

THE POLITICAL ECONOMY OF EXTRA-BILLING

by

Pran Manga

University of Ottawa

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### I. Introduction

There is a popular but mistaken perception that extra-billing is a recent phenomenon. Many wrongly believe that extra-billing was introduced after the passing of the Established Programs Financing Act<sup>1</sup> in 1977 or somewhat later, specifically after the termination of the wage and price control program that was initially implemented in late 1975. It is commonly argued that extra-billing by physicians was mainly a reaction to the decrease in real or relative incomes that physicians had experienced during most of the past decade.<sup>2</sup> Indeed, it is quite accurate to assert that the general public only came to regard extra-billing as a problem in the fall of 1979 with the rapid increase in the rate of opting-out in Ontario and the notable increases in balance-billing in Alberta and Nova Scotia. It is not an exaggeration to contend that the phenomenon of extra-billing was the single most important health policy issue that defined the so-called "medicare crisis" of the late seventies. This issue elicited a great amount of commentary in virtually every submission to the Hall Review of 1979-80. The other phenomena that characterized the crisis include the introduction of new authorized charges for hospital care or the raising of existing ones<sup>3</sup>, the increase in health insurance premiums in the provinces that still levied them<sup>4</sup>, and the growing perception that government restraint of health care expenditure<sup>5</sup>, most notably on hospital services, was excessive to the point that the

principles and standards fundamental to the Canadian medical and hospital insurance plans were being jeopardized.

However, all of these phenomena were in force throughout the seventies. Extra-billing, for example, existed in Ontario and in Nova Scotia from the very beginning of Medicare. While there are no official statistics on the extent of extra-billing during these early years and, regrettably, there is a serious dearth of reliable data even for the past few years, there is nevertheless a general consensus that in the aggregate there has been a noteworthy increase in extra-billing over the post-medicare period. Indeed, it is the perceived rapid spread of the practice of extra-billing in conjunction with the rapid increases in authorized charges and premiums that alarmed the public and engendered a feeling of a crisis. What was once ignored, if not tolerated, was now seen as a serious erosion of the principles of Medicare. Numerous interest groups were sufficiently alarmed to initiate and organize concerted action to preserve hard-won advances in health policy.

The heightened concern about extra-billing should also be seen as a specific manifestation of a more general concern about future social policy. The nineteen eighties may represent, at worst, a break from, or at best, a severe strain in the historic pattern of development of the so-called Welfare State since the great depression. The recent resurgence of conservative political currents has already eroded and continues to threaten a variety of social programs and policies. More worrisome is the dismal or, at best, marginal prospects for economic growth and fears that we are in the midst of major technological and structural changes that are likely to exact very high social costs. The fiscal dividends of economic growth

have diminished just when public solutions may be most needed to solve present and future social and economic crises. As well, the recent policy debates in Canada over universality versus selectivity, together with some disconcerting social indicators (for example, on the extent of poverty, income inequalities, unemployment and differences in morbidity and mortality) suggest that the social consensus on how to deal with these problems is disappearing just when the economic system is apt to generate a more unequal distribution of income, wealth and opportunity.

There are considerable pressures on many national governments of the western world to push back the fiscal responsibilities for social policies to lower levels of government, and for all levels of government to consider various notions of "privatization" with the main objective of transferring public costs to individuals. This is true for Canada as well. The risk in these developments is, of course, the fragmentation and balkanization of social policy and programs.

In this emerging political and economic environment the policy outcomes of current debates are more likely to be determined by the power structures and pressures exerted by interest groups in society than by the basic value systems and preferences of the population.

An often overlooked fact is that in much of the western world the public provision of hospital and medical services was among the last of the policies and programs normally associated with the aforementioned Welfare State. The lateness is largely due to the resistance and antipathy to such programs by professional and commercial insurance interests.<sup>6</sup> However, despite the recentness of Medicare in Canada it is the most cherished and popular of the public programs.

Partly as a result of public pressure, the newly elected Progressive Conservative federal government in 1979 decided to institute a comprehensive review of health policy to be undertaken by Justice Emmet Hall.<sup>7</sup> The central task of the review was to assess if and to what extent the principles of Medicare were being breached by the recent developments.<sup>8</sup> The Hall Review unequivocally identified the phenomenon of extra-billing as a grave threat to the principles and, indeed, the very survival of Medicare. Soon thereafter a report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements reaffirmed this judgement.<sup>9</sup> These two reports left no doubt that the existing pieces of legislation, specifically the Hospital Insurance and Diagnostic Services Act of 1957, the Medical Care Act of 1958 and the Established Programs Financing Act, needed to be revised if the original intent and spirit of the publicly financed universal, comprehensive health insurance programs were to be maintained. The reports confirmed what was generally known, that the existing standards and principles expressed in the aforementioned legislation were weak, vague and vacillating and badly needed to be rewritten.

These reports together with the growing expression of concern by the public legitimized the need for a new Canada Health Act. In the ill-fated budget of November 1981, the federal government formally announced its wish to clarify the principles and standards of Medicare and to develop mechanisms to ensure their maintenance. This was to be achieved in consultation with the provinces and to result in new legislation by March 1983.

In May 1982, the federal Minister of Health and Welfare outlined the federal proposals for the new Act.<sup>10</sup> The occasion drew considerable

attention to the clear retreat from the previously declared wish of the federal Minister of Health and Welfare to ban physician extra-billing. Subsequently, her department prepared a working draft of a more detailed description of the Minister's proposals and in September revised the earlier draft or "working paper" as it is called by federal officials.<sup>11</sup> This draft is available to the public and it incorporates many of the concerns the provinces had expressed to earlier drafts and proposals. Evidently, the Department of Health and Welfare itself seems to want a new Canada Health Act so as to preserve the original intent of the current principles and standards embodied or thought to be embodied in the existing legislation, but with a few additional changes with respect to enforcement, accountability and, not unimportantly, federal visibility.

To date, however, the critics of the September draft have gone far beyond the Department's narrow and partial objectives. Thus, some have called for a major rethinking of health policies with vastly different views and perspectives, for example, about comprehensiveness, the role of the physician, the exclusive concern with sickness, the integration of health and social policies, remuneration methods to professionals, and so on.<sup>12</sup> It is noteworthy that a number of the proposals and suggestions for reform are clearly not within the jurisdiction of the federal government and hence cannot be addressed by the new Canada Health Act. Many public interest briefs have explicitly called for the forthright prohibition of extra-billing and are not content with attempts to merely control the extent of extra-billing. Others have demanded equally radical changes, for example, the re-introduction of private health insurance. Thus it appears that even to re-establish the "essence of Medicare" is by no means an easy task. The medical associations, as well as provincial ministers of health, have persistently and emphatically attacked the federal intentions to control let

alone ban extra-billing. The divisions on extra-billing are fundamental. What is clear from both the events leading up to the new Canada Health Act and the public, professional and provincial government reaction to the draft or "working paper" version of the new Act is that extra-billing is by far the most controversial issue that has to be addressed.

The following sections consider briefly what precisely is meant by extra-billing, the legal framework governing extra-billing, the consequences of extra-billing, and the validity of the arguments for extra-billing. This is followed by a discussion of the policy options at the federal and provincial levels of government to counter the practice of extra-billing. In the final section the arguments are summarized and a number of recommendations are offered.

## II. Extra-Billing: Definition, Legal and Statistical Overview

### Definition

There is a considerable and largely unnecessary terminological confusion surrounding the concept of extra-billing. In this report the concept is defined simply as point-of-service charges patients are required to pay for insured medical services that are higher than the provincial benefit schedule. The profession appears to avoid the term extra-billing, preferring instead the euphemism "patient participation."<sup>13</sup> [Extra-billing thus involves an out-of-pocket cost to the patient for the use of medical services and a transfer of the sum to the physician providing the service.] This generic definition incorporates the practice of balance-billing found in Alberta and Nova Scotia whereby the physician bills the patient only the amount above the provincial benefit schedule and bills the provincial insurance

plan for the allowable benefit amount. All other provinces have disallowed balance-billing by legislation at various points since the inception of Medicare (for example, Ontario in 1972 and British Columbia in 1981).

