No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO, WALID KALFALLAH by his litigation guardian DEBBIE WAITKUS, and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH OF BRITISH COLUMBIA, and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

AND:

DR. DUNCAN ETCHES, DR. ROBERT WOOLLARD, GLYN TOWNSON, THOMAS McGREGOR, BRITISH COLUMBIA FRIENDS OF MEDICARE SOCIETY, CANADIAN DOCTORS FOR MEDICARE, MARIËL SCHOOFF, DAPHNE LANG, JOYCE HAMER, MYRNA ALLISON, and the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY

INTERVENORS

AND:

THE ATTORNEY GENERAL OF CANADA

Pursuant to the *Constitutional Question Act*

PLAINTIFFS' EXPERT: YANICK LABRIE, M.A. ECONOMICS

Response report

Submitted by
Yanick Labrie
July 31, 2014

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LIST OF ACRONYMS

CSST	Commission de la santé et de la sécurité du travail
ISTC	Independent Sector Treatment Centres (England)
MSSS	Ministère de la santé et des services sociaux
NHS	National Health System
OECD	Organisation for Economic Cooperation and Development
PHI	Private health insurance
RAMQ	Régie de l'assurance maladie du Québec
SMC	Specialized Medical Centre (Quebec)
SIMASS	Système d'information sur les mécanismes d'accès aux services spécialisés

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Acknowledgement

I am aware of my duty under Rule 11-2 of the British Columbia Supreme Court Civil Rules to assist the court and not assume the role of advocate for any party, and I certify that this report is made in conformity with that duty and that if called upon to give a testimony, I will do so in conformity with that duty.

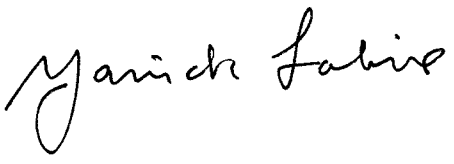
Qualifications

I am an economist and health care policy analyst associated with the Montreal Economic Institute, an independent, not-for-profit research and educational organization. I am also a tenured professor of economics and statistics at CEGEP Saint-Jean-sur-Richelieu, a public college in Quebec, where I have been teaching since 2006. I earned my bachelor's degree in economics from Concordia University in 2002 and my master's degree in economics from the Université de Montréal in 2004, where I specialized in econometrics.

I am frequently invited to participate in conferences and debates, and to analyze economic affairs in the media. I have spoken at national conferences in Montreal, Toronto and Winnipeg on the lessons to be drawn from Europe's health care systems. I also appeared before the House of Commons Standing Committee on Finance last year regarding the issues of income inequality and economic mobility in Canada.

I have written several studies and articles analyzing the health care policies and reforms implemented in different countries over the last decade. I am the author of a recent research paper entitled *For a Universal and Efficient Health Care System: Six Reform Proposals*, released in March 2014. In order to formulate these six reform proposals, I consulted and carried out an in-depth analysis of over 250 books, studies and reports on health care policies and reforms undertaken in various OECD countries. Last June, I was invited to present the results of my research at the 20th edition of the International Economic Forum of the Americas, held in Montreal.

A copy of my *Curriculum Vitae* is attached to the present document, and marked as Appendix "A".



Introduction

I was approached by lawyers from Gall, Legge, Grant & Munroe LLP on behalf of the plaintiffs and asked to produce a report rebutting some opinions expressed by experts Marie-Claude Prémont, Professor at the École nationale d'administration publique, and Damien Contandriopoulos, Assistant Professor at the Faculty of Nursing of the University of Montreal, in the present case before the Supreme Court of British Columbia: *Cambie Surgeries Corporation et al. v. Medical Services Commission of British Columbia et al*.

I have carefully read the reports submitted by the two expert witnesses, as well as the Third Amended Notice of Civil Claim and the Response to Further Amended Civil Claim filed in the present court proceedings.

In their respective reports, Ms. Prémont and Mr. Contandriopoulos express a range of opinions about the effects the *Chaoulli* ruling (and the government's subsequent response) have had on the health care system in Quebec. Both experts share the opinion that the government's response to the *Chaoulli* judgement has, to some extent, contributed to the emergence of a two-tier health system which negatively affects universality and equity in access to care in the province of Quebec. I reply to some of their opinions in the paragraphs that follow.

1. Response to Marie-Claude Prémont's expert report

Ms. Prémont was asked by the defendants in the present case to describe and comment on the reforms implemented in the province of Quebec following the decision of the Supreme Court of Canada in *Chaoulli v. Quebec* (Attorney General), [2005] 1 S.C.R.

In the following sections, I will offer my rebuttal to some of her opinions pertaining to three specific issues she addresses in her report, namely:

a) the potential effects of duplicate private health insurance;
b) the behaviour of private providers in a health care system; and
c) the effects of the legal and administrative changes in Quebec following the *Chaoulli* decision.

1.1 Opinions about the potential effects of duplicate private insurance

Opinion 1:
"[It] is recognized that duplicate private insurance may lead to important equity problems in access to care (OECD, 2004, p. 21)." (p. 6)

This opinion is supported neither by theory nor by empirical evidence.

First, Ms. Prémont does not present data showing that equity problems in access to care arise, or arise to a greater extent, in a health system where private duplicate insurance is allowed. The source given as a reference, namely OECD,[1] 2004, p. 21, does not provide any evidence of equity problems related to access to care (nor does it even acknowledge the existence of such problems). On p. 21 of this document, there are simply two figures entitled "Analytical framework for the OECD private health industry study" and "Key variables for an analysis of PHI markets" with no explicit reference to the term "problem" (or any synonym for that term).

