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INTERNATIONAL HEALTH PERSPECTIVES: COMPARING PRIMARY CARE IN CANADA, GERMANY, AND THE NETHERLANDS

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·
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HIGHLIGHTS

A well-functioning healthcare system is one that is available when called upon, that is responsive to patients' needs, and that improves the health of individuals. Yet, Canada's primary healthcare system is not living up to its potential. In 2023, 14% of Canadian adults did not have regular access to a primary care provider or place to get care, compared with only 1% of the Dutch and 4% of the German population. For Canadians who did have access, almost 3/4 were unable to secure a timely appointment. To increase access to primary care, it is imperative to learn from better-performing systems such as those of Germany and the Netherlands.

Chapter 1 – The Importance of a Well-Functioning Primary Care System

- Primary care is a critical piece of the overall healthcare "puzzle," and evidence confirms that accessible primary care can help us live longer and avoid disability and disease.
- In addition, since primary care serves as a substitute for other forms of health care and is comparatively less expensive, timely access to it can also contribute to lower overall health system costs.
- 46% of Canadians with access to a primary care provider or place to get care waited six days or more for an appointment, compared with only 26% of German patients and 13% of Dutch patients.
- The lack of access does not appear to be an issue of funding: Canadian spending on primary care is comparable to spending by Germany and the Netherlands, albeit with sub-optimal results.
- In the absence of timely access to primary care, patients often end up in emergency rooms, with 30% of all ER visits across Canada between April 2022 and March 2023 being for nonurgent or less urgent issues.
- Not only do these unnecessary ER visits add to health system costs, but they also contribute to lengthening wait times in the ER, leaving patients languishing and leading to additional complications.
- Besides delays in accessing care, long wait times can result in patients leaving the ER without being seen at all. In Quebec in 2022-2023, 11.5% of the patients who visited an ER left without being treated, over 1/4 of whom were categorized as urgent.

Chapter 2 – The Key System Differences That Allow for Increased Access to Primary Care in Germany and the Netherlands

- The German and Dutch systems allow for more patient and provider choice, more system flexibility, and more competition, all of which have the result of increasing access to primary care in comparison with Canada's system.
- What defines the Canadian system is that insured patients and health professionals alike face a public single-payer, without any choice in insurer or plan, for medically necessary care.
- This contrasts sharply with the situation in Germany and the Netherlands, where there are plenty of insurers to choose from, encouraging the improvement of service quality as well as expanded benefits to attract and retain customers.
- The ability to choose among (and change) insurers ensures that patients are active participants in their healthcare decisions, something that has been shown to increase patient satisfaction.
- Though the objective of a strict gatekeeping system like Canada's is to reduce expenditures, what it achieves is to shift the cost onto patients by increasing the physical, psychological, and social tolls of waiting to receive specialist care.
- The healthcare systems in Germany and the Netherlands allow patients greater choice in how they access specialist care, which has a direct positive effect on their access to primary care.

- Canada's strong discouragement of mixed practice is an exception among highly developed countries. Among other high-income countries with universal healthcare systems, such as Germany and the Netherlands, such regulation is virtually nonexistent.
- Mixed practice is important, as it allows greater flexibility for primary care professionals and improved access for patients.

Chapter 3 – Public Policy Recommendations to Improve Access to Primary Care for Canadians

These reforms to increase Canadians' access to primary care, while ambitious, relate to the administration and delivery of healthcare services and are wholly within provincial jurisdiction to implement.

- **Recommendation 1 – Allow Duplicate Private Insurance.** Allowing duplicate private insurance in Canada would infuse a level of competition and patient choice that is currently non-existent.
- **Recommendation 2 – Remove the Gatekeeper for Specialist Care.** Canadian provinces should relax their gatekeeping requirements and allow patients to consult with specialists directly.
- **Recommendation 3 – Allow Mixed Practice for Healthcare Workers.** Allowing healthcare workers to divide their time between the public sector and the independent sector would make more efficient use of limited resources.

Germany and the Netherlands have been able to maintain universal healthcare coverage and primary care access while addressing common challenges seen in the Canadian system such as wait times and resource allocation. Our proposed changes would expand patient choice, increase health provider flexibility, and allow for improved overall access to primary care services for Canadians. As wait times continue to grow and access problems persist, it is imperative that provincial governments take steps toward implementing meaningful healthcare reform, for the sake of all Canadians.

INTRODUCTION

A well-functioning healthcare system is one that is available when called upon, that is responsive to patients' needs, and that improves the health of individuals. Fundamental to these goals is *primary care*, a collection of services offered by a range of providers that often serves as the first line of healthcare defense, a patient's first point of contact with the healthcare system.

Primary care is commonly provided in outpatient settings such as community clinics, and primary care or private practice clinics. It typically consists of prevention, diagnosis, treatment, and management of a wide range of conditions and illnesses, as well as health promotion.

Primary care providers frequently coordinate care and refer their patients to specialists when necessary. While some patients may seek primary care services outside of an outpatient or clinic setting, such as in an emergency room, especially if they lack access to a regular primary care provider, this type of hospital care is not considered primary care for the purposes of our analysis, even if it does provide the first line of care. This is because ERs are intended for acute, urgent, or emergency situations, and are not designed for the provision of primary care; while the ER *can* provide immediate care for non-emergency conditions, this is not its intended purpose.

There is nearly universal agreement on the importance of primary health care and its potential to offer significant benefits, both to Canadians and to the larger healthcare system that serves them.[1] Despite this recognition, Canada's primary healthcare system is not living up to its potential. In 2023, 14% of Canadian adults did not have regular access to a primary care provider or place to get care.[2] For those who did have access, almost three quarters were unable to secure a timely appointment.[3]

This compares unfavourably with other high-performing universal healthcare systems in countries like Germany or the Netherlands, whose patients have greater access to primary care. In fact, only 4% of Germans and 1% of the Dutch were without regular access to a primary care provider or place to get care—a fraction of the proportion of Canada.[4] In terms of timeliness, 51% of German patients and 54% of Dutch patients were able to get a same- or next-day appointment, double the proportion of Canadians.[5]

In 2023, 14% of Canadian adults did not have regular access to a primary care provider or place to get care.

To increase access to primary care, it is imperative to learn from better-performing systems such as those of the Germans and Dutch. Doing so will empower Canadian policymakers to guide improvements in healthcare policies so as to better meet population health needs, as well as enable them to design systems that improve primary care delivery.

This research paper explores primary care and the differences in such systems across these three countries. Chapter 1 will explain the importance of primary care and outline the performance differences between Canada, Germany, and the Netherlands. Ultimately, Canada's underper-

1. Roy J. Romanow, "Building on Values: The Future of Health Care in Canada," *Commission on the Future of Health Care in Canada,* November 2002, p. 115.

2. This is often referred to as the attachment rate. Canadian Institute for Health Information, "How Canada Compares: Results From The Commonwealth Fund's 2023 International Health Policy Survey of the General Population Age 18+ in 10 Countries — Data Tables," Question 11, 2024. The 86% of Canadians with access includes the 13% of Canadians who report having a regular place for care and the 73% who report having a regular doctor/general practitioner/nurse practitioner/physician assistant. More recent data exists but is incomplete for all provinces.

3. Timely here refers to a same-day or next-day appointment, and only 26% were able to obtain this. This number excludes respondents who did not need to make an appointment to see a doctor or nurse, who were never able to make an appointment or who visited a hospital emergency department, urgent care clinic or facility instead of making an appointment. Canadian Institute for Health Information, "How Canada Compares: Results From The Commonwealth Fund's 2023 International Health Policy Survey of the General Population Age 18+ in 10 Countries — Data Tables," Question 9, 2024.

4. The 96% of Germans who report having access includes the 8% who report having a regular place for care and the 88% who report having a regular doctor/general practitioner/nurse practitioner/physician assistant. For the 99% of the Dutch, these numbers are 12% and 87%, respectively. Canadian Institute for Health Information, *op. cit.,* footnote 2.

5. This proportion excludes respondents who did not need to make an appointment to see a doctor or nurse, who were never able to make an appointment or who visited a hospital emergency department, urgent care clinic or facility instead of making an appointment. Canadian Institute for Health Information, *op. cit.,* footnote 3.

forming primary care system has a ripple effect which can be seen in every corner of the health-care system as a whole. This comparison forms the foundation of our assessment and, in turn, of our case for change.

It is imperative to learn from better-performing systems so as to better meet population health needs.

Chapter 2 will outline three key differences between the models in these three countries in terms of their ability to impact a patient's access to primary care. These include the way the system (and by extension, primary care) is funded, how patients are able to access specialist care (gate-keeping by primary care providers), and whether, or to what extent, healthcare workers are allowed to operate in both public and independent sectors simultaneously (permitting mixed or dual practice). These differences impact patient choice, provider choice, and freedom, and put varying levels of pressure on primary care. Despite their variations, Canada, Germany, and the Netherlands all aim to provide universal access to primary care, regardless of a patient's income.

Chapter 3 will present practical recommendations that can be applied to Canadian health care in order to increase access to primary care. Not only are our pragmatic recommendations likely to increase access to primary care for Canadians, but they have the potential to reduce disability and disease, and to lower health system expenditures as well.

CHAPTER 1

The Importance of a Well-Functioning Primary Care System

Primary care is a critical piece of the overall healthcare "puzzle" and an important part of the healthcare systems of all industrial nations. According to the World Health Organization, there are five core features of well-functioning primary care systems (see Figure 1-1). Implicit to the "first contact" feature is that a patient should have access to it in a timely manner to receive a diagnosis and expedite the provision of therapies and treatments that will improve their quality of life.

Indeed, a well-functioning primary healthcare system requires that a patient first be able to access it. Greater access to care has been linked with a higher number of primary care doctors, among other things.[6] The data show associations between a greater number of primary care doctors and a range of better health outcomes including lower rates of infant mortality, of all-cause mortality and, more specifically, of death from heart disease, cancer, and stroke.[7] Yet, other factors affect access to primary care, as we shall see.

Evidence confirms that accessible primary care can help us live longer and avoid disability and disease.[8] For example, chronic obstructive pulmonary disease (COPD) can be successfully managed on an outpatient basis, yet approximately 70% of Canadians with COPD have not received a diagnosis and experience worse long-term health outcomes resulting from these diagnostic delays.[9] COPD is the third leading cause of death worldwide and affects nearly one in five Canadians between the ages of 35 and 79 years.[10]

Accessible primary care can help us live longer and avoid disability and disease.

In addition, since primary care serves as a substitute for other forms of health care and is comparatively less expensive, timely access to it can also contribute to lower overall health system costs.[11] A lack of primary care, then, can lead to more complex and costly courses of treatment due to the greater need for specialty care and hospitalizations. Research shows that access to primary care can reduce overall costs through decreased usage of healthcare resources, notably a decline in non-urgent emergency room visits, lower hospitalization rates, and decreased hospital costs and healthcare system expenditures.[12]

Moreover, effective primary care also serves to facilitate early disease detection and intervention, which is more cost-effective than no detection at

6. Barbara Starfield, Leiyu Shi, and James Macinko, "Contributions of Primary Care to Health Systems and Health," *The Milbank Quarterly,* Vol. 83, No. 3, 2005, pp. 460 and 469.

7. This includes family doctors and general practitioners, general internists, and general pediatricians. However, primary care is not only provided by doctors and can be provided by nurse practitioners and pharmacists, among others. *Ibid.,* p. 460.

8. *Idem;* U.S. Department of Health and Human Services, Healthy People 2030, consulted August 15, 2024; The Commonwealth Foundation, Primary Care: Our First Line of Defense, June 12, 2013.

9. Karen Hodgson, Sarah R. Deeny, and Adam Steventon, "Ambulatory care-sensitive conditions: their potential uses and limitations," *BMJ Quality & Safety,* Vol. 28, 2019, p. 430; Kjell Larsson *et al*., "Impact of COPD diagnosis timing on clinical and economic outcomes: the ARCTIC observational cohort study," *International Journal of Chronic Obstructive Pulmonary Disease,* Vol. 14, 2019, pp. 1001–1002; E.F.M. Wouters, "Economic analysis of the confronting COPD survey: an overview of results," *Respiratory Medicine,* Vol. 97, 2003, pp. S4–S10; The Ottawa Hospital Research Institute, World-first trial shows benefits of finding, treating undiagnosed asthma and COPD, May 19, 2024.

10. World Health Organization, Chronic obstructive pulmonary disease (COPD), March 16, 2023; Jessica Evans *et al*., "Estimating the prevalence of COPD in Canada: Reported diagnosis versus measured airflow obstruction," *Health Reports,* Vol. 25, No. 3, 2014, as cited in M.A. Malik Farooqi *et al*., "Prevalence and burden of COPD misclassification in the Canadian Longitudinal Study on Aging (CLSA)," *BMJ Open Respiratory Research,* Vol. 9, 2022, p.1.

11. Zirui Song and Suhas Gondi, "Will Increasing Primary Care Spending Alone Save Money?" *JAMA,* Vol. 322, No. 14, 2019, pp. 1–2.

