The illegality of private health care in Canada

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Abstract

WE ADDRESSED THE QUESTION OF WHETHER PRIVATE HEALTH CARE IS ILLEGAL in Canada by surveying the health insurance legislation of all 10 provinces. Our survey revealed multiple layers of regulation that seem to have as their primary objective preventing the public sector from subsidizing the private sector, as opposed to rendering privately funded practice illegal. Private insurance for medically necessary hospital and physician services is illegal in only 6 of the 10 provinces. Nonetheless, a significant private sector has not developed in any of the 4 provinces that do permit private insurance coverage. The absence of a significant private sector is probably best explained by the prohibitions on the subsidy of private practice by public plans, measures that prevent physicians from topping up their public sector incomes with private fees.

Review

Synthèse

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Concerns have been increasing about access to and quality of hospital and physician services within Canada's public health care system. At the same time, there has been increasing criticism of the alleged illegality of private medical practice. Canada's restrictions on the private health care sector are said to "rival those of Cuba and North Korea"[1] and are seen by some as an important factor in limiting access, choice and quality in health care.[1,2] The impression left by such criticism is that the legal system traps patients and physicians in an eroding public plan. Here, we address the question of whether this characterization of private health care as illegal is correct. In particular, we pose the following questions:

- Is it unlawful for physicians to receive private financing to supply the kind of services that the public system is meant to cover?
- Does the answer to the first question depend on whether the private financing is received from private insurance or directly from patients?

To answer these questions, we reviewed the following aspects of health insurance legislation and regulations for all 10 Canadian provinces:

- Constraints on direct billing, the practice of charging patients directly for publicly insured services
- Constraints on extra-billing, the practice of charging patients an amount in addition to the amount receivable from the public plan for services covered by that plan
- Constraints on the ability to obtain private insurance coverage for services that ostensibly are covered by the public sector but that patients would prefer to buy privately. Patients may prefer to buy such services because of a desire to avoid public sector queues or to obtain services of higher quality than those available in the public system. In other situations, services must be purchased privately because a determination has been made within the public system that the patient does not "need" the service (i.e., that his or her condition does not warrant publicly funded service).

Our results (Table 1) are discussed in detail below.

Opting in and opting out

Before describing the constraints on direct billing and extra-billing, we want to clarify the concept of opting out. A Canadian physician may, at any time, choose to give up his or her rights to bill the public plan and take up practice in the private sector. Although there are differences in terminology (e.g., "non-participation,"

"non-enrolment," "practising outside the Act," "not subject to the agreement"), every provincial plan permits physicians to opt out.[3–13] In Manitoba, Nova Scotia and Ontario the financial incentive to do so is significantly dulled because opted-out physicians cannot bill more than they would receive if they were working within the public plan. In every other province, opted-out physicians can set their fees at any level. However, as the status disincentive row in Table 1 shows, all of the remaining 7 provinces except Newfoundland and Prince Edward Island have in place measures that prohibit the public purse from subsidizing the private sector. In other words, patients of opted-out physicians are not entitled to any public funds to subsidize the cost of buying their services privately.

Direct billing

Direct billing, whereby physicians collect payments from patients rather than from the public plan, may adversely affect access to health care services, as patients must bear the up-front cost of the care and then seek reimbursement from the public plan. Thus, in all but 4 provinces, opted-in physicians are prohibited from billing their patients directly.[14–19] Only in Alberta, New Brunswick, Prince Edward Island and Saskatchewan can opted-in physicians bill patients directly at any time for insured services.