### Legislative Overview

The billing procedures under Medicare vary from province to province. Table 1 presents an overview of the current legal situation governing extra-billing by fee-for-service physicians in the provinces.<sup>14</sup> Evidently, Quebec is the only province that has technically legislated an end to extra-billing by requiring opted-out (or "non-participating" as the profession sometimes like to call it) physicians to bill patients for all their services and simultaneously refusing to reimburse their patients for such services. In Quebec, non-participating physicians can be said to be entirely in private practice with no government insurance payments to them or to their patients.

Participating or opted-in physicians in Newfoundland, Quebec, Ontario, Manitoba and British Columbia bill the provincial insurance plan for all services and accept the plan payments as full reimbursement.

As shown in Table 1, opted-in physicians in Prince Edward Island, New Brunswick and Saskatchewan can bill the insurance plans for services they provide to some patients (and accept plan reimbursement as full payment) or they may bill some patients directly for all services (legally termed mode III under the well-known Saskatoon Agreement of 1962). Such direct billing of patients may involve extra-billing. Put differently, doctors in these three provinces do not have to opt-out of the provincial plan in order to extra-bill patients. These direct-billed patients are subsequently reimbursed by the provincial insurance plan for only the provincial benefit

TABLE 1. Extra-Billing by Fee-for-service Physicians: An Overview of the Legal Situation in the Provinces

	Patients Entitled to Plan Benefits						
	Physicians <u>MAY NOT</u> Extra-Bill			Physicians <u>MAY</u> Extra-Bill			
	Opted-out			Opted-in			
	Physician BILL PATIENT for ALL Services	Physician BILL PLAN for ALL Services	Physician BILL PLAN for Services HE WISHES TO	Physician BILL PLAN for Benefit Amount AND PATIENT for Extra Charge if any (extra \$ made known to plan)	Physician BILL PATIENT ONLY for Services HE WISHES TO	Physician BILL PATIENT ONLY for ALL Services	
Nfld.	X					X	
P.E.I.			X			X	
N.S.				X*		X	
N.B.			X			X	
Que.	X						
Ont.							**
Man.							
Sask.						X	X***
Alta.						X*	X***
B.C.		X			X	X*	X

\*Notion of "opted-in" or "opted-out" does not really apply in Alberta and Nova Scotia.

\*\*Patients not entitled to plan benefits.

\*\*\*Ontario allows "opted-out" physicians to bill for certain services as if they were "opted-in" (i.e., bill the plan without extra-billing patient), e.g., services rendered in any public hospital in Ontario when the doctor is a member of an "associate medical group" registered with the plan. Manitoba allows for assignment of benefits in respect of medical services provided in a University of Manitoba Clinical Teaching Unit:

\*\*\*\*Physician may elect to do so on a patient by patient basis.

Source: Health Information Division; Policy, Planning and Information Branch (revised in 1982).

amount.

Since balance-billing is still permitted in Alberta and Nova Scotia, the notion of opted-in or opted-out doctors does not really apply in these provinces.<sup>15</sup> In both provinces the physician must inform the provincial insurance plan how much the patient was billed directly for the services.

Finally, both Ontario and Manitoba permit some opted-out physicians to bill for certain services as if they were opted-in, that is, bill the provincial insurance plan without extra-billing patients.

It should be clear from this description of billing procedures in Canada that, depending on the province in question, it is not necessary for a physician to be opted-out to extra-bill nor is it the case that all opted-out physicians always extra-bill their patients.

#### The Extent of Extra-Billing: A Statistical Overview

Accordingly, there are different ways of assessing the extent of extra-billing: one can look at the number of physicians currently opted-out (and hence having the potential to extra-bill) or actually extra-billing; one can consider the number and percentage of services which involve extra-billing (not all opted-out physicians extra-bill for all their services and not all extra-billing physicians extra-bill all their patients); and finally, one can look at the amount of such extra-billing in relation to some numeraire (such as the total amount of provincial payments made to doctors) or to the average amount of extra-billing income per physician (who extra-bills).

While all of these ways of describing the extent of extra-billing would be useful and interesting, much of the required data is somewhat difficult to obtain for the provinces except for Nova Scotia and Alberta.

The Department of National Health and Welfare conducted a province by province survey on these issues in 1980. The resulting study is, unfortunately, not available to the public. Whether this is because of the confidentiality of the information supplied by the provincial governments or the problems with the reliability of the data or other reasons is not known. The Department is presently making another attempt to discover the extent of extra-billing in Canada.

There are, of course, some indicative evidence of the extent of extra-billing in Canada as presented in Table 2. It is clear from the data that provinces that do not require opting-out as a precondition for extra-billing (Alberta, Saskatchewan, Nova Scotia, New Brunswick and Prince Edward Island) have more extra-billing. The notable exception is Ontario where, even though doctors must opt-out to extra-bill, about 16 percent of them do so and the value of extra-billing in relation to plan payment is the second highest in Canada.<sup>16</sup>

Opting-out rates and extra-billing have markedly increased recently.<sup>17</sup> However, it must be noted that for any one province the extent of opting-out and/or extra-billing varies over time and sometimes considerably so. For example, in Ontario about 13.5 percent of physicians were opted-out in 1972. The rate declined thereafter and fluctuated between 10 and 12 percent until the middle of 1978. Thereafter, the rate increased dramatically to 18 percent within nine months and remained at that level for about a year.<sup>18</sup> It has stabilized to between 15 and 16 percent over the past year. To cite a more dramatic example, in Prince Edward Island, about 44 percent of the doctors were opted-out as a result of the failure to negotiate a new benefit schedule with the government. Presently, however, only 8 percent

TABLE 2. Extra-Billing by Province, March 31, 1981<sup>a</sup>

Province	Doctors <sup>b</sup>		Value of Extra-Billing	
	Number	%	Amount (\$)	% <sup>c</sup>
B.C.	1	.5	--	-
Alta.	994	44.1	8 200 000	4.8
Sask.	350	30.7	2 100 000	2.3
Man.	96	5.9	1 200 000	1.1
Ont.	9 997	15.5	40 000 000	3.5
Que. <sup>d</sup>	(49)	(.5)	--	-
N.B.	83	13.7	100 000	0.2
N.S.	663	52.8	2 800 000	3.5
P.E.I.	8	5.8	200 000	2.2
Nfld.	2	0.5	80 000	0.3

<sup>a</sup>As of March 31, 1981 or nearest date. Alberta results are for January 1982 except for the estimated value of extra-billing which refers to 1981.

<sup>b</sup>Figures for Newfoundland, Ontario and Manitoba are for opted-out doctors.

<sup>c</sup>Estimated dollar value of extra-billing as a percentage of medicare plan payments for insured services.

<sup>d</sup>The 49 Quebec doctors practice outside the medicare plan. Most of these "non-participating" doctors are over 70 years old or undertake activities other than rendering insured services, so in practical terms direct billing is virtually a non-existent problem in Quebec.

Source: Medicare: The Public Good and Private Practice (Ottawa: National Council of Welfare, 1982), Appendix B.

of the doctors are opted-out. The Prince Edward Island case in 1979 was clearly a sporadic one.

A significant number of physicians extra-bill in Nova Scotia, Alberta, and Saskatchewan. In Nova Scotia, the proportion of physicians who extra-bill for at least some services increased from 42 percent in 1977 to 51 percent in 1979 and is currently about 53 percent. In Alberta the proportion of doctors who extra-bill has varied between 44 and 47 over the last four years.

In every province the proportion of services actually involved in some extra-billing is lower than the proportion of physicians extra-billing.<sup>19</sup> For instance, while slightly more than 15 percent of Ontario's doctors are opted-out, only 7 percent of all services are billed above the OHIP benefit schedule. This discrepancy is largely due to billing procedure changes implemented in December 1978 which allowed opted-out doctors to bill the provincial plan directly for services provided in clinics of all public hospitals. Similarly for the province of Manitoba. However, the difference between the proportion of doctors who extra-bill and the proportion of services that involve extra-billing in each of the other provinces is much smaller in percentage terms than it is for Ontario. However, comprehensive and reliable data are not readily available and it is hoped that the study currently undertaken by the Department of National Health and Welfare will be able to furnish the required data.

Extra-billing also appears to be more moderate in scale when measured in terms of the value of extra-billing as a percentage of total plan payments as indicated in Table 2. That it should be, of course, obvious, unless physicians begin to extra-bill for all their services and the amount of

extra-billing is no less than the benefit amount.

