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Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care

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Abstract:

Choice is often touted as a means for change within health care systems. Yet ‘choice’, in this context, takes at least three distinct forms: choice between providers within a publicly funded health care system; choice between competing insurers within a universal plan; and, lastly, choice as between privately financed health care and universal public coverage. In Canada, it is this last form of choice that is under active debate, particularly in light of the Supreme Court of Canada’s decision in *Chaoulli* which found a regulation banning private health insurance for medically necessary care to be unconstitutional. The argument is frequently made that Canada is an outlier in having regulation that effectively precludes this kind of choice. This article tests that argument by exploring regulation of choice of privately financed health care in several European countries – the Netherlands, Germany, Sweden, England and France. We highlight commonalities as well as differences, showing the extent to which these countries employ regulation to fetter growth of a large privately-financed sector. The article’s thesis is that Canada, in employing more intrusive forms of regulation, is not an outlier per se but at one end of a regulatory spectrum.

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I. Introduction

Choice is frequently touted as the means to improve performance in health care systems. There are at least three models of choice presently popular in health care systems across Western Nations. First, in a system like that of England, choice is primarily framed in the context of delivery *within* the publicly-funded health care system, (e.g. increasing the ability of a patient to choose between public, private not-for-profit or for-profit providers). Second, in a country like the Netherlands, choice within a universal plan of competing private insurers is seen as being a driver for change (Maarse, 2007). In both of these models, choice is framed in the context of improving a universal public or quasi-public system: advocates and critics square off as to whether in fact such distinctions between public and private delivery of care will improve quality and efficiency within the publicly-financed system. In some countries, however, choice is framed around increasing private financing of the system and thus improving options for those able to pay for care either through private health insurance or out-of-pocket. Thus, for example, in Australia and Ireland private health insurance is encouraged and subsidized so that those financially able to exercise this choice may jump wait times/queues. It is this model of choice that is under debate in Canada and attention is focused on an iconic feature of the Canadian system, namely governmental regulation that effectively

eliminates a private-pay sector for “medically necessary” hospital and physician services (Flood & Archibald, 2001). Proponents of privatization have focused on this unique feature of the Canadian system and claim that if only these laws were liberalized, and this third model of choice embraced, quality and efficiency would improve and wait times would fall.

We debate this third model of choice and, in particular, consider the characterization of Canada as an outlier from developed countries in employing regulation to effectively throttle choice of private financing for medically necessary hospital and physician services. We do this by examining regulation of choice of private payment for care across a number of European countries and argue that Canada’s approach, whilst at one end of a spectrum, is not dissimilar to that employed in a number of other jurisdictions. Countries employ different levels of regulation to limit the extent of private payment for health care and this seems to be done for a mix of reasons; sometimes on the grounds of ensuring some level of equity and sometimes in order to protect access to quality and timely care in the public system (e.g. by reducing incentives for providers to spend too much time providing services to private-pay patients). We conclude with some comments on the complex interaction between regulation, access, and choice.

II. The Canadian Model and the *Chaoulli* Case

Canada has not one but ten provincial and three territorial health insurance schemes which are linked through the need to comply with federal standards set out in the *Canada Health Act* (CHA) in order to receive federal funding. The CHA bans extra-billing and

user-charges and effectively requires first dollar (public) coverage for medically necessary hospital and physician services. In meeting the requirements of the CHA each province has chosen its own distinct legislative scheme resulting in a complex web of health insurance regulation across Canada. Canada nonetheless does have a significant role for private health insurance (66% of the population holds private health insurance and it accounts for 12.5% of total spending), as prescription drugs are not covered by the CHA.

Tensions over the Canadian model centre on provincial governments' concerns regarding rising levels of public spending. From the public's perspective the issue is wait-times, which have been a problem since the mid 1990s when there were significant cuts in Medicare (Tuohy, Flood & Stabile, 2004). The quick-fix, advocated by some, is to allow privatization and, in particular, to allow Canadians to escape the public "monopoly" and have a "choice" of insurer (public or private). Allowing this choice, some argue, would alleviate pressure on the public system and reduce wait times. This issue of choice of private payer is now being framed in the Canadian context as not one of mere policy, but as one engaging fundamental human rights and the constitution and the Supreme Court of Canada, in the *Chaoulli* decision in 2005, legitimized choice of private insurer as a policy option.

At issue in *Chaoulli* was whether, in the face of long wait times, it was constitutional for the Quebec government to ban private insurance for medically necessary care. The court briefly surveyed other health care systems, comparing them favourably to the Canadian system and noting that in contrast to the Canadian system they all apparently allowed

private health insurance for medically necessary care. Whatever one's position is ideologically on the outcome of this case, most students of policy are likely to find disturbing the court's treatment and understanding of the dynamics of public and private health insurance (Flood, Roach & Sossin, eds., 2005). For example, the court failed to distinguish between systems where private health insurance is alternative (covers particular segments of the population for their entire health care needs as in Germany and (pre 2006) the Netherlands), complementary (covering co-payments required in a public system, such as in France), and/or duplicate or parallel (where private health insurance covers elective treatments for which there are concerns about waiting in the public system such as in England and Ireland.) These distinctions are significant and should not be conflated. This concern about judicial understanding has heightened as future constitutional challenges to regulations impeding the flourishing of a parallel private-pay system are now pending in Ontario and Alberta. If successful they will be likely to result in the dismantlement of the Canadian model, wherein the universality and fairness of the single-payer public system for medically necessary hospital and physician services is buttressed by measures that forbid or inhibit private insurance. The relevant courts deciding these new cases will once again look internationally to see if Canada's "unique" approach can be justified given the alleged infringement to individual liberty. But despite the existence of different systems of private health insurance, just how different is Canada really from other jurisdictions in regulating the flourishing of a parallel private-pay system?

