Provincial Approaches to Funding Health Services in the Post-Chaoulli Era

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The *Chaouilli* decision, rendered by the Supreme Court one year ago, gave renewed impetus to provincial efforts to reform provincial health care systems including arrangements governing the funding of health services.[1] The *Chaoulli* decision was widely portrayed as representing a challenge to the *Canada Health Act* (CHA) both in terms of preparing the ground for further legal challenges to provincial public health insurance systems as well as strengthening the hand of provinces considering reforms that may challenge the *CHA* such as those recently proposed by Alberta. Furthermore, the Québec response to the decision – especially its proposal to loosen restrictions on the provision of third-party insurance for specific procedures – has also been perceived to be a challenge to the spirit, if not the letter, of the *CHA*.

In considering the means by which governments regulate the relationship between public and private financing of health care in Canada and the context for such regulation post-Chaoulli, the paper makes a number of observations. First, the direct impact of the *Chaoulli* decision, even if were to be applied to provinces outside of Québec, would be limited. The *Chaoulli* decision is not a fundamental challenge to the *CHA* as the latter does not require (or even suggest) a ban on third-party insurance for insured services. An examination of the various approaches taken by different provinces highlights that there are a wide range of alternative means for provinces to effectively restrict the growth of private insurance for insured services in addition to an outright prohibition. So long as provinces continue to maintain the political will to effectively preclude private insuring and funding of publicly-insured services, they will be able to do so. Secondly, no province allows for private funding of publicly-insured health services, including the development of private insurance for such services or the mixing of private and public income streams by physicians, to the full scope allowed under the *CHA*. Even the provinces which are often portrayed as been the most vociferous proponents of increasing the level of private funding of health care – especially Alberta and Québec – have amongst the most stringent regulations in terms of discouraging both private insurance for publicly-insured services and the mixing of public and private income streams by physicians. Moreover, current proposals for reform in these provinces are relatively mild in comparison with the scope of reforms that are potentially allowable under the *CHA*. This clearly implies that these limits result from the political dynamics within individual provinces rather than being externally imposed by the federal government through the *CHA*.

The paper begins by examining the *Chaouilli* decision of the Supreme Court outlining its implications for the *CHA* as well as health care legislation in the ten provinces. Secondly, the paper examines the range of provincial regulation of private funding of insured services, private insurance for those services as well as the combining of public and private income streams by physicians. Finally, the paper documents proposals for reform in Québec and Alberta and considers them from the perspective of reforms allowable under the *CHA* and the approaches to regulating private insurance and the mixing of public and private income streams by physicians already in place in other provinces.

[1] Chaoulli *v.* Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35.

The Chaoulli Decision

First brought before the courts in 1997, the Chaoulli case, in which the Court considered whether Québec's public health legislation violate the individual rights of Québec citizens, was finally addressed by the Supreme Court in June 2005. On the question of whether Québec's health care legislation violated the Canadian *Charter of Rights and Freedoms*, the Court found that it did not with three judges of the seven judge panel ruling in the affirmative, three against, and one abstaining. However, four of the seven justices ruled that the Québec legislation did, in fact, contravene the Québec *Charter of Human Rights and Freedoms*. The Court stayed the judgment for a period of one year to allow the Québec government to respond by amending the legislation or by addressing the central issue of the case – waiting times for publicly-insured health services.[2]

At issue was the Québec government's ban on the provision of third-party insurance for publicly-insured services. The plaintiffs claimed that the prohibition on private health insurance provided for in s. 15 of Québec's *Health Insurance Act* and s. 11 of its *Hospital Insurance Act* violated citizen's rights under s. 7 of the Canadian *Charter of Rights and Freedoms* and s. 1 of the Quebec *Charter of Human Rights and Freedoms* by effectively denying them, where significant waiting lists exist, access to health services. A Québec Superior Court and, subsequently, the Court of Appeal ruled against the claim on the basis that the infringement of the right to life, liberty and security of the person which is guaranteed by s. 7 of the Canadian *Charter* was justifiable as it was in accordance with the principles of fundamental justice.

In considering the appeal, the Supreme Court split evenly (3-3) on the issue of whether the prohibition violates the Canadian *Charter of Rights and Freedoms* with one justice abstaining on the basis that the legislation violates the Québec *Charter of Human Rights and Freedoms* and, thus, consideration of the Canadian *Charter* is superfluous.[3] However, the majority found that the legislation violated the Québec Charter on the basis that there was no proportionality between an absolute prohibition on private insurance and the objective of preserving the integrity of the public health care system. Furthermore, the Court found that a ban on private insurance was not clearly demonstrated to be the minimal impairment of individual rights necessary to achieve the broader policy objective and, rather, that "[t]here are a wide range of measures that are less drastic and also less intrusive in relation to the protected rights."[4]

In their concurring opinion, three justices also argued that the prohibition on private health insurance violates the Canadian *Charter* and cannot be justified under s.1 of the *Charter* because the government of Québec was failing to deliver public health care "in a reasonable manner."[5] The prohibition on private health insurance was found to be arbitrary in that the government of Québec could not demonstrate with sufficient evidence that a prohibition on private health insurance was required to maintain the

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[2] *Ibid.*

[3] The Canadian Charter outlines that rights to life, liberty and security of the person are not to be infringed "except in accordance with the principles of fundamental justice." The relevant section of the Québec Charter has no comparable exception and is, thus, of broader applicability than the Canadian Charter.

[4] Chaoulli *v.* Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35.

[5] S.1 of the Canadian *Charter of Rights and Freedoms* stipulates that the rights guaranteed in the Charter are subject to "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

quality of public health care. Furthermore, the prohibition was judged to go further than necessary in order to protect the public system and that the benefits of the prohibition did not outweigh its negative effects.

The three dissenting justices found that the prohibition on private insurance did not violate any established principle of fundamental justice and that the public policy objective of "health care of a reasonable standard within a reasonable time" is not a legal principle of fundamental justice. Furthermore, the dissenting justices found that the legislation was consistent with the intended goal of providing "…high-quality health care, at a reasonable cost, for as many people as possible in a manner that is consistent with principles of efficiency, equity and fiscal responsibility" and, thus, did not constitute an arbitrary infringement of individual rights. Similarly, the prohibition was justifiable under s. 9.1 of the *Québec Charter* which requires rights to be exercised with "proper regard" to "democratic values, public order and the general well-being of the citizens of Québec".

Despite claims in the media that the decision represented a fundamental challenge to the *CHA* and the existing system of public health insurance in Canada more broadly, there are a number of critical caveats to this line of reasoning. First, the decision was based on the Québec Charter and not the Canadian Charter. Given her reasons for decision, there does, however, seem to be little doubt that, had the abstaining justice ruled on the basis of the Canadian *Charter*, she would have found the Québec legislation to be in violation. Nevertheless, unless a similar challenge is successfully undertaken, presumably in a province which also bans private insurance in a manner similar to that of Québec, the ruling has no legal force outside of Québec although, as discussed below, it may be of considerable political consequence. Secondly, the majority ruled that an absolute ban on private insurance was an infringement of individual rights in the context of unreasonably long waiting lists although the Court did not specify the standard that might be used to determine whether a waiting time is unreasonably lengthy. That is, a ban on private insurance for publicly-insured services is not intrinsically an unjustified violation of individual rights. The majority clearly stated that the infringement could be remedied by addressing the length of waiting lists.

