

PART I
THE CONTEXT AND
CONTESTATIONS
OF PUBLIC AND PRIVATE
IN THE CANADIAN HEALTH
CARE SYSTEM

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Private Finance and Canadian Medicare: Learning from History

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From the time that medicare was conceived to the present day, there has always been a polarized debate on the issue of private finance in Canadian medicare. Initially, in the early decades of medicare, the ongoing negative view of medicare by the medical profession, despite medicare's growing popularity in the general population, was perpetuated by perceived constraints on the ability of physicians to maximize profits, especially the restrictions on extra-billing introduced by the federal government through the *Canada Health Act* and the banning of extra-billing by some provincial governments.¹ In recent years, the debate has been spurred by the less-than-satisfactory performance in terms of timeliness and quality in the provision of health services, especially Canada's relatively poor performance in successive international surveys published by the Commonwealth Fund, a health policy think tank based in the United States.²

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- 1 Carolyn J Tuohy, "Medicine and the State in Canada" (1988) 21:2 *Can J of Pol Science* 267 at 279–81; S Heiber and R Deber, "Banning Extra-Billing in Canada: Just What the Doctor Didn't Order" (1987) 13:1 *Can Pub Pol'y* 62 at 62–64.
 - 2 The Commonwealth Fund's 2017 international survey comparing eleven high-income countries ranked Canada ninth overall, largely due to its relatively poor performance on access, equity, and health care outcomes. See Eric C Schneider et al, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better US Health Care* (New York: Commonwealth Fund, 2017). Numerous

It needs to be emphasized that the debate on private finance is limited to medicare. For all other areas of health care aside from hospital, diagnostic, and medical care, defined as “insured services” under the *Canada Health Act*, there is no government regulation of private finance. Indeed, Canadians pay for a considerable amount of their health care through private health insurance (generally through employment benefit plans) and out-of-pocket payments, such that these forms of private finance constitute roughly 30 per cent of total health expenditures, one of the highest private shares among the higher-income countries of the Organisation of Economic Co-operation and Development (OECD).³

When it comes to medicare, however, provincial and territorial governments regulate private finance in order to live up to the universality requirement under section 10 of the *Canada Health Act* that all their respective residents have access to these insured services “on uniform terms and conditions.” The single-tier nature of Canadian universality—a strong form of universality—has been upheld by provincial and territorial governments through banning or discouraging private health insurance (in some provinces); preventing physicians from practicing public (medicare) and private medicine simultaneously (in most provinces); and banning hospitals and clinics from imposing user fees, as well as physicians from extra-billing their medicare patients (in all provinces).⁴

The rules on these practices have evolved in different ways and at different times over the decades since medicare was first implemented. While there are both significant and nuanced differences among the thirteen provincial and territorial regulatory regimes on

journalists and popular authors have used the Commonwealth Fund results, and Canada’s relatively low rankings on timeliness of service and quality, to draw a causal link between the performance and the failure of medicare. See, e.g., Jeffrey Simpson’s many columns in the *Globe and Mail* since the end of the 1990s and his book *Chronic Condition: Why Canada’s Health Care System Needs to be Dragged into the 21st Century* (Toronto: Penguin, 2012) at 157–159, 165, and 200. A more recent example is Stephen Skyvington’s *This May Hurt a Bit: Reinventing Canada’s Health Care System* (Toronto: Dundurn, 2019).

3 Canadian Institute for Health Information, *National Health Expenditure Trends in Canada, 1975–2017* (Ottawa: Canadian Institute for Health Information, 2017).

4 Gregory P Marchildon, “The Three Dimensions of Universal Medicare in Canada” (2014) 57:3 *Can Pub Admin* 362 at 364 [“The Three Dimensions of Universal Medicare in Canada”]; Colleen M Flood & Tom Archibald, “The Illegality of Private Health Care in Canada” (2001) 164:6 *CMAJ* 825 at 826–829.

private finance, the intent remains the same: not to allow one group of residents privileged access to medicare services based on ability to pay or the preferential terms of private health insurance relative to all other residents. It is this policy objective in general—as well as the particular regulatory regime in place in British Columbia—that is the issue under litigation in the *Cambie Surgeries* case.⁵

This chapter examines the history of the regulation of private finance in terms of key decision points that would establish this regulatory regime in two key areas. The first was the active contestation among provincial governments over a single-payer design versus a multi-payer design, and the ultimate selection of the latter as the dominant design. The second key area concerns hospital user charges and physician extra-billing as part of the medicare policies of selected provincial governments and their eventual elimination.

The Historical Contest between Single-Payer and Multi-Payer Financing

Although the main conflict between single-payer versus multi-payer approaches occurred in the 1960s, when universal medical coverage was introduced, the debate over the best approach to achieving universal coverage can be traced to the immediate postwar period. In January 1947, Saskatchewan implemented universal hospital coverage on a single-payer design in which the provincial government paid directly on behalf of patients for all necessary hospital care and diagnostic services.⁶

While this design feature was similar to general tax-based financing as implemented eighteen months later for the National Health Service (NHS) by the British government, there were important differences between the Saskatchewan plan and the NHS. The most important of these differences was that, unlike the NHS, where

5 *Cambie Surgeries v British Columbia (Medical Services Commission)*, (2015) Vancouver S090663 [*Cambie*]. In his interlocutory ruling in *Cambie Surgeries v British Columbia (Medical Services Commission)* 2015 BCSC 2169 at paras 14–28, Chief Justice Cullen provides summary of the proceedings in the case to that date. A complete timeline and links to key legal documents in the *Cambie* case has been compiled by the BC Health Coalition, online: <<http://savemedicare-bchealthcoalition.nationbuilder.com/court-documents>>.

