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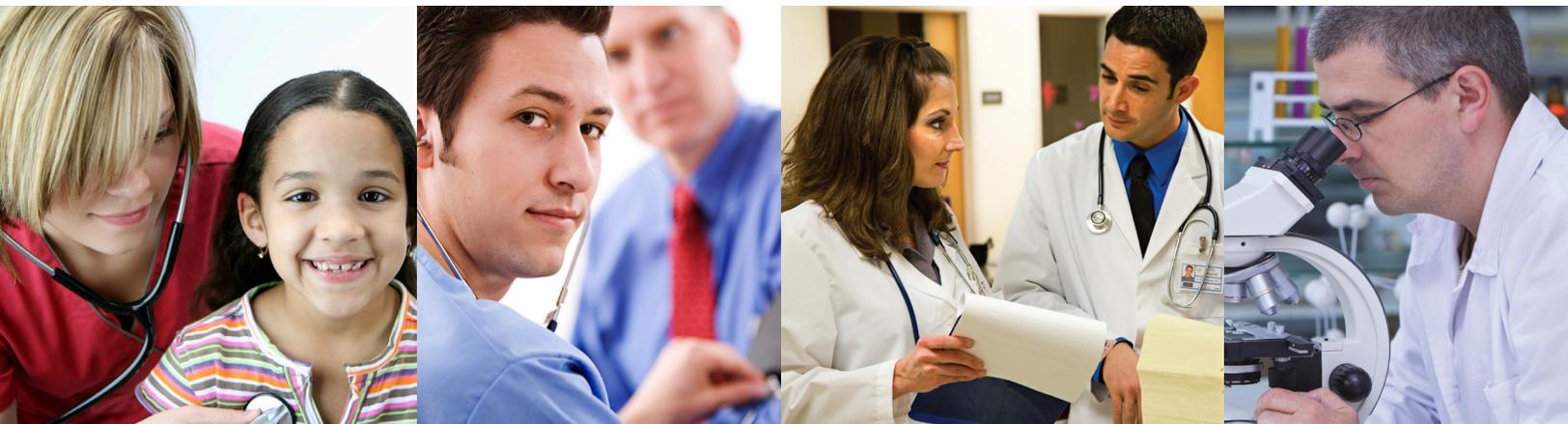
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The Regulation of Private Health Funding and Insurance in Alberta Under the Canada Health Act: A Comparative Cross-Provincial Perspective

Gerard W. Boychuk
Associate Professor
Department of Political Science
University of Waterloo

Summary

The range of options for provincial regulation of private funding and private insurance for health services under the Canada Health Act (CHA) is much wider than conventionally thought. While provinces tend to be considerably more restrictive than required by the CHA, existing legislation across the Canadian provinces presents a wide and varied menu for reform in the funding of health services. Given this, other factors including provincial public opinion appear to more significantly constrain reform than the CHA. The paper considers these issues with a focus on Alberta – a province often seen to stand at the forefront of health care reform in Canada.



EXECUTIVE SUMMARY

Four Key Points

- The range of options for health funding reform in Alberta that are consistent with the CHA is much wider than is often thought to be the case.
- Alberta's regulation of private funding and insurance of health services is more restrictive than required by the CHA and is more restrictive than legislation in a number of other provinces.
- Reforms that have been proposed by the Government of Alberta in the past have included significant reforms which were fully consistent with the CHA.
- Albertans are less receptive to private funding and insurance for health services than Canadians on average.

Specifics

- The CHA allows a wide range of latitude in regulating the private purchase and insurance of health services. The CHA stipulates the principles which provinces must follow in providing financial reimbursement under their public health plans (in order to be eligible for full federal transfers) but does not relate to the delivery of services or preclude private payment or insurance of health services.
- The CHA does not require that provinces ban the private purchase of any type of health service but only limits the conditions under which privately-purchased services may be subsidized through the public provincial plan. The CHA does not require that medical practitioners operate fully inside of (or outside of) the public system but, rather, places specific limits on billing procedures for insured services. The CHA does not require that provinces prohibit private insurance including insurance for otherwise publicly-insured services. Virtually all federal transfer reductions under the CHA have been related to user fees. The issue of extra-billing (physician fees charged in addition to the fee paid under the public plan) is less clear.
- Enforcement of the CHA by the federal government is largely discretionary. Interpretation and enforcement of the CHA remains primarily a prerogative of the federal minister with important areas remaining open to the minister's discretion. The CHA legislation is not justiciable – it is neither agreed to by both parties, legally binding on either party, nor does it create a set of citizen entitlements which may be claimed through the courts. Discerning the limits of CHA requirements requires an understanding of previous federal interpretations of the CHA as well as practices allowed in other provinces.
- Current regulation in Alberta goes significantly beyond CHA requirements. Alberta's prohibition of the provision of certain medical services outside the public health system, requirement that physicians operate either completely inside the public system or opt-out of public payment completely, and blanket ban on the provision of private insurance for otherwise publicly-insured health services are all not required by the CHA. Other provinces allow some or all of these practices.
- A range of CHA-compliant options can be drawn from cross-provincial comparisons. Existing provincial legislation elsewhere allows for private funding, private provision of services, and private insurance including the following:
 - o no restrictions on the private purchase of health services where fully privately funded;
 - o no restrictions on the provision of private insurance for health services (restrictions only on public reimbursement for health services);
 - o no restrictions allowing non-participating physicians to bill privately at unrestricted rates with patients being reimbursed (up to the public rate schedule) while allowing patients to insure for the difference;

- o no restrictions allowing participating physicians to bill the public plan directly for particular instances of provision of a service and bill patients directly for other instances of service provision (at unrestricted rates and without public compensation) with the patient being able to insure for the latter.
- Other practices which may be considered CHA-compliant based on federal interpretations to date include:
 - o the charging of facility fees by either private or public facilities for services provided by a physician (either opted-in or opted-out) where the physician fee is not remunerated by the public plan;
 - o the charging of annual registration fees by private facilities which offer a mix of uninsured and insured services (contravening the CHA only if non-payment of the annual registration fee reduces patient access to insured services.)
- The CHA did not appear to constitute the main factor constraining the Government of Alberta from proceeding with the recommendations of either the Premier's Advisory Council on Health (The Mazankowski Report) or the Alberta's Health Policy Framework, 2006. Public opinion appears to have been a more significant constraint.
- Public support in Alberta is relatively divided between support for strong enforcement of the CHA versus greater provincial latitude. However, based on a number of surveys conducted between 2005 and 2007, public opinion in Alberta was less supportive of private health funding and insurance than is the case in other provinces and relative to Canadian public opinion more generally. Albertan respondents are the least likely in any province to feel that private insurance will have a positive impact on them personally. Alberta is the only province in which public perceptions were that greater private involvement would lower the quality of health services.

In recent debates over health care financing reform in Alberta, the options for reform have typically been portrayed as a dichotomy between marginal adjustments to the status quo versus broad-reaching change which would necessarily entail violation of the *Canada Health Act (CHA)*. The paper examines the scope for the redefinition of the public/private divide in health funding under the rubric of the *CHA*. In so doing, the paper provides an overview of the existing regulatory status quo including the requirements of the *CHA* and the enforcement of the *CHA* to date. Secondly, it examines the regulation of private funding and insurance in Alberta from a cross-provincial comparative perspective in light of existing regulation in other provinces. Thirdly, the paper considers reforms that have been proposed in Alberta (including the Mazankowski Report and *Health Policy Framework, 2006*) in light of *CHA* requirements, practices in other provinces, as well as recent reform proposals in other provinces. Finally, the paper provides a review of existing public opinion polling relating to public support for private payment for quicker/enhanced services, private insurance as well as various health insurance scenarios and considers the political implications for health finance reform.

Using a cross-provincial comparative perspective, the paper argues that no province allows private funding and insurance for health services to the full extent available under the *CHA* and, secondly, that Alberta is currently more restrictive in its regulation of private funding and insurance of health services than a number of provinces.

Despite the conventional portrayal of a dichotomy between marginal adjustments to the current system of funding health services under the *CHA* and more far-reaching changes that violate the *CHA*, the empirical findings presented here imply that the range of options for health funding reform in Alberta under the *CHA* is much wider than conventionally thought to be the case. While the paper does not assess the likely effects or desirability of various reforms, it argues that significant reform is possible under the *CHA* and that the main constraints on such reform are more likely to lie in patterns of provincial public support for various reform options than in the constraints posed by the *CHA*.

REGULATION OF PRIVATE FUNDING AND INSURANCE FOR HEALTH SERVICES UNDER THE CHA

As the legislation itself states, the primary policy objective of the *CHA* is to “facilitate reasonable access to health services without financial or other barriers.”¹ In so doing, the *CHA* requires that, in order to qualify for full federal funding, provincial public health insurance coverage be universally available on uniform terms and conditions without any barriers to reasonable access including barriers of a financial nature.² In pursuit of these outcomes, the *CHA* places three types of restrictions on transfers to provinces – conditions, criteria (with provisions for discretionary penalties), and non-discretionary penalties for two defined practices (extra-billing and user fees).³

The two “conditions” of the *CHA* are that provincial governments provide the federal Minister with information required for the purposes of administering the *Act* and that provincial governments give recognition to federal transfers in advertising and promotional material related to insured health services.⁴ In addition to these non-substantive conditions, the overarching policy goal of reasonable access to health services without financial or other barriers is embodied in the five criteria of the *CHA*: universality (public insurance coverage must be available on uniform terms and conditions to all provincial residents), comprehensiveness (public insurance must cover all medically-necessary physician and hospital services), accessibility (reasonable access to insured services is not to be impaired by charges or other mechanisms and reasonable compensation must be made to physicians for providing insured services), portability (residents must be covered when they are temporarily out of the province) and public

1 *Canada Health Act, 1984*, s. 3. Accessed online (13/05/08) at <http://laws.justice.gc.ca/en/c-6/17077.html>.

2 *Canada Health Act, 1984*, s. 6.

3 User-fees are defined as charges by a facility in cases where physician fees are covered by the provincial health insurance plan and extra-billing occurs where a physician directly bills the provincial health plan for a service and simultaneously bills the patient an additional amount for the service.

4 *Canada Health Act, 1984*, s. 13.

administration (a public agency must administer the public plan). The enforcement mechanism for these five principles is the federal ability to withhold federal fiscal transfers on a discretionary basis.⁵ No province has yet been penalized for a violation of any of the five criteria of the *CHA*.⁶

In addition to the discretionary enforcement of the five criteria of the Act, the *CHA* also sets provisions for mandatory deductions for non-compliance with its provisions regarding user-fees and extra-billing which are spelled out in separate sections of the Act. Thus, the *CHA* provides for dollar-for-dollar penalties for extra-billing allowed within a province: "...no payments may be permitted...under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists."⁷ A similar provision exists for user-fees. Supplementing the *CHA* legislation, the 'Marleau letter' of 1995 outlines the federal interpretation of the *CHA* that fees charged by private medical facilities constitute a user fee if physician-services portion of the costs is covered directly by the provincial health insurance plan.⁸

There are two means by which such mandatory penalties may be assessed under these sections of the Act. The first is triggered when provinces self-report extra-billing and user-fees under provisions spelled out in the *Extra-billing and User Charges Information Regulations* put in force under the Act.⁹ Given the provisions of the *CHA*, the federal minister has no discretion in imposing transfer reductions on provinces that self-report extra-billing and user-fees. In the second instance, where extra-billing and charging of user-fees takes place but is not reported as such by the province, the federal Minister shall ("where information is not provided in accordance with the regulations") levy penalties "in an amount that the Minister estimates to have been so charged."¹⁰ In such cases, it remains the prerogative of the federal minister to determine whether extra-billing and the charging of user-fees is taking place although deductions, in an amount determined by the minister, are mandatory if this is found to be the case. To date, no penalties have been levied based on a ministerial determination that extra-billing and the charging of user-fees has occurred and transfer reductions have only taken place when extra-billing and user-fees have been self-reported by a province.¹¹

Taking these various provisions together, the *CHA* at the broadest level stipulates the principles which provinces must follow in providing *financial reimbursement* under their public health plans in order to be eligible for full federal transfers. That is, the legislation relates primarily to the financing of health services and not directly to how they are actually provided or by whom. The *CHA* does not speak, whatsoever, to the delivery of services and thus draws no distinction between funding and delivery. Put most simply, if funding arrangements are *CHA*-compliant, the delivery is necessarily *CHA*-compliant. Thus, funding and delivery should not be considered separately in terms of *CHA*-compliance and funding must receive central focus.

Moreover, in terms of funding, it is important to realize the limited scope of *CHA* proscriptions. First, the *CHA* does not require that provinces ban the private purchase of any type of health service. What it does limit are the conditions under which privately-purchased services may be subsidized through the public provincial plan. Secondly, the *CHA* does not require that medical practitioners operate fully inside of (or outside of) the public system but, rather, places specific limits on billing procedures for insured *services*. Of course, all physicians

5 *Canada Health Act, 1984*, s. 15.

6 Health Canada, *Canada Health Act Annual Report 2006-2007*, 6.

7 *Canada Health Act, 1984*, s. 18.

8 Minister of Health and Welfare, *Federal Policy on Private Clinics*, 6 January 1995. Accessed on 15/05/08 at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/interpretation/index_e.html.

9 *Extra-billing and User Charges Information Regulations* Accessed on 14/05/08 at <http://laws.justice.gc.ca/en/ShowFullDoc/cr/SOR-86-259/en>.

10 *Canada Health Act, 1984*, s. 18.

11 The only exception was the case of BC in which the province reported extra-billing in a given fiscal year and then failed to report it in subsequent years. In this case, estimates of extra-billing were made for the non-reported years on the basis of information provided by the province in the year in which it reported extra-billing. Information from telephone interview with official in Health Canada, *Canada Health Act* Enforcement Branch.

combine income streams from public and private incomes sources – the latter primarily for services that are not insured under the public plan. However, even for medically-necessary services, the *CHA* makes reference only to the status of *services* (i.e. either insured on non-insured) and makes no reference whatsoever to the status of *practitioners*.¹² Thirdly, as it only governs public reimbursement for health services, the *CHA* does not require that provinces prohibit private insurance for otherwise publicly-insured services. However, as it requires federal transfer reductions for extra-billing and charging of user-fees for insured services, the *CHA* implicitly places limits on the room for third-party insurance to supplement public insurance for services that are publicly-covered and directly billed to the plan.