III Canada's Legislative Framework

Canada's ten provinces vary in size, with Ontario and Quebec being by far the most populous, and each province has chosen a different mix of regulation to thwart private payment for medically necessary hospital and physician services, thus affecting "choice" of private payment on the part of patients for care. Below we provide a typology of Canadian regulation and highlight similar regulation in European countries, which are discussed in greater depth in subsequent sections.

i. Ban Private Health Insurance for Medicare Services

Six Canadian provinces ban the sale of private health insurance for medically necessary physician and hospital care. Although we can find no direct equivalents in other countries, there is a related provision in France where the government recently prohibited private insurance from covering the new user fee of one Euro per medical visit (the *participation forfaitaire*). (There is also a similar measure in Australia, which prevents private health insurers from covering a copayment at point of service.) In the latter case, however, the purpose of the restriction is to stimulate a measure of cost awareness as opposed to protecting the public system from a private tier and/or for the purpose of ensuring equality in access.

ii. Opt Out Requirement for Private Practice

All Canadian provinces have an “Opt Out” requirement for private practice relating to medically necessary care.[†] A doctor wishing to sell, for example, a hip operation to a private-pay patient must completely opt out of the public plan and can no longer be paid for providing public treatments. Historically, very few physicians chose to opt out (in 2006-2007, just 49 doctors out of 23,201 had opted out in Ontario – Health Canada, 2007). As discussed further below, several other countries prohibit, limit and/or restrict doctors’ ability to work in both the public and private sector.

iii. Ban Private Practice of Medically Necessary Care

In 2004 one Canadian province (Ontario) banned private practice for medically necessary physician and hospital care. In other words, physicians are required to work only for and in the public system with respect to medically necessary care (a grandfather clause is included in the legislation, exempting physicians who opted out of the public system before May 13, 2004). This law is more symbolic than substantive given that prior to this point so few physicians had opted out. Although Sweden has regulation and policy that severely limit the scope for private financing of medically necessary care there does not seem to be equivalent legislation in other jurisdictions. Australia, however, does impose a ten year prohibition on medical graduates from other countries from billing private-pay patients for care, thus forcing them to work for (and bill) public Medicare (Department of Health and Aging, 2008).

[†] Note there is no opt-out requirement to provide non-medically necessary care, such as cosmetic surgery, IVF services etc. Thus a physician can work in the public system and also bill privately patients for services considered not medically necessary.

iv. Price Regulation of Private Sales

Three Canadian provinces regulate the prices that opted-out physicians can charge to private-pay patients, tying prices to the public tariff and thus eliminating a financial incentive for physicians to opt out of the public system. Similarly in the Netherlands (pre 2006) the payment of providers in both the public and private sectors was regulated and uniform (through budgeting and maximum caps on provider payments) (OECD, Netherlands, 2004). The Health Care Tariffs Act sets a maximum ceiling for provider reimbursement. Because of the uniform tariff, doctors received the same amount irrespective of a patient's insurance status and thus had no incentive to prefer private-pay patients over public (social health insurance) patients. Colombo and Tapay report that other European countries such as Greece, Italy and Luxembourg also employ various price regulation methods including limiting and prohibiting the extent to which physicians can bill the public system and also receive private payment (OECD, Benefits & Costs, 2004).

v. Ban on Extra Billing

Extra billing is a situation where a provider of care bills the public plan and then in addition seeks further funding from the patient herself (whether out of pocket or from her private insurance company). Eight out of Canada's ten provinces prohibit physicians in the public system from billing a patient more than the amount received from the public plan (subject to some narrow exceptions) (Flood & Archibald, 2001). France takes a similar approach in so far as it seeks to protect low income individuals with state funded insurance (*Couverture Maladie Universelle (CMU)*). Physicians who are usually

permitted to charge above the official tariff (known as Sector 2 doctors) are prohibited from extra-billing CMU patients (Couffinhal & Paris, 2003).

vi. Ban on Direct Billing

Direct billing involves patients paying the cost of treatment upfront and then later seeking reimbursement from a public or private insurer. Six Canadian provinces prohibit direct billing by opted-in physicians because of concerns regarding access on the part of those unable to pay the cost up-front (Flood & Archibald, 2001). In contrast, in 2006 the Netherlands has introduced the possibility of direct-billing in the universal plan (Greß, Manouguian, & Wasem, 2007). The issue is largely rendered moot in Sweden and the UK where providers are more frequently reimbursed on a salary basis or mixed payment system (OECD, Sweden, 2005); NHS, 2008a). France embraces the concept of direct billing as a means to highlight the true cost of care to users; however, low income individuals on CMU are exempted from direct-billing requirements (Couffinhal & Paris, 2003).