6 This plan was based on *The Saskatchewan Hospitalization Act, 1946*, ss 1946, c 82, and the regulations thereunder.

hospitals were publicly owned and operated, hospitals and their boards in Saskatchewan remained independent of the provincial government. In other words, the Saskatchewan plan changed financing but kept the multiplicity of delivery arrangements—a public-payment but private-practice system.⁷ The term “single payer” only came into general use decades later, and mainly to distinguish a Saskatchewan/Canadian style of universal health coverage and its private delivery from a NHS-style system.⁸

In 1950, three years after the Saskatchewan plan came into operation, a very different hospital-insurance plan based on a multi-payer design was implemented in Alberta. Contrary to Saskatchewan, the Alberta government subsidized the purchase of private health insurance by residents who could demonstrate their inability to pay market-rate hospital insurance premiums. Unlike the compulsory scheme in Saskatchewan, where all residents were expected to be registered in the program, Alberta residents could choose to go without health insurance. In addition, since the cost of the subsidies were shared with municipalities, local governments could also choose whether or not to participate in the program. Finally, although the Alberta plan, similar to the Saskatchewan plan, was financed through general taxation and fixed premiums (a particular form of taxation known as poll taxes), additional revenues were generated through a hospital user fee based on days spent in hospital.⁹

Until the federal government passed the *Hospital Insurance and Diagnostic Services Act (HIDSA)* in 1957, these two plans were the main alternatives. However, federal cost sharing of provincial hospital-insurance plans were conditional on accepting key national standards in *HIDSA*, which, in turn, supported—even if they did not require—a single-payer approach. In particular, the definition of universality required that all residents have access to hospital services

7 C David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911–1966* (Montreal and Kingston: McGill-Queen’s University Press, 1986).

8 Carolyn Hughes Tuohy, “Single Payers, Multiple Streams: The Scopes and Limits of Subnational Variation under a Federal Health Policy Framework” (2009) 34:4 *J Health Pol Pol’y & L* 453 at 453–454.

9 For more details on these differences, see Gregory Marchildon, “Douglas versus Manning: The Ideological Battle over Medicare in Postwar Canada” (2016) 50:1 *J Can Stud* 129 at 133–140 [“Douglas versus Manning”].

“on uniform terms and conditions.”¹⁰ This wording implied that (1) all provincial residents be registered for coverage, thereby making a scheme based on voluntary enrollment ineligible for federal cost sharing; and (2) all provincial residents would have the same coverage, thereby preventing major differences in coverage based on price, risk (e.g., pre-existing conditions), and insurance company.

With 25 per cent of provincial residents uninsured, and an infinite variation in the scope and cost of individual health insurance policies, Alberta’s scheme was deemed ineligible under *HIDSA* for federal cost sharing. As a consequence, the Alberta government converted its decentralized, multi-payer financing model into a (solely) provincially administered single-payer plan. Although a few other provincial governments, in particular the government of Ontario under Progressive Conservative Premier Leslie Frost, would have preferred multi-payer financing, between 1958 and 1961, they eventually accepted the single-payer design in order to be deemed eligible for federal cost sharing under *HIDSA*.

The Multi-Payer Alternatives: Manningcare, Bennetcare, and Robartscare

The real battle over single-payer would come in the 1960s with the expansion of coverage from hospital care to physician services. Although Saskatchewan again took the lead in being the first province to establish universal medical coverage in 1962, this time it would find itself almost alone in promoting the single-payer approach, and in enduring a bitter twenty-three-day doctors’ strike when first implemented.¹¹ Between 1963 and 1966, three provincial governments set up rival, multi-payer universal health plans in a bid to convince the federal government to legitimate multi-payer plans

10 Under section 5(2)(a) of the *Hospital Insurance and Diagnostic Services Act*, SC, c. 28, provincial governments were required “to make insured services available to all residents of the province upon uniform terms and conditions” in return for federal cost sharing.

11 *The Saskatchewan Medical Care Insurance Act*, ss 1962, c 1, inelegantly subtitled *An Act to provide for Payment for Services rendered to Certain Persons by Physicians and Certain other Persons*. See Malcolm G Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and their Outcomes*, 2nd ed (Montreal and Kingston: McGill-Queens University Press, 1987) at 285; Gregory P Marchildon & Klaartje Schrijvers, “Physician Resistance and the Forging of Public Healthcare: A Comparative Analysis of the Doctors’ Strikes in Canada and Belgium in the 1960s” (2011) 55:2 *Med Hist* 203 at 207–219.

in any future federal standards and cost sharing. These provincial plans—providing a level of coverage for physician services—became known by the names of their respective premiers—Manningcare in Alberta, Bennetcare in British Columbia, and Robartscare in Ontario—were supported by organized medicine, most other provincial governments, the insurance companies, and the business establishment.

