

Contracting our Way Around Two-Tier Care? The Use of Physician Contracts to Limit Dual Practice

Bryan Thomas

At the time of medicare's inception, in the early 1960s, Canadian physicians feared becoming employees of the state and staged protests to protect their professional autonomy, securing the ability to operate as independent contractors and bill government on a fee-for-service basis—a status most physicians enjoy to this day.¹ This long-standing professional independence has left some Canadian physicians perennially alive to the temptation of selling their services privately, particularly in high-demand areas of care that frequently carry long wait times. With court challenges like *Chaoulli*² and *Cambie Surgeries Corp.*,³ entrepreneurial physicians have tried to advance this agenda on the coattails of patients, arguing, in effect, that long wait times violate patients' rights to "life, liberty and security of the person"—a problem they claim is best remedied by lifting restrictions on private for-profit care.

To gain some perspective on how Canada's historic concession to physicians' professional independence shapes debate surrounding two-tier care, contrast their situation with that of public-school teachers—another professional group tasked with delivering a universal

1 H. Michael Stevenson & Paul A Williams, "Physicians and Medicare: Professional Ideology and Canadian Health Care Policy" (1985) 11 Canadian Public Pol'y 504.

2 *Chaoulli v Quebec (AG)*, [2005] 1 SCR 791 [*Chaoulli*].

3 *Cambie Surgeries v British Columbia (Medical Services Commission)*, Docket S090663 (Vancouver) [*Cambie*].

public service. Public-school teachers are obliged to work certain hours, instruct the cohort of students assigned to them, and deliver a curriculum tailored by provincial decision makers. Canadians would recoil at the thought of public-school teachers extra-billing students, or shirking their responsibilities to the public-school system for part of the school day as they cater to lucrative private-pay students. The analogy can perhaps be pushed even further: as in the case of health care, students (and their parents) have *Charter* rights in education—notably a right to be educated in accordance to their religious beliefs (within reason).⁴ Yet nobody is tempted to conclude—along the logic of the *Cambie* challenge—that public-school teachers must be granted the freedom to sideline in private education during school hours as a way of ensuring that religious students have a “safety valve” from the state monopoly on secular education. We happily restrict all of this behaviour, not through statutory prohibitions on private education—Canada has private schools, after all—but by imposing fairly stringent *contractual* conditions on public-school teachers. Again, this comparison is offered only to highlight the extent to which historical contingencies—related to Canadian physicians’ unique employment status—have contributed to the political-economic framing of the *Chaoulli* and *Cambie* legal challenges.

This chapter explores whether and how Canadian physicians might be contractually bound, along similar lines, as an alternative mechanism for limiting the spread of two-tier care. This is an approach taken by some high-performing health care systems around the world—perhaps most notably England—using diverse contractual modalities to prevent or limit public-sector physicians from engaging in private practice. Section 1 provides a brief background on the legal and historical factors driving Canada’s debate over two-tier care. Section 2 explains the policy rationale(s) for limiting physician autonomy contractually—identifying the risks associated with allowing physicians participating in universal public systems to simultaneously participate in private for-profit care (i.e., dual practice). In section 3, I survey how physician contracts have been used in other jurisdictions to limit physician autonomy against the proliferation of two-tier care.

4 *Loyola High School v. Quebec (Attorney General)*, [2015] 1 SCR 613.

Canadian Restrictions on Two-Tier Care Explained

As previous chapters have explained in great detail, the legislative framework of Canada's single-payer health care system has come under *Charter* challenge.⁵ While the specifics of these challenges vary by province, it is broadly alleged that, given long wait times in Canada's universal health care system (medicare), laws restricting the emergence of a parallel private tier infringe patients' right to "life, liberty and security of the person."⁶ As others have observed, there is an air of unreality to the framing of these cases around patients' rights: these challenges are generally funded and championed by physicians—notably specialists in high-demand areas like orthopedic surgery—who stand to profit handsomely from the liberalization of a parallel private tier.⁷ It is telling, for example, that the challenge now underway in British Columbia was triggered not by any egregious patient experience, but in response to the BC government's audit of Cambie Surgeries Corporation for surreptitiously extra-billing orthopedic-surgery patients to the tune of hundreds of thousands of dollars annually.⁸ The remedies sought in these challenges are likewise indicative of the underlying motivations: the courts are not asked to help fix medicare's wait times for any specific patient(s), let alone for patients generally. All that is asked is that the courts strike down restrictions on physicians and private insurers, which stand in the way of private for-profit care.⁹

5 *Chaoulli*, *supra* note 2; *Cambie*, *supra* note 3; *Allen v Alberta*, 2015 ABCA 277; *McCreith v. Ontario (A.G.)*, Toronto 07-CV-33945PD3 (Ont. Sup. Ct.).