Thirdly, the central issue was the Québec government's prohibition on third-party insurance for insured services. However, the *CHA* itself does not mandate a legal prohibition on third-party insurance for insured services. The *CHA* requires that public health insurance coverage be universally available on uniform terms and conditions without any barriers to reasonable access including barriers of a financial nature.[6] To this end, it provides for dollar-for-dollar penalties for user fees and extra-billing: "…no payments may be permitted…under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists."[7] However, as outlined below, this does not require a ban on private insurance.

Finally, only six of the ten Canadian provinces explicitly prohibit third-party insurance for services which are publicly covered. As outlined below, the remaining four provinces – Saskatchewan, New Brunswick, Nova Scotia, and Newfoundland -- do not. That is, if the *Chaoulli* decision were applied outside Québec, it would not affect

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[6] *Canada Health Act, 1984*, c. 6. Accessed online (25/05/06) at http://laws.justice.gc.ca/en/c-6/17077.html.
[7] *Canada Health Act, 1984*, c. 6, s. 18.

legislation currently existing in four of the ten provinces. In this sense, the disallowance of a ban on private insurance does not challenge the fundamental elements of universal public health insurance provision.

Provincial Regulation of Private Funding of Insured Health Services

The issues raised in the *Chaoulli* case relate to provincial regulation of private funding of publicly-insured services. Provinces have a number of potential options in limiting the extent of private funding of publicly-insured services. The demand for privately-funded options to publicly-insured services is determined by, among other things, the availability of private insurance for these costs. In terms of supply, a key determinant of the ability of physicians to offer a privately-financed option for insured services is the degree to which they are able to combine public and private income sources.

The following section examines the extent to which, and means by which, provinces place limits on private funding of publicly-insured medical services. It argues that a wide range of options are available to provinces under the *CHA*, that provinces vary significantly in the approaches they take, and that no province allows private funding to the full degree allowed under the *CHA*. The paper then specifically considers the degree to which provinces limit the provision of private insurance coverage for publicly-insured services as well as the combining of private and public income sources by physicians.

Provincial Regulation of Private Funding for Publicly-Insured Medical Services

Provinces have a range of options which allow them to effectively limit the scope of private funding of publicly-insured services including regulating private insurance, regulating billing practice, and regulating fees. Because provincial legislation generally treats non-participating physicians differently than participating physicians combined with the wide variation among provinces in regard to both, it is necessary to differentiate between provincial regulation of private-funding of insured services provided by opted-out and opted-in physicians.[8]

Opted Out Physicians

In all provinces except Ontario, physicians have the right to opt out of the public plan which, in essence, implies that they forfeit their ability to bill the public plan directly.[9] The most stringent method of restricting private-funding of insured services provided by non-participating physicians (outside of not allowing them to opt out) is to limit the fees they may legally charge to the levels determined in the provincial rate schedule thus greatly reducing the incentive to operate outside the public plan. In Manitoba and Nova Scotia, the scope for private financing of services provided by opted-out physicians is limited by the disincentives caused by provincial regulations which limit

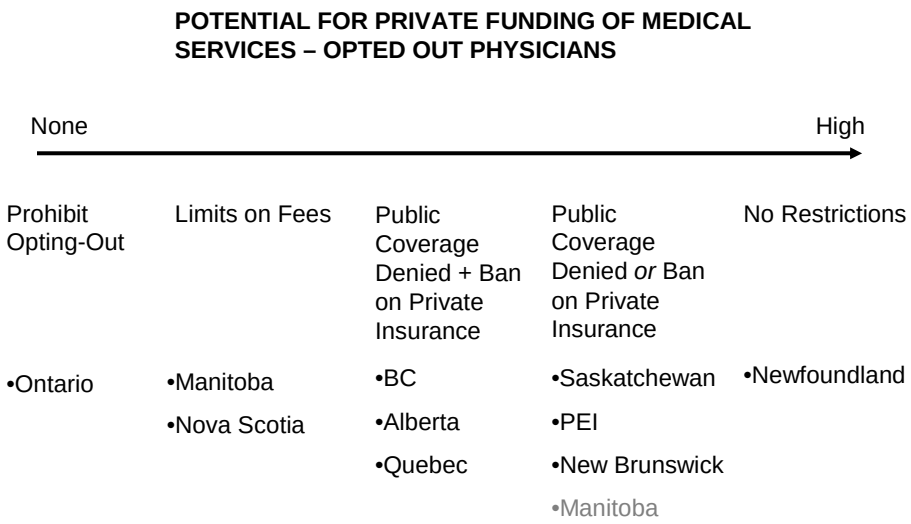
[8] The paper uses opted-in/opted-out and participating/non-participating interchangeably. Given the fact that opted-out physicians in Newfoundland can still receive indirect public payment (their patients would be reimbursed by the provincial plan), the baseline definition of an "opted out" physician is one that does not have the right to bill the public health plan directly.

[9] Opting-out of the public plan is no longer generally allowed in Ontario effective September 2004 as a result of the coming into effect of the *Commitment to the Future of Medicare Act, 2004.*

the fees of opted-out physicians to levels specified in the provincial fee schedule. In these two provinces, services provided by opted-out physicians are also covered by public insurance (reimbursed to the patient.) Because fees are also capped, there is simply no room for the private financing of publicly-insured services provided by opted-out physicians. (See Figure 1 and Appendix, Table 1.)

The remaining provinces use a variety of means to limit the potential for the private funding of publicly-insured services. Three provinces (Alberta, British Columbia and Québec) deny public coverage for services provided by opted-out physicians while, at the same time, implementing a legal ban on the provision of private, third-party insurance for those services. Thus, patients are able to receive services outside the plan at rates determined solely by the physician although the patient must absorb the full cost of those services. Saskatchewan and New Brunswick also deny public compensation for services provided by opted-out physicians although they do not prohibit private insurance coverage for those services. PEI, in contrast, allows public compensation for such services but prohibits private insurance which would otherwise cover costs above those covered under the provincial rate schedule.

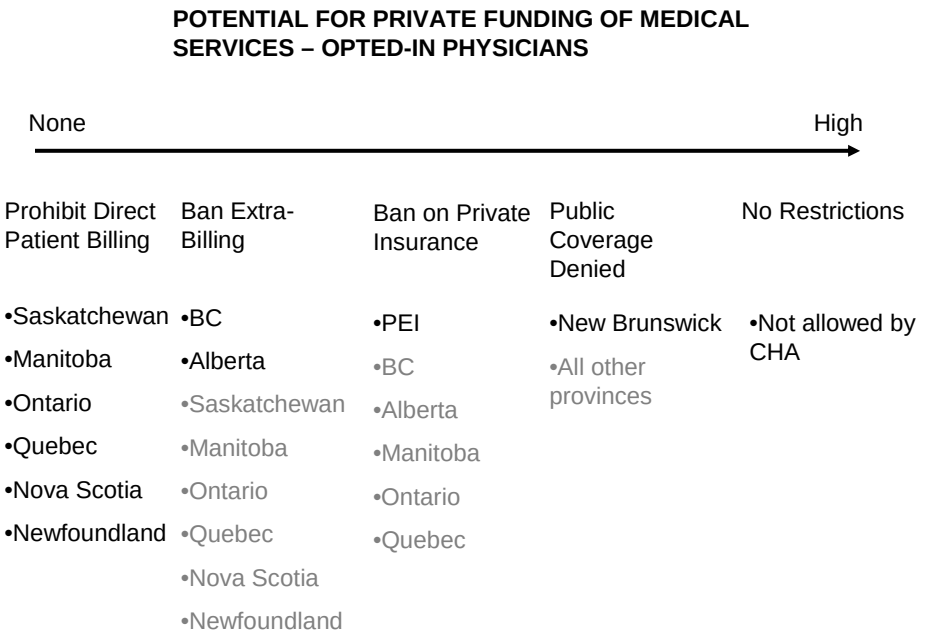
Figure 1: Regulation of Private Funding for Publicly-Insured Medical Services, Opted-Out Physicians



Source: See Appendix: Table 1.
Note: Provinces appear in shadow where a more stringent existing regulation makes subsequent limitations on private insurance coverage superfluous.