Almost identical to the design of the Alberta multiplayer hospital-insurance plan of the 1950s, Manningcare provided public subsidies to low-income residents to pay the premiums for private health insurance. Premier Ernest Manning held the strong belief that providing subsidies for the poor would address the problem of access without damaging the principle of individual responsibility, while universality on a single-payer model would eliminate both choice and individual responsibility. In keeping with this philosophy, coverage was voluntary, unlike the compulsory coverage in the Saskatchewan plan of 1962. Manning's government worked closely with the Alberta Medical Association and the insurance industry on the design of the plan.¹² After the plan became operational, in 1963, Manningcare was continually advocated by organized medicine and the health insurance carriers as the model for the federal government and all other provincial governments in Canada.¹³

Like Premier Manning of Alberta, Premier W. A. C. Bennett of British Columbia ideologically preferred a multi-payer model and also worked with organized medicine in his province to design a plan that would be acceptable to the doctors. However, unlike Manning, Bennett was prepared to compromise to increase the probability of his program complying with any future national standards for federal cost sharing of the program. As a consequence, his plan was limited to non-profit health insurers, including a physician-owned insurer. Although Bennett did not want the government involved in providing insurance, the non-profit health insurers resisted the idea of taking on the poor risks and insisted the provincial government provide medical coverage through its own plan for these individuals. As a consequence, a governmental insurance plan—the British

12 Ronald Hayter, "'Manningcare' cheered by Alberta Doctors," *Toronto Star* (29 March 1963) 1–2.

13 Cam Traynor, "Manning against Medicare" (1995) 43 *Alta Hist* 7 at 7–19; Marchildon, "Douglas versus Manning," *supra* note 9 at 143.

Columbia Medical Plan (BCMP)—was established in order to cover higher-risk individuals and families. However, Bennett insisted on a common, comprehensive package of medical services, which all the non-profit health insurers were required to offer, a contrast with Manningcare. Bennetcare became law through a series of regulations passed under an already existing law in June 1965.¹⁴

In comparison to Manningcare and Bennetcare, Robartscare took a longer time to gestate. Carefully observing the Saskatchewan doctors' strike in July 1962, Robarts's government decided to adopt an approach that would be acceptable to both organized medicine and the powerful insurance carriers in Canada, many of which were headquartered in Ontario. The bill that would eventually become the *Medical Services Insurance Act* was sent out for consultations in late 1962 and early 1963 before being presented in the provincial legislature.¹⁵ When the bill went to second reading, in April 1963, the provincial minister of health, Dr. Matthew Dymond,¹⁶ laid out the ways in which it would differ from the Saskatchewan approach.

First and foremost, it would be a multi-payer plan based on subsidizing the purchase of existing private health insurance contracts. In Dymond's words, the private insurance carriers had "done an outstanding job" in covering "some 70 per cent of the people of Ontario" with "some type or degree of coverage." He stated that there was "no sound evidence" that the "monopolistic control" of a single-payer plan could deliver coverage at a "lower cost" than the type of multi-payer plan his government was introducing. He further argued that a multi-payer model, through the "competition of the open market-place" would "put a better, more effective check on rising costs" than single-payer financing. Dymond also pointed

14 Gregory P Marchildon & Nicole C O'Byrne, "From Bennetcare to Medicare: The Morphing of Medical Care Insurance in British Columbia" (2009) 26:2 Can Bull Med Hist 453 at 460–467.

15 This bill would not become law until 1965: *Medical Services Insurance Act*, RSO 1965, c 56. See *Table of Public Statutes and Amendments: R.S.O. 1960; 1960–1961; 1961–1962; 1962–1963; 1963; 1964; 1965; 1966; 1967; 1968; 1968–1969; and 1970* (Toronto: Queen's Printer for Ontario, 1970), online: *Statutes at Osgoode Digital Commons* <http://digitalcommons.osgoode.yorku.ca/ontario_statutes/vol1970/iss1/174>.

16 Matthew Bulloch Dymond (1911–1996) was Ontario's minister of health from 1958 until 1969 and, as such, was responsible for the implementation of universal hospital coverage in the province, first introduced on 1 January 1959, and the chief architect of Robartscare. Ontario Legislative Assembly parliamentary history, online: <<https://www.ola.org/en/members/all/matthew-bulloch-dymond>>.

out that his government had “very closely collaborated” with both the Ontario Medical Association and the Canadian Health Insurance Association on the drafting of the bill.¹⁷

Although welcomed by organized medicine¹⁸ and the insurance industry, the bill was heavily criticized in some of the Ontario media as a sellout to these same pressure groups.¹⁹ The editor of the Kingston *Whig-Standard*, for example, charged that the government was using “public funds” to “underwrite a medical scheme which” would “profit the private insurers (who, of course, would never agree to assume the risks of the comprehensive, all-inclusive coverage guaranteed under the proposed bill).” The *Whig-Standard* then pointed out how the Beveridge report in the United Kingdom had stated many years before “that the insurance principle was not a sound method of financing medical services, and that the broader the services provided, the more difficult it would be to retain that basis.” For this reason, Lord Beveridge had concluded “that the ultimate solution would be to finance medical benefit in the same manner as all public health activities—from public funds.”²⁰

The bill was a strategic effort on the part of the Robarts administration to convince the federal government to reject the single-payer approach that marked the *HIDSA* of 1957 and instead propose cost sharing for multi-payer plans for physician services. Robarts and Dymond were able to play for time while they negotiated with the federal government. Although the Ontario government waited until 1965 to get Robartscare passed into law, it had still not finished

17 John P. Robarts fonds (Statement made by MB Dymond on second reading of the *Medical Services Insurance Act*, 25 April 1963), Toronto, Archives of Ontario (RG 3-26, Apr.–Dec. 1963, file Premier Robarts general correspondence: Medicare).

18 AO, John P. Robarts fonds, RG3-26, file Premier Robarts general correspondence: Medicare (Apr.–Dec. 1963), clipping from article entitled “Doctors’ Group Favours Plan for Health Care” in *Globe and Mail* (14 May 1963).

19 AO, John P. Robarts fonds, RG3-26, file Premier Robarts general correspondence: Medicare (Apr.–Dec. 1963), clipping from article entitled “Half-Baked Medical Plan is Effort to Resist Progress” in the *Toronto Star* (15 May 1963): in this respect and in contrast to the *Globe and Mail*, the *Toronto Star* consistently favoured single-payer Saskatchewan-style medicare over Robartscare in a series of editorials, including “A Test for Medicare” (16 May 1963) and “Caricature of Medicare” (13 January 1964).