In addition to the limits on the range of practices to which the *CHA* applies, it is also critical to note that, given the nature of the legislation, enforcement of the *CHA* is primarily a *political* rather than legal issue. First, despite the existence of a dispute resolution mechanism,¹³ the interpretation and enforcement of the *CHA* remains primarily a prerogative of the federal minister and, as outlined above, the legislation confers considerable discretion on the minister with important areas remaining open to federal interpretation.¹⁴ Secondly, the legislation is not justiciable – it is neither agreed to by both parties, legally binding on either party, nor does it create a set of citizen entitlements which may be claimed through the courts.¹⁵

Given this, it is not primarily to legal interpretation but, rather, previous federal interpretations of the *CHA* as well as practices allowed in other provinces to which one must turn in attempting to discern the limits of the *CHA* requirements. At the same time, the highly discretionary basis of *CHA* enforcement implies that the federal government is not bound by such precedents in future interpretations of the *CHA*. However, it would undoubtedly be more difficult politically for the federal government to levy transfer reductions against a province for practices which it has allowed in the past or which are currently allowed under provincial legislation in other provinces.

An Overview of Penalties Imposed Under the CHA

Some indications of the boundaries of the *CHA* can be discerned from an examination of the enforcement of the *CHA* to date. Upon coming into force in 1984, the *CHA* allowed provinces a three-year grace period under which transfer reductions would be refunded to the provinces if the practices generating reductions were discontinued by April 1987. Seven provinces (New Brunswick, Québec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia) faced transfer reductions during this three year period which were refunded as all Canadian provinces were deemed to be complying with provisions regarding extra-billing and user-fees by April 1987.¹⁶ No further transfer reductions were levied against any province until 1994-95 when federal transfers to British Columbia were reduced as a result of provincial reporting of extra-billing in that province. Since 1994, federal transfer reductions

12 The legislation requires that “...no payments may be permitted...under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.” However, it might alternatively have required that no payments may be permitted under the health care insurance plan of the provinces in respect of health services that have been provided by *medical practitioners* engaging in practices where public health insurance plan payments have not been accepted as payment for services in full.

13 The dispute avoidance and resolution process was agreed to by the federal and provincial ministers of health (except Québec) in April 2002. The agreement provides that where dispute avoidance is unsuccessful, either the federal or provincial minister “may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations.” However, the federal Minister of Health retains final authority to enforce the *CHA* and is only required to “take the panel’s report into consideration” in so doing. *Canada Health Act Annual Report, 2006-2007*, 8 and esp. Appendix C.

14 As the *CHA* is federal legislation rather than an intergovernmental agreement, even in those cases where a practice is clearly within or outside the parameters established by the *CHA*, the federal government retains the prerogative to unilaterally amend the legislation.

15 As the Report of the Task Force on the Funding of the Health Care System (Québec) notes: “From the legal standpoint, the *Canada Health Act* does not confer any rights on persons that they could invoke to have their province adopt measures intended to give them access to health services...” (255) This conclusion is based on a legal study commissioned by the Task Force. See Patrick Molinari, “L’interprétation de la Loi canadienne sur la santé: repères et balises.” November 2007.

16 Health Canada, *Canada Health Act Annual Report 2006-2007*, 10.

under the *CHA* have become more commonplace and have set precedents for current enforcement of the *CHA* -- especially in regard to user-fees charged by private clinics. (See Table 1.)

Virtually all of the federal transfer reductions under the *CHA* (except reductions for extra-billing in British Columbia from 1992-1995) since the initial grace period have been related to non-compliance with the federal policy on private clinics as outlined in the Marleau letter which stipulates that fees charged by a private facility for services for which the physician fee is paid by the provincial public plan constitute a user fee and require a mandatory *CHA* reduction in federal transfers. Fees charged by facilities (both public and private) continue to be a central issue in *CHA* enforcement. While reporting has not yet taken place for the period following fiscal year 2004-05, British Columbia in 2006 ordered public hospitals to discontinue the practice of allowing the charging of fees for expedited access to insured diagnostic services and Québec “took action to discourage” private clinics from charging user-fees for insured services.¹⁷

Table 1: Federal Transfer Reductions under *CHA*, 1987-2008

| PROVINCE | PERIOD | DEDUCTION | ISSUE |
|------------------|------------------|-----------------|---|
| British Columbia | 1992-1995 | \$2.025M | Extra-Billing by Physicians |
| Alberta | 1995-1996 | \$3.585M | Non-compliance with federal policy on private clinics (user fees) |
| Newfoundland | 1995-1997 | \$284,430 | Non-compliance with federal policy on private clinics (user fees) |
| Manitoba | 1995-1998 | \$2.355M | Non-compliance with federal policy on private clinics (user fees) |
| Nova Scotia | 1995-2003 | \$372,135 | Non-compliance with federal policy on private clinics (user fees) |
| British Columbia | 2000-2005 | \$347,718 | Non-compliance with federal policy on private clinics (user fees) |
| Newfoundland | 2002-03 | \$4,610 | User fee in public hospital |
| Nova Scotia | 2004-05 | \$9,460 | Extra-Billing* |
| TOTAL | 1987-2008 | \$8,977M | |

Source: Health Canada, *Canada Health Act Annual Report, 2006-2007*.

*Reported by province but no further details provided by Health Canada.

The precedents for federal transfer reductions under the *CHA* make clear the federal commitment to the principles outlined in the Marleau letter of 1995 – facility fees charged for services where the physician fee is covered by the provincial health insurance plan are considered user-fees triggering a dollar-for-dollar reduction in federal transfers. However, the issue of extra-billing (as opposed to user fees) is much less clear in certain respects as outlined below. The single existing precedent (federal transfer reductions for extra-billing in British Columbia from 1992-1995) is much less clear in its implications than is the case for user fees charged in private facilities.

¹⁷ Health Canada, *Canada Health Act Annual Report, 2006-2007*, 11.

Transfer Reductions for Extra-Billing in British Columbia, 1992-1995

The case of transfer reductions for extra-billing in British Columbia in the period from 1992 to 1995 warrants special attention as it marked the first penalties levied under the *CHA* following the 1984-87 grace period for provinces to come into *CHA* compliance and is the only significant example of transfer reductions made in respect of extra-billing.¹⁸ The technical matters at issue in this instance of transfer reductions are quite complex. Furthermore, the corresponding political context in which these transfer reductions occurred was quite peculiar making it difficult to discern the enforcement precedents set. As reported in the *Canada Health Act Annual Report, 2006-07*:

As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the Act. Including deduction adjustments for prior years, dating back to fiscal year 1992-1993, deductions began in May 1994 until extra-billing by physicians was banned when changes to British Columbia's *Medicare Protection Act* came into effect in September 1995. In total, \$2.025 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992-1993 and 1995-1996.¹⁹

Technically, the billing practices in question constituted extra-billing under the *CHA* not because the federal minister had investigated the practices and made a determination that this was the case in fact but, rather, because the BC Minister of Health had investigated the practices, determined that (in the provincial Minister's estimation) extra-billing was occurring, and reported specific amounts to the federal Minister as extra-billing. Thus, these practices constituted extra-billing under the *CHA* because they were reported by the province as extra-billing leaving the federal Minister with no discretion in imposing transfer reductions under the extra-billing provision of the *CHA*.

Legislation was brought in by the BC government to ban extra-billing to which the *CHA Annual Report* attributes the cessation of federal transfer reductions.²⁰ This legislation stipulates that medical practitioners enrolled in the public health insurance plan (whether billing the plan directly or electing to bill patients who would then seek reimbursement from the plan) could not charge in excess of the provincial rate schedule for insured services. Furthermore, medical practitioners not enrolled in the provincial health insurance plan cannot charge in excess of the provincial rate schedule if the service is provided in a hospital or continuing care facility.²¹ This represented a change from the 1992 legislation which allowed physicians operating under the plan to elect to bill patients directly (potentially at rates higher than the provincial fee schedule) with the latter being allowed to make a claim to the provincial health insurance plan for amounts up to the provincial fee schedule rate.²² By virtue of making an election to bill patients directly, practitioners would be required to bill all patients directly for all services thus forfeiting their ability to bill the plan directly for any services provided to any patient.

18 With the exception of a nominal transfer reduction of \$9,460 applied against Nova Scotia for provincially-reported extra-billing charges in 2004-05.

19 Health Canada, *Canada Health Act Annual Report 2006-2007*, 11-12.

20 British Columbia Legislative Assembly. Bill 54 (1995) – An Act to Protect Medicare. Accessed online 15/05/2008 at http://www.leg.bc.ca/1995/1st_read/gov54-1.htm.

21 British Columbia Legislative Assembly. Bill 54 (1995) – An Act to Protect Medicare, s.17.2(2).

22 British Columbia Legislative Assembly. Bill 71 (1992) – Medical and Health Care Services Act, esp. s.13 (1) and s.13 (9)(a)(ii). The 1992 legislation also prohibited the provision of third-party private insurance for publicly-insured services. See s.39(1). The 1992 legislation represented a significant change from the status quo under which, by virtue of the *Medical Service Plan Act, 1981*, direct and extra-billing were completely prohibited: "No medical practitioner participating in the plan shall...seek compensation by means of balance billing, extra billing or extra charging, or demand or receive any payment other than a payment under the agreement and plan at the rate applicable for that service..." s.3(2). By virtue of this provision, medical practitioners would be required to bill either completely inside the provincial plan or completely outside of it and, in the latter case, the legislation made no provision for financial compensation to patients.

In terms of the political context, the NDP government in British Columbia was opposed to “extra-billing” and believed that federal transfer reductions levied against the province would help increase political pressure on provincial physicians to end the practice.²³ As a result, the government of British Columbia had “encouraged the federal government to go ahead with its punishment...”²⁴ The BC Health Minister Paul Ramsey stated publicly: “We agree with the [federal] minister that extra-billing is not an acceptable practice, and the federal government is within its rights if they choose to cut our transfer payments because of it.”²⁵ In fact, by reporting specific amounts as having been extra-billed, the province went beyond encouraging the federal minister to apply transfer reductions and actually made the reductions mandatory under federal legislation. That is, federal transfer reductions were levied because the provincial Minister made a determination that specific practices were non-compliant with *CHA* requirements – the federal Minister did not formally make such a determination. This makes it difficult to use this instance of federal transfer reductions as a precedent for federal enforcement of *CHA* restrictions against extra-billing.

Two clear base points emerge from a combined reading of the *CHA* itself and its enforcement following its full adoption: user-fees and extra-billing are non-compliant and require a mandatory reduction of federal transfers. Practices outside of these two clear instances of non-compliance remain open to interpretation and subject to the politics of *CHA*-enforcement.

Health Reform in Alberta (Bill 11) and the Politics of Federal *CHA* Enforcement

The political dynamics shaping the politics of *CHA* enforcement are highlighted by federal-provincial conflict in early 2000 over Alberta’s Bill 11 -- which now as the *Alberta Health Care Protection Act* comprises a central pillar of health funding regulation in Alberta. The federal-provincial politics around the issue of Bill 11 and *CHA*-compliance illustrate the limited constraints on provinces under a strict reading of the provisions of the *CHA*, the degree of latitude for federal interpretation of the *CHA*, and the complexity of the politics of *CHA* enforcement.

Compliance with the *CHA* was a central issue in the politics of the reform legislation. The central political strategy of opponents of the legislation when the Alberta government introduced Bill 11 in the legislature in early March 2000 was to argue that it contravened the *CHA*. Perhaps most notably, there was extensive media coverage of legal analysis (commissioned by CUPE) which alleged that the legislation violated *CHA* criteria of comprehensiveness, universality, accessibility, and, possibly, public-administration.²⁶ Moreover, prominent critics of the legislation such as Saskatchewan Premier Roy Romanow also argued that the legislation violated the *CHA* (and continued to argue that this was the case even after the federal government conceded that the legislation did not do so.) Proponents, most notably Premier Klein, maintained consistently that the Alberta government did not believe that the legislation represented a violation of the *CHA*.²⁷ Apparently anticipating that the federal government would not conclude that the legislation was in violation of the *CHA*, the Alberta government, on introducing the bill to the Alberta legislative assembly, forwarded a copy to the federal Health Minister Allan Rock and formally requested confirmation in regard to whether the legislation represented a violation of the *CHA*.²⁸

23 Ross Howard, “Marleau to Punish BC for Fees,” *Globe and Mail*, 19 May 1994, A1.

24 Ibid.

25 Rod Mickleburgh, “Ottawa Gets Tough Over BC Extra-Billing,” *Globe and Mail*, 23 April 1994, A1.

26 Heather Scoffield, “Legal Opinions Rip Klein’s Health Bill: Alberta’s Plan Would Violate Canada Health Act,” *Globe and Mail*, 14 March 2000, A1.

27 Tim Harper, “Rock Takes Medicare Fight to Alberta,” *Toronto Star*, 10 March 2000, NE06.

28 Jill Mahoney, “Ottawa Taking Its Time on Health-Care Bill, Klein Says,” *Globe and Mail*, 21 March 2000, A5; Dean Bennett, “Health Care Debate Becoming Ugly,” *Toronto Star*, 14 March 2000, NE07; Tim Harper, “Rock Says He Will Go Directly to Albertans,” *Toronto Star*, 17 March 2000, NE07.

The federal government was extremely careful to avoid confirming publicly whether the legislation was considered to be in violation with the *CHA* or *CHA*-compliant. In the face of questions regarding *CHA*-compliance, the federal Minister's first response was that the federal government was in the process of reviewing the legislation as introduced in the Alberta legislature but that federal legal opinions were not yet available.²⁹ The federal Health Minister would later argue that the federal government would not consider the draft legislation as it would be subject to amendments but would wait for final legislation before making a determination on *CHA*-compliance.³⁰ Prime Minister Chrétien then announced that the federal government would only make a determination after both the final legislation and associated regulations were announced.³¹ Finally, the federal government announced it would only monitor the operation of the legislation and associated regulations in practice to determine if violations of the *CHA* were occurring.³²

Despite its unwillingness to make a determination in regard to *CHA*-compliance, the federal government did clearly state its opposition to the bill.³³ While broadly opposed to the philosophical underpinnings of the legislation, the federal Health Minister outlined two major concerns in regard to the specific proposals made by Alberta: first, concerns in respect of add-on fees for enhanced care and, second, concerns in respect of private clinics being allowed to keep patients overnight.³⁴ As the federal Health Minister would argue, "To permit for-profit facilities to sell enhanced services in combination with insured services would create a circumstance that represents a serious concern in relation to the principle of accessibility."³⁵ The main federal concern in this regard was that allowing fees for enhanced services when provided in combination with insured services may lead to quicker access to publicly-funded services for those patients able and willing to pay the associated private fees.³⁶ It was this aspect of Bill 11 which the federal minister warned *might*, but did not conclusively, constitute a violation of the *CHA*.