In Newfoundland, opted-out physicians are able to set their own fees, patients are compensated by the province for costs up to the provincial fee schedule, and private third-party insurers are allowed to insure for the difference. Presumably, a significant private health insurance market has not grown up in Newfoundland as there is not sufficient demand for privately paid (but publicly-subsidized) services to warrant physicians opting of the public plan (which, in turn, requires billing all patients directly.)[10]

Figure 2: Regulation of Private Funding for Publicly-Insured Medical Services, Opted-In Physicians



Source: See Appendix: Table 1.
Note: Provinces appear in shadow where a more stringent existing regulation makes subsequent limitations on private insurance coverage superfluous.

Opted In Physicians

The potential for private funding of publicly-insured services provided by physicians participating in the public health insurance plan is closely related to their ability to combine both private and public income streams (discussed more fully below.) In order for physicians participating in the public plan to have access to both public and private income streams for services covered under public plans, they need to be able to bill patients directly. If opted-in physicians bill patients (or at least some patients) directly for services, the patient pays the bill and then must receive compensation from the public plan, absorb the cost directly, or receive compensation from a third-party

[10] In 2005, no physicians in Newfoundland had opted-out of the Newfoundland medical care program. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/pt-plans/nl_e.html#f1

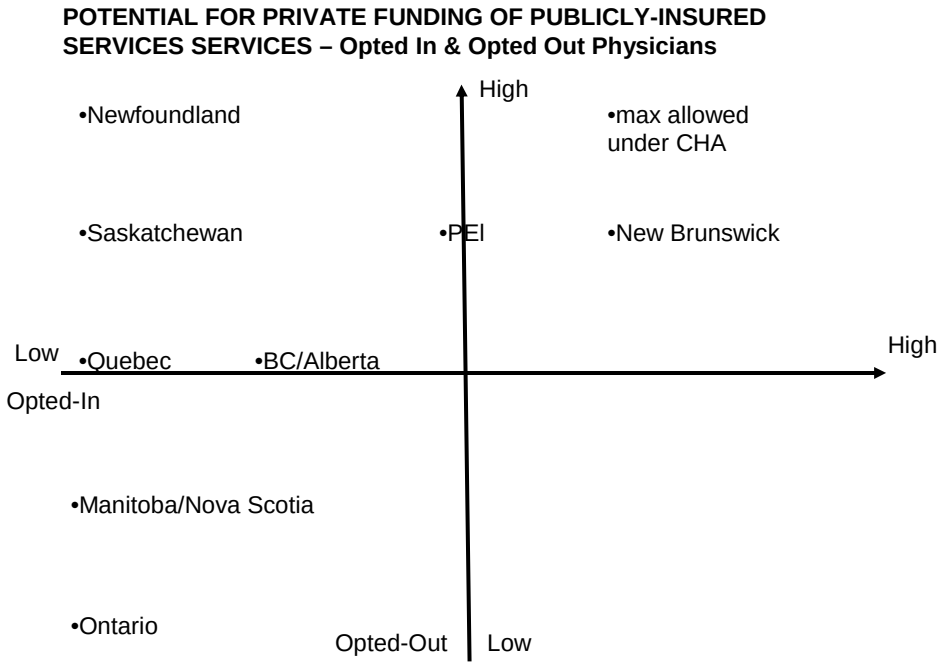
indemnity insurance plan. In any case, the billing physician may not even be aware of the party which ultimately bears the burden of the payment. Currently, the practice of participating physicians billing patients directly is allowed only in Alberta, Saskatchewan, New Brunswick and PEI. (See Figure 2.) In all other provinces, physicians who opt into the public plan are not able to bill patients directly and, therefore, have no means by which to collect private payment for publicly-insured services.

Secondly, even in those provinces where direct billing of patients is allowed, physicians must also be able to bill at rates over and above the rate stipulated in the public rate schedule in order to create a space for private payment by creating an incentive for physicians to provide faster or better service. In turn, it is better and/or faster service that creates the incentive for patients to pay for and/or insure for rates higher than those otherwise paid for by the public plan. In the four provinces which allow direct billing of patients by physicians participating in the public plan, Alberta and Saskatchewan do not allow billing at rates which are higher than the public fee schedule. Thus, there is no incentive for physicians to provide faster/better service and, in turn, no incentive for patients to pay extra for (or insure for) those services.

The situation is somewhat different in New Brunswick and PEI where participating physicians can bill patients directly at rates above those stipulated by the provincial fee schedule; however, in these provinces, payment from the public plan is forfeited if the physician bills above the provincial fee schedule. Thus, physicians are able to bill both the public plan and bill privately, however, in the latter case, the private payer must absorb the entire cost of the service. In PEI, the province also bans third-party insurance for publicly-insured services, so the patient must absorb the entire cost of the service directly. In New Brunswick, there is no ban on third-party insurance so doctors are allowed to bill patients directly for fees above the public fee schedule which may be, in turn, covered by third-party insurance but are not eligible for public reimbursement.

Figure 3 highlights three aspects of provincial regulation of private funding for publicly-insured services. First, there is wide variation among provinces in their approach to such regulation and little clustering of provinces on a given approach although provinces differ more significantly in their treatment of opted-out physicians than in their treatment of opted-in physicians. Secondly, the correspondence between the stringency of regulation of opted-out and opted-in physicians is not clear cut. Some provinces, like Ontario, tightly restrict both. Others are more lenient in their regulation of both. However, some, like Newfoundland and Saskatchewan, tightly regulate opted-in physicians while providing much more scope for the private funding of services provided by opted-out physicians. Finally, no province allows for private funding to the full extent allowed under the *CHA*.

Figure 3: Regulation of Private Funding for Publicly-Insured Medical Services, Opted-In and Opted-Out Physicians



Source: See Appendix: Table 1.

Provincial Regulation of Private Insurance

The potential for private funding of publicly-insured services is determined, to a significant degree, by the scope for private, third-party insurance of those services – the aspect of private funding of publicly-insured medical services most directly implicated in the *Chaoulli* case. As outlined below, provinces have a range of options open to them in discouraging private insurance coverage of publicly-insured services – emphasizing that a ban on private insurance (brought into question by the *Chaoulli* decision) is only one of several options. That said, the discussion below also highlights the differing degrees to which provinces make efforts to forestall the development of private insurance. In some provinces, the potential for private insurance coverage of publicly-insured services appears considerably greater than in others.

Six Canadian provinces have an explicit ban on private insurance for publicly-insured services for both participating and non-participating physicians. In the remaining four provinces, there are different measures in place which regulate the space allowed for private insurance of services provided by both participating and non-participating physicians. The four provinces with no explicit ban on private insurance differ significantly in the degree to which there is potential for the development of a private insurance market.

