DEFENDING MEDICARE

A Guide to Canadian Law and Regulation

CUPE | Canadian Union of Public Employees

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EXECUTIVE SUMMARY

Our public health care system is being eroded by privatization in new ways and at an ever-increasing pace. For-profits and their allies in government and the courts are finding new inroads for private insurance, for-profit delivery, and two-tier access, working around and sometimes in direct violation of the law. This guide is intended to help activists challenge health care privatization by explaining the current medicare legal framework and how it can be both strengthened and enforced.

Medicare requires robust regulation to withstand the pressures of privatization. There is a fundamental conflict between the aims of medicare, centred on patients, and the aims of the market, centred on profits. Accordingly, robust legal controls are needed to protect medicare where it co-exists with for-profit health care. The controls are even more important in the context of free trade agreements and the increasing role of investor-owned clinics and public private partnerships.

This guide describes the legal infrastructure of medicare embodied by the *Canada Health Act* and related provincial and territorial health care laws and regulations, particularly as they apply to private payment and for-profit delivery. Specifically, the guide covers these three components of medicare's legal framework:

- the *Canada Health Act*, which sets out the overarching template for medicare;
- provincial laws and regulations, which establish provincial health insurance plans in accordance with the criteria of the *Canada Health Act* and which ban extra billing and user charges, as required by the Act, and;

- provincial rules governing health care providers' business and billing practices, which are not explicitly required by the *Canada Health Act* but which are nevertheless essential to a single-tier health care system.

This guide is both descriptive and prescriptive. It describes the principle controls on private payment and for-profit delivery of insured health services in medicare laws and regulations, highlighting some of the best examples and exposing some of the worst violations. It also recommends ways to strengthen medicare laws and regulations. While legal measures have served to impede the growth of private insurance and for-profit delivery of medically necessary services in Canada, governments are increasingly reluctant to enforce those measures or are weakening them outright. It is up to us to raise awareness on medicare rights and hold governments to account.

The following recommendations, presented in this guide with supporting evidence, are targeted at federal and provincial/territorial governments.

1 Make decisions on what gets listed and delisted based on evidence, using a process that is transparent, accountable, and free from any taint of self-interest.
2 Stop and reverse the privatization of administration and delivery of insured health services for groups excluded from the *Canada Health Act*.
3 Maintain and expand current restrictions on private health insurance.
4 Entrench and enforce the ban on extra-billing.
5 Entrench and enforce the ban on user fees, including facility fees and covering all insured health services.
6 Prohibit co-mingling of insured and uninsured services.
7 Regulate block fees.
8 Prohibit queue jumping for all insured health services.
9 Prohibit a physician from (a) paying or offering to pay kickbacks to or from any person, and (b) referring patients to clinics he or she owns or operates.
10 Stop and reverse the privatization of health care infrastructure.

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INTRODUCTION

This guide describes the legal framework for Canadian medicare, and it recommends how that framework can be strengthened. It is geared to medicare advocates who work to defend and improve the laws and regulations that safeguard our public health care system.

What does this guide cover?

This guide addresses the legal infrastructure of medicare embodied by the *Canada Health Act* and related provincial and territorial health care laws and regulations.[1]

The broad legislative template for medicare is set out by the *Canada Health Act*. To qualify for federal funding under the Act, each province and territory must (1) establish health care insurance plans that operate in accordance with the five criteria of the Act – public administration, universality, comprehensiveness, accessibility, and portability,[2] and (2) ban extra-billing and user charges for such insured services. The provinces and territories also regulate the business and billing practices of industries, institutions and individuals that provide health care services and insurance.

Under the *Canada Health Act*, provincial insurance plans must fund all "medically necessary" hospital services and all "medically required" physician services. Neither of these terms is defined by the Act, and no meaningful distinction has been drawn between them. For simplicity, this guide uses the term "necessary" to delineate the boundaries of publicly funded hospital and physician services.

One aspect of this medicare legal framework – and the focus of this paper – is the regulation of private payment and for-profit delivery in relation to insured health services. With the exception of the bans on user charges and extra-billing, the *Canada Health Act* does not explicitly prohibit private payment for insured health services – for example, when doctors are permitted to opt out of provincial health care insurance plans and charge patients directly. The Act also allows health care services to be provided on a for-profit basis as long as this takes place in accordance with the criteria of the Act. While Canada's health care system nonetheless remains predominantly publicly funded, when it comes to delivering health care services, the system is a mix of not-for-profit institutions, self-employed health professionals, and for-profit companies.

What does this guide not cover?

This document highlights some exemplary provisions in provincial law, but it is not an exhaustive review of provincial statutes or inventory of "best practices". Readers can find additional detail on these provincial laws and regulations, including inter-provincial comparisons, in some of the references.

This document focuses on insured health services. It does not describe or make recommendations on the regulation of continuing care, community care, medical devices, pharmaceuticals, or any number of other health services and products. While regulation in those areas is vital to protecting the public interest, such an analysis is beyond the scope of this paper.

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LISTING AND DELISTING

RECOMMENDATION #1

Make decisions on what gets listed and delisted based on evidence, using a process that is transparent, accountable, and free from any taint of self-interest. Committees should include health care providers, government health officials, and advocates of patients and the public interest. Committee membership and decision-making must be governed by strict conflict of financial interest rules. There should be a mechanism for complaints and appeals. The activities and reports of such committees should be public and readily accessible.

The *Canada Health Act* mandates that provincial health care insurance plans provide comprehensive health care services. Provinces decide what specific services get covered by the public plan; they regularly list and delist services.

