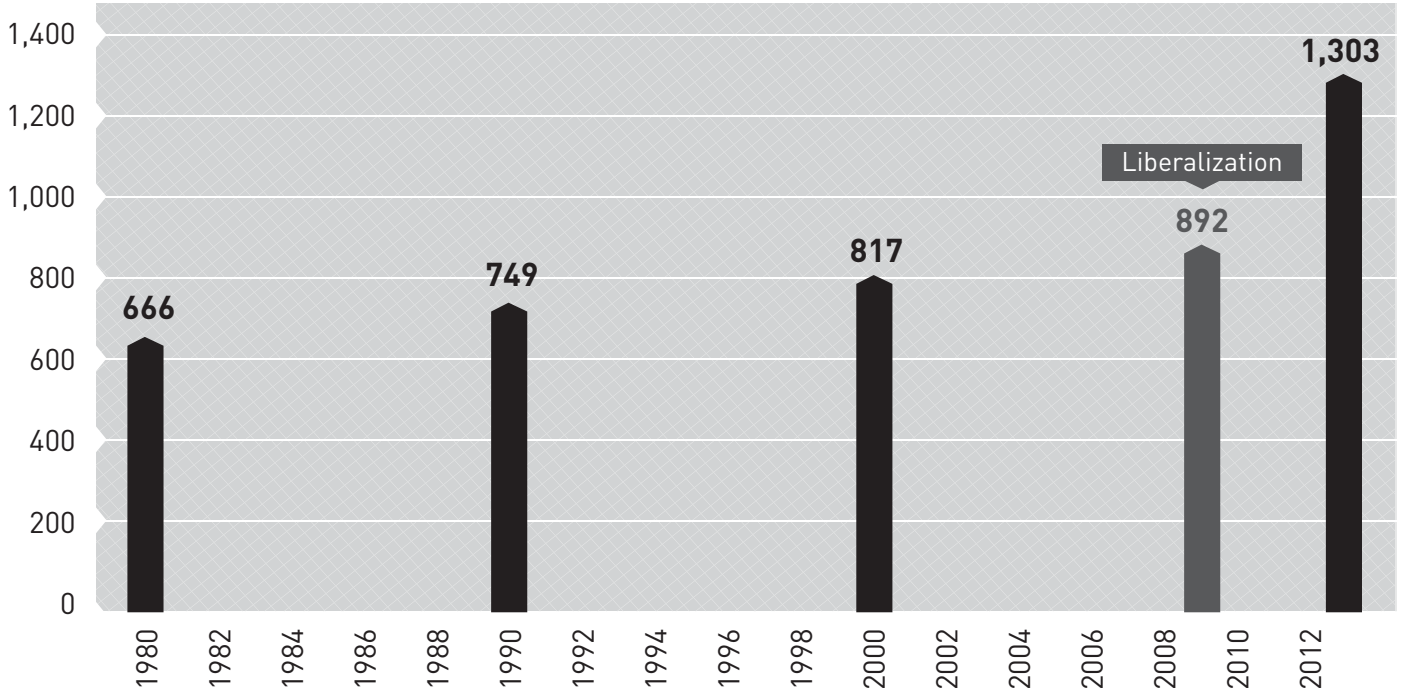
Supermarkets can now sell non-prescription drugs, and pharmacies have products on their shelves that they were not allowed to sell when the public monopoly was in place. Increased competition not only improved Swedes' access to required medications; it also encouraged retailers to expand the range of products and services offered and to innovate in order to reduce costs and wait times at the pharmacy. For example, some of them equipped themselves with automated procedures in order to speed up service[54] all while reducing the risks of medication errors. Swedish researchers estimate that among other things, the liberalization of the pharmacy sector has helped consumers save money, since retail drug prices fell by 19% (per defined daily dose) following the reforms.[55]

53. LIF, *FAKTA 2012: Swedish Pharmaceutical Market and Health Care*, p. 64; Sveriges Apoteksförening, *Branschrapport 2013*, p. 2.

54. Joerg Heise, "Learning from a Changing Market – Sweden's Pharmacy Industry," *International Trends*, Willach Pharmacy Solutions, November 2010, p. 40.

55. Mats A. Bergman, David Granlund and Niklas Rudholm, *Reforming the Swedish Pharmaceutical Market – Consequences for Costs per Defined Daily Dose*, HUI Working Papers, No. 105, June 2014, p. 3.

Figure 2-4
Evolution of the number of pharmacies in Sweden, before and after the liberalization of the sector in 2009



Sources: LIF, *FAKTA 2012: Swedish Pharmaceutical Market and Health Care*, p. 64; Sveriges Apoteksförening, *Branschrapport 2013*, p. 2.

Conclusion

Whereas the public health care system in each Canadian province struggles to adequately meet the needs of patients, private pharmacies in Canada continue for their part to provide the services we expect from them. Without a doubt, pharmacies offer health care services that are among the most accessible to the population.

"We tend to take it for granted that pharmacies will continue to offer quality services that meet the needs of the population regardless of the governmental rules that are imposed upon them."

As much as we seem to have developed a feeling of resignation when it comes to long wait times in the public health care system, we tend to take it for granted that pharmacies will continue to offer quality services that meet the needs of the population regardless of the governmental rules that are imposed upon them. The experiences of numerous European countries, however, reveal the dangers of excessive government regulation.

A health policy analyst reminded us recently, in an article appearing in the *New England Journal of Medicine*, of the old adage that "we learn more from failure than from success." He added, "If that's true, other countries have a lot to learn from [the public health care system in] Canada."[56] In the same way, we could say that Canada must learn from the failures of excessive government regulation in the area of pharmacy services in Europe. By comparison, the private pharmacy sector in Canada, where entrepreneurship and competition are more encouraged, is definitely a model worth emulating.

56. Steven Lewis, "A System in Name Only — Access, Variation, and Reform in Canada's Provinces," *New England Journal of Medicine*, Vol. 372, No. 6, February 2015, p. 500.

CHAPTER 3

Dental Care in Canada: The Private Sector Responds Effectively to Demand

In Canada, dental care is essentially a private sector matter. Contrary to the public health care system, dental clinics are very accessible and waiting times to see a dentist are minimal to nonexistent.

Each year, three out of four Canadians visit a dental clinic, one of the highest rates among OECD countries (see Figure 3-1). The vast majority of patients, namely 85% of the population, say they are satisfied with the services they receive.[57] The most recent data indicate moreover that the dental health of Canadians has improved dramatically in recent decades and compares favourably with that of other industrialized countries' populations.[58]

In spite of these successes, calls for greater government involvement in this sector of economic activity have become increasingly common over the past few years. Lamenting unequal access, several critics imply that the situation would improve in this regard if Canada followed the example of countries where the public sector plays a larger role in the financing and provision of dental care.[59]

While this solution may seem attractive at first glance, as we shall see in this chapter, the countries that have gone down this road are now grappling with worrisome wait times, without having managed to eliminate or even significantly reduce inequality of access to services.

