ECONOMIC NOTE

"Health" Series

Montreal Economic Institute

April 2003

Health care reforms: Just how far can we go?

A debate has raged for several years in Quebec and elsewhere in Canada on ways to remedy the shortcomings of the public health care system. However, this debate has been confused by uncertainty with respect to the Quebec and Canadian legal context. The legislative framework under which the public health care system has operated for the last twenty years is indeed not only complex, but prone to various interpretations. Just what is allowed under the current laws? Which laws could a reform-minded provincial government modify in order to successfully carry out its reforms? How much room do the provinces that would like to reform the system have under current federal legislation?

The purpose of this *Economic Note* is to shed light on these questions, without arguing for or against any particular proposal. Two types of reforms are discussed: 1. those that seek to reorganize the public sector or allow the recourse to the private sector for delivery of services, which could be made without major legislative change and without calling into question the state monopoly on health care; 2. those that challenge the public financing of health care, which would require amendments to the *Canada Health Act*[1] and, at the provincial level, to the *Health Insurance Act*[2] and the *Hospital Insurance Act*[3].

Legal context

The federal government's role in health care is defined in the *Health Act*, which establishes the conditions that provinces and territories must observe in order for them to be entitled to the federal monetary contributions. The *Health Act* is not binding. A provincial law that violates it is thus not invalid or illegal. The sanction is purely political and its repercussions are financial, not legal.

To qualify fully for federal funds, the provinces must satisfy several requirements. There are five conditions: public administration, comprehensiveness, universality, portability and accessibility. Other requirements relate to extra billing and user charges as well as the official recognition that must be given to the federal contribution to the province's health care system.

The public health care system in Canada is established almost entirely by provincial legislation. The *de facto* monopoly of the Quebec government on health care financing is created principally by article 15 of the *Health Insurance Act* and by article 11 of the *Hospital Insurance Act*. The entire public health care system is based on the notion of "insured health care service." An insured health care service is a service that is dispensed by a doctor and is necessary from a medical standpoint[4].

[1] R.S.C. 1985, c. C-6 (*"Health Act"*).
[2] R.S.Q., c. A-29.
[3] R.S.Q., c. A-28.
[4] See Articles 1 a) and 3 a) of the *Health Insurance Act*.

This *Economic Note* was written with legal advice from the law firm of Trudel & Johnston, in collaboration with Messrs. Philippe H. Trudel, Bruce W. Johnston and Michel Bédard.

Article 15 of the *Health Insurance Act* prohibits any person from making or renewing an insurance contract or effecting a payment under an insurance contract for an insured service on behalf of a beneficiary covered by the Quebec health care plan. Article 11 of the *Hospital Insurance Act* prohibits contracts and payments for hospital services included in insured health care services. This requirement supplements the preceding one. Not only is insurance prohibited, so is any payment for a hospital service[5].

Not only is insurance prohibited, so is any payment for a hospital service.

The law allows private insurance or a direct payment for health care services which are not medically required or which do not qualify as insured services, dental care for example. One can infer from article 11 of the *Hospital Insurance Act* that payment for an insured health care service is also allowed for non-hospital services (within the meaning of the provincial legislation). Only doctors not participating in the provincial health insurance plan can, however, request such a payment, since article 22 of the *Health Insurance Act* prohibits such payment to participating doctors. The law in effect prevents doctors from being remunerated for insured health care services both inside and outside the public insurance system. Thus, a doctor can practise medicine outside of the public system if he does not render any hospital services, i.e. if he dispenses only services that do not require the hospitalization of a patient. Payment is thus allowed for day surgeries and elective surgeries (ophthalmologic or orthopaedic), as well as for home visits.

1. Reforms within the legal framework

Within the legal framework outlined above, any administrative reorganization of the public system is permitted. We refer here to reforms such as the elimination of ceilings and billing quotas imposed on doctors, the decentralization towards the regions of the decision making role of the Ministry of Health and Social Services or the replacement of the regional health boards by other structures.

Reforms that would allow greater access to the private sector for delivery of services are more controversial and have been denounced as contrary to the spirit of the Canadian public health care system by those opposing them. Despite this, provincial governments have room to proceed along those lines if they chose to do so.

