Legal Constraints on Privately-Financed Health Care in Canada: A Review of the Ten Provinces

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There have been increasing concerns about access to and the quality of hospital and physician services within Canada's public health care system. Concomitant with these increasing concerns has been increasing criticism leveled at the alleged illegality of private medical practice, which is said to deny choice and limit access.[1] The impression left by such criticism is that the legal system traps patients and physicians in an eroding public plan. Given that we see very few privately-funded clinics operating in Canada, to what extent is this due to legal constraints and in particular,

1) Is it unlawful for physicians to receive private financing to supply the kind of services that the public system is meant to cover?

2) Does the answer above depend on whether the private financing received is from private insurance or directly from patients?

To address these questions, we reviewed the following aspects in health insurance legislation and regulations in all ten provinces:

1. Constraints on "direct billing" – the practice of charging patients directly for publicly insured services;

2. Constraints on "extra billing" – charging patients amounts in excess of the fees payable under the public plans; and

3. Constraints on the ability of patients to obtain private insurance coverage for services that ostensibly are covered by the public sector but are not available without waiting, or are not perceived as of high a quality, or where within the public system a determination has been made that the patient does not 'need' a service (e.g. that his or her condition would not warrant a publicly-funded service.)

I. Opting In/Opting Out

Before describing the constraints on direct and extra billing, the concept of "opting out" should be clarified. The provinces describe opting-out in a variety of ways (e.g. "non-participation", "non-enrolment", "practicing outside the Act", "not subject to the agreement" etc.). What is essential to note is that every provincial plan permits physicians to opt out.[2] Thus a Canadian physician may always choose to give up his or her rights to bill the public plan and practice in the private sector. However, in Manitoba, Nova Scotia and Ontario the financial incentive to do so is significantly dulled as opted-out physicians cannot bill their patients more privately than the fees they would receive if they worked in the public plan. In every other province, opted-out physicians can set their fees at whatever level they wish; however, patients of opted-out physicians in all these provinces (except Newfoundland) are not entitled to any public funds to subsidize the cost of buying services privately.

II. Direct Billing

In all but four provinces, opted-in physicians are prohibited from billing their patients directly.[3] Only in Alberta, New Brunswick, Prince Edward Island and Saskatchewan can opted-in physicians bill patients directly at any time without having to opt out.

In the other six provinces, physicians must give up their rights to be paid from the public plan for the time period in which they want to bill their patients directly. This is accomplished either by opting out of the public plan entirely or, as in British Columbia and Quebec, by making an election to receive payment from sources other than the public

plan without completely opting out of it.[4] There is a narrow exception to this 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.[5]

III. Extra Billing

An important incentive for physicians to practice outside their public insurance plans is the freedom to charge patients any fee they wish, i.e. fees greater than that payable under the public scheme. “Extra billing” is where a physician charges his or her patients an additional fee or extra charge. Thus the physician receives not only what the public plan pays but also whatever extra he/she is able to bill the patient. In such a case a patient would have to pay that additional cost out of pocket (a user charge) and may or may not (subject to other legal restrictions) have private insurance to cover the additional cost.

The various provincial prohibitions on extra billing are required by Section 18 of the *Canada Health Act*.[6] If a province allows extra billing then the federal government must claw back dollar for dollar, pursuant to Section 20, the amounts charged through extra billing in the province and may, under Section 15, withhold further sums. The Federal government has on several occasions clawed back transfer payments on a dollar-for-dollar basis because of extra-billing occurring in a province, e.g. Alberta, Manitoba, Newfoundland, and Nova Scotia.[7]

In complying with the *Canada Health Act*, the provinces use two basic types of measures to deter extra billing: “direct prohibition” measures that make extra billing an offence, and “public cross-subsidy elimination” measures that diminish patient demand

for opted-out or extra billing physicians by eliminating any public insurance for their services. Most provinces use a combination of the two.

