Payments by patients for health care paid out of public funds

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People under the age of 50—those born after 1961—have barely experienced anything except the public health care system in which patients have access to hospital and medical services free of charge. This younger cohort represents more than 60% of the current population of Quebec. These people would find it difficult to imagine the impact of partial privatization of health care. The older cohort, those 50 and over, represent 40% of the population. They can remember—some hazily, some vividly—the economic difficulties that families endured in order to gain access to health care before the public system was put in place. None of them had imagined ever again paying for a doctor's care. Nowadays, almost everyone has heard of or experienced private care, either by word of mouth, through the media, or by personally having to pay for a consult. Nobody could have guessed that the hard-won social achievement of universal health insurance could crumble so quickly. And yet the phenomenon has affected everyone. Too many patients in Quebec, deprived of the care of a family doctor, take their chances at walk-in clinics or crowded emergency rooms, often facing intolerable waiting lines. Others are frustrated by the months it can take to obtain an appointment with a specialist. All of these people are tempted by various startup businesses that offer privileged access for a fee.

Why are we seeing the return of direct payments by patients in Quebec? Has legislation changed to authorize these payments? What form do these expenditures take? Who benefits from them? Will they improve access to health care?

These are the questions tackled in this short paper, which focuses on patient payments for services covered by the public system. We will see the varied forms these practices take and conclude with some thoughts on their potential impact.

The discreet charm of private insurance

One might have expected that the main cause of payments by patients who lack a doctor or timely care could be linked to the insurance industry. After all, the only issue at stake in the Supreme Court of Canada's 2005 decision in the *Chaoulli* case was private insurance to cover care already insured by the public system—what is called duplicate private insurance. The Supreme Court declared invalid the ban on selling insurance products duplicating public insurance in Quebec that had been imposed on the insurance industry since the inception of universal public insurance (in 1961 for hospital stays and 1970 for doctors' services).

Legislative amendments in 2006 following the decision of the highest court in the land partly opened the door to the sale of private insurance. However, no significant market has developed for the insurance products currently authorized—hip, knee, and cataract surgery—confirming once again that an available market will not necessarily be occupied by the industry. Such a market must be potentially profitable, and even better if it is very profitable. The insurance industry's response to the limited opening provided by the Charest government has been cool and circumspect. It is waiting for profitability to be part of the equation. It is important to recall that private insurance can be applied only to services provided by doctors who have completely opted out of the public system, since doctors are prohibited from receiving private payments at the same time as they receive public money. That's why lifting the ban on double-dipping, advocated by the Castonguay Report among others, would favour the development of the insurance industry in health care.

The industry has also held back from developing new health insurance products whose legality has not been clearly established. Hence, for the moment, we should not be looking to the insurance industry to find the driving force behind direct payments demanded of patients who consult a physician. It should also be remembered that another major health-related market has been available to the private insurance industry and has grown dramatically since the prescription drug insurance system was instituted in 1996. Under this system, all group drug insurance contracts entered into by Quebec employers are reserved for the private industry. Under the law, these contracts are required to cover prescription drugs, but they may also extend to any complementary service or care that is delisted from the public system.

The circumstances fuelling the increase in private payments

Time is money, but health is priceless. This is the slogan of a new medical business in Quebec that offers brokerage services to secure a quick appointment with a specialist. This marketing formula summarizes the current circumstances that favour the establishment of this kind of business. A patient lured by this formula will pay to gain access to a service that is insured by the public system. Let us look at these circumstances in more detail.

The government's role: Public delisting of services

Direct payments have been completely banned in Quebec since the very beginning of the public system. This policy has two objectives. The first is to prevent economic distortion of accessibility to health care—in other words, to promote equitable access based on need and not on the patient's financial means. The second is to maintain better control of overall health costs. While Quebec was the last province to join the federal cost-sharing program to finance public health insurance, it was among the first to completely ban ancillary fees, extra billing, and user fees. These provisions subsequently became a common characteristic of all Canadian health systems through their inclusion in the federal government's 1984 *Canada Health Act* (Prémont, 2010).

