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CHAPTER 3

Borders, Fences, and Crossings: Regulating Parallel Private Finance in Health Care

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Motivated by equity concerns and the desire to avoid adverse effects on the publicly financed health care system, Canadian provinces have implemented a remarkably effective set of regulations that limit parallel private finance and delivery of core medicare physician and hospital services in Canada. Without necessarily prohibiting parallel private finance itself, these regulations reduce physicians' economic incentive to provide privately financed medicare services, patients' incentive to demand them, and private insurers' ability to insure them, effectively shutting down the market for privately financed parallel services. These regulations, however, are under threat by court challenges. In 2005, the Supreme Court of Canada in *Chaoulli* struck down Quebec's prohibition of private insurance that would duplicate that covered by public medicare, and in the ongoing case of *Cambie*, a private-clinic claimant is not only challenging British Columbia's prohibition of private insurance but also the other restrictions on physician billing options. Should the courts strike down one or more of these latter regulations, Canadian provinces will face greater regulatory challenges as they pursue their health policy goals in the presence of a less restricted parallel private sector.

Although analysts debate whether the overall effect of parallel private finance on a public system is positive or negative, no one disputes that the parallel private and public health care sectors

unavoidably interact in ways that can have adverse effects on the public system. To mitigate these adverse effects, countries internationally adopt quite different regulatory approaches to parallel private finance, ranging from grudging tolerance to active promotion. Even countries such as Australia, which promotes parallel private insurance in the belief that overall it can benefit the public system, regulate the private sector so as to protect the public system. Indeed, such promotion of parallel private finance generally leads to even more regulation given the expanded opportunities for adverse effects on the public system. Countries regularly tinker with their regulations in an attempt to strike the right regulatory balance, and occasionally we see countries adopt quite radical changes to regulatory regimes (e.g., recent policy changes in Ireland, discussed by Thomas et al in chapter 11).

Regulating parallel private finance is hard. Private and public systems interact in complex, often nuanced ways, but the regulatory tools available are limited and often can't be deployed in correspondingly nuanced ways. Conflict among policy goals forces difficult choices when advancing one set of goals detracts from another. The impact of commonly found regulatory tools for private health insurance—for example, premium regulation and benefit design—can differ when insurance provides secondary coverage than when private insurance is the primary source of coverage. And effective regulation must encompass in a coordinated way both health care insurance markets and health care service markets.

This chapter examines the regulation of parallel private finance, emphasizing features of health care insurance and health care service markets, and the interactions between the private and public sectors that motivate regulation, to identify regulatory options for Canadian provinces in a context in which parallel private insurance is allowed and/or physicians face fewer restrictions on providing privately financed services—that is, the regulatory context the provinces will face if the courts strike down some or all of the key components of Canada's current regulatory approach.

Two prefatory comments are in order. First, parallel private finance is defined as patients paying privately to obtain services *for which they are covered by the publicly financed health care system*. Patients may pay directly out of pocket or by purchasing private insurance that pays some or all of the cost of obtaining services privately. Parallel private finance is sometimes called "duplicative" finance

or "supplementary" finance.[1] Parallel private finance contrasts with complementary private finance, which is when patients pay privately for services excluded from the publicly financed system. While parallel private finance is highly restricted in Canada, complementary private finance predominates for drugs, dental, and other health services excluded from public coverage, and a large share of Canadians hold complementary private insurance.[2]

Second, private finance should be distinguished from private delivery: the two raise distinct analytic, policy, and regulatory issues.[3] Publicly financed health care systems may opt to deliver services through private organizations, such as private physician practices or private clinics; and publicly funded delivery organizations may deliver health care to private-pay patients, such as occurs in the United Kingdom, Australian, Ireland, and other countries.[4] This chapter focuses on *financing*, regardless of the nature of the organization (public, private not-for-profit, or private for-profit) delivering the service.

Parallel Private Markets in Health Care

Interactions between the public and private sectors under parallel finance are unavoidable: it is not possible to fully isolate the two sectors from each other. Regulation can limit the nature and amount of such interaction but it cannot eliminate it. The two sectors, for example, compete for the time and talents of the same physicians, nurses, and technicians, among other inputs, needed to deliver care—competition that increases wages and prices for these inputs and reduces the real purchasing power of a given nominal public budget. Services produced by the two sectors are both substitutes and complements: sometimes a patient's privately financed care

1 Anna Sagan & Sarah Thomson, *Voluntary Health Insurance in Europe: Country Experience* (Copenhagen: European Observatory on Health Systems and Policies, 2016) at 2.

2 Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2017* (Ottawa: Canadian Institute for Health Information, 2017) online: https://www.cihi.ca/sites/default/files/document/nhex2017-trends-report-en.pdf; Jeremiah Hurley & G Emmanuel Guindon, "Private Insurance in Canada" (2008) McMaster University Centre for Health Economics and Policy Analysis Working Paper 08-04.

3 Jeremiah Hurley, *Health Economics* (Toronto: McGraw-Hill Ryerson, 2010).

4 Sagan & Thomson, *supra* note 1.

substitutes for care they otherwise would have obtained through the public system; other times, demand for private services generates an associated demand for public services, such as when private-pay patients experience complications that must be treated in the public system. Because these interactions raise both efficiency concerns (e.g., inefficient risk selection) and equity concerns (e.g., unequal access and queue-jumping), regulation of the markets in health care insurance and health care services seeks to mediate the interactions so as to achieve key policy goals.