6 *Canadian Charter of Rights and Freedoms*, s 7, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

7 Some have likened *Chaoulli* to the infamous *Lochner* case of US constitutional law, where business interests successfully challenged a law limiting the work week to sixty hours, ostensibly in defense of workers' right to freedom of contract. See, Sujit Choudhry, "Worse than *Lochner*?" 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: University of Toronto Press, 2005) 75.

8 That audit was completed in 2012, finding that Cambie Surgeries Corp. had extra-billed patients, in violation of British Columbia's *Medicare Protection Act*. See, Ministry of Health, *Specialist Referral Clinic and Cambie Surgeries Corporation: Audit Report* (June 2012), online: <www.bchealthcoalition.ca/sites/default/files/uploads/Specialist%20Referral%20Clinic%20Inc.%20and%20Cambie%20Surgeries%20Corporation%20Audit%20Report.pdf>.

9 Arguably, the focus on "negative rights" was integral to the success of the *Chaoulli* challenge. Courts, wary of overreach, are more comfortable with the tidy

Viewed in this light, these court challenges can be understood as the latest twist in the longer history of physician resistance to “socialized medicine.” A segment of Canadian physicians has long bristled against the establishment of medicare, and its implications for their earning power and professional autonomy.¹⁰ At the time of medicare’s enactment, physicians’ groups across the provinces feared becoming employees of the state, subject to increased managerial oversight and salary restrictions. Doctors’ strikes were organized, resisting the rise of “socialism” in the health care sector. This physician resistance was mollified, in large part, by provinces agreeing to allow physicians to retain their status as independent contractors, billing medicare on a fee-for-service basis in an arrangement that persists to this day.¹¹

Over time, there was growing concern that physician extra-billing was compromising the accessibility of medicare services. The *Canada Health Act*, passed in 1984, addressed this concern by empowering the federal government to wield its spending power as a carrot and stick, withholding health transfers from provinces that allow extra-billing and user fees, on a dollar-for-dollar basis, and authorizing financial penalties for provinces that breached the core principles of medicare (comprehensiveness, universality, accessibility, portability, and public administration).¹² The provinces complied—against renewed protest from physicians’ groups¹³—each enacting their own combination of restrictions drawn from a basic regulatory tool kit: bans on parallel private health insurance, bans on extra-billing and user fees, bans on dual practice (i.e., physicians selling medically necessary care privately must opt out of medicare), and requirements that medically necessary care sold privately be priced at or below

work of overturning laws, as opposed to the messy work of solving wait times. See Kent Roach, “The Courts and Medicare: Too Much or Too Little Judicial Activism?” 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: University of Toronto Press, 2005).

10 See Marchildon, this volume.

11 Gregory P Marchildon, “Physicians Resistance and the Forging of Public Healthcare: A Comparative Analysis of Doctor’s Strikes in Canada and Belgium in the 1960s” (2011) 55 *Medical History* 203.

12 *Canada Health Act*, RSC 1985, c C-6.

13 S Helber & R Deber, “Banning Extra-Billing in Canada: Just What the Doctor Didn’t Order” (1987) 13 *Canadian Public Pol’y* 62.

the public fees rate.¹⁴ With each province enacting one or more of these restrictions, the market for privately financed care has been effectively tamped down. These are the restrictions now under constitutional challenge as infringing patients' *Charter* right to life, liberty and security of the person.

Rationales for Restricting Two-Tier Care

The core issue in these constitutional challenges is whether these restrictions on privatization are necessary to the preservation of public medicare. Critics claim that these restrictions are arbitrary, pointing to the fact that comparator countries manage to sustain high-performing universal health care systems without reliance on such statutory prohibitions.¹⁵ As leading comparativist scholars have been keen to point out, this approach of asking whether high-performing comparator countries employ the *exact same* regulatory modalities as Canada is potentially misleading.¹⁶ After all, no two health care systems are exactly alike, and the unique design features of Canadian medicare may require unique regulatory modalities.¹⁷

It makes sense, therefore, to begin with more fundamental questions: regulatory modalities aside, does it make sense as a matter of public policy to prevent or limit the emergence of a parallel private tier? For present purposes—anticipating our later discussion of contractual restrictions on physicians engaging in private practice—the core question is this: putting aside the specific regulatory instruments used, does it make sense to restrict the ability of physicians in a universal health care system to moonlight in private/dual practice?

Though it is not possible to conduct controlled experiments in the design of health systems, there are various reasons—both theoretical and empirical—for thinking that a thriving parallel private

14 For a province-by-province typology of provincial restrictions on private health-care, see Colleen M Flood & Tom Archibald, "The Illegality of Private Health Insurance in Canada" (2008) 164 CMAJ 825–830.