The federal government also evinced concern in regard to overnight stays. Under this proposal, surgical facilities would be able to bill the public insurance system for the surgery but potentially charge patients more for "hotel" arrangements for post-operative care.³⁷ Such practices were already allowed by for-profit clinics for day surgery as well as public facilities for accommodation beyond semi-private accommodation (as the *CHA* requires coverage of accommodation and meals only at the standard ward level.) The federal minister did not argue that this provision would violate the *CHA* but, rather, that "[t]he Alberta government has now proposed a role for private, for-profit facilities that goes beyond what is already in place in other provinces in Canada."³⁸ The federal minister's argument in this regard illustrates a central point in the politics of federal *CHA* enforcement: the importance placed by the federal government on practices existing in other provinces in making determinations in regard to the acceptability of provincial reforms.

29 Scoffield, "Legal Opinions Rip Klein's Health Bill."

30 Harper, "Rock Says He Will Go Directly To Albertans"; Mahoney, "Ottawa Taking Its Time."

31 Tim Harper, "Alberta Premier Will Be Threatened with Sanctions over Health Bill," *Toronto Star*, 22 March 2000, NE01.

32 Health Scoffield, "Ottawa Can't Stop Alberta's Health Bill," *Globe and Mail*, 12 May 2000, A1; "Rock Vows to Stand Guard on Alberta's Health Changes," *Winnipeg Free Press*, 12 May 2000, B6.

33 Mahoney, "Ottawa Taking Its Time."

34 Canada Wire, "Alberta Overstepping Bounds: Rock," *Winnipeg Free Press*, 9 April 2000, A6.

35 *Ibid.*

36 *Ibid.*

37 This practice was already allowed in Alberta for day surgery.

38 *Ibid.*

All three major players – the Alberta Premier, the federal Health Minister, and the Prime Minister – recognized the importance of legislation in other provinces. Premier Klein consistently claimed that the bill included only provisions that were in place in other provinces and, as such, respected the *CHA*.³⁹ In apparent response, Prime Minister Chrétien stated that he would request provincial health ministers review the bill to compare it with health programs in other provinces – a proposal to which Premier Klein agreed.⁴⁰ This proposal by the Prime Minister illustrates two central aspects of *CHA* enforcement. First, it highlights the degree of latitude in interpreting the *CHA*. While the *CHA* clearly outlines particular practices that require federal transfer reductions, there is also a wide range of practices on which the legislation is not clear and requires significant interpretation. Secondly, in turning to provincial health ministers in making this determination, the Prime Minister implicitly recognized the *realpolitik* of *CHA* enforcement – it is politically much more difficult for the federal government to challenge practices currently allowed under provincial legislation in other provinces than would otherwise be the case. The federal government, however, eventually abandoned this tack.

Despite the fact that the Alberta government did not make any of the amendments publicly requested by the federal health minister, the federal government would ultimately concede that the legislation did not violate the *CHA*. Federal officials “...concede privately that the bill as written is in keeping with the principles of public health care...” and do not believe that it violates the *CHA*.⁴¹ Premier Klein, when finally informed indirectly on the day of the final legislative reading of the bill that “federal government sources” reported that Bill 11 did not violate the *CHA*, responded, “It’s nice to know, but it doesn’t come as much of a surprise.”⁴² It was not surprising to the degree that nothing in legislation constituted a clear violation of the *CHA*. As the issue of *CHA*-compliance was then pushed into the greyer area of federal interpretation of the discretionary criteria of the *CHA* regarding practices already allowed by legislation in other provinces, the likelihood of federal penalties diminished.

The enforcement of the *CHA* was highly politically charged with claims and counter-claims of *CHA*-compliance being a central political weapon in the arsenals of both proponents and opponents of the legislation with the federal government included in the latter camp: “...the federal government has been careful not to come out and state directly that the bill does not violate the Canada Health Act. Ottawa did not want to lend support to [the] campaign to win public support.”⁴³ Clearly, there were no provisions in the Alberta legislation that constituted a clear violation of the *CHA* – making the politics of opposition to the legislation much more complex than would have otherwise been the case given that the primary political strategy of opponents was to claim that the legislation was not *CHA*-compliant. At the same time, the legislation included provisions that the federal minister, under his discretion to interpret the federal legislation, could have claimed constituted a violation of the *CHA* – demonstrating that it is not only a strict legalistic interpretation of the *CHA* that determines the politics of *CHA* enforcement. In the face of a lack of political will to make such an interpretation (shaped in part by the existence of legislation allowing similar practices in other provinces), a strict legalistic interpretation of the *CHA* allowed significant latitude for the Alberta government to implement reforms. The revisions which the Alberta government did make to the reform package were in response to political dynamics within the province rather than pressures generated by federal government or constraints posed by the *CHA*.⁴⁴

39 Adrian Wyld, “Other Provinces Have Similar Laws: Klein,” *Toronto Star*, 24 March 2000, NE01. Premier Klein publicly made specific reference to legislation in BC, Saskatchewan, Manitoba and Ontario and argued publicly that all four had legislative provision similar to the proposed legislation in Alberta.

40 Ibid.; “Ottawa Finally in Position to Fight Klein on Health,” *Toronto Star*, 14 April 2000, NE06.

41 “Key to Alberta Bill is How It’s Used,” *Globe and Mail*, 10 May 2000, A2.

42 James Cudmore, “Klein’s Bill 11 Set to Pass Final Hurdle,” *National Post*, 10 May 2000, A8.

43 “Key to Alberta Bill is How It’s Used,” *Globe and Mail*, 10 May 2000, A2.

44 Canada Wire, “Extended Overnight Stays at Private Clinics OK, says Klein,” *Winnipeg Free Press*, 8 April 2000, A2.

Current Regulation in Alberta and CHA Compliance

Alberta goes well beyond the requirements of the *CHA* in its regulation of private provision, funding and insurance for health services under both the *Health Care Protection Act* (HCPA) and the *Alberta Health Care Insurance Act* (AHCIA).⁴⁵ First, Alberta goes beyond the requirements of the *CHA* in its prohibition of the provision of certain medical services outside the public health system as the *CHA* does not require that provinces ban the private purchase of any type of health service. Alberta prohibits private facilities providing emergency care requiring medically-supervised stays of more than twelve hours⁴⁶ as well as restricting physicians from performing ‘major’ surgical services except in a public hospital.⁴⁷ It is this legislated public monopoly that led Brian Day, the President of the CMA and founder of Cambie Surgical Services in British Columbia, to publicly assert: “Alberta, of all the provinces in Canada, is the most hostile towards private clinics. We couldn’t function in Alberta.”⁴⁸

Secondly, the province requires that physicians operate either completely inside the public system or opt-out of public payment completely. Provincial legislation requires that physicians completely forfeit all claims to any public compensation if they wish to bill patients above the provincially-determined fee schedule for *any* service.⁴⁹ As outlined above, the *CHA*, in relation to extra-billing, only refers to publicly-insured *services* which receive direct payment under the provincial health plan and does not make any mention whatsoever to medical practitioners.⁵⁰

Thirdly, Alberta has a blanket ban on the provision of private insurance for otherwise publicly-insured health services under the *Alberta Health Care Insurance Act* (AHCIA).⁵¹ As outlined above, no such requirement is explicit or implied in the *CHA*. Under the *Health Insurance Premiums Act*, residents may opt out of the Alberta Health Care Insurance Plan and, as a result, not be liable for provincial health insurance plan premiums.⁵² However, the AHCIA prohibits the provision of third-party insurance to opted-out residents who must bear the full financial risk of foregoing participation in the public health insurance plan.

Alberta in Comparative Cross-Provincial Perspective

An examination of the means by which provinces place limits on private funding of publicly-insured medical services highlights the wide range of options available to provinces under the *CHA*. Provinces vary significantly in the approaches they take, no province allows private funding to the full degree allowed under the *CHA*, and regulation in Alberta tends to be more stringent than in a number of other provinces and clearly more stringent than required by the *CHA*.

45 *Alberta Health Care Insurance Act*, R.S.A. 2000, c.A-20. Accessed online on 16/05/2008 at <http://www.canlii.org/ab/laws/sta/a-20/20060718/whole.html>. *Health Care Protection Act*, R.S.A. 2000, c. H-1. Accessed online on 16/05/2008 at <http://www.canlii.org/ab/laws/sta/h-1/20060718/whole.html>.

46 *Health Care Protection Act*, R.S.A. 2000, Part 1, S.1 and Part 5, S.29 (m).

47 *Health Care Protection Act*, R.S.A. 2000, Part 1, S.2(2). The definition of ‘major surgery’ is determined by the College of Physicians and Surgeons of Alberta. See College of Physicians and Surgeons of Alberta, 2006.

48 Michelle Lang, “The Quickening Pulse of Private Health Care,” *Edmonton Journal*, 18 September 2005, E6.

49 *Alberta Health Care Insurance Act*, R.S.A. 2000, Part 1, S.9 (1) and *Health Care Protection Act*, R.S.A. 2000, Part 1, 4(b). Fees may be collected for enhanced medical services; however, purchase of enhanced services cannot be required in order to access the insured services. *Health Care Protection Act*, R.S.A. 2000, Part 1, S. 5 (1 and 2).

50 There were no opted-out physicians in Alberta as of March 31, 2007. Health Canada, *Canada Health Act Annual Report, 2006-2007*, 149.

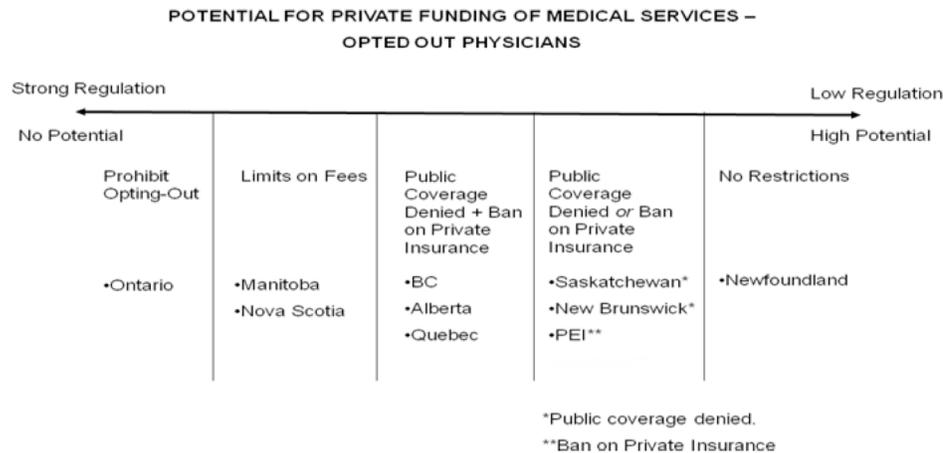
51 *Alberta Health Care Insurance Act*, R.S.A. 2000, Part 1, S.26(2, 4) This is the issue that was raised in the Chaoulli case in which the Supreme Court of Canada found that Québec’s ban on private insurance – similar to the ban on private insurance in Alberta – constituted a violation of the Québec Charter of Human Rights and Freedoms although the Court was split (with one justice abstaining) as to whether the ban constituted a violation of the Canadian Charter of Rights and Freedoms. The ruling had little direct applicability to the *CHA* itself as the latter does not require a ban on private insurance for publicly insured services. *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 2005 SCC 35.

52 *Health Insurance Premiums Act*, Chapter H-6, S.25(1). Accessed online on 16/05/2008 at <http://www.qp.gov.ab.ca/Documents/acts/H06.CFM>.

Opted Out Physicians⁵³

Provinces have a range of options which allow them to effectively limit the scope of private funding of publicly-insured services including regulating private insurance, regulating billing practices, and regulating fees. In all provinces except Ontario, physicians have the right to opt out of the public plan which, in essence, implies that they forfeit their ability to bill the public plan directly.⁵⁴ (See Figure 1 and Table 2.) Outside of not allowing physicians to opt out as is now the practice in Ontario, the most stringent method of restricting private-funding of insured services provided by non-participating physicians is to limit the fees they may legally charge to the levels stipulated in the provincial rate schedule thus greatly reducing the incentive to operate outside the public plan.

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



Sources for Figures 1 and 2: Colleen M. Flood and Tom Archibald, “The Illegality of Private Health Care in Canada,” *Canadian Medical Association Journal* 164, 6 (20 March 2005): 825-30. Supplemented from CHA Annual Report, 2004-5.

Notes: Provinces appear in shadow where a more stringent existing regulation makes subsequent limitations on private insurance coverage superfluous. SK and NB – public coverage denied; PEI and MB – private insurance prohibited.

53 Because provincial legislation generally treats non-participating physicians differently than participating physicians combined with the wide variation among provinces in regard to both, it is helpful to differentiate between provincial regulation of private-funding of insured services provided by opted-out and opted-in physicians. The paper uses opted-in/opted-out and participating/non-participating interchangeably.

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

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

| Physician Status | Regulation | BC | AB | SK | MB | ON ^A | QB | NB | NS | PEI | NF |
|------------------|-----------------------------------|----|----|----|----|-----------------|----|----|----|-----|----|
| Opted Out | Prohibits Opting Out | N | N | N | N | Y | N | N | N | N | N |
| | Limits on Fees | N | N | N | Y | n/a | N | N | Y | N | N |
| | Ban on Private Insurance | Y | Y | N | Y | n/a | Y | N | N | Y | N |
| | Public Coverage Denied | Y | Y | Y | N* | n/a | Y | Y | N* | N* | N |
| Opted In | Direct Patient Billing Prohibited | N* | N | Y* | Y | Y | Y | N | Y | N | Y |
| | Limits on Fees | Y | Y | Y | Y | Y | Y | N | Y | N | Y |
| | Ban on Private Insurance | Y | Y | N | Y | Y | Y | N | N | Y | N |
| | Public Coverage Denied*** | | | | | | | Y | | Y | |

Basic source for provincial regulation of private health insurance is Colleen M. Flood and Tom Archibald, “The Illegality of Private Health Care in Canada,” *Canadian Medical Association Journal* 164, 6 (20 March 2005): 825-30. Supplemented from CHA Annual Report, 2004-5.