Private Insurance Markets

People demand privately financed services already covered by public insurance because they perceive a shortcoming in the public system. The precise shortcoming differs across individuals and systems, but four dominate: long wait times in the public system, perceived lower quality of clinical care in the public system,[5] restrictions on choice in the public system, and lesser amenities in public facilities.[6] The dominant driver of demand for parallel private care in most systems is a desire to avoid long waits in the public system.[7] This is true in Canada, where concerns about wait times have been used to galvanize court challenges to overturn regulatory restrictions on private finance. Differences in quality of clinical care across the public and private systems can be large in many low- and middle-income countries but they do not figure prominently in most developed countries, especially given that private care is usually delivered by the same providers who work in the public system, is often obtained in publicly funded facilities, and evidence indicates that private for-profit facilities provide lower quality of care in some settings.[8]

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5 I distinguish two aspects of quality: (a) quality of the clinical care, which depends on the clinical skills of the provider, the nature of the facilities and equipment used, and related matters; and (b) performance of the system of care, which is influenced by factors such as wait times. By "clinical quality," I mean only the former.

6 Sagan & Thomson, *supra* note 1.

7 Jeremiah Hurley & Malcolm Johnson, *A Review of Evidence Regarding Parallel Systems of Public and Private Finance* (Hamilton: McMaster University Centre for Health Economics and Policy Analysis, 2014), online: <www.chepa.org/docs/documents/14-2.pdf >.

8 PJ Devereaux et al, "A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals" (2002) 166 CMAJ 1399; PJ Devereaux et al, "Comparison of Mortality

Choice-related demand is particularly common in the inpatient sector when the public system restricts one's ability to choose a provider or care facility: paying privately enables a person to choose their provider or facility. Canadians do not face such restrictions on their choice of provider or facility. Amenities refers to non-clinical aspects of care, particularly in an inpatient setting, such as the degree of privacy, quality of food, entertainment options, and so forth. Private facilities commonly have better amenities than public facilities, and while public facilities have an obligation to provide reasonable levels of amenities, it would be a poor use of scarce tax dollars to provide a level of amenities akin to high-end private facilities. Thus, overall, concerns about wait times appear to be a prime driver in Canada of demand for parallel private services.

The cost of private care creates an associated demand for parallel private insurance. Indeed, a market for parallel private insurance is necessary for a parallel private sector to flourish. In the absence of private insurance, the demand for privately financed care will remain limited to a small set of high-income or high-wealth individuals. This reality motivates provincial prohibitions against parallel private insurance.

The demand for private insurance is directly related to socio-economic status—internationally, those of higher socio-economic status are consistently more likely to hold private insurance.[9] Greater demand by those of higher socio-economic status is driven substantially by their greater ability to pay but also reflects differences in the value of time, tastes/attitudes, and the increasing tendency in many countries for high-ranking employees to obtain private insurance as an employment benefit.[10] This socio-economic gradient means that the relatively well-off can best take advantage of the private options and the associated preferential access to care. Differential access to care by those with and without private insurance prompts some countries to try to create broader access to private insurance through regulations that mandate community-rated premiums (the same premium must be charged to all individuals in a defined risk pool, regardless of their actual risk status) or, in the case

Between Private For-Profit and Private Not-for-Profit Hemodialysis Centers: A Systematic Review and Meta-Analysis" (2002) 288 JAMA 2449.

9 Hurley & Johnson, *supra* note 7; Sagan & Thomson, *supra* note 1.

10 Mark Stabile & Maripier Isabelle, "Rising Inequality and the Implications for the Future of Private Insurance in Canada" (2018) 13 Health Econ Pol'y & L 406.

of Denmark, favourable tax treatment when employers offer parallel private insurance as a benefit to all employees rather than only to senior management.[11] Ironically, such efforts to equalize access to parallel private insurance can produce larger system-wide inequities by supporting a stronger parallel private sector.

Demand for parallel private insurance does not automatically induce a corresponding supply of insurance. The viability of a private insurance industry depends on an array of factors, such as a risk-pool sufficiently large to spread risks effectively and an ability to avoid crippling adverse risk selection, the nemesis of health insurance markets. Adverse selection, whereby costly high-risk individuals disproportionately purchase insurance, can undermine an insurance market. It can be a particular challenge in secondary insurance markets, such as those for parallel private insurance, for in the presence of a reasonably functioning public system, parallel private insurance is attractive primarily to high users of care. Adverse selection is thought, for instance, to have contributed to the premium spiral, shrinking beneficiary base, and unprofitability that threatened the Australian private insurance sector during the 1990s, prior to the introduction of public subsidies and regulations to support the industry.[12] Adverse selection can be exacerbated by regulation designed to improve access and equity, such as community-rated premiums, which makes insurance particularly attractive to high-risk individuals for whom the community-rated premium makes insurance a bargain. For this reason, community rating in these markets is sometimes accompanied by risk-equalization or risk-sharing arrangements among insurers, such as in Ireland and Slovenia, and strategies such as offering insurance through group policies to attract a sufficiently diverse mix of risks to the insurance pool.[13]

Private health insurers themselves strive for the opposite type of selection—favourable selection—whereby they selectively enroll low-risk, profitable individuals. Except where regulation prohibits them from doing so, private insurers commonly deny coverage based on age, exclude coverage for pre-existing and chronic conditions, and

11 Maria Olejaz et al, *Denmark: Health System Review* (Copenhagen: European Observatory on Health Systems and Policies, 2012) at 70.