Second, what is recognized is that inequity in access to care, as generally defined[2] in the economic literature, exists to varying degrees in most countries (Devaux and de Looper, 2012). The evidence does not show that the presence of a duplicate private insurance market leads to greater inequity when it comes to access to medical services. In a recent analysis of 19 countries, for instance, OECD researchers found that Denmark and the United Kingdom, where duplicate insurance covers 27% and 16% of the population respectively,[3] were the two most egalitarian countries in this regard. In fact, among the countries analyzed, Denmark is the only one where the probability of consulting a doctor is higher among low-income people (bottom quintile) than among high-income people (top quintile). In the UK, people with lower incomes are as likely to consult a doctor as those with higher incomes when needs are taken into consideration (Devaux and de Looper, 2012, pp. 19-20). Conversely, Canada fares poorly by this measure in this international ranking.

Third, there is a large body of empirical evidence showing that access to care varies with socioeconomic status in Canada, despite the prohibition of duplicate private health insurance (see for instance McIsaac, Goel and Naylor, 1997; Alter, Basinski and Naylor, 1998; Hawker et al., 2002; Pilote et al., 2003; Alter et al., 2004; Curtis and MacMinn,

[1] OECD (F. Colombo, N. Tapay) (2004), *Private Health Insurance in OECD countries*, 247 p.
[2] Ms. Prémont did not define what she meant by "equity in access to care," a concept that may be subject to different interpretations. In the economic literature, the notion of equity in access to care is usually interpreted as requiring that "people in equal need of care [be] treated equally, irrespective of characteristics such as income, place of residence, race, etc." (Van Doorslaer and C. Masseria, 2004, p. 9).
[3] See Table 2 on page 13 of the current document for references.

2008; McGrail, 2008). Many studies conducted over the past two decades have shown that it is the poorest Canadians who have the least access to health care, especially when it comes to a first contact with the health care system. According to one of these studies, 30% of Quebecers among the poorest segment of the population (compared to 16% among the richest one) reported in 2005 having unmet needs when it comes to health care, primarily due to long wait times or the impossibility of seeing a doctor when needed (Lévesque et al., 2012). Available evidence also indicates that the richest in Canada generally enjoy privileged access to the public health care system, because of personal relationships and other factors that allow them to jump the queue (Alter et al., 1998).

Moreover, according to researchers at the University of Waterloo and at the Department of Finance of the Government of Canada who investigated the pattern of health care utilization over a period of 25 years, from 1978 to 2003, access to care is becoming more and more inequitable in Canada. They mention that "prior to the introduction of the *Canada Health Act*, studies indicate that equity principles were intact" (Curtis and MacMinn, 2008, p. 67).

Opinion 2:
"Collective insurance plans are prominent in Canada within markets where insurance industry is relatively free to sell insurance, such as drug (outside hospitals) and dental care markets." (p. 12)

This statement is correct. Other forms of private health insurance are already well established in Canada, and insurance companies offer a wide range of policies to citizens all over the country (see Table 1 below).

Table 1: Percentage of the population covered by various types of private insurance, Canadian provinces, 2012

Province	Disability	Extended health benefits	Dental care
British Columbia	24.8 %	47.0 %	27.0 %
Alberta	38.0 %	61.3 %	32.5 %
Saskatchewan	29.3 %	69.6 %	42.1 %
Manitoba	29.6 %	63.8 %	33.0 %
Ontario	32.7 %	78.8 %	47.9 %
Quebec	31.1 %	70.0 %	35.7 %
New Brunswick	26.7 %	33.2 %	19.6 %
Nova Scotia	26.0 %	39.4 %	25.0 %
Prince Edward Island	32.4 %	46.8 %	17.9 %
Newfoundland and Labrador	28.3 %	69.1 %	36.1 %
Canada	31.7 %	68.2%	38.7 %

Sources: Canadian Life and Health Insurance Association, Facts & Figures, Canadian provinces, p. 1; Statistics Canada, *Population by Year, by Province and Territory*, Table CANSIM No.051-0001; Author's calculations.

Opinion 3:
"Unless complex regulations are adopted, private insurers are free to cherry-pick the lower risk clienteles and focus on more profitable services, while the public insurer has duties to all citizens of all risks. When duplicate insurance is free to cream-skim the insurance market, public insurance is crowded out to the higher risk citizens and services." (p. 14)

This criticism is unfounded. Ms. Prémont's assumption that low-risk clienteles are more profitable than high-risk ones, and that the existence of a duplicate insurance market will necessarily benefit private insurers and be detrimental to the public insurer is not grounded in fact.

First of all, low-risk clienteles may be less likely to insure themselves or to seek extensive coverage and are thus not necessarily a large source of revenues for private insurers. Further, steps can be taken to insure that private insurers offer the same level of coverage to all clients, regardless of their risk level. In many countries, such as Australia and Ireland, private insurers are not allowed to charge differentiated premiums based on risk or individual characteristics. Governments impose uniform premiums set according to a community's average estimated risk (Kozhaya, 2006).[4]

Second, the high-risk patients in Canada are already being treated at this moment in the public system and are thus already a burden for the government. With the addition of a duplicate insurance market, some of them would not be treated anymore in the public system. And all patients not being treated in the public system, whether they are low- or high-risk clienteles, would leave more resources to be devoted to other patients there, while still funding the public system through their taxes. Both the public and the private insurers would benefit from the additional financial resources brought by the emergence of duplicate insurance.

In Ireland, for example, where private duplicate insurance is available and premiums are set uniformly on the basis of community rating, data show that privately insured patients have a more complex mix of treatments than others (Turner and Shinnick, 2012, pp. 3-4). As the conclusion of a recent Irish study makes clear:

[4] Even in instances where there exists no particular regulation that imposes uniform premiums, it does not follow automatically that premiums are determined by individual risk and that high-risk individuals therefore find it hard to obtain insurance because they are required to pay exorbitant amounts. In Canada, private extended health, disability and dental insurance plans are commonly offered on a group basis, for example by an employer (refer to Table 1, on page 9). Guaranteed renewal insurance has also been developed, whereby premiums are set uniformly and individuals remain insurable even if they become high-risk customers one day after having contracted a certain type of illness, for instance.