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

*Source: CHA Annual Report, 2006-7.

**Required by CHA.

In Manitoba and Nova Scotia, provincial regulations limit the fees of opted-out physicians to levels specified in the provincial fee schedule. Services provided by opted-out physicians are covered by public insurance (reimbursed to the patient) but, because fees are also capped, there is simply no room for the private financing of publicly-insured services provided by opted-out physicians.

The remaining provinces use a variety of means to limit the potential for the private funding of publicly-insured services. Three provinces (Alberta, British Columbia and Québec) deny public coverage for services provided by opted-out physicians while, at the same time, implementing a legal ban (partial in the case of Québec) on the provision of private, third-party insurance for those services.⁵⁵ Thus, patients are able to receive services outside the plan at rates determined solely by the physician although the patient must absorb the full cost of those services. Saskatchewan and New Brunswick also deny public compensation for services provided by opted-out physicians although they do not prohibit private insurance coverage for those services.

Both PEI and Newfoundland allow for public compensation of patients (up to the provincial fee schedule) for services provided by opted-out physicians billed at unrestricted rates. While PEI allows public compensation for services provided by opted-out physicians, it prohibits private insurance. Thus, the patient must bear the full cost of charges above rates specified in the provincial fee schedule. In Newfoundland, opted-out physicians are able to set their own fees, patients are compensated by the province for costs up to the provincial fee schedule, and private third-party insurers are allowed to insure for the difference.⁵⁶

⁵⁵ Québec maintains only a partial ban following changes to allow private insurance for specified services in order to comply with the Chaoulli decision. As it was based on the Québec Charter of Human Rights and Freedoms, the decision has no force or effect outside of the Province of Québec.

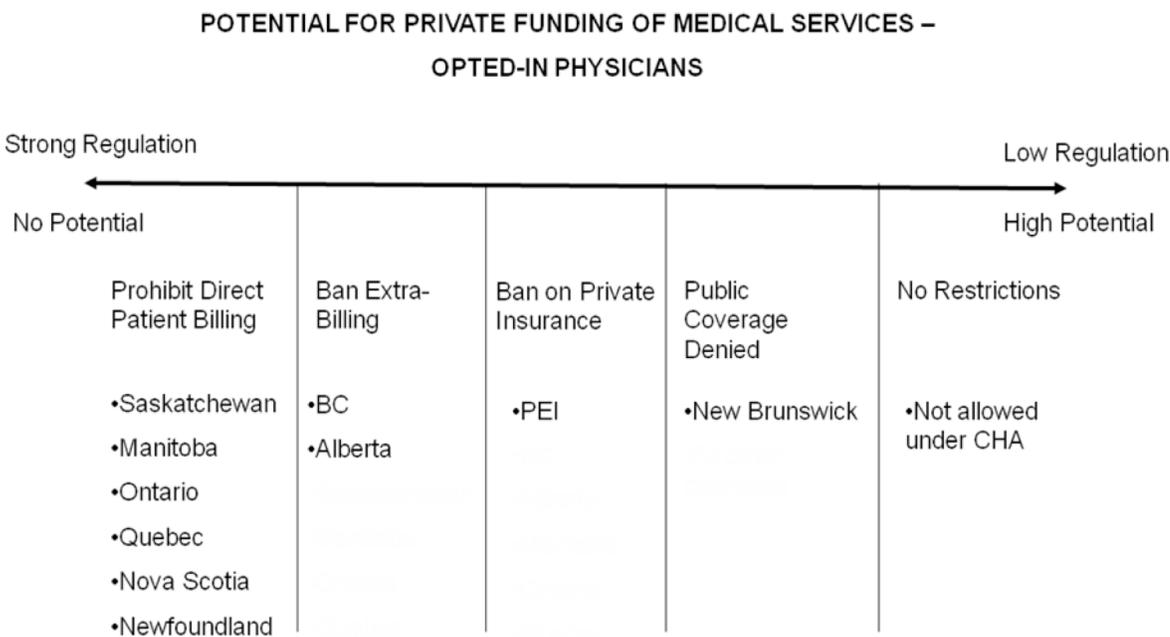
⁵⁶ In 2005, no physicians in Newfoundland had opted-out of the Newfoundland medical care program. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/pt-plans/nl_e.html#f1

Opted In Physicians

The potential for private funding of publicly-insured services provided by physicians participating in the public health insurance plan is closely related to their ability to combine both private and public income streams (discussed more fully below.) In order for physicians participating in the public plan to have access to both public and private income streams for services covered under public plans, they require the ability to bill patients directly. If opted-in physicians bill patients (or at least some patients) directly for services, the patient pays the bill and then must receive compensation from the public plan, absorb the cost directly, or receive compensation from a third-party indemnity insurance plan. In any case, the billing physician may not even be aware of the party which ultimately bears the burden of the payment.

Currently, the practice of participating physicians billing patients directly is allowed only in Alberta, British Columbia, New Brunswick and PEI. (See Figure 2.) In all other provinces, physicians who opt into the public plan are not able to bill patients directly and, therefore, have no means by which to collect private payment for publicly-insured services. In these four provinces which allow direct billing of patients by physicians participating in the public plan, Alberta and British Columbia do not allow billing at rates which are higher than the public fee schedule and, in turn, there is no incentive for patients to insure for those services.

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



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

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

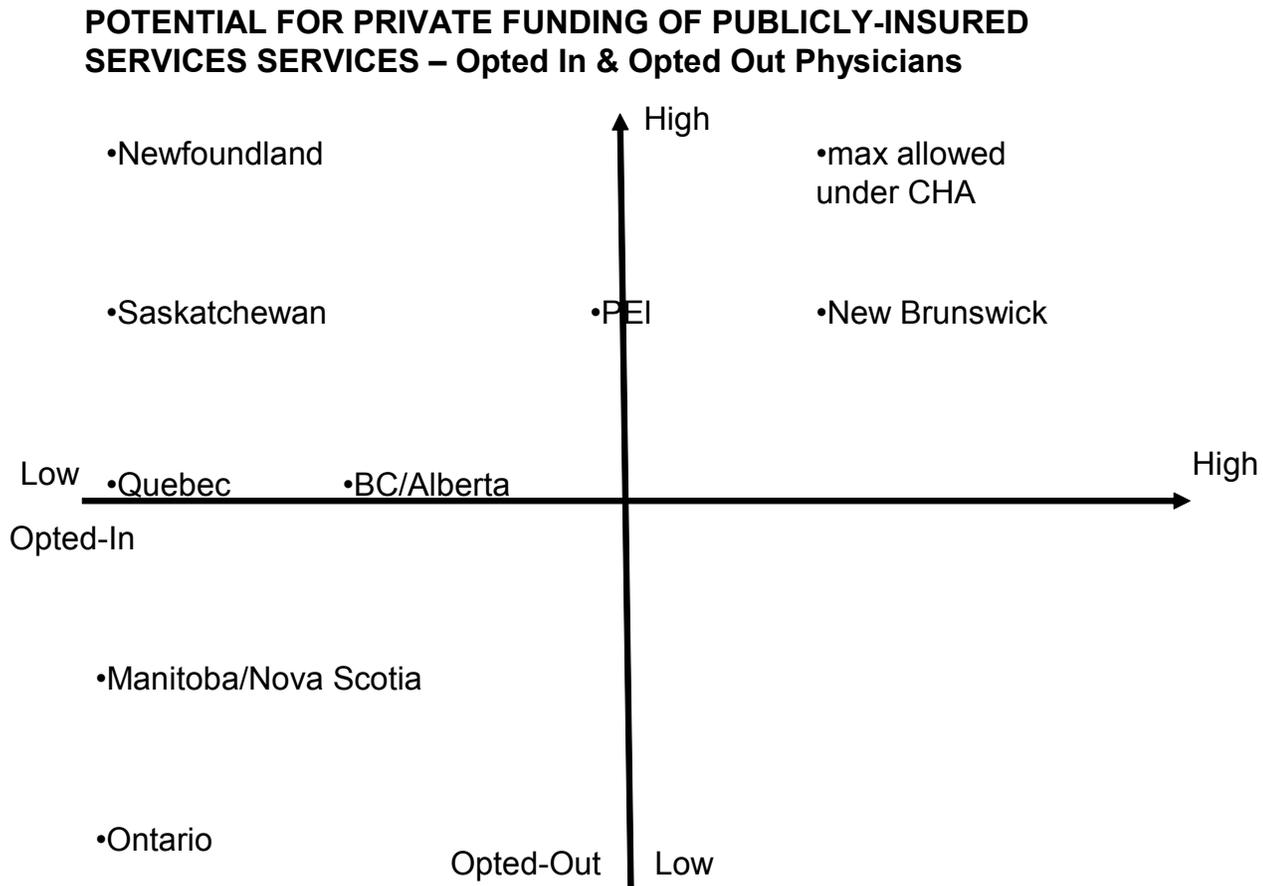


Figure 3 combines the regulation of non-participating and participating physicians and highlights at least two aspects of provincial regulation of private funding for publicly-insured services. First, there is wide variation among provinces in their approach to such regulation and little clustering of provinces on a given approach although provinces differ more significantly in their treatment of opted-out physicians than in their treatment of opted-in physicians. Secondly, no province allows for private funding to the full extent allowed under the *CHA*.

The Public-Private Divide

A critical issue in the regulation of private funding is the degree to which these systems enforce a sharp distinction between private and public income streams for service providers with providers opting-into the public plans receiving income only from public sources for insured services and providers opting-out receiving income only from private sources for otherwise publicly-insured services. Emphasizing the imagery of such a sharp distinction, Flood and Choudhry assert that “[i]n all provinces, physicians can opt out of the public system and operate wholly in the private sector – but they cannot work in both.”⁵⁷

In contrast to this claim that in all provinces physicians are prohibited from working in both the “public” and “private” systems, there are two sets of circumstances in which physicians can be said to be allowed to work both in the public and private systems: first, where physician services are billed directly to patients at unrestricted rates and receive public subsidization and, second, where physicians (whether opted in or opted out) are able to receive public payment for some services (at rates restricted to the provincial fee schedule) and private payment for other

⁵⁷ Flood and Choudhry, 2002: 15. Flood and Archibald note that, with the exception of Newfoundland, “...physicians must opt in or out of the public plan and thus are effectively prevented from working in both the public and private sectors.” Flood and Archibald, 829.

services. The first set of circumstances occurs in Newfoundland where non-participating physicians may direct bill at rates above the provincial fee schedule with patients then being reimbursed (up to the provincial fee schedule) by the province.

The second set of circumstances obtains for opted-in physicians in both New Brunswick and PEI who may bill patients directly at rates above the provincial fee schedule for some services (though with no provincial compensation being provided for those services) while also billing the provincial plan directly for other services. In New Brunswick, patients are allowed to carry private insurance for such instances while, in PEI, private insurance coverage is prohibited. In PEI, opted-out physicians may also provide services for which patients are reimbursed by the public plan (if they are not billed at rates above the provincial fee schedule) while also billing for services (if they are billed at rates above the provincial fee schedule) which are not eligible for public benefit payments.

In each of these instances, physicians are allowed to combine both public and private income streams for publicly-insured services and, thus effectively, are allowed to work in both the public and private system. These sets of circumstances again emphasize central points made earlier. Firstly, the *CHA* regulations focus on the status of services and not on the status of service providers. Secondly, provinces vary significantly in how they regulate the mixing of public and private income streams for publicly-insured services. Thirdly, provinces also vary significantly in their regulation of private insurance – regulation that is neither specified in or required by the *CHA*.

Discussion

Taking existing practices in the Canadian provinces as the starting point, the maximum allowance for private funding, provision of services, and private insurance given existing provincial practices is as follows:

- no restrictions on the private purchase of health services where fully privately funded;
- no restrictions on the provision of private insurance for health services (restrictions only on public reimbursement for health services);
- allowing non-participating physicians to bill privately at unrestricted rates with patients being reimbursed (up to the public rate schedule) while allowing patients to insure for the difference;
- allowing participating physicians to bill the public plan directly for some services (at rates limited to the provincial fee schedule) and bill some patients directly for services at unrestricted rates (without public compensation) with the patient being able to insure for the latter.

All of these practices are currently allowed by legislation in various provincial jurisdictions. To the extent that existing provincial legislation is presumed to be *CHA* compliant, the combination of the four practices above could also be presumed to be *CHA* compliant. As noted above, there is nothing that binds the federal government to accept these practices as *CHA*-compliant; however, it would be much more difficult politically to levy penalties against these practices which are currently allowed under provincial legislation in other provinces.

Other practices (for an inventory of alternatives, see Table 3) may be considered *CHA* compliant based on federal interpretations to date of *CHA* requirements – most notably, the interpretation of user fees as outlined in the Marleau letter. The Marleau letter clearly outlines that facility fees are not *CHA* compliant in cases where the physician fee is covered under the provincial plan. The converse of this interpretation is that, if the physician fee is *not* paid under the provincial plan, any associated facility fee is not, by definition, a user fee contrary to the *CHA*. In the case of participating physicians billing patients directly according to the method outlined above, the charging of facility fees by either private or public facilities for those services would not constitute a user fee in contravention of the *CHA*.

Table 3: Private Funding Sources and CHA Compliance

| Mechanism | Provinces Allowed/ In Use | CHA Compliance | Notes |
|---|--|--|---|
| Co-Payment* | None | Not CHA compliant | |
| Extra-Billing** | None | Not CHA compliant | |
| Public Insurance Premium | Ontario, British Columbia | CHA compliant | -failure to pay premium must not restrict access to publicly-insured services |
| Private Insurance | Saskatchewan, New Brunswick, Nova Scotia, Newfoundland | CHA compliant | -CHA does not require regulation of private insurance |
| Allowing Physicians to Bill Both Publicly and Privately | New Brunswick, Prince Edward Island, Newfoundland | CHA compliant | -PEI and Newfoundland allow public reimbursement for unrestricted fees charged by opted-out physicians |
| Facility Fee (User Fee) | *** | CHA compliant under specific circumstances | -facility fees are CHA compliant (charged by private or public facilities) if physician fee is not covered by public plan |
| Enhanced Service Fee | **** | CHA compliant under specific circumstances | -enhancement must not be medically-necessary and must relate to quality of service (must not allow quicker access) |
| Annual Registration Fee | British Columbia | CHA compliant under specific circumstances | -failure to pay access fee must not restrict access to publicly-insured services |
| MSA Corridor | None | CHA compliant under specific circumstances | -failure to pay charges must not restrict access to publicly-insured services |

*Co-payment here refers to a fee charged to the patient by the public insurance plan for services that are billed directly to the plan.

