DISCUSSION AND DEBATE

Under the Radar: Stealth Development of Two-Tier Healthcare in Canada

Sous l'écran radar : implantation subreptice d'un système de soins de santé à deux vitesses au Canada

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Abstract

The shocked reaction of commentators to the recent Canadian Supreme Court decision (*Chaoulli v. Quebec*) overturning Quebec's ban on private healthcare insurance is difficult to square with the facts and policy options realistically open to provincial governments. The problem is that rhetoric has centred on preserving a single-tier universal system that has never existed in the form its supporters imagine. Meanwhile, quasi-private agencies and healthcare entrepreneurs have been improvising private care options, either ignored or abetted by governments. Consequently, policy and practice have become increasingly divergent. Supporters of Canadian-style medicare can only hope that the *Chaoulli* decision will force clearer-headed policy re-appraisal. Towards that end, this paper argues that provincial governments ought to focus more on robust regulation of already existing, privately financed healthcare, including the commissioning of care by Workers' Compensation Boards.

Résumé

La réaction-choc des commentateurs suite à la récente décision de la Cour Suprême (*Chaoulli c. Québec*) invalidant l'interdiction, au Québec, de recourir à des assurances privées pour les soins de santé est difficile à réconcilier avec les faits et les options de politiques qui s'offrent, de façon réaliste, aux gouvernements provinciaux. Le problème est que la rhétorique s'est concentrée sur la préservation d'un système universel à une vitesse qui n'a jamais existé sous la forme que ses défenseurs prétendent. Entretemps, les agences paraprivées et les chefs d'entreprise oeuvrant dans le domaine de la santé s'affairent à improviser des options en matière de soins privés, sous les regards peu soucieux des gouvernements ou avec l'aide de ceux-ci. On constate donc une divergence croissante entre les politiques et la pratique. Les défenseurs d'un système de soins de santé « à la canadienne » ne peuvent qu'espérer que la décision *Chaoulli* entraînera une réévaluation plus éclairée des politiques. À cet égard, le présent article soutient que les gouvernements provinciaux devraient mettre davantage l'accent sur une réglementation plus musclée des soins de santé privés déjà existants, y compris la prestation de soins par les commissions des accidents du travail.

Public Health Insurance in Canada

Following introduction of a provincial hospital insurance program in Saskatchewan, the federal *Hospital Insurance and Diagnostic Services Act* offered financial assistance to provincial programs covering the cost of hospital care. By 1961, all 10 provinces had signed agreements with Ottawa. In 1966 the federal government, again following developments in Saskatchewan, introduced the *Medical Care Act*, which, from July 1, 1968, provided federal funding support to provinces establishing insurance programs to pay the cost of doctors' services. By 1972, all provinces and territories had added medical insurance plans to supplement the hospital ones. The framework left uninsured a class of hospital services, notably, amenity services such as preferred accommodations, and non-medically necessary doctors' services such as adult cosmetic surgery.

The Established Program Financing block funding arrangements, which replaced cost sharing in 1977, helped the federal government to gain control over its health expenditures but did so at the expense of capping provincial revenues from federal sources. Provincial efforts to reduce the rise in their spending through demand-side measures, such as allowing doctors to bill above the public insurance tariff, provoked the *Canada Health Act* in 1984. That Act mandates financial penalties on provinces that impose or permit private charges on insured residents for insured services.

Initial Conditions: Policy Limits on Private Financing

Controversially, federal funding conditions required coverage of all residents within participating provinces, rendering private cover redundant. Various disincentives to bill privately were also built into provincial healthcare insurance legislation. In Ontario, for example, if a physician wishes to bill at a rate other than the established tariff, he or she is required to "opt out" of the provincial healthcare insurance plan and directly bill all his or her patients. In Quebec, an opted-out ("non-participating") physician was not only barred from billing the plan directly, but also his or her patients were ineligible to apply for public reimbursement of any part of the fee. In light of these various policy instruments, very few doctors chose to "go private."

In spite of strong policy disincentives, concern about the possible return of privately funded hospital and medical care led six of Canada's 10 provinces – British Columbia, Alberta, Manitoba, Ontario, Quebec and Prince Edward Island – to ban private insurance for services that were insured under their provincial plans. Private funding through private insurance policies invoked the spectre of a "second tier of care" – care that can be differentially accessed based not on health needs but rather on ability to pay. Additionally, policy makers at the time believed that a duplicate, privately financed care system running alongside the publicly funded one could drain the public system of resources and political support, a belief recently supported by evidence from Spain (Costa-Font 2005).

Policy Limits on Universal Public Insurance

The policy window for expanding universal entitlement programs closed over the decade following 1975 because (a) federal tax cuts and economic slowdown drove budgets into deficit (Evans 2005), (b) resistance to federal involvement in areas of provincial jurisdiction grew, notably in Alberta and Quebec and (c) concern over healthcare spending deepened. The planned extension of universal health insurance into such areas as drugs dispensed outside a hospital never happened.