"The widespread availability of private health insurance clearly provides substantial savings to the public healthcare system, particularly as the operation of community rating encourages higher numbers of older consumers to take out insurance than would be the case in a risk-rated market. The savings to the public system are, however mitigated by the state subsidisation of private health insurance as mentioned above. Nevertheless, in its absence, such patients would be forced to rely on the public system, which would increase the overall average length of inpatient stay and complexity of treatment among public patients, thereby increasing the utilisation of public inpatient beds. If these patients were to rely on the public healthcare system then either the public system would require additional resources or waiting lists for public treatment would be lengthened further." (Turner and Shinnick, 2012, p. 5)

Opinion 4:
"[The] repercussions of allowing the private industry to cover the same publicly insured services inspired most provinces to ban duplicate private insurance from the market on the assumption that it would injure more than it would help provinces to meet the pan-Canadian public policy of providing good quality services to all without distortion based on means" (p. 14)

First, the policy goal of providing good quality services to all without considerations based on means is shared by all developed OECD countries with universal health care systems. Nevertheless, many of them allow their citizens to voluntarily purchase duplicate private insurance, while still retaining the coverage offered by the public plan. Duplicate health insurance is indeed available in many OECD countries with universal health care systems including Australia, Denmark, Finland, Greece, Ireland, Israel, Italy, Norway, New Zealand, Portugal, Spain, Sweden, and the United Kingdom (see Table 2). Conversely, Canada is often characterized as being unique in banning the coverage of medically required services by private insurance companies (see, for instance, Detsky and Naylor, 2003, p. 805).

It is after having reviewed the evidence on this matter that the *Task Force on the Funding of the Health System*, chaired by Claude Castonguay,[5] recommended in its 2008 report a greater role to private duplicate insurance in Quebec. According to the *Task Force*, the fact that a certain proportion of the population in many developed countries voluntarily decides to purchase duplicate private insurance is not incompatible with having health services accessible to all.[6]

[5] Claude Castonguay is widely considered the founding father of Medicare in Quebec, so much so that Quebecers usually refer to the Quebec health card (carte d'assurance maladie) as the "castonguette."

[6] As stated in the report: *"[The] question of private insurance raises the whole question of freedom of choice. Freedom of choice is compatible with a public plan accessible to all. An individual's freedom of choice will not have the effect of limiting the rights and freedoms of other citizens, if it is well governed. On the contrary, it will have the indirect consequence of increasing the overall supply of care, and thus its accessibility. This is not a matter of choice for higher-income individuals. The following very real case clearly illustrates the importance of this freedom of choice for everyone. It concerns a truck driver who, instead of having to wait weeks for an operation decided to pay out of his pocket to return to work faster. On the basis of what principle can he be refused the right to obtain insurance against such a risk, when the public system is unable to meet his needs satisfactorily?"* (Castonguay, Marcotte and Venne, 2008, p. 95)

Table 2: Percentage of the population holding duplicate private insurance and basic primary health insurance, various OECD countries

Country	Percentage covered by duplicate private insurance	Percentage covered by basic primary health insurance (2012)
Australia	47% (2013)	100%
Denmark	27% (2012)	100%
Ireland	43% (2011)	100%
Italy	21% (2001)	100%
New Zealand	30% (2013)	100%
Norway	<10% (2013)	100%
Portugal	20% (2006)	100%
Spain	18% (2011)	100%
Sweden	4% (2011)	100%
United Kingdom	16% (2012)	100%

Sources (duplicate private insurance): AUS: Private Health Insurance Administration Council, Quarterly Statistics, March 2013. **DEN:** Statistics Denmark, Table BEF5: Population – 1 January, by sex, age and country of birth; Forsikiring & Pension, *Sundhedsforikring Antal forsikede, praemier og erstatninge*; authors' calculations; **SPA:** Lostao et al., 2014, p. 23; **IRE:** Millward Brown Lansdowne, 2012, p. 3. **ITA:** Fabbri and Monfardini, 2011, p.3; **NOR:** Thomson et al., 2013, p. 6; **NZ:** Health Funds Association of New Zealand, 2013, p. 4. **POR:** Barros, Cristovao and Gomes, 2013, p. 238; **SWE:** Anell, Glenngard and Merkur, 2012, p. xvii; **UK:** Dusheiko, 2014, p. 83.

Source (basic primary insurance): OECD, Health System Characteristics Survey 2012.

Second, Ms. Prémont's comment suggests that Canadian provinces have rationally weighed the pros and cons before deciding to prohibit duplicate private insurance. A neutral expert would have also discussed the positive aspects of duplicate insurance.

Indeed, health economists generally recognize that duplicate private insurance has advantages, from a public standpoint (for an in-depth review and analysis of this issue, see Kiil, 2011). Among these are the potential to improve overall access to care by bringing additional resources into the system on a voluntary basis (Hoel and Saether, 2003, p. 602) and the potential to improve equity in the funding of the health system by favouring redistribution from the rich to the poor.

Insofar as those covered by duplicate insurance policies use the private system while continuing to contribute to the funding of the public system through their taxes, more resources can be devoted to each patient in the public system. Thus, duplicate insurance has the potential to reduce waiting times for treatment and improve access to care for all, not only for the privately insured. This thesis has recently been verified empirically with data from Denmark. According to a group of Danish researchers who looked into the matter, private duplicate insurance coverage "was associated with an average 10% reduction in the use of public hospitals. This means that the public health care budget was relieved and that overall access to health services, ceteris paribus, must have improved for the uninsured as well as the insured." (Søgaard, Pedersen and Bech, 2013, p. 65).

Some economists also argue that duplicate private health insurance accentuates the progressivity of the financing of the health care system (Wagstaff and Van Doorsaler, 2000, p. 1826). Researchers who recently sought to evaluate this thesis using data from Italy concluded that "the better-off individuals, who more frequently buy VHI [voluntary health insurance] coverage, opt out of the public provision, so that the Italian NHS [national health system] redistributes, from high income to low income individuals, through the operation of the VHI market." (Fabbri and Montfardini, 2011, p. 4).