Section 9 of the *Canada Health Act* states:

> *In order to satisfy the criterion respecting* ***comprehensiveness,*** *the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.*

Provinces list insured services as schedules to their respective public insurance statutes. Typically, the task of developing these lists is assigned to committees with representatives of the provincial government and the medical profession. Rarely is there any provision for public scrutiny or participation.[3]

Public officials and the medical profession have economic interests that may influence their view of what services to fund. For governments, it is the provincial budget. For doctors, uninsured services may be a source of additional income. Given the consequences, the process of listing and delisting services must be evidence-based, and free from any taint of self-interest.

A related issue concerns recourse for individuals who find that a particular service they require is not publicly funded, either because it has been delisted or is new and has never been listed. While in most provinces individuals are forced to seek relief in the courts, Ontario, Alberta and British Columbia have established administrative tribunals. Of these, Ontario's has the broadest mandate.[4] The Ontario Health Service Appeal and Review Board (the "Board") is composed of at least twelve members, all cabinet level appointees. To ensure balance and independence, no more than three members can be physicians, and there can be no members from the public service.

While its structure is sound, the Board has limited discretion to review delisting or failure-to-list decisions.[5] Instead, much of its work is taken up with claims concerning payment for services rendered outside Canada, either because these were provided as emergency treatment to Ontario residents while traveling, or because they are unavailable, or unavailable in a timely manner, in the province. With an expanded mandate, Ontario's Health Service Appeal and Review Board provides a good model for other provinces to consider.

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CANADA HEALTH ACT EXCLUSIONS

RECOMMENDATION #2

Stop and reverse the privatization of administration and delivery of insured health services for groups excluded from the *Canada Health Act*.

A substantial number of individuals and groups are excluded from coverage under the *Canada Health Act*, and the private sector is exploiting this market.

The *Canada Health Act* excludes members of the Canadian Forces and the Royal Canadian Mounted Police, federal penitentiary inmates, and injured workers covered by federal and provincial workers' compensation. Third party insurers, not the provincial health plans, cover the approved health care costs for these persons. The Act also excludes persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months), as well as persons covered under any other Act of Parliament (eg. refugee claimants).[6] [7]

Many of those excluded from the publicly funded system receive care, including hospital care, from for-profit providers. In fact, this client base has fuelled the growth of for-profit hospitals and clinics in Canada. In addition, the administration of these health plans for excluded groups is being increasingly privatized.

Union members who deliver workers' compensation services understand the negative impact of privatization and have signed on to the "Standhope Manifesto on Workers' Compensation".[8] Among other things, the Declaration calls for workers' compensation to be publicly delivered and administered on a not-for-profit basis.

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PRIVATE HEALTH INSURANCE

RECOMMENDATION #3

Maintain and expand current restrictions on private health insurance for services covered under the public system. Provinces that have yet to ban private insurance for necessary health services should do so.

Private insurance for necessary health services has thus far been limited in Canada, in part due to legal measures. It is important that we maintain and strengthen those measures.

While many Canadians have private health insurance, rarely does it cover necessary physician and hospital care. Many Canadians have private health insurance for dental services, drugs, eye care, home care, nursing homes and other health services that are not fully publicly funded.[9] For the most part, however, no private insurance market exists in Canada for necessary physician or hospital services. This is true in the five provinces[10] that prohibit private insurance for such services, and in the five provinces that do not.

The role of private insurance for necessary health care is now being revisited in light of the decision of the Supreme Court of Canada in the *Chaoulli* case.

In June 2005, the Court ruled by a narrow majority that Quebec's ban on private insurance for necessary health services violated the Quebec *Charter of Human Rights and Freedoms* where publicly funded care is not provided in a reasonably timely manner.[11]

The Chaoulli decision has been exploited by for-profit health care interests; it was not in itself a definitive blow to single-tier health care. First, it was limited to Quebec. No other health care statutes are affected, including those of other provinces that also ban private insurance. Even in Quebec, the government could have satisfied the ruling by demonstrating that it had taken steps to meet "reasonable" expectations for timely access to health care.

Instead, however, the Quebec government used the Chaoulli ruling as a justification for passing Bill 33[12], which legalizes private insurance for designated

necessary health and hospital services, which may now be provided by privately-owned facilities. It also introduces co-mingling of private and public delivery and funding.[13]

Quebec has used the Chaoulli decision as the justification for authorizing private insurance for certain necessary health services, and for expanding the role of for-profit providers of such services. Bill 33 authorizes duplicate private insurance for procedures "required for a total hip or knee replacement, a cataract extraction and intraocular lens implantation or any other specialized medical treatment"[14] determined by the government, in conformity with the new Section 15.1 of the *Health Insurance Act* and where these procedures are performed outside public institutions by non-participating doctors.[15]

The bill breaches the prohibition on private funding for hospital services that has endured since the very beginning of medicare. Moreover, the list of procedures that can be privately insured may be expanded by regulation after study by a parliamentary committee.[16]

There are serious questions about the compatibility of Quebec's scheme with the requirements of the *Canada Health Act*. Why would anyone pay privately for services available in the public system unless it is to access higher quality care? Moreover, Quebec legislation allows opted-out physicians to charge privately-insured patients more than the public tariff for insured procedures - reinforcing the conclusion that the regime authorizes elite care for those who can afford it.

For all but a privileged few, private health insurance undermines access, choice, and cost-effectiveness.[17] Jurisdictions with parallel public and private insurance have developed complex and costly regulatory frameworks, and still there are negative impacts on the public system.[18] Australia, after expanding private health insurance along lines contemplated in Canada, now faces longer public wait lists, higher overall costs, and unequal access to care.[19] Both the Romanow and Kirby Commissions soundly rejected the private insurance model.[20]

In addition to the policy reasons for maintaining a single payer regime, there are several practical considerations that must be borne in mind. The first is that Canada's international trade obligations will seriously constrain public policy flexibility if private investors are given a greater role in the health care system.[21] Canada's obligations under the *North American Free Trade Agreement* and the *General Agreement on Trade and*

Services make it exceedingly difficult for governments to abandon or even scale back privatization. If private health insurance is allowed to expand, the safeguards described in this guide could become much harder to defend.