12. Elizabeth T. Momany *et al*., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Services Research,* Vol. 41, No. 4, 2006, pp. 1364–1370; Bernard Friedman and Jayasree Basu, "Health Insurance, Primary Care, and Preventable Hospitalization of Children in a Large State," *The American Journal of Managed Care,* Vol. 7. No. 5, 2001, pp. 477–481; Ann S. O'Malley *et al*., "New approaches to measuring the comprehensiveness of primary care physicians," *Health Services Research,* Vol. 54, 2019, pp. 362–364; Adam J. Rose *et al*., "Primary Care Visit Regularity and Patient Outcomes: an Observational Study," *Journal of General Internal Medicine,* Vol. 34, 2019, p. 87.

Figure 1-1

The core features of primary care

FIRST CONTACT ACCESSIBILITY
creates a strategic entry point for and improves access to health services.

CONTINUITY
promotes the development of long-term personal relationships between a person and a health professional or a team of providers.

COMPREHENSIVENESS
ensures that a diverse range of promotive, protective, preventive, curative, rehabilitative, and palliative services are provided.

COORDINATION
organizes services and care across levels of the health system and over time.

PEOPLE-CENTRED
care ensures that people have the education and support needed to make decisions and participate in their own care.

Source: World Health Organization, Primary care, consulted August 15, 2024.

all.[13] In the case of individuals with COPD, for example, delivering appropriate care to those with severe disease is much more expensive than for patients with mild or moderate forms, and not only to the healthcare system, but also to employers and other economic actors.[14] Indeed, the indirect cost of lost productivity due to hindered workforce participation is higher for those with severe disease.[15]

Canada's Primary Care System Is Not Functioning Well

Canadians are struggling to gain access to primary health care. In 2023 one in seven Canadian adults did not have regular access to a primary care provider or place to get care, compared with only 1% of the Dutch and 4% of the German population.[16]

13. Martijn J. Oude Wolcherink *et al.*, "Health Economic Research Assessing the Value of Early Detection of Cardiovascular Disease: A Systematic Review," *PharmacoEconomics,* Vol. 41, 2023, p. 1191; Saadia Sediqzadah *et al.*, "Cost-Effectiveness of Early Intervention in Psychosis: A Modeling Study," *Psychiatric Services*, Vol. 73, No. 9, 2022, pp. 973–976.

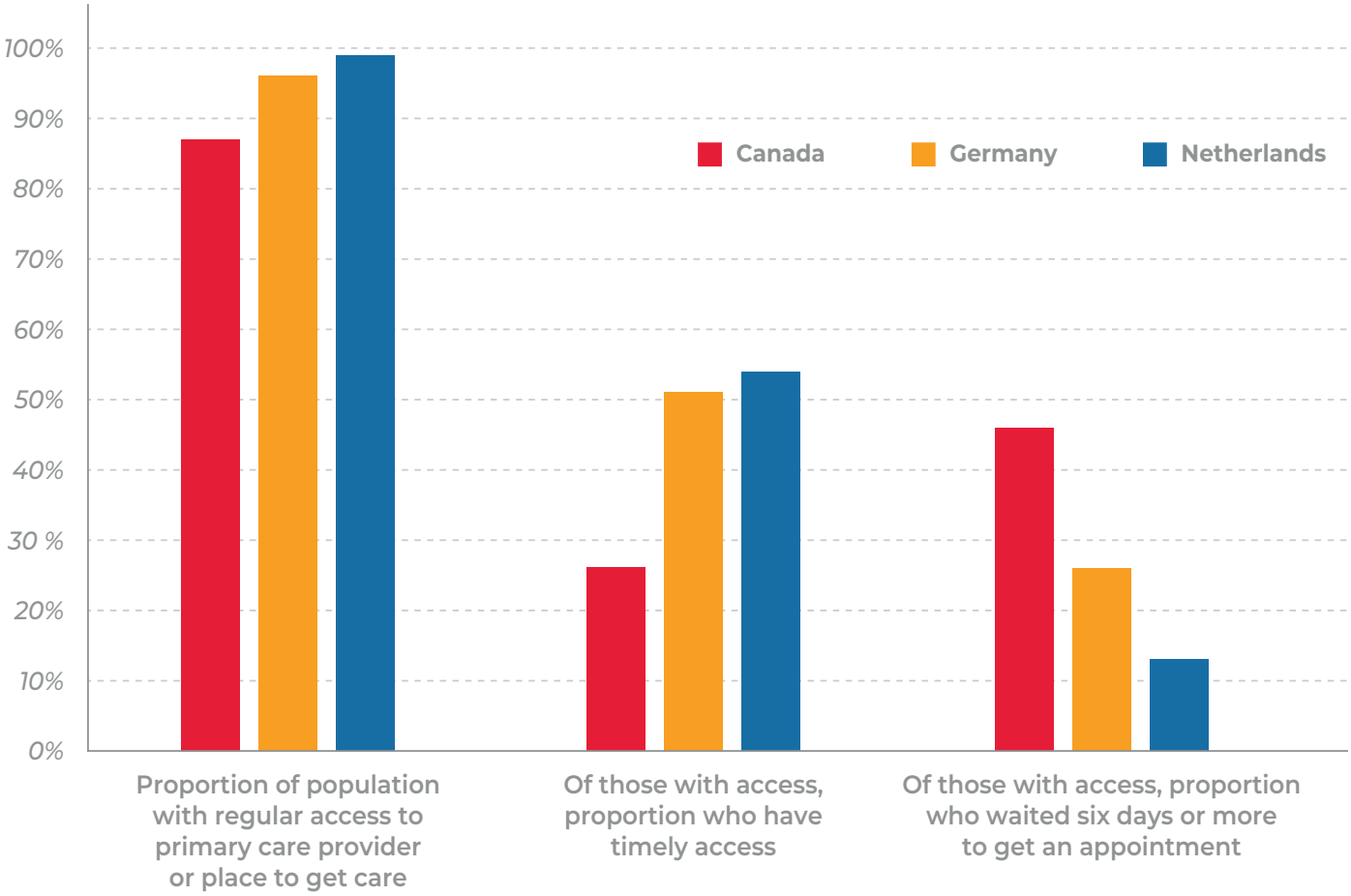
14. This was true for the seven countries in the study: Canada, Spain, the UK, the US, Italy, France, and the Netherlands. E.F.M. Wouters, *op. cit.,* footnote 9, pp. S6–S13.

15. *Ibid.,* pp. S7–S10.

16. Canadian Institute for Health Information, *op. cit.,* footnote 2.

Figure 1-2

Better access to primary care in Germany and the Netherlands (2023)



Note: This excludes respondents who did not need to make an appointment to see a doctor or nurse, who were never able to make an appointment or who visited a hospital emergency department, urgent care clinic or facility instead of making an appointment
Source: Canadian Institute for Health Information, "How Canada Compares: Results From the Commonwealth Fund's 2023 International Health Policy Survey of the General Population Age 18+ in 10 Countries — Data Tables," Question 11, Question 9, 2024.

Strikingly, even those who did have nominal access to a primary care provider often found it difficult to get such access in practice: almost three quarters of Canadian patients were unable to secure a timely appointment, compared with less than half in Germany and the Netherlands.[17] Additionally, 46% of Canadians waited six days or more for an appointment, while only 26% of German patients and 13% of Dutch patients waited that long (see Figure 1-2).

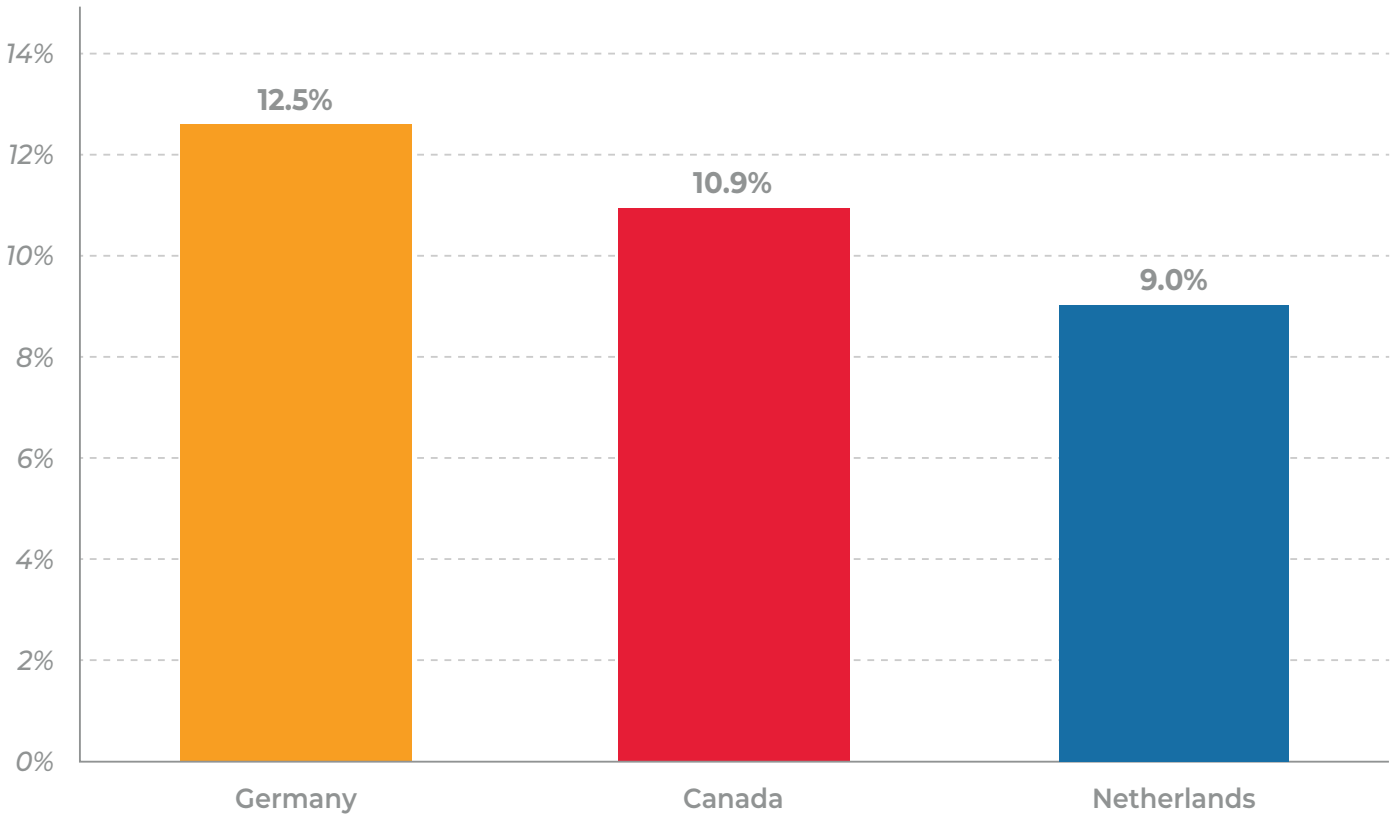
The lack of access does not appear to be an issue of funding: Canadian spending on primary care is comparable to spending by Germany and the Netherlands, albeit with sub-optimal results. In fact, when quantified as a proportion of total health spending, Canada spends about 10.9% of its overall health expenditure on primary care, compared with Germany's 12.5% and the Netherlands' 9.0% (see Figure 1-3).[18]

17. 74% of Canadian patients, 49% of German patients, and 46% of Dutch patients. Canadian Institute for Health Information, *op. cit.,* footnote 3.

18. OECD, OECD Health Statistics 2023, Health at a Glance 2023, Health expenditure – Figure 7.17, Spending on primary healthcare services as a share of current health expenditure, 2021 (or nearest year).

Figure 1-3

Spending on primary care as a share of total healthcare expenditure, 2021 or nearest year (%)



Source: OECD, OECD Health Statistics 2023, Health at a Glance 2023, Health expenditure – Figure 7.17, Spending on primary healthcare services as a share of current health expenditure, 2021 (or nearest year).

While it might appear to be a quick fix, the idea that simply increasing spending on primary care

Since primary care serves as a substitute for other forms of care and is less expensive, timely access to it can contribute to lower overall system costs.