12 Jane Hall, Richard De Abreu Lourenco & Rosalie Viney, "Carrots and Sticks—The Fall and Fall of Private Health Insurance in Australia" (1991) 8 Health Econ 653.

13 Sagan & Thomson, *supra* note 1 at 25.

more generally exclude health conditions and health care services that place the insurer at risk of moral hazard, whereby consumers might purchase the insurance strategically when they anticipate using care (e.g., care for pregnancy and childbirth) or use of services is thought to be highly sensitive to the presence of insurance (e.g., mental-health care), and services that can be especially resource intensive (e.g., accident and emergency services).[14] Private insurers in more than half of the thirty-four EU countries examined by Sagan and Thomson (see note 1), for example, impose age-related coverage exclusions, and in twenty-nine of thirty-four EU countries, private insurers can exclude pre-existing conditions.[15] Fundamentally, without regulation, parallel private insurance will cover a narrow range of acute health conditions and health care services, with a focus on uncomplicated, elective surgical procedures targeted at a relatively healthy (and wealthy) population.

Parallel private insurance is regulated in many countries exclusively as a financial service, with regulation falling under an insurance regulator or similar body. Such regulation is aimed at a narrower set of policy goals pertaining to ensuring solvency (e.g., sufficient reserves) and related matters rather than the broader set of policy goals related to access and equity often associated with health insurance.[16] The industry is highly concentrated in most countries; in three-quarters of the EU countries examined by Sagan and Thomson, the market share controlled by the three largest insurers exceeded 50 per cent, which has attracted the attention of antitrust regulatory bodies in some cases.[17] And deceptive, or at least highly confusing, marketing and administrative practices has heightened the calls for greater consumer protection to simplify policies and make it easier for consumers to compare policies in a meaningful way. Canadian regulation of the complementary private insurance sector matches this, with regulation largely limited to financial matters that apply to all insurance products.[18]

Broader regulatory attention to parallel private insurance occurs particularly in countries that embrace parallel private finance as an

14 Thomas Foubister et al, *Private Medical Insurance in the United Kingdom* (Copenhagen: European Observatory on Health Systems and Policies, 2006) at 27.

15 Sagan & Thomson, *supra* note 1 at 62.

16 *Ibid* at 89.

17 *Ibid* at 60.

18 Hurley & Guindon, *supra* note 2.

integral part of their overall system of health care financing, such as in Australia and Ireland. The greater regulatory role arises in the first instance, to encourage uptake of private insurance through tax subsidies, community-rating schemes, and related policies to broaden access. This regulation—and the associated commitment of public resources—then spurs greater regulation, such as regulation of premium increases for private insurance, since premium increases translate directly into greater public expenditure on premium subsidies, regulation to ensure risk equalization and risk-sharing among insurers, and related efforts. Regulation in Australia and Ireland exemplify this pattern.[19]

Health-Services Markets

More common across countries is regulation of the health-services market to mitigate negative spillovers from the private to the public system. In the presence of parallel finance, the behaviour of individuals, who can obtain services in both sectors, and providers, who can work in both sectors, can create adverse effects across the public and private sectors. These effects and the associated need for regulatory response can be understood best by considering separately the demand- and supply-sides of the health-services markets, and the kinds of regulations that can be targeted at each.

Demand Side of the Health-Services Market

Expanding the role of parallel private finance would change the total demand for health care, the demand in each of the public and private sectors, and the composition of people who demand care. The demand for a health care service depends on its full cost to individuals, including both monetary and non-monetary costs. A public system with wait times does not charge patients a fee, but it does impose other non-monetary (e.g., pain, anxiety) and monetary (e.g., lost income) costs associated with waiting. Advocates of private finance emphasize private care as a substitute for public care. An expansion of privately financed care and the opportunity for quicker treatment will unquestionably cause some of those waiting in the

19 Judith Healy, Evelyn Sharman & Buddhima Lokuge, *Australia: Health System Review* (Copenhagen: European Observatory on Health Systems and Policies, 2006); David McDaid et al, *Ireland: Health System Review* (Copenhagen: European Observatory on Health Systems and Policies, 2009).

public system to seek private treatment, forgoing public care. But this is not the only effect on demand—the expansion would also generate *new* demand in both the private and public sectors, increasing the total demand for health care.

New demand arises, for instance, when expanded parallel private options enable individuals to access specialist care directly rather than only through referral by a family physician.[20] Some of this direct demand for specialist care would never have been expressed in a public-only system with gatekeeper family physicians, who would triage the patient at the primary-care level. Expanded opportunities for private care may also alter referral patterns and treatment thresholds for private care as physicians weigh more heavily the non-clinical preferences of patients compared to the prioritization criteria in the public system. New private demand would also occur when investors in private facilities promote their facilities and services to ensure a good return on their investment, prompting the "worried well" to seek tests and treatments they may not need.

New public demand arises because public and private care are sometimes complements, so increased demand for privately financed care can also increase demand for publicly financed care.[21] New complementary public demand occurs, for instance, when an individual considering private care first consults their primary-care physician, or when individuals privately obtain an assessment or diagnostic test and then subsequently demand publicly financed services on the basis of the private assessment or test, and/or when a complication develops during private treatment that must then be treated in the public system.