More importantly, these are aggregate, province-wide measures. The ratios presented in Table 2 are grossly diluted by the fact that (a) not all doctors extra-bill, (b) even those who do extra-bill do not extra-bill all their patients or for all services or by the same amount, (c) extra-billing is largely an urban practice so that the province-wide averages understate the problem for urban residents, and (d) within certain specialties the proportion of physicians who have opted-out or extra-bill is extremely high. All these factors suggest that even if some people regard the figures in Table 2 as seemingly benign, they distort and understate the realities of extra-billing to those who are subject to such direct charges for medical care.

For example, in some counties of Ontario the proportion of physicians who extra-bill is about 40 percent and in some towns it is more than 80 percent.<sup>20</sup> In Alberta, extra-billing is especially concentrated in Edmonton (55 percent) and in Calgary (62 percent). In Alberta the majority of dermatologists, obstetricians and ear, nose and throat specialists and more than 90 percent of ophthalmologists extra-bill their patients.<sup>21</sup> Such examples can be cited for every province where extra-billing occurs and it is clear that extra-billing is a clustered phenomenon both in terms of specialty and geography.

There is also considerable variation in the amount charged by extra-billing physicians. An earlier 1976 Ontario survey showed that extra-billing ranged from 9 percent above the OHIP benefit schedule for internists to 35 percent for psychiatrists.<sup>22</sup> A later study reported that almost 50 percent of opted-out doctors had charged amounts above the Ontario Medical

Association fee schedule which at that time was 43 percent above the OHIP benefit schedule.<sup>23</sup>

It might be noted that while province-wide statistics usually cited by some provincial ministers of health and the provincial medical associations are misleading, the Canada wide picture often portrayed by the Canadian Medical Association is downright deceptive. The CMA is rather fond of pointing out that only two per cent of physicians incomes is derived from extra-billing. Such a global measure suffers from all of the reasons cited earlier. However, the extent of extra-billing is further diluted by the fact that not all of the provinces permit extra-billing.

Even if one could obtain reliable and highly disaggregated data to describe the extent of extra-billing such a picture would be insufficient as a portrayal of the effects of extra-billing. As will be argued in the following section extra-billing deters particular population groups from obtaining care. Thus, one cannot regard low percentages for the value of extra-billing in relation to plan payments as benign or within acceptable "parameters" as one provincial Minister of Health put it.<sup>24</sup> Such figures obviously cannot incorporate the deterrent effects of extra-billing. Stated differently, the fact that extra-billing is a clustered phenomenon and may have a deterrent effect on some population groups suggest that even seemingly moderate levels of province-wide measures of extra-billing probably conceal within them particular areas of concern.

### III. The Effects of Extra-Billing

There is ample evidence that extra-billing is a highly sensitive issue, provoking reactions ranging from impassioned demands for its abolition to

an ideological and sometimes illogical defence of the practice. The convictions behind these diametrically opposed policy positions are so strong and fundamental as to defy attempts at reconciliation and compromise. It is hardly surprising that the federal intentions to control the extent of extra-billing, rather than to ban it outright or to tacitly accept the current situation as most of the provincial governments appear to be doing, came under very strong criticism from both the opponents and the defenders of extra-billing. What is also clear from the rancorous debates of the past few years is that the resolution of the extra-billing problem is not only an economic matter but also a complex constitutional, political, legal and value judgemental issue.

In this section some of the effects of extra-billing that warrant careful attention in designing the public policy responses to the practice by government are briefly examined.

Opponents of extra-billing have argued that it violates a number of the principles of Medicare explicitly articulated in the Medical Care Act of 1968. Some have thought these violations serious enough to advocate the withholding of federal transfers for health care programs.<sup>25</sup>

Extra-billing per se violates neither the principles of public administration of the insurance program on a non-profit basis, nor the condition that provinces must cover 95 percent of their insurable residents.

With respect to the portability of benefits across Canada, extra-billing does introduce some complications and inconveniences to patients and doctors alike. There is a belief among bureaucrats at both levels of government that the resulting problems are not insurmountable and could be resolved by procedural adjustments to billing and the settling of interprovincial accounts.<sup>26</sup> Whether a fully effective arrangement satisfactory to patients and doctors could be worked out and implemented,

however, remains to be seen.

Extra-billing assumes a greater significance in relation to the other principles of Medicare. The Medical Care Act states that "the plan provides...upon uniform terms and conditions to all insurable residents of the province...insured services...on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons."<sup>27</sup>

There are essentially four ways in which the uniformity principle is or can be violated by the practice of extra-billing. Firstly, physicians who extra-bill readily admit that they practice price discrimination by charging some patients more for some services than others. In fact, the government and the society generally expect them to do so and to specifically exempt the poor from extra charges. Price discrimination was, of course, common in the years before Medicare.<sup>28</sup>

Secondly, as was stated earlier, extra-billing is a group phenomenon. This implies that some residents in certain localities or needing specific specialist physicians are more subject to extra-billing than other residents of the province.

The third way in which the uniformity principle may be violated is, ironically, a result of governments' wish to reduce the barrier to access of care to poorer patients. In Ontario, for example, opted-out physicians can separate their billing of poor patients from the richer ones and hence be assured of guaranteed reimbursement at OHIP benefit rates for the former by scheduling them into hospital clinics while reserving their private office hours for those who are able to pay the extra charges. "The actual extent to which such a two-tiered system is being put into place is not accurately known as yet, but some initial indications are

disturbing."<sup>29</sup> Such "streaming" of patients by opted-out doctors has the potential of creating a two-class medical care system. The care provided in clinics may be less prompt, less comfortable and more impersonal and in the current context of stringent hospital budgets some clinics may lack the full provision of auxiliary resources.

The fourth and potentially most significant way in which extra-billing may contravene the uniformity principle relates to the impact of the practice on the quality of care different patients are likely, or expected, to receive. Should the phenomenon of extra-billing become more widespread, there is a very real risk that it will affect the way physicians, and through them hospitals as well, will treat patients on the basis of whether or not they pay the extra charges just as was the case before the introduction of medicare. Should that transpire Canadians would have lost a precious feature of medicare, if not in reality nevertheless in intent, that patients are to be treated uniformly based solely on medical need. We have come to believe that the hallowed doctor-patient relationship and the clinical and ethical principles it entails is not conditioned upon patients ability to pay.

Price discrimination by physicians, the clustering of extra-billing physicians and a two-tier system of medicine violate the requirement that medical services be provided upon "uniform terms and conditions to all residents of the province." While many in society may tolerate price discrimination believing it to be at least well-motivated (the Robin Hood principle) especially if the poor were effectively exempted (but there is evidence that they are not), they may not be so benign towards the fact that some are subject to extra charges which can be substantial while others who may be in like economic circumstances are not. Finally, on the basis of numerous briefs to the Hall Review and of commentary on the Canada Health Act, one may infer that a two-tier system is probably

not acceptable to a majority of Canadians. In any case, the political and philosophical rhetoric has always asserted that the uniformity principle was central to Medicare.<sup>30</sup>

The Medical Care Act makes reference to "reasonable compensation for insured services rendered by medical practitioners." This matter is discussed in the next section together with other rationale for the practice of extra-billing.

Finally, and most importantly, the Act explicitly discourages the use of charges that "impede or preclude" "reasonable access to insured services by insured persons." The removal of income and price barriers to hospital and medical services is the principal *raison d'être* of the Canadian public health insurance schemes. Extra-billing is seen by many as contrary to the spirit and letter of Medicare. But the Act itself refers to "reasonable" access and provides very little, if any, guidance to its interpretation. The concept "reasonable" is inherently and inescapably open to a subjective interpretation. There is, however, no doubt that extra-billing does "impede or preclude" access to some patients, and, in our view, more than may be commonly suspected. Indeed, physicians themselves occasionally justify extra-billing for its deterrent value, a view that will be discussed further in the next section.