15 *Chaoulli*, supra note 2 at 834–836.

16 Colleen M Flood & Amanda Haugan, "Is Canada Odd? A comparison of European and Canadian approaches to choice and regulation of the public/private divide in health care" (2010) 5 Health Economics, Pol'y and Law 319.

17 Ted Marmor, Richard Freeman & Kieke Okma, "Comparative Perspectives and Policy Learning in the World of Health Care" (2005) 7 J Comparative Pol'y Analysis 331.

tier may threaten access and quality of care within public health care systems.¹⁸ When extra-billing is combined with dual practice, there is a concern that physicians will prioritize private-sector patients, exacerbating wait times in the public sector—a problem that has been observed, for example, with Australia's experiments with two-tier care.¹⁹ Others suggest that dual practice may result in a kind of brain drain from the public system. The worry here is that private-pay patients will flex their buying power to receive care from leading specialists, while less experienced and/or reputable physicians attend to patients who wait their turn in the public system.²⁰ Adding to this concern is the further risk that these highly skilled physicians will, in their private practice, attend to patients with easier-to-treat medical conditions—a phenomenon referred to as cream skimming—leaving more complicated cases to the public system (and possibly more junior physicians).²¹ Biglaiser and Ma, in their theoretical work on dual practice, worry that a flourishing private tier may have a demoralizing effect on public-sector physicians. Confronted with the fact that dual practitioners earn higher incomes through their private practice, dedicated doctors in the public system may feel underappreciated, and react by “reducing quality in their public service and by participating in moonlighting [themselves].”²² Finally, conflicts of interest may arise, as dual-practice physicians have an incentive to see wait times grow in the public system, driving up demand for private care.²³ There is evidence of this problem manifesting itself in Manitoba in the 1990s, when dual practice was allowed for cataract surgery. Public-stream patients of dual-practice physicians faced

18 For a more exhaustive discussion, see Hurley, this volume.

19 Stephen J. Duckett, “Living in the Parallel Universe in Australia: Public Medicare and Private Hospitals” (2005) 173 CMAJ 745. See also, P Ferrinho et al, “Dual practice in the health sector: review of the evidence” (2004) 2 Human Resources for Health 14; A Garcia-Prado & P Gonzales, “Whom do physicians work for? An analysis of dual practice in the health sector” (2011) 36 J Health Pol, Pol’y & Law 265.

20 A Garcia-Prado & P Gonzalez, “Whom do physicians work for? An analysis of dual practice in the health sector” (2011) 36 J Health Pol, Pol’y & Law 265 at 282

21 T Iversen, “The effect of a private sector on the waiting time in a National Health Service,” (1997) 16 J Health Econ 381.

22 Gary Biglaiser & Ching-to Albert Ma, “Moonlighting: public service and private practice” (2007) 38 Rand J Economics 1113 at 1131.

23 P Ferrinho et al, “Dual practice in the health sector: review of the evidence” (2004) 2 Human Resources for Health 14 at 17.

wait times up to thirteen weeks longer than patients of public-only physicians.²⁴ A 1994 study of Alberta's experience with cataract surgeons splitting their time between public hospitals and private clinics—charging facility fees in the latter—found similar results.²⁵

To be fair, the literature on the effects of dual practice is limited, and suggests arguments both pro and con. On the pro side, for example, permitting dual practice may encourage sought-after specialists to keep one foot in the public sector, rather than opting out entirely to the private sector. Allowing public-sector physicians to dabble in private sector may also provide opportunities to train on new and experimental treatments and technologies that have yet to receive medicare funding.²⁶ The main argument from proponents of privatization of Canada, it seems, is that dual-practice physicians will not shirk obligations to the public system, but instead will increase their overall volume of care; when confronted by bottlenecks for surgical time in public facilities, the dual practitioner can use their surplus hours to see private patients at no cost to the public system. Indeed, this may have benefits to the public system, it is argued, as patients treated after hours in the private sphere will ease pressures on the public system.²⁷ The concern, of course, is that, depending on market demand, after-hours dabbling in private practice may grow to pose a real threat to accessible care within the public system.

There is certainly room for more research on these questions. One shortcoming with the literature on dual practice is a lack of attention to the structural features of specific health care systems. For example, the impact of dual practice will surely vary depending on whether physicians are employed on a salaried basis or, as in Canada, on a fee-for-service basis. Under a fee-for-service scheme, physicians can freely migrate their time between the public and private streams, making it difficult to monitor, predict, and control the spillover effects on accessibility within the public system.