(within the current health system structure) will by itself reduce *total* healthcare spending is not strongly supported by the empirical evidence.[19] Studies show that despite cost savings from enhanced primary care, other important reforms, including administrative reforms, are needed to slow total spending growth.[20]

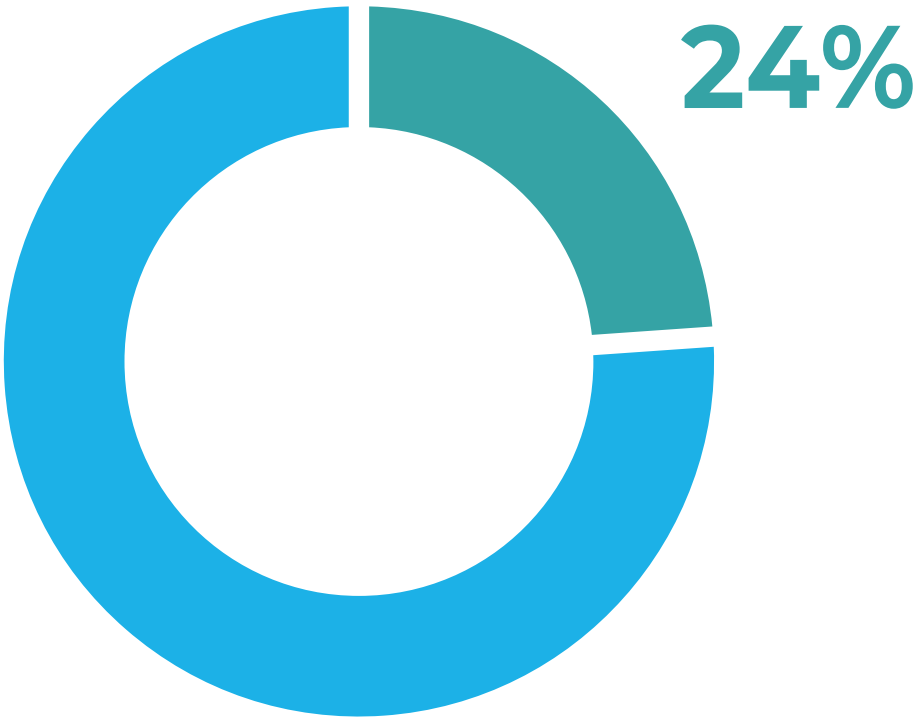
However, such comparisons of spending based on OECD data must be considered with caution. First, in order to help contextualize primary care spending, the OECD uses each country's reported spending estimates for a range of basic services as a proxy measure. These services include general outpatient, dental and home-based curative care,

19. Zirui Song and Suhas Gondi, *op. cit.*, footnote 11, p. 3.

20. Richard A. Young, "Increasing Spending on Primary Care to Reduce Health Care Costs," *JAMA*, Vol. 323, No. 6, 2020, p. 571; Zirui Song and Suhas Gondi, *Ibid.*, p. 2.

Figure 1-4

Percentage of Canadian adults without access to a family doctor who sought non-urgent care in the ER in 2022



Source: MAP Centre for Urban Health Solutions, *OurCare: The final report of the largest pan-Canadian conversation about primary care*, 2024, p. 35; OurCare, OurCare National Survey Findings: Summary Report, May 2023, p. 13.

and preventive services.[21] This is used in the absence of a standardized definition, as no definitive agreement exists on which services or providers belong under the primary care umbrella.[22] This makes comparing spending on primary care rather difficult.

Second, these estimates do not capture the costs associated with primary care when it is provided in other facilities not included in the OECD definition, such as the ER—which is notably the case across Canada. As 24% of Canadian adults without access to a primary care provider reported seeking care in the ER for a non-urgent health concern in 2022, the cost associated with providing primary care—including that which should have been provided in primary care settings—would be higher.[23] Therefore, spending by governments in Canada on primary care is likely much higher as a propor-

In 2023 one in seven Canadian adults did not have regular access to a primary care provider or place to get care, compared with only 1% of the Dutch and 4% of the German population.

21. Services are those that are provided by ambulatory care providers. The same services provided in hospitals or as outpatient specialist care are not included. OECD, *op. cit.,* footnote 18.

22. *Idem.*

23. MAP Centre for Urban Health Solutions, *OurCare: The final report of the largest pan-Canadian conversation about primary care,* 2024, p. 35; OurCare, *op. cit.,* footnote 16.

Table 1-1

Unnecessary ER visits in Canada, 2022-2023

	Total ER visits	Less urgent or non-urgent visits	Visits that could have been managed in primary care
Yukon	41,737	20,849	4,378
British Columbia	1,769,587	522,662	109,759
Alberta	2,227,674	692,812	145,491
Saskatchewan	606,903	241,843	50,787
Manitoba	282,416	79,971	16,794
Ontario	6,213,334	1,427,973	299,874
Quebec	3,626,684	1,503,940	315,827
Nova Scotia	294,976	68,087	14,298
Prince Edward Island	66,002	17,178	3,607
TOTAL	**15,129,313**	**4,575,315**	**960,816**

Note: Information presented here includes only participating provinces and those facilities that submitted data to NACRS in 2022–2023. Therefore, these are underestimates, and results comparing jurisdictions should be interpreted with caution.
* Indicates incomplete data across province/territory's ERs. In 2022–2023, NACRS included all ERs in Quebec, Ontario, Alberta and the Yukon, but only 30 in B.C., 56 in Saskatchewan, 8 in Nova Scotia, 7 in Manitoba and 2 in P.E.I.
Source: Canadian Institute for Health Information, *NACRS Emergency Department Visits and Lengths of Stay by Province/Territory, 2022-2023 (Q1 to Q4)*, August 2023; Canadian Institute for Health Information, Source of Potentially Avoidable Emergency Department Visits, November 2014, p. 7.

tion of total health expenditure. This substitution of emergency care for primary care has real consequences for the broader healthcare system.

A Lack of Primary Care Access Comes with Broader Health System Consequences

In the absence of timely access to primary care, patients are left with two undesirable options for addressing their healthcare needs. First, as already stressed, a patient may seek primary care in other settings not meant to provide it, e.g., the ER. In fact, in 2022, nearly a quarter of Canadian adults without access to a primary care provider last sought care in the ER for a non-urgent health concern (see Figure 1-4).[24] Not only is this a mismatch for the patient in terms of the care they require, but it also creates a domino effect that increases pressure on other parts of the healthcare system.

In the absence of timely access, patients may seek primary care in the ER, and even worse, may elect not to seek care at all.

Second, and even worse, given the unavailability of primary care options patients may elect not to seek care at all. In this case, new concerns may not be caught, or chronic conditions may worsen. Patients are then more likely to present later with more advanced disease, which will ultimately have a greater impact on their quality of life, as well as on healthcare costs downstream.

24. *Idem.*

Table 1-2

Resources consumed by unnecessary ER visits

	Cost of unnecessary ER visits ($)
Yukon	$328,137
British Columbia*	$18,514,151
Alberta	$21,849,766
Saskatchewan*	$8,338,215
Manitoba*	$3,381,958
Ontario	$42,216,308
Quebec	$47,304,628
Nova Scotia*	$2,566,253
Prince Edward Island*	$414,416
TOTAL	**$144,967,833**

Note: Information presented here includes only participating provinces and those facilities that submitted data to NACRS in 2022–2023. Therefore, these are likely underestimates, and results comparing jurisdictions should be interpreted with caution. The cost of an ER visit for QC is not provided by CIHI and so the Canadian average is used.
* Indicates incomplete data across province/territory's ERs. In 2022–2023, NACRS included all ERs in Quebec, Ontario, Alberta and the Yukon, but only 30 in B.C., 56 in Saskatchewan, 8 in Nova Scotia, 7 in Manitoba and 2 in P.E.I.
Source: Authors' calculations. Canadian Institute for Health Information, An overview of physician payments and cost per service, November 17, 2022; Canadian Institute for Health Information, *Trends in Hospital Spending, 2005–2006 to 2021–2022 — Data Tables — Series C: Average Direct Cost per Patient by Selected Functional Centre*, 2023.

Patients Seeking Primary Care Often End Up in Emergency Rooms

Of the total ER visits across the country between April 2022 and March 2023, 30% were for non-urgent or less urgent issues.[25] The Canadian Institute for Health Information (CIHI) previously estimated that one in five of these cases, which can be referred to as "family practice sensitive conditions" (FPSC),

More than 1.6 million Canadian adults without access to a primary care provider reported seeking care in the ER for a non-urgent health concern in 2022.

could have been appropriately managed in a family physician or primary care setting.[26]

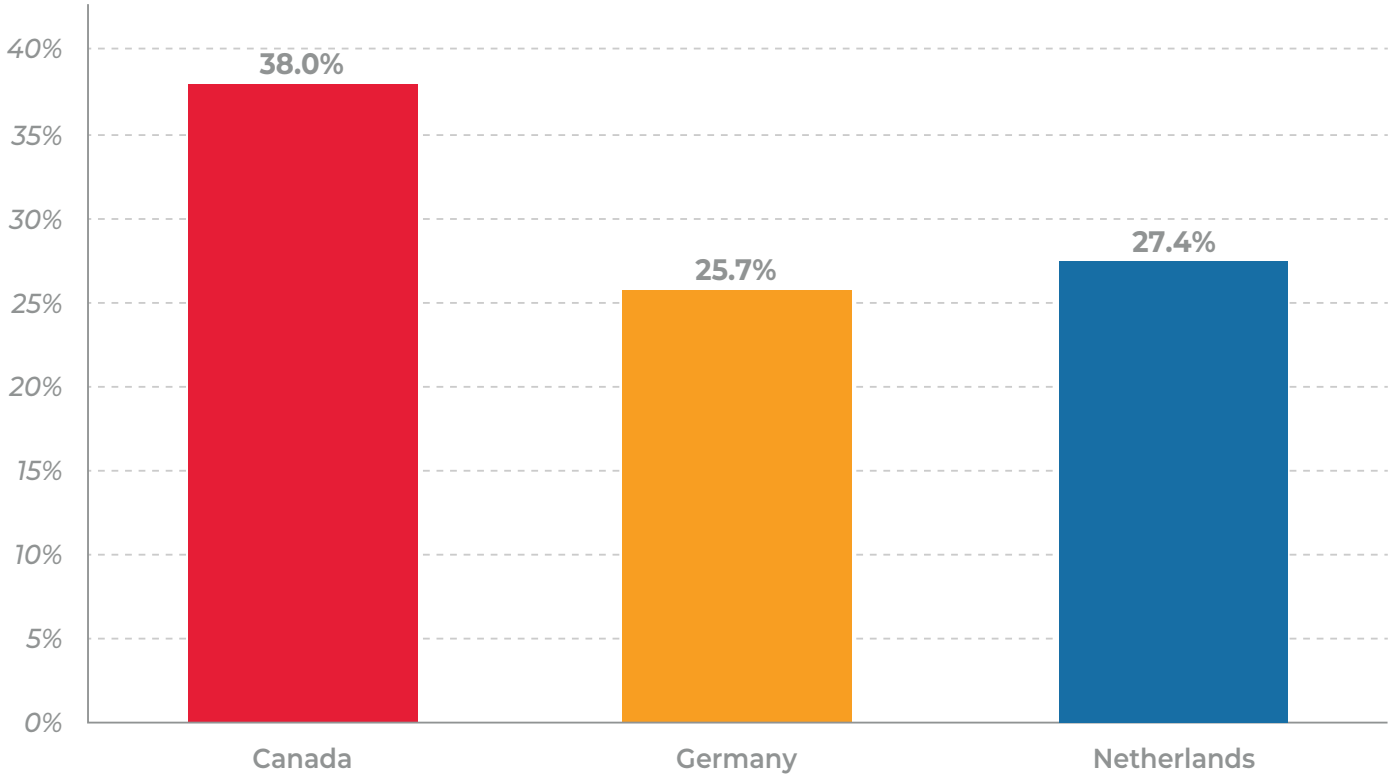
Using data from the National Ambulatory Care Reporting System (NACRS) on hospital-based care (including ERs) from across the country, we estimate

25. This is based on the Canadian Triage and Acuity Scale (CTAS) levels 4 and 5 which include patients with a triage level of less urgent or non-urgent and a visit disposition of discharged home; these levels exclude patients who were transferred to another facility and those who died. Canadian Institute for Health Information, NACRS emergency department visits and length of stay, February 22, 2024.

26. 21% of cases are considered family practice sensitive conditions, which are typically low acuity and do not result in admission. The results are also limited by the regions that reported to CIHI. Canadian Institute for Health Information, Source of Potentially Avoidable Emergency Department Visits, November 2014, p. 7.

Figure 1-5

Percentage of patients who sought care in ER for a condition they thought was treatable by their primary care provider if they had been available, 2023



Source: Canadian Institute for Health Information, "How Canada Compares: Results From the Commonwealth Fund's 2023 International Health Policy Survey of the General Population Age 18+ in 10 Countries — Data Tables," Question 20, 2024.

Of the total ER visits across the country between April 2022 and March 2023, 30% were for non-urgent or less urgent issues.

that there were over 960,000 unnecessary ER visits in Canada between April 2022 and March 2023 (see Table 1-1).[27] As not all provinces and territories are included (nor all emergency departments), this estimate may be considered quite conservative.

As the costs of ER visits and primary care visits differ greatly, the lack of access to primary care in Canada results in an enormous loss due to this volume of unnecessary ER visits. In fact, the cost of an ER visit is three times that of a visit to a family medicine practitioner: In 2020-2021, CIHI estimated the direct cost of an ER visit in Canada to be $205.80, and that of a family medicine visit at just over $56.[28] With at

27. NACRS contains much more than this data and is a rich source of information on how health care is utilized across the country. Canadian Institute for Health Information, National Ambulatory Care Reporting System (NACRS), metadata, consulted August 15, 2024.

28. This is the cost per visit to the ER in Canada, with values ranging from a low of $143.30 in YT to a high of $257.40 in MB. A family medicine visit is estimated to cost $56.02 in Canada (not broken down by province or territory). The cost of a visit to an alternative primary care provider, such as a nurse practitioner or pharmacist, is not included here, but is likely lower than or equivalent to the per visit cost for family medicine practitioners. Canadian Institute for Health Information, An overview of physician payments and cost per service, November 17, 2022; Canadian Institute for Health Information, Trends in Hospital Spending, 2005–2006 to 2021–2022 — Data Tables — Series C: Average Direct Cost per Patient by Selected Functional Centre, 2023.