An expanded privately financed sector will alter the characteristics of those who obtain care. The "switchers" who substitute private care for public care will be those with high sensitivity to the costs of waiting and low sensitivity to the money price of private care (or

20 Ma Luz González Álvarez & Antonio Clavero Barranquero, "Inequalities in Health Care Utilization in Spain Due to Double Insurance Coverage: An Oaxaca-Ransom Decomposition" (2009) 69:5 Soc Sci Med 793.

21 Mark Stabile, "Private Insurance Subsidies and Public Health Care Markets: Evidence from Canada" (2003) 34:4 Can J Econ 921; Sherry Glied, "Universal Public Health Insurance and Private Coverage: Externalities in Health Care Consumption" (2008) 34 Can Pub Pol'y 345; Sara Allin & Jeremiah Hurley, "Inequity in Publicly Funded Physician Care: What is the Role of Private Prescription Drug Insurance?" (2009) 18 Health Econ 1218.

private insurance), such as high-income, working individuals. Hence a system with expanded private finance devotes more resources to those with higher incomes. Further, to the extent that new demand is from individuals with relatively lower levels of clinical need but a high degree of impatience and risk aversion, the share of care devoted to those with lower needs would increase.

In sum, these demand-side effects generate two types of concern that underlie calls for regulation. First, the changed mix of demanders exacerbates socio-economic-related inequality of access to health care. Second, increased private and total demand can divert resources from the public sector, reducing access to the public system for those who must rely on it. As described below, the ultimate impact of parallel private finance on access to the public system depends on the net effect of changes in the demand for care and changes in the supply of care.

Supply-side regulation under parallel finance targets the interactions between the two systems that can have a negative impact on the public system. These interactions can be particularly problematic when providers are permitted to work in both the public and private sectors—dual practice—and so that is a particular focus of regulation (and explains why dual practice is restricted in a number of Canadian provinces). But interactions arise even in the absence of dual practice.

As noted already, expanded parallel private finance increases competition for shared inputs into the delivery of care, driving up the prices of those inputs (e.g., the fees paid to physicians), and reducing the real value of the nominal public budget. These price increases can be implicit or explicit. Implicit higher wages arise when physicians are allowed to collect a full public salary but work more than the officially sanctioned hours in their private practices at the expense of time spent on public care, implicitly raising the public-sector hourly wage. Such implicit wage increases have been particularly problematic in mixed health care systems with salaried hospital-based consultants.[22] Evidence from tax records, care audits, surveys, case studies, and anecdote indicates that in England, for instance, specialist consultants in the NHS commonly devoted more

22 Ariadna García-Prado & Paula González, "Whom Do Physicians Work For? An Analysis of Dual Practice in the Health Sector" (2011) 36:2 J Health Pol Pol'y & L 265.

time to the delivery of private care than was officially allowed by their contract.[23] The problem has been less severe in recent years because, among a number of changes, the 2003 consultant contract explicitly increased NHS pay rates by approximately 25 per cent, enhancing the attractiveness of NHS work—precisely the kind of wage increase that exemplifies how competition between the sectors can lead to higher prices for inputs to care.[24] The UK experience is not isolated. In an effort to combat brain drain from the public to the private sector, in 1996 the Norwegian government increased hospital physician wages for overtime and extended work by approximately 11 per cent so as to increase the allocation of physician time to public sector work.[25] Nor are such competitive wage effects isolated to the physician sector. In presenting to the Standing Senate Committee on Social Affairs, Science and Technology, Dr. Brian Day of the Cambie Clinic observed that:

> We are not a unionized facility because if we were, we would have the same trouble getting nurses as the hospitals have. We pay our nurses 15 percent higher than the highest level they can achieve after 12 years in the public system, because we need these nurses … Again, to attract those people [central sterile technicians], we have to pay higher than union wages.[26]

In addition to its effects on costs, such competition tends to bid away from the public sector more senior, experienced physicians, leaving

23 John Yates, *Private Eye, Heart and Hip: Surgical Consultants, the National Health Service and Private Medicine* (London: Churchill Livingstone, 1995); Audit Commission, *The Doctor's Tale: The Work of Hospital Doctors in England and Wales* (London: HMSO, 1995); Stephen Morris et al, "Analysis of Consultants' NHS and Private Incomes in England in 2003/4" (2008) 101 J Royal Soc Med 372.

24 National Audit Office, *Managing NHS Hospital Consultants* (London: The Stationary Office, 2012), online: <https://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf>.

25 Karl-Arne Johannessen & Terje P Hagen, "Physicians' Engagement in Dual Practices and the Effects on Labour Supply in Public Hospitals: Results from a Register-Based Study" (2013) 14 BMC Health Serv Res 299.