20 RA O’Brien quoted in *Kingston Whig Standard* (25 April 1963) 1. O’Brien sent this article to Premier Robarts: AO, John P. Robarts fonds, RG 3-26, file Premier Robarts general correspondence: Medicare (Apr.–Dec. 1963).

writing all of the administrative regulations under the law by March 1966.²¹ However, by 1966, the federal government, under Liberal Prime Minister Lester Pearson, was beginning to better specify the areas where it would be flexible and the overarching design principles on which it would not bend.

The Federal Government's Response

Highly influenced by the recommendations of the Royal Commission on Health Services (commonly known as the Hall Commission) delivered two years earlier, the Pearson government followed the reasoning in the commission's report in its negotiations with the provinces and in the legislation establishing national medical coverage.²² After carefully weighing the advantages and disadvantages of a non-universal subsidy model compared to a universal tax-based approach, the Hall Commission concluded in favour of the latter for three main reasons. First, universality avoided the need for a stigmatizing means test. Second, single-payer tax financing eliminated the expensive overhead involved in insurance risk rating. And third, it would take far less time to achieve close to 100 per cent coverage of provincial populations through a compulsory, publicly administered, and universal enrollment than on a voluntary approach through the subsidy of private health insurance.²³ At the same time, the Hall report did not foreclose the possibility of a multi-payer plan as long as it was carefully regulated in the public interest and report to the provincial minister of health.²⁴

21 AO, John P. Robarts fonds, RG3-26, file Premier Robarts general correspondence: Medicare (Apr.–Dec. 1963), clipping from article entitled “Easy Adjustment to OMSIP” in the *Toronto Telegram* (26 March 1966).

22 PE Bryden, “The Liberal Party and the Achievement of National Medicare” (2009) 26:2 *Can Bull Med Hist* 315 at 324; Canada, *House of Commons Debates*, 27–31, vol 7 (12 July 1966) at 7544–7545 (Hon Allan J MacEachen).

23 Royal Commission on Health Services, *Royal Commission on Health Services: Volume 1* (Ottawa: Queen's Printer, 1964) at 723–745. A recent version of this debate (as well as trade-offs involved in relying on private health insurance originally identified by the Hall commission) continues to play out in the Netherlands: see Robert AA Vonk & Frederik T Schut, “Can Universal Access be Achieved in a Voluntary Private Health Insurance Market? Dutch Private Insurers Caught Between Competing Logics” (2019) 14 *Health Econ Pol'y & L* 315.

24 See Royal Commission on Health Services, *supra* note 23 (“Administration at the provincial level should be a Commission representative of the public, the health professions, and Government, reporting to the Minister of Health, and it should

Allan MacEachen, the federal minister of health who had recently taken over the portfolio from Judy LaMarsh, exhibited more flexibility than his predecessor on two key points in order to expedite the acceptance of national medical coverage. The first was his willingness to consider voluntary schemes as eligible for federal cost sharing as long as a minimum of 90 per cent of residents were enrolled in the program. The second compromise—aimed at appeasing Bennett in British Columbia—involved relaxing the definition of public administration so that private not-for-profit insurers could be part of the provincial scheme as long as these carriers were answerable and accountable to a public authority. Previously, LaMarsh had said that private carriers could not be part of eligible provincial plans.²⁵ This new position opened up the possibility of a multi-payer plan along the lines of Bennetcare but required major changes in the cases of Manningscare and Robartscare.

At the same time, MacEachen held firm on the principle that eligible provincial governments had to demonstrate that their plans offer comprehensive medical coverage to all residents on uniform terms and conditions. The federal government insisted that eligible provincial plans would have to provide comprehensive medical coverage and meet the definition of universal in the sense of access based on uniform terms and conditions for coverage of physician services, as had been required under the national insurance plan for hospitalization. When asked about the eligibility of Robartscare by the media, MacEachen said that it was “not readily apparent” that the plan, based largely on private for-profit insurers, could meet these criteria.²⁶ While Manning was opposed to national medicare on the level of basic religious and political values,²⁷ Robarts felt that universal medicare on the Saskatchewan model was a bad idea from a more pragmatic standpoint. Indeed, he failed to understand why

also assume administration of the hospital-insurance plan in the province. In a province where a voluntary prepayment agency operates, we recommend that such an agency may be used as the administrative vehicle augmented by additional representation of the public, the health professions and the Government” at 20).

25 Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 11 at 369.

26 MacEachen quoted in article entitled “Medicare won’t Drive Us Out: Insurance Men” in the *Toronto Star* (21 May 1966): AO, John P. Robarts fonds, RG3-26, file Premier Robarts general correspondence: Medicare (Apr.–Dec. 1963).

27 Marchildon, “Douglas versus Manning,” *supra* note 9.

Ottawa would not agree to what he viewed as a far more practical, less expensive, and less complicated subsidy model than a government-administered single-payer plan.²⁸

When the federal *Medical Care Act* went to first reading in the House of Commons on 12 July 1966, MacEachen stated the basic principle upon which the bill was based—"that all Canadians should be able to obtain health services of high quality according to their need for such services and irrespective of their ability to pay," and "that the only practical and effective way of doing this is through a universal, prepaid, government-sponsored scheme."²⁹

When the bill was passed into law, in December 1966, the Alberta and Ontario governments realized they had lost the war to get their respective multi-payer schemes accepted for federal cost sharing. Section 4(1)(a) of the *Medical Care Act* required that, to be eligible, provincial plans had to be "administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province," which, in turn, had to be answerable to the "government of the province or to a provincial minister." In addition, under section 4(1)(b), the provincial plan had to provide medical services "upon uniform terms and conditions to all insurable residents of the province."³⁰ This strong form of universality³¹ blocked the eligibility of any provincial multi-payer plan that permitted variable forms of coverage under different prices through individual insurance carriers, a problem avoided in BC through setting the terms constituting the basic (yet reasonably comprehensive) package of universal medical coverage.