Summary

Overall this complex mix of different regulatory approaches throughout the Canadian provinces has had the desired effect of largely preventing a two-tier system for medically necessary hospital and physician services. In our view the lack of a flourishing private sector in Canada is most likely attributable to regulations that minimize the incentives for doctors to practice in both the public and private sectors simultaneously. However, it is not clear given the range of regulatory approaches and the mix of provinces employing them which are important regulations and which are more symbolic. For example,

although six provinces ban private health insurance for medically necessary care, the provinces without this ban generally do not have a large private sector. It is possible that this may be because the more populous provinces (Ontario, Quebec) have employed the ban thus diminishing the national market for health insurance products (although 66% of Canadians do have private health insurance, primarily for the purpose of covering pharmaceuticals outside of hospitals, and this would seem to be a strong base for expansion) or it may be that other laws (e.g. the laws requiring opting-out and those pertaining to price regulations) are simply more important.

IV. Lessons from Europe

How then do other countries approach the issue of choice of private financing and how do they balance this against ensuring sufficient quality in the public health care system? Is Canada truly an outlier from an international perspective? To probe these questions in greater detail we turn now to European healthcare and explore regulatory approaches and the nature of choice in the Netherlands, Germany, Sweden, England, and France. These countries represent part of the spectrum of different approaches to financing care and of roles for private health insurance: both the Netherlands (pre 2006) and Germany are examples of social health insurance financing with private health insurance covering (in full) wealthier groups; the Netherlands post 2006 is an example of regulated private insurance; Sweden and England are more akin to Canada provinces in being primarily tax-financed,[‡] but in contrast to Canada allow a two-tier system for physician/hospital care; and France is a melange of tax financing, social health insurance funds, with a

[‡] Although Sweden's County Councils have direct revenue raising power, unlike Canada where health is financed out of general federal and provincial revenues

significant role for private health insurance to cover co-payments and extra-billing and with a significant role for private delivery. We approach describing the systems with humility; clearly one cannot sum up an entire health care system in a snapshot. Our goal is merely to summarize those parts of the systems that most directly pertain to the issue of regulation of private payment for medically necessary care.

i. Netherlands

The Dutch Health care system underwent significant reform in 2006. Prior to 2006, there was compulsory social health insurance for those earning under €33,000 and (voluntary) private health insurance for those earning over €33,000 (Greß, Manouguian, & Wasem 2007). The 2006 reform merged these private and public components creating universal health insurance coverage provided by private companies.

Pre 2006 wealthier individuals and their dependants were excluded from statutory health insurance coverage and had to purchase alternative private insurance for all their health care needs (Klazinga, 2008). As a result approximately 36 per cent of the Dutch population held private insurance as their primary coverage (OECD Health Data, 2008). Given the large number of individuals with private health insurance there was concern about the potential risk of these patients receiving preferential treatment and access to services. It is important to note the difference between this state of affairs and the kind of reform being considered in Canada. In the Canadian model, what is being mooted is that everyone would maintain public coverage and those with means will be able to buy more timely care. In the Dutch model pre 2006, the wealthy had to self-insure or purchase

private health insurance in order to cover *all* their needs and not simply in order to purchase more timely care or preferential treatment. Moreover, concerns about the possibility of having a different level of care for those with private care were mitigated by regulation. For example, as in three Canadian provinces the Dutch regulated the prices charged by private providers, which prevented private insurance companies from inducing more providers to selectively contract with them through the payment of higher fees for service (OECD, Netherlands, 2004). As such individuals, whether holders of private or public (social health) insurance, had access to the same care providers. Post 2006 the need for price regulation was negated by the merging of social health and private health insurance into one regulated scheme. Moreover, the Dutch have also employed professional self-regulation to ensure equity in access. The Royal Dutch Medical Association requires that all doctors follow a professional code of responsibility and ethics that, at least in principle, requires them to treat all patients on equal terms regardless of whether or not they can afford to pay more.

As a result of the 2006 changes the Netherlands now has a mandatory universal health insurance scheme in which coverage is provided by competing private insurance companies, but which is heavily regulated to ensure cross-subsidies from the wealthy to the poor, and from the healthy to the sick. The propensity of the 2006 Dutch reform to achieve its goals is beyond the scope of this article; our focus is limited to how choice has been framed in the new reforms and linkage to regulation of the public/private divide. In making health insurance mandatory for all citizens in a sense the Dutch government has restricted “choice”, yet on the other hand the entire population is now in a system where

choice of insurer/purchaser is intended to drive efficiencies, improvements in quality and timeliness, etc. So the value of choice is, if anything, given more prominence in the new reforms than previously. However, the goal is for competition between insurers to drive efficiencies on the supply side and the result may be that insurers move towards managed care, which in turn may further limit a patient's choice of provider. In the latter regard, citizens now have a choice of three different types of insurance contracts; in kind (natura), cash (restitution), and combination policies (which provide both in kind and in cash benefits) (Ministry of Health, Welfare & Sport, 2006a). The policies differ in terms of price and the ability of patients to choose a provider without having to pay additional fees. Concerns have been expressed that distinctions in types and prices of packages “may result in the development of different ‘classes’ within the insurers’ membership and of a multi-tier health system” (Muiser, 2007).