26 Dr. Brian Day, Evidence Government of Canada, Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology, First session Thirty-seventh Parliament, 2001, Thursday, 18 October 2001, quoted in Teresa Healy, "Health Care Privatization and the Workers' Compensation System in Canada" (Paper delivered at Canadian Political Science Association meetings, Saskatoon, 1 June 2007).

a disproportionate share of public care to junior, less-experienced consultants, a phenomenon that also likely applies to other types of health professionals.[27]

Probably the most contentious question in relation to parallel private finance is its impact on access to the publicly funded system by those who continue to rely on the public system for care—the problem that is captured by the term "two-tier care" in the title of this book. The impact depends on the relative magnitudes of various counteracting effects. Current empirical evidence on these effects is contestable, often derived from observational studies that suffer measurement problems, possible sources of bias, and challenges to establishing causation. Despite these analytic and empirical challenges, we know a considerable amount about many of the most important determinants of the ultimate impact.[28]

The expansion of parallel private finance will change the total supply of a service, the supply offered through the public sector, and the supply offered through the private sector. Such supply-side changes depend importantly on the institutional details of the system design. For this discussion, I assume that the rate of pay offered in the private sector would be higher than that in the public sector (the norm internationally); dual practice is allowed and feasible; that there is a positive relationship between physician labour supply and service supply, and an increase in physician labour is required to produce more services;[29] and that the supply of care is not limited by some factor (e.g., the restricted amount of some inputs) for which the expansion of private finance would have no impact.

The expansion of parallel private finance, and the associated opportunity to earn additional income at a higher rate of pay, influences two types of work decisions for physicians: the decision whether to work, and, among those who do work, decisions regarding the total number of hours to work and the allocation of

27 García-Prado & González, *supra* note 22.

28 Hurley & Johnson, *supra* note 7.

29 Physician time and effort are the primary but not the only inputs into the production of most health care services. Physicians combine their labour with non-physician personnel (e.g., receptionists, nurses, other non-physician professionals) and capital (office space, equipment). By substituting these other inputs for their own time, in some circumstances physicians can simultaneously increase the supply of services while reducing their own labour supplied.

time across the public and private sectors and among professional activities such as patient care, administration, teaching, and research.

By affecting retirement and migration decisions, parallel private finance could influence the number of active physicians in Canada. In the short-term, new private-sector opportunities for practice could cause some currently retired physicians to re-enter the workforce, though such an effect would be temporary. More generally, on an ongoing basis it could alter the retirement decisions of working physicians, and this impact could cut both ways: the ability to earn higher income could cause physicians to delay retirement, thereby increasing the overall supply of physician labour relative to what it would have been in the absence of parallel finance, but the ability to earn higher income throughout their career could cause some to retire earlier than otherwise would have been the case (having achieved the required retirement savings at a younger age). In addition, if the current restricted options for private practice causes some physicians to choose not to work in Canada, less restrictive regulation could induce some of these physicians to practice in Canada. If these factors expand the supply of physicians providing patient care, private provision could expand without diverting resources from the public system; otherwise, it could draw net physician resources away from the public sector. We have no reliable evidence regarding the magnitude of these possible effects on the supply of active physicians.

Among those physicians in active practice, a new opportunity to earn private-sector income at a higher rate of pay creates counteracting incentives regarding the total hours of work, and changes incentives regarding the allocation of work effort across the two sectors and across professional activities. A higher rate of pay in the private sector means that, for the same total work effort, physicians can earn a higher income (the income effect). If the demand for leisure time increases with income, as is commonly true, then this income effect would induce a physician to decrease the overall amount of time spent working. At the same time, the higher rate of pay in the private sector increases the opportunity cost of not providing private-sector patient care. This creates incentive to reallocate time by working more overall (and taking less leisure; the substitution effect), and, within the time spent working, to reallocate time to the private provision of patient care and away from the provision of patient care in the public sector and away from non-patient-care professional activities. On net, the predicted impact on total hours of work is ambiguous—if

the income effect dominates, total physician work hours would fall; if the substitution effect dominates, total physician work hours would increase, but the analysis predicts unambiguously that among the hours worked the share of hours devoted to direct patient care in the private practice would increase, the share devoted to direct patient care in the public sector, and non-patient-care professional activities would decrease. But because of the ambiguous effect on total hours of work, the amount of physician time spent providing patient care could increase, decrease, or remain the same.

We have no direct evidence specifically documenting the impact of parallel private finance on physician labour supply and the associated supply of physician services. We do, however, have evidence regarding how physician labour and service supply responds to changing fees, on the impact of payment on the allocation of physician effort across professional activities, and on the allocation of time and effort across the public and private sectors in systems that allow dual practice. Studies of the total number of hours worked by physicians find that, in general, it is not highly responsive to modest changes in earnings, with some studies showing small positive responses (higher wages cause physicians to work more) and others small negative ones (higher wages cause physicians to work fewer hours).[30] The evidence regarding their allocation of time across the public and private sectors is more limited but indicates that increases in wages in one leads physicians to allocate more time to that sector for which the wage increased while holding total hours of work constant.[31] Within Canada, higher expedited fees offered by some provincial workers' compensation boards have led physicians to allocate work effort toward workers' compensation cases, though we

30 Thomas F Crossley, Jeremiah Hurley & Sung-Hee Jeon, "Physician Labour Supply in Canada: A Cohort Analysis" (2008) 18 Health Econ 437; Sung-Hee Jeon & Jeremiah Hurley, "Physician Resource Planning in Canada: The Need for a Stronger Behavioural Foundation" (2010) 36:3 Can Pub Pol'y 359; Leif Andreassen, Maria Laura Di Tommaso & Steinar Strøm, "Do Medical Doctors Respond to Economic Incentives?" (2013) 32:2 J Health Econ 392; Guyonne Kalb et al, "What Factors Affect Physicians' Labour Supply: Comparing Structural Choice and Reduced-Form Approaches" (2017) 27 Health Econ 749.