If the governments of Alberta and Ontario wanted plans that would be eligible for federal cost sharing, then Manningcare and Robartscare were dead in the water, and, indeed, these multi-payer plans were soon abandoned in favour of single-payer plans that met the federal criterion of universality. However, due to its non-profit design and the existence of a government-administered insurance fund offering a public coverage option, Bennetcare was able to

28 AK McDougall, *John P. Roberts: His Life and Government* (Toronto: University of Toronto Press, 1986) at 168.

29 Canada, *House of Commons Debates*, 27–31, vol 7 (12 July 1966) at 7545 (Hon Allan J MacEachen).

30 *Medical Care Act*, 1966–1967, c 64, s 1 (RSC 1970, c M-8).

31 Marchildon, "The Three Dimensions of Universal Medicare," *supra* note 4 at 364.

rapidly adapt its non-profit plan to meet the requirements of the *Medical Care Act*.³²

On 1 July 1968, the date set for the implementation of the *Medical Care Act*, British Columbia and Saskatchewan were the only jurisdictions deemed ready and eligible for federal contributions. The government of Alberta would take an additional year to establish a regulatory and administrative structure acceptable to the federal government. Ontario needed more time and did not implement its plan until 31 October 1969.³³

While this was the end of the story for Manningcare and Robartscare, it was not the end for the multi-payer program in British Columbia. The non-profit insurance carriers provided to their subscribers free coverage for physician services but, over time, they found it increasingly difficult to live off the thin profit margins provided through government subsidies. Moreover, members of the general public increasingly obtained comprehensive medical coverage through the BC government's public plan, the BCMP. By 1972, only two of the non-profit plans operated as licensed carriers of medicare insurance. Before the end of the decade, only the BCMP remained, and Bennetcare had officially morphed into a single-payer plan no different than any other provincial plans in Canada.³⁴ In 1992, many years after the BCMP had become the de facto single payer in British Columbia, the provincial government introduced a blanket prohibition on the sale of private health insurance for all medicare services (hospital and physician services).³⁵

32 Gregory P Marchildon, "Canadian Medicare: Why History Matters" in Gregory P Marchildon, ed, *Making Medicare: New Perspectives on the History of Medicare in Canada* (Toronto: University of Toronto Press, 2012) 3 at 13–14.

33 Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 11 at 375.

34 *Cambie Surgeries Corporation et al v Medical Services Commission of British Columbia et al* (British Columbia Supreme Court) (Expert affidavit of Gregory P Marchildon on the Evolution of Medicare in Canada at 55–7) (3 March 2014).

35 Section 39(1) of the *Medical and Health Services Act* stated that "[a] person must not provide, offer or enter into a contract of insurance with a resident for the payment, reimbursement or indemnification of all or part of the cost of services that would be benefits if performed by a practitioner," and section 39(3) stated that any such contract "is void." These sections were replicated in section 45 of the *Medicare Protection Act*, RSBC 1966, c 284. See Gregory P Marchildon, "Private Insurance for Medicare: Policy History and Trajectory in the Four Western Provinces" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto:

User Charges and Extra-Billing

Similar to the question of single-payer government financing versus multi-payer public-private financing, the policy of user fees in health care has long polarized both researchers and decision makers, particularly in jurisdictions where there are significant populations that cannot afford even the most modest user fees easily affordable by the broad middle class in higher-income countries.³⁶ Although there is considerable evidence that user fees are, in fact, ineffective in reducing the *inappropriate* use of such services, the policy of user fees was advocated, and continues to be advocated, by governments, policy advisors, and think tanks.³⁷ Although there is evidence to support the logical proposition that the more patients have to pay directly for medical care, the less they will use it, the problem is that a portion of this reduction is for *needed* care as demonstrated in the multi-year, large-scale RAND Health Insurance Experiment and other studies.³⁸

In other words, while user fees can save public plans in the short run, they can generate higher downstream costs for governments by discouraging necessary care—particularly preventative care—and result in poorer outcomes for those who have been

University of Toronto Press, 2005) 429 at 438. I was unable to determine the government's reasons for this change, although it is perhaps significant that the NDP, a party dedicated to preserving the single-payer and single-tier aspects of medicare, won a landslide electoral victory in October 1991.

36 Mylene Lagarde & Natasha Palmer, "The Impact of User Fees on Access to Health Services in Low- and Middle-Income Countries" (2011) 4 Cochrane Database Syst Rev, online: <<https://doi.org/10.1002/14651858.CD009094>>.

37 This literature is summarized by the Canadian Foundation for Healthcare Improvement: "Myth: User Fees Ensure Better Use of Health Services" (2012) Canadian Foundation for Healthcare Improvement Mythbusters, online (PDF): <https://www.cfhi-fcass.ca/sf-docs/default-source/mythbusters/Myth_User_Fees_EN.pdf?sfvrsn=47dfa44_0>.