To encourage choice and drive price competition, the new system of financing is *prima facie* more regressive as a portion of the premium is flat (community rated), although overall the system may be less regressive through mandatory inclusion of the top 35% percent of income earners in the general scheme. In any event the value of choice is counter-weighted by a strong value of ensuring access to care and what the Dutch call “solidarity” (or what others may call risk-sharing, equity, etc.). Thus, there is extensive regulation to reduce incentives to risk-rate, requiring insurers to provide coverage on the same terms and conditions to all (open enrolment), and to help those individuals unable to pay the flat premium from their own means (the government pays a care allowance to approximately five million individuals (two thirds of households)) (Enthoven & Van de

Ven, 2007; Cooper & Helderma, this volume). One way of viewing the new Dutch system is as a tense marriage of access and choice with regulation acting as some form of prenuptial agreement attempting to minimize conflict.

ii. Germany

The German health care system for core services consists of both social health insurance (held by 90 percent of the population) and (optional) private health insurance (held by 10 percent of the population) (OECD, Germany, 2008). In addition 16 per cent of Germans hold supplementary insurance (OECD, 2008) for services not fully covered by core insurance such as co-payments for dental care and better amenities including single/double rooms, and treatment by senior medical practitioners (Busse, 2008).

In contrast to the Dutch system pre-2006 where the top 30 percent of the population was not permitted to be covered by the statutory scheme, in Germany those earning above €48,000 per year may choose to opt out and either buy private insurance or self insure. The reader who is wondering why an individual in Germany may choose private health insurance needs to understand that for a healthy single individual it is often cheaper to be in the private health insurance plan than to contribute to the social health insurance system (Greß, 2007). There may also be non-financial incentives for individuals to move to private insurance as the range of services covered by private insurance may be more comprehensive and may include drugs or treatments not covered by social health insurance plans.

On 1 April 2007, the German government introduced reforms to improve both solidarity and sustainability. Every German must now hold some form of health insurance, but the distinction between the public and private health insurance schemes is maintained. Individuals who have opted out of social health insurance must now purchase private health insurance and can no longer choose to self insure. The new reform attempts both to capture individuals who were “free-riding” on the public system (by refusing to insure themselves and relying on emergency care in hospital) and to assist those seeking private insurance who have difficulties because of pre-existing conditions. In the latter regard, all companies must now accept all individuals for the minimum package regardless of whether they had been previously denied coverage. In addition, all private insurance companies must offer a core package of services and benefits similar to those under social health insurance and regulations prohibit companies from charging risk surcharges on core private insurance coverage. The reforms also attempt to make social health insurance coverage more affordable by centrally setting the contributions for all the social insurance companies (who previously set their own income-dependent premiums) and by lowering the contributions payable by the self-employed.

The new German reforms and the overarching regulations in place demonstrate the importance of the goal of access to care on the basis of need and the goal of protecting the public system from the potentially deleterious effects of a parallel system. However, the system still allows the wealthy to opt out of the public scheme and into private health insurance. The public system bears a double burden when individuals exercise a choice to opt out of the public system, as it loses income-dependent premiums for these high

earners and is left with a higher percentage of individuals in poor health. Studies suggest that the estimated loss to the social health insurance system as a result of opting out is €750 million annually (OECD, Germany, 2008). There have also been concerns about the preferential treatment of those holding private insurance due to differences in provider payments. Both public and private patients are seen by the same physicians and specialists in the same hospitals (Greß, 2007) and, while both private and public insurance pay general practitioners and specialists on a fee-for-service basis, private insurance pays higher prices. This generates a financial incentive to treat more private patients or to treat private patients instead of public patients.

The German system seems to endorse the concept of two-tier choice in the sense debated in Canada although there is an important distinction in that choice in Germany is for private health insurance as an *alternative* for wealthy individuals for core coverage of *all* services and not merely for duplicative insurance for queue jumping. In the Canadian context, the argument is made that allowing a two-tier system will reduce the burden on the public system and shorten wait lists. This does not seem to be argued in the German system; indeed the argument more strongly made is that allowing opt-out for the wealthy to purchase private health insurance removes funding for redistribution and increases rather than decreases strain on the public system. To respond to this concern the German government is increasingly fettering the “choice” to opt-out both by making it more difficult to opt-out and by making it difficult to return to the public system once a choice to opt-out has been made. Individuals are only allowed to return to the public system under ‘very exceptional circumstances’ and the legislature has suspended the right of

those 55 years of age or older to rejoin the social insurance scheme (Ministry of Health, Germany, 2008). In addition, from 2 February 2007, in order to be able to opt out of the public plan, an individual must exceed the income threshold for three successive years. These restrictions, over time, may significantly reduce the size of the private health insurance tier in Germany.

iii. Sweden

The Swedish health care system is universal, regionally based, and publicly funded through central and local taxation (Anell, 2008). Financing is more decentralized than in many jurisdictions and it is within the ambit of the County Councils to levy proportional income taxes on their populations to finance health care services (Glenngård et al., 2005; Or et al., this volume). Tax funding is supplemented by state grants and (small) user fee charges.