1.2 Opinions about private providers of health services

Opinion 5:
Private providers of health services "usually require for their viability and growth: 1) ***Favourable public policies and legislation*** *including: protected markets, freedom to cherry-pick the most profitable services or clienteles, back-up by a reliable public service when things go wrong or to handle complex cases"* (p. 11)

This opinion about the behavior of private providers of health services is not data- or evidence-based. My research on foreign health systems (Labrie, 2014), particularly those of Australia, Denmark, England, France, and Germany, leads me to conclude that this generalization about the behavior of private health care providers does not stand up to scrutiny.

First, when hospital facilities operate in a context of competition and when their remuneration varies according to the complexity of procedures, there is no incentive to avoid treating complex cases. Rejecting them can only harm a facility's reputation and drive away potential clients, and hence, precious revenues.

In Germany, for instance, private hospitals are fully integrated into the public health care system and treat all patients, not just the easier, more profitable ones or those who have purchased private insurance (Augurzky, Beivers and Gülker, 2012, p. 31). According to a recent German study, "profit orientation is not to the detriment of the medical care delivered to patients, and private providers are not 'cherry pickers', leaving loss-making business to their public competitors." This study also confirms that private hospitals in Germany are all well equipped to handle complications and complex cases and pathologies: "In the area of intensive care beds, the private hospitals even make a disproportionate contribution to the treatment of patients suffering from severe conditions and thus ensuring (emergency) care" (Augurzky, Beivers and Gülker, 2012, pp. 26-29).

In France, private for-profit providers account for 39% of all health institutions with hospitalization capacity (see Table 3). In all, they take care of approximately eight million patients a year, without discrimination based on financial means or medical conditions, and carry out 54% of all surgeries (Boisguérin and Brilhault, 2014, pp. 102-103). Private hospitals also play a non-negligible role in ensuring emergency services, as they run nearly 20% of institutions with emergency rooms and receive over 2.3 million emergency room visits a year (Boisguérin and Brilhault, 2014, p. 137). Given that the hospital funding system takes into account complications and the severity of cases

treated, private providers take on tough cases at a rate that is comparable to that of public hospitals (Guérin and Husser, 2011, p. 19).[7]

Table 3: Distribution of hospitals in various OECD countries, by type of ownership, 2012

Countries	Public hospitals	Private non-profit hospitals	Private for-profit hospitals
Australia (2011)	56.0%	8.6%	35.5%
Austria	55.6%	15.5%	28.9%
France	34.9%	25.9%	39.2%
Germany	25.8%	32.2%	42.0%
Italy	42.7%	3.1%	54.2%
Netherlands	0	69.5%	30.5%
New Zealand (2013)	51.9%	17.5%	30.6%
Portugal	51.4%	24.8%	23.8%
Spain	45.8%	15.0%	39.1%
United States (2010)	26.5%	52.7%	20.8%

Source: OECD, Health Statistics Database 2014; Author's calculations.

In England, the situation is slightly different. In 2002, the government set up a network of private treatment centres (ISTC), specializing in elective surgeries. The objective was not only to reduce waiting times but also to improve efficiency of elective care by separating routine treatment from more complex and emergency care. An Audit Steering Committee, composed of members of the Royal College of Surgeons of England, was set up to investigate the results of the program in 2010. Their analysis has shown that these specialized centres, far from selecting only the least complex cases, instead raised the bar in terms of both efficiency and quality of care. As the conclusion of the Committee makes clear:

> "In line with their contracts, ISTCs treat patients with a more favourable case mix profile. The difference in severity of symptoms before surgery between ISTC and

[7] We observe the same phenomenon in Australia as well. The Productivity Commission who investigated this issue a couple of years ago concluded that "private hospitals undertake, on average, relatively more complex cases than public hospitals" (Productivity Commission, 2009, p. 190). It is noteworthy that 77% of the sample of private providers was made up of for-profit hospitals (p. 186).

> NHS patients, however, were small. For example, the preoperative hip or knee score in NHS patients was less than one point lower than in ISTC patients. Consequently, our results lessen concerns that ISTCs are 'cherry-picking' the more healthy patients and that they have a negative impact on service configuration and surgical training. [...] Our findings support the idea that separating elective surgical care from emergency services could improve quality of care. This might result from a more predictable work flow, which will increase senior supervision of complex cases." (Chard et al, 2011, p. 4)

Ms. Prémont's thesis, therefore, according to which the success of private health care providers depends on them being sheltered from competition, on selecting the least complex cases or on a reliance upon the public sector for the serious cases, does not fit the facts observed in many foreign countries with universal systems.

1.3 Opinions about the changes in Quebec following the *Chaoulli* decision

Opinion 6*:*

"The new rules, and particularly the setting up of private for-profit surgical facilities in combination with the wait-time guarantee, has now led to some out-sourcing of surgical services from the public network. […] Table 7 presents the number of surgeries performed by private facilities (SMCs) for three hospitals, as of June 2014." (sic) (p.19)

The numbers presented by Ms. Prémont in Table 7 of her report are inaccurate. The information on the number of surgeries performed at the Institut de l'oeil des Laurentides (13,000) was taken from an article in *La Presse* newspaper, but this source indicates that it is rather the Rockland MD Surgical Centre that has performed 13,000 surgeries (Duchaine and Lacoursière, 2014). Moreover, the actual data made public by the Government of Quebec show that the Rockland MD Surgical Centre has performed 10,681 surgeries under its agreement with the Sacré-Coeur Hospital from 2008-2009 to 2013-2014, and not 25,000 (as claimed by Ms. Prémont) (see Table 4).

Table 4: Number of surgeries performed in Rockland MD Surgical Centre by virtue of its partnership agreement with Montreal's Sacré-Coeur Hospital, from 2008-2009 to 2013-2014

Year	Number of surgeries performed
2008-2009	1024
2009-2010	1936
2010-2011	2160
2011-2012	2175
2012-2013	1809
2013-2014	1577
Total	10,681

Source: Commission de la santé et des services sociaux (2014b, p. 61).