31 Erik Magnus Sæther, "Physicians' Labour Supply: The Wage Impact on Hours of Practice Combinations" (2005) 19:4 Labour 673; Terence C Cheng, Guyonne Kalb & Anthony Scott, "Public, Private or Both? Analyzing Factors Influencing the Labour Supply of Medical Specialists" (2018) 51:2 Can J Econ 659.

do not know what impact this may have had on time spent treating patients in the public system.[32]

We have more limited evidence regarding how the allocation of effort across different professional activities responds to financial incentives, but a study from Quebec found that a policy that increased wages for some professional activities and decreased them for others caused hospital-based specialist to reallocate work effort, decreasing hours of work spent seeing patients by 2.6 per cent and increasing time spent on teaching and administrative duties (tasks not previously remunerated) by 7.9 per cent.[33]

The evidence available, therefore, suggests that the expansion of a parallel private system and higher earnings opportunities for physicians would have little or no effect on the total hours worked by physicians, would cause them to reallocate effort from the public to the private sector, and may cause some to reallocate effort from non-patient care to patient care. Overall, it would be expected to decrease labour supplied to patient care in the public sector.

In recent years, concern has emerged about underemployment of certain types of specialist physicians in Canada, a situation with roots in an array of health-system, economic, social, and personal factors.[34] A particular concern among some surgical specialities has been the impact of limited access to operating room time and/or hospital beds in the public system. In such a situation, it is argued, physicians could undertake increased surgery in the private sector with no loss to the public system. To the extent that some physicians who desire to work more overall are truly sitting idle, this would represent untapped capacity that could be employed in the private sector with no loss to the public system. Often, however, the challenge is less that of no work or underemployment overall but of allocation of work effort across clinical activities within the public system; some surgical specialists spend less time doing surgery and

32 Jeremiah Hurley et al, "Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers" (2008) 8:3 Healthcare Papers 6.

33 Etienne Dumont et al, "Physicians' Multitasking and Incentives: Empirical Evidence From a Natural Experiment" (2008) 27:6 J Health Econ 1436.

34 Danielle Frechette et al, *What's Really Behind Canada's Unemployed Specialists? Too Many, Too Few Doctors?* (Ottawa: Royal Colleges of Physicians and Surgeons of Canada, 2013).

more time on non-surgical clinical care than they desire.[35] In such a situation, unless increased private-sector surgery represented a net addition to work overall, it would come at the expense of clinical care in the public system. Unfortunately, we have limited data on the nature and extent of these issues within the Canadian system.

Regulatory Approaches

The ongoing *Cambie* case challenges multiple elements of the Canadian approach to the regulation of private finance—private insurance, extra-billing, and opted-in physicians' ability to charge patients directly—and its impact would be national in scope. If the prohibition against parallel private insurance is struck down, it would affect five provinces (British Columbia, Alberta, Manitoba, Ontario, Prince Edward Island) that currently prohibit parallel private insurance, and possibly pose a threat to Quebec's (newer) restrictive limits on such insurance passed in response to *Chaoulli*.[36] If the prohibition on extra-billing is struck down, this would affect the eight provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Nova Scotia, Newfoundland and Labrador) that explicitly prohibit extra-billing. If the restrictions on billing patients directly are struck down, this would affect five other provinces (Manitoba, Ontario, Quebec, Nova Scotia, Newfoundland and Labrador) with similar provisions. And if the restrictions on the amount opted-out physicians can charge are struck down, this would affect four other provinces (Alberta, Manitoba, Ontario, Nova Scotia) with similar provisions. If fully successful, therefore, the Cambie case would strike down multiple elements for most

35 Geographic preferences can also play a role in this phenomenon. Some physicians prefer to be located in urban areas, even at the cost of a less desired mix of professional activities, while opportunities exist in more rural areas. Although beyond the scope of this analysis, an expanded private sector would likely be concentrated in urban areas, which could exacerbate the geographic maldistribution of physicians.

36 Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 CMAJ 825; Gerard W Boychuk, "The Regulation of Private Health Funding and Insurance in Alberta under the Canada Health Act: A Comparative Cross-Provincial Perspective" (2008) 1:1 U Calgary SPS Research Papers, online: <https://www.policyschool.ca/publications/regulation-private-health-funding-and-insurance-alberta-under-canada-health-act-comparative/>.

provinces.[37] Note that, with the exception of Ontario since 2004, no province explicitly bans dual practice; rather, the inability to engage in dual practice follows from the combination of restrictions on physicians' billing practices and beneficiaries' ability to obtain public reimbursement if billed directly by a physician for a covered service. Although the details vary across provinces, with the exception of Newfoundland and Labrador, in each province these restrictions preclude dual practice.

While court decisions change the regulatory tools available, they do not directly change the fundamental policy goal, which to date has been to restrict the role of parallel private finance so as to limit adverse spillovers from the parallel private system to the public system. The present regulatory approaches in Canada makes sense if one believes that other regulatory tools do not sufficiently limit the negative spillovers associated with a parallel system, making a highly restrictive approach the only effective option. If one or more of the current regulations are struck down, provincial governments will have to consider alternative approaches in pursuit of the overall goal of minimizing the negative impact on equity and access.