The *Health and Medical Services Act 1982* entitles all residents to health care and states that the principles of need and solidarity rank above that of cost-effectiveness (Glenngård, 2005). The goal of high quality care for all is also evident from the generous range of services provided under the public system (hospital and primary care and most other medical treatments including dental, mental health care, rehabilitation services and home care) and low co-payments capped at a maximum of 100 Euro annually (OECD, 2005). This is likely to be why the supplementary private insurance market in Sweden is so small (Mossialos & Thomson, 2004).

In Sweden just 2.5 per cent of the population hold private health insurance – this is for the purposes of covering services not covered by the public plan (supplementary) and to allow for queue-jumping for elective procedures (duplicative) (Glenngård, 2005). In contrast, 66 per cent of Canadians hold private health insurance. Private health insurance in Sweden accounted for less than 1 per cent of total health expenditures in 2005 (Anell, 2008) as opposed to 12.5 per cent in Canada (OECD Health Data, 2008). The enormous differences between the two countries both in terms of the percentage of the population holding private health insurance and its role in funding the system, is largely explained by the fact that prescription drugs are not included in Canada’s universal plan (although each province provides some coverage to certain groups, like the elderly or poor). Thus, whilst formally Sweden has a two-tier system and Canada does not, there is such a small role for private health insurance that the Swedish financing model is arguably effectively equivalent to the Canadian system.

Growing wait times for elective surgery have led to some increase in private insurance (duplicative) which allows for quick access to ambulatory care and allows individuals to jump waiting lists for elective treatment. (Glenngård, 2005). That said, the market for private insurance in Sweden remains small and this may be due to the fact that private delivery is regulated and limited in several ways similar to Canadian provinces (in other words, without a large private delivery sector there are limited gains from buying private health insurance). Most physicians are publicly employed and receive a monthly salary from the County Councils (Swedish Medical Association, 2003).[§] Sweden prohibits its

[§]Although County Councils are increasingly moving to activity-based payments including mixed fee-for service and capitations in order to increase productivity (OECD, 2005).

public doctors, working on salary, from working in private practices that receive public funds and the National Board of Health and Welfare must be notified by any physicians wishing to provide private health care. Unlike in England and Ireland, Sweden does not have private beds within public hospitals (Mossialos & Thomson, 2004). In addition, although a County Council cannot prohibit the establishment of a private practice, they can prevent public reimbursement of private practitioners (OECD, 2005). The Councils also regulate the patient numbers that can be seen by private practitioners and set a fee schedule which must be followed in order to seek reimbursement from the public plan.

In 2004 a debate over the effect of privatization was sparked by the private purchase of one of Stockholm's emergency hospitals. The Swedish government responded by banning private companies from running hospitals that treat both private patients and those with public insurance. "Health Minister Lars Engqvist...said that new legislation would end the practise of private patients 'buying their way past' hospital waiting lists" (Burgermeister, 2004). Although this ban has since expired the legislation shows concerns about the protection of the public health system and the need to ensure equal access to public health care.

In Sweden there is increased emphasis of choice on the part of patients of primary care clinics, general practitioners, and hospitals. This type of 'choice' (choice within a public health care system) is similar to the type of choice currently being advocated in England (Or et al., this volume). Choice of private health insurance to allow queue jumping (as is under debate in Canada) is possible in Sweden, but regulations relating to public

reimbursement of private physicians effectively limit the sphere of a second private tier in Sweden as physicians cannot receive public funding in both the private and public sectors. Thus whilst a citizen may superficially have choice of obtaining two-tier private insurance, such a choice is illusory unless there is a significant private market and the latter cannot usually flourish without being able to leverage itself off of the resources of the public system.

iv. England

The English system combines universal, first-dollar, public coverage of a broad range of services with a relatively small, parallel private sector that mainly specializes in a narrow range of elective procedures (Klein, 2005). The system is primarily tax-financed and the National Health Service's (NHS) mandate is to deliver universal and comprehensive access to health care mostly free at point of service.

Just over 11 percent of individuals in UK hold duplicate/parallel private health insurance (OECD Health Data, 2008) which allows for a choice of specialists, higher standards of comfort and privacy, and allows people to jump queues in the public system. Thus, England has long embraced the type of "choice" presently under debate in the Canadian system. The privately-financed system in England (described as symbiotic with the NHS, and sometimes, less flatteringly as parasitic (Klein, 2005)) exists to offer choice to those who can afford to pay for quicker access, and to allow physicians, particularly consultants, to top up their public salaries with private pounds. As duplicative insurance covers services ostensibly available under the public system the demand for this type of

insurance is generally linked to the quality and timeliness of services within the public system.