Another issue is the formidable resources and influence of the private insurance industry. In the United States, we have seen this lobby frustrate even modest proposals to reform that country's hopelessly inefficient and inequitable health care system. Transnational insurance companies do not dominate the health care market in Canada as they do in the U.S. It would be prudent to keep it that way.

Finally, given the complexity of the regulatory regimes involved, the bans on private health insurance provides a backstop if other regulatory barriers to privatization fail.

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PUBLIC SUBSIDIES TO FOR-PROFITS

A parallel private health care system is only financially viable if it is publicly subsidized.[22] [23] Current rules limit how much public money goes to providers who charge private fees, and those rules must be strengthened. If governments instead weaken those rules or fail to enforce them, the result will be an inequitable health care system where the wealthy few get faster care, subsidized by the rest of us.

Private clinics and hospitals that charge patients privately for necessary health services have grown slowly. In some provinces, patients are allowed to purchase such health services from doctors who have "opted out" of medicare – ie. who do not bill the provincial plans. While some doctors have opted out, no province has a large parallel system of health care, even those that allow private insurance for necessary health care.

The private health care market has been limited for two main reasons. First, very few individuals are willing to pay privately for health care services that are available through the publicly funded system. Second, provinces limit the use of public funds to subsidize private care, largely by regulating the billing and business practices of physicians and clinics. The regulation may be direct (for example, through a ban on extra-billing) or indirect (for example, through professional regulation that discourages provision of unnecessary services).

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EXTRA-BILLING

RECOMMENDATION #4

Entrench and enforce the ban on extra-billing.

The ban on extra-billing is a direct limit to two-tier care and one that needs to be entrenched and enforced. Extra-billing is the practice of charging an additional private fee for physician services that are funded publicly. Under the *Canada Health Act*, Section 18, provinces are required to ban the practice.[24]

Section 18 of the *Act* states:

> *In order that a province may qualify for a full cash contribution referred to in Section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year 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.*

Typically, provinces meet their obligation by prohibiting physicians from receiving payment for insured health services from any source other than the provincial health insurance plan.[25]

Under the *Canada Health Act*, the federal government must automatically withhold federal funds to provinces that allow extra-billing.[26] The penalty must be equivalent to the sum of the extra-billing.[27] Federal transfers have been withheld on several occasions for this reason.[28]

Nevertheless, federal enforcement of the *Canada Health Act* has been notoriously lax,[29] and this in turn has allowed certain provinces to ignore growing non-compliance with their own regulations banning extra-billing.

8

USER FEES

RECOMMENDATION #5

Entrench and enforce the ban on user fees, including facility fees and covering all insured health services.

As with extra billing, the ban on user fees is a direct control on two-tier care that must be entrenched in provincial legislation and enforced by both the federal and provincial governments. Prohibited user fees must explicitly include facility fees and must apply to all insured health services, not only surgical services.

The *Canada Health Act* defines "insured health services" to include both physician and hospital services, and it proscribes user charges for such services. The advent of private clinics has meant that many traditional hospital services, such as diagnostics and day surgery, are being delivered outside of hospitals.

In 1995, then Minister of Health, Diane Marleau, took an important step to preserve medicare by advising her provincial colleagues that 'hospital services' would be considered subject to the Act even when delivered in private clinics. This meant that private clinics would not be able to charge patients privately for any insured service, including facility and related fees. Most provinces have since proscribed direct billing for facility fees.[30]

However, certain provinces have ignored the minister's directive by allowing private clinics to charge privately for diagnostic and surgical services which should be publicly funded because they are clearly necessary hospital services within the definitions of the *Canada Health Act*.[31]

9

CO-MINGLING

RECOMMENDATION #6

Prohibit co-mingling of insured and uninsured services by, at minimum:

- Prohibiting physicians from operating in both the public and private systems at the same time; and
- Prohibiting private clinics from co-mingling the delivery of insured and uninsured services, subject only to limited exceptions where alternative providers are not available.[32]

Prevented from extra-billing and charging user fees, some physicians and private clinics have found less direct ways to top up their income from the public insurance plan. The most common way is to charge patients for uninsured services.

As noted earlier, provinces decide what gets included on the list of insured health services. To varying degrees across the country, certain health services and products fall outside of the public funding envelope. Examples include physiotherapy, some cosmetic surgery, certain specialized diagnostic tests, and upgraded devices like a fibreglass cast in place of the standard plaster cast.

The questionable labelling of certain health services as "unnecessary" – something called "definitional drift" – can lead to queue jumping and conflicts of interest. For example, a full body MRI scan may not be considered a "necessary" service for someone suffering pain in the hip. However, by purchasing such a scan, that patient might get diagnosed for a hip replacement and be in the queue sooner for a publicly insured hip replacement. The referring physician benefits if he has a financial stake in the MRI clinic.