**Extra-billing here refers to a fee charged to the patient by the physician for services that are billed directly to the plan.

***Physician fees at rates above public schedule are billable (but not publicly covered) in New Brunswick and PEI (opted-in physicians) and British Columbia, Alberta, Saskatchewan, Québec, New Brunswick, PEI and Newfoundland (opted-out physicians). In these case, facility fees may be being charged but there is no requirement that they be publicly reported. I am not aware of instances of public facilities charging facility fees for services where the physician fee is not covered by the public plan.

****Unknown. However, this is a common practice and fees for enhanced service quality are probably in effect in all provinces.

While this would certainly also be the case in regard to non-participating physicians if there were no public compensation for such services, it may also be the case with regard to non-participating physicians billing patients directly at unrestricted rates where patients are reimbursed for costs up to the provincial fee schedule (as is currently allowed in Newfoundland.)

Given this interpretation, a province which allowed the charging of facility fees where the physician fee is not covered by public insurance, would not have to report these fees as user fees under the *CHA* reporting requirements. Should the federal government choose to interpret such fees as prohibited user fees, it would be free to do so under ministerial discretion (either under provisions relating to the reporting of user fees or the general accessibility criterion) although the federal government has never yet exercised these provisions. Certainly, the politics of doing so would be much more complex than is the case for practices where the province is bound to report the charging of fees and the federal minister is obligated to impose federal transfer reductions.

An additional issue that has percolated onto the political agenda is the charging of annual registration fees by private facilities which then offer a mix of uninsured and insured services. Such fees contravene the *CHA* only if non-payment of the annual registration fee blocks or reduces patient access to publicly insured services. In British Columbia, the Medical Services Commission audited one Vancouver clinic charging annual registration fees to determine whether its practices were *CHA* compliant and determined that "...the clinic was operating within provincial and federal laws because there was no evidence of extra billing or enhanced services related to the fees."⁵⁸ The issue is not whether all patients in the clinic receiving insured services have paid the annual registration fee. A private clinic's patient list may become filled (a matter determined by the physician) with patients who are paying the registration fee without the clinic actually denying care to prospective patients unwilling to pay the annual registration fee.⁵⁹

The central issue in regard to annual registration fees is whether non-paying patients are expressly denied access to insured services. Two situations are most likely to establish *CHA* non-compliance: first, where two patients with identical health needs attempt to receive insured services from a private clinic with the clinic refusing to provide services to the patient who did not pay the annual registration while simultaneously agreeing to provide insured services to the patient who agreed to pay the fee and, secondly, where a registered patient discontinues payment of the annual registration fee and subsequently is removed from the patient list and, as a result, denied access to insured services. However, in the absence of such practices, annual registration fees appear to be otherwise *CHA*-compliant – subject to the caveat that the federal government could always unilaterally issue an interpretation of the *CHA* to the contrary should it choose to accept the political trade-offs and challenges inherent in doing so.

There are basic but important conclusions that flow from this analysis: it will be politically more difficult for the federal government to implement transfer reductions for access fees when, as in BC, they are not reported as extra-billing by the province and when they are allowed in other provinces (where they were investigated and found to be *CHA* compliant) than if neither of these conditions were to obtain. Similarly, it is politically more difficult for opponents of such fees to oppose them if they are *CHA* compliant than if they are not.

PROPOSED PROVINCIAL REFORMS AND THE *CHA*

The following section examines proposed reforms in both Alberta and Québec in terms of their compliance with the *CHA*. Alberta has had two major reports over the past seven years outlining major new directions for health care reform – the major elements of which are summarized in Table 3. While neither report uses rhetoric challenging the *CHA*, both reports recommended against significant changes that could be made under the *CHA* while, at the same time, including reforms that would violate the *CHA*. In both cases, the *CHA* did not constitute the main constraint on reform as the government chose not to proceed with even with the elements of reform that were *CHA*-compliant.

58 Michelle Lang, "\$3,000-a-year Will Get You Privileged Care," *Calgary Herald*, 16 April 2008, A1.

59 Michelle Lang, "Private Clinic Willing to Treat Patients for Free," *Calgary Herald*, 18 April 2008, B5.

Premier's Advisory Council on Health – The Mazankowski Report

In December 2001, the Premier's Advisory Council on Health made recommendations in a wide range of areas including health financing. Despite recommending further study of an option that would clearly contravene the *CHA* while dismissing another option that would clearly not contravene the *CHA* (on the basis that it would), the Report concludes that "We believe our recommendations are consistent with the spirit and intent of the Canada Health Act." (72)

Several of the Report's recommendations proposed significant changes within the parameters of the *CHA*. First, the Report argued that "Physicians should be able to work in public, private or not-for-profit systems and retain their privileges at public hospitals." (51) As outlined above, the *CHA* only makes reference to the status of health services and not the status of health care providers. The Report also recommended, pursuant to "further study," variable health care premiums which would vary based both on income as well as health service usage. (61) Premiums, regardless of whether they vary according to health service usage, do not contravene the *CHA* unless non-payment of premiums results in the denial of access to public health services. (See Table 3.) The Report also considered private insurance.⁶⁰ The Report did not recommend "expanding private insurance for publicly funded services..." but, rather, concluded that "...this approach *would clearly contravene* the Canada Health Act." (56, italics added) However, there is nothing in the Report's description of private insurance which is contrary to the *CHA* (which has no provisions relating to private insurance) and private insurance, as described in the Report, is allowed under provincial legislation in five other Canadian provinces.

Instead, the Report recommends the further study of medical savings accounts -- as one of two reforms (along with variable premiums) having "the most positive features." (61) The Report, however, notes that "...if people are required to pay for some services once their medical savings account is exhausted, this *may* contravene the Canada Health Act." (58) However, if individuals have to pay for medically necessary services (above a certain total spending limit) in order to receive those services, this would *clearly* contravene the *CHA*. (See Table 3.)

Rather than moving ahead on those aspects of the report which could be implemented without contravening the *CHA* including allowing physicians to mix public and private income streams for publicly insured services and removing the province's ban on private insurance, the recommendations of the report would languish in face of opposition, in part, to possible violations of the *CHA* – thus setting the stage for another set of reform proposals.

Alberta's Health Policy Framework

Released in February 2006, Alberta's *Health Policy Framework* proposed ten new directions for reform of the existing health care system. While being couched in very careful language, the Alberta proposals contained elements (typically designated "for discussion") that, if adopted, would violate the *CHA*: requiring co-payments (e.g. user fees) for non-emergency acute care or allowing public facilities to charge for expedited access to services where the physician fee is billed directly under the provincial plan. At the same time, many elements of the Alberta proposals which appear to be relatively radical shifts in policy – such as allowing third-party private insurance for services provided by both opted-out and opted-in physicians, allowing both opted-out and opted-in physicians to combine both public and private incomes sources, and encouraging public facilities to charge facility fees for privately-funded services – are within the bounds of the *CHA* and currently, in a number of cases, are allowed in other Canadian provinces.

⁶ Alberta, *Getting On with Better Health Care: Health Policy Framework*, August 2006. Accessed online on 16/05/2008 at <http://www.health.alberta.ca/key/health-care-renewal.html>.

Of those recommendations most germane to the issue of private funding and private health insurance, several

⁶⁰ In the Report, a system allowing private insurance is defined as follows: "People would be able to choose to get both insured and non-insured health service at a private facility. They could pay for these services directly or through some form of private or supplementary insurance. The public system would continue to provide the full range of insured health services." (56)

proposals would entail a significant shift in current practice but would not pose a challenge to the *CHA*. The report (Direction 5) suggests reshaping the role of hospitals and, although vague, makes reference to the possibility of “delivering more services through private surgical facilities.” (13) While essential health services would still be publicly funded, Direction 6, emphasizes limiting publicly-funded health services by excluding health services which are “discretionary, are not of proven benefit, or are experimental in nature...” (14) and leaving those services to be financed either by patients directly or through third-party insurance. The latter would increase the scope of private funding and the potential for private insurance but is not a violation of the *CHA*.

The report (Direction 7) commits the government to examining alternatives to the single-payer public insurance system – including co-payments and private insurance options -- while noting the need to “...consider how to implement safeguards to protect the public system and how to provide benefits to those unable to afford private insurance.” (14) Co-payments, fees charged to the patient by the public insurance plan for services that are billed directly to the plan, for non-emergency but medically-necessary services would clearly contravene the *CHA*. (See Table 3.) That said, the report is carefully couched and only commits the Alberta government to “examining how various alternative funding mechanisms...would work in this province.” (14)

In regard to private insurance, the provincial government had announced in 2005 that it would begin a process of studying the possibility of ‘opening up’ the health care system to private insurance. Rather than simply removing legislative bans on the provision of private insurance, the Alberta government publicly called for requests for proposals to undertake an actuarial review of providing private health insurance for publicly-provided health services. Implicit in the proposal was a highly directive approach to opening up the health care system to market forces including approving a single private insurer to provide such insurance. While this initiative stalled, the 2006 report revisits the role of private insurance. While much of the 2006 proposal focuses on service areas which are currently outside universal public health insurance coverage (e.g. prescription drugs, dental services, etc.), the proposal also makes reference to the possibility of introducing third-party private insurance for non-emergency acute care. In terms of allowing third-party insurance for non-emergency acute care, the *CHA* has no restrictions against Alberta lifting its current ban and, as outlined above, four provinces have no such ban.

The proposals (Direction 9) also recommend allowing health care providers to both bill publicly for some procedures and bill privately for others in contrast to the current legislation which requires that a provider must completely opt out of the public system completely in order to undertake any private billing for insured services. Certainly, allowing physicians to bill some of the services they perform publicly and others privately would remove legislative barriers to the growth of privately funded services. As outlined above, the mixing of public and private income sources is allowed for opted-out physicians in PEI (where individual services are either paid publicly in full or privately in full) and Newfoundland (where payment for individual services can combine partial public remuneration with partial private remuneration) while mixing of public and private incomes sources (though not for individual services) is allowed for opted-in physicians in both PEI and New Brunswick.

This section of the report also discusses “...allowing both public and private providers to offer enhanced services and expedited access to a limited range of ‘non-emergency’ services at an appropriate charge.” (16) Whether charged by a publicly-funded hospital or a privately-owned clinic, such charges would be a violation of the *CHA* if the associated physician services were paid for under the public insurance plan. However, this would not be the case for charges by private or public facilities where the associated physician fees are not paid publicly. It may also not be the case if the services were to be provided by a non-participating physician where the patient would then be eligible to be reimbursed with public funds (up to the provincial rate schedule) as is currently allowed in PEI and Newfoundland.

Following a public consultation process subsequent to the release of the *Health Policy Framework*, Alberta released a revised version of the recommendations in August 2006.⁶¹ The revised report does not include the proposals under the headings of Direction 7 and Direction 9 in the February report (please see above). The remaining recommendations are not directly related to the issue of public and private funding of health services and, as financial reimbursement for health services is the main focus of the *CHA*, do not implicate issues which fall under the purview of the *CHA*.

Québec Health Reforms -- The Castonguay Report Proposals

More recently, the Castonguay Report, made public in February 2008, proposes an additional range of reform alternatives. The report clearly creates the perception that the proposed changes to the Québec health system would contravene the *Canada Health Act* and reinforces the perception of a dichotomy between minor adjustments which respect the *CHA* and radical reform that challenge the *CHA*. Certainly, this perception was evident in media coverage of the report: “Some of Mr. Castonguay’s key recommendations also would lead to a confrontation with Ottawa, since they go squarely against the *Canada Health Act*.” (Gagnon, 2008) This perception is not surprising considering that the Task Force states bluntly: “The federal government must ease the requirements contained in the *Canada Health Act*.” (Québec, 2008a: 5) The Task Force concludes that “The *Canada Health Act*...hampers progress in defining the public health systems of the provinces.” Furthermore, “...sooner or later, the *Canada Health Act* will have to be adapted to current realities.” (Québec, 2008a: 23) There are two aspects to the report: those that deal directly with the *CHA* and, secondly, the substantive proposals for health service funding and provision which have implications for *CHA* compliance.

The Task Force was mandated to “...formulat[e] recommendations on the best means to ensure adequate health care funding” and, in so doing, to “study changes that could be suggested so that the *necessary* adjustments are made to the *Canada Health Act*.” (2008b: 1, italics added) The chapter of the report which details this study is a scant five pages and, ultimately, no specific recommendations are made in regard to the *CHA* with the exception of the call outlined above to ease *CHA* requirements. The Report tersely notes: “Since 1984, the provincial health care systems have been closely governed by the random interpretation of the five criteria of the federal Act.”⁶² (2008b: 255) However, the Report does not acknowledge that no province has ever been penalized under the five criteria outlined in the *CHA*.⁶³ The Task Force report is highly critical of the imprecision of the *CHA*: “...there is no longer anyone who can say for sure, without consulting a lawyer, exactly what services are really insured, within what time period, by who and in what circumstances they must be produced.” (2008b: 257) This clearly misses the point of the Report’s own legal analysis.⁶⁴ The *CHA* is not legally enforceable, it is not a contract between two parties, and it does not confer rights on citizens which can be invoked to force provinces to provide health services in any particular way. The critical point is that *CHA* enforcement is primarily a political – not legal – issue.

61 Alberta, *Getting On with Better Health Care: Health Policy Framework*, August 2006. Accessed online on 16/05/2008 at <http://www.health.alberta.ca/key/health-care-renewal.html>.

62 The Task Force concludes that it has been “via the five criteria” that the federal government “...seized this opportunity to introduce tight control...over the provincial hospitalization and medical care plans and their operation.” (2008b: 253)

63 Nevertheless, this criticism of the *CHA* is not surprising given that, as the Task Force notes, the *CHA* “...is contested by the Québec government[.]” (Québec, 2008a: 23)

64 The Task Force commissioned a legal study in regard to the *CHA* which concluded that “From the legal standpoint, the *Canada Health Act* does not confer any rights on persons that they could invoke to have their province adopt measures intended to give them access to health services that would be in compliance with the Canadian legislation.” (2008b: 255) The central implication of this interpretation is that the *CHA* is non-binding.