a. Direct Prohibition Measures

All provinces except two (Prince Edward Island and New Brunswick) specifically prohibit extra billing for opted-in physicians; i.e. opted-in physicians cannot bill patients more than they or the patient would receive from the public plan.[8] Alberta and British Columbia provide for a narrow exception to this where an opted-in physician "reasonably determines", in the view of the public plan's administrator, that materials or equipment related to a publicly insured service are necessary for the provision of that service.[9]

If physicians in those provinces that explicitly prohibit extra billing nonetheless choose to do so then 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.[10] For instance, in Alberta, physicians who extra bill are subject to fines of $1,000 for the first, and $2,000 for the second and subsequent occurrences. In addition, depending on the number of infractions, Alberta physicians are subject to a range of additional measures from written warnings, referral to the professional regulatory body, and an order that the physician is deemed to have opted out of the public plan.[11]

The other two provinces (New Brunswick and Prince Edward Island) do not directly prohibit extra-billing by opted-in physicians, and instead rely solely on the elimination of public cross-subsidization of private services, explained 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.[12] In essence, this is a form of price regulation of the private sector. In Ontario, for example, the legislation provides as follows:

> 2(1) 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.[13]
> (Emphasis added)

In the other seven provinces, opted-out physicians are free to bill whatever fee they wish. However, in Alberta and British Columbia, this freedom is subject to two narrow exceptions. In Alberta, physicians who render services in an emergency are not allowed to extra bill.[14] And in British Columbia, opted-out physicians may not extra bill when rendering services in public hospitals or community-care facilities.[15]

b. Elimination of Public Cross-Subsidization

Six provinces (Alberta, British Columbia, New Brunswick, Prince Edward Island, Quebec and Saskatchewan) deny any public coverage to patients whose physicians charge them more that the public tariff for the service.[16] The effect is to diminish the demand for those physicians who practice outside the public plan's constraints on extra billing.

Three provinces (Manitoba, Nova Scotia and Ontario) do not explicitly prohibit cross-subsidization and rely instead on the express prohibition of extra billing by all physicians and by diminishing any financial incentive to shift to the private sector by

preventing charging fees higher than that payable in the public sector. 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 that physician charges them a fee greater than the amount payable under the public plan.

In the six provinces that prohibit public cross-subsidization of the private sector from the public purse, there are two basic models:

(i) **Status Disincentives**: Those that eliminate public coverage if the treating physician has opted out, and

(ii) **Price Disincentives**: Those that eliminate public coverage if the treating physician, whether or not they are opted out, extra bills the patient.

(i) Status Disincentives

Five provinces (Alberta, British Columbia, New Brunswick, Quebec and Saskatchewan) use status disincentives to deter opted-out physicians from extra billing by making public coverage of their services contingent on whether or not they are opted into the public plan.[17] 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 provides that:

> 5.05
>
> …
>
> (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.[18]

"Emergency" for the purposes of this section is not defined in the Alberta legislation.

(ii) 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 she has opted in or out, charges more than the amounts set out in the public plan. The New Brunswick plan deems such services to be “uninsured services”, whereas the Prince Edward Island scheme directly disentitles patients from any coverage where extra billing occurs.[19]

Newfoundland is the only province that, in respect of opted-out physicians, uses neither direct prohibition nor elimination of public cross-subsidization 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.[20] However, unlike the other provinces, patients of opted-out physicians are still entitled to public coverage up to the amounts set out in the public tariff.[21] In this respect, Newfoundland is distinct from the other provinces.

IV. Prohibitions on Private Insurance

The final aspect of public health insurance 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 the kinds of services covered by a public plan (but for which there may be long waits or concerns about quality) dampens

the demand for opted-out physicians by limiting consumers' ability to finance those services. If neither public nor private insurance covers services provided by opted-out physicians or those who extra bill, the market for those physicians' services is restricted to those who can afford to pay out of pocket.

Six of the ten provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit contracts of private insurance that cover the kinds of services that are publicly funded.[22] The other four provinces (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan) have no such prohibitions. 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 a contract of insurance that covers the kinds of services covered by the public plan.