24 C DeCoster et al, *Surgical Waiting Times in Manitoba* (Winnipeg: Manitoba Centre for Health Policy and Evaluation, 1998), online: <<http://mchp-appserv.cpe.umanitoba.ca/reference/surgwait.pdf>>.

25 W Armstrong, *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft* (Alberta: Consumers' Association of Canada, 2009), online: <<http://www.albertaconsomers.org/CanaryReportrevised2.pdf>>.

26 Garcia-Prado, *supra* note 20 at 265.

27 *Cambie Surgeries*, *supra* note 3 at 229–235.

The Supposed Arbitrariness of Provincial Restrictions on Two-Tier Care

As explained, critics have portrayed Canada as an outlier, internationally, for its reliance upon *statutory prohibitions* to restrict two-tier care. The claimants in *Chaoulli* were at pains to show that many Western European health care systems manage to maintain high-performing universal health care systems while at the same time allowing a parallel private tier. The Supreme Court of Canada was receptive to this argument, with the majority in *Chaoulli* concluding that:

The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care.²⁸

There is much to say about the quality of comparative analysis involved here. Many have reviewed the *Chaoulli* verdict's cursory description of foreign health care systems and complained about a lack of nuance; the decision has spurred debate about Canadian courts' institutional competence to adjudicate complex questions of public policy, involving polycentric trade-offs.²⁹ A basic concern—brought up elsewhere in this volume—is how Canadian discourse around two-tier care, inside and outside the courts, reliably invokes apples-and-oranges comparisons.³⁰ For example, Germany is often held up as an example of a high-performing health care system that allows a role for private health care. The comparison is fundamentally misleading, because private health care plays mostly a

28 *Chaoulli*, *supra* note 2 at para 140.

29 Christopher P Manfredi & Antonia Maioni, "Judicializing Health Policy: Unexpected Lessons and an Inconvenient Truth" in James B Kelly & Christopher P Manfredi, eds, *Contested Constitutionalism* (UBC Press, 2009); Kent Roach, "The Challenges of Crafting Remedies for Violations of Socio-economic Rights" in Malcolm Langford, ed, *Social Rights Jurisprudence* (Cambridge: Cambridge University Press, 2009).

30 CM Flood, *supra* note 16.

substitutive role in the German system: patients who “go private” must opt out, irreversibly, from the social health insurance scheme that covers some 90 per cent of the population. The species of privatization on offer in Canadian debates is fundamentally different, with a parallel private tier serving as a purported safety valve for wait times in the public system. The political and economic dynamics surrounding this model are quite unlike those surrounding Germany’s two-tier system. For example, there would be a much lower barrier of entry for Canadians entering the private insurance market, absent any requirement of relinquishing public-system coverage.³¹

There is a kind of bait-and-switch in Canadian public discourse around the use of comparative international evidence. Critics of the status quo purport to draw lessons from foreign experiences with two-tier care, but the lesson-drawing ceases the minute it has been established that other countries maintain universal systems while allowing a parallel private tier. There is, in other words, seldom any further inquiry into the alternative approaches employed by these countries to ensure that two-tier care does not lead to serious problems of access and quality of care for patients in the public system.

There is more at play here than a selective use of international evidence by vested interests (though there is that); arguably, the judicialization of these complex questions, by its very nature, encourages a focus on blunt, simplistic answers. As Kent Roach has explained, courts wary of the appearance of judicial activism will be naturally disinclined to explore the nuanced *positive* measures used by foreign health systems to protect universality and accessibility.

[T]he Court [in *Chaoulli*] considered only the case for an easy remedy—a simple, one-shot negative remedy of holding Quebec’s legislative restrictions on private health insurance inoperative—as opposed to more difficult and positive remedies that would give an affected person needed medical treatment or address systemic flaws in the delivery of health care... This makes it even more important that Canadian governments do not take *Chaoulli* as the last word on medicare reform.³²

31 For detailed discussion, see Schmid & Frisina Doetter, this volume.

32 Roach, *supra* note 9.

Roach's exhortation in that last sentence is vitally important. The *Chaoulli* verdict is often misleadingly summarized as holding that restrictions on two-tier care are constitutionally suspect. In fact, the Supreme Court's reasoning is a good deal more open-minded than this: while concluding that Quebec's statutory restrictions on private health insurance are over restrictive, the court alludes open-mindedly to the mechanisms used to protect public plans in other countries. After noting that the United Kingdom does not restrict access to private health insurance, nor restrict a physician's ability to withdraw from the public plan, Justice Deschamps, writing for the majority, observes that "physicians working full-time in public hospitals are limited in the amounts that they may bill in the private sector to supplement income earned in the public sector."³³ At no point does the court imply that these alternative regulatory approaches would run afoul of the *Charter*. While champions of privatization in media discourse portray this issue as a binary choice between allowing or prohibiting private care, international experience—and indeed the very text of *Chaoulli*—suggests that Canadian lawmakers have a possible array of intermediate options at their disposal.³⁴