Figure 1-6

Increase in the median wait time in Quebec ERs, 2018–2024

Note: In 2018-2019 the median wait time in the ER was 4.52 hours and in 2023-2024 it was 5.22, a difference of 15.5%.
Source: Emmanuelle B. Faubert, "ER Wait Times in Quebec are Stagnating," Viewpoint, MEI, March 18, 2024, p. 1.

least 960,000 unnecessary ER visits, the Canadian healthcare system could have saved a minimum of nearly $145 million by managing these visits through primary care providers (see Table 1-2).[29] Not to mention the impact this would have had on wait times for those patients who really did need emergency care.

While these visits could have been managed appropriately in a primary care setting, patients simply cannot get access to their primary care providers in a reasonable amount of time. As can be seen in Figure 1-5, Canada again compares unfavourably with patients in Germany and the Netherlands. In 2023, 38% of Canadian patients reported that the last time they went to the ER it was for a condition that was treatable at their general practitioner or regular doctor's office, had they been available. This same proportion was 26% for German patients, and 27% for the Dutch.[30]

In 2020, 29.3% of Canadian adults waited more than four hours before being seen, compared with only 10% of the Germans and 3.1% of the Dutch.

Not only do these unnecessary ER visits add to health system costs, but they also contribute to lengthening wait times in the ER, leaving patients languishing and leading to additional complications. In Nova Scotia, for instance, ERs have been overrun with non-urgent patients, resulting in high numbers of deaths in emergency departments. In 2023, the province saw 666 patients die while waiting to receive medical attention in an ER, an increase of 19% from the year before.[31] In Quebec, more and more people have been seeking primary care in the province's ERs, resulting in an increase in median wait time of 15.5% between 2018 and 2024 (see Figure 1-6). In the CISSS des Laurentides region of the province, median waits stretched to over seven hours.[32]

When Wait Times in the ER Are Long, Patients Leave without Being Seen or Do Not Seek Treatment at All

Given the volume of Canadians visiting the ER for their primary medical care, it comes as no surprise that Canada fares worse than Germany and the Netherlands in terms of ER wait times (see Table 1-3). In 2020, more than half of German patients and nearly two-thirds of the Dutch waited less than one hour on their last visit to the ER. In Canada,

29. *Idem*. Author's calculations. This does not include the Northwest Territories, Nunavut, Newfoundland and Labrador, or New Brunswick.

30. Canadian Institute for Health Information, "How Canada Compares: Results From The Commonwealth Fund's 2023 International Health Policy Survey of the General Population Age 18+ in 10 Countries — Data Tables," Question 20, 2024.

31. Sarah Smellie, "N.S. emergency department deaths hit six-year high, doctors point to 'bed-blocking,'" *Toronto Star,* July 10, 2024.

32. In 2018-2019 the median wait time in the ER was 4.52 hours and in 2023-2024 it was 5.22 hours, a difference of 15.5%. Emmanuelle B. Faubert, "ER Wait Times in Quebec are Stagnating," Viewpoint, MEI, March 18, 2024, pp. 1–2.

Table 1-3

ER wait times in Canada, Germany, and the Netherlands, 2020

	Canada	Germany	Netherlands
Proportion of adults who waited less than one hour before being treated in the ER at last visit	34.5%	55.2%	62.0%
Proportion of adults who waited between one and fours hours before being treated in the ER at last visit	34.7%	33.2%	30.2%
Proportion of adults who waited more than four hours before being treated in the ER at last visit	29.3%	10.0%	3.1%

Source: Canadian Institute for Health Information, "How Canada Compares: Results From The Commonwealth Fund's 2020 International Health Policy Survey of the General Population in 11 Countries — Data Tables," Question 27, 2021.

just over a third could make the same claim.[33] At the other end of the spectrum, 29.3% of Canadian adults waited more than four hours before being seen, compared with only 10% of the Germans and 3.1% of the Dutch.

Besides delays in accessing care, long wait times in ERs can result in patients leaving the ER without being seen at all. Many of these patients are of a priority level for which leaving without being seen can have severe consequences. For instance, in Quebec in 2022-2023, 11.5% of patients who visited an ER in the province left without being treated, over a quarter of whom (27.5%) were categorized as urgent and requiring rapid treatment.[34] Were the provinces' ERs not congested with patients seeking primary care services, they would be in a better position to serve critically ill patients.

Finally, given that the public is well aware of the extended waits in ERs, many undoubtedly choose not to seek care at all, often presenting later with more advanced disease along with the attendant complications. The final tally for extended waits in ERs is immense: system costs multiply, along with the human cost borne by patients. While the latter is often difficult to quantify, it is nevertheless very real.

In Quebec in 2022-2023, 11.5% of the patients who visited an ER in the province left without being treated.

Due in part to the failings of primary care, Canadian health care underperforms relative to both Germany and the Netherlands, a conclusion reinforced by a recent Commonwealth Fund analysis.[35] The 2024 report examined 70 healthcare system performance measures across five areas (access to care, care process, administrative efficiency, equity, and health outcomes) and when it came to access, Canada ranked 7th of the 10 countries included in the study. The Netherlands was the best performer and Germany third. Canadians themselves recognize that something is not quite right: a significantly lower proportion of them, 56%, were satisfied with the availability of quality health care, as compared with 85% of Germans and 83% of the Dutch (2019 data).[36]

33. Canadian Institute for Health Information, "How Canada Compares: Results From The Commonwealth Fund's 2020 International Health Policy Survey of the General Population in 11 Countries — Data Tables," Question 27, 2021.

34. Emmanuelle B. Faubert, "Quebecers Should Not Have to Leave Emergency Rooms Untreated," Viewpoint, MEI, June 20, 2024, p. 2.

35. David Blumenthal *et al.*, "Mirror Mirror 2024, A Portrait of the Failing U.S. Health System: Comparing Performance in 10 Nations," **The Commonwealth Fund**, September 2024, pp. 3-4.

36. OECD, OECD Health at a Glance 2023 Country Note, Canada, 2023, p. 1 ; OECD, OECD Health at a Glance 2023 Country Note, Germany, 2023, p. 1; OECD, OECD Health at a Glance 2023 Country Note, The Netherlands, 2023, p. 1.

CHAPTER 2

The Key System Differences That Allow for Increased Access to Primary Care in Germany and the Netherlands

The primary care systems in Canada, Germany, and the Netherlands are all universal insofar as they provide comprehensive health care to all residents regardless of their income or employment status. But each country has its own unique model for financing and delivering these services. There are a few key differences within the German and Dutch systems that allow for more patient and provider choice, more system flexibility, and more competition, all of which have the result of increasing access to primary care in comparison with Canada's system.

These differences include: how health care is funded and, by extension, how primary care is funded (2.1); the use of primary care providers as gatekeepers to restrict access to more specialized health care (2.2); and permission for healthcare workers to offer their services in both the public sector and the independent sector (2.3).

2.1 Multiple Funders in Germany and the Netherlands Allow Greater Access and Flexibility Than Canada's Single-Payer System

Canada

Canadian health care is made up of a collection of provincial and territorial health insurance plans that provide access to services in their respective jurisdictions. The system is funded indirectly by way of general taxation, with each province and territory allocating a sum of their general revenues towards their public health insurance plan (see Figure 2-1).[37]

Additional funding is received from the federal government by way of the Canada Health Transfer on an equal per capita basis, making up about 22% of the total cost of public health insurance in 2023.[38] What defines the Canadian system, in all provinces, is that insured patients and health professionals alike face a public single-payer, without any choice in insurer or plan, for medically necessary care as per the *Canada Health Act*. This contrasts sharply with the situation in Germany and the Netherlands.

The German and Dutch systems allow for more choice, more system flexibility, and more competition.

Germany

Germany's universal mixed system is a multi-payer insurance system comprising statutory health insurance (SHI) and private health insurance (PHI), both of which are operated by private entities.[39] While health insurance in Germany is mandatory, there are plenty of insurers to choose from. There are currently 140 insurance funds ("sickness funds") in the SHI system, which covers about 90% of the population, and 34 insurers in the PHI system, which covers the remaining 10% of the population (see Figure 2-2).[40] Whether insured within the SHI or PHI system, the individual can expect extensive

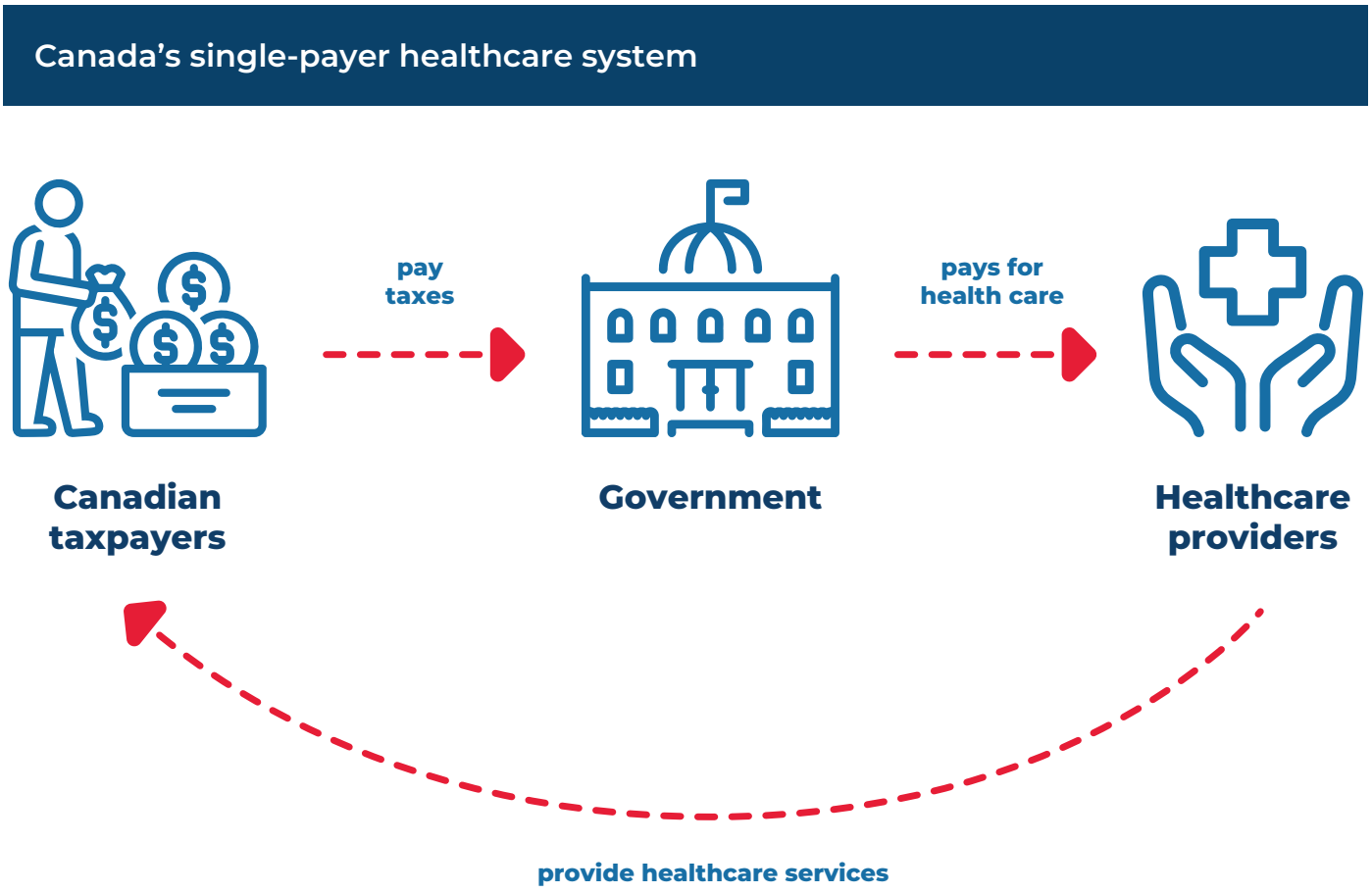
37. Canadian Medical Association, How Is Health Care Funded in Canada? consulted August 23, 2024; Government of Canada, Canada Health Transfer, What is the Canada Health Transfer (CHT)? February 15, 2022.

38. Canadian Medical Association, *Ibid.*

39. Florence Jenkins, "Germany's Insurance Landscape: Understanding the Most Essential Policies," *The Munich Eye,* April 12, 2024; The Fraser Institute, "How Germany embraces the private sector to deliver universal health care," *The Fraser Institute Blog,* April 5, 2016; Goran Ridic, Suzanne Gleason, and Ognjen Ridic, "Comparisons of Health Care Systems in the United States, Germany and Canada," *Materia Soci-Medica,* Vol. 24, No. 2, 2012, pp. 114–115.