The Provision of Dental Care in Canada

In 2013, the number of dentists in Canada was just over 21,000 according to data compiled by the Canadian Dental Association. That same year, there were 60 dentists per 100,000 inhabitants, which places Canada right around the OECD average.[60] Practically all dentists have their own private practices, either alone or in partnership (92%). Only a small proportion work in public organizations, either a hospital or an educational institution.[61]

Since the turn of the new millennium, the dentistry sector has become more and more competitive as a result of the massive influx of new professionals.[62] Between 2003 and 2012, the number of dentists and dental hygienists has gone from 35,122 to 48,945, an increase of nearly 40%. On an annual basis, the average growth rate of this workforce was more than three times that of the Canadian population.[63]

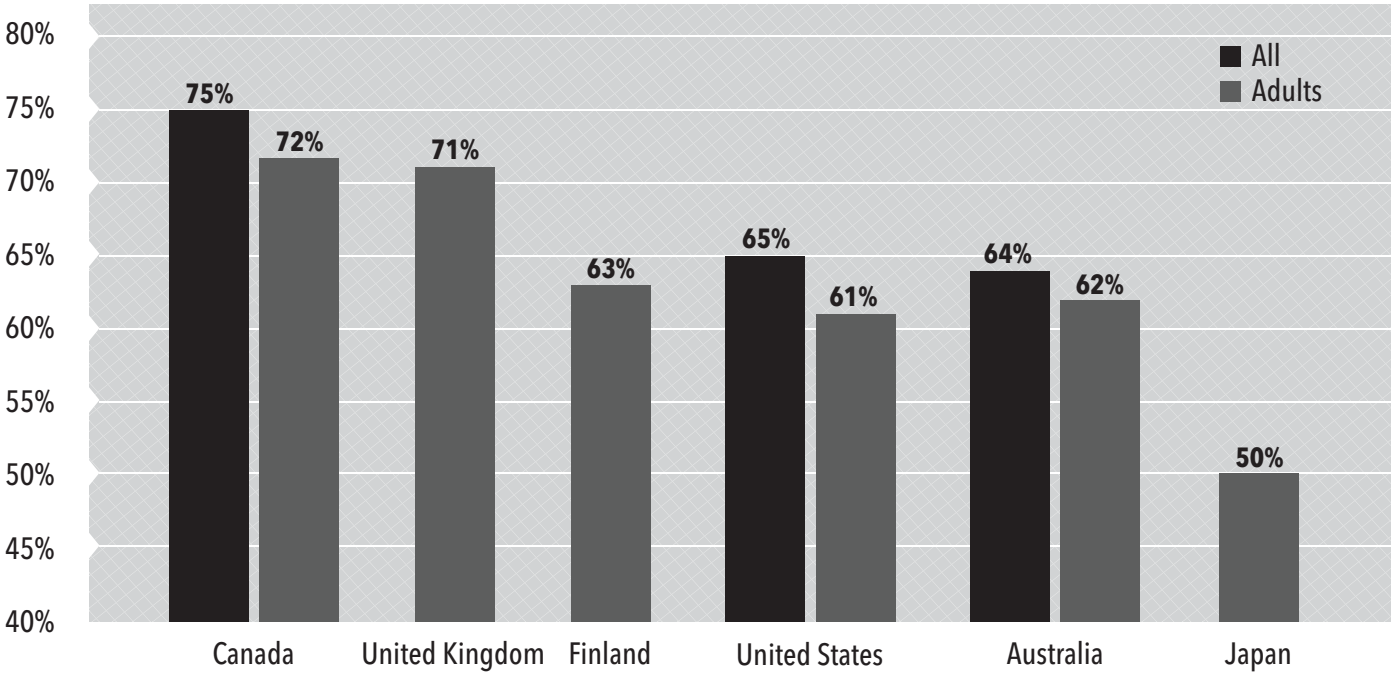
"Contrary to the public health care system, dental clinics are very accessible and waiting times to see a dentist are minimal to nonexistent."

In recent years, a few large private groups have appeared in the Canadian dentistry market, including the Dental Corporation of Canada, which owns a network of 110 dental clinics and has 1,700 employees on its payroll. This group, with an annual sales figure of $230 million, is present in five provinces plus the Yukon Territory.[64]

There are also over 400 dental hygiene clinics spread out across Canada, half of which are located in Ontario. Indeed, for several years now, all the provincial governments except for Quebec's have allowed dental hygienists to perform certain tasks alone, without the supervision of a dentist.[65] By expanding the scope of dental

57. Percentage of Canadians who said they were "very satisfied" or "somewhat satisfied" according to a recent poll. Forum Research, Saskatchewan, Manitoba, *New Brunswick Top Health Care Satisfaction Poll Overall*, June 2012.
58. See among others Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, pp. 45-49; Statistics Canada, *Oral Health: Edentulous People in Canada 2007 to 2009*, Health Fact Sheets, January 2010.
59. Armine Yalnizyan and Garry Aslanyan, "Introduction and Overview," in *Putting Our Money Where Our Mouth Is: The Future of Dental Care in Canada*, Canadian Centre for Policy Alternatives, April 2011, pp. 7-10; Paul Allison, "Why dental care should be included in the public health system," *The Globe and Mail*, September 16, 2014.
60. Canadian Dental Association, Licensed Dentists in Canada by Province - 2013; Statistics Canada, CANSIM Table No. 051-0005: Estimates of population, Canada, provinces and territories, Quarter IV, 2013; Organisation for Economic Co-operation and Development, *Health at a Glance 2009: OECD Indicators*, December 2009, p. 83.
61. Canadian Dental Association, *Dental Health Services in Canada, Facts and Figures 2010*, p. 2.
62. Tom Blackwell, "Glut of dentists means tough times for them, good deals for customers, 'doom and gloom' report says," *National Post*, March 25, 2013.
63. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2014*, October 2014, p. 55.
64. "Dental Corporation of Canada: 'Revolutionizing the Business of Dentistry'," *Canadian Business Journal*, Vol. 8, No. 1, 2015, pp. 152-157.
65. Isabelle Ducas, "Les cliniques d'hygiène dentaire, c'est pour bientôt?" *La Presse*, April 7, 2012.

Figure 3-1
Percentage of the population that visits a dental clinic every year, various OECD countries



Sources (year): Australia (2010): Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia, Key Facts and Figures Trends 2014*, 2014, p. 8; Sergio Chrisopoulos and Jane Harford, *Oral Health and Dental Care in Australia: Key Facts and Figures 2012*, Australian Institute of Health and Welfare, Australian Government, 2013, p. vii. **Canada (2007-2009):** Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, p. 51. **United States (2010):** National Center for Health Statistics, *Health, United States, 2013: With Special Features on Prescription Drugs*, 2014, p. 287. **Finland (2007):** Eero Raittio *et al.*, "Dental Attendance among Adult Finns after a Major Oral Health Care Reform," *Community Dentistry and Oral Epidemiology*, Vol. 42, No. 6, 2014, p. 595. **Japan (2011):** Yuich Ando *et al.*, "The Status of Routine Dental Visits by Web-Based Survey in Japan," *Journal of Dental Health*, Vol. 62, No. 1, 2012. **United Kingdom (2009):** John Morris *et al.*, *Service Considerations – A Report from the Adult Dental Health Survey 2009*, The Information Centre for Health and Social Care, March 2011, p. 6.

hygienists' work, governments hope to improve access to certain services and to reduce prices, as has happened in other countries.[66]

The Financing of Dental Care in Canada

In 2013, total spending related to dental care was estimated at $12.9 billion for the country as a whole.[67] This care is almost entirely privately financed, either directly by patients themselves or through their private insurers. Only a small portion of spending is covered by governments (federal and provincial), in the form of targeted programs that aim to help certain segments of the population, such as low-income individuals and children, receive basic dental care.

For example, in several provinces, dental examinations and certain curative services are insured by governments for children and for recipients of welfare and unemployment insurance. Surgical treatments provided in a hospital setting are also covered in virtue of the health insurance plans of each province. In addition, certain provinces offer, under various conditions, specific programs for people aged 65 and over (see Table 3-1).