In fact, there is very little scope for potential conflict between the Castonguay recommendations and *CHA* legislative requirements. The report recommends allowing physicians to engage in ‘mixed medical practice’ (allowing physicians to practice simultaneously both with the public and private systems.) As outlined above, this practice is currently allowed in other Canadian provinces. The report also recommends that the government review the scope of services covered under the public system. The Report is careful to frame its proposals for qualitative limits on the provision of health care by defining “medically necessary” in a way that would ensure that the criteria of comprehensiveness would continue to be met as all medically necessary health services would continue to be insured. The Task Force recommends a tax-based deductible charge for use of health services. As the Report argues, the tax deductible approach differs from user fees in one critical way: “the user fee is a direct obstacle to access to care, because it is collected at the same time as the care is claimed...” while the tax deductible is not collected at the time the service is used nor, presumably, would failure to pay the tax deductible result in ineligibility to receive public health services in the future. (226) As such, it would not infringe the *CHA* ban on user fees. Finally, the Report recommends that “health clinics...would be entitled to collect an annual contribution from registered patients.” (2008b, 237) As discussed above, such fees do not constitute a financial barrier to access if payment of the fee is not required to access insured services.⁶⁵

The Report notes a number of hypothetical examples of ways in which the *CHA* could potentially block health system innovation. (2008b: 255-6) The Task Force notes that the Québec government is hesitant to limit access to care: “In the past, the Gouvernement du Québec actually used these powers, particularly to limit the age at which vision examinations and dental care are covered. But it hesitates to do so when medical and hospital care are involved, particularly out of fear that the federal government will rely on the *Canada Health Act* to penalize the provinces financially.” (2008b: 59) However, the Task Force gives no examples of any ways in which the *CHA* constrains any recommendations for action the Task Force would have otherwise made.

In response to its direct mandate to suggest changes to the *CHA* necessary to implement its recommendations on the best means to ensure adequate health care funding, the Report does not make a single recommendation. The central message of this, in light of the concrete recommendations of the Report, is that significant health funding reform can occur under the auspices of the *CHA*.⁶⁶ The important question which remains is whether such reforms are judged to be politically feasible.

PUBLIC OPINION ON PRIVATE HEALTH FUNDING AND INSURANCE

While public opinion in Alberta is often seen as generally supportive of market-based solutions to policy problems, public opinion polling strongly suggests that Albertans are, in fact, less receptive to private funding and insurance alternatives in the health field than Canadians on average.⁶⁷ This pattern of public support mirrors cross-provincial patterns in the relative stringency of regulation of private health funding and insurance relative as outlined above.

65 The recommended fee in Québec would be \$100 annually and it may be argued that this does not pose an unreasonable barrier to access.

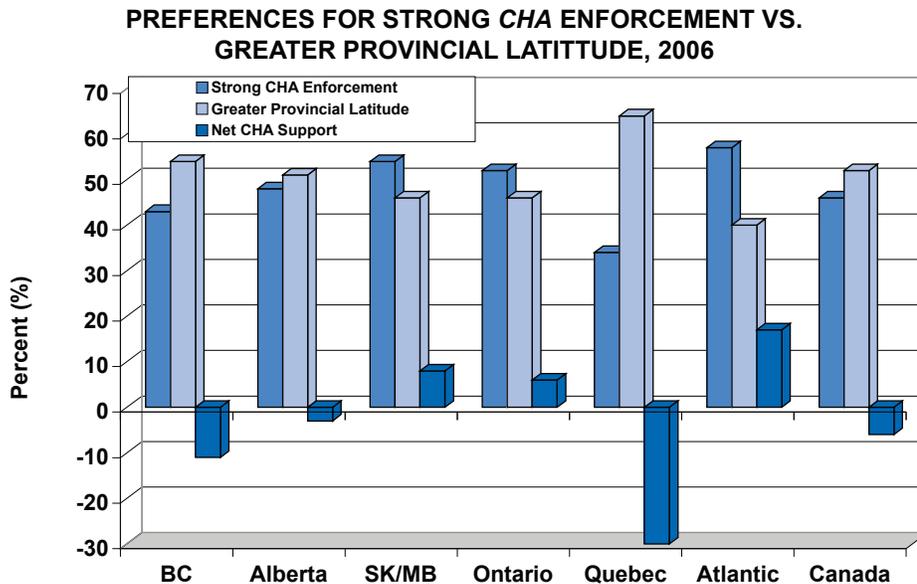
66 Somewhat surprisingly, the Task Force concludes: “The Task Force is convinced that the orientations proposed in its report not only respect the spirit of the five criteria of the *Canada Health Act*, but would have the effect of improving access and the quality of care.” (2008b: 257)

67 This conclusion is consistent across a wide number of polls done recently (since 2005) by a number of Canadian polling firms including Environics, Compas, Pollara and Ipsos-Reid.

Public Support for the CHA and Its Central Principles

Overall public opinion in Canada is relatively evenly divided between support for strong enforcement of the *CHA* versus support for allowing greater provincial latitude in the provision of health services. (See Figure 4.) Similarly, Albertans are relatively evenly divided on the question. Certainly, Alberta does not exhibit exceptional support for allowing greater provincial latitude in health care as does Québec. Even of the English Canadian provinces, Alberta is not the most supportive of greater provincial latitude – an option which receives more support in British Columbia.

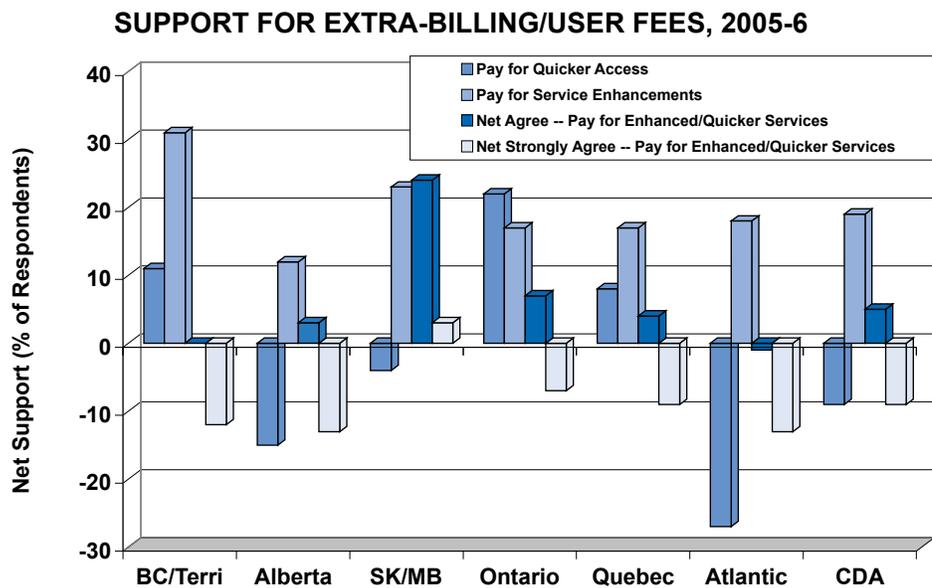
Figure 4: Support for Strong *CHA* Enforcement, 2006



Source: Ipsos-Reid, *Canadian Federation of Nurses Associations*, 2006.

Nor is Alberta public opinion exceptional in regard to allowing extra-billing and user fees. In Figure 5, the first two columns for each province report the net support (percentage of respondents in favour minus the percentage of respondents opposing) for allowing payments for quicker access and payments for service enhancements. In comparison with BC, Ontario and Québec where net opinion was in favour of allowing payment for quicker access, net opinion in Alberta was opposed – more strongly, in fact, than the national average as well as other provinces/regions with the exception of Atlantic Canada. While net opinion across all regions is in favour of allowing payments for service enhancements, this option receives the least support in Alberta.

Figure 5: Support for Paying for Quicker Access and/or Service Enhancements, 2005, 2006



Source: Support for ‘Pay for Quicker Access’ and ‘Pay for Service Enhancements’ – Pollara, *Health Care in Canada*, 2005; net agree and net strongly agree with pay for enhanced/quicker services -- Ipsos-Reid, *Canadian Medical Association Survey*, 2006.

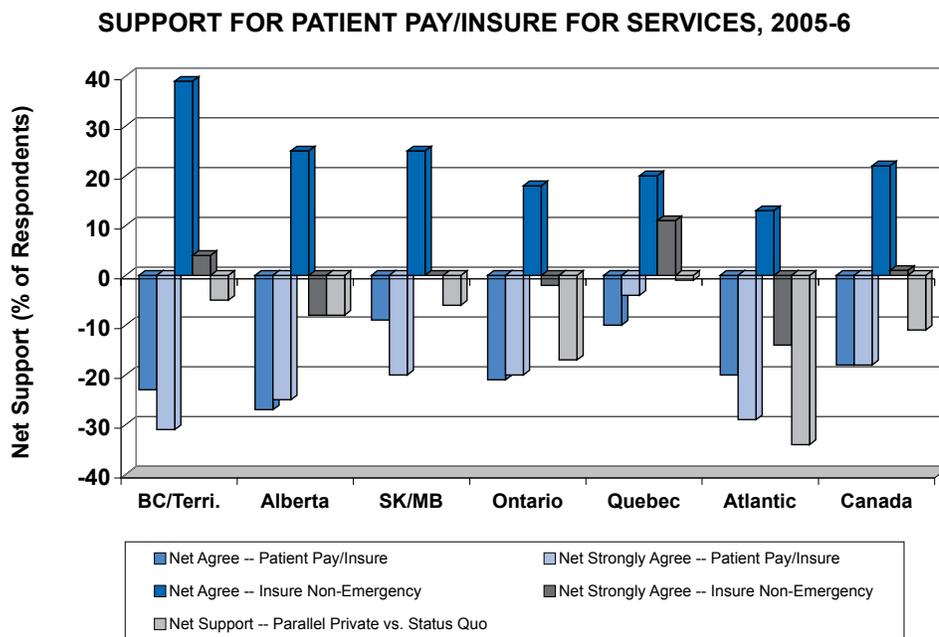
Notes: The second set of questions (Ipsos-Reid) asks respondents if they strongly agree/agree/disagree/strongly disagree that the ‘best health care system’ would be one in which government pays only for emergency or essential care with an option for patient payment for enhanced or quicker services. ‘Net agree’ reports the total percentage of agree/strongly agree responses minus the total percentage of disagree/strongly disagree. ‘Net strongly agree’ reports the percent of strongly agree responses minus the percentage of strongly disagree responses.

In Figure 5, the third and fourth column for each province report agreement with the statement that the best health care system would be one in which the government pays for emergency and essential medical care while patients would have the option to pay for enhanced or quicker services. Overall support is similar among Albertan and Canadian respondents more generally with opinion being marginally in favour. However, examining only respondents with strong opinions in favour or against, Alberta is among the provinces/regions (along with British Columbia and Atlantic Canada) where this model receives the most opposition.

Public Support for Private Purchase and Insurance of Services

As argued above, Alberta goes beyond the requirements of the *CHA* in banning the private provision/purchase of certain health services as well as in banning private insurance for all publicly-insured services. There is strong public support in Alberta for these regulations and Alberta is not exceptional in this regard.

Figure 6: Support for Patient Paying/Insuring, 2005, 2006



Source: ‘Net Agree – Patient Pay/Insure,’ ‘Net Strongly Agree – Patient Pay/Insure’ and ‘Net Support – Parallel Private vs. Status Quo’ from Ipsos-Reid, *Canadian Medical Association Survey*, August 2006; ‘Net Agree – Insure Non-Emergency’ and ‘Net Strongly Agree – Insure Non-Emergency’ from Pollara, *Health Care in Canada*, 2005.

In Figure 6, the first two columns for each province report responses to the question of whether respondents support allowing patients to pay for and/or insure for services when the public system does not provide timely access to those services. Of all provinces, opposition among all respondents is highest in Alberta. When examining only those with strong opinions, opposition in Alberta remains significantly above levels in Canada in general although lower than in Atlantic Canada and British Columbia.

The next two columns for each province report agreement with the statement that patients should be allowed to insure and/or pay for non-emergency services outside of the public system. The balance of public opinion among all respondents across all provinces/regions is favourable with opinion in Alberta (26% net in favour) being only slightly more favourable than the national average (22% net in favour.) However, examining only respondents with strong opinions in favour and against, opinion in Alberta is the most resistant except for the Atlantic provinces.

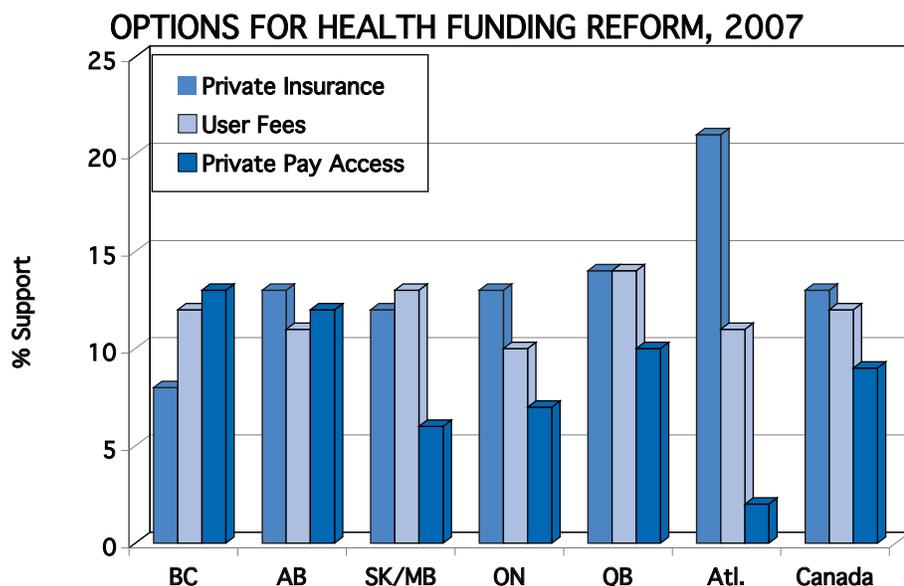
A similar pattern emerges in regard to support for a parallel private system versus the status quo.⁶⁸ Comparing net levels of support for a parallel private system versus the status quo, Alberta respondents were slightly less opposed on balance than Canadian respondents more generally but more resistant than respondents in BC, Saskatchewan, Manitoba and Québec.