40. The PHI system is for certain occupations and those who are self-employed, or who earn above a certain threshold. It is funded by premiums paid by those who elect to purchase this form of health insurance. The amount paid by an individual varies according to the specific health insurance plan selected and the individual's overall health, among other things. GKV-Spitzenverband, Statutory health insurance, May 3, 2024; Euro-Informationen, "List: Statutory health insurance companies," *Krankenkassen,* consulted August 23, 2024; Frederik T. Schut, Cornelia Henschke, and Zeynep Or, "Changing roles of health insurers in France, Germany, and the Netherlands: any lessons to learn from Bismarckian systems?" *Health Economics, Policy, and Law,* Vol. 18, 2023, p. 366; Euro-Informationen, "List: Private health insurance companies," *Krankenkassen,* consulted August 23, 2024; World Health Organization, "Germany: Country overview," *European Observatory on Health Systems and Policies,"* Consulted August 23, 2024.

Figure 2-1



Note: In this graphic, health care refers to that which is publicly funded, such as primary care. It does not include care provided by professionals outside this scope.

coverage in general, and complete primary care coverage in particular.[41]

While health insurance in Germany is mandatory, there are plenty of insurers to choose from.

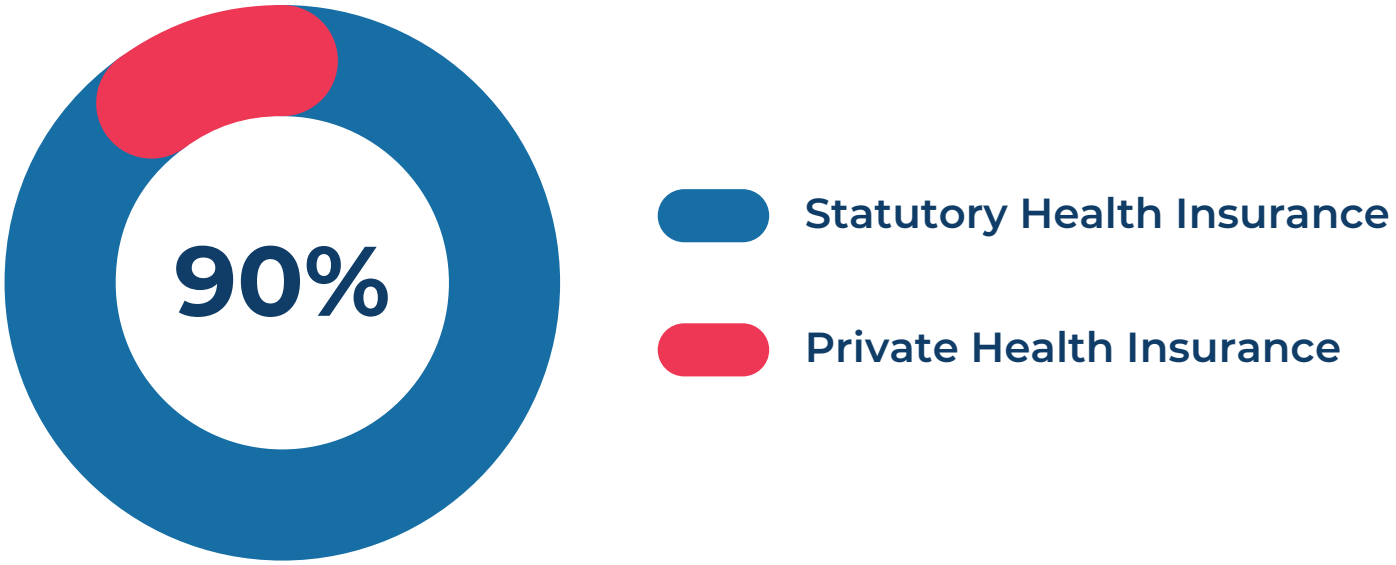
In the SHI system, employees and employers share the payment of the premium cost equally.[42] All of those enrolled in an SHI insurance plan receive the same basic benefits, although some pay more than others for their coverage given that

41. The SHI package includes inpatient and outpatient care, mental health services, and prescription drugs. The greater benefits in the PHI system include private hospital rooms and more flexible appointment times, among others. Germany Visa, Health Insurance in Germany – The German Healthcare System, consulted August 30, 2024; InformedHealth.org, Health care in Germany: Learn More – The German health care system, *Institute for Quality and Efficiency in Health Care (IQWiG),* 2018.

42. Funded with compulsory contributions from employees and employers, Germany's SHI system is essentially a payroll tax with a contribution rate of 14.6% that is split equally between employer and employee plus a supplementary contribution of about 1%. The tax contributions are pooled then reallocated to SHI funds based on a risk-adjusted capitation formula. Euro-Informationen, "Additional contribution from health insurance companies," *Krankenkassen,* consulted August 23, 2024; Ottonova, Employee Contribution, consulted August 23, 2024; Bundesministerium der Justiz, Social Code (SGB) Book Five (V) – Statutory Health Insurance – (Article 1 of the Act of 20 December 1988, Federal Law Gazette I p. 2477), § 257 Contribution subsidies for employees, consulted August 23, 2024; Deutsche Flagge, "Current Contributions – Operands," Federal Ministry for Digital and Transport, June 28, 2024.

Figure 2-2

Germany's health insurance coverage, percentage of the population



Source: GKV-Spitzenverband, Statutory health insurance, May 3, 2024.

contributions are income dependent.[43] Individuals insured under SHI can opt to change insurance each year, or sometimes earlier, should their circumstances call for it.[44]

Alternatively, those who opt for PHI pay premiums that are based on plan coverage and their individual health risk profile; in this case, a person's income has no bearing on their policy premium.[45] Like SHI, insurance premiums are split between the employee and employer, however, this split is not necessarily equal.[46] Just as in the SHI system, those insured with PHI can change their insurer annually.[47]

The health insurance system in Germany places a high degree of emphasis on patient choice. Residents can select from a variety of health insurers, which encourages the improvement of service quality as well as expanded benefits to attract and retain customers. Individuals can choose a health insurance plan that best suits both their financial situation and their healthcare needs.[48] It must be stressed that while Germans in the SHI can choose their coverage (preferring lower premiums if the

43. Percentage of income applies up to a certain threshold of gross monthly earnings of €5,175. Different SHI funds can offer additional benefits such as professional teeth cleaning, extended cancer screenings, or bonus programs. Generally, PHI premiums can range from €350 to €900 per month for a healthy 35-year-old, depending on the particular plan type and coverage. Deutsche Flagge, *Ibid.*; Culpeck, "Statutory Health Insurance," consulted August 23, 2024; Euro-Informationen, "What Does Private Health Insurance Cost?" *Krankenkassen,* consulted August 23, 2024.

44. Anyone who has been a member of a given health insurance fund for at least 12 months can change to any other SHI fund. However, if the insurer increases the contribution, a special right of termination applies. A notice period of two month applies. Euro-Informationen, "You Want to Change Your Health Insurance Fund," *Krankenkassen,* consulted August 28, 2024.

45. The PHI system is for certain occupations, and those who are self-employed, or earn above a certain threshold. Once it meets the threshold for eligibility, income has no bearing. GermanPedia, Employer Contribution to Private Health Insurance in Germany [2024 English Guide], July 28, 2024; InformedHealth.org, *op. cit.,* footnote 41.

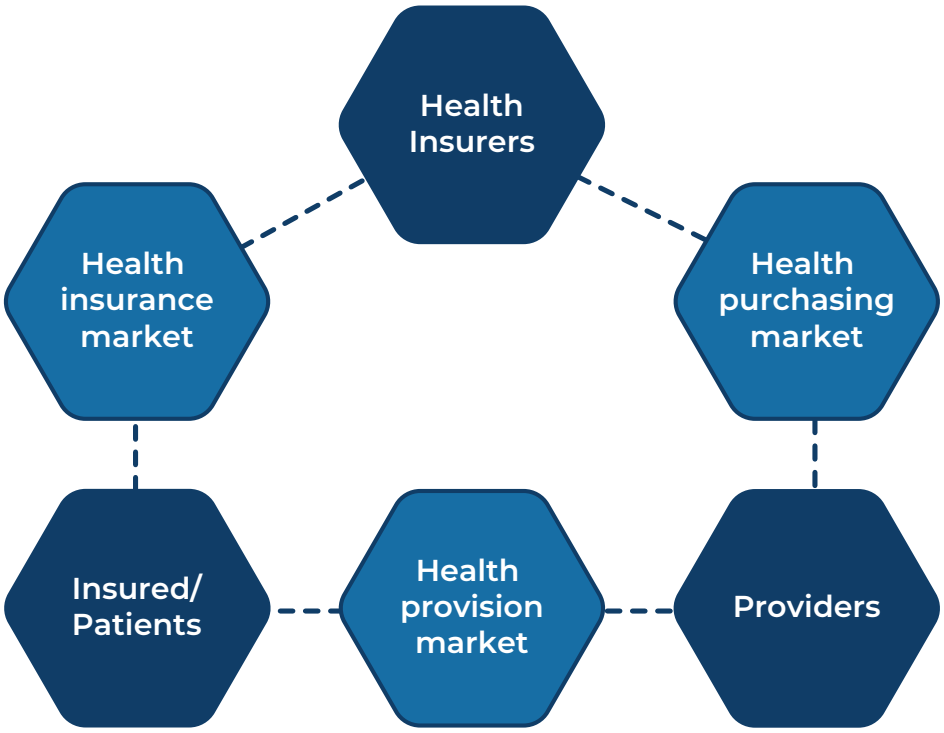
46. This is because premium amounts cannot exceed SHI contributions on the part of the government and therefore an employee is only entitled to the amount that the employer would otherwise have contributed towards a statutory insurance policy. InformedHealth.org, *Ibid.*; Ottonova, *op. cit.,* footnote 42.

47. The change will only be effective if it is proven within two months of termination that a new insurer is in place without interruption. PHI can be changed at the end of the calendar year, or at the end of the policy year, with a notice period of three months. Federal Financial Supervisory Authority, Private health and compulsory long-term care insurance, May 16, 2024.

48. Jana Koehler, "Public vs. Private health insurance in Germany: What's better?" *HalloGermany,* January 16, 2024.

Figure 2-3

The multi-payer healthcare market in the Netherlands



insurance implies higher co-payment and/or deductibles, for example), there are no co-payments or deductibles specifically for basic primary care services.[49]

The Netherlands

In the Netherlands, the healthcare system is a regulated, market-based model in which basic health insurance is provided by private insurers (see Figure 2-3). In 2023, there were 20 separate health insurers that offered 60 different health insurance policies, each required to cover at least the mandated basic package, which includes primary care.[50]

The funding of this system somewhat resembles a combination of the German PHI and SHI systems: Dutch residents pay a flat-rate premium directly to their chosen insurer for the basic mandatory package, regardless of income, plus a wage contribution, which does vary based on income.[51] The wage contribution is shared between employer

49. Michaela Olm *et al.*, "Impact of the abolition of copayments on the GP-centred coordination of care in Bavaria, Germany: analysis of routinely collected claims data," *BMJ Open,* Vol. 10, 2020, p. 2; Personal communication with German health economist, September 13, 2024. There can be deductibles for primary care under the PHI, but this is something agreed between patient and insurer.

50. The basic package includes a wide range of services such as hospital care, prescription medications, and of course, consultations with a primary care provider. NZA, "Key figures health insurers," consulted August 23, 2024; Canadian Medical Association, Public and private health care: How do other countries do it? Health care in the Netherlands, consulted September 13, 2024.

51. Premium payment amounts vary by plan and provider, but average approximately €1,200 annually. Wage contributions are pooled and help fund the system. National Health Care Institute, Health care in the Netherlands, consulted August 23, 2024, p. 10; Belastingdienst, Percentages of income-related contribution ZVW, consulted August 23, 2024; Business.gov.nl, Income tax (IB) and healthcare insurance premium (ZVW), consulted August 23, 2024; Boundless, Taxes in Netherlands, consulted August 23, 2024; Roosa Tikkanen *et al.*, "International Health Care System Profiles: Netherlands," The Commonwealth Fund, June 5, 2020.

and employee, as in Germany, and is applied up to a certain income threshold.[52] Similar to the German system, co-payments and deductibles integrate a measure of cost-sharing and vary by insurer, or by policy chosen by the insured. Again, however, these do not apply to primary care.[53]

Since all insurers are operating in the private sector, as in Germany, they must compete on price and quality.[54] Individuals can compare different insurance plans and switch insurers annually, guaranteeing that insurers will remain responsive to the needs and preferences of those they insure.[55] In addition, the ability to choose coverage allows individuals to purchase additional insurance for services not covered by the basic package, which results in more personalized coverage that better reflects the needs of the insured.[56]

The Limitations of a Single Health Insurer for Canadian Patients and Providers

The way the overall healthcare systems are funded has ramifications for responsiveness and degree of patient-centredness. Canada's single-payer health insurance system is the only option for the entire population, and therefore all Canadians are forced to accept a single health insurer, and plan, for medically necessary care (including primary care). There is no personalization.

In contrast, residents of both Germany and the Netherlands benefit from the ability to select and change their insurance plan and insurer according to their specific needs.[57] This element of choice is a foundational component of their respective health insurance systems, which fosters competition among insurers and encourages them to offer better service in addition to a range of coverage options. The ability to choose an insurer sets the stage for a patient-centered system, one that allows patients to best decide their own needs, dependent on their preferences.