In consequence, some form of private financing, combined with a hodgepodge of provincial programs, is the norm everywhere except for insured hospital and medical services, where private financing virtually disappeared after passage of the *Canada Health Act* (Office of the Auditor General 1999, 2002; Choudry 1996). This situation is uniquely Canadian and has been aptly named "sectoral" financing (Tuohy et al. 2004).

The Ambiguity of "Medical Necessity"

The criterion for public hospital and medical insurance coverage, "medical necessity," has not been without difficulties. Under financial pressure and the influence of the evidence-based medicine movement, provincial governments engaged in bound-

ary shifting. First, services of dubious clinical merit, such as neo-natal circumcision, were de-insured. Then, following the *Canadian Task Force Report on Periodic Health Examination* in 1979, provinces began to de-insure or place limits on the frequency of routine medical examinations and impose meaningful constraints on the routine ordering of laboratory tests and imaging (Canadian Task Force 2005). The result was the creation of a small niche market for privately financed health examinations, including privately financed diagnostic imaging services for the worried well. While not of great moment in and of itself, the policy point is significant: boundary setting by provincial insurance authorities establishes not only the limits of public coverage, but also marks the terrain that can be, and increasingly is, occupied by privately financed service providers.

The lengthening in Canada of wait times for elective procedures has proven to be the biggest problem associated with equating "insured service" with "medical necessity." Privately financed diagnostic and treatment clinics advance the argument that if a three-month wait time is medically acceptable, providing the service sooner cannot, strictly speaking, be "medically necessary" (Day 2005). While plainly trading on an ambiguity, the privately financed diagnostic and treatment clinics exist precisely to provide services more expeditiously than is justified by the evidence-based guidelines informing the publicly funded system. In and of itself, the ambiguity is unimportant because the potential market for expedited service is too small to finance private diagnosis and treatment. But coupled with unused capacity funded from another source, a more serious threat is posed to the universal insurance plan. As this paper will show, another source exists in the form of Workers' Compensation Boards.

Private Health Insurance in Canada

An underappreciated fact is Canada's heavy reliance on private healthcare insurance. In 2002, only four OECD countries depended on private insurance for more than 10% of their total healthcare expenditures. Canada is among them. Only in five countries – Canada, the United States, Switzerland, France and the Netherlands – does more than 60% of the population have private insurance coverage (Colombo 2004). This largely accounts for the fact that Canada's public share of healthcare expenditure is on the low side at less than 70% (CIHI 2005a).

Currently, less than 50% of the cost of prescription drugs, including those dispensed in hospital, is financed by the public sector; roughly 35% is covered by the private insurance industry (Health Council 2005). With the exception of Quebec, provinces have been reducing drug coverage; the new Quebec drug plan actually shifts coverage from public to private insurance. British Columbia recently increased co-payments and thresholds, and Ontario narrowed eligibility criteria, decreasing the number of beneficiaries by 9%.

As Evans (2002) pointed out, private healthcare insurance in Canada is subsidized. It is expensed as a business cost, but the benefits are tax free in the hands of employees, resulting in an estimated 30% tax expenditure. While important for the profitability of companies offering drug and other non-insured service coverage, subsidization is even more important for duplicate coverage of services wholly or partially paid by universal public plans. Underwriting is only marginally viable without hefty public subsidies, as evidenced by the small market share in the United Kingdom (6%) and the need for massive subsidies in Australia (Davidson 2004b). Removing public supports for private insurance in Canada would go some considerable distance towards ensuring that private corporate insurance will not expand beyond its beachhead in drugs and other non-insured benefits.

Workers' Compensation Boards and Private Care in Canada

The absence of commercial insurance companies in the Canadian medical and hospital care sectors does not mean that Canada has been without a significant source of private insurance financing for services that would normally be covered by medicare. The arrangements respecting workplace injury preceded medicare and were grandparented into the policy mix. Workers' Compensation Boards (WCBs), structured under provincial legislation, continued to be responsible for paying for medical care and rehabilitation of injured workers. As quasi-autonomous agencies, WCBs were and remain private healthcare insurance operations funded by premiums paid by employers. The services they cover are, from the perspective of the universal public insurance plan, an amalgam of insured and non-insured ones – medically necessary care, but also drugs dispensed in the community, community-based rehabilitation services, and so on. Technically, WCB coverage is not duplicate insurance coverage comparable to duplicate coverage in Australia, where the same baskets of services may be paid for by either private insurance or public medicare. In the Canadian case, treatment stemming from a workplace accident is exempted from public coverage, defined as an "uninsured service" even though it is medically necessary, because the legal responsibility to pay was legislatively assigned to WCBs.

Workers' Compensation Boards commission services from physicians in private practice, hospitals and private rehabilitation centres such as physiotherapy clinics, paying rates negotiated independently from the provincial healthcare insurance plans. That funding facilitated the expansion of privately funded/privately provisioned care, especially in the areas of diagnostic imaging and rehabilitation.