Opinion 7:
"Potential administrative changes can also be measured by looking at the number of physicians who have opted out of the public regime since the Chaoulli decision. Numbers are presented in the following Table 8, comparing numbers for 2005 (the date of the Chaoulli decision), to the current numbers for 2014. The number of physicians leaving the public system is increasing. The number of general practitioners not enrolled in the public system has doubled since 2005, while the number of specialists has quadrupled." (p. 21)

The numbers presented in Table 8 of Ms. Prémont's report are once again inaccurate.

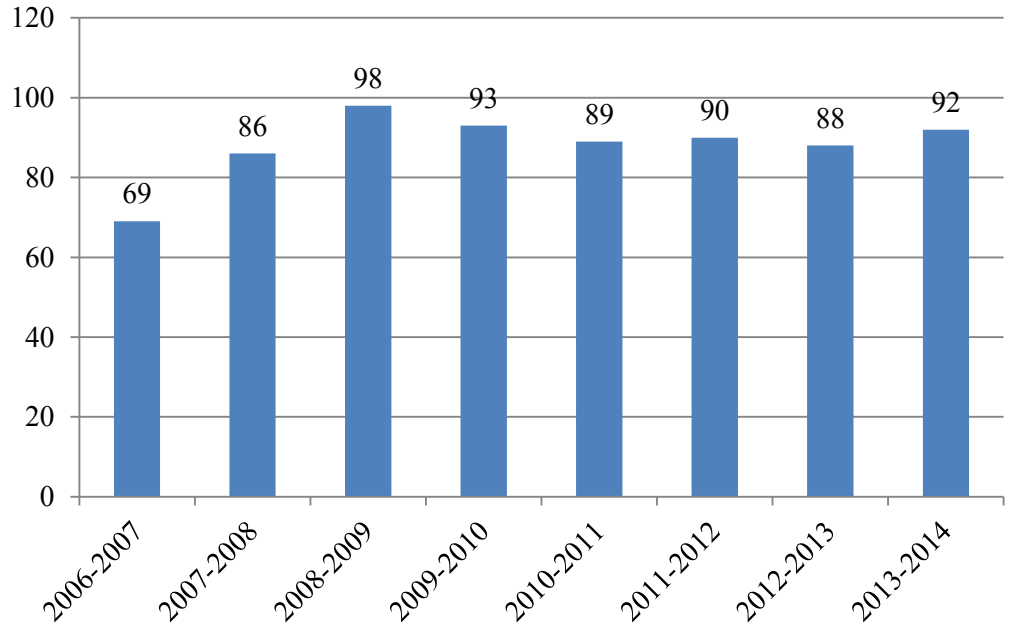
First, for the year 2005, the numbers cannot be extracted from the source she provided as a reference. The Régie de l'assurance maladie du Québec (RAMQ) only publishes on its website the list of the physicians (specialists and general practitioners) who are currently not participating in the public plan, as of a specific date (this document is updated periodically on the RAMQ website) and does not publish time trends.

Second, for the year 2014, Ms. Prémont reversed the numbers in Table 8 of her report. As of July 2014, the RAMQ list contains the names of 80 non-participating specialists (not general practitioners, as she claims) and 204 non-participating general practitioners (not specialists, as she claims).

Third, the RAMQ list cannot be used for the purpose of showing a time trend. Indeed, this list may change several times during a given year. The valid data made public by the RAMQ is the one presented every year in the context of the so-called "Étude des crédits" session before Quebec's National Assembly (Commission de la santé et des services sociaux, 2014; Commission parlementaire aux affaires sociales, 2011). The data pertaining to the number of specialists who chose to opt-out of the system from fiscal year 2006-2007 to fiscal year 2013-2014 are presented below in Figure 1.[8] We can see by looking at these data that, after an increase between 2006-2007 and 2008-2009, the number of physicians choosing not to participate in the public plan started to level off, and even to decrease slightly thereafter. Therefore, her conclusion that the number of specialists not enrolled in the public system "has quadrupled" since the *Chaoulli* decision is invalid.

[8] In fact, it is not possible to obtain data for 2005-2006 because the documents "Études des crédits" available on the MSSS website do not go back far enough in time to retrieve this data.

Figure 1: Number of medical specialists not participating in the public health insurance plan (RAMQ) in Quebec, from 2006-2007 to 2013-2014



Sources: Commission parlementaire des affaires sociales (2011, p. 135); Commission de la santé et des services sociaux (2014a, p. 134)

2. Response to Damien Contandriopoulos's expert report

Mr. Contandriopoulos was asked to describe the response of the Quebec government following the decision of the Supreme Court of Canada in *Chaoulli v. Québec* (Attorney General), [2005] SCC 35, and to describe the effects that this decision and the government's response had on the public health care system in Quebec.

In the following paragraphs, I reply to Mr. Contandriopoulos's overall opinion about these issues, as summarized in the conclusion of his report.

2.1 Opinion about the impact of the *Chaoulli* decision on Quebec's health system

Opinion 1:
"Overall, my opinion is that the Chaoulli ruling had a significant impact on the evolution of Quebec's health care sector. It fed a steady evolution toward the social acceptance and the development of a two-tier system that negatively impact the universal and equitable access of medical services." (p. 12)

First, Mr. Contandriopoulos does not present any measure of the significance of what he refers to as the "social acceptance" of a "two-tier system." His alleged link between the *Chaoulli* ruling and the "steady evolution toward the social acceptance and the development of a two-tier system" is not supported by any data or evidence. He presents in his report what he himself qualifies as anecdotes about the growing number of private medical clinics observed in Quebec since the *Chaoulli* decision and assumes that this is proof of a trend "toward the social acceptance and the development of a two-tier system." However, a much more plausible reason behind the growing number of private clinics is rather a declining tolerance of long waiting times by a growing portion of Quebecers, leading to a growing demand for private medical services.