Moreover, this environment fosters a competitive health provision market that encourages insurers to innovate and experiment with delivery options as they compete to attract and retain patients as insurance customers. It gives insurers the freedom to design diverse insurance products and accommodate patient preferences, such as unrestricted (direct) access to specialists, as in Germany, or varying levels of deductibles and copays (relevant for non-primary care). The environment also allows insurers to quickly adapt their policies should healthcare needs and/or preferences evolve. In multi-payer systems, like those of Germany and the Netherlands, this is particularly important, as patients have the option to switch insurers whether it be for cost, or for other reasons.

In the Netherlands, in 2023, there were 20 separate health insurers that offered 60 different health insurance policies.

In addition, when multiple insurers compete in a healthcare market, they have an incentive to negotiate the healthcare services that best fit patients' preferences so as to be able to offer more attractive premiums. This leads to more dynamic negotiations with healthcare providers to secure accessible services, which ultimately benefits patients who get the lowest possible premiums while maintaining the high levels of access to care necessary for their health and well-being.[58] In the Netherlands for example, in most cases, individual insurers negotiate prices with healthcare providers directly.[59] Things are similar in Germany, where associations of insurers and associations of providers enter into agreements with health professionals.[60]

52. The wage contribution is income dependent and is split between employer and employee, with the employer paying a higher percentage. For 2024 the split is 6.57% employer, and 5.32% employee, up to an annual earnings threshold of €71,628. Belastingdienst, *Idem.*

53. Roosa Tikkanen *et al*., *op. cit.,* footnote 51.

54. *Idem.*

55. Leiden International Centre, Time to Change Your Health Insurance, December 4, 2023.

56. Government of the Netherlands, Standard health insurance, consulted August 30, 2024.

57. P. Hussey and G.F. Anderson, "A comparison of single- and multi-payer health insurance options and options for reform," *Health Policy,* Vol. 66, 2003, p. 221.

58. As shown in hospital settings. Kate Ho and Robin S. Lee, "Insurer Competition and Negotiated Hospital Prices," Federal Trade Commission, 2013, p. 29.

59. Commission Services (Directorate-General for Economic and Financial Affairs) and the Economic Policy Committee (Ageing Working Group), "The Netherlands: Health C and Long-Term Care Systems," *Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability*, June 2019, p. 196.

60. Frederik T. Schut, Cornelia Henschke, and Zeynep Or, *op. cit.,* footnote 40, pp. 362–363.

The existence of multiple payers is, in fact, also important for healthcare providers, who benefit from the ability to negotiate agreements with multiple private insurers rather than being restricted to working for, or billing, a single public insurer (a monopsony), as happens in Canada.[61] This leads to greater contractual flexibility and can also lead to better outcomes, particularly for those physicians who are able to improve service access and delivery. Healthcare providers can negotiate terms that are more favourable to their operations, which can potentially lead to increased revenue when, for example, they deliver more value for payers and their patient base.[62]

This element of choice fosters competition among insurers and encourages them to offer better service in addition to a range of coverage options.

Furthermore, there is an incentive to innovate and experiment, which benefits patients and providers alike.[63] Partnerships between healthcare providers and insurers can facilitate collaboration, allowing them to undertake mutually beneficial improvement projects should new ways of delivering care (e.g., telemedicine) emerge. Were there but a single public insurer, these might not be implemented as rapidly and effectively.

Examples of projects that have been successfully co-funded by independent healthcare providers and insurers in Germany and the Netherlands include creating networks of specialized professionals for certain diseases, and digital health initiatives that have resulted in reduced healthcare costs and improved care quality.[64]

Overall, the ability to choose among (and change) insurers in Germany and the Netherlands ensures that patients are active participants in their healthcare decisions, something that has been shown to increase patient satisfaction.[65] The role that these competitive, choice-based health insurance systems play in Germany and the Netherlands cannot be overlooked. They ensure the systems remain patient-centred, which leads to much better access to primary care than Canada achieves.

Within the systems themselves, there are additional differences, such as gatekeeping, that mediate access to primary care, as we shall see in the next section.

2.2 Patients Have Greater Choice in Accessing Care in Germany and the Netherlands

Restricting the use of specialist care by requiring patients to receive a referral from a primary care provider beforehand—known as gatekeeping—is one way that some universal healthcare systems have chosen to restrict healthcare supply in the face of patient demand. Gatekeeping practices are typically put in place in an attempt to prevent the overuse of healthcare services and, by extension, to help manage health system costs.[66] The logic behind the practice is that requiring patients to obtain a referral prior to seeing a specialist will better control expensive specialist services, and this should allocate scarce healthcare system resources more efficiently.

Though the objective is to reduce budgetary costs, at least in the short term, what this rationing ultimately achieves is to shift the cost to the patient

61. A monopsony in this context refers to a situation where there is effectively one payer, legally shielded from competition in the case of provincial public health insurers. The single buyer purchases goods or (healthcare) services from multiple sellers (healthcare professionals). ScienceDirect, Monopsony, consulted August 28, 2024.

62. Frederik T. Schut, Cornelia Henschke, and Zeynep Or, *op. cit.,* footnote 40, pp. 366–369.

63. Gitit Greenberg, "Bridging the gap: how digital platforms can enhance collaboration between insurers and healthcare providers," *EasySend,* consulted August 30, 2024.

64. Bradford Gray, Dana O. Sarnak, Marit Tanke, "ParkinsonNet: An Innovative Dutch Approach to Patient-Centered Care for a Degenerative Disease," The Commonwealth Fund, December 23, 2016; Iris Tinel *et al.*, "Effectiveness of an interactive web-based health program for adults: a study protocol for three concurrent controlled-randomized trials (EVA-TK-Coach)," *Trials*, Vol. 22, No. 526, 2021, pp. 2, 12–13.

65. A 2018 Finnish study found choice to be particularly important for primary care. Anna-Mari Aalto *et al.*, "What patients think about choice in healthcare? A study on primary care services in Finland," *Scandinavian Journal of Public Health,* Vol. 46, No. 4, 2018, pp. 10–12.

66. Kurt R. Brekke, Robert Nuscheler, and Odd Rune, "Gatekeeping in health care," CESifo Working Paper, No. 1552*, Center for Economic Studies and ifo Institute (CESifo),* 2005, pp. 2–6.

by increasing the physical, psychological, and social tolls of waiting to receive the needed specialist care. Moreover, in the context of primary care, suffering patients systematically overburden their primary care gatekeepers with multiple (unnecessary) visits while waiting for specialist care.[67]

Canada

In a strict gatekeeping system like Canada's, a patient's ability to access medical specialists is impeded, and this introduces a plethora of unintended consequences such as delaying a patient's access to care (which can worsen patient outcomes), eroding patient autonomy, and increasing the burden on primary care providers.[68] In addition, its effectiveness in controlling healthcare expenditures is unclear.[69]

As expected, the gatekeeping requirement has driven up the number of primary care visits across Canada. This has placed a greater administrative burden on primary care providers, which deflects them from direct patient care and other important care-related activities.[70] Research shows that it can take an extended period of time for a referral to be administratively processed.[71]

As a consequence, some primary care physicians are left having to arrange extra appointments with patients in order to address the effects brought on by these delays in accessing secondary healthcare services.[72] These repeated visits diminish the ability of primary care providers to see other patients or to accept new ones, directly affecting access to primary care for Canadians (see Figure 2-4).

This results in a lengthy process which can lead to delayed diagnoses for patients. Some studies have shown that countries with strict gatekeeping systems have worse outcomes due to these very consequences.[73] In addition to increasing the burden on primary care through increased visits, gatekeeping can erode a patient's trust in their primary care provider, notably when a referral is discouraged.[74]

What this rationing achieves is to shift the cost to the patient by increasing the physical, psychological, and social tolls of waiting to receive the needed specialist care.

Patients navigating the Canadian healthcare system have no choice but to participate in this gatekeeping scheme. Once a referral is made, they often also have limited choice when it comes to specialist selection. Though patients *may* discuss their preferences, such as a preferred specialist, with their primary care provider, and while these preferences *may* be taken into account, in most cases the final decision of selecting a specialist is made by the primary care provider and not the patient.[75]

In contrast with Canada, the healthcare systems in Germany and the Netherlands allow patients greater choice in how they access specialist care, and this has a direct effect on the access to primary care.

The Netherlands and Germany

Though the Netherlands does employ a gatekeeping system, there are some notable differences

67. A recent systematic review found that gatekeeping resulted in fewer hospitalizations and use of specialist care, but was also associated with more primary care visits and less patient satisfaction than direct-access systems. Poompong Sripa *et al.,* "Impact of GP gatekeeping on quality of care, and health outcomes, use, and expenditure: a systematic review," *British Journal of General Practice,* Vol. 69, 2019, pp. e296–e301.

68. Marcial Velasco Garrido, Annette Zentner, and Reinhard Busse, "The effects of gatekeeping: A systematic review of the literature," *Scandinavian Journal of Primary Health Care,* 2011, Vol. 29, No. 1, pp. 30–34; *Ibid.,* pp. e296–e301.

69. Poompong Sripa *et al.*, *op. cit.,* footnote 67, p. e294.

70. *Ibid.,* p. e301.

71. Ieva Neimanis *et al.,* "Referral processes and wait times in primary care," *Canadian Family Physician,* August 2017, Vol. 63, pp. 621–622.

72. Emily G. Marshall, Laura Miller, and Lauren R. Moritz, "Challenges and impacts from wait times for specialist care identified by primary care providers: Results from the MAAP study cross-sectional survey," *Healthcare Management Forum,* Vol. 36, No. 5, 2023, p. 341.

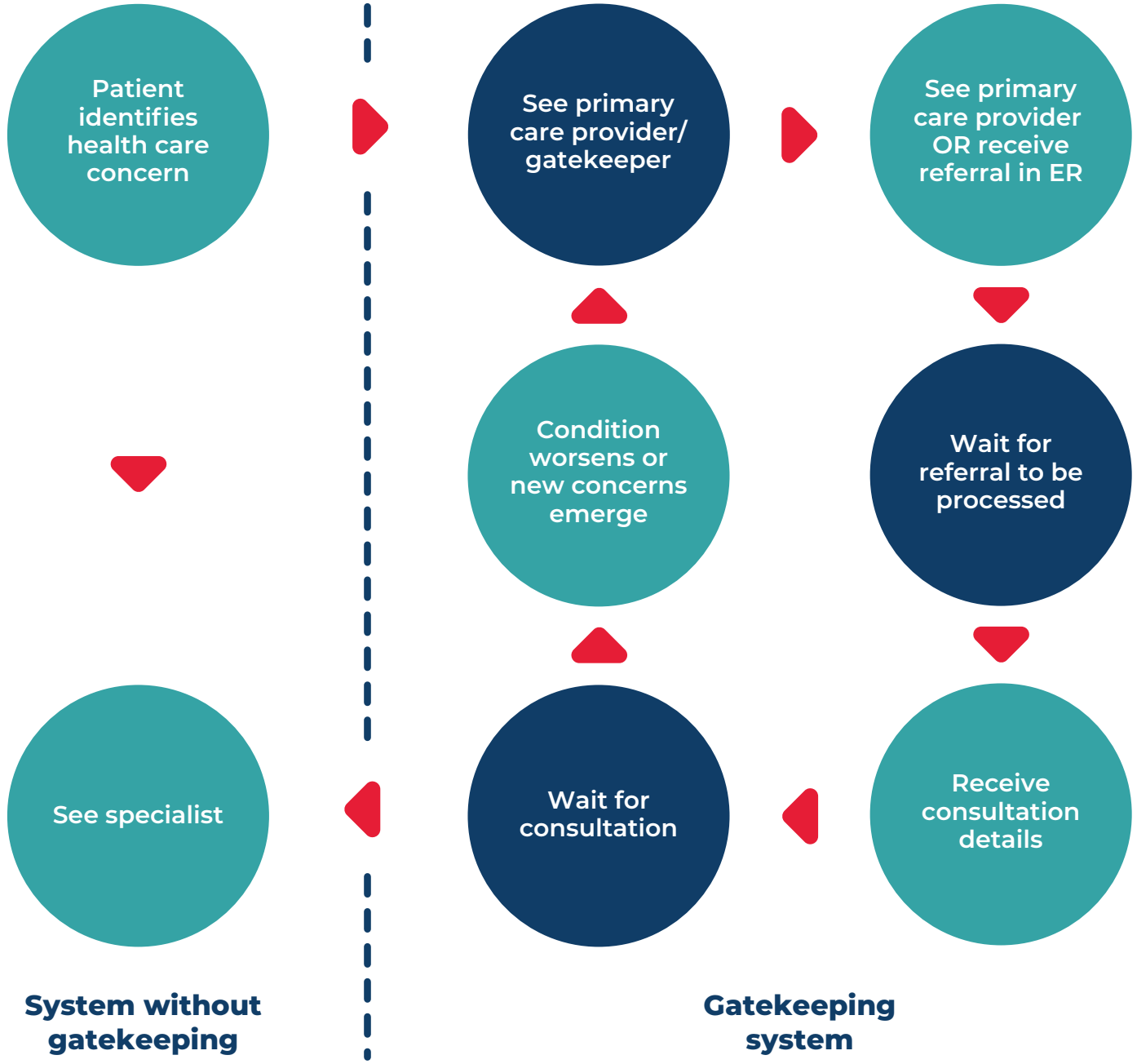
73. Peter Vedsted and Frede Olsen, "Are the serious problems in cancer survival partly rooted in gatekeeper principles? An ecologic study," *British Journal of General Practice,* Vol. 61, No. 589, August 2011, pp. e508–e510; Poompong Sripa *et al.*, *op. cit.,* footnote 67, p. e294; e302.