On the whole, any additional recourse to the private sector for the delivery of services is allowed by the *Health Act* as well as by Quebec laws insofar as the public system remains universal, no medically necessary service is withdrawn from the list of insured services and the state continues to finance all insured care *completely*. Also, any additional recourse to the private sector must not infringe upon the obligation that the system be publicly administered, as stated in the *Health Act*. This obligation assumes that the provincial health care insurance plan is managed on a non-profit basis by a public authority, that this authority is accountable to the provincial government for its management and subject to verification of its accounts and financial transactions[6].

Any recourse to the private sector as a service supplier in partnership with the public sector does not require any change to the Health Act nor to articles 15 and 11 of the Quebec laws.

Inasmuch as these requirements are respected, any recourse to the private sector as a service supplier in partnership with the public sector does not require any change to the *Health Act* nor to articles 15 and 11 of the Quebec laws mentioned above. Among reforms of this type, one could consider the privatization of hospital laundry services, cafeteria or cleaning services. Outsourcing of specialized clinical services or support services (diagnostics, radiology, laboratories, surgical operations of short duration, post-operative follow-ups, etc.) to private clinics affiliated with hospital centres does not violate the law either. Furthermore, following a controversy in 2000, the federal government gave up challenging the *Health Care Protection Act*[7] of Alberta that allows private clinics to treat patients on hospital waiting lists under the same conditions and the same tariffs as in the public sector.

[5] The constitutionality of these articles was contested without success until now in *Chaoulli vs. Quebec (P.G.)*, which is presently seeking leave to appeal to the Supreme Court of Canada. The argument of the plaintiffs Chaoulli and Zeliotis in this case is that insofar as the state is not able to provide, in a timely manner, the medically necessary services and insofar as the state does not use all available resources for the public system, it cannot prevent the patient from using his own financial resources to obtain care without there being a violation of the right to life and security. These rights are guaranteed by article 7 of the Canadian Charter of Rights and Freedoms, part I of the Constitution Act of 1982, constituting annex B of the Canada Act 1982 (U.K), 1982, c. 11.

[6] Art. 8 of the *Health Act.*

[7] R.S.A 2000, c. H-1, better known under the name of "Bill 11."

Public-private partnerships could also be considered where for-profit corporations finance, build and manage private hospitals whose facilities are rented to the government. In this type of arrangement, the state would continue to assume any covered medical expenses and would remain responsible for the management of the public system. Only the management of the physical infrastructures would be assigned to the private sector. The governments of Ontario and British Columbia have already announced the start up of three projects of this type.

2. The state monopoly on financing

The real controversy when it comes to interpreting the legal framework of health care reforms centers around the challenge to the state's monopoly on financing insured health care services.

The real controversy centers around the challenge to the state's monopoly on financing insured health care services.

One way of getting around the legal obstacles is to remove certain services from the list of insured services when they are offered in private clinics by modifying article 22 of the *Regulation respecting the application of the Health Insurance Act*[8], thereby putting them out of reach of articles 15 of the *Health Insurance Act* and 11 of the *Hospital Insurance Act*. A parallel system of private health care, allowing payment or private insurance, could then develop by simple amendments to the *Regulation*. That is already the case for some services such as magnetic resonance imaging. But the government could remove coverage for other services and the doctors could offer them without having to opt out of the public plan.

So long as the public system continues to offer these services free of charge, such modifications do not violate the conditions of the *Health Act*. If they were implemented, a participating doctor could invoice the Régie de l'assurance maladie du Québec (RAMQ) for a service when he delivers it in a hospital and invoice a patient who is in a rush and willing to pay for the same service in his private office.

The second way of putting an end to the state's monopoly on the financing of services is to rescind articles 15 and 11 in order to allow payment and private insurance for all types of services, including hospital care. It is here, however, that the federal law comes into play. Even if the provincial legal obstacles are removed, this scenario could violate the *Health Act* requirements relating to "user charges," insofar as the patient pays out of his own pocket for facility fees (administrative or clinical) and the doctor is remunerated by the public health insurance plan.

In a January 6, 1995 letter, which helps to interpret the law, Diane Marleau, Canadian Health Minister at the time, applied restrictions contained in the *Health Act* concerning user charges to "facility fees" when these were charged for a medical service. This is the case even when the service is delivered in a private clinic because, according to the Minister, a clinic is a "hospital" within the meaning of the *Health Act*. Without this restriction, the federal contribution, according to her, would be used to subsidize a two-tier system[9]. Insofar as the provincial health insurance plan remunerates the doctor, the medical acts that he performs are inside the public plan. Consequently, to allow somebody to pay for faster access contravenes the conditions of accessibility and universality because the services are not offered according to uniform methods. One should note that if the surplus were payable to the doctor and not to the state, it would then be considered "extra billing," and would also be illegal[10].