Opted-Out Physicians

These four provinces different most significantly in terms of regulations applying to non-participating physicians. (See Figure 4.) The fees of non-participating physicians in Nova Scotia are limited to the levels set in the provincial rate schedule and these fees

are reimbursed to the patient. [11] As a result, there simply is no real room for the development of private insurance for publicly-insured services provided by non-participating physicians. In the remaining three provinces, there are no limits on the amounts that non-participating physicians may bill creating the potential for non-participating physicians to offer faster/better service by charging higher fees – thus generating demand for insurance for such services. In both Saskatchewan and New Brunswick, opted-out physicians are allowed to bill above the provincial fee schedule although public coverage is withdrawn in such cases so that the individual (or insurer) must bear the full cost of the service. Thus, to the extent that private insurance is allowed, it is not subsidized by any public funding. However, Newfoundland allows opted-out physicians to charge fees above the provincial schedule and provides coverage for these fees up to the provincial rate schedule and, thus, there is the potential for medi-gap insurance (e.g. insuring for the difference between the actual fees charged by opted out physicians and the levels of compensation under the public plan.)

Figure 4: Regulation of Private Insurance Coverage, Opted-Out Physicians

Source: See Appendix: Table 2.
Note: Provinces appear in shadow where a more stringent existing regulation makes subsequent limitations on private insurance coverage superfluous.

Opted-In Physicians

These four provinces also differ considerably in terms of the regulations relating to participating physicians. (See Figure 5.) Saskatchewan, Nova Scotia and Newfoundland all prohibit opted-in physicians from billing patients directly and, as a

[11] Regulation of fees charged by opted-out physicians exist in Manitoba and Ontario as well although, in both cases, they are superfluous in terms of their effects on private insurance as the latter is explicitly banned.

result, also implicitly ban opted-in physicians from charging differential fees or "extra-billing."[12] Thus, there is little scope for private financing of services and no potential market for private insurance. New Brunswick allows opted-in physicians to bill above the provincial fee schedule but, in all such cases, public coverage is withdrawn.[13] Thus, there is scope for private insurance of publicly-insured services provided by participating physicians although, as is the case for opted-out physicians in New Brunswick (and Saskatchewan), there is no public subsidization of those services.

Figure 5: Regulation of Private Insurance Coverage, Opted-In Physicians

POTENTIAL FOR PRIVATE INSURANCE COVERAGE OF OPTED-IN PHYSICIAN SERVICES

None → High

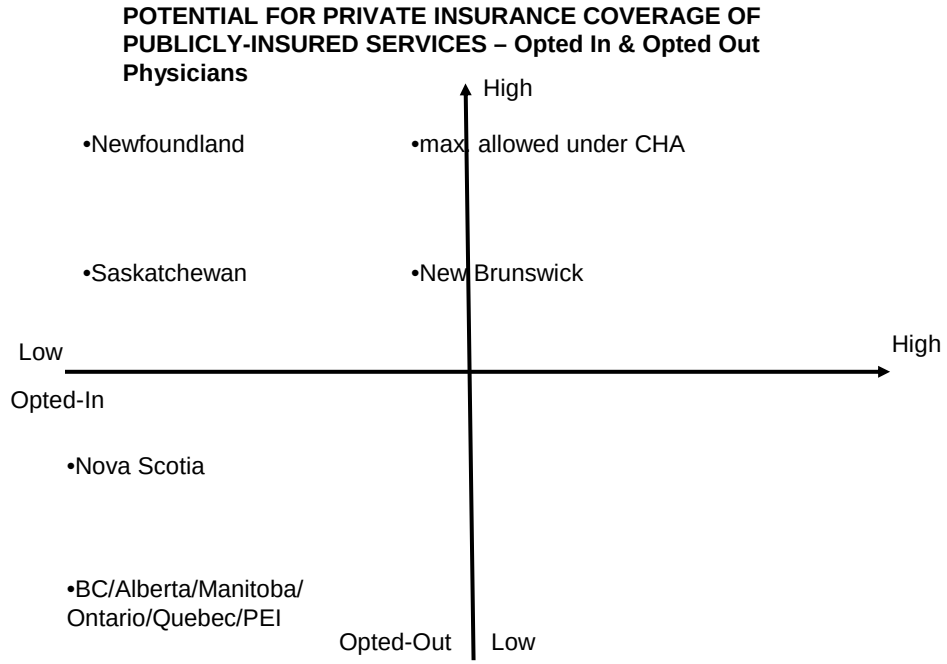
Explicit Ban on Insurance or Direct Patient Billing	Ban on Differential Fees	Withdrawl of Public Coverage	No Restrictions
•BC	•BC	•New Brunswick	•Not allowable under CHA
•Alberta	•Alberta	•BC	
•Saskatchewan	•Saskatchewan	•Alberta	
•Manitoba	•Manitoba	•Saskatchewan	
•Ontario	•Ontario	•Manitoba	
•Quebec	•Quebec	•Ontario	
•Nova Scotia	•Nova Scotia	•Quebec	
•PEI	•Newfoundland	•Nova Scotia	
•Newfoundland		•PEI	
		•Newfoundland	

Source: See Appendix: Table 2.
Note: Provinces appear in shadow where a more stringent existing regulation makes subsequent limitations on private insurance coverage superfluous.

Provinces vary in the manner in which they regulate the provision of private insurance for publicly-insured services although they differ more significantly in their treatment of private insurance for opted-out physicians than they do for opted-in physicians where New Brunswick is the only significant exception. (See Figure 6.) There is also a clearer pattern of provincial clustering in regard to the regulation of private insurance than is evident in regard to the regulation of private funding more generally. Secondly, no province allows private insurance of publicly-insured services to the full degree allowed under the *CHA* and most provinces (including the six provinces with explicit bans) are much more stringent in disallowing private insurance of publicly-insured health services than is required by the *CHA*.

[12] Extra-billing is defined as billing at rates greater than stipulated in the public fee schedule.
[13] PEI also allows all physicians to bill above the provincial rate schedule but withdraws public coverage for such services. Again, this regulation is superfluous in terms of its effect on private insurance in PEI as the latter is explicitly banned.

Figure 6: Regulation of Private Insurance Coverage, Opted-In and Opted-Out Physicians



Source: See Appendix: Table 1.