In the other 6 provinces, physicians must give up their rights to be paid from the public plan for the period during which they want to bill patients directly. This is accomplished either by opting out of the public plan entirely or, as in British Columbia, by electing to receive payment from sources other than the public plan without completely opting out of it.[20] There is a narrow exception to the latter option in British Columbia and Newfoundland, where opted-in specialists who provide services to patients who were not referred to them by another opted-in physician may bill those patients directly up to the level of the public tariff.[21,22]

Extra-billing

Extra-billing is a system whereby a physician charges his or her patients an additional fee or extra charge for services

Table 1: Provincial regulation of privately financed hospital and physician services

Policy issue	BC	Alta.	Sask.	Man.	Ont.	Que.	NB	NS	PEI	Nfld.
Opting out of public insurance plan										
Can physicians opt out of the public plan?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Can opted-in physicians bill patients directly?	N*	Y	Y	N	N	N	Y	N	Y	N
Extra-billing measures										
Direct prohibition: Is there an explicit ban on extra-billing for opted-in physicians?	Y†	Y†	Y	Y	Y	Y	N‡	Y	N‡	Y†
Can opted-out physicians bill any amount?	Y†	Y†	Y	N	N	Y	Y	N	Y	Y
Status disincentive: Is public sector coverage denied for patients receiving insured services from opted-out physicians?	Y	Y†	Y	N§	N§	Y	Y	N§	N	N ¶
Private insurance for publicly insured services										
Are contracts of private insurance for publicly insured services prohibited?	Y	Y	N	Y	Y	Y	N	N	Y	N
Can private insurance pay for all or part of opted-out physician's fees?	N	N	Y	N	N	N	Y**	Y††	N	Y ¶

Note: Y = yes, N = no.
*British Columbia permits direct billing by opted-in physicians who make a revocable election to do so; however, until they revoke the election, they may not receive any payment from the public plan.
†Some exceptions allowed or enforced.
‡New Brunswick and Prince Edward Island have no specific ban on extra-billing but rather rely on the elimination of public subsidy of private service. In particular, these provinces deny public coverage for patients receiving publicly insured services from physicians who charge more than the fee set by the public plan.
§Manitoba, Ontario and Nova Scotia use neither status disincentive nor public subsidy elimination measures, relying instead on what amounts to a price cap, which prevents opted-out physicians from charging more privately than they could earn through the public plan.
¶Newfoundland uses neither status nor price disincentives to deter extra-billing by opted-out physicians and permits private insurance coverage to top up public coverage for insured services rendered by these physicians.
**New Brunswick voids public coverage where any private insurance payment is received.
††In Nova Scotia an opted-out physician can charge privately no more than the fee set in the public sector.

covered by the public plan. Thus, the physician receives not only the payment from the public plan, but also whatever extra he or she is able to bill the patient. In this situation, the patient would either pay that additional cost out of pocket (a user charge) or would have private insurance to cover the additional cost (subject to other legal restrictions). From the physician's perspective, the attraction of extra-billing is the ability to set his or her own price without restriction and to have that price partially subsidized by the public plan.

Provincial prohibitions on extra-billing are required by section 18 of the Canada Health Act.[23] If a province allows extra-billing, then (pursuant to section 20 of the act), the federal government must "claw back," dollar for dollar, the amounts charged through extra-billing in the province and may, under section 15 of the act, withhold further sums. The federal government has on several occasions clawed back transfer payments on a dollar-for-dollar basis because of extra-billing in a province (e.g., Alberta, Manitoba, Newfoundland and Nova Scotia).[24]

In complying with the Canada Health Act, the provinces use 2 basic types of measures to deter extra-billing, and most provinces use a combination of these measures. The first type of measure we term here a "direct prohibition," for it makes extra-billing an offence. The second type we term "elimination of public subsidy." This sort of measure indirectly deters extra-billing by eliminating any public insurance for the services supplied by opted-out physicians and for the services supplied by opted-in physicians who try to extra-bill. Thus, patient demand for the services supplied by these groups of physicians is diminished, because patients must pay for these services with wholly private funds.

Direct prohibition

All provinces except 2 (New Brunswick and Prince Edward Island) specifically prohibit extra-billing by opted-in physicians. In other words, opted-in physicians cannot bill patients more than they or the patient would receive from the public plan, including amounts for non-insured goods or services they provided in connection with the insured services.[25–33] Alberta[34] and British Columbia[21] provide for a narrow exception to this latter prohibition, whereby an opted-in physician may charge more for non-insured goods or services provided in connection with the insured medical services if, in the view of the public plan's administrator, the physician has "reasonably determined" that materials or equipment related to a publicly insured service are necessary for the provision of that service.