74. Kevin Grumbach *et al.,* "Resolving the Gatekeeper Conundrum: What Patients Value in Primary Care and Referrals to Specialists," *JAMA,* 1999, Vol. 282, No. 3; Poompong Sripa *et al.*, *op. cit.,* footnote 67, p. e301.

75. This is because family doctors in Canada typically refer patients to a specialist based on their established professional network rather than scheduling patient appointments with the next available specialist. Erin Keely and Clare Liddy, "Transforming the specialist referral and consultation process in Canada," *CMAJ,* April 2019, Vol. 191, No. 15, p. e408; Barbara L. Conner-Spady *et al.,* "Patient Factors in Referral Choice for Total Joint Replacement Surgery," *Medical Care,* Vol. 52, No. 4, 2014, pp. 300–301.

Figure 2-4

The navigation of Canada's strict gatekeeper healthcare system as experienced by patients who need to see a specialist



that make it more flexible than its counterpart in Canada. Dutch patients can go to their primary care provider for referral, but they can also choose to bypass the gatekeeper. In the Dutch system, the patient is also usually free to choose among a multitude of specialists once the referral is made.[76]

If the patient has this option as part of his or her insurance policy (usually more expensive), any specialist can be chosen.[77] In comparison, those with more basic (and less expensive) coverage will have the ability to choose a provider from a list of specialists within their health insurance network.[78] Thus, the gatekeeping system in the Netherlands offers patients extensive freedom to choose not only between insurers and insurance policies in a bid to expand their options, but also between specialists.[79]

Alternatively, a Dutch patient who wishes to can confer with the insurer about going directly to see a specialist, and if the insurer refuses to cover the consultation, he or she can still consult by paying out of pocket.[80] This allows the patient to sidestep the gatekeeping system, and reduces the burden on primary care providers by avoiding unnecessary extra primary care visits when specialist care is needed, thus mitigating the problem that plagues the system in Canada. The Dutch gatekeeping system thereby grants patients considerably more autonomy and a greater degree of control.

Germany has pushed patient freedom of choice even further. Unlike Canada and the Netherlands, gatekeeping is not mandatory in Germany and patients can freely consult with a specialist without first acquiring a referral from a primary care provider.[81] This allows providers more time for seeing additional patients, and gives the whole population greater access to primary care. In principle, there is no extra burden on primary care providers such as GPs, as German patients can see the specialist directly. This means insurers can save on the remuneration related to the (often-unnecessary) visit to the GP, and German patients receive the appropriate care without the delays typical of the Canadian referral pathway.

In contrast with Canada, the healthcare systems in Germany and the Netherlands allow patients greater choice in how they access specialist care.

Patients still have the freedom to *choose to enroll* in gatekeeping programs to take advantage of potential incentives (often financial, such as cheaper premiums). Such options are offered under both the SHI and PHI systems.[82] The important thing is that patients can choose whether or not to enroll in these programs, given their unique circumstances and healthcare needs.

2.3 German and Dutch Doctors Have Greater Professional Flexibility and Can Work for the Public and Independent Sectors Simultaneously

The universal healthcare systems in Germany and the Netherlands allow mixed (or dual) practice, meaning that healthcare professionals are permitted to practise in both the public and independent sectors at the same time (and to bill both public payers and independent ones). Mixed practice is important, as it allows greater flexibility for primary care professionals and improved access for patients.

76. Patiëntenfederatie Nederland, Reference, consulted August 30, 2024.

77. This type of policy is called a Restitutie polis or restitution policy. Healthcare for Internationals Network, Types of Policies, consulted August 30, 2024.

78. This type of policy is called a Natura polis or in-kind policy. *Idem.*

79. Zorgwijzer, Health Insurance Act (Zvw), consulted August 30, 2024.

80. Individuals who have purchased a Natura polis policy will only be fully reimbursed by their insurer for care provided by a contracted healthcare provider. If the individual wishes to be treated by a non-contracted healthcare provider they are usually only reimbursed 75% to 80% of the cost, and sometimes less. Amanda Bulthuis, "Difference between kind and refund," *Geld nl,* October 18, 2023; Patiëntenfederatie Nederland, *op. cit.,* footnote 76; Jared Penner, "Doctors in the Netherlands," *Expatica for Internationals,* August 9, 2024.

81. Sarah M. Hofmann and Andrea M. Mühlenweg, "Gatekeeping in German Primary Health Care – Impacts on Coordination of Care, Quality Indicators and Ambulatory Costs," *CINCH Series,* 2016, p. 2.

82. Tim Boekemeier, "Primary doctor principle in private health insurance: definition & explanation," *PKV Welt,* March 22, 2024; Reinhard Busse *et al.,* "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition," *The Lancet,* Vol. 17, 2017, p. 889; *Ibid.*, pp. 5–7; Personal communication with German health economist, August 14, 2024.

Table 2-1

Mixed medical practice, Canadian provinces and Germany and the Netherlands

	Allow mixed practice?
Germany	✓
The Netherlands	✓
British Columbia	✗
Alberta	✗
Saskatchewan	✗
Manitoba	✓
Ontario	✗
Quebec	✗
New Brunswick	✗
Nova Scotia	✓
Prince Edward Island	✓
Newfoundland and Labrador	✓

Source: Maria Lily Shaw and Emmanuelle B. Faubert, "The Winning Conditions for Quebec's Mini-Hospitals," MEI Research Paper, June 2023, p. 24.

Canada's strong discouragement of mixed practice is an exception among highly developed countries.[83] Among other high-income countries with universal healthcare systems, such as Germany and the Netherlands, such regulation is virtually nonexistent.[84] While Canada has no formal legislative ban at the federal level (the *Canada Health Act* does not expressly prohibit mixed practice), the majority of provinces do forbid mixed practice. Such bans exist in British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and New Brunswick, while the other four provinces (Manitoba, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador) do not formally ban the practice (see Table 2-1).[85] The literature shows that an outright ban on mixed practice is "seldom optimal" since it disincentivizes skilled healthcare professions from staying in public practice.[86]

By contrast, not only do Germany and the Netherlands not ban mixed practice, but they actually enable it, allowing care providers to operate in a variety of settings in addition to offering services to a range of insured patients. In Germany, most physicians can work for, and bill, both SHI and PHI insurers.[87] This benefits patients due to the greater

83. Livio Garattini and Anna Padula, "Dual practice of hospital staff doctors: Hippocratic or hypocritic?" *The Royal Society of Medicine,* Vol. 111, No. 8, 2018, p. 265.

84. Kiwanuka SN *et al.,* Dual practice regulatory mechanisms in the health sector: A systematic review of approaches and implementation, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, March 2011, pp. 2–3.

85. Colleen M. Flood and Tom Archibald, "The illegality of private health care in Canada," Canadian Medical Association Journal, Vol. 164, No. 6, March 2001, p. 828.

86. Paula González and Inés Macho-Stadler, "A Theoretical Approach to Dual Practice Regulations in the Health Sector," *Journal of Health Economics,* Vol. 32, No. 1, 2013, p. 25.

87. Miriam Blümel *et al.,* "Germany Health System Summary 2022," *European Observatory on Health Systems and Policies,* 2022, p. 4.

accessibility and availability of providers. German healthcare providers also enjoy more professional autonomy and potential for increased revenue streams stemming from the flexibility of being able to operate in both systems.

In the Netherlands, much like in Canada, most general practitioners are self-employed and run their own private practices.[88] However, Dutch GPs can normally bill anybody, usually the patient's private insurer, for healthcare services delivered, whoever that insurer happens to be.[89] For healthcare providers, this means they are not reliant on a single insurer for all of their income, as they would be in Canada (where the public insurance plans are in a position of monopsony, legally shielded from competition). This allows them to manage the financial stability of their practice more effectively, while maintaining the independence of Dutch healthcare providers.

Canada's strong discouragement of mixed practice is an exception among highly developed countries.

Despite the primary care systems in Canada, Germany, and the Netherlands all being universal, there are key differences in how they are funded and delivered, as this chapter has shown. When compared with Canada's system, these two European countries allow for more patient and provider choice, more system flexibility, and more competition. This allows for increased access to primary care. Based on these issues, Chapter 3 will provide recommendations to improve access to primary care in Canada.

88. Some GPs work in group practices or health centers (also considered part of the private sector) where they may be salaried employees. In 2021, 51% of GPs in the Netherlands were self-employed practice owners. Melanie Lefevre, Muriel Levy, and Carine Van De Voordep, "General Practitioner Remuneration: Overview of Selected Countries with a Mixed System of Fee-for-Service and Lump-Sum Payments," Belgian Health Centre, 2023, p. 9.

89. Primary care is covered under the basic health insurance plan. Amsterdam University of the Arts, Student Affairs/Financial Matters, Dutch health care, consulted August 30, 2024; Roosa Tikkanen *et al.*, *op. cit.*, footnote 16.

CHAPTER 3

Public Policy Recommendations to Improve Access to Primary Care for Canadians

The Canadian healthcare system in general, and primary care specifically, is facing significant challenges: patients face obstacles in accessing care and long wait times are systemic, as are ever-increasing costs. In Chapter 1, we carefully considered the disparities between patient experiences in Canada as compared with those in Germany and the Netherlands. In Chapter 2, we looked closely at the respective health system differences that contribute to these disparities. Here in Chapter 3, we make use of our earlier analyses to outline three recommended reforms that provincial policymakers can undertake to increase Canadians' access to primary care. These reforms, while ambitious, relate to the administration and delivery of healthcare services and are wholly within provincial jurisdiction to implement.[90]

Recommendation 1 – Allow Duplicate Private Insurance

As explained in Chapter 2, the ability to choose an insurer and an insurance plan in Germany and the Netherlands sets the stage for healthcare systems that are more patient-centred, whereby patients choose their coverage based on their own needs and preferences. Canada's single-payer system is the opposite: its monopsony position actually works against competition, innovation, and patient choice.

Therefore, insurance that privately covers medically necessary care (also called basic health services), or those services provided by the public sector, should be allowed across Canada.[91] Provinces and territories have the authority to determine what is considered a medically necessary service and what falls under the public insurance scheme.[92] It is also at this level that prohibitions on the offering of duplicate private insurance exist by way of legislation (see Table 3-1).

The *Canada Health Act* does not ban or otherwise regulate in any way the private purchase of health services or third-party health insurance.

The *Canada Health Act* does not ban or otherwise regulate in any way the private purchase of health services or third-party health insurance.[93] It focuses primarily on ensuring universal coverage for medically necessary hospital and physician services and stipulates criteria that provincial health insurance plans must follow to be eligible for full federal transfers. It does not mention the provision of private third-party insurance for any health service.[94] This leaves room for provinces to innovate in other areas of healthcare delivery and financing.

Currently, only New Brunswick, Nova Scotia, and Newfoundland and Labrador neither expressly permit, nor prohibit, duplicate private insurance.[95]

90. The *Canada Health Act* defines the national principles that govern the Canadian health insurance system to ensure access to medically necessary health services for all Canadians. The Act sets out the requirements that the provinces and territories must satisfy in order to receive their entitlement of Canada Health Transfer funds. While the Act provides a framework, it is up to the provinces and territories to administer and deliver healthcare services. The repercussions of non-compliance with the *Canada Health Act* can result in financial penalties and deductions from the Transfer. Government of Canada, *Canada Health Act*, 1985, last amended on December 12, 2017. Much work has been done on the *Canada Health Act* and its applicability within this context so we will not be duplicating that here. See Valentin Petkantchin, "Using Private Insurance to Finance Health Care," Economic Note, MEI, November 2005; Maria Lily Shaw, "Lifting the Ban on Duplicate Private Health Insurance in Quebec ," Economic Note, MEI, January 2023; Maria Lily Shaw, *Real Solutions for What Ails Canada's Health Care Systems – Lessons from Sweden and the United Kingdom,* Research Paper, MEI, February 2022.

91. This is not to be confused with supplementary insurance for non-medically necessary healthcare services, which is plentiful across the country and was forecast to account for approximately 11.8% of all spending on health care in Canada in 2023. Canadian Institute for Health Information, Who is paying for these services? accessed October 15, 2024.

92. What is considered a "medically necessary service" varies across provinces, but, in general, medically necessary services provided by physicians and in hospitals are covered as required by the *Canada Health Act*.

93. Gerard W. Boychuk, "Grey Zones: Emerging Issues at the Boundaries of the *Canada Health Act*," C.D. Howe Institute, Commentary No. 348, April 2012, p. 3.