In the four 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, as in Nova Scotia opted-out physicians are limited to billing privately up to what the public plan allows it is only New Brunswick[23], Newfoundland and Saskatchewan which allow private insurance to cover all or part of the costs of opted-out physicians' services. Thus, in three of the ten Canadian provinces, the availability of private insurance creates greater economic opportunities for physicians to practice outside the public plan and charge whatever fees they wish. Nonetheless, we still do not see the development of privately financed clinics in these provinces.

V. Conclusion

Regulation of physicians' ability to practice in the privately funded sector is complex and diverse across the ten provinces. We have found multiple layers of different kinds of regulation that seem to have as their key objective to prevent the development of a private sector that is dependant upon cross-subsidization by the public sector.

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

By comparison Alberta, British Columbia, New Brunswick, Quebec, Saskatchewan, and Prince Edward Island take the approach of preventing cross-subsidization of the privately financed sector from the public sector. Thus in these provinces patients who use the services of opted-out or extra-billing physicians receive no public monies to aid them in buying these services.

All but three provinces prohibit private insurance covering the kinds of services that should be covered by the public sector. However, in New Brunswick, Newfoundland, and Saskatchewan there is no prohibition on private insurance and we still do not the development of a significant private sector.

Newfoundland is the outlier amongst the provinces. Although opted-in physicians may not extra bill, opted-out physicians are free to bill patients whatever they wish[24] and patients of opted-out physicians are still entitled to public coverage up to the

amounts set out in the public tariff.[25] Moreover, there is no prohibition on private insurance covering the kinds of services the public sector is meant to cover.

In determining what is constraining the development of a supplementary private insurance system it is instructive to look at the features of other countries that have two-tier systems. In countries, like the UK and New Zealand, private insurance is available for the kinds of services that the public service is meant to cover.[26] It is worthwhile noting however, that despite the availability of private insurance that the private sector focuses only on elective care and not on the expensive and catastrophic treatments like cardiac care, oncology, accident and emergency services, etc. What also distinguishes Canada from these countries is the fact that physicians are not allowed to work in both the public and private sectors. In the UK and New Zealand physicians are normally employed in the public sector and top-up their incomes by working in the private sector on a fee-for-service basis. Thus, in Canada, the absence of a private system is not due to the fact that private health care is illegal. Rather, it is due to a combination of:

1. prohibitions on private insurance for the kinds of services that the public service is meant to cover;
2. prohibitions on cross-subsidization of private practice from the public plan; and
3. indirect prohibitions on physicians relying on the public sector for the core of their incomes and upon the private sector to top up their incomes.

Provincial Variations in Regulation of Privately-Financed Hospital and Physician Services

Policy Issue	BC	Alta	Sask	Man	Ont	Que	N.B.	N.S.	P.E.I.	Nfld.
Opting Out of Public Insurance Plan										
Can Physicians Opt Out of the Public Plan?	yes	y	y	y	y	y	y	y	y	y
Can Opted-In Physicians Bill Patients Directly?	no[1]	y	y	n	n	n[1]	y	n	y	n
Extra Billing Measures										
Direct Prohibition: Explicit Ban on Extra Billing for Opted-In Physicians?	y[2]	y[2]	y	y	y	y	n[3]	y	n[3]	y[2]
Can Opted-Out Physicians Bill Any Amount?	y[2]	y[2]	y	n	n	y	y	n	y	y
Status Disincentive: Deny Public Sector Coverage for Patients Receiving Insured Services from Opted-Out Physicians?	y	y[2]	y	n[4]	n[4]	y	y	n[4]	n	n[5]
Private Insurance for Publicly-Insured Services										
Prohibit Contracts of Private Insurance for Publicly Insured Services?	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[6]	y[7]	n	y[5]

[1] British Columbia and Quebec permit direct billing by opted-in physicians who make revocable election to do so; until they revoke the election they may not receive payment from the public plan.
[2] Some exceptions allowed.
[3] New Brunswick and Prince Edward Island have no specific ban on extra billing, but rather rely on the elimination of public cross-subsidization of private service. In particular, they deny public coverage for patients receiving publicly insured services from physicians charging more than the fee set by the public plan.
[4] Manitoba, Nova Scotia and Ontario use neither status disincentive nor public subsidy elimination measures, relying solely on direct prohibition of extra billing by opted-out physicians.
[5] Newfoundland uses neither status nor price disincentives to deter extra billing by opted-out physicians, and permits private insurance coverage for a top-up of public coverage for insured services rendered by them.
[6] New Brunswick voids public coverage where any private insurance payment is received.
[7] In Nova Scotia an opted-out physician can only charge privately up to the fee set in the public sector.