Conflicts of interest are of even greater concern when health care corporations, not individual practitioners, are the service providers.[33] While doctors who work on a fee-for-service basis are in business for themselves, they also have a professional obligation to act in their patients' best interests. For this reason they have been described as "not-only-for-profit providers". When a clinic is owned by

investors, whose overarching goal is to make profit, there is a stronger incentive to factor financial interests into treatment decisions.[34]

Few provinces have attempted to curtail "definitional drift", and some provinces[35] have actually sanctioned the practice. For example, under the Alberta *Medicare Protection Act*, patients of a surgical clinic may be billed directly for "enhanced medical goods and services" and non-medical goods and services, subject to certain consumer protection safeguards.[36]

The better approach is to limit or entirely proscribe the sale of uninsured services, of whatever description, by those funded to provide insured health services. In several provinces, physicians may not operate in both the public and private system at the same time.[37] In some provinces, opted-out physicians may charge no more for services than the public fee schedule for those services.[38] Before changing its *Independent Health Facilities Act* in 1996, Ontario refused to license clinics that co-mingled the delivery of insured and uninsured health care services.[39]

Co-mingling of insured and uninsured services in the same clinic setting was analysed in a paper published by the Romanow Commission, where it was described as endangering the sustainability of the public health care system. As the author put it:

> "The co-existence within the same institutions of insured and uninsured services, with the mechanisms described above, offers a structure that is not only conducive to but inherent in the two-tier system, in which one client's money and private insurance coverage give him or her priority over another whose coverage is limited to public insurance."[40]

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BLOCK FEES

RECOMMENDATION #7

Regulate block fee billing by, at minimum:

- establishing a cap on block fees;
- requiring that unutilized fees be returned to the patient;
- requiring that patients have the option of paying for services only if and when they are required; and
- prohibiting health care providers from withholding service to patients who decline to pay a block fee.

Some physicians and clinics augment their income by charging patients for uninsured services that are considered "incidental". Examples include telephone consultations, prescription renewals or the preparation of documents relating to employment or insurance. Some physicians charge for these services by way of annual block fees, which range from less than $100 to several thousand dollars.

Some physicians have used the pretext of billing for uninsured services to charge very substantial block fees, which represent a significant financial barrier to accessing publicly funded care. For example, one private clinic charges $2,300 a year for such services, and there are reports of block fees that are considerably higher.[41]

Few provinces deal directly with the question of block fees. Ontario is the exception. Section 18 of the Ontario *Commitment to the Future of Medicare Act* provides:

> *18. (1) If regulations have been made under this section, a person or entity may charge a block or annual fee only in accordance with those regulations.*
>
> *(2) A physician, practitioner or hospital shall not refuse to render an insured service to an insured person or refuse to continue rendering insured services to an insured person for any reason relating to an insured person's choice not to pay a block or annual fee.*

Despite this general constraint, the Ontario government has failed to pass regulations under Section 18 and has done little in effect to control block fees. Furthermore, the Act imposes no cap on the block fee that may be charged and no requirement that patients get reimbursed for any unutilized portion.

Professional rules of conduct in some provinces address block fees, but these are no substitute for provincial regulation. (See examples of relevant professional rules of conduct in the box.) Patients unwilling to pay a block fee would have to lodge a complaint with the provincial college of physicians and surgeons or with other public officials. Patients may be reluctant to put their relationship with their doctor to this test.

There is a strong argument that provinces are obligated by the *Canada Health Act* to control the practice of block fees. Under the Act, the criterion of accessibility requires insured health services to be provided "on *uniform terms and conditions* and on a basis that does not impede or preclude, *either directly or indirectly whether by charges made to insured persons or otherwise*, reasonable access to those services by insured persons."[43]

In Ontario, rules of professional conduct[42] stipulate that:

physicians who charge a block fee must also provide patients with the alternative of paying for each service individually at the time that it is provided; and that

a physician may not discontinue seeing a patient or refuse to see a new patient because that person chooses not to pay a block fee. In addition, a physician must not offer to or provide preferential services to a patient who agrees to pay a block fee.

Other more general rules prohibit:

refusing to perform a medically necessary service unless all or part of the fee is paid before the service is performed;

charging a fee that is excessive in relation to the services performed;

charging a fee for an undertaking not to charge for a service or class of services;

charging a fee for an undertaking to be available to provide services to a patient;

conduct unbecoming a physician.

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QUEUE JUMPING

RECOMMENDATION #8

Prohibit queue jumping for all insured health services.

As noted above, private clinics present significant opportunities for queue jumping. The Romanow Commission described the problem this way:

> *The growth of private advanced diagnostic facilities has permitted individuals to purchase faster service by paying for these services out of their own pocket and using the test results to "jump the queue" back into the public system for treatment. While this is not currently a common occurrence, Canadians made it clear to the Commission that they are deeply concerned about the prospect of this becoming routine.*[44]

The *Canada Health Act* criteria of accessibility and universality require provincial governments to ensure that no financial barrier exists to publicly funded health care services. Private clinics in a number of provinces are violating the Act by charging service and enrolment fees. Where a clinic refuses service to someone who is unwilling to pay a fee, it is creating a barrier to service, and where the service should be publicly insured, it is also a breach of the ban on extra billing and user charges. Provincial governments are allowing the practice, and the federal government is failing to impose penalties – in breach of their obligations.

To illustrate the importance of this prohibition, take the case of Copeman Healthcare Inc., which proposed in 2006 to open several private clinics in Ontario that would charge an annual services fee of $2,300 and a one-time enrolment fee of $1,200. The company's promotional literature indicated that some portion of these fees would entitle clients to preferential access to physician and related services, including those that are publicly insured. In its marketing material, the company offers clients "immediate access to the Centre's highly trained physicians" and shorter wait times for any needed specialist, surgery or other follow-up care.

While the company does not explicitly state that it will refuse the same standard of care to persons who do not pay the $3,500 service and enrolment fees, it begs

credulity to imagine that the same level of service will be provided to patients who decline the clinic's substantial fees.