94. Government of Canada, *op. cit*., footnote 90.

95. Although there are considerations surrounding the cancelling of public coverage where any private insurance payment is received in New Brunswick. Colleen M. Flood and Tom Archibald, "The illegality of private health care in Canada," *Canadian Medical Association Journal*, Vol. 164, No. 6, March 2001, p. 826.

Table 3-1

Duplicate private insurance is restricted in one way or another in most provinces	
	Restrictive Legislation
British Columbia	*BC Medicare Protection Act*
Alberta	*Alberta Health Care Insurance Act*
Saskatchewan	*Saskatchewan Medical Care Insurance Act*
Manitoba	*Health Services Insurance Act*
Ontario	*Health Insurance Act*
Quebec	*Health Insurance Act*
Prince Edward Island	*Health Services Payment Act Regulations*

Note: New Brunswick, Nova Scotia, and Newfoundland and Labrador are not represented as there are no specified provisions prohibiting duplicate private insurance in the *Medical Services Payment Act* (NB), *Health Services and Insurances Act* (NS) or *Medical Care and Hospital Insurance Act* (NL).
Sources: Government of British Columbia, *Medicare Protection Act*, Section 45 (1-2) – Private Insurers; Government of Alberta, *Alberta Health Care Insurance Act*, Section 26 (2), pp. 32-34; Government of Saskatchewan, *The Saskatchewan Medical Care Insurance Act*, Section 18 (3) – Deemed Payments; Government of Manitoba, *The Health Services Insurance Act*, Section 96 – Termination of Certain Contracts and Prohibition of Others; Government of Ontario, *Health Insurance Act*, Section 14 – Other Insurance Prohibited; Government of Quebec, *Health Insurance Act*, Section 15 – Contract of Insurance and Subrogation; Government of Prince Edward Island, *Health Services Payment Act Regulations*, Section 37 (2) – Payment by Insurers.

British Columbia, Saskatchewan, and Quebec do prohibit it under certain conditions, and Alberta, Manitoba, Ontario, and Prince Edward Island explicitly and wholly prohibit duplicate insurance.[96] The legislation in these provinces extends beyond that which is required by the *Canada Health Act*, and consequently, those who wish to liberalize the health insurance market can strike down these prohibitions.

The healthcare systems in Germany and the Netherlands rely on a market of multi-payer private insurers which fosters competition and encourages them to offer better service in addition to a range of coverage options. This leads to benefits for patients arising from the ability to select and change their insurance plan and healthcare provider according to their specific needs. Healthcare providers also benefit from greater contractual flexibility, incentives for improved service access and delivery, and the potential for increased revenue. Allowing duplicate private insurance in Canada will infuse a level of competition and patient choice that is currently non-existent.

Allowing duplicate private insurance in Canada will infuse a level of competition and patient choice that is currently non-existent.

Recommendation 2 – Remove the Gatekeeper for Specialist Care

As discussed previously, gatekeeping practices can create barriers to primary care and delay treatment, despite their stated objectives of

96. These conditions stipulate only if the insurer is private non-profit (SK), and only for services provided by practitioners outside of the public system (BC). See Government of Saskatchewan, *The Saskatchewan Medical Care Insurance Act,* Section 18 (3) – Deemed Payments; Government of British Columbia, *Medicare Protection Act,* Section 45 (1-2) – Private Insurers. In Quebec, certain medical services are permitted following the 2005 Supreme Court of Canada decision in the Chaoulli case whereby Quebecers were authorized to purchase duplicate private insurance for total hip or knee replacement or cataract extraction and intraocular lens implantation. The legislation allows for the government to determine and add additional specialized medical treatments to this exception. For the case of Quebec, see Yanick Labrie, "The Chaoulli Decision and Health Care Reform: A Missed Opportunity?" Viewpoint, MEI, June 2015; for more details see: Government of Quebec, *Health Insurance Act*, Section 15 – Contract of Insurance and Subrogation; Supreme Court of Canada, *Chaoulli v. Quebec (Attorney General) [2005] 1 SCR 791,* June 9, 2005.

streamlining health care and managing resources. Therefore, Canadian provinces should relax their gatekeeping requirements and allow patients to consult with specialists directly if they so choose. Evidence shows that this can reduce the burden on primary care providers, which would work to increase access to primary care for Canadians.

Policymakers can look to the example of the Harvard Vanguard Medical Associates (HVMA) for concrete evidence on how eliminating the gatekeeping requirement can result in more patient-centred health care without significant increases to expenditures. In 1998, HVMA, a large American multi-specialty non-profit medical group, provided care for approximately 190,000 patients through roughly 170 primary care doctors and pediatricians.[97] HVMA decided to eliminate their gatekeeping system after over 25 years due to the costs to both patients and healthcare providers (in terms of time and money).[98]

This resulted in an improved patient experience with higher satisfaction levels as patients could bypass the often time-consuming process of obtaining a referral from their primary care provider. They found that despite patients being able to access specialists directly and without referral by a primary care provider, there was no significant increase in the rate of specialist visits.[99] Therefore, gatekeeping did not appear to cut specialty visits.[100] Other research has also shown that patients whose healthcare plans lack gatekeeping reported higher satisfaction levels compared to those in gatekeeping plans.[101]

Timely access to primary care and patient satisfaction can be improved for Canadian patients by applying the lessons from HVMA and relaxing gatekeeping requirements, all while preserving the core strengths of Canada's universal healthcare system without necessarily resulting in substantial cost increases.

Private duplicate insurance may also give rise to different gatekeeping contracts

If our first recommendation is followed, the removal of the gatekeeper system may be stimulated by the emergence of a duplicate private insurance market. Depending on the preferences of the insured, the differentiation of insurance plans could be stimulated by the presence of multiple insurers operating in a competitive market.

Canadian provinces should relax their gatekeeping requirements and allow patients to consult with specialists directly.

Certain segments of the population may value direct access to specialists, which could lead insurers to offer plans that would allow patients to bypass gatekeeping practices altogether. Patients who prefer direct access to specialists could opt for such plans, while those who choose to remain in the gatekeeping system, for whatever reason, could do so.[102] Therefore, the presence of multiple insurers for medically necessary care, including primary care, could lead to the development of insurance plans that allow patients to bypass the traditional gatekeeping system, as seen in Germany and the Netherlands.

Recommendation 3 – Allow Mixed Practice for Healthcare Workers

Allowing mixed practice for healthcare workers offers a promising path to expanding Canadians' access to primary care. As discussed in Chapter 2, evidence from Germany and the Netherlands demonstrates that allowing healthcare workers to

97. Patients were insured through Harvard Pilgrim Health Care and included approximately 140,000 adults and 50,000 children. Physicians were general internists who served as primary care providers. Timothy G. Ferris *et al.,* "Leaving Gatekeeping Behind—Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization," *New England Journal of Medicine*, Vol. 345, No. 18, November 1, 2001, p. 1313. Timothy G. Ferris *et al.*, "Effects of Removing Gatekeeping on Specialist Utilization by Children in a Health Maintenance Organization," *Archives of Pediatrics & Adolescent Medicine*, Vol. 156, No. 6, June 2002, p. 574.

98. Massachusetts General Hospital, "HMO gatekeeping does not appear to cut specialty visits," *EurekaAlert*, AAAS, October 31, 2001.

99. *Idem*.; Timothy G. Ferris *et al.*, *op. cit*., footnote 97, p.574. Timothy G. Ferris *et al., op. cit*., footnote 97, p. 1315.

100. These results do have limitations as delineated by the authors themselves. Application to other systems or models of care require careful consideration.

101. Poompong Sripa *et al.*, "Impact of GP gatekeeping on quality of care, and health outcomes, use, and expenditure: a systematic review," *British Journal of General Practice*, May 2019, p. e299.

102. This could potentially enable insurers to offer lower premiums for plans with gatekeeping requirements while charging higher premiums for more flexible options, as is currently the case in countries like Germany and the Netherlands. See discussion in Chapter 2.

divide their time between the public sector and the independent sector, rather than requiring them to choose to participate only in one or the other, makes more efficient use of limited resources and highly skilled medical professionals. This is particularly important in the context of primary care physicians leaving the public system across Canada.

In Quebec, in the past year alone, 780 doctors, or about 4%, have withdrawn entirely from the public insurance system and stopped billing it.[103] Of these, about two-thirds are GPs, who are leaving the public system at a faster rate and earlier in their careers than ever before.[104] The reasons these doctors are leaving the public system are a critical lack of resources, the bureaucratic burden of costly red tape, the growing constraints of public sector family practice, and more demanding and rigid working conditions in the public sector.[105] Simply put, the public system is driving them out.

Given that the number of doctors opting out has been on an upward trend in recent years, and has more than doubled in the past decade, this is important.[106] By permitting mixed practice, these doctors would be free to split their time between the two, providing much-needed medical care in both the public and independent sectors. This would contribute to retaining these professionals by keeping them engaged in the public system, thus increasing the total volume of medical services available to patients. This phenomenon is not unique to Quebec, and this recommendation applies to all provinces that ban the practice.

The *Canada Health Act* does not address the delivery of healthcare services or require physicians to operate exclusively within or outside of provincial public health insurance programs.[107]

Therefore, mixed practice does not contravene the Act, and the requirements around universality and accessibility can still be met. Most Canadian provinces, however, have decided to prohibit it through various laws and regulations; these are the primary barriers to implementation.

Allowing healthcare workers to divide their time between the public sector and the independent sector makes more efficient use of limited resources.

For example, Alberta's *Health Care Insurance Act* restricts physicians from receiving payment from both public and private sources for services covered by the public health insurance plan.[108] British Columbia's *Medicare Protection Act* and Quebec's *Health Insurance Act* also force physicians to choose between working entirely within the public sector, or entirely within the independent sector.[109] It is these acts that ban private duplicate insurance, and that would have to be amended in order to allow mixed practice for physicians. Thus, the onus is on the provinces.

103. This number includes general practitioners and specialists. Aaron Derfel, "Quebec doctors are abandoning the public system in record numbers," *Montreal Gazette*, July 21, 2024; Aaron Derfel, "780 doctors opted out of medicare in Quebec. Only 14 have in the rest of Canada," *Montreal Gazette*, July 29, 2024.

104. The other third refers to medical specialists. Tu Thanh Ha and Yang Sun, "Why more Quebec family doctors are leaving the public health system," *The Globe and Mail,* August 8, 2023.

105. Stéphane Bordeleau, "Record number of Quebec doctors left public system in last year," *CBC News*, July 24, 2024; Aaron Derfel, *op. cit.*, footnote 103.

106. In 2012, 280 opted out, and in 2023 that number was 642. Aaron Derfel, *op. cit.*, footnote 103; Tu Thanh Ha, *op. cit.*, footnote 104.

107. Government of Canada, *op. cit.*, footnote 90.

108. Government of Alberta, *Alberta Health Care Insurance Act*, Revised Statutes of Alberta 2000, Chapter A-20, sections 9 and 11, current as of June 21, 2024.

109. Government of British Columbia, *Medicare Protection Act*, [RSBC 1996] Chapter 286, Section 14 and 17–18, current as of October 8, 2024; Government of Quebec, Légis Québec, A-29 - *Health Insurance Act*, section 22.

CONCLUSION

Primary care is an important component of healthcare, and greater access to it is associated with a range of better health outcomes. Yet a well-functioning primary healthcare system requires that a patient first be able to access it, and Canadians are struggling to gain that access. This is not the case (or is true to a far lesser extent) in other OECD countries with universal healthcare systems, notably Germany and the Netherlands.

Chapter 1 outlined clearly that Germany and the Netherlands have been able to maintain universal healthcare coverage and primary care access while addressing common challenges in the Canadian system such as wait times and resource allocation.

A well-functioning primary healthcare system requires that a patient first be able to access it.

As discussed in Chapter 2, these outcomes arise from several differences between the healthcare systems in Canada, Germany, and the Netherlands. The first is the way the healthcare systems are funded, with Canada's single-payer health insurance system the outlier. The second difference is that when, as in Canada, patients are strictly required to see a primary care provider before being able to access specialist care (gatekeeping), primary care can be overburdened with extra visits and administration, and patients can suffer from delayed diagnoses (among other things). The final difference concerns whether, and to what extent, healthcare workers are allowed to operate in both public and independent sectors (mixed practice).

The successful German and Dutch examples provide valuable insights for Canadian policymakers considering healthcare reforms, demonstrating that mixed elements can coexist with, and even enhance, a universal public healthcare system. As such, we have presented practical recommendations in Chapter 3 that can be applied to Canadian health care in order to increase access to primary care. These are: 1) the allowance of duplicate private insurance for medically necessary health care (including primary care); 2) amendment of the strict gatekeeper model; and 3) allowing mixed practice for healthcare workers. These proposed changes would expand patient choice, increase health provider flexibility, and allow for improved overall access to primary care services for Canadians.

Despite having the authority to pursue such reforms within the existing *Canada Health Act* framework, provincial policymakers have so far failed to act. This inaction represents a missed opportunity to enhance healthcare delivery and improve patient outcomes. As wait times continue to grow and access problems persist, it is imperative that provincial governments take steps toward implementing meaningful healthcare reform, for the sake of all Canadians.

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