Canada is among the OECD countries with the highest proportion of private funding for dental care (see Figure 3-2). Historical reasons explain why dental care is largely excluded from the public health care system in Canada. Certain authors report that when the country's health legislation was being developed in the 1960s, the belief among Canadians was that taking charge of and maintaining one's oral health were primarily individual responsibilities.[68] Therefore, whereas governments

66. See among others Coady Wing and Allison Marier, "Effects of Occupational Regulations on the Cost of Dental Services: Evidence from Dental Insurance Claims," *Journal of Health Economics*, Vol. 34, 2014, pp. 131-143.
67. Canadian Institute for Health Information, *op. cit.*, footnote 63, p. 148.
68. Carlos Quiñonez, "Why Was Dental Care Excluded from Canadian Medicare?" *NCOHR Working Paper Series*, Vol. 1, No. 1, 2013, pp. 1-5.

Table 3-1
Public dental care insurance programs by Canadian province

PUBLIC PROGRAMS	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Dental surgery provided in a hospital setting	X	X	X	X	X	X	X	X	X	X
Dental care for children*	X	X	X		X	X	X	X	X	X
Dental care for seniors**		X							X	
Dental care for welfare recipients	X	X	X	X	X	X	X	X	X	X

Source: Federal, Provincial and Territorial Dental Working Group, Access to Dental Care.
***BC: below 19 years of age, low-income; AB, NB: up to 18 years of age, low-income; SK: below 18 years of age, low-income; ON: below 17 years of age, low-income; QC: below 10 years of age; PEI: between 3 and 17 years of age; NS: up to 14 years of age; NL: up to 12 years of age and up to 17 years for low-income families.
****AB: 65 years and older, as a function of income; PEI: provided to residents of long-term care centres.

covered around 20% of overall dental care spending in the 1960s and 1970s, this percentage fell gradually in subsequent decades, and is now just 6%.[69]

Overall, the number of Canadians who have dental insurance (public or private) has been growing since the mid-1990s. Whereas 53% of Canadians said they had such insurance in 1996-1997, this percentage had climbed to 61% by 2003, and to 68% by 2009.[70]

Dental Health Is Improving

In 2010, Health Canada published a report on the dental health of Canadians, based on the results of the Canadian Health Measures Survey carried out by Statistics Canada. The data compiled show that 75% of Canadians visit a dental clinic annually, and 86% do so at least once every two years. In the early 1970s, barely half of the population consulted a dentist on an annual basis.[71] Access to dental care has therefore improved dramatically.

The Health Canada study also revealed that the vast majority of patients today, fully 85% of the population, consider their dental health to be good, very good or excellent.[72] This has not always been the case, however. Indeed, Canadians have made considerable progress in terms of dental health since the 1970s, as can be seen in Table 3-2. Barely 6% of Canadians aged 20 or older had no remaining natural teeth in 2009, whereas in 1972 this was the case for nearly one quarter of the adult population.[73] The percentage of children and adolescents with cavities, missing teeth, or fillings has also fallen significantly during this same period.

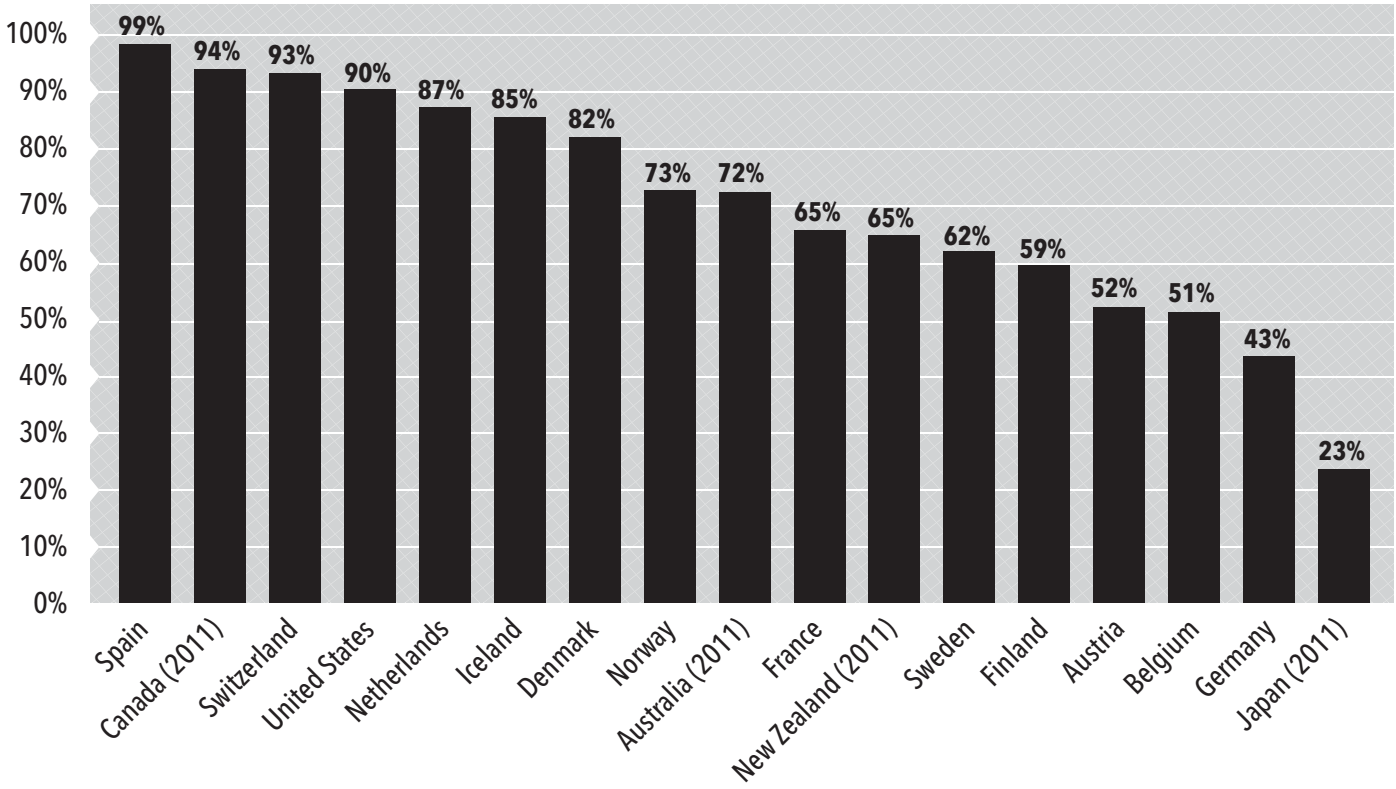
"Canada is among the OECD countries with the highest proportion of private funding for dental care."

Furthermore, even if the proportion of public financing in dental care spending has declined over the years, inequality in terms of dental health results has narrowed since the 1970s. The assessment made recently by McGill University researchers leaves no doubt regarding these improvements:

> [O]ral health outcomes have improved for adults in both Canada and the US. In the 1970s, Canada had a higher prevalence of edentulism and dental decay and a lower prevalence of filled teeth. This was also combined with a more pronounced social

69. Carlos Quiñonez, "Wicked Problems: Policy Contradictions in Publicly Financed Dental Care," *Journal of Public Health Dentistry*, Vol. 72, 2012, p. 262; Canadian Institute for Health Information, *op. cit.*, footnote 63, pp. 138 and 160.
70. Canadian Institute for Health Information, *Exploring the 70/30 Split: How Canada's Health Care System Is Financed*, 2005, p. 75; Health Canada, *op. cit.*, footnote 58, p. 71.
71. Health Canada, *ibid.*
72. *Ibid.*, p. 28.
73. *Ibid.*, p. 49.

Figure 3-2
Percentage of dental care spending financed by private sources, various OECD countries, 2012



Source: Organisation for Economic Co-operation and Development, Database of health statistics.

inequality gradient among place of birth, education and income groups. Over time, both countries demonstrated an improvement in the prevalence of these oral health outcomes, with a decline in absolute socio-economic inequalities. However, Canada appears to have made somewhat better progress in improving oral health among disadvantaged populations.[74]

A Greater Role for the Public Sector?

