POLICY BRIEF:
Health Care Partnerships and Hospital Funding

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Executive Summary

The best universal health care systems in the world put patients first. Such systems generally partner with any accredited provider capable of delivering high-quality care to patients in a cost-effective manner – it doesn't matter if it's a government or non-government hospital or surgical facility. What matters most is that the hospital or surgical facility can help patients.

Evidence shows partnerships with non-government health providers have the potential to expand supply, improve timely access to care, introduce cost-efficiencies, and drive innovation, among other benefits. However, the rules of the game matter, and problems can certainly arise when governments negotiate poorly structured contracts with non-government health providers.

Allegations of "sweetheart deals" have recently arisen between a handful of third-party providers and provincial governments in Alberta, Saskatchewan, and Ontario. Even if these allegations prove to be false, they risk eroding Canadians' support for exploring third-party health care partnerships.

This policy brief examines how to avoid such problems. It builds on the work of think-tanks including the Fraser Institute, C.D. Howe Institute, and MEI (Montreal Economic Institute), among others, that have published multiple studies exploring the concepts of partnerships with the non-government sector and patient-focused (aka activity-based, or ABF) funding. However, this paper goes one step further in making the case that shifting towards an activity-based funding model should be used as a tool to depoliticize the choice of health care provider – a key consideration for Canadians wary of health care reform. While this point was previously advanced by the author of this paper in an essay for the 2022 Hunter Prize, as well as in multiple columns with The Hub, the present work takes a deeper look at how health care funding reform can depoliticize and safeguard health spending.

Specifically, this policy brief seeks to advance that discussion by documenting how these partnerships and funding incentives work together in other countries within a universal health care construct, including in Canada. Specifically, this brief examines:

a) The role of non-government hospitals and facilities in other countries that have universal health care;

b) How government and non-government hospitals and facilities in these countries are funded;

c) The current efforts to deliver publicly funded care through non-government clinics in four Canadian provinces; and

d) How to depoliticize partnerships with non-government hospitals and facilities via funding reform.

This study focuses on eight universal health care systems that outperformed Canada in the C.D. Howe Institute's recent rankings. It finds that these systems have a relatively larger presence of non-government hospitals than Canada (as defined by the OECD) – ranging from seven percent in Sweden, to over 75 percent in Germany, Switzerland and the Netherlands. More broadly, non-government hospitals and surgical facilities are not only relied upon as a pressure-valve for the public system but are also generally viewed as partners within the universal health care construct and are accessible to patients with public or private insurance.

Another key difference is the widespread adoption of patient-focused financing models (specifically, activity-based funding or ABF) to remunerate providers, in contrast to Canada's outdated global-budgeting approach. Simply put, in Canada, governments tend to provide annual funding transfers to hospitals and hope for the best. In countries with ABF, surgical health care providers generally receive funding from the government each time they treat a patient. Of course, amounts differ based on the type and complexity of the service provided, among other considerations. Not only does this method of funding have the potential to increase volumes and efficiency (as well as potentially reduce wait times), but it also depoliticizes where treatment is provided, with funding following patients to wherever they receive treatment, whether that be in government or non-government facilities.

Policymakers in Canada should consider following the examples of other successful universal health care systems by expanding the use of publicly funded non-government facilities. At the same time, this expansion should be complemented by reforms to pay all hospitals and surgical facilities – whether government or non-government – according to actual activity in order to incentivize treatment, potentially improve efficiency, and depoliticize the public-private debate to focus on a patient-first philosophy instead.

Introduction

Canada's public health care system is failing patients. Data obtained by SecondStreet.org reveals that since 2018/19, about 75,000 Canadians have died while waiting for surgical and diagnostic services.[1] This is unfortunate, but unsurprising, given that wait list surveys by the Fraser Institute show wait times increased 52 percent during that same period – with patients waiting an unprecedented 30 weeks for treatment after referral by a general practitioner last year.[2] [3]

And there's no relief in sight.

Factors such as a growing and aging population, a relative shortage of physicians, an exodus of disillusioned nurses, aging medical technology, and routine ER closures will undoubtedly compound the challenges currently facing our public health care system.

Comparisons of health care performance with our international peers further corroborate Canada's poor performance. A recent study by the C.D. Howe Institute (based primarily on survey data from the Commonwealth Fund) ranked Canada ninth out of the ten health care systems compared, with only one – the United States – faring worse.[4] The countries that performed better than Canada, in order from highest to lowest, were the Netherlands, the United Kingdom, France, Australia, Germany, Switzerland, Sweden, and New Zealand – all of which have universal health care systems.

While the C.D. Howe study did not directly include measures of total spending in determining health system performance, OECD data show that, in 2023, about half of the eight countries that outperformed Canada – Australia, the Netherlands, the United Kingdom, New Zealand and Sweden – actually devoted a smaller share of their GDP to health care.[5 a b]

This evidence makes it clear that Canada's underperformance is not the result of inadequate spending. Rather, it is the policy framework that differentiates our health care system from our international peers.

One notable difference is that in delivering universally insured health care, the systems in these countries partner more broadly with the non-government sector. Another difference is that they generally fund hospitals based on activity.

The Promise of Partnerships with Non-Government Providers

Research has consistently shown that Canada's health care system departs from the international norm in several important ways, including with patient cost-sharing, dual practice for physicians (allowing doctors to easily work for both government and non-government providers), how hospitals are funded, and patient options for care beyond those controlled by government.[6] Notably, research by the MEI and the Fraser Institute found that Canada also departs from its peers with respect to the relative share of non-government hospitals.[7 8] Since these studies were conducted more than 10 years ago and only examined a limited set of countries, we decided to take a look at newer data for the set of countries identified as top performers in the more recent C.D. Howe Report.

Table 1 Share of Non-Government Hospitals in Universal Health Care Systems, 2022 (or nearest)

Countries	Government	Non-Government	Total	Non-Government Share
Canada	**697**	**7**	**704**	**1%**
Sweden (2020)*	**77**	**6**	**83**	**7%**
United Kingdom***	**930**	**218**	**1,148**	**19%**
Australia (2016)	**698**	**657**	**1,355**	**48%**
New Zealand	**86**	**78**	**164**	**48%**
France	**1,338**	**1,638**	**2,976**	**55%**
Germany	**743**	**2,239**	**2,982**	**75%**
Switzerland (2023)**	**41**	**234**	**275**	**85%**
Netherlands	**0**	**733**	**733**	**100%**

Sources: *OECD, 2024; *Tikkanen et al. 2020; **Office fédéral de la santé publique; Soffee, 2023 calculations by author, *** Soffe, 2023 calculations by author.*

a) The United Kingdom, New Zealand, and Australia also spend less than Canada on health care per person.

b) International comparisons of spending and performances should ideally be adjusted for differences in age – however, doing so is beyond the scope of this paper. The findings of reports such the Fraser Institute's annual Comparing Performance of Universal Health Care Countries series suggest that age-adjustments will result in Canada ranking notably higher on spending as a percentage of GDP and slightly higher per capita.

c) Canada has many hospitals that are technically non-profit, but are almost entirely funded by the government and these same hospitals have boards that are appointed by the government. The OECD treats these hospitals as government hospitals despite their non-profit structure.