In 1970, difficult negotiations took place between public authorities and the medical federations (which are the equivalent of unions protecting doctors' interests) over public payment of doctors. Medical specialists went on strike that year in the midst of the October Crisis, one of the worst political crises in Quebec history. The strike ended with a compromise, enshrined in special legislation. The doctors were demanding the discretionary power to charge patients

supplementary fees, in addition to the payments that they would now be entitled to receive from the Régie de l'Assurance Maladie du Québec (RAMQ), Quebec's health insurance agency. The tradeoff offered to qualifying doctors allowed them, if they wished, to maintain a completely private medical practice where they could charge patients whatever fee they chose. These doctors are referred to in the legislation as "non-participating" physicians. However, once doctors collect a public payment for their services, they are no longer allowed to receive any private payment, whether from the patient, an insurer, or a third party. In this way, the law requires doctors who want to receive income from public funds—"participating" doctors—to devote all their professional time to the public system. They are not allowed to divide their time between the public system and a completely private practice serving Quebec residents, nor can they demand payment for a covered service once a patient is asked to show his or her health insurance card. This ban applies not only to doctors themselves but also to any other person, company, or organization, including the manager of a doctor's practice (clinic, hospital, medical centre, etc.). The only exceptions relate to uninsured services and minor supplementary costs provided for in the labour agreement (drugs, anaesthetics, bandages).

These rules have remained intact in order to make it impossible for doctors or their clinics to try to obtain additional income from the pockets of patients or third parties. To reinforce the situation, the only amendments that have been introduced have further tightened the restrictions on additional payments to doctors, making them stricter than they were in the original agreement between the Quebec government and the medical federations. Thus, in 1979, amendments to the legislation explicitly banned charging ancillary fees for insured services. Bonuses paid for by some hospitals to attract physicians to their staffs have been banned since 1993. Hence, a relaxation of the rules limiting payments to doctors can also be eliminated as a possible source of the increase in demands for payment from patients. Where, then, is the source?

Part of the answer can be found in the public system's delisting of some diagnostic tests when they are performed outside a hospital. Since the early 1990s, the Quebec government has gradually restricted public insurance of some diagnostic tests, limiting coverage to the delivery of these tests in a hospital setting. The same test performed in a private clinic is an uninsured service, so the clinic can bill the patient for it directly. The patient could get the test done for free at the hospital, but might choose to forgo that option, finding the waiting list too long. The tests that have given rise to commercial practice alongside public practice are mammograms, ultrasounds, CAT scans, and MRIs. The clinics offering these tests are often run by doctors who practise in a nearby hospital. The doctor can quite openly recommend to his or her patients in the hospital that they go across the street to get quicker results for a fee, which can be anywhere from a few hundred dollars to more than a thousand dollars depending on the test and how much the clinic decides to charge. Furthermore, clinics offering such services often supplement their revenues with hospital and public authority contracts (through the cancer screening program for women over 50, for example) providing quicker access to diagnostic services and reducing their waiting lists. The clinics also frequently have contracts with the public automobile insurance and workers' compensation agency, allowing them to benefit from a number of revenue streams and strengthen their business plan.

The doctor shortage

At 30%, Quebec's proportion of patients without a family doctor is the highest in Canada, even though there are 20% more family doctors in relation to population than in the rest of Canada. A

number of hypotheses have been put forward to explain this apparent contradiction, such as the greater responsibilities Quebec general practitioners have in hospitals. This is not the place to argue over the complex causes of this situation. There is no doubt, however, that difficulties in gaining access to the ongoing care of a family doctor have a major impact on the ground. Patients who find themselves in an insecure and vulnerable position are more likely to spend money on guaranteed timely access to a health professional for themselves and their families.

Long wait times to see a specialist mean that another solution must be found. The various players involved are well aware of this situation. Public authorities are engaged in trying to find answers. We are told that recent agreements with the two medical federations, whose contents are not yet known, should address the problem (Lia Lévesque, June 17, 2011). Individual doctors are also making efforts to meet the needs of patients in distress, often beyond the call of duty. At the same time, financial strategists see this pressing need as fertile ground for dubious marketing strategies. It becomes an opportunity to change the forms of medical practice into market niches, thereby providing additional income not only for doctors, but for investors as well. This is where the third and fourth factors contributing to the increase in payments requested from patients come in.

Methods of payment for medical clinics

Payment for the operation of medical clinics, which is negotiated with the medical federations, has changed little since the introduction of public health insurance. Financing the administration of clinics essentially takes the form of a supplement of roughly 35% [1] (called the technical component) paid to a doctor for any consultation that takes place outside a hospital. This supplement is paid as compensation for office expenses and administrative costs that physicians assume when they practise in their own clinic as opposed to in the hospital.