If opted-in physicians in those provinces that explicitly prohibit extra-billing nonetheless choose to do so, they may be subject to a range of penalties, including fines, suspension from participation in the public plan and even disciplinary proceedings before professional regulatory bodies.[35–42] For instance, in Alberta, physicians who extra-bill are subject to fines of $1000 for the first occurrence and $2000 for the second and subsequent occurrences. In addition, depending on the number of infractions, Alberta physicians are subject to a range of additional measures, ranging from written warnings and referral to the professional regulatory body to an order that the physician is deemed to have opted out of the public plan.[35]

The other 2 provinces (New Brunswick and Prince Edward Island) do not directly prohibit extra-billing by opted-in physicians and instead rely solely on the disincentive to private practice that occurs because of the lack of any public subsidy. This system is explained more fully in the next section.

Three provinces (Manitoba, Nova Scotia and Ontario) not only directly prohibit extra-billing by opted-in physicians, but also explicitly prohibit opted-out physicians from charging more privately than they could get from the public sector.[27,29–31] In essence, this is a form of price regulation of the private sector. In Ontario, for example, the legislation[31] reads as follows:

> A physician or an optometrist *who does not submit his or her accounts directly to the Plan* under section 15 or 16 of the Health Insurance Act or a dentist shall not charge more or accept payment for more than the amount payable under the Plan for rendering an insured service to an insured person [emphasis added].

In the other 7 provinces, opted-out physicians are free to bill whatever fee they wish. However, in Alberta and British Columbia, this freedom is subject to 2 narrow exceptions. In Alberta, physicians cannot extra-bill for services rendered in an emergency,[43] and in British Columbia, they cannot extra-bill for services rendered in public hospitals or community care facilities.[44]

Elimination of public subsidies

There are 2 methods by which provinces eliminate public subsidy of the private health care sector: status disincentives and price disincentives. Five provinces (Alberta, British Columbia, New Brunswick, Quebec and Saskatchewan) deter physicians from opting out (and thus from billing at prices higher than those paid by the public plan) by making *any* public coverage of their services contingent on whether or not they are opted-in.[45–49] We describe this approach as a "status disincentive," and it is discussed further in the section "Status disincentives." Prince Edward Island takes a slightly different approach and does not specifically prohibit extra-billing. Instead it denies *any* payment from the public plan to patients whose physician charges more than the amount payable under the public plan.[50] In addition to using status disincentives, New Brunswick also denies any public funding for the services of physicians who attempt to extra-bill.[51] We describe the measures taken in New Brunswick and Prince Edward Island as "price disincentives," and they are discussed further in the section "Price disincentives."

Three provinces (Manitoba, Nova Scotia and Ontario)

do not explicitly prohibit public subsidy of private health care. Instead, they expressly prohibit extra-billing by all physicians and diminish any financial incentive to shift to the private sector by preventing physicians from charging fees higher than those payable in the public sector.[27,29–31]

In the remaining province, Newfoundland, opted-in physicians may not charge patients more than the amount payable under the public plan, but opted-out physicians are free to do so. Moreover, patients of opted-out physicians are still covered by the public plan, up to the plan limits, even if those physicians charge them a fee greater than the amount payable under the public plan.

Status disincentives

Five provinces (Alberta, British Columbia, New Brunswick, Quebec and Saskatchewan) use status disincentives to deter physicians from opting out and charging more than what is payable under the public plan. The status disincentives make public coverage of the physicians' services contingent on whether or not they are opted into the public plan.[45–49] Opted-out physicians in these provinces may charge any fee they wish (subject in Alberta and British Columbia to the narrow exceptions noted above). However, patients in these provinces are not covered by the public plan for any services rendered by opted-out physicians. For example, the Alberta legislation[52] provides that:

(2) No resident may receive the payment of benefits from the Minister for insured services provided in Alberta to the resident by a physician or dental surgeon unless the physician or dental surgeon who provided the insured services was opted into the Plan when the insured services were provided.