As Table 1 illustrates, Canada has the lowest share of non-government hospitals (only one percent) among the nine countries in the cohort. By contrast, non-government hospitals (non-profit and for-profit) in other countries play a larger role in the provision of core health care services, representing about half (or more) of all hospitals and inpatient facilities in New Zealand, Australia, France, Germany, Switzerland, and the Netherlands. Readers should note that Table 1 includes a combination of sources for data. This is because OECD data for some countries are either unavailable or incomplete. Detailed explanations are provided in the country summaries in following sections.

Clearly, our international peers examined in this study – all of which share our goal of universal health care insurance coverage – have a very different attitude towards the role of the non-government sector in the delivery of medically necessary care. Moreover, and as can be seen in Figure 1, there appears to be an inverse relationship between the share of non-government hospitals and the wait time for elective surgery. Although a comprehensive econometric analysis of this relationship is beyond the scope of this paper, and only limited data is available, it's worth noting that the correlation coefficient between the two variables is -0.961 (where -1 represents a perfectly inverse relationship). Simply put, a higher share of non-government hospitals is associated with shorter wait times for non-emergency or elective surgery. Of course, correlation does not imply causation. The share of non-government hospitals may also be a proxy for other institutional characteristics. For example, and as will be seen later in this paper, the three universal health care countries with the shortest wait times for elective surgery in 2023 all primarily rely on ABF for funding hospitals. By contrast, the three worst performers (including Canada) rely to a greater degree on global budgets.

Readers should note that the data in Table 1 is primarily derived from the OECD, which defines *hospitals* as establishments that principally provide inpatient health services (i.e. requiring an overnight stay).[9] However, there may be definitional differences between countries. For example, whereas most hospitals in Canada are technically non-government institutions that operate on a not-for-profit basis, the OECD, 2023 classifies them as public hospitals, as they are "controlled by government units."[10] While many non-government clinics in Canada can legally provide same-day care, these are not included in OECD data. By contrast, it is possible that some independent treatment centres in

Figure 1 **Patients waiting more than two months for surgery vs Share of Non-Government Hospitals**

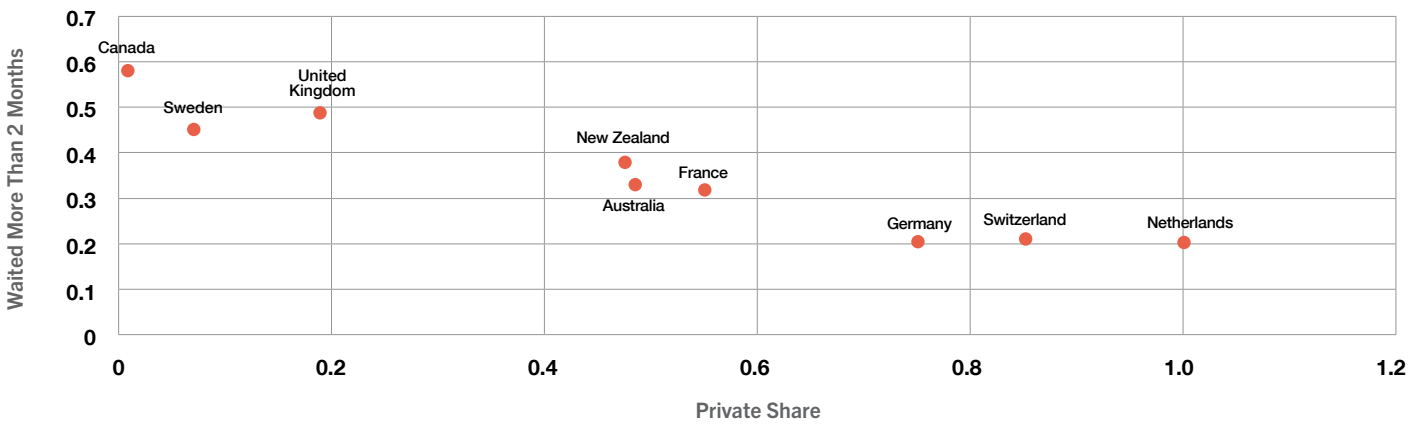

Figure 1: Calculations by author

the Netherlands (for example) may focus primarily on routine day surgeries, but are included. We rely on OECD definitions for comparability to the extent it is possible, unless more detailed data is readily available (as with the United Kingdom, for example). The use of independent clinics for day surgeries is examined in greater detail in the following sections.

Non-Government Hospitals and Facilities: International

This section contains brief overviews of eight universal health care systems that outperformed Canada according to the C.D. Howe Institute's recent analysis. It highlights the role of care delivered through non-government hospitals and clinics, as well as the use of activity-based funding for hospital remuneration. Countries are examined in order of increasing delivery of care by non-government hospitals, as documented in Table 1 (with the exception of Canada, which is examined in-depth in a subsequent section). While individual citations are provided where appropriate, it is worth noting that this section is primarily informed by country profiles published by the European Observatory on Health Systems and Policies' Health Systems in Transition (HiT) series [The Observatory] as well as the Commonwealth Fund's International Health Care System Profiles [CWF].[11] [12]

Sweden

Sweden has a universal health care system that is primarily funded by general taxation.[c] However, Swedish residents can also purchase voluntary non-government health care insurance that provides quicker access to specialist care, as well as to preventative and rehabilitative care.[d] About 7.2 percent of the population had non-government insurance in 2022, the majority of which was acquired through employment.[13]

According to a 2023 study by The Observatory, the non-government sector plays a significant role in primary care.[14] This sector is generally free to establish primary care clinics (so long as they meet regional requirements), and patients can choose to register with the public or private primary care centre [PCC] of their choice. In 2020, non-government facilities accounted for about 44 percent of PCCs and generally have contracts for public reimbursement. In 2021, about 35.4 percent of public payments for primary care were directed towards non-government PCCs, with only about 3.8 percent directed towards specialized somatic (i.e. physical) care.

Patients can choose to receive outpatient care funded by the public system at either a government or non-government hospital throughout Sweden. Patients waiting beyond a certain period for a specialist or surgery can receive publicly funded care in a different region. However, almost all hospitals are publicly owned.