A study by Stoddart and Woodward commissioned for the Hall Review clearly shows that extra-billing does have a significant deterrent effect, especially on the poor.<sup>31</sup> While the results of their study are too numerous to detail here, the few findings that follow are quite indicative of the utilization effects of extra-billing. In response to extra-billing by their physicians, 18.7 percent of the respondents reported that although they remained with their doctor they made fewer visits for medical care. Also, 14.1 percent felt that there was at least one occasion in which they

or an adult member of their family did not visit their doctor even though they felt they should have.<sup>32</sup> About 17 percent of the respondents said that they had sometimes delayed contacting the doctor for themselves, 9 percent reported delays in calling a doctor for another adult, 5 percent for children and 2 percent for an older person. In the aggregate, 19 percent of the respondents reported delays in seeking care for themselves or for a family member. These are global figures. Throughout their report the authors emphasize that "the poor are significantly more likely to reduce their utilization and/or delay seeking care than are the non poor."<sup>33</sup> Similarly, a study by Richard Plain for Alberta also indicates that extra-billing does have a deterrent effect and that the poor were particularly affected by such charges.<sup>34</sup>

Contrary to public expectation and reassurances by various medical spokesmen that physicians do not extra-bill those who cannot afford to pay, there is both survey and official administrative data indicating beyond any doubt that low income patients are being extra-billed. For example, Richard Plain concludes, for Alberta, that "it is an unquestionable fact that the aged, welfare recipients and the lowest income groups in the province are forced to bear additional out-of-pocket charges in order to receive medical attention."<sup>35</sup> Thus, in the richest province with the highest average income physicians in Canada, the poor are not exempted from additional medical charges despite the fact that the province's College of Physicians and Surgeons had issued directives requesting physicians to refrain from extra-billing the poor.

The extent of extra-billing observed and examined in some provinces does violate the "reasonable access" criterion of Medicare. It might be pointed out here that the advocates of extra-billing have not produced a single study to support the contrary claim, that is, that extra-billing

does not unduly or unreasonably jeopardize accessibility to care. Indeed, they have not even bothered to undertake such a study. One is left wondering whether this is because they are so convinced that the effects are negligible or whether the consequences of extra-billing are of no concern to the proponents of extra-billing. It is, of course, curious, to say the least, that the medical profession itself does not seriously challenge the findings of the existing studies. Similarly for the administrations of the provinces where such studies were undertaken.

While the medical associations appear to be insensitive to the deterrent effects of extra-billing they have expressed concern that the poor have been extra-billed. In such instances they have been quick to lay the blame on the provincial governments for being reluctant to issue "identity cards" to the poor and thus facilitate the extra-billing physician in being a more accurate poor-discriminator.

There are many other consequences of extra-billing worth noting briefly. Extra-billing reintroduces financial risk for ill health relative to first dollar insurance coverage that Medicare is supposed to provide. It involves a shift in the burden of paying for health care services from public sources (that is, general revenue) to the individual patient, that is, it redistributes the burden of financing health care costs from all taxpayers to the sick. In light of the rather tight fiscal position of most provinces, transferring the burden directly onto patients is increasingly tempting for governments. Such shifting does not necessarily result in lower public and private health care expenditure.<sup>36</sup> Indeed, the reverse may be true and what we may be dealing with here is a peculiar type of fiscal illusion or myopia. Extra-billing generates a number of transaction costs such as the inconveniences, search and possibly transportation costs for patients

trying to avoid extra charges and waiting for reimbursement from the provincial insurance plan. Also the practice of extra-billing generates higher administrative costs for the physician as well as the medical insurance plan.

The critics of extra-billing are, to a varying extent, aware of all of these arguments. There is, however, one as yet unrealized consequence of extra-billing that they are particularly concerned about and which they regard as a serious threat to the survival of Medicare. It is felt that as extra-billing becomes more pervasive and costly, it, in isolation or even more so in conjunction with the imposition of a variety of authorized charges for institutional care, would bring about the reintroduction of private health insurance--a situation that the Hall Commission examined and rejected and one which even American health policy analysts find seriously deficient in assuring equity in health care at reasonable cost.<sup>37</sup> It is precisely this fear that leads the defenders of Medicare to insist that the new Canada Health Act should maintain the existing prohibition of private health insurance coverage for insured medical and hospital services.

#### IV. The Reasons for Extra-Billing

In this section the various rationales for the practice of extra-billing are discussed briefly. Medical associations are naturally the most vigorous defenders of the right to extra-bill.<sup>38</sup> Among the oft-cited reasons for extra-billing, but offered here in no particular order of importance, are the following: (1) extra-billing as with most forms of user fees reduces unnecessary consumption and patient abuse of the system, (2) extra-billing is basically a reintroduction of prices into what is now a priceless system (except for authorized charges for hospital care) and hence should promote the efficiency with which health care services are produced, (3) it can be instrumental in lowering health care expenditure, (4) extra-billing is a means of income supplementation for doctors in reaction to a

lack of meaningful benefit schedule increments and/or bargaining with provincial authorities, (5) extra-billing is defensible as a method to reward the better physicians providing a higher quality of care, (6) extra-billing is warranted because the health care system is underfunded and given the existing and expected fiscal predicaments of both levels of government further public financing is unlikely if not undesirable, and finally (7) it is the right of independent professionals to price their own services, which is occasionally expressed in excessively ideological or emotive terms (such as, the banning of extra-billing makes the Canadian health care system "a socialist scheme", and doctors are effectively "conscripted" or made "third class civil servants"<sup>39</sup>).

(1) The notion that extra-billing is a necessary corrective for abuse of the health care system by patients is simply untenable. Much of the evidence of abuse by patients is anecdotal and formal attempts to examine its quantitative significance have concluded that the abuse is quite insignificant.<sup>40</sup> Admittedly, the concept is rather difficult to define and hence will inescapably present problems in establishing empirically the extent of it.

However, would extra-billing be the appropriate response to "frivolous" or "unnecessary" use of physician services? Extra-billing, by its very nature, impedes access in terms of a patient's ability to pay and not only in terms of whether or not a patient's condition genuinely warrants a visit to a physician. Thus the poor as was argued earlier will be deterred for even medically necessary care.<sup>41</sup> The wealthy may not be deterred even for frivolous use of medical services. The thesis also overlooks the fact that for many conditions patients are not in the best position to know whether a visit to a doctor is warranted. One should also consider the possibility that if extra-billing were to be more widespread in a given

area, the poor may be more likely to visit emergency units of local hospitals, a result which ironically would be interpreted as abuse of the system by patients. This is not to say that there is no unnecessary use of the health care system which is patient initiated. There probably is. But such abuse almost wholly consists of unnecessary visits to doctors and as such is not very costly to the system.

The physicians, the "gatekeepers" of the system, have a role to play in keeping down such costs by making sure that in such instances further wasteful use of health care resources is avoided. It might be noted at this point that there are also allegations of abuse by physicians of the health care system in terms of unnecessary hospitalization of patients, unnecessary surgery, requesting too many laboratory tests, keeping patients longer than necessary in hospitals, requiring too many referrals or revisits, inappropriate use of health manpower, and so on.

There is also widespread concern about the efficacy and effectiveness of a large and growing number of medical technologies and procedures.<sup>42</sup> While abuse by patients is relatively inexpensive, the "abuse" by doctors by contrast is very costly. The former is probably only a small fraction of the waste and inefficiencies inherent in our health care delivery system and technologies. In summary, extra-billing is a wrong solution to an economically small problem.

(2) Extra-billing by physicians involves varying charges established through doctor-patient "negotiation" and paid for by the patient. But the process of price determination and the function of prices for physician services have very little resemblance to those found in competitive markets. Regulations disallowing advertising by physicians is just one impediment to effective price competition. Another is that a physician can rightly claim not to have a uniform rate of extra-billing, indeed, that is what price

discrimination means. Thus, meaningful price shopping by patients is virtually impossible even if patients had the luxury of choice between alternative physicians in their localities. Furthermore, one of the requirements of critical importance for the efficiency of competitive markets is that the consumer/patient must also be sufficiently informed about options available for the quantity and the quality of physicians' services. Such an assumption is surely untenable for a majority of medical services for the average patient. For these and other reasons the practice of extra-billing cannot be relied on to promote the efficiency of the delivery systems for medical services.<sup>43</sup> Indeed, initiatives to improve efficiency through the promotion of alternative delivery systems (such as health services organizations and community health centres) and medical manpower substitution have always provoked strong resistance by the medical associations.