Despite the existence of a parallel private health insurance sector, the English system has been plagued by long wait lists such that in 2001 the government asserted that “the public’s top concern about the NHS is waiting for treatment” (Leatherman & Sutherland, 2008). To address the problem of long wait times, the English government has *not* placed greater emphasis on private insurance or financing-- as advocated by proponents of choice in Canada-- but instead has taken a range of measures internal to the publicly-financed system. In addition to increasing public funding to reduce wait times the NHS has looked both to targets and externally to the private *delivery* sector (as opposed to private finance). With respect to targets, in 2000 the NHS introduced wait time targets coupled with the publications of the results and sanctions for failure to meet targets in a scheme dubbed ‘targets and terror’ (Bevan & Hood, 2006).** With respect to increased emphasis on private delivery, the English government has sought to stimulate the public system by encouraging private for-profit providers. To this end, the Independent Sector Treatment Centre (ISTC) program was launched in several waves (Leatherman & Sutherland, 2008). There has been strong debate as to whether the ability to choose between public hospitals and private-for-profit clinics will improve the performance of the NHS (Or et al., this volume; Audit Commission, 2008). Proponents argue that apart from additional capacity, the for-profit sector improves contestability within publicly-funded health care, raising overall performance (Dept. of Health, 2004a). Critics contend

** A recent paper shows the program has resulted in a decrease in waiting times but cautions that “a decrease in waiting times does not, on its own, imply that the policies have been welfare increasing” (Propper et al, 2007).

that the addition of private for-profit clinics raises costs and diminishes quality (Devereux, P. J. et al. (2002)) and because they cream-skim off easier work, the complex tasks (and the mop-up of their mistakes) are left to public providers (Martin & Smith, 1996). In contrast to Canada, the debate here is about whether choice inside the public system will improve performance as opposed to whether choice of private finance will improve the public system.

Unlike Canada and other European countries, England has not employed explicit regulation to dampen or inhibit the development of a privately financed sector, for example, it has not regulated prices that consultants can charge for privately financed care. Recent reforms suggest that the English government is, however, concerned with the effect of the privately financed tier on the public system and in particular the problem of consultants spending too much time treating private-pay patients at the expense of patients in the public system. To this end, the government introduced a new consultant contract in 2003 which marked the first major revision in almost 50 years (House of Commons Committee of Public Accounts, 2007). “The ‘vexed issue’ of consultants’ private practice ... was at the heart of concerns about the old contract (Williams & Buchan, 2006).

The 2003 contract implemented a full time work commitment of forty hour work week, broken down into ten programmed activities (PA) of four hours each. Consultants are permitted to accept extra PAs in the private sector or with the NHS, but “should accept an extra paid programmed activity in the NHS, if offered, before doing private work.”

(British Medical Association, 2003). In addition, a separate code of conduct was introduced outlining how to avoid conflicts of interest when working in both the NHS and the privately-financed sector (Dept. of Health, 2003). An early version of the code stated that private practice must not “result in detriment of NHS patients or [s]ervices [and] diminish the public resources that are available for the NHS.” In 2004, the language was watered down and now states that “the provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services [and] with the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work” (Dept. of Health, 2004b). Compliance with the code of conduct is required for eligibility for clinical excellence awards and pay progression (National Audit Office, 2007).

Whether the provisions of the new consultant contract will have impact or are mere bromide is yet unknown though it is clear its provisions will only be as effective as the extent to which they are enforced. The evidence is scant and mixed at this stage and most of the emphasis has been placed not on the impact of the changes to the consultant contract, but on whether or not the increased payments made to consultants for their work in the public system has provided sufficient incentive to spend more time in public practice. In the latter regard, despite consultants now being paid on average 27 percent more than they were previously there appears to be no measureable increase in their level of productivity (O’Dowd, 2007). A House of Commons Committee reports “[h]igher pay has helped improve recruitment and retention and has halted a rising trend in the amount of private practice carried out by NHS consultants. The increased pay will only be

justified, however, if the expected improvements to productivity are achieved” (House of Commons Committee, 2007). A survey conducted by the National Audit Office does show a slight decrease in the amount of private work carried out by consultants (National Audit Office, 2007).

Despite a hearty emphasis on choice, the English government has not promoted an increase in private funding by subsidizing or promoting the private insurance sector. Rather enhancement of choice in England has focused more on a greater plurality in delivery on the supply side as discussed above. The new consultant contract and code of conduct do suggest a concern on the part of the English government about the siphoning off of labour from the public sector to the privately-financed sector. In Canada, there are no contracts with consultants as specialists are generally not paid on a salary basis but on a fee-for-service basis. Thus Canada’s regulatory/policy response to concerns about the siphoning off of human resources has to be calibrated to reflect the historical use of fee-for-service payments.

v. France

The French health care system is a complex mix of social health insurance, tax and private financing with a significant role for private delivery and this is further complicated by an extensive overlay of regulation so that which appears “private” may in fact be better characterized as quasi-public.

The funding of the general public scheme (l'Assurance Maladie) (accounting for 80% of total health spending) comes primarily from two income-based taxes: a payroll tax paid by employers and employees, and the *Contribution Sociale Généralisée* which is a broader based tax on total income. The bulk of the remaining revenue is sourced in specific taxes (including tax on alcohol, cars, and tobacco) (Durand-Zaleski, 2008). The National health insurance system in France is composed of three main schemes: the general scheme, the agricultural scheme and the scheme for self employed individuals. Private health insurance plays a relatively large role (92% of the population hold it (Durand-Zaleski, 2008)) but is “complementary” in the sense that it is primarily for the purposes of covering co-payments imposed in the national insurance schemes and extra-billing by private physicians. Complementary insurance is not regulated in France and as such there are no standardized plans or required packages. A high percentage of complementary insurance in France is provided by employers (OECD, France, 2004) and the quality and scope of private insurance (and one’s choice of providers) is linked to one’s employment and there are large disparities between plans.