Second, social acceptance vis-à-vis a parallel (or a two-tier) system is not a new phenomenon, as illustrated by the case of the Workers' Compensation Board in Quebec (the CSST). From the late 1980s, this public organization, which provides insurance coverage for work injuries to 94% of the workforce in Quebec (Table 5), started using the private sector for the provision of medical care and rehabilitation services[9]. As shown in Table 6, nearly 80% of all expenses incurred in medical care and rehabilitation by the CSST each year since 2002 have been for services provided by private clinics. In fact, the CSST has long been considered by many as the No. 1 purchaser of health services in the

[9] The situation evolved in the same way and for similar reasons in other Canadian provinces, notably Alberta, British Columbia, Manitoba and Ontario (see Hurley et al., 2008).

private sector in Quebec (Tremblay, 2008). The quicker access to treatment in the private sector allows the CSST to reduce significantly the wage-replacement costs it has to incur while the injured workers are waiting for treatment. This situation has never been seen as problematic or regarded as contrary to the equitable access of medical services, even by the government itself (Arpin et al., 1999, p. 29).

Table 5: Percentage of the workforce covered by the Workers' Compensation Boards, Canadian provinces, 2013

Province	Percentage of the workforce covered
British Columbia	94.6%
Alberta	90.9%
Saskatchewan	73.5%
Manitoba	72.4%
Ontario	72.7%
Quebec	93.7%
New Brunswick	92.1%
Nova Scotia	72.5%
Prince Edward Island	95.5%
Newfoundland and Labrador	97.6%

Source: Association of Workers' Compensation Boards of Canada (2014)

Table 6: Expenses for medical care and rehabilitation services in the private sector from the Commission de la santé et de la sécurité au travail (CSST) in Quebec, from 2002 to 2012

Year	Expenses (current dollars)	Percentage of all medical care and rehabilitation services purchased by the CSST in the private sector
2002	$238,112,000	76.1%
2003	$255,137,000	77.2%
2004	$277,350,000	79.0%
2005	$272,090,000	78.9%
2006	$304,935,000	80.8%
2007	$342,826,000	80.8%
2008	$339,962,000	80.5%
2009	$324,285,000	78.8%
2010	$322,680,249	77.5%
2011	$322,127,000	77.0%
2012	$350,146,000	76.7%
	Total = $3,349,650,000	Average = 78.5%

Source: CSST, annual reports (years: from 2003 to 2012); RAMQ, Oris statistical platform, table SM.30; Author's calculations.

Third, available evidence do not allow for the conclusion that universal access to medical services deteriorated after the *Chaoulli* ruling and the government's response to it—quite the contrary. Government data indicate that the number of surgeries performed increased substantially from 2002-2003 (before the *Chaoulli* ruling) to 2012-2013 (after the *Chaoulli* ruling), especially for hip, knee and cataract operations (see Table 7). As shown in Figure 2, waiting times for nearly all surgical specialties also fell significantly from 2008-2009 to 2011-2012 according to the Expert Panel mandated by the government to evaluate the feasibility of a patient-based funding reform for hospitals (Thomson, Paquet and Shedleur, 2014, p. 13). As well, the evidence shows that the three partnership

agreements[10] signed between public hospitals and three specialized medical centres (SMCs) in recent years have led to improvements in the waiting lists of these hospitals (Denis, 2011; Courchesne, 2013; Le Guen, 2014).

The Commissaire à la santé et au bien-être, whose mission[11] is to "appraise the outcomes achieved by the health and social services system" and make recommendations to the Minister of Health and Social Services in Quebec, suggested last February that the wait time guarantee adopted by the government in the wake of the *Chaoulli* decision could be one of the reasons why access to care improved in recent years in Quebec, contrary to what happened in the rest of Canada. As stated in his recent report on this issue (own translation):

> "For a number of years, the Commonwealth Fund surveys show that access to care - both for front line services and for specialists - remains difficult in Quebec. However, there has been a significant improvement since 2010. Whereas in 2010 only 38% of respondents waited less than a month for elective surgery, by 2013, this percentage had risen to 53%. Unlike Quebec, there is no evidence of improvement in the rest of Canada.
>
> Access to family doctors has also improved. In 2010, only 32% of Quebec respondents indicated that they could see a doctor or a nurse the same day or the next, versus 40% in 2013. It should be noted that during this same period, this percentage fell significantly in the rest of Canada.
>
> These improvements can be explained by the many efforts put in place in Quebec in recent years to facilitate access to care. Examples include guaranteed access in less than six months for surgery of the hip, knee and cataract, as well as the deployment of a provincial system of information tracking wait times for medical services (SIMASS)" (Commissaire à la santé et au bien-être, 2014).

[10] Montreal's Sacré-Cœur Hospital with Rockland MD Surgical Centre, Laval's Cité-de-la-santé Hospital with Clinique chirurgicale de Laval, and St-Jérome Hospital with Institut de l'œil des Laurentides.

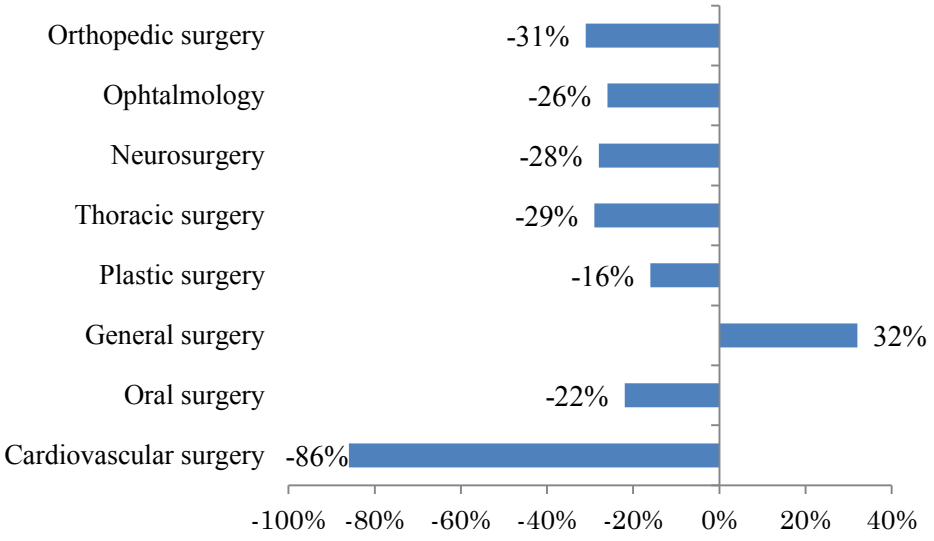
[11] The detailed mission of the Commissaire à la santé et au bien-être is available online at www.csbe.gouv.qc.ca/en/the-commissioner/organization/the-mission.html