(3) It is difficult to assess the claim that extra-billing will help reduce the growth in health care expenditure. The overall effect would depend on several important factors. Extra-billing can be said to raise medical costs inasmuch as physician charges are additional to negotiated benefit schedules. However, the provincial governments could in theory adjust the benefit schedule downwards or not raise them as much as they would have otherwise, so as to maintain some equilibrium between a purely public system and a public plus extra-billing system of physician reimbursement. The past few years in Canada have revealed that extra-billing is a powerful weapon in the arsenal of the medical associations in bargaining over fee schedule changes. In some instances, however, even very large increases in fees have brought about only marginal decreases in the extent of extra-billing illustrating that "bribing" the minority of extra-billing physicians can be a rather costly and uncertain proposition.<sup>44</sup> Such lessons, especially in

the context of fiscal difficulties and strengthened by simple rationalizations of making the patients aware of health care costs and reducing abuse of the system by patients, may tempt provincial governments to shift the cost of medical services from tax revenue to private out-of-pocket sources of financing. The dynamics between fee schedule negotiations and extra-billing have yet to be carefully examined in Canada.

Extra-billing may be thought to reduce health care costs through its deterrent effect on utilization of physician services. That low income patients are deterred is not a matter of speculation as was discussed in the previous section. However, whether this leads to savings in health care costs is far from clear. Patients who delay seeking care may ultimately require more costly treatment. Also there is considerable theoretical argument<sup>45</sup> and supporting empirical evidence<sup>46</sup> that physician induced utilization would counter any significant level of reduction in utilization by those patients having the ability to pay. This problem may well be worse in an environment in which the growth in physician supply has been far greater than that of the population to a point where some provincial ministers of health have openly expressed concern about an "oversupply" of physicians.<sup>47</sup>

In the light of these considerations it is clear that one cannot assume that extra-billing will necessarily slow down the increase in health care expenditure. It has been suggested by some that just the opposite should be expected. An empirical analysis of the issue, however, has yet to be undertaken.

(4) The belief that the rapid rise in extra-billing was primarily a reaction to physicians' perception of inadequate incomes resulting from low fee schedule increases during the seventies is widespread and acknowledged by many opponents of extra-billing. Justice Hall echoed this view: "if

physicians are adequately paid, there will be no need for extra-billing nor for strike action."<sup>48</sup> He, like many others believed that higher fee schedule settlements would reduce the tendency for physicians to opt-out and extra-bill. While this may appear to be reasonable and logical, such a policy is not guaranteed to succeed and requires considerable discretion in its application. The principal difficulty lies in the fact that individual physicians or groups of physicians choosing to extra-bill are rewarded from doing so and have little incentive not to do so even when they succeed in collectively persuading the provincial governments to significantly raise the fee schedule. For example, in Alberta, even a large fee schedule increase of 15.5 percent in 1979 made no discernible impact on the extent of extra-billing, forcing an embarrassed and exasperated minister to threaten legislation outlawing the practice (which, of course, was never carried through).<sup>49</sup>

Hall's view and the experience in Alberta highlights a fundamental issue, namely, who determines the adequacy of physician incomes? If physicians themselves define what is adequate then they must be offered sufficiently high fee schedules. If not, they resort to extra-billing. Extra-billing then is simply an argument for higher fees. Hall recommended that "this gordian knot", that is, physician dissatisfaction with their incomes and the consequent extra-billing, be resolved through the outlawing of extra-billing and an agreement between the provincial medical association and government to submit to binding arbitration whenever an impasse in fee schedule bargaining occurs. He was emphatic that the two part recommendations be implemented simultaneously. Hall's suggestion was rejected by both parties. Nevertheless, the idea bears serious reconsideration if some pre-conditions and reforms are first put into place.

Physicians justifiably complain that in most provinces there is no

genuine and meaningful "bargaining" over fee schedules. Indeed, they assert that "bargaining" is a misnomer. There is no doubt that we badly need to reform the legislative framework and establish formal structures and processes within which bargaining between medical associations and governments can take place. Beck and Horne cogently argue that "such a framework does not now exist. Each province should re-examine its medical care act, its professions act, and its labour legislation with a view to providing a more formal environment for fee determination."<sup>50</sup> They also suggest two ideas pertinent to fee schedule bargaining that deserve careful study. One is that the medical profession be formally unionized. The other is the adoption of an independent review board.<sup>51</sup> Another precondition for accepting Hall's twin proposal is for governments to take decisive control over the supply and distribution of physicians to a far greater degree than they have hitherto.<sup>52</sup>

The argument that low incomes and low fee schedule increases is the only or principal motivation behind the practice of extra-billing needs further and careful study. The vast majority of doctors have opted to accept the provincial benefit schedule and do not extra-bill for any of their services. This suggests that they are content with their incomes or at least suggests that doctors as a whole do not think that extra-billing patients is an appropriate response to their dissatisfaction over fee schedules. Despite these trends extra-billing is more extensive now than in the earlier period. Also, extra-billing is over-all more common in the provinces where physician incomes are generally high. More curiously, specialists are more likely to extra-bill despite their relatively higher incomes and fees.

Whatever the relationship between low fee schedules and extra-billing, the appropriate solution to the problem is not to resort to extra-billing

patients but to bargain effectively with the provincial governments. The sick should not be used to resolve the difficulties between the profession and the provincial administration.

(5) Physician dissatisfaction with another aspect of benefit schedules provides another rationale for extra-billing. It is argued that since physicians do not provide a uniform quality of care, higher prices are warranted and justifiable for the better doctors. The premise that physicians do differ in terms of the quality of care they provide is doubtlessly true. But the policy conclusion that extra-billing physicians draw from this is a matter for debate. While higher fees for better doctors is legitimate and desirable, both to reward and encourage improvement in the quality of care, it does not follow that such quality differentials must be implemented through extra-billing. To ration better physicians through extra-billing implies that only the wealthier patient would have access to such doctors. The more reasonable social policy objective is surely to allocate the better physicians to appropriately complex illnesses irrespective of the ability-to-pay of the patients. Quality differences among physicians call for a peer-determined merit award system reflected in fee schedules and not extra-billing per se.

Furthermore, extra-billing implicitly permits each physician to assess his/her own level of quality and charge accordingly. This presents several difficulties. There is first the temptation for physicians to declare themselves above average even though this is statistically absurd. Secondly and more importantly, it puts pressure on opted-in physicians to opt-out lest they be seen as providing inferior quality care. Thirdly, there would be a mistaken tendency to equate quality with price by both physicians and patients. Patients cannot truly assess the quality of physicians so that we cannot rely on patient selection to generate price

differentials that accurately reflect the quality differentials among physicians. It might be noted here that a surprisingly high proportion of patients who received care from opted-out doctors in Ontario were dissatisfied with the quality of care they received.<sup>53</sup>

Physicians have also justified extra-billing as a reaction to undesirable practice styles. It is believed that low fee schedules penalize physicians who choose the long-visit with careful diagnosis and treatment style of medicine and encourage the "revolving-door" style of practice. Extra-billing allows physicians a more desirable style of practice by substituting higher prices for volume of visits. This hypothesis among others was empirically examined by Wolfson and Tuohy in their study of opting-out in Ontario. Their overall conclusion "challenges conventional wisdom...that once other differences between opted-in and opted-out physicians were taken into account there is no indication that opting-out in itself made a difference to their practice behaviour. Except in limited circumstances, the patient loads, hours of work, waiting times for appointments, or other important dimensions of a given physician's practice did not appear to differ according to whether he was opted-in or opted-out."<sup>54</sup>

In summary, physicians do differ in terms of quality of care they provide, and a uniform fee schedule is unfair but extra-billing is not the appropriate solution to this problem. What is called for is a fee schedule that reflects the experience, expertise and other determinants and indicators of quality differentials among doctors.

(6) Over the past three years the medical associations have mounted a concerted campaign to convince Canadians that their health care system is grossly underfunded and have defended extra-billing as one of the ways to counterbalance this deficiency. They have emphasized almost exclusively the financial plight of hospitals as proof of underfunding. Indeed, and curiously, spokesmen for the medical associations have occasionally stated

quite explicitly that the charge of underfunding has nothing to do with physician incomes. The medical associations' overall claim and the basis for their position have been disputed by a number of commentators<sup>55</sup> and suffice it to state here that the case for underfunding is both simple-minded and dubious. But even, for the sake of argument, if we accept that there is underfunding, is extra-billing an effective or even a logical answer to the problem? Since extra-billing basically involves a transfer of income from patient to physician, the answer to the question is, of course, no. A recommendation to permit extra-billing by hospitals would at least be a logical solution to the "underfunding crisis" but it too would suffer from similar drawbacks that were pointed out in the case of physicians extra-billing and therefore unacceptable as an appropriate solution to the problem of underfunding.

