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Grey Zones: Emerging Issues at the Boundaries of the *Canada Health Act*

For a meaningful public dialogue on healthcare reform in Canada, the federal government should provide certainty and clarity in regard to the grey zones that exist at the boundaries of the Canada Health Act.

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The Study In Brief

The *Canada Health Act* (CHA) creates a series of "grey zones" in which considerable discretion is granted to the federal health minister to determine what is subject to penalty under the Act. But Ottawa's unwillingness to provide clarity with respect to these grey zones has generated a political "negativity-bias" against reform. While the CHA provides considerable latitude for provinces to experiment, the political scope for reform would be broadened if Ottawa were to clarify the boundaries of the CHA by clearly stating its position on the consistency of various practices with the Act as issues arise on the public agenda.

The *Commentary* outlines the provisions of the CHA, and examines four current issues relating to the Act: annual fees charged by integrative health clinics; provincial healthcare deductibles; provincial funding of health services purchased or insured out-of-country; and provincial funding of out-of-province health services facilitated by private medical concierge services. In each case, the *Commentary* examines how the practice might be subject to penalties under the CHA, and highlights the federal role to date in debates on these issues.

The *Commentary* suggests that Ottawa stop avoiding public debates about the compliance of proposed reforms – such as the health deductibles recently proposed in Quebec or integrative health clinic block fees – with the provisions of the CHA, and instead clearly state its position on these issues as they arise on the public agenda. Such statements likely would go a long way toward clarifying the public debate and increase the political scope for healthcare reform.

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In December 2011 the federal government unilaterally announced its new plan for funding healthcare in Canada for the next decade.

Despite claims in the national media that the provinces are being granted more autonomy to reshape healthcare, that the federal government is abandoning its use of the spending power in the pursuit of "national standards," or that Ottawa is reducing "its role in shaping medicare to writing cheques" – see, for example, Ibbitson et al. (2011); Romanow, Silas, and Lewis (2012) – the *Canada Health Act* (CHA),[1] remains firmly in place. While the federal government has significantly clarified its role in funding, there is nevertheless little clarity in regard to its role in actually shaping the provision of health services.

The CHA itself and the federal government's interpretation of it constitute a significant barrier to healthcare reform in Canada – not because the CHA is too restrictive or enforced too vigilantly but because its lack of clarity creates a political "negativity bias" against reform.[2] The Act creates a series of "grey zones" in which considerable discretion is granted to the federal minister and cabinet in determining what is and is not subject to penalty under its provisions. Ottawa's unwillingness to provide clarity in regard to these grey zones has led opponents of reform proposals to label them as contrary to the spirit of the CHA and subsequently to their being abandoned. It is not necessary, however, to suspend, repeal, rewrite, or even interpret the CHA more narrowly for significant healthcare reforms to take place. The CHA provides considerable latitude for provinces to experiment with reforms, especially given that the Act embodies a much less restrictive model than either its critics or its supporters often portray. If Ottawa were to clarify the boundaries of the CHA, however, especially by clearly stating its position on the compliance with the Act of various practices on the public agenda, the political scope for reform would be expanded.

I begin this *Commentary* by outlining the provisions of the CHA. I then examine four current issues relating to the CHA – annual fees charged by integrative health clinics, provincial healthcare deductibles, the provincial funding of health services purchased or insured outside Canada, and the provincial funding of out-of-province health services facilitated by private medical concierge services – to determine whether or not these practices are subject to penalties under the CHA. I also highlight the federal government's role to date in these debates, especially in the first two cases. In the final section, I draw conclusions from these discussions and argue that a more robust federal presence in clearly interpreting the CHA and its requirements would provide greater political opportunity for reform. At the very least, it would

I would like to thank Colin Busby, Finn Poschmann, Herb Emery, John Richards, John Church and a number of other external reviewers for their very helpful comments on earlier drafts of this *Commentary*.

1 The CHA is the framework that governs federal financial contributions to the provinces for the provision of health services. It is available online at http://laws-lois.justice.gc.ca/eng/acts/C-6/index.html.

2 While there is broad scope for healthcare reform outside the CHA, and while the CHA is only one of several potential constraints on reform, many of the health reform proposals on the political agenda, including those illustrated here, fall under the ambit of the CHA. Reforms outside the purview of the CHA and constraints other than the CHA – such as, for example, the Canadian Charter of Rights and Freedoms – remain, due to limitations of space, outside the scope of the discussion presented here.

constitute an important first step in clearing the ground for a meaningful public debate on these issues.