On the delivery side, medical services are provided by public or private hospitals and by physicians working in public and private institutions. Private French doctors are paid on a fee-for-service basis and doctors in public hospitals are paid on a salary basis (Sandier, Paris & Polton, 2004). However, unlike in Canada, historically French patients have paid for most ambulatory services at point-of-service (direct billing), and the general insurance scheme reimburses the patient for a percentage of the cost of services. The remainder is paid by the patient in the form of a co-payment (Sandier, Paris & Polton, 2004) but 92%

of the French have complementary private health insurance to cover the cost of the co-payment (Durand-Zaleski, 2008). However, above and beyond the co-payment required by the general public scheme, some physicians (Sector 2 discussed below) are allowed to charge additional fees (extra-billing).

Direct billing and co-payments were initially introduced to encourage efficient use of health care services; however, their potential impact is diluted by the prevalence of complementary private insurance coverage. Moreover, such measures raise access issues. In response to this problem, the French government introduced the *Couverture Maladie Universelle* (CMU) in 2000 which has two parts. The *couverture maladie universelle de base* (basic CMU) provides coverage for those residents who do not have basic coverage under the main public scheme (l'Assurance Maladie) and the CMU *complémentaire* which provides complementary private health insurance coverage for low-income individuals. CMU beneficiaries are also exempt from any direct billing and providers instead directly bill the CMU (Couffinhal & Paris, 2003).

In an attempt to curb utilization the French government in 2008 introduced new non-reimbursable payments of one Euro per medical visit (*participation forfaitaire*). These payments cannot be covered by private health insurance but are capped at an annual ceiling of €50 and CMU beneficiaries are exempt. In addition, the French government recently implemented measures whereby patients are encouraged to choose one primary general practitioner (a *médecin traitant*) and pay a lower co-payment if care is provided by his/her selected GP (Or et al., this volume). Although it is not mandatory for patients

to select a *médecin traitant*, approximately 80% of French patients have done so (Dourgnon et al., 2007). However, those holding complementary private health insurance have copayments covered apart from the *participation forfaitaire* and so it is not clear to what extent these measures will deter consumption on their part.

Private French doctors are paid on a fee-for-service basis and are classified as either Sector 1 or Sector 2, with Sector 2 doctors being permitted to freely extra bill above the negotiated tariffs and in addition to the required co-payments. (Sandier, Paris & Polton, 2004). Patients seeing Sector 2 doctors are reimbursed the general tariff from *l'Assurance Maladie* (minus the co-payment) and then either bear the costs of the co-payment *and* the additional provider billing out of pocket or have private health insurance to cover these costs.

Sector 2 was introduced in 1980 when the *l'Assurance Maladie* agreed to reimburse all doctors for the negotiated tariff, but allowed doctors to choose the right to extra bill in exchange for forgoing sickness and pension benefits (Poullier & Sandier, 2000). It was assumed that price competition and market forces would discourage a high number of doctors from joining Sector 2 and would prevent Sector 2 doctors from increasing fees excessively. It was also thought that the higher cost of visiting a Sector 2 physician would equate with better quality of care by encouraging longer appointment times and fewer prescriptions. However, the opposite occurred: prices in Sector 2 went up to 45% higher than the negotiated fees, practices developed in mainly affluent areas, length of visits did not increase and prescription rates did not fall. In response, in 1990 the French

government restricted new entry of doctors into Sector 2 to a small elite group of new physicians. The doctors who had already switched Sectors were allowed to remain. Today approximately 25% of French doctors are classified as Sector 2 – 15% of general practitioners and 39% of specialists (including 75% of surgeons) (Sécurité Sociale, 2007). The result is that a patient seeing a sector 2 specialist will general pay (on average) € 17.3 in addition to the mandatory co-payment.

By limiting the number of doctors who can join Sector 2 the French help ensure access by limiting the size of the private-pay tier which is only accessible to those who can afford extra billing (either out of pocket or by having insurance coverage for extra billing). Price regulation in the French system comes from the negotiated tariff and precluding doctors from charging above this tariff unless are they in Sector 2. This regulation would not have been required unless there was an underlying assumption that a parallel tier of care would have a deleterious effect on the public system. Choice in France is mainly that of provider and once again this choice is not of the same quality of choice under debate in Canada. What *prima facie* seems like a great deal of reliance on market mechanisms and choice, on closer examination turns out to be heavily regulated so as to achieve access objectives. For example, although all individuals potentially have the choice of visiting Sector 2 doctors there are two groups more likely to exercise this choice. The first is the wealthy who can either afford to pay the extra billing charges or hold private health insurance cover for these extra billing costs. The second group is those low income individuals on the CMU as Sector 2 doctors are not allowed to extra bill for CMU patients and doctors must bill the health insurers for services instead of directly billing

the patient (Grignon, Perronnin & Lavis, 2008). The losers in this system may in fact be middle income individuals who are unable to afford the extra billing charges and have little or no private health insurance coverage for extra-billing.

V. Conclusion

What insights can Canada glean from approaches in European countries to the question of choice and regulation of the public/private divide? We conclude with seven observations.