Varying Approaches to Contracting Against Two-Tier Care

As detailed by Quesnel-Vallée et al in chapter 4, the *Chaoulli* decision has not been as disruptive to Quebec's single-payer system as some had initially feared. This is thanks in large part to the province's calibrated response in liberalizing private insurance only for select services identified in the ruling (i.e., total hip or knee replacement, major cataract surgery); meanwhile, access to these services within the public system was shored up with wait time guarantees. The *Cambie* challenge now underway in British Columbia is more expansive—targeting restrictions on extra-billing, dual practice, and user charges. If this complete teardown of restrictions on two-tier care succeeds, Canadian decision makers may wish to go back to the drawing board, and look for regulatory options apart from the statutory restrictions; a good place to start would be by examining the

33 *Chaoulli*, *supra* note 2 at para 80.

34 For a broader discussion, see Colleen M Flood & Bryan Thomas, "A Successful Charter Challenge to Medicare? Policy Options for Canadian Provincial Governments" (2018) 13 (Special Issue) *Health Economics, Policy & Law* 433.

approaches taken by high-performing foreign health care systems, which all sides agree or offer worthwhile guidance.

An approach that is common in Western Europe but little discussed in the Canadian context is to address extra-billing and dual practice through government contracts with physicians. Such contracts could draw from the example of public-school teachers, mentioned above, and stipulate the time physicians must devote to public patients or, alternatively, limit the time that physicians practice privately. What follows is a typology of these contractual approaches.

Exclusivity Clauses in Physician Contracts

One option is to contractually *forbid* private billing by physicians working in the public sector, through an exclusivity clause—an approach equivalent, functionally, to statutory bans on dual practice now in place in some provinces. A concern raised in the literature with this option is that specialist physicians will opt out of the public system altogether or relocate to provinces with more permissive contracts (if such exist). In the mid-1980s, the universal health care system in Greece recognized the “powerful financial incentives to minimise time and effort devoted to salaried institutional practice, and to spend time instead in private work.”³⁵ As a solution, the Greek system imposed exclusivity clauses in physician contracts, offering significant salary increases as a quid pro quo. The strategy was deemed a policy failure, as many senior doctors simply resigned from public practice altogether. (Ireland’s restrictions on dual practice are discussed below; for present purposes, it bears noting that a 2018 poll by the Irish Medical Organization similarly found that a majority of hospital-based specialists would leave the public system in the event that existing time-based restrictions on dual practice were strengthened to a full-fledged prohibition.)³⁶

Admittedly, there are a host of confounding factors when drawing lessons from Greece’s experience for the Canadian context. For one thing, Canadian physicians have never relied on dual practice to supplement their income from medicare; indeed, laws banning dual practice exist in most provinces, and the practice is under challenge

35 *Ibid.*

36 Irish Medical Organisation, “Private Practice in Public Hospitals” (February 2018), online: <<https://www.imo.ie/news-media/publications/IMO-Submission-to-the-Independent-Review-Group-on-Private-Practice.pdf>>.

in the *Cambie* case. From a negotiation standpoint, this would surely have a framing effect, as dual practice was a bird in the hand for senior Greek physicians negotiating in 1985, but would not be for the vast majority of Canadian physicians today (surgeons at the Cambie clinic and other scofflaws excepted). Moreover, Canadian physicians are, according to Marchildon and Sherar's recent analysis, "among the more highly remunerated among OECD countries for which data is available,"³⁷ which raises the stakes for Canadian physicians contemplating opting out of medicare. Under the existing statutory bans on dual practice now in place in British Columbia and other provinces, we have not seen a significant number of physicians opting out of medicare; indeed, there appears to be a buyer's market for physician services in Canada in recent years.³⁸ Of course, should court challenges succeed in overturning all of Canada's restrictions on two-tier care in one fell swoop—restrictions on dual practice *as well as* restrictions on parallel private insurance—the economic calculus for physicians considering "going private" would change drastically.