The Observatory reports that in 2023 there were 59 regional emergency hospitals, seven publicly owned university hospitals, and only one privately managed hospital that offered emergency care.[15] Using a broader definition, the CWF estimates about 83 hospitals, six of which are non-governmental, while the International Trade Administration estimates there are 100 hospitals in Sweden, of which 15 are non-government.[16] [17] Based on these estimates, non-government hospitals range from two percent to 15 percent of the total stock – with the CWF estimate (used in Table 1) falling somewhere in the middle at seven percent.

c) A national tax-equalization fund redistributes revenues between Swiss states (aka cantons) based on socioeconomic (and other) factors, mirroring (to some extent) the Canada Health Transfer and associated payments.

d) Emergency care, intensive care, childbirth, cosmetic treatments and palliative care are generally not covered.

Regardless of the definition, one notable example of the non-government sector's involvement in the delivery of care is St. Göran Hospital in Stockholm. Although the hospital is owned by the government, St. Göran is managed by Capio – a private, for-profit company – which was recently acquired by Ramsay Santé. The facility provides care to patients in the public system and is "Sweden's largest emergency hospital in number of acute patients" offering care across about 30 specialities. It is consistently the top-ranked emergency hospital in Stockholm in terms of quality and reports the shortest wait time (31 minutes) to see a doctor among emergency hospitals in the region.[18] Remarkably, this high level of quality is achieved at about 15-30 percent lower cost to the public purse compared to publicly managed hospitals.[19] Unsurprisingly, Capio was reappointed to continue to manage the hospital, starting a new term in 2026, due to its success.[20]

There are also a number of private specialized care clinics that treat both publicly funded patients and those covered by non-government insurance. Stockholm is again notable for active efforts to increasingly move "some of the specialised care from public hospitals to private clinics, for example orthopaedics, specialised gynaecologic care, and planned surgery as hip and knee prosthesis surgery and back surgery." [21] Capio manages about 30 non-government specialist clinics in the country that primarily provide outpatient care for select specialities such as ophthalmology, gynaecology, maternity, ENT, and urology.[22] These clinics report some of the shortest wait times for hip and knee replacement in the country.

The method of payment for hospitals varies by region, some of which have switched back-and-forth between global budgets and activity-based funding. Later referred to as the Stockholm Model (the first state it was implemented in), empirical evidence shows the switch to ABF in 1992 was associated with increased inpatient activity, outpatient visits and day surgeries just a year after reform. Interestingly, despite the increase in activity, slightly lower overall costs were recorded at the beginning of the switch due to a reduction in prices paid for services; however, over time, overall costs increase in accordance with activity.[23] Despite this success, hospital funding in 2015 switched back from ABF to global budgets (often supplemented with other forms of payments) in most regions, although Stockholm region switched back to partial ABF payments once again in 2021.[24]

United Kingdom

The health care system in the UK generally falls into the same category as Canada, Australia, and Sweden in that it is primarily a tax-funded system that provides universal health coverage to all residents. However, unlike in Canada, about one in ten residents in the UK has non-government insurance which can offer out-of-hours care, "more rapid access to care, choice of specialists, and better amenities, especially for elective hospital procedures."[25] Patients can also pay directly out-of-pocket to receive care from a non-government facility. Dual practice is permitted which allows physicians to work in both the government and non-government sectors. Full-time specialists were previously only allowed to "earn up to 10% of their NHS pay via private practice" (although the proportions were larger in practice). This cap was subsequently lifted, although physicians are expected to prioritise NHS work.[26]

According to the Commonwealth Fund, there were 206 NHS trusts and foundation trusts that provide health care services. However, it does not have information on the precise number of public hospitals, as each trust may manage several. The Commonwealth Fund reports about 515 non-government hospitals in the UK using data from the Private Health Insurance Network; however, it is unclear if these also include NHS hospitals that treat private patients.[27] By contrast, the OECD reports there were about 2,000 public hospitals in the

UK in 2022, but it provides no data on non-government hospitals.[28] One source that includes comparable data for both public and non-government hospitals using a common definition is available from Interweave (a health care textiles company) which suggests that of the 1,148 identified hospitals in 2023, about 19 percent were private/non-government.[29] e It is worth noting that the majority of MRI scans are performed via private providers.

After seeing a general practitioner (GP), either publicly paid or privately financed, patients in England can choose to receive publicly funded treatment in either an NHS or independent provider. They can also ask for a GP referral for privately funded treatment. A 2012 Act introduced increased competition and choice by establishing clinical commissioning groups (CCGs) and competitive tendering (i.e. contracting private providers). Though some of these requirements for tendering were abandoned in 2022, patient choice for publicly funded care in a public or private hospital remains a legal right.[30] [31]

Non-government hospitals tend to focus on elective care, with an estimated 10% of treatments delivered in their facilities.[32] Of these, about half were NHS patients, while the rest paid privately. Independent service providers conducted "30% of all NHS-funded hip replacements, 27% of inguinal hernia repairs and 20% of cataract procedures" in 2017/18.[33] In 2022, there were 847,000 privately funded admissions, of which 565,000 were paid for with insurance.[34]

According to a study by The Observatory, the UK has had a purchaser-provider split, with activity-based funding (payment by results, or PbR) introduced in the early 2000s and is now the dominant method of remunerating hospitals.[35] Under this system a Healthcare Resource Group [HRG] code is assigned to a specific spell of activity, and hospitals are paid accordingly. The shift to PbR resulted in increases in day surgeries, reduced length of stays, and reductions in the unit cost (or patient resource use).[36] By 2011/12, PbR payments were about "40 per cent of spending on secondary care, and covering around 60 per cent of an average hospital's activity."[37] According to a report by the OECD in 2013, although the UK funded public hospitals through DRG payments, these payments were located within a global budget.[38] In 2020, hospitals began to move to a blended payment system which included "fixed block payment, a quality-based or outcomes-based element, and a "variable" element, which would reflect to what degree waiting lists are reduced for elective care."[39]

Australia

Like Canada, Australia ensures universal insurance coverage through a tax-funded system called Medicare. However, unlike in Canada, this public system is both augmented and integrated with a robust non-government parallel health care sector.

According to data from the OECD presented in Table 1, almost half of all hospitals in Australia (48 percent) are non-government facilities. Public hospitals provide the majority of emergency care while non-government hospitals tend to be smaller and focus primarily on elective (i.e. scheduled) treatment. In 2022/23, 41% of all hospitalizations occurred in a non-government facility. However, more than two-thirds (68%) of elective (i.e. scheduled) admissions involving surgery were performed in non-government hospitals.[40] Though non-government hospitals are primarily focused on the provision of elective/scheduled care, they also provide other treatments including chemotherapy and cardiac care.

e) If one were to combine the OECD data for public hospitals with private hospitals data from the Commonwealth Fund, a similar ratio for private ownership would be estimated.