In the 1990s, in response to growing wait times for elective procedures in the public system, provincial WCBs sought private care providers who would treat injured workers sooner than the publicly funded healthcare system. The shift in WCB funding away from publicly funded hospitals towards privately funded private treatment

centres made these centres financially viable by adding to their traditional revenues from non-insured services such as cosmetic surgery. Falling costs of, and improved technology in, arthroscopic surgery allowed for product line expansion in light of WCB demand and WCBs' willingness to pay premium prices for repairs of joint and ligament injuries. Consequently, there was a proliferation of private treatment centres and an expansion of existing ones.

Once established, diagnostic and treatment centres have the obvious objectives of stabilizing their funding and expanding their market. Those objectives require four strategies. The first is to promote the idea that delays in the public system may cause health to deteriorate. The second is to argue a quality and amenity advantage over public care. The third is to expand the product line by including high-demand items. The fourth is to find means to make the care more affordable for potential private-paying patients, given that the alternatives are entirely free to the user. The first three are evident in the intensive advertising by private treatment centres (False Creek Surgery Centre 2005; Cambie Surgery Centre 2005). The fourth is evident in private care centres' lobbying for, on the one hand, private insurance to cover their services and, on the other, contracts with the health authorities to treat public patients with public funds, putatively to shorten waiting times for all publicly insured patients. As predicted (Deber 2002), once established the Canadian private care providers formed political coalitions to defend and increase their share of funding. Not surprisingly, 14 private treatment centres, the majority from British Columbia and most of them recipients of WCB funding, were intervenors in *Chaoulli v. Quebec*.

British Columbia's WCB makes no apology for its robust support for the expansion of private, specialized facilities offering services for which there are long queues for publicly supported access in public facilities. "To improve rehabilitation and return-to-work timelines for injured workers, the WCB provides expedited medical services to many claimants who would otherwise be subjected to lengthy waiting lists in the public health care system" (WCB 2003: 20). The amounts of money are not trivial. For example, in 2002, British Columbia's WCB reported expenditures on healthcare of over $237 million (WCB 2003).

WCB funding has not only incubated private treatment centres; it has also expanded private care within public hospitals. British Columbia's health authorities are competing with private treatment facilities for the business, bringing additional resources into the hospitals and, according to WCB managers, expanding capacity, as opposed to shunting aside public patients (LeBourdais 1999). The development is welcomed by cash-strapped health authorities and surgeons who benefit from additional operating room time. De facto, it means a two-tiered healthcare system of expedited privately financed patients and patiently waiting public patients. To date, there is no evidence regarding the effect of the private funding stream on the fate of those publicly supported patients because there has been no effort to find out. But it

would be surprising if hospital managers and health authorities in Canada are doing what their counterparts in Britain and Australia cannot – preventing the privately funded care from adversely affecting access for publicly funded patients (Pollock 2005; Duckett 2005a,b).

Conclusion

The perception of increased waiting times and decreased quality of service (Blendon 2002) has harmed public support for Canadian medicare. The reality of some extreme waits led the Supreme Court to conclude that the current situation poses an unacceptable threat to security of the person. More is required than the benchmark wait times belatedly delivered by the provinces in December 2005. What is needed is meaningful action on wait times, including much-improved health information management, a transparent system for setting priorities and a democratically accountable approach to the provision of care. Additionally, technical improvements, such as the elimination of "choke points" and the building and staffing of specialized high-volume facilities for eye and joint care, are urgently required. The private assault on the public system can be stopped only if the public system is regarded as worth defending. Provincial health policy must begin to demonstrate that governments are bearing this in mind.

Given the reality in Canada of multiple growth nodes in privately funded care, it is hard not to agree with the majority of the Supreme Court justices. They found the argument that a provincial ban on private health insurance is required to protect Canada's unique, single-tiered healthcare system to be either cynical or naïve. They were no doubt influenced by the fact that privately financed healthcare, along with privileged access, has grown, not only for WCB clients, but also for corporate executives, politicians – and judges. Moreover, the justices reasoned that protecting publicly funded programs does not require a ban on private insurance because some provinces and some countries have no such ban, yet maintain publicly financed, universal healthcare systems. That is because other policy instruments are available to governments and, from the Court's perspective, it is up to provincial governments as to whether they will deploy them. An example here is the 2004 *Ontario Healthcare Insurance Act* amendment requiring Ontario doctors to submit all bills for insured services to the public plan (*Health Insurance Act* 1990: 15(1)).

The Supreme Court was correct to conclude that the ban on private insurance is not strictly necessary, although it is plainly helpful, to protect the publicly funded healthcare system. Other, equally effective policies are available for regulating the scope and role of private healthcare in Canada. Those policies include (a) clarifying the boundaries of insured and uninsured services, (b) establishing regulations regarding privately financed services in treatment settings, (c) more closely regulating the billing practices of providers, (d) removing subsidies for private insurance, (e) controlling the com-

missioning practices of quasi-public agencies such as WCBs and (f) most importantly, improving the responsiveness of, and public confidence in, the publicly financed system.

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