Respondents were asked which of six options they would most strongly support if more money was needed to improve the health care system. Albertans, along with respondents from all provinces, were most strongly supportive of moving money from other policy areas to health care (31%). Of the three main alternatives to increasing public funding (either through budgetary shifts or increased taxes as reported in Figure 7), Albertan respondents were relatively equally split among allowing private insurance (13%), requiring patients to pay a portion of the costs [user

⁶⁸ Respondents were asked about their support for four options. The medicare plus private parallel system scenario would include a public system providing universal coverage of services but allowing individuals the option of purchasing private insurance for all services (with tax incentives to promote access) and allowing physicians deliver services in both systems. Ipsos-Reid, 2006: 6.

fees] (11%) and allowing off-hours access for private paying patients (12%). In all three cases, levels of provincial support closely matched the national average although support for off-hours access for private paying patients was somewhat higher in Alberta than in Canada as a whole (9%). However, for none of these options was Alberta public opinion the most supportive of all provinces.

Figure 7: Support for Options for Health Funding Reform, 2007



Source: Pollara, *Health Care in Canada*, 2007. [Question 19.]

Notes: Respondents were asked to identify one of six options in response to the following question: “If more money was needed to improve the health care system, which of the following options would you most strongly support?” The six options were as follows: moving money from other non-health care, having private insurance cover portion of cost, increasing taxes and directing it to the health care system, requiring patients to pay portion of costs, off hours access for private paying patients, and off hours access for patients from other countries.

Overall, the public opinion data discussed above suggest that public opinion in Alberta is not exceptional in its resistance to allowing patients to pay or insure for services but it does appear to lie on the more resistant end of the cross-provincial spectrum. Not surprisingly, these patterns of public support are mirrored in the relative stringency of the regulation of private payment and insurance of health services in Alberta.

Explaining Public Opinion in Alberta

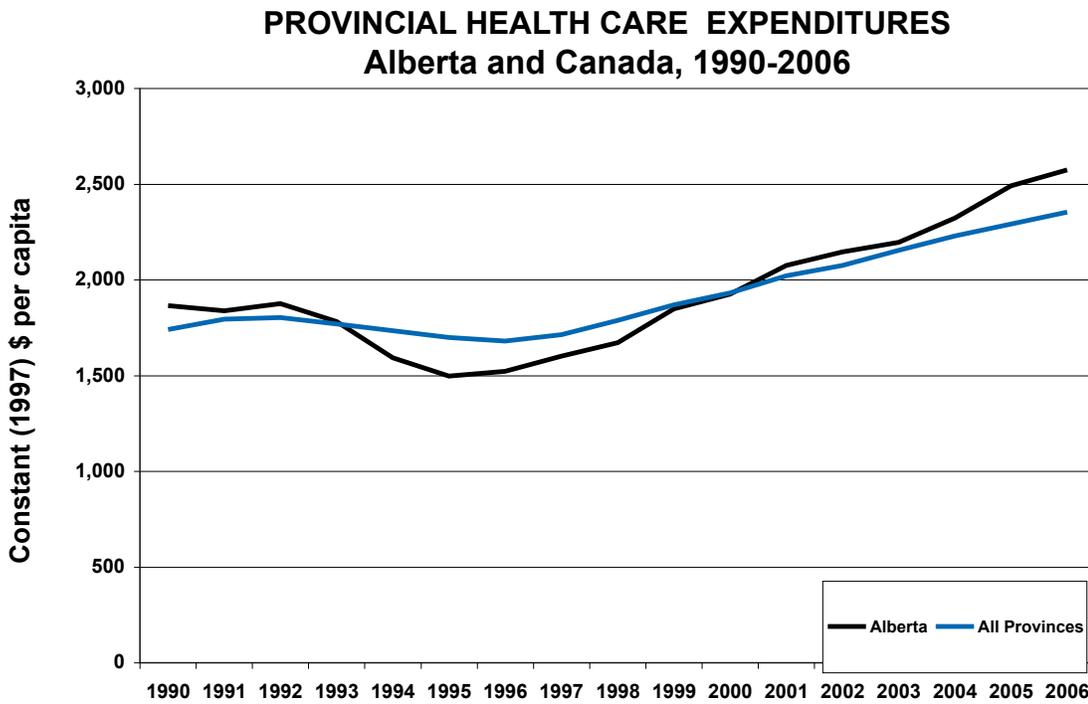
This raises the obvious question as to why Alberta public opinion is less favourable to private funding/private insurance than public opinion in other provinces. The next section considers three possible explanations: levels of public spending on health services, public perceptions regarding the quality of public health services in Alberta, and, finally, public perceptions regarding the impacts of private funding on the quality of health services.

Levels of Public Spending on Health Services

Perhaps the most obvious explanation for resistance to reform would be that the system is relatively well-funded. Health care expenditures in Alberta (in real dollars per capita) were at the national average in the early 1990s. (See Figure 8.) However, following cutbacks in Alberta, provincial expenditures fell significantly below the national

average. In the period from 1996 to 2005, health care expenditures grew at a faster rate in Alberta than nationally with Alberta surpassing the national average per capita expenditure after 2000.

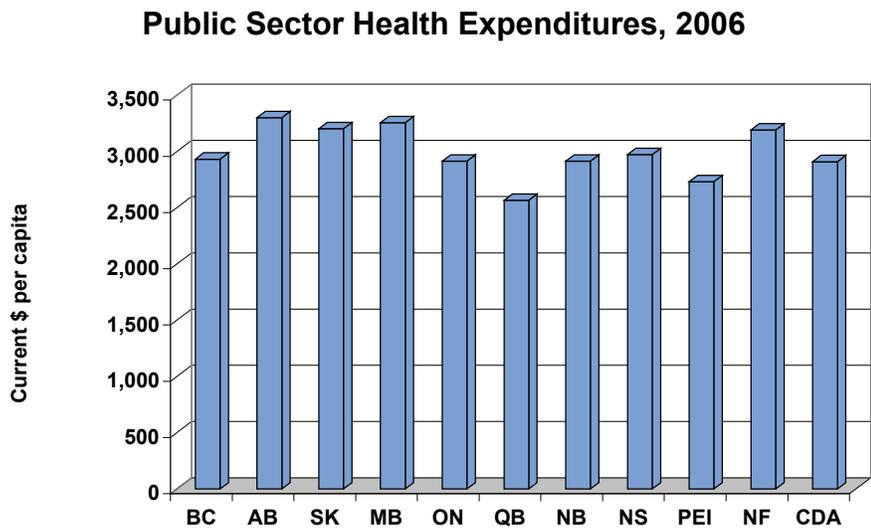
Figure 8: Public Health Care Expenditures in Alberta and Canada, Constant \$ per capita, 1990-2005



Source: Canada Institutes for Health Information, Statistics Canada. Table B.4.7.

Thus, by 2006, while provincial government health expenditures per capita in Alberta were comparable to expenditures in Saskatchewan, Manitoba, and Newfoundland, they were the highest of all provinces and just under 10% higher than the average for all provinces. (See Figure 9.) Perhaps more strikingly, the rate of growth in provincial health care expenditures has been highest in Alberta by a considerable margin over the six year period from 2000 to 2006. (See Figure 10.) Expenditure increases in Alberta from 2004 to 2005 were nearly double the national average. Expenditure growth in Alberta from 2005 to 2006 moderated but was still above the national average.

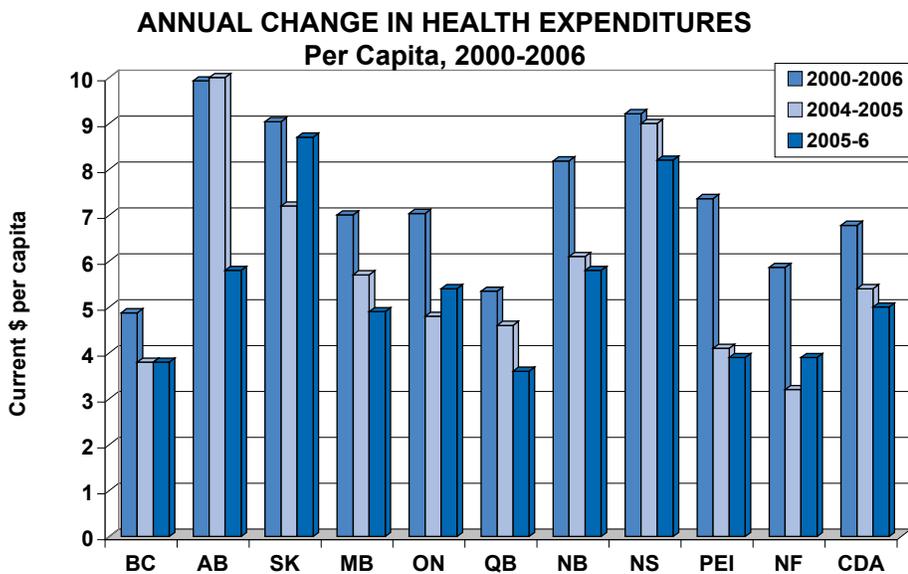
Figure 9: Public Health Care Expenditures in Alberta and Canada, 1990-2005



Source: Canada Institutes for Health Information, Statistics Canada. Table B.4.2.

Note: These expenditures are in current dollars per capita and are not comparable with expenditure data reported in Figure 8.

Figure 10: Change in Provincial Health Care Expenditures, All Provinces, real (constant) dollars per capita, 2000-2006



Source: Canada Institutes for Health Information, Statistics Canada. Table B.4.2. Constant dollars as calculated by author.

Public Perceptions of the Quality of Public Health Services

The comparatively high levels of expenditure and expenditure growth in Alberta may have a significant impact on the limited public demand for reform. Most simply, the limited appetite for reform in Alberta may be the result of higher levels of satisfaction with the quality of health services provided in this province with the latter being a function of comparatively high levels of public expenditure and expenditure growth. While there does appear to be a general relationship across provinces between overall levels of health funding and perceptions of quality and levels of personal satisfaction with health services, the evidence of Alberta exceptionalism in terms of public satisfaction with the health system is mixed.

Table 4: Total Health Expenditures (per capita), Public Health Expenditures as % of Total, and Change in Provincial Health expenditures, 2000-2006

| | Total Expenditure (\$ per capita) 2007 | % Public (provincial) 2007 | Annual Average % Change in Public (provincial) Expenditure (real \$ per capita) |
|----------|---|-------------------------------|--|
| | 2007 | 2007 | 2000-2006 |
| BC | 4713 | 71.5 | 2.0 |
| AB | 5390 | 74 | 6.4 |
| SK/MB | 5218 | 77.8 | 4.7 |
| ON | 4975 | 67.2 | 3.9 |
| QB | 4371 | 71.7 | 2.5 |
| Atlantic | 4946 | 76.6 | 4.8 |

Source: Canada Institutes for Health Information, Table B.1.2 (total expenditure), Table B.4.3 (provincial government expenditure as proportion of total expenditure), and Table B.1.4 (provincial government health expenditure) with constant dollars calculated by author.

Notes: Regional totals (SK/MB and Atlantic) are population-weighted averages as calculated by author. The public opinion data used in the correlations were not available on a disaggregated basis for these regions.

In their comparative examination across 26 nations (primarily North American and European), Tuohy, Flood and Stabile find that "...both the level of public funding and the public share of total health spending are significantly correlated with aggregate levels of satisfaction with the system as a whole."⁶⁹ The correlation of various measures of expenditure (including total health expenditures, public expenditures as a percent of total health expenditures, and change in provincial health expenditures as reported in Table 4) with both perceptions of the quality of available health services as well as perceptions of personal experiences with the health system in Tables 5 and 6.

⁶⁹ Carolyn Hughes Tuohy, Colleen M. Flood and Mark Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations," *Journal of Health Politics, Policy and Law*, 29, 3 (June 2004): 388.

Table 5: Expenditure Measures and Perceptions of Quality of Available Health Services

| % of Respondents | Report Card -- Quality of Available Health Services | | | | | | |
|------------------|---|-------|-------|------|------|-------|-------------|
| | A | B | C | F | A+B | C+F | (A+B)-(C+F) |
| BC | 25 | 38 | 32 | 5 | 63 | 37 | 26 |
| AB | 16 | 46 | 27 | 11 | 62 | 38 | 24 |
| SK/MB | 29 | 35 | 18 | 18 | 64 | 36 | 28 |
| ON | 22 | 42 | 26 | 10 | 64 | 36 | 28 |
| QB | 14 | 45 | 32 | 8 | 59 | 40 | 19 |
| Atlantic | 35 | 27 | 30 | 7 | 62 | 37 | 25 |
| Total 2007* | 0.05 | -0.01 | -0.46 | 0.36 | 0.39 | -0.33 | 0.37 |
| Change 2000-6* | 0.01 | 0.00 | -0.25 | 0.25 | 0.06 | -0.06 | 0.06 |
| % Public 2007* | 0.27 | -0.33 | -0.16 | 0.20 | 0.00 | -0.01 | 0.00 |

*rho squared

Source: Public opinion data from Ipsos-Reid, *Canadian Medical Association 2007 Report Card Study*. Information regarding online availability at <http://www.ipsos-na.com/news/pressrelease.cfm?id=3604>.

Notes: Expenditure measures (rows 7-9) correspond with the three measures presented in Table 4.

Table 6: Expenditure Measures and Perceptions of Personal Experience Accessing Health Services

| % of Respondents | Report Card -- Personal Experience Accessing Health Services | | | | | | |
|------------------|--|------|-------|-------|------|-------|-------------|
| | A | B | C | F | A+B | C+F | (A+B)-(C+F) |
| BC | 34 | 34 | 25 | 7 | 68 | 32 | 36 |
| AB | 28 | 46 | 17 | 7 | 74 | 24 | 50 |
| SK/MB | 30 | 39 | 19 | 13 | 69 | 32 | 37 |
| ON | 35 | 36 | 18 | 10 | 71 | 28 | 43 |
| QB | 29 | 37 | 22 | 11 | 66 | 33 | 33 |
| Atlantic | 33 | 37 | 20 | 6 | 70 | 26 | 44 |
| Total 2007* | -0.04 | 0.49 | -0.56 | -0.01 | 0.75 | -0.43 | 0.58 |
| Change 2000-6* | -0.17 | 0.72 | -0.76 | -0.03 | 0.74 | -0.66 | 0.73 |
| % Public 2007* | -0.22 | 0.12 | -0.01 | 0.00 | 0.00 | -0.01 | 0.00 |

*rho squared

Source: See Table 5.