(3) Notwithstanding subsections (1) and (2), the Minister may pay benefits for insured services provided in Alberta to a resident by a physician or dental surgeon who was opted out of the Plan if the insured services were provided in an emergency.

However, the Alberta legislation does not define "emergency" for the purposes of this section.

Price disincentives

Two provinces (New Brunswick and Prince Edward Island) use price disincentives. These are measures that eliminate public coverage for otherwise publicly insured services where the treating physician, regardless of whether he or she has opted out, charges more than the amounts payable from the public plan. The New Brunswick plan deems such services to be "uninsured services,"[51] whereas the Prince Edward Island scheme directly disentitles patients from *any* coverage if their physician charges them more than would be payable under the public plan.[50] The Prince Edward Island scheme still pays for the services of opted-out physicians, if their fees are equal to or less than the public tariff. However, given that a physician would presumably wish to opt out so as to be able to charge more than is allowed under the public plan, the Prince Edward Island scheme effectively eliminates any public subsidy of opted-out physicians.

Newfoundland

Newfoundland is the only province that, with respect to opted-out physicians, uses neither direct prohibition nor elimination of public subsidy to deter a privately financed sector. Opted-in physicians may not extra-bill, but opted-out physicians are free to bill patients whatever they wish.[28] However, unlike the situation in other provinces, patients of opted-out physicians are still entitled to public coverage up to the amounts set out in the public tariff.[53] In this respect, Newfoundland is distinct from the other provinces, although, as mentioned above, Prince Edward Island patients can collect a public subsidy if their opted-out physician does not charge them more than the public plan tariff.

Prohibitions on private insurance

The final aspect of public health insurance that we reviewed was limitations on the availability of private insurance to cover the kinds of services covered by provincial insurance plans. Prohibition of private insurance for hospital and physician services that are covered by a public plan (but for which there may be long waits or concerns about quality) dampens the demand for opted-out physicians and physicians who extra-bill by limiting patients' ability to finance those services. If neither public nor private insurance covers services provided by opted-out physicians and those who extra-bill, the market for those physicians' services is restricted to patients who can afford to pay out of pocket.

Six of the 10 provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit contracts of private insurance to cover the kinds of services that are publicly funded.[54–59] All of the provinces that prohibit private insurance do so by prohibiting any person from entering into a contract that covers publicly insured health services. Four of these provinces (British Columbia, Manitoba, Ontario and Prince Edward Island) also explicitly void any part of an insurance contract that covers the kinds of services covered by the public plan.

In the 4 provinces that permit private insurance (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan), patients of opted-out or extra-billing physicians can substitute private for public coverage. However, in Nova Scotia opted-out physicians are limited to billing privately only as much as the public plan allows. Thus, only New Brunswick, Newfoundland and Saskatchewan allow private insurance to cover all or part of the costs of opted-out physicians' services. Thus, in 3 of the 10 Canadian provinces, the availability of private insurance creates greater economic opportunities for physicians to practise outside the public plan and charge whatever fees they wish.

Nonetheless, we have not seen the growth of a significant privately funded sector in these provinces.

All provinces allow for private insurance coverage of hospital and physician services that are not "medically necessary." Action by the provinces to delist certain hospital and physician services, deeming them no longer medically necessary, potentially increases the role for private insurers. Such an increased role of course depends on private insurers finding it profitable to extend coverage to these kinds of services. Much more important, however, is the growing role of private insurers in covering goods and services not protected by the Canada Health Act (e.g., drugs needed outside of hospitals, medical equipment and home care). As an example of the growing importance of these sectors, total (public and private) spending on drugs in 1998 accounted for 14.8% of total health care spending (public and privated), whereas only 13.9% was devoted to physician services.[60] A form of passive privatization has occurred as technology and fiscal concerns have shifted care out of the hospital setting and beyond the bounds of the Canada Health Act, such that private spending on health care now accounts for more than 30% of total health care spending. This mix of public and private financing varies drastically depending on the service in question. For example, 69.1% of all monies spent on drugs come from the private sector, whereas only 1.2% of spending on physician services comes from the private sector. Thus, the present prohibitions on private insurance, which target only hospital and physician services, are becoming less important as other kinds of care, such as drug therapy, gain in importance.