For the past few years, several interest groups have been calling for increased public funding for dental care in Canada.[75] They highlight the fact that 17% of the Canadian population foregoes seeing a dentist annually because of the cost.[76] They also deplore inequality of access between different groups in society.[77] These critics imply that the situation would improve if we followed the example of countries where public dental insurance is more generous.[78]

First of all, it is important to point out that even in countries where the state finances a larger proportion of dental services, unequal access to care exists and many people admit to having to postpone dentist visits for financial reasons. In the United Kingdom, around one fifth of the population falls into this category according to survey data.[79] Even though services are provided free of charge in the public system, one third of British people surveyed admit to choosing a private clinic because

74. H. W. Elani *et al.*, "Socio-Economic Inequalities and Oral Health in Canada and the United States," *Journal of Dental Research*, Vol. 91, No. 9, 2012, p. 868.
75. See among others Canadian Dental Hygienists Association, *Bulletin de santé buccodentaire canadien* : un *appel à l'action*, Document presented to the Standing Committee on Finance of the House of Commons in view of pre-budgetary consultations, August 2010; Canadian Academy of Health Sciences, *Improving Access to Oral Health Care for Vulnerable People Living in Canada*, September 2014.
76. Chantel Ramraj *et al.*, "A Macroeconomic Review of Dentistry in Canada in the 2000s," *Journal of the Canadian Dentist Association*, Vol. 80:e55, 2014, p. 4.
77. Michel Grignon, Jeremiah Hurley, Li Wang and Sara Allin, "Inequity in a Market-Based Health System: Evidence from Canada's Dental Sector," *Health Policy*, Vol. 98, 2010, pp. 81-90.
78. Armine Yalnizyan and Garry Aslanyan, *op. cit.*, footnote 59.
79. K. B. Hill *et al.*, "Adult Dental Health Survey 2009: Relationships between Dental Attendance Patterns, Oral Health Behaviour and the Current Barriers to Dental Care," *British Dental Journal*, Vol. 214, No. 1, 2013, pp. 25-32.

Table 3-2
Evolution of dental health indicators among the Canadian population, 1970-72 to 2007-09

INDICATORS	1970-72	2007-09
Percentage of the population that consults a dentist every year	49.5%	74.5%
Percentage of children with at least one decayed tooth	74%	23.6%
Percentage of adolescents with at least one decayed tooth	96.6%	58.8%
Average number of decayed, missing or filled teeth (per child)	6	2.5
Percentage of adults with no natural teeth	23.6%	6.4%

Source: Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, pp. 47-51.
Note: The children surveyed were between 8 and 10 years old for the 1970-1972 poll and between 6 and 11 years old for the 2007-2009 poll.

they were unable to get access to a dentist in the public system.[80] In Sweden, a study showed that 71% of people who decided to forego seeing a dentist did so for economic reasons. Unemployed individuals receiving welfare income were seven to nine times more likely to forego a required dental treatment than employed individuals in good financial health.[81]

"The vast majority of patients today consider their dental health to be good, very good or excellent."

Furthermore, the vast majority of these countries have major difficulties with access. Rationing leads to long wait times, and many people find themselves deprived of the services they need. Finland and Australia, where public spending on dental care has increased considerably in recent years, both continue to grapple with serious waiting list problems (see Table 3-3).

Finland

In Finland, a country frequently held up as a model for Canada to follow,[82] 41% of spending on dental care is covered by governments (central and municipal).[83] The coexistence of a public sector and a private sector in the provision of dental care dates back to the 1970s. Nearly half of Finnish dentists work in public facilities, usually connected to a hospital.

Up until the early 2000s, only children and adolescents, as well as certain groups with particular needs, had the right to be treated in public dental centres, 80% subsidized by the state. In 2001, the age limits that restricted adults' access to public dental care were abolished. Subsidies for patients attending private clinics were also expanded to cover all age groups.

Dental services thus became available to the population according to the same principles as the universal public health care system. The Finnish government hoped to increase the volume of services provided and reduce

80. John Morris *et al.*, *Service Considerations – A Report from the Adult Dental Health Survey 2009*, The Information Centre for Health and Social Care, March 2011, p. 17.
81. Sarah Wamala, Juan Merlo and Gunnel Boström, "Inequity in Access to Dental Care Services Explains Current Socioeconomic Disparities in Oral Health: The Swedish National Surveys of Public Health 2004-2005," *Journal of Epidemiology and Community Health*, Vol. 60, 2006, pp. 1027-1033.
82. André Picard, "Cost of dental care in Canada keeps patients away," *The Globe and Mail*, September 12, 2014.
83. Organisation for Economic Co-operation and Development, Database of health statistics. A report from the Canadian Academy of Health Sciences states that the public contribution to the funding of dental care spending in Finland amounts to 79%. However, this percentage only concerns care received in public dental centres. Once the entire dental care sector is accounted for (including private clinics), the percentage of total spending that is public amounts to 41%. See Canadian Academy of Health Sciences, *op. cit.*, footnote 75, p. 3.

Table 3-3
Comparisons of the dental care sectors in Canada, Australia and Finland

	CANADA	AUSTRALIA	FINLAND
Public funding of dental care (as a percentage of total)[1]	6%	28%	41%
Public provision of dental care[2]	Less than 2% of dentists work in public hospitals	18% of dentists work in the public sector	45% of dentists and dental hygienists work in the public sector
Active dentists per 100,000 inhabitants[3]	61	58	86
Visit to a dentist in the past year (children and adolescents)[4]	• 91% of children aged 6 to 11 • 84% of adolescents aged 12 to 19	• 78% of children aged 5 to 14	• 77% of children aged 6 to 17
Visit to a dentist in the past year (adult population)[5]	72%	62%	63%
Visit to a dentist in the past year (low-income population)[6]	60%	Between 50% and 56%	n.a.
Waiting list for access to dental care[7]	Waiting is not an issue	Around 400,000 patients on waiting lists in the public system	Over 13,000 patients waiting more than 6 months in the public system (2006-12)
Children without cavities[8]	• 53% of 6-year-olds • 61% of 12-year-olds	• 48% of 6-year-olds • 45% of 12-year-olds	• 39% of 5-year-olds • 26% of 12-year-olds
Adults with natural teeth[9]	• 96% of adults aged 45 to 54 • 88% of adults aged 55 to 64 • 75% of adults aged 65 to 74	• 96% of adults aged 45 to 64 • 79% of adults aged 65 and over	• 94% of adults aged 45 to 54 • 84% of adults aged 55 to 64 • 64% of adults aged 65 to 74

Sources: 1. Year 2011. Organisation for Economic Co-operation and Development, Database of health statistics. **2.** Australian Institute of Health and Welfare, *Dental Workforce 2012*, National health workforce series No. 7, January 2014, p. 22; Service Canada, Dentists; Lauri Vuorenkoski, "Finland – Health System Review," H*ealth Systems in Transition*, Vol. 10, No. 4, 2008, p. 91. **3.** Year 2012. Organisation for Economic Co-operation and Development, Database of health statistics. **4.** Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, p. 79; Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia, Key Facts and Figures Trends 2014*, 2014, p. 12; Eeva Widström and Seppo Järvinen, "Caries Prevalence and Use of Dental Services in Finnish Children and Adolescents in 2009," *Oral Health and Dental Management*, Vol. 10, No. 4, 2011, p. 187. **5.** Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, p. 51; Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia, Key Facts and Figures Trends 2014*, 2014, p. 8; Eero Raittio *et al.*, "Dental Attendance among Adult Finns after a Major Oral Health Care Reform," *Community Dentistry and Oral Epidemiology*, Vol. 42, 2014, p. 595. **6.** Low-income Canadians and Australians are those earning less than $30,000 a year in their respective currencies. Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, p. 29; Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia, Key Facts and Figures 2012*, 2013, p. 20. **7.** Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times*, November 2012, p. 16; Parliament of the Commonwealth of Australia, *Bridging the Dental Gap: Report on the Inquiry into Adult Dental Services*, Standing Committee on Health and Ageing, June 2013, p. 9; Pia Maria Jonsson *et al.*, "Finland," in *Waiting Time Policies in the Health Sector: What Works?* OECD Health Policy Studies, 2013, p. 142. **8.** Health Canada, *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, September 2010, pp. 31-34; Sergio Chrisopoulos and Jane Harford, *Oral Health and Dental Care in Australia: Key Facts and Figures 2012*, Australian Institute of Health and Welfare, Australian Government, 2013, p. 4; Eeva Widström and Seppo Järvinen, "Caries Prevalence and Use of Dental Services in Finnish Children and Adolescents in 2009," *Oral Health and Dental Management*, Vol. 10, No. 4, 2011, p. 189. **9.** Statistics Canada, *Oral Health: Edentulous People in Canada 2007 to 2009*, Health Fact Sheets, January 2010; Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia, Key Facts and Figures Trends 2014*, 2014, p. 6.