Only Alberta and Ontario specifically define and prohibit queue-jumping. Alberta's legislation applies only to surgical services and may be seen as simply a way to legitimize the privatization of hospital services. Ontario's prohibition is broader. Section 17 of the *Commitment to the Future of Medicare Act* provides:

> *17. (1) No person or entity shall,*
>
> *(a) pay or confer a benefit upon any person or entity in exchange for conferring upon an insured person a preference in obtaining access to an insured service;*
>
> *(b) charge or accept payment or a benefit for conferring upon an insured person a preference in obtaining access to an insured service;*
>
> *(c) offer to do anything referred to in clause (a) or (b).*
> *. . .*
>
> *(3) A prescribed person who, in the course of his or her professional or official duties, has reason to believe that anything prohibited by subsection (1) has occurred shall promptly report the matter to the General Manager.*

Section 17 of the *Commitment to the Future of Medicare Act* clearly proscribes the Copeman clinic's proposed billing scheme. Moreover, under the Act, the company, its physicians and even its patients would be liable to prosecution for charging or offering to pay for preferred access to insured health care services.

The problem of queue jumping is an inevitable consequence of allowing privately owned clinics to provide necessary services. Queue jumping becomes extremely difficult to regulate when a parallel system of care is allowed to operate outside the framework of provincial health care insurance plans. For example, under Quebec's Bill 33, certain "Specialized Medical Centres"(SMCs) may operate in parallel with - but independent of - the publicly funded system. As a Quebec legal expert puts it:

> … depending on the treatments that it offers, an SMC with non-participating doctors could well be the equivalent of a for-profit hospital. Such an SMC is authorized to practise surgery, provide in-patient care and be remunerated by patients or their insurers for some of these services. SMCs with non-participating doctors could thus become the basis for the development of a parallel private health care network.

Bill 33 establishes a number of safeguards to isolate these private facilities from the public system such as allowing only opted-out physicians to provide services in a privately funded SMC. Nevertheless, by authorizing private insurance for necessary health services, Bill 33 has breached an important threshold that until now has preserved the integrity of Canada's medicare system.[46]

12

KICKBACKS AND SELF-REFERRALS

RECOMMENDATION #9

Prohibit a physician from (a) paying or offering to pay kickbacks to or from any person, and (b) referring patients to clinics he or she owns or operates.

Another way to protect patients is by prohibiting kickbacks and self-referrals. The term *kickback* refers to the financial compensation of physicians for patient referrals. The payments may come from private clinics, specialists, physiotherapists, companies selling pharmaceuticals or medical equipment and supplies, or any number of other referral sources. Payments could be cash payments or discounts on office space, medical supplies, loans, or other services and products. The term *self-referral* refers to a situation in which physicians own the clinics to which they make referrals and thus stand to benefit financially from the clinic's profits.

The potential for such abuse has prompted some provinces to regulate the financial relationships associated with referrals.[47] Seven provinces prohibit kickbacks and regulate referrals to physicians, private clinics, pharmaceutical companies and medical device suppliers.

Only five provinces prohibit physicians from paying or offering to pay kickbacks to non-physician health care professionals. Of all provinces, Saskatchewan and Ontario have the most complete prohibition of kickbacks.[48]

Provincial regulation of self-referral is patchy. Newfoundland, Nova Scotia and PEI have no controls on such practices, while Manitoba, Ontario and Quebec only require physicians to disclosure their investment interest. As pointed out in an article published in the *Canadian Medical Association Journal*, however, "disclosure to relatively inexpert patients does not work, particularly when they require treatment. Patients may also interpret disclosure not as a warning to take care, but rather as a warranty…" of the private clinic's quality.[49]

The best provincial practice is in Saskatchewan, which prohibits self-referrals to private clinics owned by the physician

or her or his family members. Only a minority of provinces prohibit referrals to private clinics owned by members of the physician's immediate family, even fewer to clinics owned by members of the extended family. Under the by-laws administered by the Saskatchewan College of Physicians and Surgeons, "conflict of interest" is defined broadly to include:

> *… a situation whereby a physician, or a member of the physician's family, or a corporation, wholly, substantially or actually owned or controlled by the physician or a member of the physician's family,*[50]
>
> *(i) receives any benefit, directly or indirectly from,*
>
> ***1*** *a supplier to whom the physician refers his patients or their specimens, or*
> *2 a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician;*
>
> *(ii) rents premises to,*
>
> ***1*** *a supplier to whom the physician refers his patients or their specimens, or*
> ***2*** *a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician, except where,*
> ***3*** *the rent is normal for the area in which the premises are located, and*
> ***4*** *the amount of the rent is not related to the volume of business carried out in the premises by the tenant;*
>
> *(iii) rents premises from,*
>
> ***1*** *a supplier to whom the physician refers his patients or their specimens, or*
> ***2*** *a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician, except where,*
> ***3*** *the rent is normal for the area in which the premises are located, and*
> ***4*** *the amount of the rent is not related to the referral of patients to the landlord, or*
>
> *(iv) Sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, unless the physician can demonstrate that the product sold or supplied was reasonably necessary for the medical care of the patient.*
> *. . .*

(v) It is a conflict of interest for a physician to order diagnostic tests other than medically necessary tests to be performed by a diagnostic facility in which the physician or a member of the physician's family has any proprietary interest.

Following Saskatchewan's lead, all provinces should prohibit self-referrals. The only possible exception would be for under-serviced areas where such a ban might impede access.

Where physicians have a financial interest in for-profit health care facilities, the stakes are clearly higher. Kickbacks and self-referrals are major problems in the United States, where physicians often own clinics. The results have been unnecessary referrals for some patients, longer waits for others, and increased costs overall.[51]

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P3 HOSPITALS

RECOMMENDATION #10

Stop and reverse the privatization of health care infrastructure.