Australians are able to purchase duplicate, substitute, and complementary insurance from non-government providers – including for core medical services listed on the public Medical Benefits Schedule [MBS]. Patients can use this insurance, or pay out of pocket, to receive care at non-government hospitals. Government incentives encourage citizens to purchase private insurance, but those at a higher income threshold ($194,000 AUD, or just over $172,000 CAD for families in 2024-25) pay a tax surcharge between 1-1.5 percent if they do not hold private health insurance.[41] In other words, if families that can afford to purchase private insurance choose not to, they must pay more in taxes to the government.

A Fraser Institute report conducted an in-depth analysis of hospital funding in 2019/20 and found that public dollars are the source of about one-third of non-government hospital expenses.[42] Updated data for 2022/23 shows that health insurance accounted for about 45 percent of spending on these hospitals, with individual direct payment accounting for another 11 percent. Governments accounted for more than a third (37.2 percent) of spending on non-government hospitals – highlighting the large role they play in the provision of publicly funded services as well.[43]

Patients who are fully funded by government to receive care at non-government hospitals include veterans and patients whose care has been contracted out by the public system. The same Fraser Institute report found that more than two-thirds (73.5 percent) of hospital expenses paid for by Australia's Department of Veteran Affairs occurred in non-government hospitals in 2021/22. Governments and public hospitals also routinely contract care to non-government hospitals through formal arrangements, as well as on an ad-hoc basis. For example, in Queensland, patients who waited longer than the medically recommended timeframe are given the choice to receive publicly funded care at a non-government hospital. Meanwhile, in Victoria, governments simply used a tendering process to allocate funds between public and non-government hospitals between 2013/14 and 2016/17.[44] The same report estimated that public hospitals contracted care for about 150,000 patients in non-government hospitals in 2021/22.[45]

According to a report by the MEI, hospitals in Australia are primarily funded according to activity-based funding as of 2012. ABF is also used for "ER services, acute services, admitted mental health services, sub-acute and non-acute services, and non-admitted services [including] rehabilitation, palliative, geriatric and/or maintenance care." Although global budgets are still used for small rural hospitals and specialized clinics, in 2023-2024 ABF accounted for 87 percent of total hospital spending.[46]

A less discussed aspect of the deep integration between government and private hospitals is the fact that any patient who receives care in a private hospital is subsidized by the public purse. Specifically, the government pays 75 percent of the MBS fee for care received at private hospitals – with patients and private insurance only responsible for the remainder.[47] Clearly, governments in Australia understand the important role private hospitals can play in delivering care to patients while also alleviating the burden on public hospitals.

New Zealand

New Zealand shares some similarities with Australia's health care system in that it ensures universal insurance coverage through a tax-funded system that is augmented and integrated with a parallel non-government health care sector. Government insurance, primarily funded by taxation, covers most health care services for residents, with the notable exception of medical care arising from motor-vehicle accidents, which are covered by the Accident Compensation Corporation [ACC].

About one third of residents have private insurance that can "cover cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations… [and] ensure faster access to nonurgent treatment."[48]

According to data from the OECD presented in Table 1, almost half of all hospitals in New Zealand (48 percent) are non-government facilities. While research by the Commonwealth Fund suggests that these hospitals do not provide emergency and intensive care, data from the Ministry of Health reveals they performed about 66 percent of all elective surgeries in 2022.[49]

Data from the same source also suggests there were 1.5 million publicly funded procedures and 242,600 privately funded procedures in 2018/19.[50] In other words, 15.7 percent of all hospital procedures were paid for privately. However, data also indicates that about 12 percent of publicly funded inpatient surgeries are done in the private sector.[51] Non-government hospitals also performed 90 percent of all surgeries funded by the ACC.[52] It is worth noting that specialists can typically work in both public and private hospitals.

Unfortunately, comparable data on hospital funding type is not available from the OECD. Analysis by the Commonwealth Fund suggest that government hospitals are primarily paid via global budgets. However, this funding is complemented by activity-based funding mechanisms. Specifically, case-mix groups (a type of activity-based funding, or rather, costing) is used to allocate budgets to inpatient services. Some of the budgeted funding is also withheld by the Ministry of Health and only paid when surgeries are delivered. Pay for performance is also incentivized by withholding funding if elective surgery targets remain unmet.[53] Limited information is available on how non-government hospitals are paid beyond being primarily funded using out-of-pocket payments and private insurance. However, one study suggests that government and ACC funded procedures in non-government hospitals are generally performed using a fee-for-service arrangement using a fixed-price contract for joint-replacement procedures.[54]

France

France has a statutory (i.e. mandatory) health insurance system [SHI], historically based on non-competitive employment-based funds. However increased consolidation over the years has resulted in almost 90 percent of the population now covered by the general scheme (which is primarily funded via payroll contributions), a general social contribution (CSG) and general taxation.[f 55]

About 96 percent of the population also holds voluntary health insurance, offered by not-for-profit organizations and private for-profit companies.[56] This insurance is used for covering patient cost-sharing (the difference between fees covered by SHI and the national schedule), extra billing (beyond the national schedule), and extended services not covered by the SHI.

Hospital care is delivered by public and non-government institutions. OECD data indicates that in 2022, 55 percent of hospitals in France were non-government institutions – the majority (59.8 percent) of which operated on a for-profit basis (see Table 1).

According to a study by The Observatory (in conjunction with the WHO), the majority of beds (about 60 percent) are in public hospitals, which tend to provide more complex treatments and deliver about 80% of emergency care.[57] Meanwhile, the majority of elective (i.e.

f) An additional 5 percent of the population is covered by the agricultural fund, with the remaining covered by over 20 special employment-based schemes

scheduled) surgeries are provided in non-government hospitals. In 2019, non-government facilities operating on a for-profit basis accounted for about 40 percent of all hospitalizations (not requiring an overnight stay).

The same report suggests that all hospitals since 2005 are primarily paid for inpatient care based on the number and complexity of care delivered – a system called Activity-Based Payment (ABP).[g] Patients can choose to be treated in a public or non-government hospital, with payments from the SHI general plan following them to the hospitals where they receive care. However, because non-government hospitals usually charge fees in excess of the national schedule, patients are usually responsible for paying a larger fee out of pocket or through voluntary insurance.