inequality of access between the various social classes, which had been highlighted by research carried out in the 1990s.[84]

Yet despite a massive injection of funds, the public system continues to grapple with substantial failings. Researchers recently showed that there had been no significant improvement in terms of access to dental care, and that inequalities have persisted following the 2001 reform. In fact, after an initial reduction in the first years, inequalities worsened once again after 2004.[85]

"According to an OECD report, wait times in 2012 were over a month long in 85% of public dental centres."

Admittedly, the proportion of adults who said they visited a dentist annually did go from 57% in 2001 to 63% in 2007.[86] However, this increase seems very modest given the additional spending of the Finnish government, which grew by over 80% over the course of the first six years of the reform. In comparison, the proportion of adult Canadians who say they visit a dentist every year went from 64% in 2003 to 72% in 2007-2009,[87] without any expansion of public programs.

Moreover, wait times continue to be extremely long in Finland. Seeing a dentist in the public system requires patience; appointments are not easily had. Barely 25% of Finns think that the public dental centres in the municipalities where they live provide a good level of availability.[88] According to an OECD report, wait times in 2012 were over a month long in 85% of public dental centres.[89] Between 2006 and 2012, over 13,000 people on average had been on a waiting list for dental services in the public system for more than six months.[90]

These access difficulties are not due to a lack of human resources, since Finland has 40% more dentists as a proportion of the population than Canada. With 86 dentists per 100,000 inhabitants, they have one of the highest rates among OECD countries.[91]

Australia

Australia is another country often used as an example by analysts in Canada. In September 2014, the Canadian Academy of Health Sciences published a report in which Australia was cited as one of the "countries that have more robust public funding and delivery of oral health care."[92]

Dental services in Australia are indeed offered both in private clinics and in public facilities. The majority of Australian dentists (78%) work in the private sector. Their workweek is on average 23% longer than that of their colleagues who work solely in the public sector.[93]

Access to public dental services is limited to young children as well as certain categories of vulnerable people, including welfare recipients, veterans and low-income retirees. Some 5 million adults are eligible to receive their dental care in the public system.[94] Only a little over one half of them see a dentist every year. In the great majority of cases (74%), they opt for a private clinic,[95] due to the government's policies of rationing services.

Indeed, access to dental services in the public system is subject to considerable delays. In June 2013, an inquiry report from the Australian Parliament summed up the situation in these terms:

> Waiting times for public dental services are often long (between two and five years in some areas), with up to 400,000 adults on waiting lists across Australia. Treatment is often focused on emergency care rather than the provision of preventive or restorative services. Public dental services also offer denture services to patients, but waiting times are long and patients may have to wait months for an

84. Teija Niiranen, Eeva Widström and Tapani Niskanen, "Oral Health Care Reform in Finland – Aiming to Reduce Inequity in Care Provision," *BMC Oral Health*, Vol. 8, No. 3, 2008.
85. Eero Raittio *et al.*, "Income-Related Inequality and Inequity in the Use of Dental Services in Finland after a Major Subsidization Reform," *Community Dentistry and Oral Epidemiology*, forthcoming, 2015.
86. Eero Raittio *et al.*, "Dental Attendance among Adult Finns after a Major Oral Health Care Reform," *Community Dentistry and Oral Epidemiology*, Vol. 42, No. 6, 2014, p. 595.
87. Canadian Institute for Health Information, *op. cit.*, footnote 70, p. 75; Health Canada, *op. cit.*, footnote 58, p. 51.
88. Eero Raittio *et al.*, 2014, *op. cit.*, footnote 86, p. 593. The study notes that 71% of Finns think that private dental clinics provide a good level of availability.
89. Organisation for Economic Co-operation and Development, *OECD Economic Surveys: Finland*, February 2012, p. 95.
90. Pia Maria Jonsson *et al.*, "Finland," in *Waiting Time Policies in the Health Sector: What Works?* OECD Health Policy Studies, 2013, p. 142.
91. Organisation for Economic Co-operation and Development, *op. cit.*, footnote 83.
92. Canadian Academy of Health Sciences, *op. cit.*, footnote 75, pp. 32-33.
93. Sergio Chrisopoulos and Jane Harford, *Oral Health and Dental Care in Australia: Key Facts and Figures 2012*, Australian Institute of Health and Welfare, Australian Government, 2013, p. 41.
94. Parliament of the Commonwealth of Australia, *Bridging the Dental Gap: Report on the Inquiry into Adult Dental Services*, Standing Committee on Health and Ageing, June 2013, p. 9.
95. Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia: Key Facts and Figures Trends 2014*, Australian Government, 2014, p. 13.

> appointment. Those on waiting lists are generally lower-income individuals who often have no choice but to wait for care.[96]

Public spending on dental care more than doubled in Australia from 2006 to 2011, growing by an average of 18% annually. During this period, the share of total funding that is public went from 18% to 28%.[97] Despite these increases, the resources devoted to the sector still seem to be insufficient to significantly reduce the problem of long wait times in the public system and facilitate access to necessary services for the less fortunate.

"Canadians were 30% more likely to have visited a dentist in the past 12 months than Australians."

According to data from a recent report published by the Australian government, the percentage of adults having foregone a visit to the dentist for financial reasons went from 25% in 1994 to 30% in 2010. The report also reveals that "in 2007–09, Canadians were 30% more likely to have visited [a dentist in the past 12 months] than Australians, across all age groups from 20 to 79."[98]

Conclusion

For all Canadians to have access to dental services regardless of income is an ideal that no one opposes. However, international examples show us that more government funding does not necessarily improve the accessibility of services. On the contrary, in these countries, we find the establishment of rationing policies and the appearance of long waiting lists to obtain required treatment.

On the other hand, wait times in the field of dental care are not a worrisome issue in Canada. The data show that Canada is among the countries with the easiest access to a dentist. As we saw, the dental health of Canadians has also improved considerably in recent decades. The private sector responds effectively to demand.

96. Parliament of the Commonwealth of Australia, *op. cit.*, footnote 94, p. 9.
97. Organisation for Economic Co-operation and Development, *op. cit.*, footnote 83.
98. Australian Institute of Health and Welfare, *op. cit.*, footnote 95, p. 12.

CHAPTER 4

Eye Care in the Private Sector: Innovation at the Service of Patients

In Canada, it is professionals working essentially in private practices who provide patients with the eye and vision care they require. Although a vision problem is rarely a life-threatening matter, it can nonetheless constitute a serious handicap in one's daily life. According to the latest available data, some 57% of Canadian adults suffer from vision problems. These people must generally wear eyeglasses or contact lenses. Others increasingly opt for corrective laser eye surgery. Whatever the method, in 97% of cases, these people receive the care they need to adequately address their problems.[99]

Contact lenses and LASIK surgery are just a few of the numerous innovations that have transformed the eye care sector in recent decades. There are now a variety of options for treating a great many ocular disorders, some of which were considered incurable not so long ago, like glaucoma, cataracts and diabetic retinopathy.[100] This chapter presents a brief overview of Canada's eye care sector, one of the most dynamic in the health care industry.