Conclusion

In our survey of health insurance legislation and regulations, we found that regulation of physicians' ability to practise in the privately funded sector is complex and diverse across Canada's 10 provinces. We found multiple layers of different kinds of regulation that seem to have as their primary objective not to make private practice illegal but rather to prevent the development of a private sector that depends on subsidy from the public sector.

It is important to recognize that, in every province, physicians are free to opt out of the public plan. In all but 3 provinces, opted-out physicians can charge whatever fee they want, whereas in the remaining provinces — Manitoba, Nova Scotia and Ontario — physicians are prohibited from charging fees greater than the amounts payable under the public plan. In these 3 provinces, private practice is not illegal but is subject to a form of price cap.

Rather than invoking a form of price cap, Alberta, British Columbia, New Brunswick, Quebec, Saskatchewan, and Prince Edward Island prevent the public sector from subsidizing the privately financed sector. Thus, in Alberta, British Columbia, New Brunswick, Quebec and Saskatchewan patients who use the services of opted-out physicians receive no public monies to aid them in buying these services. In addition, New Brunswick does not provide any public monies for the services of physicians who attempt to extra-bill. Prince Edward Island takes a somewhat different approach and eliminates public coverage for otherwise publicly insured services where the treating physician, regardless of whether he or she has opted out, charges more than the amounts payable from the public plan.

All but 4 provinces prohibit private insurance from covering the kinds of services that the Canada Health Act protects (i.e., medically necessary hospital and physician services). In New Brunswick, Newfoundland, Nova Scotia and Saskatchewan there is no prohibition on private insurance, yet there has been no development of a significant private sector. As mentioned, Nova Scotia does not permit any physicians, whether opted in or out, to charge more than the public plan rates; however, the other 3 provinces allowing private insurance have no such cap (Table 1).

Newfoundland is the outlier among the provinces. Although opted-in physicians may not extra-bill in that province, opted-out physicians are free to bill patients whatever they wish,[28] and the patients of opted-out physicians are entitled to public coverage up to the amounts set out in the public tariff.[53] Moreover, there is no prohibition on private insurance covering the kinds of services the public sector is meant to cover.

Arguably, Canada already has a 2-tier health care system because of the rigid division between medically necessary hospital and physician services (enshrined and protected in the Canada Health Act) and other kinds of goods or services for which there is significant private financing, such as drugs and home care. To the extent that Canada is successful in preventing a 2-tier system for medically necessary hospital and physician services, some insights can be gained from considering the features of other countries that have 2-tier systems. In countries such as the United Kingdom and New Zealand, private insurance is available for the kinds of hospital and physician services that the public service is meant to cover.[61] It is worthwhile noting, however, that despite the availability of private insurance, the private sector focuses only on elective care and not on expensive acute care such as cardiac care, oncology, and accident and emergency services. What seems to distinguish nearly all of the Canadian provinces (except Newfoundland) from these countries is the fact that physicians must opt in or out of the public plan and thus are effectively prevented from working in both the public and private sectors. In the United Kingdom and New Zealand, physicians are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis.

We conclude by noting that in Canada, the absence of a private system is not due to the illegality of private health care per se. Private insurance for the kinds of medically necessary hospital and physician services that the public service is meant to cover is illegal in only 6 provinces. However, there has been no development of a significant private sector in New Brunswick, Newfoundland, Nova

Scotia or Saskatchewan, all of which permit private insurance coverage without any restriction on the extent of the coverage, although as noted Nova Scotia is the only province among these 4 that caps the fees of all physicians (whether opted in or out) at the public plan rates. Rather, the lack of a flourishing private sector in Canada is most likely attributable to prohibitions on subsidization of private practice from the public plan, prohibitions that prevent physicians from relying on the public sector for the core of their incomes and turning to the private sector to top up their incomes.

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