(7) Finally, physicians defend extra-billing as simply a matter of professional "rights". Sometimes, such a right is asserted as fundamentally a philosophical and moral matter and as such is placed beyond debate in the sense that the discussion ultimately reduces to a difference in value judgements. A more pragmatic and reasoned view in our view was offered by the Royal Commission on Health Services and recently repeated by Justice Hall: "the emphasis on the freedom to practice should not obscure the fact that the physician is not only a professional person but also a citizen. He has moral and social obligations, as well as self-interest to do well in his profession. The notion held by some that the physician has an absolute right to fix his fees as he sees fit is incorrect and unrelated to the mores of our times. The nineteenth century "laissez-faire" concept has no validity in its application to medicine, dentistry, law, or to any other organized group. Organized medicine is a statutory creation of legislatures and of parliament. When the state grants a monopoly to an

exclusive group to render an indispensable service it automatically becomes involved in whether those services are available and on what terms and conditions..."<sup>56</sup>

There is little doubt that physicians are determined to oppose the banning of extra-billing by governments and that the right to extra-bill is highly valued not only by physicians who presently extra-bill but also by those who do not. The ramifications of banning the practice therefore are as serious as they are uncertain. It is thus incumbent upon policy makers to consider a number of alternative policy options in addition to banning it outright. Some of these policy options are discussed in the next section.

#### V. Policy Options

Before proceeding to discuss the various policy options available to governments to combat extra-billing, it would be wise to reflect on just how determined the federal and provincial governments are in doing anything about the problem. Recent government policies have led many to be rather skeptical and pessimistic about concerted and meaningful government initiatives. The governments of the provinces in which extra-billing occur did not react quickly to the growth in extra-billing and at first expressed an amazing indifference to it, and indeed defended the practice in briefs to the Hall Review. Even now very little has been done by the provincial governments to tackle the problem, other than agreeing to sizable increases in fee schedules to mollify the physicians. Indeed, a communique of the meeting of provincial ministers of health in October 1982 denied that the problem of extra-billing and user fees, that is, the "erosion of medicare", was of a magnitude that required a new Canada Health Act. The medical associations have similarly denied that the principles of medicare were being eroded and have persistently lobbied the federal government not to

introduce the long awaited Canadian Health Act. The federal government, in contrast, quickly and unequivocally condemned the practice at first, only to retreat from its original threat to ban it outright. Following the recent announcement by Alberta that it intends to introduce rather large hospital user fees, the federal Minister of National Health and Welfare has once again revived the policy option of banning extra-billing together with other forms of user fees. The apparent wavering and irresolute policy pronouncements, however, have led many to be somewhat doubtful about the federal government's ultimate intentions about extra-billing.<sup>57</sup>

Another general observation pertinent to this discussion is that the Established Programs Financing Act has dramatically changed the responsibilities and influence of the federal government over health policy. It is important to recognize that the provincialization of health is going to affect markedly the nature of the health policy process in Canada and that ideological and pressure-group interests in the determination of policy within the provincial context will become more important.<sup>58</sup> Indeed, the medical associations' constant and vigorous reference to the unconstitutionality of federal initiatives in health policy<sup>59</sup> is understandable, since they are much more powerful and influential vis-a-vis provincial administrations than with the federal government. This is hardly surprising in the light of the ideological alliance between most provincial governments and the medical associations based on various notions of privatization as the solution for our health care problems.

The federal government has, of course, three policy options concerning extra-billing. It can accept the status quo, ban it outright, or attempt to control the extent and nature of the practice.

Given the knowledge and widespread concern about the effects of extra-billing and the growing realization of the need to protect medicare from

further erosion and perhaps even its eventual demise, the status quo option cannot be seriously entertained. The moral authority and political credibility of the federal government is at stake, for it is one thing to be indecisive between banning or controlling extra-billing but it is quite another matter to capitulate to the wishes of the medical associations and some provincial governments. Such a policy outcome would be neither representative of the popular will nor responsible in serving the public interest.

The majority of the briefs to the Hall Review, the Task Force on Federal-Provincial Fiscal Arrangements and the new Canada Health Act have urged the banning of extra-billing. There are, however, serious questions about the constitutionality of such a policy. Perhaps more importantly, such a policy will wreak an immediate and lasting federal-provincial conflict. The political ramifications are both serious and uncertain.

This is not to argue that banning extra-billing is beyond consideration. It is interesting to recall that the Royal Commission on Health Services recommended "that the schedule of maximum fees or other payments should be that negotiated between the medical association and the respective provincial administrative agency without extra-billing. Provincial legislation should provide for an appeal procedure in the event of disagreement"<sup>60</sup> (emphasis added). This recommendation was, of course, not followed since the Medical Care Act does not preclude extra-billing and provides a rather vague and imprecise limit to such charges (the "reasonable access" clause). The Royal Commission's recommendation is as valid and even more relevant to-day than it was in the sixties. While simply banning extra-billing may be unwise and politically unacceptable, a conditional banning is quite another matter. The condition refers to provisions

in the new Canada Health Act requiring the provinces to provide a formal framework for physician fee schedule negotiations and for resolving disputes. Provinces and the medical associations would still have the right to meet these requirements in a number of different ways. For example, it could entail binding arbitration as outlined in the Hall Review, or "final position binding arbitration" in which the arbitrator is only allowed to choose one of the positions presented by the two contending parties, or a prices review board and so on. The formal framework for negotiation too can be met in a variety of ways.

Perhaps an equally controversial and somewhat less effective federal policy would be to control extra-billing. Under Established Programs Financing the sanction available to the federal government against provincial failure to meet the conditions of medicare consist of withholding the cash transfer. While legally permissible, the application of such a sanction is politically unrealistic. Automatic or discretionary financial penalties tied specifically to the different principles of medicare is eminently more workable, the objective being to make it financially less attractive for provinces not to control the extent of extra-billing. For example, the federal government could reduce the cash transfer to a province by the amount of extra-billing occurring in that province.

Such a policy requires information and mechanisms to monitor the extent and effects of extra-billing. While the working paper version of the Canada Health Act is cognizant of the need to monitor and enforce the principles and conditions of the Act, there is no provision for individuals or groups to request a review of their local situation. Given the recent history of extra-billing the apparent reliance placed on provincial bureaucracies to initiate inquiries is questionable, if not naive. At the very least the new Act should also insist that provinces establish assessment

committees with representation from both the profession and the lay public and accountable to the Minister of Health. Such committees should be authorized to allow or disallow in whole or in part any claim it is required to adjudicate.

The control option will, of course, have to be reinforced by the prohibition of supplementary private health insurance coverage for services insured by medicare.

It is important to note that the control option may not be effective in reducing the extent of extra-billing in some of the wealthier provinces. After all, it is the provincial government and not the extra-billing doctors who face the financial penalties imposed by the federal government. The control option, to put it simply, operates on the provincial government and not on doctors. It is quite possible that a province may decide to suffer these financial penalties and refuse to curtail the practice of extra-billing.

At present much of the attention and efforts of the opponents of extra-billing is focussed on Ottawa. However, it is the provincial capitals that are the real battlegrounds for reform. After all, jurisdictionally, health is a provincial matter and policies to contain and reduce extra-billing must be implemented and administered by the provincial administrations. Indeed, it can reasonably be argued that the federal government can only clarify the objectives of medicare and the role of user fees and extra-billing vis-a-vis these objectives. It cannot impose a solution to extra-billing on the provinces.

At the provincial level, extra-billing can be effectively outlawed by adopting the Quebec option. Under this policy patients with bills for services received from non-participating physicians are not eligible for

any reimbursement from the provincial insurance plan. It must be acknowledged that such a policy is easier to implement in Quebec than in other provinces, the central difference being the relatively lower mobility (emigration) of Quebec doctors. However, a province adopting such a policy in isolation from the others risks losing physicians. This may present a problem in the case of specialists even if in the aggregate the risk is negligible given the relatively good supply of physicians almost all of them currently enjoy (or suffer from if one believes that there is in fact an oversupply of doctors). The risk of losing specialists is far from certain, of course. Indeed, given the rapid decrease in the availability of hospital beds in relation to specialist physicians throughout Canada, the risks of losses are certainly lower presently than they were in the past. The risk is inversely related to the supply of specialists and the latter is still growing in Canada. In any case, such a policy would, of course, engender great political controversy and much heated opposition from the profession. The medical associations have likened such initiatives as tantamount to "civil conscription." In any case, to be effective, the Quebec option would have to be implemented in several, though not necessarily all, provinces simultaneously, a prospect that is rather unlikely at present.