The Provision of Eye Care in Canada

In the field of visual health, a majority of primary care is delivered by optometrists, who perform eye examinations and prescribe glasses or contact lenses as needed. Canada had 5,356 active optometrists in 2012.[101] The majority of them work in private practice. The rest work in collaboration with ophthalmologists or opticians, practice in visual impairment rehabilitation centres, or teach in a university. Statistics Canada counted 2,077 optometrists' offices in the country in December 2014.[102]

Ophthalmologists are medical specialists in eye and vision care. They are the professionals responsible for diagnosing ocular disorders and seeing to their treatment. They are the ones who conduct surgeries to treat certain diseases like cataracts and glaucoma, and to correct various visual impairments.[103] Canada-wide, there were 1,208 ophthalmologists in 2013.

Opticians, for their part, are the professionals dedicated to the preparation and the sale of eyeglasses and contact lenses, work that is carried out based on prescriptions prepared by optometrists or ophthalmologists. In certain provinces, they are also authorized to perform eye exams, without being able to write prescriptions, however.[104] In 2012, there were 7,444 opticians in Canada (see Table 4-1).

"Between 1997 and 2012, the number of optometrists grew by 67%, far outpacing population growth."

The optometry sector in Canada has become more and more competitive over the years, with a growing demand for this type of service and an increasing number of active professionals.[105] Between 1997 and 2012, the number of optometrists grew by 67%, far outpacing population growth (see Figure 4-1). This increased competition has given optometrists an incentive to adopt the latest information technology in order to improve the quality of services offered. Over 96% of Canadian optometrists use computers in their practices. Compared to general practitioners working in the public system, a much larger proportion of optometrists use computerized medical files for their patients.[106]

Overall, the data from the most recent studies indicate that 40% of Canadians aged 12 and over consult an eye care specialist each year. For people older than 70, this proportion climbs to 60%. These rates seem to be in line with the recommendations of the Canadian Ophthalmology Society in terms of frequency of exams for people not suffering from any known visual problems.[107] As for patients suffering from glaucoma (86%),

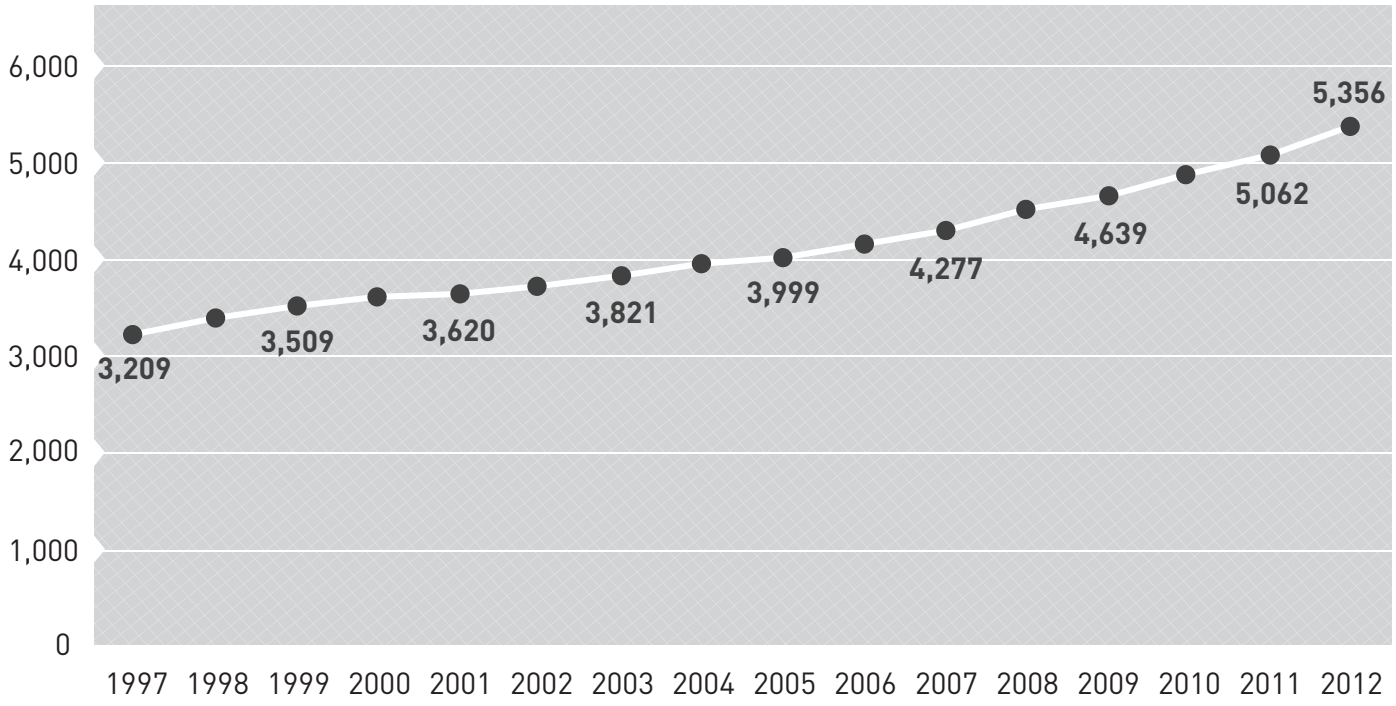
99. Anthony V. Perruccio, Elizabeth M. Badley and Graham E. Trope, "A Canadian Population-Based Study of Vision Problems: Assessing the Significance of Socioeconomic Status," *Canadian Journal of Ophthalmology*, Vol. 45, No. 5, 2010, p. 479.
100. Canadian Institute for Health Information, *Exploring the 70/30 Split: How Canada's Health Care System Is Financed*, 2005, p. 84.
101. Canadian Institute for Health Information, *Canada's Health Care Providers: Provincial Profiles—2012, Canada*, March 2014.
102. Statistics Canada, CANSIM Table No. 552-0001: Canadian business patterns, location counts with employees, by employment size and North American Industry Classification System (NAICS), Canada and provinces, December 2014.
103. Royal College of Physicians and Surgeons of Canada, Objectives of Training in the Specialty of Ophthalmology.
104. Competition Bureau, *Self-Regulated Professions — Balancing Competition and Regulation*, December 2007, pp. 82-83.
105. Robert J. Campbell, Wendy V. Hatch and Chaim M. Bell, "Canadian Health Care: A Question of Access," *Archives of Ophthalmology*, Vol. 127, No. 10, October 2009, p. 1384.
106. Paul Stolee *et al.*, "'Eye-T': Information Technology Adoption and Use in Canada's Optometry Practices," *Optometry*, Vol. 82, 2011, pp. 166-174.
107. Lorne Bellan, "Abandoning Monitoring Eye Care Utilization in Canada: Something Doesn't Smell Right," *Canadian Journal of Ophthalmology*, Vol. 46, No. 2, April 2011, p. 123.