Exclusivity clauses are at the more restrictive end of a spectrum of possibilities for dampening dual practice; other countries, discussed below, rely on milder contractual measures like income and/or time limits on dual practice. A possible concern, therefore, is whether a move by government to impose exclusivity contracts after a (hypothetical) loss in *Cambie* might also be challenged in court under section 7 of the *Charter*. Given there have never been exclusivity contracts within medicare, there is no jurisprudence directly on point, and the matter raises esoteric and untested questions in constitutional law that are beyond the scope of this chapter. On the face of it, it seems highly unlikely that the courts would overturn exclusivity clauses so as to ensure that an adequate supply of physicians is available for the private for-profit health care market. For one thing, this would take the courts far beyond the one-shot remedy of the sort applied in *Chaoulli*. In a world where public-sector physicians are bound by exclusivity contracts, the health care workforce that remains to serve the private sector would be a function of supply and demand. If few physicians are tempted to opt out to the private

37 Gregory P Marchildon & Michael Sherar, "Doctors and Canadian Medicare: Improving Accountability and Performance" (2018) 17 *Healthcare Papers* 14.

38 D Fréchette et al, "What's really behind Canada's unemployed specialists? Too many, too few doctors? Findings from the Royal College's employment study" (Ottawa: The Royal College of Physicians and Surgeons of Canada, 2013).

sector, this reflects the workings of the free market; it is not indicative that negative rights have been violated. Needless to say, the *optics* of the courts intervening to ensure an adequate supply of physicians to the private for-profit sphere would not be ideal, given the courts have almost uniformly refused to intercede to defend patient access in the public system, citing concerns about democratic legitimacy and institutional competence.³⁹

Contractual Limitations on Private-Practice Income

Short of demanding exclusivity, provinces might contractually limit private-practice *income*—an approach taken by England until recently.⁴⁰ As with exclusivity clauses, income limits may prompt some physicians—particularly senior physicians whose services command higher prices—to opt of the public system altogether, or relocate to jurisdictions with laxer rules around dual practice. There is also evidence of enforcement problems with income limits: data from England shows that its 10 per cent income cap was routinely violated, until it was dropped in 2003 contract renewals.⁴¹ It is unclear whether the problem of lax enforcement is due to some technical impracticality of monitoring (e.g., privacy protections for physicians) or simply a lack of political will. In principle, it seems that compliance could be monitored by auditing physicians' tax returns—a measure unlikely to fly in the Canadian system given the history of physician resistance to restrictions on their autonomy.

Contractual Limitations on Time Spent in Private Practice

A similar option is to contractually limit the *time* that physicians are permitted to spend in private practice. This strategy has been used in Ireland, for example, where public physicians are prohibited from devoting more than 20 per cent of their clinical workload to private-pay patients.⁴² An advantage here, from the standpoint of negotiating with physicians, is that time limits impose no hard cap on income earned in the private sector: dual-practice specialists can

39 *Auton (Guardian as litem of) v British Columbia (Attorney General)*, [2004] SCJ No 71.

40 N Rickman & A McGuire, "Regulating providers' reimbursement in a mixed market for healthcare" (1999) 46 *Scottish J of Political Economy* 53.

41 S Morris et al, "Analysis of consultants' NHS and private incomes in England in 2003/2004" (2008) 101 *J Royal Society of Medicine* 372.

42 J Purcell, *Medical consultants' contract* (Dublin: Office of the Comptroller and Auditor General, 2007).

earn whatever the market will bear for their services, within the time limit.

Here too there are enforcement issues, as a 2016 report from Ireland's auditor general found that the country's 20 per cent time limit has been so routinely breached as to be a "farce."⁴³ Because Ireland encourages private care, and facilitates its delivery in public hospitals, it has been possible to monitor non-compliance⁴⁴ and gain some understanding of its root causes. As the consultants' contract was formed, all parties agreed that a national data-collection system would be used—the Hospital Inpatient Enquiry system—to track public and private activity for inpatient and day cases; a separate system would track outpatient and diagnostic activity.⁴⁵ Interestingly, the auditor general's 2017 annual report finds that violations of the 20 per cent rule were not primarily due to shirking per se, but instead due to the country's large quotient of private patients who turn up at hospitals at unpredictable rates:

In practice, the HSE, hospitals and individual consultants have limited control over the private activity levels as the majority of patients admitted to hospital are maternity admissions or admitted from the hospitals' emergency departments, which must be admitted and treated in order of clinical priority.⁴⁶

There are obvious difficulties in translating Ireland's experience here to the Canadian context. In the event that private for-profit care is

43 Martin Wall, "Rules limiting private practice in hospitals 'a farce'- HSE chief" (9 January 2016) *The Irish Times*, online: <www.irishtimes.com/news/health/rules-limiting-private-practice-in-hospitals-a-farce-hse-chief>. An attempt is now underway to audit hospital consultants; see, Martin Wall, "Hospital consultants face audit over private-practice rules" (3 March 2017) *The Irish Times*, online: <<https://www.irishtimes.com/news/health/hospital-consultants-face-audit-over-private-practice-rules>>.