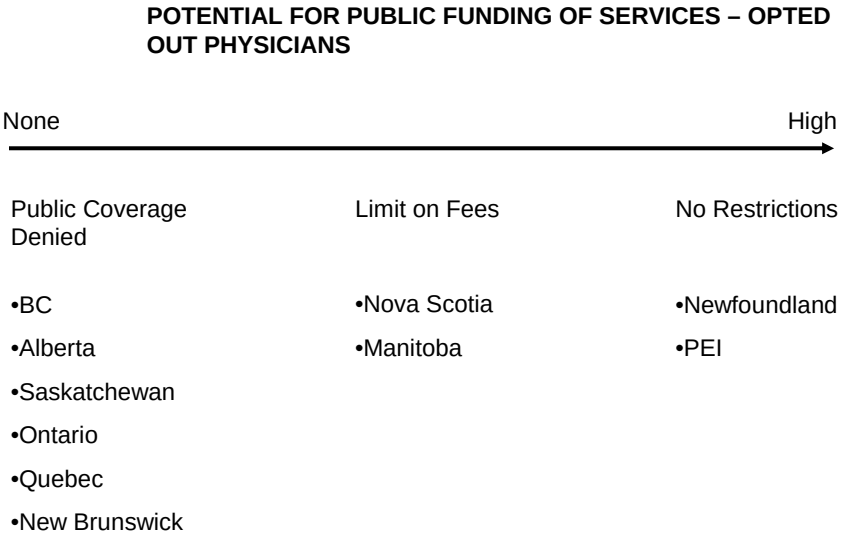
In regard to the *Chaoulli* decision, even if the Court's ruling in regard to Québec's ban on private insurance were generalized to the other nine provinces, the expected effects on the relationship between public and private health insurance would be difficult to anticipate given the wide provincial variation in regulations. All provinces which currently have an explicit ban on private insurance (with the exception of PEI) also have additional measures in the place that would limit the scope of private insurance in the absence of the explicit ban. In some cases such as Manitoba and Ontario, these secondary measures are relatively stringent and would likely the preclude the development of private insurance even in the absence of an explicit ban. In other cases, additional regulations restricting the growth of private insurance may be considerably weaker than the explicit ban (e.g. British Columbia, Alberta, Québec.) Finally, in the case of PEI, there is less to prevent a significant expansion in private insurance should the explicit ban be removed except the withdrawal of public coverage of opted-in physicians charging fees higher than the provincial rate schedule.

Supply of Medical Services -- Provincial Regulation of Mixed Public-Private Income Sources

Provinces may also regulate the mix of private and public funding of publicly-insured health services from the supply side – providing incentives or disincentives to the reliance by physicians on either public or private funding. The most obvious option in this regard is for provinces to disallow physicians receiving any private payment from

receiving any payments from the public plan. The rationale is that, if physicians are forced to choose between accepting only private payments or only public payments, there will be a strong disincentive to rely on private payment and the overall supply of physician services available for private payment will decline. Two distinct factors determine the degree to which individual physicians can combine private and public income: the degree to which non-participating physicians are eligible to indirectly receive public funding and, secondly, the degree to which participating physicians are allowed to combine their publicly-funded income with income from private sources. Provinces have adopted a wide range of approaches in addressing these issues. In regard to the combining of public and private income streams by physicians, the section outlines the wide range of approaches allowed under the *CHA* and the wide differences among provinces in this regard.

Figure 7: Regulation of Public and Private Income Mixing , Opted-Out Physicians



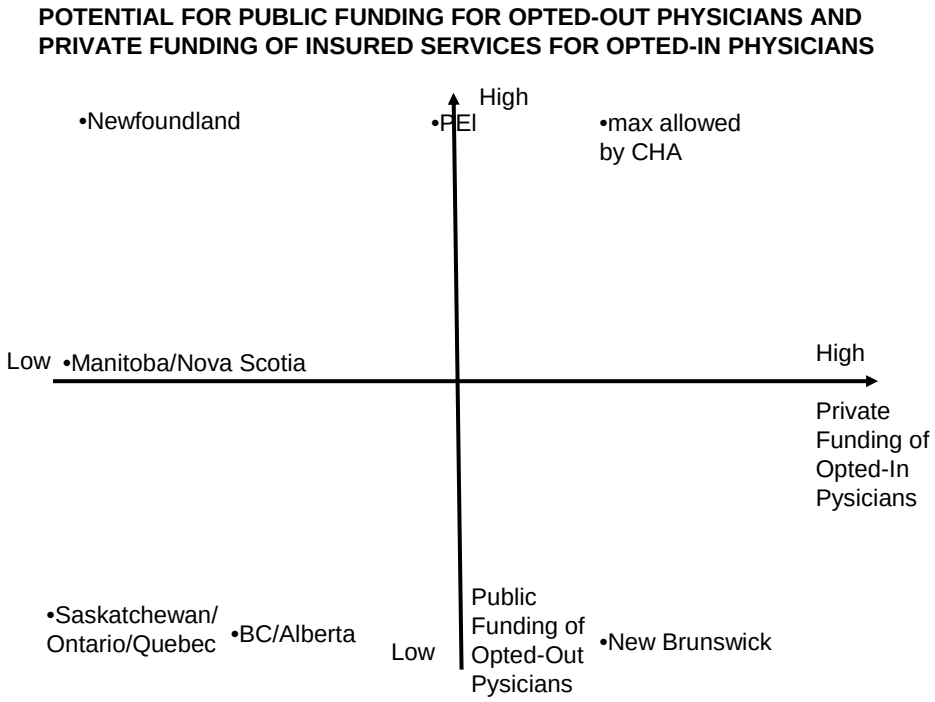
Source: See Appendix: Table 3.

Public Funding of Services Provided by Opted-Out Physicians

Six Canadian provinces deny any public coverage for service which are provided by physician's who have opted out of the public plan. (See Figure 7.) Nova Scotia and Manitoba allow patients paying for services provided by opted-out physicians to be reimbursed by the public plan; however, in these two provinces, physicians are not allowed to charge rates above the public fee schedule. Being that there is no real scope for private funding of services provided by opted-out physicians in these two provinces, there is virtually no scope for the combining of public and private income streams by physicians. However, in PEI and Newfoundland, non-participating physicians can set their own fees and patients are subsequently reimbursed for fees up to the provincial rate schedule. Thus, there are no formal limits on opted-out physicians combining private and

public income streams except that they cannot bill the public plan directly and the public subsidization of services takes place indirectly through reimbursement paid to the patient.

Figure 8: Regulation of Public Funding of Services Provided by Opted-Out Physicians and Private Funding of Publicly-Insured Services Provided by Opted-In Physicians



Source: See Appendix: Table 3.

Private Funding of Opted-In Physicians

Flood and Archibald are largely correct in concluding that, in all Canadian provinces (except Newfoundland and PEI) "…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 sense that physicians opting out do not receive public payments.[14] However, the converse – that physicians opting into the public system are prohibited from receiving any private payment for otherwise publicly-insured services – does not necessary hold. As discussed above (see Figure 2), provinces take a wide range of approaches to this issue and there is scope for the private funding of publicly-insured services provided by participating physicians – primarily in PEI and New Brunswick.

Figure 8 highlights the fact that there is wide variation among provinces both in terms of the potential for public funding for services provided by opted-out physicians as well as allowing opted-in physicians to combine public and private income sources. Secondly, while Newfoundland and PEI go as far as possible in allowing the public funding of opted-out physicians and New Brunswick goes as far as possible under the *CHA* in allowing for the private funding of opted-in physicians, no province goes as far as possible under the *CHA* on the two measures combined.

[14] Flood and Archibald, 829.

Discussion

A number of conclusions may be drawn from this overview of provincial approaches to the regulation of private funding of publicly-insured health services.. First, the *CHA* is sufficiently flexible to allow for a wide-range of policy options and the provinces are clearly availing themselves of this flexibility. Secondly, there is little similarity across the provinces and no set templates for approaching the regulation of funding of health services. Of the 45 possible pairs of provinces, there is only one pair of provinces which share similar policies across all seven factors examined here (outlined in Table 1): British Columbia and Alberta. Thirdly, no province has gone as far as allowed under the *CHA* in opening up their health insurance system to private funding, private insurance, or the combining of private and public income streams by physicians. Fourthly, this implies that the limits placed on the role of private funding, the development of private insurance and the subsidization of privately-funded services by publicly-funded services is largely a matter of political dynamics within each province rather than imposed externally by the *CHA*. Certainly, the *CHA* has important effects in effectively limiting user fees and extra-billing by participating physicians. However, all provinces have stopped short of fully developing opportunities for the development of private insurance options and the mixing of public and private income streams that are allowed under the *CHA*. Finally, the provinces which are often characterized as pushing the envelope in terms of the development of private alternatives to publicly-funding of health services – Québec, Alberta and British Columbia – are well above average in the stringency of their regulation of private funding of health services while other provinces characterized as more supportive of the publicly-funded model like Saskatchewan, often lauded as the birthplace of medicare, have less stringent regulations.