First, regulation may interact with other policies to achieve a result not predicted and the effect of regulation can be altered, enhanced or distorted by other policy choices. So for example, as a result of *Chaoulli*, Quebec has liberalized the law regarding private health insurance for hip, knee and cataract surgery. However, at the same time the Quebec government has put in place a wait time guarantee (although not in legislation). If successful, this policy may negate incentives to buy private health insurance thus rendering the liberalization largely moot. If the wait times guarantee is not implemented appropriately or subsequently the government does not invest to achieve its realization, then the liberalization of the law regarding private health insurance may have more substantive impact.

Second, regulations that appear distinct across jurisdictions require close analysis as what may superficially appear very different could have a similar impact in terms of outcome. For example, in a number of Canadian provinces, there is price regulation on the fees that doctors in the private sphere can charge patients for medically necessary care. In the

French system, there is not the same kind of price regulation but there is a policy fixing payments from insurers to patients. Thus, the fee that private physicians can charge is set by the insurer as is the co-payment; only a limited number of doctors in Sector 2 can charge above and beyond that set co-payment amount. Thus, arguably, the impact of the policy approaches in both Canada and France is not that different, namely (most) providers can't charge more than the public tariff.

Third, a greater understanding of the complexity of regulation across jurisdictions requires a deeper knowledge of the context of different health care systems. In the case of *Chaoulli*, the Supreme Court of Canada signalled that courts may take a significantly larger role in Canadian Medicare in the future, reaching judgments on policy initiatives on the basis of their understanding of comparative evidence of system performance. To be more effective (and less disruptive), courts, counsel, and litigants will need to be better apprised of the complex structures and dynamics of different health care systems. In particular, a greater understanding that the context of each system fundamentally affects regulatory selection is required. Moreover, a court in assessing the legitimacy of regulation should not assume that because there is no equivalent in another jurisdiction that the regulation under scrutiny before them is somehow illegitimate as the particular regulatory choice in a specific jurisdiction is shaped by accidents of history and particular institutional configurations. Courts should then be particularly careful about wading into this complex policy arena.

Take for example, the issue of ensuring a sufficient supply of physicians to treat public patients. In Sweden, which pays physicians on a salary basis, this is achieved through regulation of the contract of employment (expectations about work hours etc.). In England, there have been moves to spell out expectations in the consultants' contract regarding work hours in the NHS. In the Canadian context, however, as most physicians are not salaried employees, this approach through contract has not been as clear an option (although it is still a possibility). Historically too, Canadian physicians have carved out a niche as independent providers, able to freely bill public Medicare without great scrutiny. Hence, Canadian provinces require instead that physicians, who wish to sell medically necessary care to private pay patients, opt out of the public system altogether. Few choose to do so as it is not financially viable. If this kind of provision is eventually found to be unconstitutional then Canadian provinces will need to turn to the experiences in England and Sweden so as to be able to articulate and enforce contracts with providers who are publicly-funded.

It is not surprising that we do not see identical regulatory approaches utilized from system to system. Regulations are generally a response to the problems inherent in the design of a particular health care system and the designs vary considerably across jurisdictions. Great caution is also required as one (apparently small) difference can make all the difference to outcomes. Thus, for example, it is incautious for a court, as it did in *Chaoulli*, to assume that liberalization of laws around private health insurance in Canada, where some 66 percent of the population already holds private health insurance, would have a similarly modest effect as in a country like Sweden where just 2.5 percent has

private health insurance. In other words, given that such a large proportion of the Canadian population already hold private health insurance, one could more readily see the development of a significant parallel private tier for medically necessary care if regulations suppressing it were liberalized.

Fourth, systems that value both access and choice face demanding regulatory challenges. The Netherlands, with its complicated regulatory framework and policies, illustrates the difficulties for the regulator in sealing the marriage of access and choice.

Fifth, reforms may seem to embrace either choice or access but upon closer inspection there may be other changes or reforms that derogate from either choice or access. In other words, choice can be given with one hand and taken away with another; similarly access/equality may be given with one hand and taken away with another. To illustrate the former, in the Netherlands, all citizens now have a choice of competing insurers who are expected to achieve efficiency gains through the selective contracting of providers. But this in turn may reduce choice on the part of patients over their providers.

Sixth, choice is popular these days in health reform circles, but it comes in many flavours, some more bitter than others. Of the countries reviewed the predominant form of encouraging choice was within the framework of a public universal system (i.e. in England encouraging competition/contestability between providers; in the Netherlands encouraging competition between regulated insurers). Canada's debate on choice is primarily limited to dismantling its distinguishing feature, namely severely restricting

private finance for medically necessary hospital and physician services. “Choice” then in the latter context is one framed about market power in the sense of being able to afford private care or private health insurance and being sufficiently healthy to qualify for coverage. But this kind of choice is meaningless for those without anything to choose with. Policy-makers that seek to promote more private finance or private health insurance, although cloaking this in the value of choice and in the robes of efficiency and access improvements, by necessity are willing to sacrifice to some degree the value of equal access.

Finally, choice is often framed as only about individual choice; but of course choice is an important value at multiple layers in society, by families, by communities, and by society more broadly. Consequently, it is important to realize that giving primacy to individual choice is to give primacy to one kind of choice over another. In their approaches to regulation of private payment for care, each system seeks to strike an appropriate balance between individual choice and the public good in protecting a universal public scheme. Canada in its approach is not an outlier but merely at one end of a regulatory spectrum.

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