However, the administrative context of medical practice has changed. The questions are as follows: Is the supplement really used to pay for rent, electricity, and the receptionist? Is it always enough, especially in the case of certain practices such as day surgery outside a hospital [2]? We know that as part of their business strategy, pharmacy chains have provided many medical clinics with cut-rate premises throughout Quebec. Even though the Code of Ethics of Physicians has been amended and in principle free premises offered by pharmacies to doctors have been prohibited since 2009, there is no study providing evidence that this practice has stopped.

Another dimension, brought to light in the 2007 report of the health and social services department's working group on ancillary fees (Chicoine Report), may be germane here. According to the *Health Insurance Act*, only the physician may bill the RAMQ, under the terms of the agreement, for services provided to an insured person who has presented his or her health insurance card. This way of doing things originally corresponded to the widespread practice of doctors operating their own clinics and being responsible on their own for paying the receptionist's salary and looking after the expenses of the office. This situation is now extremely rare. The corporate structure outlined in the next section has taken the distinction between medical staff and administrative staff to a new level. Thus, administrative supplements paid out of public funds sometimes remain in the hands of clinicians who have the upper hand over the administrative staff. This creates strong pressure to find other sources of income to cover unavoidable administrative expenses.

It is doubtful that new financing formulas involving family medicine groups and network clinics will be more effective in ensuring that money provided for the management of the clinic will be used for this purpose alone. As we will see, questionable behaviour regarding ancillary fees charged to patients to increase revenues takes place in these settings as well. These financing mechanisms are also part of the context that could favour the increase in direct payments being demanded of patients.

Business models and corporate medical practice

The time when each doctor had his or her own office is long gone. There is an extensive literature explaining how medicine is now practised in groups, many of them multidisciplinary teams through which the patient receives continuing care. This model is better suited to the new forms of morbidity represented by chronic illnesses and the accumulation of pathologies characteristic of an aging population.

However, group practice has taken on a new dimension that can have a major impact on the organization of medical practice outside of hospitals. Since March 2007, after years of lobbying by the medical federations, Quebec has authorized doctors to practise their profession through corporations with share capital. The immediate tax benefit of this measure is clear: the income tax rate for small and medium-sized businesses (a designation that medical clinics can take advantage of) is substantially lower than the rate for individuals earning the same income.

But the repercussions of corporate medical practice do not end with the tax benefit to the physician. Organizing a medical practice as a corporation with share capital can lead to the new phenomenon of the strategic plan designed to maximize shareholders' income. In addition, it can mean that administrative teams are devoted to the task of optimizing revenues from the clinical practice. The longstanding and generalized prohibition on professional practice under a corporate veil (for all professions) is worth recalling here. It was based on the fear that the influence of managers and shareholders could affect the professional's judgement. It was believed at the time that the only way to preserve doctors' autonomy from outside pressures and influences and to ensure that they would always be motivated by the best interests of the patient was to keep them outside corporate structures.

This complete prohibition has been abandoned. It has been transformed into a regulation that relies on overseeing the corporation's decision-making process, at the level of shareholders and the board of directors, to attain the same objectives. The theory is that as long as the corporation remains formally under the direction of members of the physicians' professional order, the corporation itself will have to submit to the ethical rules of the profession and will not be able to force or incite doctors to contravene these rules. Thus, the rule currently in force in Quebec requires that all shareholders of a medical "enterprise" be members of the Collège des Médecins (College of Physicians), except for children and spouses who are authorized to hold nonvoting shares—clearly to allow income-splitting for tax purposes. There is a major exception to this general rule: in the case of Specialized Medical Centres (SMCs) and medical imaging laboratories, private investors who are not members of the Collège des Médecins can hold up to one share less than 50%.

We will not delve into the longstanding arguments and studies showing that there is no need to hold a majority of shares to influence the corporation's decisions or even control them. However, it can certainly be hypothesized that the corporate structure could have a significant impact on ways of practising medicine and could well be among the main causes of the increased tendency to charge patients for services. It could also explain why the market for medical practice outside hospitals has become segmented, with different niches having their own distinct strategies.

The highest bidder gets a doctor

In the spring of 2010, a foundation in Boucherville, on the south shore of the St. Lawrence across from Montreal, launched a campaign to finance the construction of a palliative care centre with a lottery in which the prize was a family doctor (Maillard, 2011)! This may be a caricature of the situation, but it's a good indication of the context in which business strategies to market access to doctors and health care are being developed.