Table 4-1
Eye care professionals in Canada, by province, 2012

PROVINCES	OPHTHALMOLOGISTS*	OPTOMETRISTS	OPTICIANS
British Columbia	200	606	1,049
Alberta	105	617	1,072
Saskatchewan	23	149	265
Manitoba	33	141	330
Ontario	423	2,106	2,500
Quebec	324	1,424	1,642
New Brunswick	26	116	216
Nova Scotia	51	113	247
Prince Edward Island	6	20	32
Newfoundland and Labrador	16	57	91
Territories	1	7	0
Canada	1,208	5,356	7,444

Source: Canadian Institute for Health Information, *Canada's Health Care Providers: Provincial Profiles—2012*, Canada, March 2014; Canadian Medical Association, Ophthalmology Profile.
*2013

Figure 4-1
Evolution of the number of optometrists in Canada, 1997-2012



Sources: Canadian Institute for Health Information, *Canada's Health Care Providers: Provincial Profiles — 2012, Canada*, March 2014; Canadian Institute for Health Information, *Canada's Health Care Providers, 1997 to 2011 - A Reference Guide, Optometrists*, April 2013.

Table 4-2
Public eye care insurance coverage programs by Canadian province

PUBLIC PROGRAMS	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Medically required ocular care	X	X	X	X	X	X	X	X	X	X
Eye exams for youths below the age of 20*	X	X	X	X	X	X	X	X		
Eye exams for people aged 65 and over**	X	X	X	X	X	X		X		
Eye exams and partial assistance for the purchase of eyeglasses for welfare recipients***	X	X	X	X	X	X	X	X	X	X

Sources: Canadian Association of Optometrists, An Overview of Provincial Coverage for Optometric Care in 2014; Chris J. Hong *et al.*, "Does Government Assistance Improve Utilization of Eye Care Services by Low-Income Individuals?" *Canadian Journal of Ophthalmology*, Vol. 49, August 2014, pp. 321-322.

* AB: Annual exam for youths below the age of 19; BC: Annual exam for youths aged 18 and under; MB: Exam every two years for youths aged 18 and under; NB: Annual exam for youths aged 18 and under from low-income households; SK: Annual exam for youths below the age of 18; QC: Exams for youths aged 17 and under; NS: Exam every two years for children below the age of 10.

** BC, QC: Annual exam; AB: Annual exam for people over 65; NS, MB: Exam every two years; SK: Annual exam for recipients of Seniors Income Plan supplements; ON: Annual exam for people over 65.

*** AB, MB, SK, ON, QC: Complete coverage for one exam per year or every two years; BC, NB, NS, PEI: Limited coverage for one exam every two years; NL: Limited coverage for one exam every three years.

cataracts (76%) or diabetes (63%), they are more likely to consult an ocular care professional on an annual basis. For these people, consultation rates are essentially the same across income and education levels.[108]

Spending on Eye Care in Canada

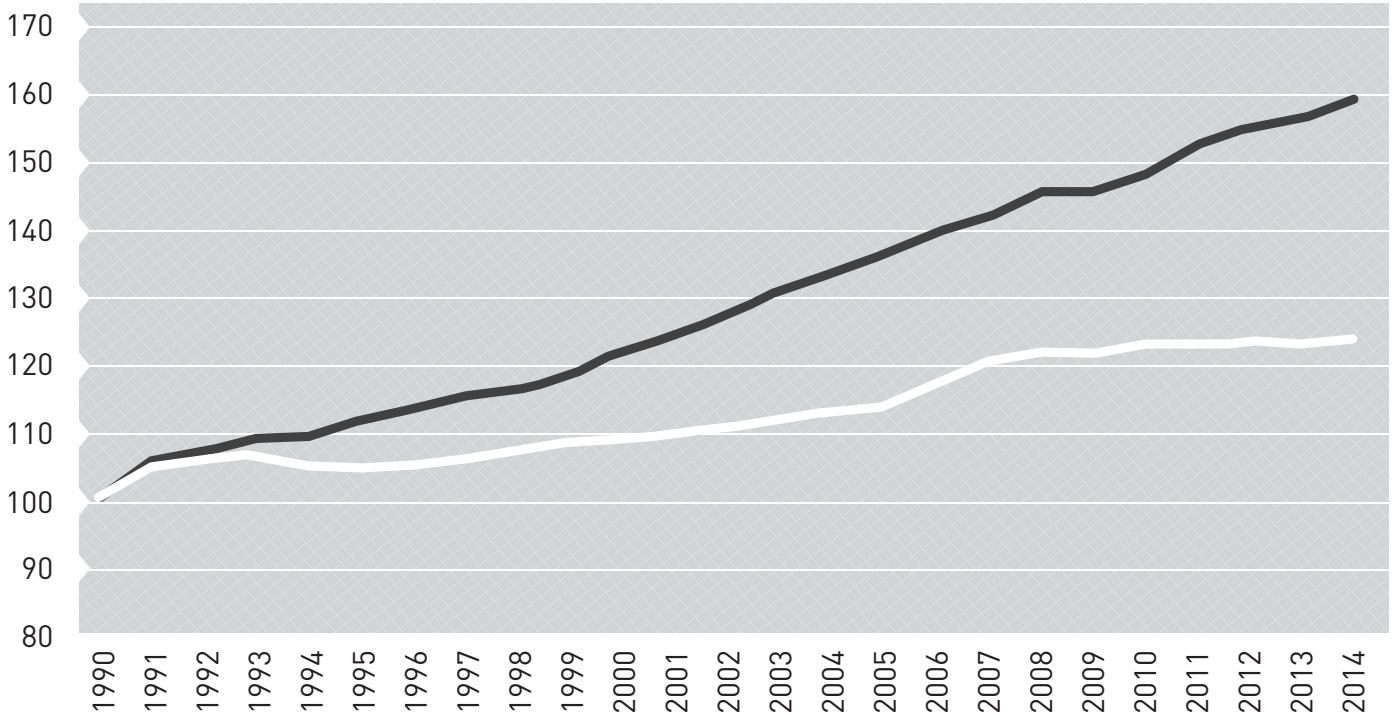
In 2012, total spending for eye and vision care amounted to $3.9 billion, according to figures from the Canadian Institute for Health Information. Over 90% of this amount comes from private sources. Private insurance companies reimbursed one quarter of these expenditures, while patients paid the remaining three quarters directly.[109]

Nearly all the provincial governments have programs that cover spending on eye care for certain categories of people, including minors, seniors, welfare recipients and the visually impaired (see Table 4-2).[110] In all cases, the provinces' public plans cover eye exams as well as prescriptions. Fees for exams required to obtain a driver's license or to qualify for a job are not covered. The cost of eyeglasses or contact lenses is also paid by patients except in the case of welfare recipients, who receive partial assistance from the government in each province.[111]

"In 2012, total spending for eye and vision care amounted to $3.9 billion. Over 90% of this amount comes from private sources."

108. Ya-Ping Jin and Graham E. Trope, "Eye Care Utilization in Canada: Disparity in the Publicly Funded Health Care System," *Canadian Journal of Ophthalmology*, Vol. 46, No. 2, 2011, p. 135.
109. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2014,* October 2014, pp. 40-136.
110. Only the provincial governments of Newfoundland and Labrador and Prince Edward Island do not cover any optometry services. Canadian Association of Optometrists, An Overview of Provincial Coverage for Optometric Care in 2014.
111. Chris J. Hong *et al.*, "Does Government Assistance Improve Utilization of Eye Care Services by Low-Income Individuals?" *Canadian Journal of Ophthalmology*, Vol. 49, 2014, p. 323.

Figure 4-2
Evolution of the eye care product price index and the consumer price index, annual data, 1990-2014 (1990 = 100)



Source: Statistics Canada, CANSIM Table No. 326-0021: Consumer price index, annual, 1990-2014.

The eye care industry encompasses manufacturers and retailers of lenses, frames and other vision devices. This industry operates in a highly competitive, international market.[112] This competitive environment leads to improvements in product quality, and limits price increases for prescription glasses and contact lenses to levels far below the rate of inflation. As can be seen in Figure 4-2, the growth rate of prices for eye care products has been half that of Statistics Canada's consumer price index since the start of the 1990s.