The development of public private partnership (P3) hospitals poses a similar but arguably greater threat to medicare than does the proliferation of private clinics. Ontario and British Columbia have a number of P3 hospitals completed and more underway. Two P3 "mega hospitals" are planned for Montreal. Other provinces are considering the model.

In a typical P3 hospital scheme, the board of the public hospital contracts with a private consortium to finance, design, build and operate the hospital and to provide most non-clinical hospital services.[52] Typically the consortium is comprised of developers, pension plans, private investors, and hospital services and management companies.

There is a substantial and growing body of evidence showing that P3 hospitals cost more and provide poorer service than do hospitals that are publicly-financed, controlled and operated.[53]

Beyond this, P3 hospitals threaten to undermine the very single-tier character of our Medicare system. This threat arises for a number of reasons.

First, the P3 hospital contracts allow the private partner to establish clinics and other health care businesses within the hospital.[54] Co-location allows for-profit operations to integrate more easily with public hospital services. Physical proximity to both patients and health care professionals significantly increases the likelihood of cream-skimming, self-referral, kickbacks and other conflicts of interest.

For example, preventing kickbacks and self-referrals will be particularly difficult in a P3 hospital where the allocation of space and support services within the hospital is no longer controlled by the public hospital board. Under P3 schemes, these decisions will be made by the private consortium or pursuant to complex negotiation and arbitration processes for making or contesting space and staff allocations.[55] The opportunity

for kickbacks and self-referrals is far greater given the lack of transparency typical of these complex contractual and leasehold regimes. Accordingly, the need for robust regulatory regimes to prohibit and police such practices is that much greater.

Second, while some provinces regulate private clinics, none has legislation to address the more complex challenges posed by P3 hospitals. Ontario and British Columbia, for example, appear to be relying on public hospital boards to ensure that their private partners operate in accordance with the principles of medicare. Locked into long-term lease agreements and services contracts, those hospital boards may have very little bargaining leverage. Moreover, to the extent that doctors, nurses and other health care professionals are able to augment their incomes by working on the private side of the public hospital corridor, there may be little incentive to get tough with the private partner.

Third, under P3 hospital schemes, revenues from selling uninsured health care services such as rehabilitation services or services to workers compensation claimants may now go entirely to, or be shared with, the hospital's private partner. Where this occurs, public hospitals will be deprived of a significant source of revenue, which has until now been used to defray hospital costs or improve the quality of medicare services.

Finally, the complexity of P3 schemes makes it very difficult to monitor or ensure compliance with provincial law. For instance, the P3 hospital contractual scheme for the William Osler Hospital complex in Ontario is comprised of more than two thousand pages of complex legal documents. Moreover, key provisions are protected from public scrutiny by confidentiality provisions that prevent even the Ministry of Health from revealing the details of these schemes.

For these reasons, P3 hospital schemes confound notions of transparency and accountability. The regulatory vacuum within which such schemes are being established seriously exacerbates these problems. Moreover, the inherent difficulty of monitoring and policing such schemes will add substantial costs to provincial health care budgets.

The evidence against the P3 hospital model is compelling and only continues to grow as the UK prototypes collapse

under spiralling costs and financial mismanagement.[56] If, despite this evidence, P3 hospitals are expanded in Canada, provincial governments will need to develop new and robust regulations, monitoring and enforcement regimes to prevent P3 hospitals from becoming platforms for two-tier care.

CUPE has joined other trade unions and health coalitions in calling on the federal government to re-establish a federal role in hospital infrastructure by creating a dedicated, stable and fully public national infrastructure financing program.[57]

14

ENFORCEMENT

With all of the above laws and regulations, existing and proposed, enforcement is critical. The federal government must be compelled to enforce the *Canada Health Act* and rein in provinces that either challenge or flaunt the requirements of the Act. Provincial governments must be forced to uphold and improve their regulatory regimes in order to defend the single-tier and public character of health care.

Health care coalitions, trade unions, health care professionals, and community groups are struggling daily to defend medicare from privatization incursions. Getting medicare laws enforced and strengthened is a big part of that struggle. This guide was prepared as a tool to assist that work.

It is also clear that a significant role exists for individuals to ensure that existing rules and regulations are respected and enforced. Many of these can be enforced by way of private prosecution under provincial health care statutes.

Complaints may also be made to provincial health officials or regulatory bodies that oversee medical professionals. For a step-by-step guide to defending your rights under medicare, check out **www.yourmedicarerights.ca**

ENDNOTES

[1] In this paper, for the sake of brevity, the term "province" is often used to encompass both provinces and territories.

[2] Public administration means the plans must be administered on a non-profit basis by a public authority. Comprehensiveness means the plans must cover all insured health services provided by a hospital, medical doctor, surgical-dental care delivered in a hospital, and other services as determined by the province. Universality means that all insured residents must be entitled to insured health services on uniform terms and conditions. Portability means that insured residents moving from one province or territory to another must be covered by their home province for the duration of the waiting period. Accessibility means that insured persons must have reasonable access to services on uniform terms and conditions, unimpeded by extra charges or discrimination.

[3] Archibald, T., and Flood, C.M. (2004). *The Physician Services Committee: The relationship between the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care*. Institute for Research on Public Policy, IRPP Working Paper Series no. 2004-3. Retrieved December 6, 2007 at http://www.irpp.org/wp/archive/medicare_basket/wp2004-03.pdf

[4] Flood, C.M., Tuohy, and Stabile (2004). *What is In and Out of Medicare? Who Decides?* Institute for Research on Public Policy, IRPP Working Paper Series no. 2004-06. Retrieved December 6, 2007 at http://www.irpp.org/wp/archive/medicare_basket/wp2004-06.pdf

[5] Ibidem, p. 10.

[6] See *Canada Health Act* S. 2 and definitions for "insured health services" and "insured person".