38 For an exceptional empirical and conceptual summary, see Ray Robinson, "User Charges for Health Care" in Elias Mossialos et al, eds, *Funding Health Care: Options for Europe* (Buckingham, UK: Open University Press for the European Observatory on Health Systems and Policies, 2002). For a concise summary of the multi-million-dollar RAND Health Insurance Experiment on user fees conducted between 1971 and 1986, see Robert H Brook et al, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (2006) *RAND Research Brief*, online: <https://www.rand.org/pubs/research_briefs/RB9174.html>.

discouraged from seeking appropriate care at an earlier stage of their illness. Given that they prevent the poor from accessing needed services (while not blocking access for those able to pay), the presence of user fees invariably reduces equity of access. As discussed below, the debate over two types of user fees—particularly hospital and clinic user charges and physician extra-billing—has a long history in Canada. As a matter of legislative language in Canada, user fees are divided into two sub-groups: (1) user charges—facility fees imposed on patients by hospitals as well as diagnostic and surgical clinics, and (2) extra-billing—physician fees imposed on patients that are in addition to the rate set by provincial governments for medicare services.

Since the introduction of the *Canada Health Act* (CHA) in 1984, with its penalties for provinces who permit user fees and physician extra-billing by hospitals, clinics, or physicians,³⁹ the assumption has been that the Canadian model of medicare requires all provincial governments to provide first-dollar coverage on all CHA-insured services. In fact, in its negotiations with provinces leading up to national implementation of universal hospital and medical coverage in the mid- to late 1950s and 1960s, the federal government did not insist on the elimination of modest user fees as a condition of eligibility for federal cost sharing. This was despite that there is legislative language in both the *HIDSA*⁴⁰ of 1957 and the *Medical Care*

39 See *Canada Health Act*, RSC 1985, c C-6, ss 18 (extra-billing), 19 (user charges), 20 (deductions and process for extra-billing and user charges). The question of user fees is also partially addressed in the accessibility criterion of the CHA in section 12(1)(a): “In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured services.” Of course, those arguing in favour of user fees have generally proposed modest user fees, with built-in exceptions, which they feel do not impede *reasonable* access to insured services, the same argument made by some provincial governments in the pre-CHA era of medicare.

40 See the definition of insured services in the *Hospital Insurance and Diagnostic Services Act*, SC, c 28, s 2(g) [emphasis added]: “‘Insured services’ means the inpatient services to which residents of a province are entitled under provincial law *without charge* except a general charge by way of premium or other amount not related to a specific service and except authorized charges... .”

*Act*⁴¹ of 1966 which could have allowed the federal government to withdraw some of its cash transfers to those provincial governments with user fees for hospital, diagnostic, or physician services.

In the pre-CHA medicare era, the question of user fees, including physician extra-billing, sharply divided provincial governments, and this, from the earliest days of medicare. While the universal hospital- and medical-coverage plans in Saskatchewan originally excluded patient fees at the point of service, the plans in Alberta and British Columbia insisted on the use of such fees as a way to reduce what the governments in those provinces defined as “unnecessary” utilization of hospital or physician services, a position grudgingly accepted by the federal governments in the pre-CHA period.

The most interesting aspect of this early history is that Saskatchewan reversed its position on user fees after a change in government in the 1960s. In 1964, the provincial Liberal Party under Ross Thatcher defeated the social-democratic government that had been in power for two decades, in part because of the controversy surrounding the implementation of universal medical coverage. Although organized medicine and much of the business and professional community expected Thatcher to undo medicare once elected, the new premier kept the program in order to avoid a backlash from the large number of residents who supported the change.

However, fixated on the growing cost of medicare, Thatcher concluded that user fees were needed to reduce what he perceived as overutilization of health services. Although the problem was linked to an increase in the use of hospital and physician services, as well as major increases in the physician fee schedule, Thatcher felt that, unless residents paid a price at the point of delivery for these services, utilization would spiral out of control. As a consequence, in April 1968 his government introduced user fees. Hospitals were thereafter required to charge \$2.50 per day for hospital stays. If a hospital stay extended beyond thirty days, hospitals charged patients

41 Section 4(1)(b) of the *Medical Care Act*, 1966–1967, c 64; RSC 1970, c M-8, has a provision that is almost identical to the accessibility criterion in the CHA: an eligible provincial is “operated so as to provide for the furnishing of insured services upon uniform terms and conditions to all insurable residents of the province, by the payment of amounts in respect of the cost of insured services ... and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.”

\$1.50 for each day after the thirtieth day. Doctors were required to charge \$1.50 for each office visit, and \$2 for any out-of-office consultation, including those at the hospital (including emergency departments) or the patient's home.

Officially labelled "deterrent fees" by the Thatcher government, these user fees remained in place until August 1971, when they were eliminated by a newly elected New Democratic Party (NDP) government under leader Allan Blakeney. This is the only experiment in the application of user fees during the medicare era that has been extensively analyzed in Canada. The experiment was studied by two academic economists, R. Glen Beck from the University of Saskatchewan and John Horne from the University of Manitoba. Their time-series analysis spanned slightly more than a decade, from 1963, one year after the introduction of universal medical coverage, to 1977, six years after the user fees were eliminated.⁴² Although there are numerous analyses of user fees in jurisdictions beyond Canada, including major analyses such as the RAND study in the United States, the very different institutional context of these user fees means that these studies are of limited application to the context of Canadian medicare. In contrast, the Beck and Horne study is directly relevant in assessing the likely impact of current policy proposals to introduce user fees in the Canadian context.

As stated above, it is only logical to expect that user fees, in the form of directly charging patient copayments at the point of service, will—holding everything else constant—reduce utilization. And, in fact, Beck and Horne found that the user fees reduced the total number of physician services per resident in Saskatchewan in the 1968–1971 period relative to the periods before (1963–1967) and after (1972–1977) the imposition of user fees.⁴³ The only question was whether user fees blocked at least as much needed care as unneeded care among those mainly lower-income residents who could not afford the fees.