Germany

Universal health care in Germany is achieved through a multi-payer system in which residents must purchase insurance in a regulated market. The German system is somewhat unique in that the multiplayer-market is split into two subcomponents: a statutory health insurance scheme (SHI), and a private health insurance scheme (PHI). According to a study by The Observatory, 87 percent of the population is covered by SHI, which is provided by 105 competing not-for-profit quasi-public corporations known as Sickness Funds.[58] A basket of core benefits must be provided by all insurers, and standard income-based SHI contributions are set at the federal level, with insurers unable to refuse coverage.[h] Patients can freely choose their insurer. Self-employed individuals, civil servants, and those with a gross income above a certain threshold (above €73,800 in 2025), can opt out of SHI for PHI, which is offered by 42 insurance companies, covering about 11 percent of the population (they cannot opt back in).[59] PHI premiums are based on age and medical risk at underwriting, offering shorter wait times and private hospital rooms. Both SHI and PHI can include supplementary private coverage.

Regardless of insurer, patients have free choice of physician (who can engage in dual practice and provide care in both systems) and hospital. In 2022, data from the OECD suggest that about 75 percent of hospitals in Germany were non-government institutions, the majority of which operate on a for-profit basis (see Table 1).[60] However, for-profit hospitals tend to be smaller and only account for about one-sixth of beds in Germany[61].

Hospitals are primarily funded for inpatient care based on activity (i.e. ABF), and patients with SHI or PHI can receive care in 99 percent of these hospitals, with only about 1 percent exclusively available to those with PHI.[62] Capital costs are paid for by states, while SHI and PHI fund the operating costs of hospitals. Prices were determined regionally but were mandated to converge (allowing for minor variation) between 2010-2014[63]. ABF was primarily used in Germany as a pricing tool, not as a means to control expenditure; however, lower DRG payments may be made after a certain volume of cases are performed, and hospitals do not receive payments for readmissions within 30 days. In other words, hospitals in Germany still negotiate contracts with "Sickness Funds" (i.e. insurers) for a certain volume of procedures and are paid lower rates per procedure for volumes in excess of that number. That being said, this is more for ensuring minimum volumes with contract negotiations often proceeding through the year and no hard cap on the total volume of procedures delivered.[64] Furthermore, hospitals are incentivized to provide quality treatment because they do not receive additional funds for patients who are readmitted for the same condition within 30 days.[65]

g) Public hospitals (and some private hospitals) may receive additional payments for research and education, and emergency departments are guaranteed a fixed minimum grant per year.

h) Contributions are redistributed among insurers based on a risk-equalization scheme. Separate contributions are not required to cover children and unemployed spouses.

Switzerland

Switzerland has a statutory health insurance system (SHI) in which residents must purchase a basic benefit package from non-government insurers in a competitive, albeit regulated, market. However, insurers cannot legally operate on a for-profit basis for the standard insurance package (which is determined by government). The 56 insurers offering the standard package can set premiums, although they must accept all applicants and can vary premiums based three age groups and the area of residence.[66] For example, all adults 26 and over in a particular state (locally referred to as a canton) must be charged the same premium by a particular insurer; however, the insurer is free to set what that rate is.[i] Residents can choose to purchase supplementary insurance for private rooms and treatments not covered by the standard plan; however, insurers can deny coverage, adjust premiums based on pre-existing factors, and earn profits on this portion of their insurance product.[67]

There is mixed ownership of hospitals in Switzerland. Although the OECD states that "[d]ifferentiation according to ownership and profit is not relevant in Swiss health system", it is possible to attribute ownership according to legal form.[68] According to the Office fédéral de la santé publique there were 275 hospitals in Switzerland in 2023 (see Table 1).[69] Of these, 41 were public enterprises (about 15 percent of the total), accounting for 39 percent of hospitalizations. The rest (about 85 percent of hospitals) were private (or privately managed), three quarters of which were registered as "SA/Sàrl" or "Sole proprietorship/company".

Part of the reason for the blurred line between public and private ownership is that all hospitals in Switzerland receive about half of their funding for inpatient care from the cantonal government.[70] The remainder is primarily funded by SHI (and, to a lesser extent, by copayments), with money following the patient according to activity. Switzerland has employed payments since 2012, and rates are negotiated between hospital associations and insurers, but they must be approved by the state which is guided by a national Price Supervisor.[71] [72] On occasion, states also provide public funding to privately managed hospitals for capital investments, specialized care (such as the Zurich Children's hospital), and/or operating deficit financing.[73]

The Netherlands

In 2006, the Dutch introduced significant reforms to establish a universal health insurance system in which multiple insurers compete in a regulated market. Residents are legally required to purchase statutory (i.e. mandatory) health insurance [SHI] from about 10 non-government companies that are able to earn profits but primarily operate on a not-for-profit basis.[j] [74] [75] Achema, a major insurer, notably operates on a for-profit basis.[76] While insurance companies are free to set the rate of premium,[k] these cannot vary based on age or pre-existing conditions, and insurers cannot deny coverage for the standard package.[77] Insurers can, however, vary premiums and deny coverage for supplementary insurance. Residents must generally pay a €385 deductible (about $600 CAD) before insurance kicks in[78].

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i) Like the Netherlands, Switzerland operates a risk-equalization pool among insurers.

j) Although the law initially opened the door towards private for-profit insurers paying dividends to shareholders after 10 years, a bill to deny this option was passed in the lower house in 2017. Patrick Jeurissen and Hans Maarse, *The Market Reform in Dutch Health Care: Results, Lessons and Prospects*, European Observatory Health Policy Series (European Observatory on Health Systems and Policies, 2021) <http://www.ncbi.nlm.nih.gov/books/NBK577820/> [accessed 18 May 2025]. A public insurer (Wlz) is available for long-term care but also provides coverage for those with several disabilities and mental illness.

k) Income-related contributions and other taxes are also major sources of SHI funding.

All major hospitals in the Netherlands are non-government institutions that operate on a not-for-profit basis and are required to reinvest profits. Specifically, hospitals providing inpatient care on a for-profit basis (i.e. distribute profits to shareholders) cannot accept reimbursement from SHI (although the Red Cross hospital is also a notable investor-owned hospital). That being said, these non-government hospitals negotiate prices with insurers and compete for funds which are allocated according to activity (via DRG payments). According to a Commonwealth Fund study, there were 71 major hospitals in 2018, all of which were non-government organizations operating on a not-for-profit basis.[79]

The Netherlands does, however, have a vast network of private independent treatment centres (ZBCs in Dutch or ITCs in English). These clinics can offer elective/scheduled surgery including ophthalmology, orthopaedics, and cardiology treatments on an outpatient basis, and they can operate on a for-profit basis.[80] These clinics often have shorter wait times and offer treatment that is reimbursable (if part of an SHI network) as well as treatments not covered by the basic insurance plan.[81] Estimates suggest that "94% [of clinics] provide insured care in more than 20 different specialties."[82] The number of ITCs in the Netherlands grew rapidly by 87% between 2009 to 2016.[83] In 2022, there were at least 136 ZBC organizations providing care at over 400 locations. About 17.4 percent of medical specialist care was provided in an ITC in 2021.[84]

Though ITCs are clearly different in operation and scope of services provided, the *Health Care Institutions Admission Act* of 2005 formally defines ITCs and Hospitals as medical specialist care providers – somewhat blurring the distinction between the two.[85]

Together, the OECD estimates there are 733 hospital locations (including ZBCs) in the Netherlands, more than 80 percent of which operate on a for-profit basis (see Table 1). Regardless of the definition of hospital used, 100 percent of the hospitals in the Netherlands are non-government facilities.