With the appropriate legislative amendments to the provincial laws, the distribution of health care services wholly outside the public sector is not incompatible with federal law.

A violation of the *Health Act* results in a deduction of the federal contribution proportionate to the extra billing invoiced[11]. In addition, non-compliance with one of the five conditions can lead to a reduction or the withholding of the federal contribution[12].

This being said, with the appropriate legislative amendments to the provincial laws (i.e., the rescinding of

[8] Not to be confused with article 22 of the *Health Insurance Act* that prohibits participating doctors from claiming payments.

[9] "Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being direct ly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable." (Diane Marleau). See the appendix to this *Economic Note* on the MEI web site at http://www.iedm.org/uploaded/pdf/santejuridiqueappendix.pdf.

[10] See article 2 "extra billing" and article 18 of the *Health Act*.

[11] Art. 20 of the *Health Act*.

[12] Art. 14-17 of the *Health Act*.

articles 15 and 11 mentioned above), the distribution of health care services *wholly outside the public sector* is not incompatible with federal law. As long as the public system is managed by the state and continues to offer care in an integral, universal and accessible way, nothing prevents a patient from resorting to the private sector and paying all expenses. There would then develop a parallel system, including hospital services, where patients would be cared for by totally private institutions and would pay out of their own pocket or with private insurance. This private parallel system would exist alongside a public system that would continue to meet the conditions of the *Health Act*.

Moreover, if hospitals entirely managed by the private sector existed in Quebec, nothing in the *Health Act* would prohibit the RAMQ from contracting with such a hospital to provide care to a beneficiary, *but the costs would have to be paid in full*. That's what the government does, for example, when it sends cancer patients for treatment in American hospitals and pays all the costs, except that the private hospitals would be located in Quebec. It should be noted that the government could not subsidize these private hospitals without contravening the *Health Act* because in this case the patients who pay would benefit indirectly from the state's contribution. Moreover, amendments to the provincial laws, in particular article 22 of the *Health Insurance Act*, would allow health professionals to work not only in the private sector but also in the public sector without contravening the *Health Act*.

A Quebec government that believes in the effectiveness of a market economy has no legal excuse for not going ahead with plans to reform the health care system.

Conclusion

To summarize, a Quebec government that believes in the effectiveness of a market economy has no legal excuse for not going ahead with plans to reform the health care system. Without any major change to the legislative barriers that maintain the state monopoly[13], it can already integrate concepts such as flexibility and competition into public management. It could also increase the recourse to the private sector for the delivery of health care, so long as it continues to completely finance all insured health care and so long as the greater role granted to the private sector does not contravene the stipulation for public management of the system, as stated in the *Health Act*.

It is the combination of public and private financing that poses a problem. It would be illegal to allow a patient to pay for faster access to obtain a service dispensed by the public sector, or conversely to partially finance, with the help of public funds, the care provided by a parallel private system, without contravening the *Health Act*. The government can however remove certain services from the list of insured services, or repeal articles 15 of the *Health Insurance Act* and 11 of the *Hospital Insurance Act*, in order to allow the growth of a private sector alongside the public sector where the patients would be free to pay for services either directly or with private insurance.

[13] Subject to existing labour laws and collective agreements in force.

Montreal Economic Institute

Montreal Economic Institute
6418 Saint-Hubert Street
Montreal (Quebec)
H2S 2M2 Canada
Telephone: (514) 273-0969
Fax: (514) 273-0967
e-mail: info@iedm.org
Web Site: www.iedm.org

The Montreal Economic Institute (MEI) is an independent, non-profit, non-partisan research and educational institute. It endeavours to promote an economic approach to the study of public policy issues.

The MEI is the product of a collaborative effort between Montreal-area entrepreneurs, academics and economists. The Institute does not accept any public funding.

One-year subscription to the MEI publications : $68.00.

Chairman of the Board:
Adrien D. Pouliot
Executive Director:
Michel Kelly-Gagnon

Printed in Canada