Hospital services were a very different matter. Beck and Horne examined changes in the length of hospital stays for seventeen

42 RG Beck & JM Horne, "Utilization of Publicly Insured Health Services in Saskatchewan Before, During and After Copayment" (1980) 18:8 *Med Care* 787.

43 Relative to the average trend line from 1963 until 1977, total physicians' services per eligible Saskatchewan resident dropped 8.1 per cent in 1968, 10.5 per cent in 1969, 5.9 per cent in 1970, and 6.4 per cent in 1971. Beck & Horne, "Utilization of Publicly Insured Health Services," *supra* note 42 at 789.

discrete diagnostic and surgical procedures. For fifteen of these procedures, there was no appreciable change in length of hospital stay. However, even in these two outlier procedures, the shorter stays were not related to the imposition of user fees. In their words, there was no “compelling evidence that the introduction of user charges shortened lengths of stay or that the elimination of such charges increased lengths of stay.”⁴⁴

Although Beck and Horne did not speculate on why patient user fees produced at least some decline in utilization of outpatient physician services without a corresponding decline in diagnostic and hospital services, it is worthwhile suggesting a hypothesis. An individual has to make his or her own decision as to whether to see a physician. If individuals are unsure about whether it is necessary, they are more likely to wait to see if the condition or concern they are experiencing disappears if they are concerned about the cost of the visit.⁴⁵ Patients, however, do not make independent choices concerning diagnostic and hospital care, particularly in Canada, where physician referrals are generally required for diagnostic tests and assessments by specialists for hospital-based treatments. Primary-care physicians, including those in emergency departments, are much more in control of making such decisions than individuals, and few patients are prepared to refuse a test or undergo surgical treatment recommended or demanded by a doctor.⁴⁶

44 The study compared patients who paid the user fees to a control group of patients not required to pay user fees: Beck & Horne, “Utilization of Publicly Insured Health Services,” *supra* note 42 at 806.

45 Of course, all bets are off after the initial visit. If a physician recommends or insists that the individual come back for a follow-up visit, once again the individual is likely to defer to the physician’s expertise rather than rely on his or her own judgement as to whether a follow-on appointment is necessary.

46 A typical patient pathway in Canada is described in Gregory P Marchildon, *Health Systems in Transition: Canada*, 2nd ed (Toronto: University of Toronto Press, 2013) at 103–04. There is some debate over the gatekeeping role in Canada. These differences are reflected in the literature. See, e.g., Benjamin TB Chan & Peter C Austin, “Patient, Physician and Community Factors Affecting Referrals to Specialists in Ontario, Canada” (2003) 41:4 *Med Care* 500 at 501 (gatekeeping role) and Marie-Dominique Beaulieu et al, “Family Practice: Professional Identity in Transition. A Case Study of Family Medicine in Canada” (2008) 67:7 *Soc Sci & Med* 1153 at 1155 (no gatekeeping role). Although there do not appear to be specific provincial laws formally stipulating a gatekeeping role, provincial governments have established strong financial incentives to encourage referrals, while administrative systems for hospitals and diagnostic clinics are designed

If this hypothesis is correct, then user fees would likely only be effective (in terms of reducing utilization) for primary medical care. The question then becomes one of whether the user fees are effective in preventing inappropriate care; and, if so, to what extent. In particular, is the amount of inappropriate care being blocked greater than the amount of appropriate care being prevented through user fees? This question cannot be answered definitely without understanding the level and distribution of income and wealth in any given society. However, if we accept that in a relatively prosperous country such as Canada, with a relatively large middle class, modest user fees would not likely reduce potentially inappropriate use of primary-care services by a large percentage of individuals because they would not be deterred by user fees. At the same time, these same fees would deter low-income individuals and families from seeking primary care—while some of this might be inappropriate care, a majority of this care could be quite needed and appropriate in the circumstances.

In summary, therefore, a regime of user fees for primary care in Canada might create the worst of both worlds: it would not significantly reduce overall utilization given the large percentage of the population that can easily afford modest user fees (the healthy, wealthy, and most of the middle class) while blocking the working poor (assuming those on social assistance are exempted from user fees), who, on average, are more likely to suffer from medical problems than higher-income Canadians. The minimal savings obtained through such a program, given the high cost of administration, including managing exemptions, would hardly seem worthwhile. Given this, the decision to impose user fees would have to be based on the idea of moral hazard and the ideological principle that only individual payment for medically necessary health care at the point of service is effective in generating sensible stewardship of resources.⁴⁷

in ways that virtually require referrals by general practitioners/family-medicine specialists: Dominika Wranik, "Health Human Resource Planning in Canada: A Typology and its Application" (2008) 86 *Health Pol'y* 27 at 31.