Table 7: Variation in volume of surgeries performed in Quebec, from 2002-2003 to 2012-2013

Types of surgeries	Variation in volume of surgeries performed, 2012-13 compared to 2002-03	Average annual growth rate from 2002-03 to 2012-13
Cataract	+71%	5.5%
Hip	+75%	5.7%
Knee	+143%	9.3%
All surgeries	+22%	2.2%

Source: Ministère de la santé et des services sociaux (MSSS) cited in Thomson, Paquet and Shedleur (2014, p. 11).

Figure 2: Variation in average waiting time for different surgical specializations in Quebec, from 2008-2009 to 2011-2012



Source: Ministère de la santé et des services sociaux (MSSS) cited in Thomson, Paquet and Shedleur (2014, p. 13).

Conclusion

Quebec's health care system has witnessed some important changes since the *Chaoulli* judgement handed down in June 2005. The Supreme Court of Canada ruled that the prohibition on purchasing private health insurance violated patients' rights to life and security of person and runs counter to the *Quebec Charter of Human Rights and Freedoms*.[12] The judgment was based on the premise that wait times in the public health care system were causing irremediable harm and suffering to patients, and even premature deaths in certain cases (Bourdeau, 2008). This Court decision struck down two provisions of Quebec health care law, namely section 11 of the *Hospital Insurance Act* and section 15 of the *Health Insurance Act*.

Following the court's ruling, the government of Quebec modified the legal framework in December 2006 so as to:

a) allow the purchase of private duplicate insurance policies for three types of surgeries, namely hip replacements, knee replacements and cataract removals;
b) guarantee access to a number of elective surgeries within a reasonable delay;
c) measure and manage the evolution of wait times based on centralized computer data accessible to the public (SIMASS);
d) authorize specialized medical centres (SMCs) to enter into partnership agreements with public hospitals for the outsourcing of some volume of surgeries and treatments.

In their respective reports, experts Marie-Claude Prémont and Damien Contandriopulous suggest that the reforms adopted by the Quebec government following the Chaoulli ruling gave birth to a two-tier system and therefore hampered, according to them, universal access and equitable health care in the province. The evidence in no way supports such a conclusion. On the contrary, the available data show that the overall productivity of the hospital sector improved in recent years and the reforms adopted have, according to analyses carried out by various independent sources, played an important role in these improvements. No data indicate that the principles of equity and universality in access to care were compromised because of the reforms adopted.

[12] *Chaoulli* v. *Quebec (Attorney General)*, [2005] SCC 35.

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Appendix "A"

YANICK LABRIE

Postal address:	164 Des Flandres Ave., Candiac, Quebec, Canada, J5R 0C9
Email address:	**ylabrie@iedm.org**
Telephone:	(514) 273-0969 ext. 2221
Languages:	French and English

CURRENT POSITIONS

Montreal Economic Institute (MEI)

Economist and Healthcare Policy Analyst — *since June 2011*
Associate Researcher — *April 2005-June 2011*

CEGEP St-Jean-sur-Richelieu

Professor of economics — *since January 2006*

PROFESSIONAL EXPERIENCE

HEC Montreal, Institute of Applied Economics (IAE)

Economics Lecturer — *2006-2007*

Centre for Interuniversity Research and Analysis on Organizations (CIRANO)

Economist — *2005- 2006*

EDUCATION

Université de Montréal

M.Sc. Economics (econometrics) *2002-2004*

Concordia University

B.A. Economics (with distinction) *1998-2002*

HONORS AND RECOGNITIONS

Recognized as a distinguished alumnus, Faculty of Arts and Science, Concordia University (Office of the Dean, February 2012)

Twice selected for the expert profile of the week (60 seconds with...) by *Les Affaires* magazine (October 2007, January 2012)

Member of the Dean's Honor List of the Faculty of Arts and Science, Concordia University (2001-2002)

SELECTED RESEARCH PUBLICATIONS

Labrie, Y (2014). *How Pharmaceutical Innovation Has Revolutionized Health Care,* Economic Note*,* Montreal Economic Institute, June.

Labrie, Y. (2014). *For a Universal and Efficient Health Care System: Six Reform Proposals*, Research Paper, Montreal Economic Institute, March.

Labrie, Y. (2013). *Wrong Prescription: The Unintended Consequences of Pharmaceutical Cost Containment Policies in Canada,* Research Paper, Montreal Economic Institute, June.

Labrie, Y. (2012). *Work Organization in the Public Sector: The Example of Sweden*, Economic Note, Montreal Economic Institute, December.

Labrie, Y. (2012). *How Can We Prevent Prescription Drug Shortages?* Economic Note, Montreal Economic Institute, June.

Labrie, Y. (2012). *Activity-based Hospital Funding: We've Waited Long Enough,* Economic Note, Montreal Economic Institute, May.

Roeder, F. C. and Y. Labrie (2012). *The Private Sector within a Public Health Care System: The German Example*. Economic Note, Montreal Economic Institute, February.