Regulating Private Insurance

As emphasized earlier, a robust parallel private sector requires a functioning market for parallel private insurance. Short of prohibition, both demand- and supply-side policies can limit the prevalence of private insurance. Tax policy can play a central role on the demand side. First and foremost would be to ensure no tax subsidies support the purchase of parallel private insurance as tax policy currently subsidizes complementary private insurance at the federal level and in all provinces except Quebec. The tax subsidy arises because the value of employer-provided private insurance is not included as a taxable benefit for an employee. The value of this tax expenditure was estimated to be $2.6 billion in 2015 for the federal government alone.[38] Unless the tax regulation is changed, the subsidy would also apply to employer-provided parallel private insurance, which has been the fastest growing component of

37 Flood & Archibald, *supra* note 36; Boychuk, *supra* note 36.

38 Department of Finance Canada, *Report on Federal Tax Expenditures: Concepts, Estimate, and Evaluations* (Ottawa: Government of Canada, 2018).

parallel insurance markets internationally.[39] Fully eliminating any subsidy would require action at both the federal and provincial levels. Tax policy, however, could go further than eliminating the subsidy; governments could tax the purchase of parallel private insurance (and ideally this could be coordinated between the federal and provincial governments, though this complicates matters). From an economic perspective, parallel private insurance imposes negative financial externalities on the public system, making the market-determined level of consumption of private insurance higher than the socially optimal level.[40] A standard economic regulatory response in such situations is to reduce consumption by imposing a tax on the good or service. The impact of the tax on purchases of parallel private insurance would depend on the size of the tax, but the evidence regarding the effects of the current tax subsidy on the demand for employer-provided private complementary insurance suggests that the impact could be substantial. A comparison of the demand for private insurance in Quebec (no provincial subsidy) with the demand in other provinces (all with subsidies) estimates that removal of the provincial tax subsidy in Quebec reduced demand by 20 per cent.[41] As a further advantage, the tax revenue could be used to counteract some of the negative financial spillovers of private insurance on the public system; the revenue could be used, for instance, to maintain the real value of public funding in the face of higher input prices caused by competition with the private sector for inputs. However, I am not aware of any country that has implemented such a tax, though private health insurance in the United Kingdom is subject to a 12 per cent "insurance premium tax" that applies to insurance premiums in general (i.e., it is not specific to health insurance).[42]

The growth of parallel private insurance could also be inhibited through regulation of permissible benefit packages. Following the *Chaoulli* decision that struck down Quebec's ban on private insurance,

39 Sagan & Thomson, *supra* note 1.

40 Glied, *supra* note 21.

41 Stabile, *supra* note 21; Amy Finklestein, "The Effect of Tax Subsidies to Employer-Provided Supplementary Health Insurance: Evidence From Canada" (2002) 84:3 J Pub Econ 305.

42 HM Revenue & Customs, "Guidance: Insurance Premium Tax Rates" (2017), online: <https://www.gov.uk/government/publications/rates-and-allowances-insurance-premium-tax/insurance-premium-tax-rates >.

for instance, the government's response (Bill 33) allowed for parallel private insurance but only for a very small number of procedures with long wait times.[43] To date, no insurer has offered a policy for sale. Somewhat paradoxically, the opposite approach—requiring a minimum basket of services that goes beyond the types of simple elective procedures that are the staple of the parallel private insurance industry—might also make offering insurance unattractive to insurance companies, effectively stifling the development of the market. Finally, regulations that prohibit discrimination on the basis of age or health status, and pre-existing conditions in particular, can be justified on grounds of equity and access but may similarly make entering the market financially unattractive for an insurer. The precise mix of policies would need to be determined, but the broader point is that regulation of benefit packages and terms of sale offers a possible regulatory approach to influence the size of the private insurance market and the nature of the services covered.

Extra-Billing

Should the courts strike down existing prohibitions on extra-billing, a number of regulatory options could limit is growth. New Brunswick and Nova Scotia do not prohibit extra-billing but curb its practice by denying public coverage to patients who obtain services from physicians who extra-bill.[44] A province could also prohibit private insurance coverage for the amount of extra-billing charged by physicians. Finally, while Australia allows extra-billing, it provides incentives for general practitioners to accept the public fee as payment in full (a practice known as bulk billing), which most general practitioners do and private insurance is not permitted to cover extra-billing charges.[45]

Dual Practice

Dual practice—which I take to include both physician dual practice and the practice of publicly funded hospitals providing care to both private-pay and publicly funded patients—presents a greater challenge. The latter has been a particular focus of regulation

43 Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*, 2nd Sess, 37th Leg, Quebec, 2006 (assented to 13 December 2006).

44 Flood, *supra* note 36; Boychuk, *supra* note 36.

45 Healy, Sharman & Lokuge, *supra* note 19.

internationally intended to ensure that public hospitals do not give priority to private-pay patients and that public dollars do not subsidize private-pay patients. Public hospitals have incentive to prioritize private patients because such patients bring additional revenue outside the public funding stream. Attempts to prevent prioritization of private patients often amount to little more than prohibiting such practices in principle, but with weak monitoring and enforcement, making the prohibition relatively ineffective. For example, although Australian regulations prohibit giving priority to private patients, in practice public hospitals do give priority to private-pay patients over public patients.[46]

The simplest and most effective approach to addressing both of these problems is to prohibit publicly funded facilities from treating private patients—but given public-sector fiscal constraints, the temptation is to allow this on the argument that such private revenue could subsidize public provision. An alternative option would be to require public facilities to charge a high price—unequivocally above the cost of care—to ensure that the public system does not subsidize private patients, and for the provincial government to then claw back that portion of the price above the cost to the facility. Such a scheme would ensure no subsidy to private patients, thwart the facility's incentive to prioritize private patients, and retain the incremental revenue for the general public funding stream rather than having all of it stay with the facility providing the care.