44 Ireland, Office of the Comptroller and Auditor General, *2017 General Report, Chapter 16: Control of private patient activity in acute public hospitals* (Dublin, 2018) at para 16.9, online: <<https://www.audit.gov.ie/en/Find-Report/Publications/2018/2017-Annual-Report-Chapter-16-Control-of-private-patient-activity-in-acute-public-hospitals.pdf>>.

45 Health Information and Quality Authority "Hospital In-Patient Enquiry (HIPE)," online: <<https://www.hiqa.ie/areas-we-work/health-information/data-collections/hospital-patient-enquiry-hipe>>.

46 Ireland, Office of the Comptroller and Auditor General, *supra* note 44.

liberalized by the courts, one question facing government will be whether to allow private care to be carried out in public hospitals, as under the Irish system. While allowing this may facilitate the monitoring of dual practice, it also heightens the risk that private care will be subsidized by the public purse—an approach that Ireland has embraced in various ways but which Canadians are likely to reject. Even modest moves in this direction, such as allowing the administration of privately purchased cancer drugs in public hospitals, have aroused heated debate in Canada.⁴⁷

Limiting Private Practice with Work Plans and Managerial Oversight

As discussed, income-based contractual restrictions were used for decades to bar NHS (National Health Service) consultants (i.e., hospital-based specialists) from earning more than 10 per cent of their income from private practice. The 10 per cent rule was routinely flouted and eventually abandoned with the introduction of a new consultants' contract in 2003 (which operates to this day). However, the autonomy gains from dropping this rule were offset by a barrage of new oversight mechanisms imposed with the 2003 contract—as part of the Blair government's regime of “targets and terror”—which aimed to incentivize consultant productivity and efficiency and curtail private practice.

The new contract requires NHS consultants to negotiate a detailed job plan with their employers, which included quality standards, outcome and efficiency measures, and clinical standards. Under the terms of the new contract, consultants were made answerable to their clinical managers—generally senior consultants—for compliance with these requirements. Poor performance on annual reviews is grounds for denial of pay progression, which had previously been based solely on years served.⁴⁸ Compliance with work plans is actively monitored with managerial oversight of a sort unheard of in Canada: practitioners are required to declare to their clinical managers where they practice, what they practice, and when they practice; they must seek approval from their NHS employer before taking up any private work; and conflicts of interests are

47 Colleen M Flood & Lorian Hardcastle, “The Private Sale of Cancer Drugs in Ontario's Public Hospitals: Tough Issues at the Public/Private Interface in Health Care” (2007) 1 McGill J Law and Health 5.

48 English National Health Service, *Terms and Conditions—Consultants (England) 2003* (London, National Health Service, 2007).

discouraged by prohibiting physicians from attempting to sell their private services to NHS patients.⁴⁹ These myriad restrictions on dual practice were further reinforced through provisions strengthening consultants' commitment to the NHS: in the case of a conflict of interest, NHS commitments are to take precedence over the consultant's private work, and any additional fees that are collected while the consultant is *on-duty* must be remitted to the employing organization (the NHS), unless their collection is expressly authorized by the employer.⁵⁰

A 2013 report by the UK National Audit Office found that many of the benefits intended by the 2003 contract were realized in the years following its implementation.⁵¹ Notably, the percentage of consultants engaged in private practice dropped from 67 per cent in 2000 to 39 per cent in 2012. The report also found that, pursuant to the terms of their contract, most consultants prioritized their NHS work over their private practice. Further objectives, such as increased consultant participation and productivity, were also realized.⁵²

Incentive-Based Approaches

Some jurisdictions have offered financial inducements to secure physician loyalty to their public systems. For example, the Spanish government offers salary supplements to physicians who sign restrictive contracts.⁵³ In Portugal, there are four categories of contract, and remuneration rises with increased time commitment to the public system.⁵⁴ In Italy, only physicians who sign exclusive public contracts are eligible for promotion.⁵⁵ As we saw, England offers pay progression to consultants who concentrate their work within the NHS.

Incentive-based approaches are touted as fostering public-service values and may appear less draconian than the restrictive

49 *Ibid* at 18–19.

50 *Ibid* at section 9.

51 Amyas Morse, *Managing NHS Hospital Consultants* (London: Department of Health, National Audit Office, 2013) at 21.

52 *Ibid* at 37.

53 P González, "Should physicians' dual practice be limited? An incentive approach" (2004) 13 *Health Economics* 505.

54 M D Oliveira & C G Pinto, "Health Care reform in Portugal: an evaluation of the NHS experience" (2005) 14 *Health Economics* S203.