"Manufacturers and retailers of lenses, frames and other vision devices operate in a highly competitive, international market."

In Table 4-3, it can be seen that in 2013, Canadian households spent an average of $184 for eye care products (prescription eyeglasses, contact lenses, etc.) and $46 for eye care services (eye exams, surgery, etc.). These amounts vary from one province to another, being generally higher in Quebec and lower in New Brunswick.

Corrective Laser Eye Surgery

Over the past decade, laser surgery has improved the vision of hundreds of thousands of people in Canada. A growing number of clinics now compete to offer this service, and the results are convincing.

Laser eye surgery is an interesting example to analyze since it is generally not covered by insurance in Canada. In the majority of cases, consumers must therefore pay full price to benefit from the procedure. Economic theory teaches us that consumers are much more careful with their money when they have to buy a product or service that is not reimbursed by a third party.[113]

112. Health Professions Regulatory Advisory Council, *A Report to the Minister of Health and Long-Term Care on Interprofessional Collaboration among Eye Care Health Professions*, Government of Ontario, March 2010, p. 34.

113. Aviva Aron-Dine, Liran Einav and Amy Finkelstein, "The RAND Health Insurance Experiment, Three Decades Later," *Journal of Economic Perspectives*, Vol. 27, No. 1, 2013, pp. 197-222.

Table 4-3
Spending by Canadian households for eye care products and services, 2013

PROVINCE	TOTAL SPENDING FOR EYE CARE PRODUCTS AND SERVICES	SPENDING SOLELY FOR EYE CARE SERVICES
British Columbia	$202	$40
Alberta	$280	$48
Saskatchewan	$231	$39
Manitoba	$184	$37
Ontario	$208	$34
Quebec	$278	$69
New Brunswick	$142	$24
Nova Scotia	$178	$28
Prince Edward Island	$217	$66
Newfoundland and Labrador	$187	$64
Canada	$230	$46

Source: Statistics Canada, CANSIM Table No. 203-0021: Survey of household spending, 2013.

We can see the effect of the demands of consumers and of increased competition on the evolution of prices and service quality. Whereas in the early 2000s, a standard LASIK procedure cost around $5,000 for both eyes, the price now fluctuates between $1,000 and $2,000.[114] The technology has greatly evolved these past few years, and personalized LASIK is now more efficient than standard LASIK, as well as being safer for the eye. Taking into account the increase in quality, the price reduction has been substantial, and all the more so considering that since 2000, Canada's consumer price index increased by 31%.[115]

"Whereas in the early 2000s, a standard LASIK procedure cost around $5,000 for both eyes, the price now fluctuates between $1,000 and $2,000."

Contrary to the situation that prevails in the public health care system, prices have fallen over the years despite the adoption of ever more advanced technology. The risks related to postoperative complications have also fallen substantially with technological improvements and increasing surgical experience.[116] According to an exhaustive study, the satisfaction rate of patients who have undergone LASIK surgery is over 95%.[117]

Conclusion

Although certain analysts would like to see more government involvement in the field of eye care,[118] available evidence shows that this is a competitive sector that is very accessible to patients.

In those areas of health care where entrepreneurial initiatives are encouraged, we can see that the market is dynamic, innovations abound and the quality of services and treatments is constantly improving. Eye and vision care, which is financed and supplied almost entirely by the private sector in Canada, provides a striking example of this.

114. Heather Kent, "Huge Declines in Price as Competition Heats Up in Vancouver's Booming Laser-Surgery Market," *Canadian Medical Association Journal*, Vol. 161, No. 7, October 1999, pp. 857-858; Nathalie Vallerand, "La force d'une vision," *Les Affaires*, February 26, 2011.
115. Statistics Canada, CANSIM Table No. 326-0021: Consumer Price Index, annual, 2001-2011.
116. Tohru Sakimoto, Mark I. Rosenblatt and Dimitri T. Azar, "Laser Eye Surgery for Refractive Errors," *The Lancet*, Vol. 367, April 2006, pp. 1432-1447.
117. Kerry D. Solomon *et al.*, "LASIK World Literature Review: Quality of Life and Patient Satisfaction," *Ophthalmology*, Vol. 116, No. 4, April 2009, pp. 691-701.
118. Chris J. Hong *et al.*, *op. cit.*, footnote 111, p. 324.

CONCLUSION

The access problems with which patients are faced in Canada's public health care system are well documented. The median wait time between seeing a general practitioner and receiving treatment from a specialist was 18.2 weeks in 2014, nearly twice as long as it was twenty years ago.[119] The increasing resources devoted to the public system for the past quarter of a century have not solved the problem of overcrowded emergency rooms, which remains as worrisome as ever in every province.

On the other hand, other areas of health care that rely almost entirely on the private sector work well in Canada. As we saw, the pharmacy, dentistry, eye care, and seniors' housing sectors provide accessible services that respond effectively to the needs of the population. While these sectors play an important role in the health care system, their successes often go unnoticed.

Around 55% of Canadians consult a pharmacist every week, in the vast majority of cases without having to make an appointment beforehand. Practically all patients are able to receive their prescriptions within a matter of minutes.

Nor are waiting times an issue of concern in the field of dental care in Canada. Each year, three in four Canadians see a dentist, one of the highest rates among OECD countries. The vast majority of patients say they are satisfied with the services they receive.

The eye and vision care sector, for its part, is one of the most dynamic in the health care industry. Innovations abound and the quality of services and treatments is constantly improving. Contrary to the situation that prevails in the public health care system, prices have fallen over the years despite the adoption of ever more advanced technology.

As for seniors' housing and care, the Quebec example shows that the private sector provides alternatives that are less expensive than the public sector, and better adapted to the varied needs and preferences of the population.

As we saw in this *Paper*, the success of these sectors in Canada is primarily due to the presence of market mechanisms that ensure their proper functioning: competition among providers, the profit motive, and freedom of choice for patients. We should not be surprised to find that these mechanisms are largely absent in the public health care system. Yet it is these mechanisms that ensure that patients remain at the centre of care providers' concerns. Motivated among other things by the desire to make a profit, private care providers are encouraged to find ways of organizing work that entail efficiency gains, reduce costs, and shrink wait times. If they fail to do so, they will lose their clientele to their competitors.

It is not inevitable that our public health care system should be characterized by rising costs, inefficient administration and longer and longer wait times for treatments. On the contrary, these past two decades, a large number of countries have undertaken reforms in order to improve the efficiency and the productivity of their health care systems by decentralizing administration, by calling on the private sector for the provision of care, and by setting up competitive mechanisms between different hospitals.[120] These experiences show that a health care system can remain public and universal all while allowing entrepreneurs to compete to provide services and attract clients, instead of leaving patients captive to a public monopoly that fails to respond adequately to the demand for treatment.

The existence of areas of health care that work well, like those described in this *Paper*, is an additional proof that it is possible to do things differently. It is now up to the governments of each province to put in place the reforms required to make our public health care system respond just as successfully to the needs of patients.

119. Bacchus Barua and Frazier Fathers, *Waiting Your Turn: Wait Times for Health Care in Canada, 2014 Report*, Fraser Institute, November 2014, p. 1.

120. See these two recent MEI publications: Yanick Labrie, "For a Universal and Efficient Health Care System: Six Reform Proposals," *Research Paper*, March 2014, in particular Chapter 1 entitled "Promoting Freedom of Choice for Patients and Competition between Care Providers"; Yanick Labrie, "The Positive Role of Profit in the Field of Health Care," *Economic Note*, November 2014.

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Yanick Labrie is an economist and health policy analyst with the Montreal Economic Institute. He holds a bachelor's degree in economics from Concordia University and a master's degree in economics from the Université de Montréal.

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ISBN 978-2-922687-57-6