Non-Government Hospitals & Facilities: Canada

British Columbia

There are an estimated 45 private clinics in B.C.[86] While not formally part of the public health care framework, many of them are contracted to deliver publicly funded care on a routine basis. The Campbell government (2001-11) introduced significant changes to health care delivery in B.C. Specifically, since 2002, health authorities were granted freedom to contract outpatient clinics services from private diagnostic and medical/surgical clinics. These include ophthalmic, urological, orthopaedic, otolaryngological, and general procedures (among others). Another notable example of how non-government clinics can play a part within a publicly funded universal healthcare framework is illustrated by Rebalance MD, which provides consultations with an orthopaedic group of surgeons for hip, knee, and other musculoskeletal surgeries funded by government (patients receive treatment at Royal Jubilee or Victoria General Hospital.)[87] Their innovative approach to group practice led to a reduction wait time for consultations from 9-18 months in 2013 to about 8 weeks in 2024 for patients referred to their clinic.[88] Publicly funded care at private clinics were also an instrumental part of B.C.'s plan to tackle the post-COVID surgical backlog.[89]

In 2021/22 approximately 5% (16,777) of day surgeries were performed across eight private facilities in B.C., in compliance with the *Canada Health Act*. In addition, WorkSafe BC pays for expedited care in both public and private settings. In the same year, it paid for 2,246 procedures at 17 private for-profit providers in

the province.[90] Research suggests that the expedited surgery program reduced wait times by two weeks in public and private hospitals; however, those who received expedited care in a public hospital had the shortest duration of disability.[91]

Alberta

Alberta has had accredited non-hospital surgical facilities to perform minor day surgeries since at least the mid-nineties.[92] However, it was the introduction of legislation about a decade later (beginning with Bill 11) that formally allowed contracting certain publicly funded surgeries to private clinics while simultaneously prohibiting full-fledged private hospitals and payments for queue-jumping.[93] These contracts slowly expanded over time, and by 2018-2019, about 15 percent of publicly funded surgeries were contracted to private clinics.[94]

The Kenney government (2019-22) introduced Bill 30 to streamline the approval of private clinics (now called Chartered Health Facilities) and (as part of the Alberta Surgical Initiative) expand their ability to receive public funding, with a stated aim to increase their involvement "from 15 to 30 percent of all procedures by 2023" – a goal yet to be achieved (likely due to the global pandemic).[l] [95] [96]

The Smith government has generally committed to the same vision, and 62,410 (just over 20 percent) publicly funded surgeries were contracted to about over 40 private clinics in 2024. These surgeries included ophthalmology, orthopedic, and otolaryngology (among others).[97]

Saskatchewan

Perhaps the most successful example of publicly funded care delivered by third-party private clinics is illustrated by the Saskatchewan Surgical Initiative [SSI], which has been examined in depth by various organizations including SecondStreet.org, the Fraser Institute, and the Macdonald Laurier Institute.[98] [99] [100]

Faced with growing wait times, the Wall government (2007-2018) commissioned a ground-breaking report in 2008, commonly referred to as the *Patient First* report, which embedded the concept of prioritizing the patient as "as a core value in health care". Key recommendations included empowering patients with information and treatment options, streamlining health care, expanding home care, and "[e]xpanding surgical and diagnostic capacity with the assistance of independent partners who meet quality and safety standards".[101]

The governing framework for Non-Hospital Treatment Facilities, the Health Facilities Licensing Act, was introduced under the Romanow government in 1996. However, this legislation also severely limited what these facilities could actually do. As a result, there was little to no activity under these arrangements until the launch of the four-year SSI in 2010.[102] This initiative was based around a "patient first" philosophy and sought to ensure that no patient would wait longer than three months for surgery by 2014. In addition to the implementation of the "LEAN" management system and centralized pooling of patient referrals, the province sought to actively partner with private facilities to deliver publicly funded care.

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l) For an in-depth analysis of health care reform in Alberta, see the 2019 Fraser Institute study 'Health Care Reform Options for Alberta' by Barua, Clemens, and Jackson.

According to a 2015 government review of the SSI, treatments in third-party clinics included cataracts, ACL repair, and select gynecology and otolaryngology procedures (among others). The province used competitive tendering to award contracts and required costs to be the same, or less, than in public facilities.[103] Procedures requiring an overnight stay are not permitted in these facilities.

A small number of contracts for publicly funded arthroscopic shoulder and knee procedures were awarded to Omni Surgery Centre and Saskatoon Surgicentre in 2010.[104] However, contracting picked up significantly in 2012 with the addition of Prairieview Surgical and Surgical Centres Inc. The number of publicly funded surgeries increased from effectively non-existent before 2010, to 15 percent by 2015.[105] During the same time, the number of patients waiting more than three months for surgery decreased by 75%.[n] By March 2015, the number of patients waiting more than 18 months was down 100%, with an estimated more than 35,000 surgeries cumulatively delivered by these clinics since 2010.[106] The Fraser Institute estimated a 26 percent cost savings per procedure during the SSI,[107] and SecondStreet.org revealed that the SSI cost about $235 million to implement. SecondStreet.org also provided more recent data indicating per-procedure cost savings achieved by independent clinics were around 35 percent for plastic and general surgery, and as high as 45 percent for orthopaedic procedures.[108]

Ontario

Ontario has a large network of independent health facilities that provide publicly funded treatments. Now called Integrated Community Health Services Centres [ICHSC] or Independent Health Facilities [IHF], these facilities are privately owned, primarily operate on a for-profit basis, and mostly provide diagnostic imaging services. In 2010/11, there were about 25 independent facilities that also provided surgery (e.g. cataract and plastic surgery).[109] However, recent legislation by the Government of Ontario has led to an expanded scope of services that can be performed at these clinics, including hip and knee replacement[110]. In 2021, just under 19,000 publicly funded surgeries were performed at these facilities, in addition to almost 10.6 million diagnostic scans. The majority of these clinics are paid on a fee-for-service basis negotiated between the OMA and Ministry. In addition, two private hospitals are also contracted to deliver publicly funded care, estimated at about $13 million in 2021/22.[111]