Provincial Reform Proposals Post-Chaouilli

Two provinces – Québec and Alberta – have proposed reforms to legislation regulating the private funding of publicly-insured health services, the provision of private insurance for such services, and the ability of physicians to combine private and public income sources. The next section examines these proposals in light of the distinct approaches to funding already existing in the various provinces as outlined above.

Québec

In the *Chaouilli* decision, the government of Québec was given one year to respond to Court's decision. [15] The response of the Québec government, presented in a public consultation document in February of 2006, was three-fold: to encourage the development of affiliated specialized clinics which would be privately-owned, for-profit facilities that would offer services that would be publicly-funded; to guarantee maximum wait-times for a range of selected procedures; and, finally, to allow private insurance for a limited range of publicly-insured services. [16] The proposed Québec reforms do not go as far in allowing private insurance coverage as is the case in other provinces or allowed under the *CHA*.

[15] The government reponse is to be reported back to the Supreme Court in June 2006.

[16] Québec. Le Ministère de la Santé et des Service sociaux. *Guaranteeing Access – Meeting the Challenges of Equity, Efficiency and Quality: Consultation Document*. Québec: MSSS, 2006.

The first of the three elements of reform, in order to expand capacity without requiring new capital outlays by government, is to allow for the development of affiliated specialized clinics which would operate in affiliation with an existing hospital to provide specific publicly-insured services through a formal agreement with a public facility. The affiliated specialized clinics would be reimbursed according to a fee schedule set out in the agreement under which the costs must be comparable to or less than costs in the public system. Secondly, the Québec government has committed itself to a wait-time guarantee for a range of health services including cardiac surgery and cancer treatments, hip and knee replacement, and cataract surgery. The guarantee commits the government to pay for procedures done at private clinics or outside the province -- including potentially the United States -- if they cannot be accommodated within public facilities within the guaranteed maximum wait-time. In regard to hip and knee replacement and cataract surgery, the proposed maximum wait-time is six months after which patients could seek treatment in another facility or in a private, hospital-affiliated clinic and, after nine months, in a private facility or another jurisdiction. Finally, the government would also lift the ban against third-party insurance for a limited range of publicly-funded procedures which are subject to an access guarantee – most notably joint replacement.[17] Private insurance would be required to cover the cost of the entire medical intervention and services could only be provided by providers having opted completely out of the public health care system.

Various observers have argued that the changes represent a challenge to the *CHA*. For example, columnist Jeffrey Simpson, by implication, argues that the changes "breach previous understandings of the limits imposed by the Canada Health Act" and notes that the federal government could impose financial penalties under the *CHA* for "non-compliance with the five principles of medicare."[18] At the same time, Premier Charest insists that the Québec proposals are in compliance with the *CHA*.[19] For its part, the federal government has lauded the Québec initiative: "Recently, the Government of Quebec, while confirming its commitment to public health care and its respect for the principles of universality and equity, has proposed a health care guarantee for certain health services. Quebec's proposed approach is innovative and will help ensure that patients receive timely access to these vital services."[20]

The proposed reforms do not pose a direct challenge to the *CHA*. In regard to the first two elements of the proposal, the *CHA* does not ban the private provision of publicly-insured services which is the central issue in regard to the development of affiliated specialized clinics as well as enforcing the wait time guarantee through public procurement of services from private facilities. Lifting the ban on private insurance for health services echoes the current practice in the four other provinces which do not prohibit third party insurance for publicly-insured services. The combination of allowing opted-out physicians to provide services covered by third-party insurance, with those

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[17] "Québec's Sensible Health-Care Saw-Off." *Globe and Mail*, 17 February 2006, online edition.

[18] Jeffrey Simpson, "Three Big Reasons for Change," *Globe and Mail*, 17 February 2006, online edition. In these statements, Simpson is referring to three provinces in which he includes the Québec proposals.

[19] Rhéal Séguin, "Québec Opens Door to Private Health Care," *Globe and Mail*, 17 February 2006. Online edition.

[20] Department of Finance, *The Budget Plan, 2006: Focusing on Priorities*. Ottawa: Department of Finance, 2006. For news coverage of the federal reaction, see, for example, Terry Weber, "Harper Praises Québec Health Plan," *Globe and Mail*, 21 February 2006, online edition.

services being ineligible for public funding, are the same arrangements that currently apply to opted-out physicians in Saskatchewan and New Brunswick although the Québec proposal does not go as far as these provinces currently do as the ban on private insurance would only be lifted for a limited number of procedures. The proposals also do not go as far as current arrangements in Newfoundland under which opted-physicians receive indirect public compensation for those services.

Alberta

Released in February 2006, Alberta's *Health Policy Framework* proposed ten new directions for reform of the existing health care system.[21] The report was greeted with considerable fanfare in the national news media. As one example, *Globe and Mail* columnist John Ibbotson wrote that the report "…marks the beginning of the end of medicare as practiced today in Canada; the end of the Canada Health Act, at least as conventionally interpreted; the end of the world's only fully publicly funded health-care delivery system; the end of the guarantee that only need, and never wealth, will determine who gets served first."[22] This reaction was, of course, fanned by inflammatory language from the Alberta government itself. In contrast to the approach of Québec, which was to forcefully assert that its reforms were in keeping with the national principles outlined in the *CHA*, the Alberta government, rather, appeared deliberately provocative. While the Alberta Minister of Health declared that she was not sure whether the plan would violate federal legislation,[23] Premier Klein, upon releasing the proposals, stated to reporters that "[i]t may violate the *Canada Health Act*..." – echoing statements made late in the 2004 federal election campaign that Alberta's reforms would fall outside the *CHA*.[24] The report advocates discussion of certain reform proposals that would clearly breach the *CHA*; however, many of its proposals – even those which might be interpreted as a radical shift in policy – are allowable under the *CHA* and are currently the practice in other Canadian provinces.

Of those issues most germane to the issue of public health insurance, several proposals would entail a significant shift in current practice but would not pose a challenge to the *CHA*. The report (Direction 5) suggests reshaping the role of hospitals and, although vague, makes reference to the possibility of "delivering more services through private surgical facilities."[25] While essential health services would still be publicly funded, Direction 6, emphasizes limiting publicly-funded health services by excluding health services which are "discretionary, are not of proven benefit, or are experimental in nature…"[26] and leaving those services to be financed either by patients directly or through third-party insurance. The latter would increase the scope of private funding and the potential for private insurance but is not a violation of the *CHA*.