Unfortunately, no systematic study of the models used by private clinics to solicit payments from patients exists in Quebec. In 2008, the Ontario Health Coalition published a Canada-wide study of the introduction of for-profit health care, which concentrated on direct payments demanded of patients. In its Quebec section, the study dealt primarily with clinics delivering delisted diagnostic tests and didn't deal with other formulas for charging patients out of pocket. Another source of documentation for some practices is the eight reports of RAMQ inquiries into the practices of various clinics previously revealed by the media. These reports were made public in 2007 and 2008. No new reports have been made public since then. However, the RAMQ reports and reports on various situations that subsequently appeared in the Quebec media make it possible to sketch the broad outlines of these commercial practices.

Developing privileged access in wealthy urban areas

In metropolitan areas, financial strategists can count on an adequate base of wealthy customers. This is where a market niche has developed consisting of people prepared to pay substantial amounts of money to secure quick access to a family doctor or specialist.

Access to a general practitioner: Hefty fees for a checkup

What appears to be the most common technique for luring paying patients into a family doctor's office is based on requiring a more or less complete checkup as a condition of access to guaranteed quick ongoing medical care. When the checkup is required every year to maintain privileged access, it can be transformed into or can be combined with an annual membership fee. These annual fees vary, but in their elite form [3] they can easily be well over $1,000. The patient initially meets with a nurse who fills out the required forms, takes samples (blood, urine) and submits the patient to certain tests (electrocardiogram, etc.). Since the tests are not prescribed by the doctor and are not medically necessary, they are considered uninsured and hence can legally be billed to the patient. Once the test results are obtained from the private laboratory with which the clinic does business, the family doctor, paid by the RAMQ, meets with the patient to discuss the results. The patient is then registered as a privileged member of the clinic. When the patient has a real health problem, a system of priority appointments allows him or her to be seen rapidly at the clinic. In some cases, no appointment is necessary if the emergency is minor.

Clinics use different stratagems to ensure instant access for customers who have paid annual fees. The receptionist gives members priority appointments, even when they show up without having called in advance. This privilege is operationalized through a separate waiting room for elite members whom the doctor will see first. The doctor's schedule includes banks of reserved time. Ordinary patients—those who have not paid annual fees—wait in another room and are unaware of the subterfuge.

Since the commercial imagination has few limits, privileged access through membership in an athletic club has also been reported. This method depends on a loophole according to which it is legal to bill for services provided to members of an association. This practice of membership in a health club exists even in network clinics, although the priority objective of these clinics is to improve access for the entire population to the frontline medical services provided by a health and social services centre. The network clinic is linked to the health and social services centre through an agreement by virtue of which the clinic operates through public funds that subsidize its administrative and clinical staff. Employees are given precise instructions for how to manage requests from members of the club who pay up to $1,000 in club membership fees and in return receive privileged access to the entire public system.

One model works like this: when a club member asks for an emergency appointment, the receptionist transfers the call to the nurse on duty, who has to answer the call on a priority basis. If she misses the call, the member leaves a message and a light begins flashing on the telephone. The nurse has to call back within 15 minutes and answer the member's questions. If a consultation with the doctor is indicated, she can give the member an appointment within the hour or at most within 24 hours. On arrival at the clinic, the member shows his or her health insurance card to the receptionist who uses it to bill the RAMQ for the appointment. The member is directed to the private waiting room and is seen by the doctor within the 15-minute guaranteed time frame.

This finely tuned ruse seems to baffle RAMQ investigators, who report that everyone can have access to a participating doctor without paying annual fees or agreeing to an uninsured checkup. The ministry of health and social services, the regional agencies, and the health and social services centres also seem to turn a blind eye to these tricks, which distort public financing of network clinics and family medicine groups for the benefit of those who have paid fees for elite status or club membership.

Access to a specialist

Privileged access to a specialist can be divided up into two major categories: access to a simple consultation and access to a procedure or surgery. The same technique of annual fees used for access to a family doctor has also been put into operation to allow patients to consult specialists, especially paediatricians. Medisys 123, a firm currently under investigation by the RAMQ, offers this service at a price of $975 per child.

Two other techniques for selling access to a consultation with a specialist paid out of public funds have come to light. The first of these techniques involves obtaining quick access to a specialist through a brokerage service. The fee for this service is in the range of several hundred dollars and varies from specialty to specialty according to difficulty of access. A reporter who

posed as a patient for a Radio-Canada investigation noted that the specialist she consulted wasn't even aware that her appointment had been made through a brokerage service. Some strategies, it would appear, may be carried out by the managers of commercial enterprises, without the knowledge of the doctors who are pressed into service against their will. This phenomenon is a striking illustration of the way in which doctors may lose some control over their own practice when it is carried out as a commercial enterprise.