The Provisions of the CHA

The primary policy objective of the CHA is to "facilitate reasonable access to health services without financial or other barriers" (CHA, preamble and s.3). In so doing, the Act applies only to the provincial provision of public health insurance, and establishes criteria and conditions that provincial health insurance plans must meet for a province to quality for full federal cash contributions. The Act then sets out a series of discretionary and non-discretionary penalties that may be levied against certain provincial practices. Given the large number of misconceptions about the CHA, however, it would be useful to outline what the Act does not do.

What the CHA Does Not Do

Most strikingly, despite presumptions in public debates and media coverage of health issues, the CHA very clearly does not mandate the public delivery of services, ban or otherwise regulate in any way the private purchase of health services or third-party health insurance, or create a set of justiciable obligations on the part of government that are enforceable by the courts.

First, the CHA relates primarily to payment for health services under provincial health insurance plans – stipulating criteria that provincial health insurance plans must follow in providing financial reimbursement for health services in order to be eligible for full federal transfers. It does not relate to – or even mention – how health services are provided or by whom. While the public insurance program itself must be publicly administered, the CHA does not speak to the delivery of services nor does it make any reference to any distinctions among public, not-for-profit, or for-profit delivery of services. Moreover, it makes no reference to the status of physicians or other medical practitioners, much less require that they operate either fully inside or outside provincial public health insurance programs.

Second, the CHA does not even mention – much less regulate or ban – the private purchase of any health service or the provision of private third-party insurance for any health service.

Third, the CHA does not create a legally binding set of obligations on either the federal or provincial level of government. To a large degree, the most significant constraint on reform is public opinion, which would exist even in the absence of the CHA – although the degree to which the CHA reinforces such dynamics remains an open question.

Enforcement of the CHA is not predominantly a legal issue but a political one. Despite the existence of a dispute resolution mechanism,[3] the interpretation and enforcement of the CHA remains largely the prerogative of the federal minister and cabinet. As I outline more fully below, the legislation confers considerable discretion on the federal minister, with important areas remaining open to federal interpretation. Moreover, the legislation is not justiciable; as federal legislation, it neither has nor requires provincial consent and is not legally binding on either party. The federal government can change the legislation at any time while the provinces are in no way breaking the law if they implement practices contrary to the CHA.

3 The dispute avoidance and resolution process was agreed to by the federal and provincial ministers of health (except Quebec) in April 2002. The agreement provides that, where dispute avoidance is unsuccessful, either the federal or provincial minister "may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations." However, the federal health minister retains final authority to enforce the CHA and is only required to "take the panel's report into consideration" in so doing (Canada 2011, 7, and esp. appendix C).

Finally, the CHA does not create a set of citizen entitlements that may be claimed through the courts.[4] Certainly, recent jurisprudence – especially the *Chaoulli* case – has raised the issue of the quality and timeliness of health service delivery, specifically in light of guarantees under section 7 of the Charter of Rights and Freedoms with respect to life, liberty, and security of the person. Thus far, however, legal claims such as those in *Chaoulli* have emerged as challenges to prohibitions on private provision and third-party insurance for services, rather than as claims to any legal obligation on the part of public health insurance plans themselves.[5]

The Substantive Provisions of the CHA

The substantive requirements of the CHA are embodied in three discretionary criteria and two non-discretionary sets of penalties by which federal cash transfers to the provinces may or must be reduced.

Discretionary Criteria

While there are numerous public references to the five "principles" of the CHA, this word does not actually appear in the Act; rather, there are five discretionary criteria. Of these five, two – public administration[6] and portability[7] – are essentially administrative and do not place substantive restrictions on the terms on which public health insurance is provided to citizens. It is the remaining three criteria – universality, comprehensiveness, and accessibility – that embody the overarching policy goal of facilitating reasonable access to health services without financial or other barriers. While the enforcement mechanism for these criteria is the discretionary federal ability to withhold cash transfers, no province has ever been penalized for a violation of any of the CHA's five criteria (Canada 2011, 6).[8]

Universality – Public Health Insurance on "Uniform Terms and Conditions": The criterion of universality stipulates that public insurance coverage for insured health services must be available to all provincial residents on uniform terms and conditions. A number of important implications flow from this criterion, and insurance offered on this basis is starkly distinct both from the terms on which private insurance is typically offered and from categorical or income-tested public insurance plans. In essence, this criterion outlines the level of risk pooling required of provincial health insurance programs – namely, that risk must be pooled at the provincial level.