The report (Direction 7) commits the government to examining alternatives to the single-payer public insurance system – including co-payments and private insurance

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[21] Government of Alberta. *Health Policy Framework*. Government of Alberta, 2006.
[22] John Ibbitson, "Klein's Revolution Gives Harper a Tough Choice," *Globe and Mail*, 5 March 2006, online edition
[23] Katherine Harding, "Alberta Reshapes Medicare," *Globe and Mail*, 1 March 2006. Online edition.
[24] Katherine Harding and Gloria Galloway, "Klein Willing to Defy Ottawa," *Globe and Mail*, 2 March 2006. Online edition.
[25] Ibid., 13.
[26] Ibid., 14.

options -- while noting the need to "…consider how to implement safeguards to protect the public system and how to provide benefits to those unable to afford private insurance."[27] While much of the proposal focuses on service areas which are currently outside universal public health insurance coverage (e.g. prescription drugs, dental services, etc.), the proposal also makes reference to the possibility of introducing third-party private insurance for non-emergency acute care. In terms of allowing third-party insurance for non-emergency acute care, the *CHA* has no restrictions against Alberta lifting its current ban and, as outlined above, four provinces have no such ban. Other options referred to in the report (such as co-payments) would clearly contravene the *CHA*. That said, the report is carefully couched and only commits the Alberta government to "examining how various alternative funding mechanisms…would work in this province."[28]

The proposals (Direction 9) also recommend allowing health care providers to both bill publicly for some procedures and bill publicly for others in contrast to the current legislation which requires that a provider must completely opt out of the public system completely if they have any private billings. Certainly, allowing physicians to bill some of the services they perform publicly and others privately would remove barriers to the growth of privately funded services. In the national news media, this provision of the proposed reforms was characterized as "crossing the Rubicon of health care" and "breaching the firewall."[29] However, it is not a violation of the *CHA*.[30] As outlined above, the mixing of public and private income sources is allowed for opted-out physicians in PEI and Newfoundland while mixing of public and private incomes sources is allowed for opted-in physicians in PEI and New Brunswick.

This section of the report also discusses "…allowing both public and private providers to offer enhanced services and expedited access to a limited range of 'non-emergency' services at an appropriate charge."[31] However, the report, while making a number of laudatory comments about such an approach, only recommends that service providers be "…encouraged to find innovative ways of providing improved consumer choice…"[32] Whether charged by a publicly-funded hospital or a privately-owned clinic, such charges would almost certainly be a violation of the *CHA* if the associated physician services were paid for under the public insurance plan.[33] The case is less clear if public (or private) facilities were to charge patients directly for services where the associated physician fees are being paid privately.

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[27] Ibidl, 14.
[28] Alberta, *Health Policy Framework*, 14.
[29] Don Martin, "Klein a Major Medicare Pain for Harper," *National Post*, 2 March 2006, online edition.
[30] In late 2005, NDP Leader Jack Layton had demanded legislation banning doctors from participating both in the private and public systems in return for his support of the minority Liberal government. When a deal could not be reached, the NDP retracted its support triggering the 2006 federal election. Walton and Curry, "Alberta Backs Off."
[31] Alberta, *Health Policy Framework*, 16.
[32] Alberta, *Health Policy Framework*, 16.
[33] The 'Marleau letter' of 1995 outlines the federal interpretation of the CHA that fees charged by private medical facilities constitute a user fee if physician-services portion of the costs is covered directly by the provincial health insurance plan. Minister of Health and Welfare, *Federal Policy on Private Clinics*, 6 January 1995. Accessed on 30/05/06 at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/interpretation/index_e.html.

In terms of the federal reaction, the federal minister refused to state whether he believed the proposed reforms would be in violation of the *CHA*.[34] Both the federal minister and Prime Minister himself had repeatedly warned the Alberta government that reforms must fall within the parameters of the *CHA*.[35] Once the proposals were released, the federal health minister outlined his preference for the Québec model which requires physicians to opt completely out of the public system in order to undertake any private billings while also stating concerns about the possibility of queue-jumping -- mirroring Prime Minister's Harper statement of preference for the Québec model of reform, [36]

The proposed reforms were derailed by Premier Klein's surprisingly poor showing in the review of his leadership at the annual Progressive Conservative Party meeting in April 2006 where he received only 55% of delegate support. Shortly thereafter, the Alberta government announced that it would be shelving its reform plans.[37] As the plans were withdrawn, Premier Klein castigated the federal government for offering no alternatives and accused it of political expediency in portraying itself as the defender of medicare.[38] This retraction follows a longer-term pattern of attempts at health care reform in Alberta. Alberta began allowing private eye surgery clinics to charge facility fees to patients directly in 1993 but, in the face of federal penalties, the government shifted policies and brought itself into *CHA* compliance by paying for the fees through the public plan. In 1998, Alberta proposed Bill 37 which would have allowed overnight stays in private surgery clinics but again relented in the face of federal pressure. A weaker version of Bill 37 was abandoned in 2000 and, instead, limited procedures allowed in private clinics and banning private hospitals. Further calls for enhanced private delivery of services were made in the Mazankowski report (on which the government took no action) and Premier Klein's pledge in the 2004 election to undertake reforms that would challenge the *CHA*. Despite these frequent commitments by the Alberta government to challenge the *CHA*, regulation of private financing of health services, private insurance and mixing of public and private income sources in Alberta remains at about the median for all provinces and considerably more stringent than regulation in some provinces.

The Alberta proposals contain elements that, if adopted, would constitute a violation of the *CHA*: requiring co-payments (e.g. user fees) for publicly-insured services or allowing public facilities to charge for expedited access to publicly-insured services. However, many elements of the Alberta proposals which appear to be relatively radical shifts in policy – such as allowing third-party private insurance for services provided by both opted-out and opted-in physicians, allowing both opted-out and opted-in physicians to combine both public and private incomes sources, and encouraging public facilities to charge facility fees for privately-insured services – are within the bounds of the *CHA* and currently allowed in other provinces.

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[34] Katherine Harding, "Alberta Reshapes Medicare," *Globe and Mail*, 1 March 2006, online edition.
[35] Canadian Press, "Alberta Health-Care Reforms Must Obey Medicare, Tories Say," *Globe and* Mail, 27 January 2006, online edition; Katherine Harding, "Alberta Reshapes Medicare," *Globe and Mail*, 1 March 2006, online edition; Katherine Harding and Gloria Galloway, "Klein Willing to Defy Ottawa," *Globe and Mail*, 2 March 2006, online edition.
[36] Gloria Galloway, "'We're Studying It,' Ottawa Says," *Globe and Mail*, 1 March 2006, online edition.
[37] Dawn Walton and Bill Curry, "Alberta Backs Off Private Medicare Blueprint," *Globe and Mail*, 21 April 2006, online edition.
[38] *Ibid.*

CONCLUSIONS

A review of provincial approaches to the private funding of health services including private insurance coverage of publicly-insured services and the ability of physicians to combine public and private income sources suggests that the degree to which provincial governments allow private funding of health services is fundamentally determined by political dynamics within each province. While provincial approaches to these issues are conditioned by political constraints created by federal legislation, they are not primarily determined by federal legislation nor does it seem likely that they will be primarily determined by judicial interpretation of the Canadian *Charter of Rights and Freedoms*. The *Chaoulli* decision may increase the political salience of arguments in favour of opening up health care to higher levels of private funding and a greater scope for private insurance; however, it will not lead to these outcomes directly.