55 A Lo Scalzo et al, "Italy: health system review" in (2009) 11 *Health Systems in Transition* 1, online: <http://www.euro.who.int/__data/assets/pdf_file/0006/87225/E93666.pdf>.

approaches discussed above. Where market demand creates a substantial disparity between public and private remunerations, attempts to buy loyalty to the public system may be very costly, if they are to succeed. Incentive-based approaches may also be difficult to negotiate, as seen in 2003 contract negotiations in the United Kingdom, where physician opposition blocked introduction of an incentive for NHS commitment.⁵⁶

Incentive-based approaches are well-suited to situations where physicians have grown accustomed to engaging in dual practice. In such jurisdictions, physicians may have agreed to lower compensation from the public system with the expectation of augmenting their salaries in private practice. When an attempt is made to roll back or eliminate opportunities for private practice, there is an understandable expectation of compensation. Yet this clearly does not describe the current scenario in Canada, where the vast majority of physicians rely exclusively on medicare for their income, and, by OECD standards, are well remunerated.⁵⁷

Conclusion

Leading Canadian constitutional scholars portray *Charter* jurisprudence as a dialogue between the courts and the legislature, implying that the courts are not to be the *last word* on questions of law and public policy that engage *Charter* protections.⁵⁸ Few *Charter* cases call out for dialogic response with the same urgency as *Chaoulli* and, depending on its outcome, *Cambie*. As explained, the fundamental *aim* of regulating two-tier care is perfectly legitimate, supported by available evidence, and commonplace among comparator countries. It is only the *means* by which Canada has chosen to regulate two-tier care that has drawn judicial reproach.

Unfortunately, Canadian discourse around two-tier care has been studiously uninterested in the question of *how to regulate in lieu of present statutory prohibition*. Indeed, public and judicial discourse

56 A Oliver, "The English National Health Service: 1979–2005" (2005) 14 Health Economics S75.

57 Gregory P Marchildon & Michael Sherar, "Doctors and Canadian Medicare: Improving Accountability and Performance" (2018) 17 Healthcare Papers 14.

58 Peter W Hogg and Allison A Bushell, "The Charter Dialogue between Courts and Legislatures (Or Perhaps the Charter of Rights Isn't Such a Bad Thing After All)" (1997) 35 Osgoode Hall LJ 75.

encourages a naive picture, fostering the mistaken impression that if Canada were simply to do away with its statutory restrictions on two-tier care, our health care system would magically default to something that approximates the high-performing health care systems of Western Europe.

Unfortunately, this is clearly not the case. As this chapter has outlined, many European countries rely on diverse contractual mechanisms to limit dual practice, and attempts to replicate these approaches in Canada would be challenging to implement. The core challenge, arguably, would be the political/economic battle of wrenching Canadian physicians from their long-enjoyed status as independent professionals, free to bill medicare on a fee-for-service basis with limited managerial oversight.

Some of the contractual and administrative tools used in other countries to blunt the deleterious effects of dual practice seem unlikely to work in the Canadian context. For example, Ireland's approach of delivering privately financed care *within* public hospitals, as a way of facilitating managerial oversight over the public-private mix, seems like a non-starter—the optics of private care being delivered in public hospitals are simply at odds with the *Canada Health Act* premise of care being allocated on the basis of medical need. Moreover, as Stephen Thomas and colleagues discuss in chapter 11, the inequities and inefficiencies of Ireland's version of two-tier are spurring reforms that rollback their two-tier system.

Perhaps physician resistance to contractual restrictions on dual practice could be overcome by using an incentive-based approach, offering bonuses to physicians who agree to work exclusively in the public system, or who at least agree to engage in private practice only upon completing a full workweek in the public system. The difficulty here is that these incentives can be costly, and Canadian physicians are *already* generously compensated, even without the option of sidelining in private practice.

Contractual limits on income or time devoted to private-sector work are more readily implemented in countries like the United Kingdom, where physicians are paid on a salaried basis and are subject to greater oversight concerning the nature of their work and their time by administrative agencies. The loosening of dual-practice restrictions in 2003 has come at a cost to consultant autonomy. This quid pro quo has arguably been necessary to ensure consultants discharge their obligations to the NHS and not shirk their contractual

duties to the public sector in favour of their more lucrative private practices. The situation in Canada has been different, with dual practice largely nonexistent, while physician autonomy has ruled supreme. Perhaps, should the current litigation in *Cambie* succeed, a similar quid pro quo will come into play, with the introduction to Canada of physician contracts ensuring that practitioners discharge their obligation to the public sector. From the English experience, it can be gleaned that such measures—particularly if combined with other quality-control measures, such as medical audits—would likely cut deep into physicians' clinical autonomy, imposing increased managerial controls and quality standards, which have been foreign to the Canadian health care system to date.

Page left blank intentionally