A number of reports has examined differences in costs and quality between publicly funded IHFs and public hospitals. For example, a report by the Auditor General of Ontario found that "that certain services—such as MRIs, dialysis and colonoscopies—were about 20% to 40% less expensive if delivered in community clinics, including independent health facilities, rather than in hospitals"[112]. A more recent study compared complications following cataract surgery in IHFs and public hospitals and found that although "[c]omplication rates at both sites were similar and within expected range" there were significantly higher perioperative complications at the hospital in comparison to the IHF.[113] Although some of this difference may arise from public hospitals dealing with more complex cases, it suggests that IHFs can play a positive role in delivering safe high-quality treatment to patients. Another study documented the positive role of a particular IHF in providing safe and timely endoscopies that meet or exceed quality standards for patients suspected to have underlying colorectal cancer.[114] Overall, these studies suggest that IHFs provide the same (and potentially better) quality of care at lower cost per-procedure to the public purse.

n) While some studies, such as 'Failing to Deliver' by Andrew Longhurst (2023) have claimed that the reduction in wait times was driven by increases in OR spending, others such as Nadeem Esmail et al., '10 Years On—Revisiting the Saskatchewan Surgical Initiative,' demonstrate that the years preceding the SSI had significantly greater increases in OR spending without positive impact on wait times.

Quebec

Following the Chaoulli decision of 2005, Quebec introduced legislation to allow private clinics called Specialized Medical Centres (SMCs) to formally operate in the provinces. These clinics must be owned primarily by Quebec physicians who can choose to either participate and accept reimbursement or opt out of the public health insurance plan (but not both).

The role of SMCs in Quebec's public health care framework has been studied extensively by the Fraser Institute and MEI (among others).[115] [116] [117] These reports suggest that, by 2023, there were an estimated 73 SMCs in Quebec, about two thirds of which accept reimbursement from the public insurer. Hospitals in Quebec also directly contract SMCs in order to reduce wait times. The Fraser Institute report reveals this is done through either lump sum payments for a certain number of procedures or through a "cost-plus model" (which ensures a pre-defined profit margin. The latter was set at about 10% during a series of pilot projects between 2016-2019 and did not necessarily incentivize hospitals clinics to innovate in order to actually earn the profit. Both organizations cite studies suggesting that SMCs can increase productivity by 20-40 percent compared to public hospitals in the province. The Fraser Institute reports that by 2022-23, more than 17 percent of publicly funded day surgeries were performed in private SMCs, playing a key role in tackling the post-pandemic surgical backlog in the province, and the MEI reported that there were 28 agreements between participating SMCs and hospitals. Given the successful partnerships with SMCs for day surgeries, the Quebec government engaged in additional limited partnerships for surgeries requiring up to three days of hospitalization.

The Potential Pitfalls of Contracted Private Partnerships

In Canada, contracts for private clinics generally have to be negotiated and renewed routinely, with the number of procedures performed determined by government. This makes the decision of where and how many patients are treated a political (rather than medical) one and has led to allegations of inflated remuneration and preferential deals with select clinics.

Recent examples include accusations of inflated rates of reimbursement and minimum stay guarantees to Alberta Medical Group [ASG], leading to an investigation by the auditor general. In Ontario, Don Mills Surgical Unit Ltd. (owned by Clearpoint) was accused of receiving "egregious" overpayment for surgeries compared to public hospitals.[118] Critics have also raised concerns that Ontario's former health minister is registered as a lobbyist for the company. Even in Saskatchewan, where clinics during the SSI were awarded contracts during a competitive tendering process and were required to charge the same or lower rates compared to the public system, Surgical Centres Inc. (a division of Clearpoint Health Network) was revealed to charge $2,000 per mammography in 2023, significantly higher than fees listed fees by other private companies.[119] Subsequent questions were also raised when it was revealed that a contract signed between the Government of Saskatchewan and a private surgical centre based in Alberta may have been influenced by lobbying activity. Again, a former finance minister was previously registered as a lobbyist for the clinic in question.[120]

To be fair, it is remarkably difficult to ascertain the true prices of publicly funded services in Canada. The majority of public hospitals in Canada are funded by an opaque and outdated method of remuneration – global budgets.[121] Under this approach, hospitals are given a budget based on historical trends. The benefit of this method of funding is that it is easy to

administer and control total costs. However, over time, it becomes increasingly difficult to determine prices for treatment, as there is no market competition. As a result, reimbursement for treatments have to sometimes be determined by means other than market forces. A well-known example is the fee for cataract surgery in B.C., which was the subject of a B.C. Supreme Court case in 2018.[122] Specifically, the rate of reimbursement for cataract surgery is determined by the Ministry of Health (not the market), which decided to reduce rates in opposition to recommendations from B.C. Society for Eye Physicians and Surgeons (BCSEPS). Another example of difficulties in understanding hospital operating costs is the Windsor Regional Hospital, which owns and operates two Tim Hortons franchises which have cumulatively lost $3 million dollars since 2010-11.[123] When disclosing the annual losses for these facilities, the hospital conceded that it did not factor in the cost of rent, utility charges and other overhead expenses – costs that private Tim Hortons franchises do obviously incur. Thus, the hospital's estimates were underreported.

In fact, Saskatchewan had to develop a procedural costing framework specifically for the SSI in order to try and determine comparative prices in the public system to contrast with those for contracted procedures.[124] However, even once this framework was in place, governments still determine the number of procedures that would be performed in these clinics as part of the contract and thereby continue to provide fodder for politically motivated decision-making.

Regardless of whether the various allegations alluded to in this section turn out to be true or not, they have cast a shadow on the critical role third party providers have performed by treating thousands of patients and alleviating the burden on the public system. One way to depoliticize the appropriate level and remuneration of non-government clinics is to simply fund them, along with government facilities, according to activity. This way, all facilities receive the same flat amount for each service provided (according to type and complexity), making the playing field both even and transparent.

Taking the Politics out of Payments: Activity-Based Funding

Global budgets do not incentivize treatment. In fact, every patient walking through the door is seen as a cost, eating into the pre-defined budget. Basically, hospital funding does not dynamically respond to changes in patient load and complexity in real-time. Furthermore, and as mentioned previously, contracts between government officials and private clinics that set the number of surgeries and rate of reimbursement are susceptible to exactly the sort of lobbying we're seeing today.