None of this is to argue that the *CHA* is of no consequence in shaping debates over public health insurance in Canada or in placing effective political restrictions against provinces implementing specific types of reforms such as extra-billing or user fees. That said, federal intervention through the *CHA* does not explain why all provinces go beyond the minimum conditions outlined in the *CHA*. Moreover, even those provinces which are often characterized as being most likely to challenge the limits of the *CHA* and most interested in introducing higher levels of private funding of health care continue to have relatively stringent restrictions in these regards in comparison with other provinces and the provision of the *CHA*. For those concerned with resisting attempts to increase the reliance on private funding of health services in Canada, it is important to recognize that the *CHA* is a political tool in health care debates and that federal intervention in the health care arena is only one of several political dynamics sustaining the existing system of universal public health insurance in Canada.

Table 1: Provincial Regulation of Private Income Sources, by Status of Physician, 2001

Physician Status	Regulation	BC	AB	SK	MB	ON[A]	QB	NB	NS	PEI	NF
Opted Out	Prohibits Opting Out	N	N	N	N	Y	N	N	N	N	N
	Limits on Fees	N	N	N	Y	n/a	N	N	Y	N	N
	Ban on Private Insurance	Y	Y	N	Y	n/a	Y	N	N	Y	N
	Public Coverage Denied	Y	Y	Y	N*	n/a	Y	Y	N*	N*	N
	*Total/3****	*2*	*2*	*1*	*3*	*3*	*2*	*1*	*3*	*1*	*0*
Opted In	Direct Patient Billing Prohibited	N*	N	Y*	Y	Y	Y	N	Y	N	Y
	Limits on Fees	Y	Y	Y	Y	Y	Y	N	Y	N	Y
	Ban on Private Insurance	Y	Y	N	Y	Y	Y	N	N	Y	N
	Public Coverage Denied***							Y		Y	
	*Total/3****	*2*	*2*	*3*	*3*	*3*	*3*	*0*	*3*	*1*	*3*
Combined /6	*Total****	*4*	*4*	*3*	*6*	*6*	*5*	*1*	*6*	*2*	*3*

Basic source for provincial regulation of private health insurance is Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal* 164, 6 (20 March 2005): 825-30.

[A]Prior to the June 2004 passage of the *Commitment to the Future of Medicare Act, 2004*, Ontario allowed physicians to opt out although it limited their fees to level set under the public plan and banned private insurance coverage for such services although patients could apply for compensation directly from the plan. Under the *Commitment to the Future of Medicare Act, 2004*, physicians are no longer able to opt out and bill patients directly.

*Source: CHA Annual Report, 2004-5.

**Chaouilli v. XX. S. 71.

***Required by CHA

****Higher scores are associated with greater levels of regulation and prohibitions on mixing public and private funding sources.

Table 2: Provincial Regulation of Private Insurance, by Status of Physician, 2001

Physician Status	Regulation	BC	AB	SK	MB	ON[A]	QB	NB	NS	PEI	NF
Opted Out	Prohibits Opting Out	N	N	N	N	Y	N	N	N	N	N
	Ban on Private Insurance	Y	Y	N	Y	n/a	Y	N	N	Y	N
	Limits on Fees	N	N	N	Y	n/a	N	N	Y	N	N
	Public Coverage Denied	Y	Y	Y	N*	n/a	Y	Y	N*	N*	N
	*Total/3****	*3*	*3*	*1*	*3*	*3*	*3*	*1*	*2*	*3*	*0*
Opted In	Ban on Private Insurance	Y	Y	N	Y	Y	Y	N	N	Y	N
	Direct Patient Billing Prohibited	N*	N	Y*	Y	Y	Y	N	Y	N	Y
	Limits on Fees	Y	Y	Y	Y	Y	Y	N	Y	N	Y
	Public Coverage Denied***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	*Total/3****	*3*	*3*	*3*	*3*	*3*	*3*	*0*	*3*	*3*	*3*
Combined /6	*Total****	*6*	*6*	*4*	*6*	*6*	*6*	*1*	*5*	*6*	*3*

Primary source for provincial regulation of private health insurance is Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal* 164, 6 (20 March 2005): 825-30.

[A]Prior to the June 2004 passage of the *Commitment to the Future of Medicare Act, 2004*, Ontario allowed physicians to opt out although it limited their fees to level set under the public plan and banned private insurance coverage for such services although patients could apply for compensation directly from the plan. Under the *Commitment to the Future of Medicare Act, 2004*, physicians are no longer able to opt out and bill patients directly.

*Source: CHA Annual Report, 2004-5.

**Chaouilli v. XX. S. 71.

***Required by CHA

****Higher scores are associated with greater levels of regulation and prohibitions on mixing public and private funding sources.

Table 3: Provincial Regulation of Mixing of Public/Private Physician Income, by Status of Physician, 2001

Physician Status	Regulation	BC	AB	SK	MB	ON[A]	QB	NB	NS	PEI	NF
Opted Out	Prohibits Opting Out	N	N	N	N	Y	N	N	N	N	N
	Public Coverage Denied	Y	Y	Y	N*	n/a	Y	Y	N*	N*	N
	Limits on Fees	N	N	N	Y	n/a	N	N	Y	N	N
	Ban on Private Insurance	Y	Y	N	Y	n/a	Y	N	N	Y	N
	*Total/2****	*2*	*2*	*2*	*1*	*2*	*2*	*2*	*1*	*0*	*0*
Opted In	Direct Patient Billing Prohibited	N*	N	Y*	Y	Y	Y	N	Y	N	Y
	Limits on Fees	Y	Y	Y	Y	Y	Y	N	Y	N	Y
	Ban on Private Insurance	Y	Y	N	Y	Y	Y	N	N	Y	N
	*Total/2****	*2*	*2*	*2*	*2*	*2*	*2*	*0*	*2*	*1*	*2*
Combined /4	*Total****	*4*	*4*	*4*	*3*	*4*	*4*	*2*	*3*	*1*	*2*

Basic source for provincial regulation of private health insurance is Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal* 164, 6 (20 March 2005): 825-30.

[A]Prior to the June 2004 passage of the *Commitment to the Future of Medicare Act, 2004*, Ontario allowed physicians to opt out although it limited their fees to level set under the public plan and banned private insurance coverage for such services although patients could apply for compensation directly from the plan. Under the *Commitment to the Future of Medicare Act, 2004*, physicians are no longer able to opt out and bill patients directly.

*Source: CHA Annual Report, 2004-5.

**Chaouilli v. XX. S. 71.

***Required by CHA

****Higher scores are associated with greater levels of regulation and prohibitions on mixing public and private funding sources.

Table 4: Provincial Regulation of Private Insurance and Physician Income Source, by Status of Physician, 2001

Physician Status	Regulation	BC	AB	SK	MB	ON[A]	QB	NB	NS	PEI	NF
Opted Out	Private Funding /3	2	2	1	3	3	2	1	3	1	0
	Private Insurance /3	3	3	1	3	3	3	1	2	3	0
	Physician Income /2	2	2	2	1	2	2	2	1	0	0
Opted In	Private Funding /3	2	2	3	3	3	3	0	3	1	3
	Private Insurance /3	3	3	3	3	3	3	0	3	3	3
	Physician Income /2	2	2	2	2	2	2	0	2	1	2
Private Funding	*Total**** /6*	*4*	*4*	*4*	*6*	*6*	*5*	*1*	*6*	*2*	*3*
Private Insurance	*Total**** /6*	*6*	*6*	*4*	*6*	*6*	*6*	*1*	*5*	*6*	*3*
Physician Income	*Total**** /4*	*4*	*4*	*4*	*3*	*4*	*4*	*2*	*3*	*1*	*2*

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