Notes

[1] See the discussion by S. Pinker, "The Chaoulli Case: One-Tier Medicine Goes on Trial in Quebec" (1999) 161 CMAJ 1306-6.

[2] **Alberta**: *Alberta Health Care Insurance Act*, R.S.A. 1980, c. A-24 as am., s. 5.11**; British Columbia**: *Medicare Protection Act*, R.S.B.C. 1996, c. 286 as am., s. 13(8); **Manitoba**: *Health Services Insurance Act*, R.S.M. 1987, c. H35 as am., s. 91(1**); New Brunswick**: *Medical Services Payment Act*, S.N.B. c. M-7 as am., s. 3(b)(iv); and *General Regulation – Medical Services Payment Act*, N.B. Reg. 84-20 as am., s. 12; **Newfoundland**: *Medical Care Insurance Act, 1999* R.S.N. c. M-5.1 (Expected to be proclaimed in force by Spring 2000), s. 7(3); **Nova Scotia**: *Health Services and Insurance Act*, R.S.N.S. 1989, c. 197, as am., s. 27(2); **Ontario**: *Health Insurance Act*, R.S.O. 1990, c. H.6, as am., s. 15(4**); Prince Edward Island**: *Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2 as am., s. 8; **Quebec**: *Health Insurance Act*, R.S.Q. c. A-29, s. 26; **Saskatchewan**: *Saskatchewan Medical Care Insurance Act*, R.S.S. 1978 c. S-29, ss. 18(2), 24(1). However, in Quebec and Saskatchewan, the government or the relevant minister of health may suspend thus right so that reasonable access to insured services is not jeopardized -- **Quebec**, *Health Insurance Act*, s. 30; **Saskatchewan**, *Saskatchewan Medical Care Insurance Act*, s. 24.1.

[3] **British Columbia**: *Medicare Protection Act*, s. 17; **Manitoba**: *Health Services Insurance Act,* s. 93; **Newfoundland**: *Medical Care Insurance Act, 1999*, s. 7(1); **Nova Scotia**: *Health Services and Insurance Act*, s. 27(1); **Ontario**, *Health Insurance Act*, s. 15(3)(b); **Quebec**, *Health Insurance Act*, s. 22.

[4] **British Columbia**: *Medicare Protection Act*, s. 14(1) and s. 17(2)(c)(i); **Quebec**: *Health Insurance Act*, s. 26.

[5] **British Columbia**: *Medical and Health Care Services Regulatio*n B.C. Reg. 426/97 as am., s. 30; **Newfoundland**: *Newfoundland Medical Care Insurance (Physicians and Fees) Regulations*, Nfld. Reg. 576/78, s. 10.

[6] *Canada Health Act*, R.S.C. 1985, c. C-6 as am., ss. 18-20. "Extra billing" is defined in Section 2 as :

> …the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province.

Section 18 also provides that

> …no payments may be permitted by the province for that fiscal year under the health insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

[7] See C.M. Flood, "The Structure and Dynamics of Canada's Health Care System", Chapter 1 in J. Downie and T. Caulfield eds., *Canadian Health Law and Policy* (Butterworths, 1999), p. 27

[8] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.2; **British Columbia**: *Medicare Protection Act*, s. 18(3); **Manitoba**: *Health Services Insurance Act*, s. 95(1); **Newfoundland**: *Medical Care Insurance Act, 1999*, s. 8(1); **Nova Scotia**: *Health Services and Insurance Act*, s. 29; **Ontario**: *Health Insurance Act*, s. 15(3) and *Health Care Accessibility Act*, R.S.O. 1990, c. H.3, as am., s. 2(1); **Quebec**: *Health Insurance Act*, ss. 22, 31; **Saskatchewan**: *Saskatchewan Medical Care Insurance Act*, s. 18(1). However, in Quebec and Saskatchewan, the government or the relevant minister of health may suspend thus right so that reasonable access to insured services is not jeopardized – **Quebec**: *Health Insurance Act*, s. 30; **Saskatchewan**: *Saskatchewan Medical Care Insurance Act*, s. 24.1.