There are, of course, a number of other policy options that provinces must consider should the Quebec option prove politically unpalatable. One such policy would be to make hospital privileges to doctors conditional on no extra-billing or, at the very least, to give preference to opted-in physicians. Hospital facilities are a public resource and its disposition and use must be made to serve the public's interest first and foremost. If physicians can justify extra charges to patients who are dependent on them for necessary services, they will have no difficulty in understanding the rationale for such a limitation on their access to a necessary resource.

Perhaps, a better alternative than the two mentioned above would be to place doctors who earn a large proportion of their earnings from hospital based services on a salary method of remuneration as is the practice in a number of western countries.

A number of studies have noted the quantitative significance of the academic physicians, especially part time appointees to medical schools, who have opted-out or extra-bill.<sup>61</sup> This is very likely due to the nominal stipends paid to them which hardly compensates them for the time spent in teaching and research and the foregone earnings of a non-academic practice. In effect, extra-billing is used inappropriately to finance/subsidize medical education. One further side effect of this phenomenon is that medical students are presented with a disproportionate number of extra-billing doctors as models to emulate. A necessary corrective for the tendency of academic physicians to extra-bill is to substantially increase their university stipends. This must be the prerequisite for disallowing them to extra-bill. What effect such a policy would have on the supply of doctors for academic positions is, of course, a matter of opinion. The practices of academic physicians are, of course, subsidized through the public provision of expensive facilities and equipment and through their use of interns and residents in providing patient care. They also enjoy better access to the facilities of medical schools, contact with academic peers and the opportunity to teach and undertake research. These advantages, enhanced by larger stipends, may well outweigh the advantages of extra-billing. This would be all the more true should provinces adopt differentiated medical fee schedules with higher compensation for the better doctors. A graduated fee schedule together with an effective peer review system thus become important instruments in the provincial governments' attempts to control extra-billing.

A related initiative required at the provincial level, as was mentioned earlier, is the reform of the provincial legislation and processes determining fee schedules with a view to establishing effective negotiations between the government and the medical association.

The provinces should also encourage alternative health care delivery systems such as community health centres or health services organizations which are funded on a global budget or a capitation system of paying physicians. The rationale for such delivery systems are primarily related to economic efficiency but if judiciously located they will also have a salutary effect in constraining the extent of extra-billing and mitigating its consequences.

If extra-billing is to be allowed there are several procedural reforms that should be seriously considered for implementation by provincial governments. A number of provinces already have legislation outlawing balance-billing. The remaining provinces should do likewise since the practice has the effect of reducing the risk of bad debts or non-payment for physicians who balance-bill. There is no reason why the government should assume such responsibilities for them. Indeed, legislation requiring strict streaming is advisable. A physician should be given a choice of either opting-in for all his patients or opting-out for all his patients.

Opted-out physicians must be required to give advance notice to the patient if there is to be any extra-billing and have the agreement of the patient. Exceptions must, of course, be permitted in situations where such prior notification and agreement is not feasible or practical. As was mentioned earlier provinces should also establish review boards appropriately mandated to adjudicate complaints about extra-billing by patients. These procedural reforms are, of course, unlikely to reduce the extent or incidence of extra-billing but are nevertheless important to patients.

A number of provinces where extra-billing is a problem have already implemented some of the policy options discussed above. However, there is much more that provincial administrations can quite reasonably do. Even if the provinces prove to be reluctant to implement the Quebec option, a number of other policy instruments are available that collectively could be highly effective in controlling the problem of extra-billing. They are both practical and reasonable and will prove to be popular with the public. All that is missing is the political will and courage to put them into effect.

#### VI. Summary and Recommendations

Extra-billing is arguably the single most important phenomenon characterising the current medicare crisis. Despite the rapid growth in the extent of extra-billing in several provinces, the medical profession and the provincial administrations persist in believing that the practice poses no threat to Medicare. Their benign tolerance is at odds with the general public and with the federal government. Their view is also challenged by two major commissions of inquiry and several independent studies on the issue undertaken over the past few years. The aggregate measures of extra-billing typically referred to by the profession and the provincial governments conceal and distort a number of disconcerting realities confronting patients in several provinces.

It was argued that extra-billing clearly violates two fundamental principles of Medicare. It directly contravenes the condition that medical services be provided upon uniform terms and conditions to all insurable residents of a province. Indeed the practice has the real potential of creating instead a two-tier system of medicine. More importantly, the result of investigations into the effects of extra-billing indicate that it violates the principle of "reasonable access" to medical services, the

very raison d'être of Medicare. The deterrent effects of extra-billing are considerable and it was noted repeatedly and emphatically that the impacts of extra-billing were significantly greater on the poorer population groups.

A number of reasons for extra-billing were discussed. It is an inappropriate solution to the alleged problems of unnecessary use of medical services by patients. It is also unlikely to promote the efficiency with which health care services are provided. Furthermore, the expectation that extra-billing would reduce the rate of increase in health care expenditure is improbable though a categorical answer cannot be offered at present. If extra-billing is seen mainly as a reaction to physicians' complaints about a lack of meaningful negotiation between them and the government then the solution lies in introducing legislative and procedural reforms to establish the required fee bargaining institutions and processes. It is acknowledged that the existing fee schedules are unfair in that no allowance is made for better doctors providing a higher quality of care. Extra-billing per se is an improper approach to this problem, and a better alternative is to develop a graduated fee schedule. Extra-billing, involving as it does a transfer of income from patient to the physician, is simply an illogical answer to the oft-repeated contention by the medical associations that the Canadian health care system is underfunded. In brief, the practice of extra-billing is generally an inappropriate response to a number of health care problems. In fact, it does little more than serve to correct physicians' own perception about the inadequacy of their incomes, while creating a price barrier to access and imposing financial risk on patients.

Given the seriousness of the problems generated by extra-billing, the federal government cannot accept the status quo. The preferred policy

response by the federal government should involve legislation that bans extra-billing but simultaneously requires provincial governments to implement a formal framework for fee schedule negotiations and for resolving disputes that might arise from such negotiations. If banning is unconstitutional, the federal government must attempt to control the extent of extra-billing by imposing penalties through the withholding of cash transfers to provinces where extra-billing occurs. The control option must, of course, be reinforced by the prohibition of supplementary private health insurance for services covered by Medicare. As well, mechanisms to monitor and enforce the principles of Medicare must form an important and integral part of the Canada Health Act.

While federal initiatives on extra-billing are crucial, it is, of course, the provincial governments that have the major and ultimate responsibility for containing extra-billing. One approach to effectively eliminate extra-billing is for each of the provinces to adopt the Quebec option. Such an approach would be difficult for any one province acting in isolation from the others and a collective decision to adopt such a policy would be unlikely at present.

Provinces should attempt to control the extent of extra-billing by making hospital privileges conditional on doctors opting-in the provincial plan, or at the very least, to give preference to opted-in physicians over those who are not. An alternative policy would be to place doctors who earn a large proportion of their earnings from hospital based services on a salary method of remuneration.

With respect to academic physicians it is recommended that the stipends they are presently paid be substantially increased and that they not be allowed to extra-bill.

Provinces should reform their legislation and processes concerning fee schedules bargaining with the objective of establishing effective negotiations between them and the medical associations. They should also seriously consider adopting a graduated fee schedule that rewards the better doctors.

Balance-billing should be outlawed by those provinces that still permit it. Indeed, provinces are advised to pass legislation that allows physicians to either opt-in or opt-out for all their patients. A further procedural reform would require extra-billing physicians to inform their patients about such charges prior to treatment whenever feasible. Provinces should also establish review boards appropriately mandated to adjudicate complaints about extra-billing by patients.

The provincial governments should also promote alternative health care delivery systems such as community health centres. Such institutions can be designed, funded and located to compete with opted-out physicians and hence restrain physicians from opting-out and extra-billing.

Many provinces have yet to take vigorous and concerted action against extra-billing. It is hoped that the policy debates and discussion engendered by the occasion of the Canada Health Act will provoke the provinces to seriously consider some of these suggested policy options.