Notes: See Table 5.

As illustrated in Table 5, there is no correlation between the three aggregated measures of perceptions of quality and either change over time in provincial health expenditures or public expenditures as a proportion of total expenditures. However, the relationship between these aggregate measures of perceptions of quality of available health services and total health expenditures are moderate and in the expected direction (with higher levels of spending being positively correlated with positive perceptions of health services and inversely related with the overall negative perceptions of health services.)

While Table 6 illustrates that there is no relationship between perceptions of personal experiences accessing health services and the proportion of total expenditures comprised of public expenditures, there is a strong correlation between perceptions of personal experiences and total levels of health service expenditure as well as change in provincial public expenditures from 2000 to 2006. These correlations are considerably more robust than the correlations between these expenditure measures and more general perceptions of the quality of available health services as examined above in Table 5.

Thus, while the comparative cross-national results of Tuohy, Stabile and Flood are not replicated in cross-provincial patterns in regard to a strong correlation between higher proportions of public spending and perceptions of the quality of health services, their findings do find some support in the correlation between total spending levels as well as increases in provincial spending over time and perceptions of personal experiences in accessing health services.

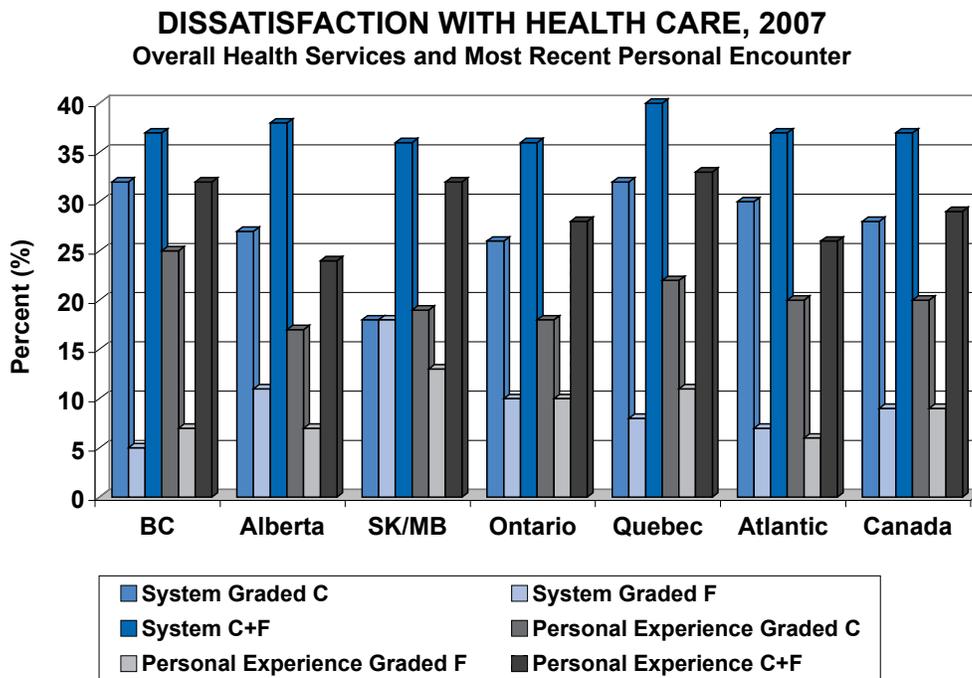
Contrary to these generalized patterns across provinces, when asked about their perceptions of the overall quality of the health care services available to them and their families, Albertan respondents are not exceptional despite the expectations generated by high levels of funding for health services in Alberta. As Figure 11 illustrates, the number of respondents assigning grades of C (27%) and F (11%) is very close to the national averages of 28% and 9% respectively. (See also Table 5.) Examining grades of C and F together as an overall indicator, Albertan respondents are no less likely to perceive the health services available to them to be of low quality than respondents in any other province (except Québec.) Thus, the general relationship between levels of funding and perceptions of quality found among all provinces does not apply in any direct sense to the specific example of Alberta.

The Tuohy, Flood and Stabile hypothesis as applied to Alberta finds only slightly more support in Albertan's perceptions of their own experience with the health care system. In terms of their grading of their own personal experience with the health care system, Alberta respondents are only slightly less likely to assign a grade of C (17%) or F (7%) than the national averages of 20% and 9% respectively.⁷⁰ (See also Table 6.) Similarly, Albertan respondents are also less likely than recipients elsewhere to assess their own personal experience a grade of A. However, Albertan respondents are significantly more likely than respondents elsewhere to assign a grade of B while recipients elsewhere are more likely to assign a grade of C. While it is possible that Albertans' more positive personal experiences with the health care system may help explain lowered support for alternative modes of health care financing, given the slightness of differences as well as the mixed evidence on this score, significant caution needs to be exercised in adopting such an interpretation.⁷¹

⁷⁰ These differences are not, however, statistically significant.

⁷¹ The other main poll to track satisfaction with health services is the Pollara *Health Care in Canada* survey asks respondents about their perceptions of the quality of health care *in Canada*. Albertans in 2007 were notably more likely than Canadian respondents more generally to answer in the affirmative. However, this marks a shift from 2006 when Albertans were equally likely to respond in the affirmative as respondents across Canada more generally. The Pollara survey reports the margin of error for the national sample but not for provincial samples so it is difficult to determine whether the difference in perceptions of quality in Alberta between 2006 and 2007 is statistically significant. Thus, the evidence from this poll is mixed, highly variable over time and statistically slight. Moreover, it is difficult to interpret at the question asks whether Canadians are receiving quality health services – shifting the focus from perceptions of the quality of the health services they themselves are receiving to perceptions regarding the quality of services received by others as well as shifting the geographic focus from the quality of health services in Alberta to the quality of health services in Canada.

Figure 11: Dissatisfaction with Overall Health Care Services and Most Recent Encounter with Health System, 2007



Source: Ipsos-Reid, *Health System Report Card*, 2007.

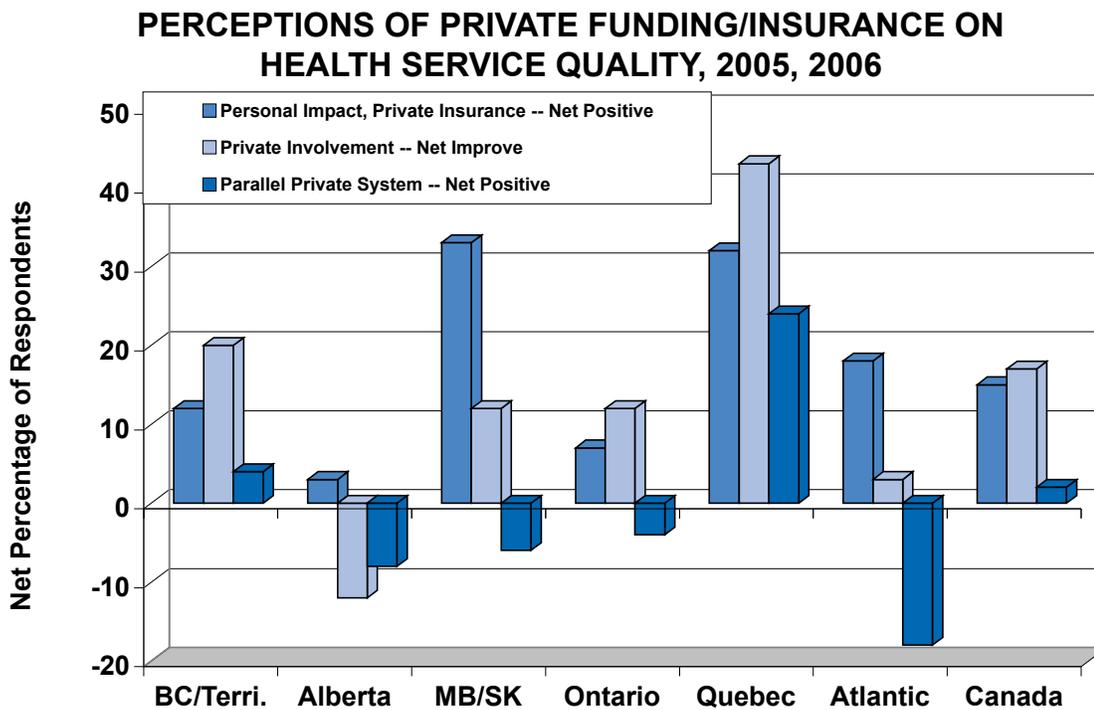
Notes: Respondents were asked to assign a grade of A, B, C, or F to overall health services and their own most recent experience with the health care system.

Perceptions of Impact of Private Funding and Insurance on Health Service Quality

While evidence of Alberta exceptionalism in regard to satisfaction with the existing health care system is mixed, the evidence is more clear that Alberta public opinion regarding the perceived impact of private funding and private insurance on the quality of health services is starkly distinct from other provinces.

Albertan respondents are the least likely in any province to feel that private insurance will have a positive impact on them personally with only 3% more Albertans anticipating a positive impact than those anticipating a negative impact. (See Figure 12.) When asked, in the context of a discussion of health care financing, whether greater private involvement would improve the quality of healthcare services offered in Canada, *Alberta was the only province in which public perceptions were that greater private involvement would lower the quality of health services.*

Figure 12: Perceived Impact of Greater Private Involvement



Sources: Personal Impact of Private Insurance, 2005 -- Pollara, *Health Care in Canada Survey*, 2005; Perceived Impact of Greater Private Involvement -- Ipsos-Reid, *Canadian Federation of Nurses Associations*, January 2006; Perceived Impact of Medicare Plus Parallel Private System -- Ipsos-Reid, *Canadian Medical Association Survey*, 2006.

In terms of perceptions of the impact of allowing a parallel private system to exist alongside public health insurance on health services, Albertans are, on balance, more likely to perceive a negative effect than respondents in any other province/region with the exception of Atlantic Canada. Thus, in terms of their perceptions of the likely impact of private funding and insurance on the quality of health services, Alberta public opinion, if it can be argued to be exceptional, is so by virtue of the prevalence of negative perceptions regarding the impacts of such changes.

The regulation of private funding and insurance of health insurance in Alberta goes beyond what is required by the *CHA* and is more stringent than is the case in a number of other Canadian provinces. This pattern mirrors cross-provincial patterns in public support for private funding and insurance by which Albertans are less supportive generally of private funding and private insurance than is the case for Canadians more generally.

CONCLUSIONS

A careful examination of the *CHA* including consideration of the provisions of the legislation, enforcement precedents and the regulation of private funding and insurance for health services in other Canadian provinces highlights that there is broad scope for reform of regulation of private funding and insurance for health services under the *CHA*. As highlighted in Table 3, only a limited number of reform options that have been discussed in Alberta are clearly non-*CHA* compliant including user fees (where the physician fee is paid by the public plan) and extra-billing (where a physician receives both public and private payment for a given instance of providing a service.) A second set of options which have been discussed in the Alberta context may or may not be *CHA*-compliant depending on the manner in which they are implemented including user fees (where the physician fee is not covered by the public plan), enhanced service fees, and annual registration fees charged by private providers who provide a mix of services including those which are publicly-insured. A final set of options which have been discussed but not implemented in Alberta despite being *CHA*-compliant include allowing private insurance for otherwise publicly-insured services and allowing physicians to receive public payment for some services and private payment for some services (though not from both sources for a particular instance in which a service is provided.)

Alberta is more restrictive in its regulation in this regard than many other provinces and than is required by the *CHA*. At the same time, the enforcement of the *CHA* is primarily a political – rather than legal – issue and there is relatively broad scope for the federal government to make discretionary determinations that particular practices are not *CHA*-compliant. However, to date, the federal government has chosen not to exercise this discretionary power. Without assessing the potential effects of specific reforms or their desirability, there are clear conclusions that can be drawn in regard to the political implications which result.

The fit between proposals for reform and the *CHA* is important in the politics of reform. Public opinion in Alberta contains a significant element supportive of strong *CHA* enforcement with Albertans being no more supportive than Canadians more generally of greater provincial latitude than allowed by the *CHA*. Reform proposals in Alberta to date have included provisions that would clearly challenge the *CHA* while, at the same time, incorporating important elements representing significant reforms to the system of health service funding which are consistent with the *CHA*. Proposals which might otherwise generate sufficient public consensus may fail to do so if successfully cast by proponents of reform as a challenge to the *CHA*.

Public opinion in Alberta is less supportive than other provinces of significant changes to the status quo in the funding of health services. This may be partly the result of a widely held perception – resulting from the history of health care reform in Alberta – that the two broad options for health funding reform are marginal adjustments to the status quo which respect the *CHA* or more far-reaching changes which violate the *CHA*. An Edmonton Journal column discussing proposed reforms in 2005 provides a powerful illustration of this perceived dichotomy: “It’s impossible to know whether [Alberta Health Minister] Evans is leading the charge for a private, parallel health-care system, finally free of the constraints of the Canada Health Act, or for more modest reforms. [...] Are we talking about a major realignment of services – as if the Canada Health Act didn’t exist... Or some tinkering?”⁷² The implication is clear: major reform requires proceeding as if the *CHA* does not exist while reforms under the ‘constraints’ of the *CHA* cannot amount to more than minor tinkering. However, there is a broad scope for reform of the regulation of private funding and private insurance for health services *under* the *CHA*. This presents another – perhaps more realistic – option for reform.

⁷² Sheila Pratt, “Klein’s Third Way is a One-Way Trip on a Merry-Go-Round,” *Edmonton Journal*, 25 September 2005, A16.

About the Author

Gerard W. Boychuk is Director, Global Governance Graduate Programs (MA and Ph.D.) in the Balsillie School of International Affairs and Associate Professor of Political Science at the University of Waterloo. His areas of interest include health policy, comparative public policy and global social governance. He is the author of *National Health Insurance in the United States and Canada: Race, Territory and the Roots of Difference* (Washington DC: Georgetown University Press, 2008.)

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