One way to take the politics out of payment is to switch to activity-based funding. This is a recommendation that has been studied extensively by the MEI, the Fraser Institute, C.D. Howe, and in previous independent research undertaken by the author of this report.[125] [126] [127] [128] [129] [130]

This approach is followed by the majority of universal health care systems in developed countries around the world. As previously noted, activity-based funding models see health providers receive funding – based on a fee schedule – each time they help a patient. For example, a hospital might receive, say, $15,000 each time it provides a knee operation, or $25,000 if it provides a hip operation (which could be further adjusted based on complexity and the patient's condition). This incentivizes the facility to want to help more patients.

While correlation is not causation, updated data from the OECD reveal that the three universal health care countries with the shortest wait times for elective surgery in 2023 all primarily rely on ABF for funding hospitals (see Table 2). By contrast, the three worst performers (including Canada) rely to a greater degree on global budgets.

Table 2

Wait Times for Elective Surgery vs. Hospital Funding

Countries	Waited More Than 2 Months	Government	Non-Government (NFP)	Non-Government (FP)
Netherlands	20%		Payment per case (DRG-like)*	
Germany	20%	Payment per case (DRG-like)	Payment per case (DRG-like)	Payment per case (DRG-like)
Switzerland	21%	Payment per case (DRG-like)	Payment per case (DRG-like)	Payment per case (DRG-like)
France	32%	Payment per case (DRG-like)	Payment per case (DRG-like)	Payment per case (DRG-like)
Australia	33%	Payment per case (DRG-like)	Payment based on procedure or service	Payment based on procedure or service
Sweden	45%	Prospective global budget (except Stockholm)		Prospective global budget (except Stockholm)
United Kingdom	49%	Payment per case (DRG-like)	Payment based on procedure or service	Retrospective payments of all costs
Canada	58%	Prospective global budget	Prospective global budget	Prospective global budget

Sources: *Blumenthal et al. 2024; OECD, 2023; OECD, 2024; author's interpretation.*

Of course, this is a simplified representation of hospital funding. As mentioned earlier, Sweden has oscillated between payment systems for its hospitals. Meanwhile, countries including Australia, France, the Netherlands, and the United Kingdom use ABF/DRG-like payments for public hospitals, but with these payments located within an overall global budget – somewhat limiting effectiveness at increasing volumes in response to demand for care. By contrast, countries including Germany and Switzerland do not generally employ these global budgeting constraints.[131] However, some price reductions were introduced in Germany in 2017 due to recent increases in health spending.[132]

Not only is ABF widely used in a number of these countries, but empirical evidence also suggests that ABF is linked to increased activity and efficiency, as well as lower wait times – especially when coupled with increased capacity, choice and competition, as well as an absence of overall spending caps.[133]

Basically, all hospitals – government or non-government – should simply be paid a set rate per procedure (adjusted for complexity, of course). This would immediately depoliticize the entire public vs. private debate, ensure comparable reimbursement, and possibly even improve efficiency. Most importantly, it would help expand the supply of health care and put patients' interests front and centre.

There has already been some movement in this direction in Canada.

British Columbia launched a pilot program that replaced up to 20% of hospital global budgets between 2010-2013 across 23 hospitals. Meanwhile, Ontario uses Quality Based Procedures [QBP] for 15%, and Health Based Allocation Method [HBAM] for 40% of hospital reimbursement.[134] Perhaps as a result of the limitations of each application, results in both provinces have been mixed. After the pilot project in B.C., one report found that "…inpatient surgical activity trended slightly higher,

though volume of medical cases fell and day surgery activity was unaffected".[135] A more recent study explored the impact of QBPs in Ontario and found "mixed and generally very small effects on quality of care, access to care, and coding behaviour".[136] However, the authors note that this may be a result of "challenges with implementing the best practice pathways featured in the QBP handbooks, together with progressive controls on hospital expenditures, and a worsening overall fiscal picture in Ontario coincident with QBP implementation".[137]

More encouraging results were observed in Quebec, which began implementing ABF in 2004 for procedures exceeding historical volumes in order to tackle wait times, and used ABF more widely beginning in 2015. A report by MEI found that the application of ABF for select specialties resulted in success. This includes a 22 percent increase in MRI procedures despite a four percent reduction in unit cost, and a 26 percent increase in productivity in the radiation oncology sector accompanied by a 7 percent reduction in cost per procedure. The same report estimates that about 25% of hospital care was funded by ABF in 2023, with the goal of shifting fully by 2027/2028.[138] More recently, Alberta has pledged to launch a pilot program to implement ABF (referred to as patient-focused funding) in 2025/26.[138]

Importantly, Canada already has its own version of DRGs called case-mix grouping [CMG+], which could serve as the backbone for any province interested in implementing activity-based funding for hospitals.[139] Simply put, we have the mechanisms in place – we just need the political will to modernize the way our hospitals are paid in order to depoliticize care decisions and put patients first.

Discussion and Conclusion

Canada's health care system is in desperate need of meaningful reform. The examples of other universal health care systems around the world reveal that many of the countries with the shortest wait times for elective surgery incorporate non-government hospitals and facilities within their universal health care framework to deliver insured services (including publicly funded facilities, where applicable). In addition, countries such as the Netherlands, Switzerland, Germany, and France primarily fund hospitals according to activity – in contrast to Canada's outdated global budgeting system.

Importantly, the ability to implement these reforms in Canada – publicly funded care delivered by non-government providers, and activity-based funding for hospitals – are not explicitly prohibited by the Canada Health Act according to research by MLI and the Fraser Institute.

Shifting towards a more modern method of hospital payment like ABF not only has the potential to improve efficiency and volumes (and potentially lower wait times), but it also depoliticizes the choice of where treatment is provided – making it a medical, rather than political, decision. Such a shift ensures a transparent and level playing field between government and non-government health providers. It is also more aligned with a patient-first philosophy, ensuring funding follows patients to the public or private facilities where they receive treatment.

About the Author

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Bacchus specializes in health care policy, and has helped shape public discourse in the field through frequent commentary on radio and television – including appearances on CBC, Global News, CTV, BNN and articles featured in the Wall Street Journal, National Post, Globe and Mail, Maclean's, and Forbes. He was also invited to provide testimony as part of a panel of witnesses for the House of Commons Standing Committee on Health (HESA) in 2022.

As the former Director of Health Policy studies at the Fraser Institute, Bacchus conducted research on a range of key health care topics including wait times, hospital performance, access to new pharmaceuticals, the sustainability of health-care spending, the impact of aging on health-care expenditures, and international comparisons of health care systems. He currently also serves as an affiliate scholar with the Canadian Health Policy Institute [CHPI].

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