Notes

1. Under the EPF arrangements, federal contributions to the provinces for the three established programs--hospital insurance, medicare and post-secondary education--are no longer tied to provincial expenditure on the basis of a roughly 50:50 cost-sharing formulae. Rather, the transfer is now a block fund and is in the form of cash payments and transfer of corporate and personal income tax points to the provinces.
2. See, for example, E. Hall Canada's National-Provincial Health Program for the 1980's: A Commitment for Renewal Health and Welfare Canada, Ottawa, 1980; and L. Soderstrom "Extra-billing and cost-sharing" Canadian Public Policy 7, 1981, 103-107.
3. For a good documentation of authorized charges see "Preliminary discussion paper on user charges in Canada" Health and Welfare Canada, March 1983 (mimeo).
4. The provinces are Ontario, Alberta and British Columbia. The Yukon, too, levies health insurance premiums. In 1978 Ontario proposed an increase in the insurance premiums by 37.5 percent, provoking a massive outcry by the opposition and the public which in turn resulted in a formal and wide ranging inquiry into the financing of health care costs in the province.
5. Indeed, one of the most noteworthy facts about health care expenditure in Canada is that they have been fairly constant (about 7 percent) in relation to the gross national product throughout the seventies. However, it is presently at 8.2 percent of GNP.
6. For a thorough account of the evolution of health insurance in Canada see M. Taylor Health Insurance and Canadian Public Policy McGill-Queen's

University Press, Montreal, 1978.

7. The terms of reference for the review were rather broad. They can be found in the resulting report of the review, op cit.
8. A notable feature of the review was that it was literally the first time a commission was asked to inquire into the effects of cost-containment policies on Medicare rather than the reverse. That is, virtually all the previous inquiries dealt with the cost implications of Medicare and on methods and means to reduce health care expenditure.
9. Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, Fiscal Federalism in Canada House of Commons, Ottawa, August 1981.
10. M. Begin "Opening statement by the Honourable Monique Begin, Minister of National Health and Welfare to Conference of Federal and Provincial Ministers of Health" Ottawa, 26 May 1982, pp. 19.
11. The working paper that is available to the public is a seven page document entitled "Canada Health Act, White Paper--Draft 2".
12. See, for example, the briefs of the Ontario Health Coalition and Canadian Health Coalition on the proposed Canada Health Act.
13. See P. Teskey "What are the billing procedures under Medicare?" Canadian Medical Association Journal Vol. 125, 1981, 1280-1282.
14. This is the most recent compilation of the information available from Health and Welfare Canada.
15. Physicians can still "opt-out" for ideological reasons and bill all their patients directly for the total bill.
16. It must be noted that these figures are basically estimates of the amount of extra-billing. The data on extra-billing for Nova Scotia and Alberta are considered to be more reliable than for the other provinces.

17. See, for example, A.D. Wolfson "Opting-out and Extra Billing" (mimeo) July 1980; and R. Plain "Charging the Sick: Observations on the economic aspects of medical social policy reforms", a paper presented at the Canadian Centre for Policy Alternatives Conference on "Medicare: A Decisive Year" Montreal, November 12-13, 1982.
18. A.D. Wolfson, *ibid.*
19. While the data supporting this assertion is not readily available, it is nevertheless true of every province where extra-billing occurs.
20. A.D. Wolfson, *ibid.*, pp 6.
21. R. Plain, *ibid.*, pp 3.
22. A.D. Wolfson, *ibid.*, pp 4.
23. G.L. Stoddart and C.A. Woodward "The Effect of Physician Extra-billing on Patients' Access to Care and Attitudes Toward the Ontario Health System" (mimeo) May 1980. This study was commissioned for the aforementioned Hall Review.
24. See the "Statement by the Honourable Larry Grossman, Minister of Health, to the Committee on Social Development" Ontario, November 1982, pp 48.
25. The current Minister of Health and Welfare Canada herself had threatened to do so in 1979 and has revived the threat as recently as March 1983.
26. Justice Hall conveyed this impression in his report of 1980. There have been several federal-provincial efforts to resolve "portability" related problems over the years and some progress has in fact been made.
27. The Medical Care Act does not refer to "equal" access as is sometimes thought by both lay people and various professionals working in the health sector.
28. The economic necessity and advantages of price discrimination is simply

explained by noting that price discrimination is a device for increasing provider incomes without a loss in the volume of utilization. Thus, there are both altruistic and self-interest motives in the practice of price discrimination.

29. A.D. Wolfson, op cit, pp 17.
30. See, for example, M. Begin, op cit.
31. This was the first empirical study of the effects of extra-billing on patients' access to care in Ontario. There is as yet no other empirical study of extra-billing in Ontario.
32. Stoddart and Woodward, op cit, pp 9.
33. Ibid.
34. R. Plain, op cit.
35. R. Plain, ibid, pp 14.
36. For a good discussion of the issue see M. Barer, R.G. Evans and G. Stoddart Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion? Ontario Economic Council, Occasional Paper 10, 1979.
37. For a good overview of the issues see Securing Access to Health Care: Volume One, A Report on the Ethical Implications of Differences in the Availability of Health Services by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Washington, U.S.A., March 1983.
38. It would be interesting to discover what proportion of the doctors in Canada subscribe to this view and under what circumstances they would relinquish this "right", in contrast to the views usually expressed by the medical associations.
39. It is not just physicians who tend to exaggerate the symbolic significance

of banning extra-billing. At least one former Minister of Health of Ontario equated such a policy as tantamount to the "civil conscription" of doctors.

40. For example, see A.D. Wolfson and A. Solari "Patient Utilization Study" (mimeo) 1976.
41. It might be noted in this context that British and American studies have shown that the poor tend to understate the prevalence and incidence of illnesses requiring medical attention. Extra-billing them may well exacerbate the potential for the underutilization of health care services by the poor.
42. There is an increasing amount of literature on this issue and there has been a growing interest in Canada for more formal evaluations of medical technology and public effort to regulate the diffusion of new medical technology and procedures. See D. Banta (ed) Resources for Health: Technology Assessment for Policy Making New York, Praeger, 1983 (forthcoming).
43. See M. Barer et al, op cit; and R.G. Evans "Health Care in Canada: Patterns of funding and regulation" in G. McLachlan and A. Maynard (editors) The Public/Private Mix for Health: The relevance and effects of change Nuffield Provincial Hospital Trust, London, 1982, 371-424.
44. A number of provinces have learned that a substantial increase in the fee schedules does not necessarily translate into a significant reduction in extra-billing. See Plain, op cit for some concrete examples.
45. For example, see R.G. Evans "Modelling the economic objectives of the physician" in R.D. Fraser (ed) Health Economics Symposium: Proceedings

of the First Canadian Conference Kingston, Queen's University Industrial Relations Centre, 1976, 33-46.

46. See R.G. Evans and A.D. Wolfson "Moving the target to hit the bullet: generation of utilization by physicians in Canada" (mimeo) 1978.
47. For instance, the Minister of Health of Ontario recently raised this issue in March 1983.
48. E. Hall, op cit, pp 28.
49. G. Beck and J. Horne "Medical Fee Determination" Canadian Public Policy 7, 1981, 107-114.
50. G. Beck and J. Horne, ibid, pp 113.
51. For a short description of its advantages see G. Beck and J. Horne, ibid, pp 113.
52. For a rationale for this precondition see P. Manga "Arbitration and the Medical Profession: A Comment on the Hall Report" Canadian Public Policy 6, 1980, 670-676.
53. G. Stoddart and C. Woodward, op cit.
54. A.D. Wolfson and C.J. Tuohy Opting Out of Medicare: Private Medical Markets in Ontario Toronto, University of Toronto Press, 1980, pp IX.
55. For example, P. Manga "The Underfunding of the Canadian Health Care System: Myth or Reality?" (mimeo) 1982, pp 14.
56. E. Hall, op cit, pp 23.
57. For example, see the letter of January 1983 of the Medical Reform Group of Ontario on the Canada Health Act (Vol. 2, No. 1 of its POLITICA letter).
58. This is an argument made among others by G. Weller and P. Manga "The Development of Health Policy in Canada" (mimeo) 1981, pp 23.
59. There are numerous instances of this. For example, see Marc Baltzan's

message to the CMA members in the "Entre Nous" of November 15, 1982.

60. The Royal Commission on Health Services, Vol. 1, 1965, pp 34.

61. The most noted analysis of this issue is found in A.D. Wolfson and C.J. Tuohy, op cit.

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