[7] Despite the fact that Canadian law establishes international students and their dependants as Canadian residents, these persons are excluded from six of the provincial/territorial health insurance plans. Reitmanova, S. (2007). *Disappearance of values in Canadian healthcare: Are market forces to be blamed?* Presentation to the European Healthcare Managers Association Annual Conference. Retrieved November 28, 2007 at http://www.ehma.org/_fileupload/File/Conference%202007/Sylvia%20Reitmonova%20PPT%20A.pdf (Note that Newfoundland Labrador has since decided to insure international students.)

[8] Canadian Union of Public Employees, National Union of Public and General Employees, Compensation Employees' Union (2002). *Standhope Manifesto on Workers' Compensation*.

[9] Thirty per cent of Canadian health spending is private, and 41 per cent of that is provided by private insurance. Canadian Institute for Health Information (2007). *National Health Expenditure Trends, 1975-2007*, p. 10.

[10] Alberta, British Columbia, Manitoba, Ontario and Prince Edward Island. See for example S. 26 of the Alberta *Health Care Insurance Act*. In response to the Chaoulli decision, Quebec has opened the door to private insurance for certain procedures.

[11] For a synopsis and critique of the Chaoulli decision, see http://www.sgmlaw.com and Canadian Union of Public Employees (2005). *Inside the Chaoulli ruling: a CUPE backgrounder*. Retrieved November 28, 2007 at http://www.cupe.ca/chaoulli

[12] *Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*, Quebec, 37th Legislature, 2nd session, Bill 33 (First Reading, June 15, 2006). Bill 33 became law on December 13, 2006, and is now cited as S.Q. 2006, c. 43.

[13] Prémont, M. (2007). "Wait-time guarantees for health services: An analysis of Quebec's reaction to the Chaoulli Supreme Court decision". First published in French in *Les Cahiers de Droit*, Vol. 47, No.3 (September 2006) and soon to be published in English in the *Health Law Journal*, Edmonton.

[14] Bill 33, s. 42, amending s. 15 of the *Health Insurance Act*.

[15] The implications of the privately funded clinics authorized by Bill 33 are considered in the section on P3 hospitals, later in this paper.

[16] Bill 33, s. 42, amending s. 15 of the Health Insurance Act and s. 11, adding s. 333.1 to the *Act Respecting Health Services and Social Services*.

[17] Gibson, D., and Fuller, C. (2006). The Bottom Line: *The truth behind private health insurance in Canada*. The Parkland Institute.

[18] Tuohy, C. H., Flood, C. M., and Stabile, M. (2004). "How does private financing affect public health care systems? Marshalling the evidence from OECD nations." *Journal of Health Politics, Policy and Law* 29(3): 359-396.

[19] Zinn, C. (2000). "Australia moves to boost private health cover." *British Medical Journal* 321: 10 (1 July 2000).

[20] Chodos, H., and MacLeod, J.J. (2003). *Examining the Public/Private Divide in Health Care: Demystifying the Debate*, p. 3. Retrieved December 6, 2007 at http://www.cpsa-acsp.ca/papers-2005/MacLeod.pdf

[21] Grieshaber-Otto, J., and Sinclair, S. (2004). *Bad Medicine: Trade treaties, privatization and health care reform in Canada*. Canadian Centre for Policy Alternatives.

[22] Archibald, T., and Flood, C.M. (2001). "The illegality of private health care in Canada." *Canadian Medical Association Journal* 164(6):825-30. Retrieved December 6, 2007 at http://www.cmaj.ca/cgi/reprint/164/6/825

[23] This is borne out by the fact that private health care, largely drug insurance, is already publicly subsidized because a portion of private health care expenses may be deducted from income for tax purposes. These subsidies do not accrue directly to physicians or other care providers.

[24] Archibald, T., and Flood, C.M. (2001). All but two provinces have enacted explicit bans on extra-billing. New Brunswick and Prince Edward Island rely instead on price disincentives, notably by not providing public funding for services where the treating physician charges more for the service than is payable under the public plan.

[25] See for example, s. 10(3) of the Ontario *Commitment to the Future of Medicare Act* which provides:

A physician or designated practitioner shall not accept payment or benefit for an insured service rendered to an insured person except,
(a) from the Plan, including a payment made in accordance with an agreement made under subsection 2 (2) of the *Health Insurance Act*;
(b) from a public hospital or prescribed facility for services rendered in that public hospital or facility; or

(c) if permitted to do so by the regulations in the prescribed circumstances and on the prescribed conditions.

[26] Deductions from federal transfers for violations of the criteria of the Act are discretionary and have never been invoked. Deductions for user charge and extra-billing violations are mandatory.

[27] *Canada Health Act*, s. 20.

[28] Choudhry, S. (2002). "Bill 11: The Canada Health Act and the Social Union", *Health Care Reform and the Law in Canada*. Caulfield, T.A., and von Tigerstrom, B., eds. Edmonton: The University of Alberta Press.

[29] Auditor General of Canada, *2002 Status Report*, Chapter Three, Federal Support of Health Care Delivery, which relates the current and historical record. See also Auditor General of Canada (1987). *Annual Report to the House of Commons*.

[30] Grosso, F., and Archibald, T. (2006). "Contracting With Private Medical Facilities: A National Review of Regulation." Unpublished paper, p. 20.

[31] Quebec and British Columbia are the biggest offenders in this regard.

[32] Where co-mingling is allowed, governments need to more closely regulate the circumstances in which uninsured services may be provided. An example of this approach can be found in Ontario regulation that was established to oversee the operation of private MRI clinics. This regulation put in place various safeguards to ensure that "uninsured" services were in fact not necessary; see the Ontario *Regulated Health Professions Act*, Regulation 107/96.