- 47 Collège des économistes de la santé, "Utilisation Fees Imposed to Public Health Care Systems Users in Europe" (Roundtable report of presentations for the Commission on the Future of Health Care in Canada, Paris, 29 November 2001). The countries covered in this report included Germany, Austria, Switzerland, Belgium, the Netherlands, Italy, Denmark, Norway, Sweden, Spain, and France. This report formed a key part of the evidence upon which the Romanow com-

One specific type of user fee—physician extra-billing—is currently the focus of a constitutional challenge by Cambie Surgeries Corporation, a private surgical clinic, in the Supreme Court of British Columbia. In this case, the plaintiff, as represented by Cambie and Dr. Brian Day, the founder and medical director of Cambie, alleges that prohibition against extra-billing in the *Medicare Protection Act*⁴⁸ in British Columbia means that a private facility is limited to charging “the fee that the doctor alone would be paid for providing the service in the public system.” In the plaintiff’s view, this restriction makes “it economically impossible for an enrolled doctor to perform any medically required services in a private facility, and also economically impossible for the private clinic to allow the doctor to do so.”⁴⁹ The logic of the argument is questionable given the requirement that independently contracted doctors working within provincial medicare systems are also expected to pay their overhead costs, and this understanding is built into the fee schedules negotiated between provincial governments and provincial medical associations. While medicare physicians will generally use the surgical operating theatres in public hospitals, provincial governments have worked with opted-in physicians to cover the capital costs of niche surgical facilities in a number of provinces. The key is whether the physicians are working under the rules of medicare or not. If they are, they agree to respect the provincial laws on extra-billing. In most provinces, including British Columbia, physicians have the right to opt out of medicare and charge patients directly.⁵⁰

The plaintiffs in the Cambie Surgeries case have argued that extra-billing in a parallel private system (with physicians allowed to practice in both sectors simultaneously) can, by providing patients

mission relied to recommend against the lifting of the Canada Health Act’s restrictions on extra-billing and user charges in order to reduce utilization and thereby reduce cost or to raise new revenues. See Roy Romanow, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 28–30.

48 The prohibition on physician extra-billing is in ss 17(1)(b) and 18(3) of British Columbia’s *Medicare Protection Act*, RSBC 1996, c 286.

49 Opening Statement of the Plaintiffs, Between Cambie Surgeries Corporation, Chris Chiavatti et al (plaintiffs), and Medical Services Commission of British Columbia, Minister of Health of British Columbia, and Attorney General of British Columbia, 6 September 2016, p. 92.

50 See Flood & Archibald, “The Illegality of Private Health Care in Canada,” *supra* note 4.

who can afford to pay the extra fee, reduce the pressure on the public system and reduce wait times. Surgical wait times are mainly associated with elective surgical procedures such as cataract surgeries and orthopaedic hip and knee procedures. Manitoba actually provides an example of the impact of extra-billing in the case of cataract surgeries. In that province, cataract surgery was available in both the public and private systems for most of the 1990s, with patients being required to pay out of pocket for the extra fee if they chose to go to a private clinic, a practice discontinued by the NDP government under Premier Gary Doer first elected in 1999. In a study of wait times during the period when extra-billing was permitted, the Manitoba Centre of Health Policy “found that waiting times for cataract surgery in the public sector were the longest for surgeons who also had a private practice.”⁵¹ While the study could not determine the precise reason for this outcome, the authors could still conclude that a parallel private system “does not result in shorter waits in the public sector.”⁵²

Conclusion

The current debate on the limited private financing of medicare in Canada has long historical roots. Single-payer financing moved Canada from an insurance-based model of health care to a public-service model of health care. Those arguing in favour of allowing the purchase of private health insurance for medicare services want a return to an insurance-based approach, with multiple, private insurers so that individuals have choice in the depth and breadth of coverage as well as in the provision of services.⁵³ However, if this is permitted, it will raise all the equity issues that existed before medicare and will ultimately create barriers to access for the poorer members of society, likely the working poor if governments continued to protect those individuals receiving social assistance. In addition, two-tier public and private insurance coverage will inevitably lead to two tiers of services; that is, public services for those residents

51 Carolyn DeCoster, Leonard MacWilliam & Randy Walid, *Waiting Times for Surgery: 1997/98 and 1998/99 Update* (Winnipeg: Manitoba Centre for Health Policy and Evaluation, 2000), at 35.

52 *Ibid* at 35.

53 See Åke Blomqvist & Colin Busby, *Rethinking Canada's Unbalanced Mix of Public and Private Healthcare: Insights from Abroad* (Toronto: CD Howe Institute, 2015).

limited to medicare coverage and a private tier of services for those with private insurance coverage or the ability to pay out of pocket.

Those arguing in favour of the continuation of single-payer financing emphasize the right of access by all citizens to the same health coverage. While the federal government does not directly impose a single-payer model on provincial governments—and historically permitted at least one version of a multi-payer approach—it will no longer be possible for Ottawa to insist that all provincial medicare coverage be on “uniform terms and conditions” as currently defined under the *Canada Health Act*. Although the government of British Columbia managed its multi-payer program for a few years, it did so under regulations that forced all non-profit carriers to offer identical coverage packages. This constrained profitability to the point that all private insurers eventually exited the sector to focus on more profitable supplementary health insurance.

User fees on patients are an additional way to inject private finance into medicare. Before the *Canada Health Act*, user fees, either in the form of hospital user charges or physician extra-billing, were a regular part of medicare in provinces such as British Columbia, Alberta, and Ontario. However, from an analytical standpoint, the most interesting user-fee experience was in Saskatchewan from 1968 until 1971. The results of this experiment demonstrated the ineffectiveness of hospital user charges in reducing utilization. Physician extra-billing did reduce the utilization of primary care; these user fees just as likely blocked care that was needed as care that was not necessarily required. As a result, physician extra-billing, while it may have saved the provincial government some money in the short term, would likely have increased the downstream costs due to lack of adequate upstream prevention and treatment. Finally, all user fees have negative equity implications. Even modest user fees, while not a serious deterrent for middle- and high-income earners, can prevent low-income individuals from seeking needed care. Extra-billing can also drive up physician remuneration in wealthier, urbanized areas more generally, making it even more difficult for smaller centres, much less rural and remote communities, to attract physicians. For all of these reasons, a policy that once again permits physician extra-billing would be a regressive step.

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