Another strategy is based on an agreement between non-participating general practitioners and participating specialists to integrate and coordinate their operations. The simple idea is to gain free access to the more expensive doctor by paying the cheaper one. It should be recalled that a rule established when Specialized Medical Centres were introduced in 2006 banned participating doctors from working in the same medical centre—under the same corporate umbrella—as non-participating doctors. However, this rule can be circumvented through agreements between formally separate clinics, which open the door to payment for privileged access to a doctor paid out of public funds. The patient pays a fee to consult a non-participating general practitioner, who then provides free privileged access to a publicly paid specialist.

Quicker access to a participating specialist for a procedure or surgery also requires a fee directly from the patient on top of the rate paid by the RAMQ. The recent attention to monthly fees of up to $230 charged for applying drops in preparation for Lucentis injections in private clinics received wide publicity. This publicity forced the health minister to negotiate an agreement putting a stop to this practice with the specialists' federation, the Fédération des Médecins Spécialistes du Québec (FMSQ).

The practice of charging fees for certain surgical operations is less well known but no less widespread. Some SMCs charge fees based on a fixed rate per ten minutes of operating time, explaining that these fees go to pay for surgical facilities and health professionals other than the surgeon, who is paid by the RAMQ. A patient may be billed between $8,000 and $15,000 for hip or knee surgery, while the participating doctor who performed the surgery bills the RAMQ. This method of billing, used by the RocklandMD Surgery Centre, was declared illegal by the RAMQ in 2008.

It is also necessary to mention the brutal system of bribes practised by some specialists in some hospitals. This practice came to light in a Montreal *Gazette* investigation in the fall of 2010. Some specialists at the Royal Victoria Hospital in Montreal and the Montreal Children's Hospital were receiving up to $10,000 to give priority to a patient's surgery (Fidelman, 2010). Subsequently, the RAMQ and the syndic (officer in charge of inquiries) of the Collège des Médecins launched inquiries into this practice.

Developing minimal access in less well-off rural areas: health cooperatives

As a response to the ongoing difficulties that some of Quebec's more rural regions face in attracting physicians, the Quebec cooperative movement has helped some local communities establish health solidarity cooperatives. These regions sometimes experience major demographic difficulties, and some areas struggle with a vicious circle of devitalization. While young people leave in search of higher education or work, these areas may also lose their older residents as a result of the lack of nearby medical care.

Cooperatives emerged as an instrument for local communities to take control in order to escape this jam and maintain basic services for the population. The cooperative solicits applications from doctors, offering advantages such as administrative staff to manage the clinic, free or cut-rate office space, and some basic equipment. These breaks offered to doctors are the cooperative's main expense item. In this way, whether the cooperative likes it or not, it is drawn into the inexorable competition of a bidding war to attract doctors (see Hébert et Prémont, 2010).

The cooperative is made up of user-members who are required to hold shares in the cooperative. The value of each share is fixed by law at $10. While it's up to the cooperative to determine the number of shares required to be a member, the amounts of money collected in this way are marginal, and are not enough to finance the generous advantages offered to doctors. Hence, cooperatives need to find other sources of income to finance their activities. A number of cooperatives receive assistance from such sources as municipal authorities and the cooperative movement. But if these sources are insufficient, the cooperative is likely to resort to an annual subscription of between $30 and $175.

According to the logic of this system, a cooperative has to entice members with advantages that are attractive enough to make them join and pay the subscriptions that are vital to its operation, but without actually guaranteeing privileged access to the doctor attracted with extra benefits and bonuses. Efforts to manage this dilemma have placed some cooperatives under the scrutiny of an RAMQ investigation.

Improving access for the general public

Other marketing strategies are aimed more broadly at middle-class Quebecers who don't have a doctor. The technique of employing telemarketers to sell more affordable checkups—under $500—appears to be slowly gaining ground. A 2007 RAMQ investigation of this practice by the Châteauguay medical clinic ended up exonerating the clinic from violation of the Health Insurance Act. However, there were hints in the report that might interest the Office de Protection du Consommateur, Quebec's consumer protection bureau. The report clearly indicates that—in contrast to the elite formula aimed at wealthier patients—"general public" patients do not obtain the ongoing care of a family doctor in exchange for their $228 checkup. The only guaranteed medical appointment (paid out of public funds) is the one where the doctor presents the results of the analysis. It's not clear that patients who accept the telemarketer's pitch fully understand this nuance in what they are paying for.