[33] See discussion infra, at Part B(2)(a), and Prémont, M. (2002). The *Canada Health Act and the Future of Health Care Systems in Canada*. The Commission on the Future of Medicare, Discussion Paper #4, p. 14.

[34] Evans, R. et al (2000). *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare?* Centre for Health Services and Policy Research.

[35] See for example, s. 5 of the Alberta *Medicare Protection Act*, and ss. 17 and 30 of the British Columbia *Medicare Protection Act*.

[36] Ibidem.

[37] See, for example, s. 6 of the Alberta *Health Insurance Act* which, subject to emergency situations, provides that public funding is only available for services provided by opted-in physicians. Also note that under s. 10 of the Ontario *Commitment to the Future of Medicare Act*, 2004, physicians are precluded from opting out of the public insurance scheme unless they had done so prior to May 13, 2004.

[38] Archibald, T., and Flood, C.M. (2001). "The illegality of private health care in Canada." *Canadian Medical Association Journal* 164: 826.

[39] Gilmour, J. (2003). "Regulation of Free-Standing Health Facilities: An Entrée for Privatization and For-Profit Delivery in Health Care." *Health Law Journal*, 134, Special Edition.

[40] Prémont, M. (2002). *The Canada Health Act and the Future of Health Care Systems in Canada*. The Commission on the Future of Medicare, Discussion Paper #4, p. 14.

[41] Sack, Goldblatt, Mitchell (2006). Legal opinion on Copeman Healthcare Inc. prepared for the Ontario Health Coalition, *Plans For Private Clinics Violate Canada Health Act*. Retrieved December 7, 2007 at http://www.web.net/~ohc/privatization/OHClegalOpinionOn2TierClinics.pdf

[42] The College of Physicians and Surgeons of Ontario (2005). *Block Fees and Uninsured Services Policy* #4-04. Retrieved December 12, 2007 at http://www.cpso.on.ca/policies/blockfees.htm

[43] *Canada Health Act*, s. 12.1.

[44] Romanow, R.J. (2002). *Building on Values: The Future of Health Care in Canada – Final Report*. Ottawa: National Library of Canada, p. 8.

[45] Prémont, M. (2007), p. 21.

[46] British Columbia has allowed for similar privately funded hospitals to operate by allowing physicians to practice while not being enrolled under the provincial health insurance plan.

[47] Some health care providers also have rules around conflict of interest. The Calgary Health Region, for example, has a bylaw prohibiting persons with an influencing interest in a private facility from holding a medical officer position. Lang, M., and Cryderman, K. "Public sell-off, Public buyback." *Calgary Herald*. 23 Sept 2007.

[48] Choudhry, S., Choudhry, N.K., and Brown, A.D. (2004). "Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral." *Canadian Medical Association Journal* 170 (7): 1115-1118.

[49] Idem.

[50] S. 51(1)(f)(iv) of the *By-Laws, Saskatchewan College of Physicians and Surgeons*.

[51] Choudhry, S., Choudhry, N.K., and Brown, A.D. (2004). "Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral." *Canadian Medical Association Journal* 170 (7): 1115-1118.

[52] William Osler Health Centre (2004). *Summary of the William Osler Health Centre Project Agreement with the Healthcare Infrastructure Company of Canada*. Retrieved December 6, 2007 at http://www.williamoslerhc.on.ca/workfiles/Project_Agreement.pdf
A similar model has been implemented for the Royal Ottawa Hospital and for the Abbotsford Hospital.

[53] Mehra, N. (2005). *Flawed, failed, abandoned: 100 P3s, Canadian and International Evidence*. Ontario Health Coalition; Wintour, P., and Boseley, S. (8 March 2006). "NHS chief quits amid worsening cash crisis." *The Guardian*; Collinson, P. (14 March 2006). "Laing defends soaring value of its hospital PFI contracts." *The Guardian*; Dawson, D. (2001). "The Private Finance Initiative: A Public Finance Illusion?" *UK Health Economics*. 10: 479–486; Pollock, A.M., Shaoul, J., and Vickers, N. (28 May 2002). "Private finance and 'value for money' in NHS hospitals: a policy in search of a rationale?" *British Medical Journal*. Vol. 324; Pollack, A.M., Leys, C., Price, D., Rowland, D., and Gnani, S. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso.

[54] William Osler Health Centre (2004). *Project Agreement between the William Osler Health Centre and The Healthcare Infrastructure Company of Canada (WOHC) Inc.*

Article 17.5 allows the private consortium to establish ancillary businesses within the hospital, including private clinics. The only businesses precluded by the P3 hospital scheme are casinos, adult entertainment facilities and the sale of alcohol and tobacco products (17.7.3).

[55] Idem, Article 48; Auerbach, L., Donner, A., Peters, D.D., Townson, M., and Yalnizyan, A. (2003). *Funding Hospital Infrastructure: Why P3s Don't Work, and What Will*. Ottawa: Canadian Centre for Policy Alternatives.

[56] See note 53.

[57] BC Health Coalition, Canadian Health Coalition, Canadian Labour Congress, Canadian Union of Public Employees, Council of Canadians, Friends of Medicare Alberta, National Union of Public and General Employees, Ontario Health Coalition, Ontario Federation of Labour (2005). *Re-establishing a federal role in hospital infrastructure finance*. Our proposal is two-fold:

1 Create and fund a national health care capital investment program in partnership with the provinces. This new health care capital funding program would be integrated as ongoing core funding.

2 Tie all health care infrastructure funding to public, non-profit ownership, control, management and operation of the facilities, equipment, and services. The current approach to private sector involvement in funding infrastructure through P3s or private finance mechanisms must be abandoned in favour of public financing approaches.