Regulating physician dual practice is more difficult, and options will depend importantly on what, if any, of current regulations are declared unconstitutional. Regulation of dual practice internationally generally takes a few basic forms, restricting the amount of private-sector activity allowable, providing incentives to devote time to the public rather than private sector, and structuring the work context to be able to monitor private provision.[47] Limitations generally

46 Meliyanni Johar, "Are Waiting List Prioritization Guidelines Being Followed in Australia?" (2014) 34:8 Med Decision Making 976; Meliyanni Johar, Glen Stewart Jones & Elizabeth Savage, "Emergency Admissions and Elective Surgery Wait Times" (2013) 22 Health Econ 749; Amir Shmueli & Elizabeth Savage, "Private and Public Patients in Public Hospitals in Australia" (2014) 115 Health Pol'y 189.

47 García-Prado & González, *supra* note 22; Karolina Z Socha & Mickael Bech, "Physician Dual Practice: A Review of Literature" (2011) 102:1 Health Pol'y 1; Paula González & Inés Macho-Stadler, "A Theoretical Approach to Dual Practice Regulations in the Health Sector" (2013) 32:1 J Health Econ 66.

take the form of limiting the amount of income an opted-in physician can earn through private-sector work, limiting the proportion of time a physician can allocate to private-sector work, or limiting the quantity of procedures that can be provided through private-sector work. Incentives take the form of increasing compensation in the public sector or offering some other kinds of perks. Attempts to enhance monitoring suggest allowing physicians to do private practice in public facilities on the logic that it is easier to observe than if private-sector work is in a different setting. Two key problems arise for Canada in drawing lessons from others' experience. First, although there is little high-quality evidence, the general consensus is that, commonly, these regulatory policies are not effective, particularly due to problems of monitoring and enforcement. Second, the context for most regulatory discussion differs from Canada's in two important ways: many studies derive from settings in which the public sector pays a fixed salary to physician employees (e.g., salaried hospital consultants), and the extant literature focuses notably on low- and middle-income settings, which face challenges distinct from those of Canada. If the courts rule that prohibiting dual practice is unconstitutional, two options may be feasible and effective. The first, which is really just an extension of the principle underlying the current approach, is to use indirect regulatory tools to make private practice economically unattractive so that, while dual practice is allowed, few choose the option. A second option would be to use carrots; for example, offer inducements for opted-in physicians who commit to not engage in dual practice. These could be financial incentives—admittedly further stressing already-strained provincial public budgets—but it may be possible to devise other inducements that make public practice easier or more attractive, similar in spirit, for example, to Australia's use of bulk billing for physicians who choose not to extra-bill. Either way, this approach amounts to competing directly with the private sector for physician time and effort.

Discussion

To achieve its goal of limiting the role of parallel private finance while not prohibiting it outright, Canadian provinces have devised an effective, coordinated set of regulations across both the insurance and health-service sectors, and across the demand and supply sides of each. Canada is frequently portrayed as an outlier among peer

countries in the extent to which it limits parallel private finance for its core medicare services, but even countries that permit a larger role for parallel private finance regulate such finance and its interaction with the public system.[48] Indeed, as emphasized, protecting the public system while allowing a larger role for parallel private finance requires a more elaborate and robust regulatory regime to address the more numerous, nuanced, and complex ways the two systems interact. Should the courts strike down components of the provinces' current regulations, the need to develop a carefully constructed regulatory approach will become even more important, while the set of available tools becomes more limited and may not be politically feasible (for a discussion of the difficulties of achieving public medicare in the first place, and of the various interest groups opposed, see chapter 1).

Regulation in such a world is likely less effective than the current regulatory approach, but provincial governments will still, in theory, have options to limit both the size of the parallel private sector and the adverse impacts of parallel private finance on the public system. Central to this will be the more active use of tax policy, more emphasis on the demand side, and a continued focus on a coordinated approach across both the insurance and service sectors with regulations that complement and mutually reinforce each other. At this time, there is limited good evidence on which to base such regulation, so governments will have to remain flexible, evaluate, and be willing to modify their approaches as they gain experience, assuming, of course, they have the political will to wish to maintain and improve publicly funded medicare.

Given the evolution of the health care sector, the opportunities and pressures for parallel finance will unquestionably expand even if the current regulations are upheld, making renewed attention to regulation, including possibly new elements, important. Both increased government contracting with private facilities for the publicly financed delivery of covered services and expanding markets for privately financed non-medically necessary services (e.g., cosmetic procedures) will attract new private capital to the health sector. The investors in these private facilities will seek to maximize their

48 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) 5:3 Health Econ Pol'y & L 319.

return, and privately financed parallel delivery represents an obvious opportunity. Further, if dual practice is allowed, these private facilities offer opportunities for physicians to provide private care without making large investments themselves, increasing the attractiveness of the option. Regardless of the outcomes of the court cases, Canadian provinces must develop more sophisticated approaches to regulating private finance.

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