Media reports also revealed that patients receive a fictitious bill for $285, of which they pay only $228. This allows them to recover the entire amount from their workplace-based group insurance plans, which typically pay only 80% of medical costs. There is another trick as well: patients are billed for "diagnostic analyses" rather than a checkup to increase their chances of being reimbursed.

Strategies to lure the general public with the promise of privileged access to a doctor also take the form of consulting the doctor by telephone, videoconference, or the Internet. Other practices include charging a fee of between $25 and $40 to open a file for the patient, without giving any priority access.

Final remarks

This discussion has been limited to payments demanded of patients for priority access to a doctor paid from the public purse. The purpose was not to present a detailed legal analysis, but rather to offer an overall picture of these dubious commercial practices and highlight the factors that encourage them. We have seen that the delisting of some diagnostic tests, the shortage of family doctors, and the difficulty in obtaining quick access to specialists create a context that fuels marketing strategies aimed at soliciting financial contributions from patients who wish to protect themselves from long waits and uncertainties. The response of public authorities (especially the RAMQ and the ministry of health and social services, but also the Collège des Médecins), directed towards penalizing certain behaviours that contravene the law or medical ethics, has been weak. This weakness, making it possible to engage in some of these practices with impunity, is undoubtedly another factor encouraging their development.

It should be recalled that charging the patient to see a doctor who does not receive any remuneration from the RAMQ has never been banned or even regulated (except lightly through medical ethics). Medical practice in exchange for private remuneration presents few difficulties in terms of equity, so long as it is not subsidized by public funding.

However, the commercial practices dealt with in this paper involve services that are paid for predominantly out of public subsidies, but are cornered by people who pay only a fraction of the costs. Therein lies the central problem with these practices. The phenomenon is based on marketing tricks that undermine the standard of the universal system: access according to medical need with no economic discrimination. These mechanisms are based on a public health care infrastructure and distort public resources for the benefit of some people who grab these resources for themselves. Those who are paying to receive privileged access are getting a bargain. They are gaining priority access to services that are largely paid for by those who have no access.

It should be noted that the marketing strategies are not being developed in isolation from and in parallel to the public system. Rather, they are being built on the foundation of public financing. This supports the hypothesis that the growth of private care is possible only with substantial public subsidies, creating economic distortions in access to health care.

The introduction of a contribution by patients who are seeking health care (even if this is just an additional contribution on top of predominant public financing) leads to segmentation into what are becoming specialized markets. Medical practices are being directed towards specific niches, targeting population segments according to their socioeconomic status. Of course, it's easier to ensure profitability when targeting a niche consisting of healthy, well-off patients. The characterization of the strategy by Dr. Yves Robert of the Collège des Médecins was an apt one: it's especially profitable to take care of people who are not sick (see the article in Le Devoir by Louise-Maude Rioux Soucy). However, this group represents a limited customer base, and other niches have developed. Thus, the cooperative model has been used for peripheral and rural regions. Other strategies—some of which would make consumer protection officials wince—have been used to market services to the general public.

History never repeats itself in the exact same way. The return of direct payments has taken diverse forms. They all turn the social achievement that is a universal health care system to the

advantage of commercial enterprises and a few doctors, as well as certain patient groups. The universal system provides for generous public compensation of doctors to ensure that all citizens of Quebec have equal access. The practices described here attack this foundation.

The corporate entrepreneur is the new player on the health care delivery stage, representing an unfamiliar element whose effects will need to be analyzed more closely. The relationship between the corporate presence and the remuneration of doctors needs to be better understood. In particular, the impact and pertinence of the bargaining monopoly granted to the medical federations in light of the presence of corporations with share capital and clinic managers, and whether the bargaining model is compatible with these new intermediaries, can be questioned. Doctors place themselves under the umbrella of their federation to negotiate their remuneration. Can they now place themselves under the cover of the medical corporation to draw additional income from the same source—that is, public funds?

Those are the daunting questions raised by these methods of drawing income from patients. One would like to believe that these practices are still marginal; however, they have the dangerous potential to shake the system to its foundations.

Notes

[1] Radiology in a private office, for which the supplement is 70%, is an exception.
[2] A Quebec Superior Court decision clearly showed that the supplement was insufficient in the case of voluntary interruption of pregnancy (*Association pour l'accès à l'avortement* c. *Procureur Général du Québec*, [2006] QCCS 4694).
[3] "Elite" is the expression used by one of these businesses to clearly indicate the different categories of privileges and the proportional relationship between the fee paid and the advantages outlined in the agreement. Other clinics refer informally to a "VIP" agreement.

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