Labrie, Y. (2011). *Health Care Entrepreneurship: Overcoming the Obstacles*, Economic Note, Montreal Economic Institute, November.

Labrie, Y. (2011). *Viewpoint on the Pharmaceutical Industry's Promotional Spending*, Economic Viewpoint, Montreal Economic Institute, September.

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Labrie, Y. and M. Boyer (2008). *The Private Sector within a Public Health Care System: The French Example*. Economic Note, Montreal Economic Institute, April.

Labrie, Y. (2007). *How to Explain the Success of the Swedish Model?* Economic Note, Montreal Economic Institute, July.

SELECTED PRESENTATIONS

"Accroître le financement du système de santé par le biais de l'assurance maladie privée", 20th edition of the International Forum of the Americas, Fairmont Hotel – Queen Elizabeth, Montreal, June 11th, 2014.

"Income inequality and economic mobility in Canada", Testimony before the Standing Committee on Finance, House of Commons of Canada, Ottawa, April 16th, 2013.

"What should Canada learn for European healthcare reforms?", First Thinkers' Conference, University of Winnipeg, Manitoba, February 21st-23rd, 2013.

"European healthcare reforms: What lessons for Canada?", 2012 Healthcare Efficiency Conference, Westin Harbour Hotel, Toronto, September 11th, 2012.

"Activity-based funding of hospitals in Quebec: We've waited long enough", MEI Policy Briefing, Ritz Carleton Montreal, September 19th, 2012.

"The private sector within a public system: the example of Germany", Round table on Health care with Quebec's Minister of Health, Dr. Yves Bolduc, Mount Royal Club, Montreal, May 14th, 2012.

"Le budget du gouvernement du Québec: vers une plus grande tarification des services publics?", Debate with Bernard Elie, Professor of economics at UQAM, Pointe-St-Charles Community Clinic, May 19th, 2010.

"The private sector within a public health care system : The French example", 1st Annual Conference of the Institute for Strategic Analysis and Innovation, McGill University Health Center, Montreal, May 28-29th, 2008.

"Quel future pour le syndicalisme au Québec?", Debate with Gerald Larose, President of the Quebec sovereign Council, Cegep of Joliette, October 25th, 2007.

"La migration des médecins spécialistes", (with J. Castonguay), Fédération des médecins spécialistes du Québec, January 13th, 2006.

"La formation qualifiante et transférable en milieu de travail ", Commission des Partenaires du marché du travail, Quebec Ministry of Labour, Montreal, March 3rd, 2005.

SELECTED INTERVIEWS

CBC (TV – Montreal). Interview about the McGill University Health Centre's decision to outsource certain functions, The National, July 11th, 2014 (Journalist: Brigitte Noël).

RDI (TV – Montreal). Debate about the future of unionism in Quebec, Période de questions, June 27th, 2014 (Anchor: Alexis de Lancer).

ARGENT Channel (TV – Montreal). Analysis of the Government of Quebec's new budget, À la une, June 4th, 2014 (Anchor: Chu Anh Pham).

CHED 630 (Radio-Edmonton). Interview on the unintended consequences of cost-containment policies in the pharmaceutical sector, June 6th, 2013 (Host: Dave Rutherford).

Radio-Canada (Radio – First Channel). Debate with Pr. Marc-André Gagnon, of Carleton University, on the unintended consequences of cost-containment policies in the pharmaceutical sector, June 5th, 2013 (Host: Michel C. Auger).

LCN (TV-Montreal). Debate with union leader Réjean Parent on public-private sector wage comparisons, November 16th, 2012. (Host: Richard Martineau).

Global (TV-Montreal). News on private health services delivered for RAMQ employees, June 4th, 2012.

Newstalk 770 (Radio-Calgary). Interview on the topic of waiting times in the health care system, May 21st, 2012 (Host: Dave Rutherford).

Radio Canada (TV – Ottawa). Interview on the proposed public spending cuts by the federal government, March 6th, 2012.

Newstalk 1010 (Radio – Toronto). Interview at The live drive with John Tory, on the German health care system, February 24th, 2012 (host: John Tory).

CTV Channel (TV – Toronto). Interview at Public Affairs, on the recently published Drummond's report in Ontario, February 16th, 2012 (Anchor: Tasha Kheiriddin).

TVA Channel (TV – Montreal). Interview at *TVA nouvelles*, on the issue of job losses in Montreal, January 27th, 2012 (Host: Pierre Bruneau).

RDI Channel (TV – Montreal). Debate at *24 heures en 60 minutes* on Federal health transfers to the provinces, with Dr. Marie-Claude Goulet and Pr. Antonia Maioni, January 17th, 2012 (Host: Anne-Marie Dussault).

GLOBAL (TV – Montreal). Interview on the prospect of implementing toll roads in Montreal, September 28th, 2011 (Reporter: Mike LeCouteur).

RDI (TV – Montreal). Interview at *Citoyens avertis*, on the financing of Quebec's road network, August 29th, 2011 (Host: Simon Durivage).

CJAD-AM (Radio – Montreal). Interview at *The Tommy Schnurmacher show*, on the debt debate in the US, July 26th, 2011 (Host: Tommy Schnurmacher).

CFRA-AM (Radio-Ottawa). Interview at *Sunday House Call*, on the contribution of private health care providers in France, May 25th, 2008 (Host: Dr. Barry Dworkin).

CBC (Radio One – Montreal). Debate with Lina Aristeo, Quebec Director of the trade union UNITE-HERE, on the issue of foreign outsourcing, July 12th 2005.

SELECTED OPINION EDITORIALS

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Labrie, Y. "Health monopoly shuts out entrepreneurs", *National Post*, November 25th, 2011, p.FP11.

OTHER EXPERIENCE

Researcher / Public policy consultant *Since July 2005*

- Research and data analysis on public policy issues, especially in health, education and international trade, for research centres and other organizations.
- Translation of research papers in the field of economics (French/English & English/French).

Volunteer

- Canadian Heart and Stroke Foundation *Since October 2011*