[9] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.31(2); **British Columbia***: Medical and Health Care Services Regulation*, s. 30.

[10] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.2(2), 5.41**; British Columbia***: Medicare Protection Act*, s. 15; **Manitoba**: *Health Services Insurance Act*, s. 95**; Newfoundland**: *Medical Care Insurance Act, 1999*, s. 26; **Nova Scotia**: *Health Services and Insurance Act*, s. 35(1); **Ontario***: Health Care Accessibility Act*, s. 8**; Quebec**: *Health Insurance Act*, s. 22; **Saskatchewan**: *Saskatchewan Medical Care Insurance Act*, s. 52.

[11] *Alberta Health Care Insurance Act*, ss. 5.2(2), 5.41

[12] **Manitoba**: *Health Services Insurance Act*, s. 95(1**); Nova Scotia**: *Health Services and Insurance Act*, s. 29; **Ontario***: Health Insurance Act* s. 15(3), and *Health Care Accessibility Act*, s. 2(1).

[13] *Health Care Accessibility Act*, s. 2(1).

[14] *Alberta Health Care Insurance Act*, s. 5.3

[15] *Medicare Protection* Act, ss. 18(1), 18(2).

[16] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.05(2) and 5.5(1); **British Columbia***: Medicare Protection Act*, s. 10(1) (residents only entitled to coverage for "benefits", defined as medically necessary services rendered by an "enrolled" (opted-in) physician as defined in s. 1); **New Brunswick**: *Medical Services Payment Act*, s. 2.01(a) and *General Regulation – Medical Services Payment Act*, Schedule 2, para. (n.1); **Prince Edward Island**: *Health Services Payment Act*, s. 14.1; **Quebec**, *Health Insurance Act*, s. 14; **Saskatchewan**, *Saskatchewan Medical Care Insurance Act*, s. 24 (services of opted-out physicians are deemed to be uninsured services).

[17] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.05(2); **British Columbia***: Medicare Protection Act*, s. 10(1) (residents only entitled to coverage for "benefits", defined in Section 1 as medically necessary services rendered by an opted-in physician); **New Brunswick**: *Medical Services Payment Act*, s. 2.01(a); **Quebec**, *Health Insurance Act*, s. 14; **Saskatchewan**, *Saskatchewan Medical Care Insurance Act*, s. 24 (services of opted-out physicians are deemed to be uninsured services)

[18] **Alberta**: *Alberta Health Care Insurance Act*, s. 5.05

[19] **New Brunswick**: *General Regulation – Medical Services Payment Act*, Schedule 2, para. (n.1); **Prince Edward Island**: *Health Services Payment Act*, s. 14.1.

[20] *Medical Care Insurance Act, 1999*, s. 8(1). The requirement to accept payment from the public fund as payment in full applies only to opted-in physicians.

[21] *Ibid*., ss. 10(3) and 10(5).

[22] **Alberta**: *Alberta Health Care Insurance Act*, s. 17**; British Columbia**: *Medicare Protection Act*, s. 45; **Manitoba**: *Health Services Insurance Act*, s. 96**; Ontario**: *Health Insurance Act*, s. 14**; Prince Edward Island***: Health Services Payment Act*, s. 21; **Quebec**: *Health Insurance Act*, s. 15.

[23] It should be noted that in New Brunswick, no public coverage is available where any private insurance benefit is received for a publicly insured service. See *General Regulation – Medical Services Payment Act*, N.B. Reg. 84-20 as am., s. 3(3).

[24] *Medical Care Insurance Act, 1999*, s. 8(1)

[25] *Ibid*., ss. 10(3), 10(5), which provide that a patient is entitled to payment up to the limits set out in the public plan.

[26] For a general discussion of these systems see Colleen M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000).