4 This statement is based on a legal study commissioned by the Task Force on the Funding of the Healthcare System (Quebec); see Molinari (2007).

5 In the *Chaoulli* case, the Supreme Court of Canada found that Quebec's ban on private insurance constituted a violation of the Quebec Charter of Human Rights and Freedoms in the context of long waiting times for insured services in that province. The ruling had little direct applicability to the CHA itself, as the latter does not require a ban on private insurance for publicly insured services. See *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 2005 SCC 35; see also Monahan (2006).

6 Generating the most prevalent misconceptions of the CHA, the public administration criterion refers only to the administration of the public health insurance plan – not the medical services provided under it – and requires that the provincial health insurance plan, though not the medical services it insures, must be administered on a non-profit basis by a public authority or a delegated agency.

7 This criterion requires that residents must continue to be covered (for a limited period of time) when they are out of the province, makes provision for compensation arrangements when residents receive care in another province or out of the country, and outlines the conditions under which insurance coverage must be extended to new residents of a province.

8 One reviewer of this study notes that provincial officials dispute this claim, but I am not aware of any specific instance where any penalty has been levied for violation of any of the five discretionary criteria.

Public health insurance plans cannot be categorical in providing different insurance coverage for particular groups such as seniors, as does Medicare in the United States. They also cannot be income tested, as is Medicaid in the United States. Moreover, they cannot be provided on different terms to different risk groups – for example, by charging different premiums based on risk grouping or by using patients' health history to determines either their level of premiums or their coverage. In this sense, the CHA essentially mandates that public health insurance be offered on what would be termed in the United States a community-rated basis, whereby the relevant community is the entire population of a province. This provision helps to ensure that medical health risk for insured services cannot be individualized in whole or in part through premium differentials, narrowing the pooling of risk, or narrowing categorical eligibility for public insurance coverage.

Comprehensiveness – Entitlement to Plan-Listed Services: The comprehensiveness criterion requires that public health insurance plans cover all medically necessary or medically required physician, surgical, and hospital services.[9] Surprisingly, medically necessary and medical necessity remain completely undefined in the Act. Medical necessity, as referred to in the Act, has not been taken to refer to entitlement to coverage for any medical procedure that a physician prescribes in a specific instance. Rather, in practice, the provincial health insurance plan lists the set of services and procedures that, in a particular instance, may be deemed medically necessary – essentially defining the universe of accepted medically necessary services eligible for insurance coverage.[10]

Drawing from the universe of eligible services listed by the provincial insurance plan, individual service providers must determine whether a service is medically necessary in a specific case. If both conditions are met, the provincial plan must provide remuneration to the provider of the service automatically. In every instance in which an insured patient receives a listed service on the basis that it has deemed to be medically necessary for that patient, the provincial plan must pay for the service. In this sense, the criterion requires that provincial health insurance plans operate on what would be termed in the United States an entitlement basis. As such, both health service providers and patients know, in advance and without regard to patients' personal circumstances except their current medical condition, that the public plan will compensate providers for their services.

This criterion thus generally precludes a wide range of practices by which public insurance

9 Interestingly, the term "medically necessary" does not appear in the definition of the comprehensiveness criterion, which states only that the provincial health plan must "insure all insured health services provided by hospitals, medical practitioners, or dentists" (CHA, s.9). The terms "medically necessary" and "medically required" appear only in the section of the CHA that provides legal definitions of the terms "hospital services," "physician services," and "surgical-dental services."

10 In Ontario, for example, the *Health Insurance Act* makes provision for a Schedule of Benefits that lists insured services (See Ontario, *Health Insurance Act*, R.S.O. 1990, chap. H6; available online at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h06_e.htm#BK6). Under an agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA), additions or deletions to the schedule are made by the ministry "following consultation with the OMA" (Ontario 2011b). The OMA has the ability to submit proposals for additions to the schedule to the Physician Services Payment Committee (PSPC), which, in turn, makes recommendations to the minister regarding the schedule of benefits. One-half of the membership of the PSPC consists of physicians nominated the OMA (and appointed by the minister) and the other half is physicians nominated and appointed by the minister. However, the list of insured services remains at the discretion of the minister.

coverage might be rationed directly. For example, a provincial plan cannot provide insurance coverage only up to a certain global budget limit, or to some specified limit for an individual patient, or to a specified number of instances of a particular procedure – such as covering only a certain number of knee replacements per year.[11] Indirectly, however, health service delivery is rationed in a wide number of ways – for example, provinces make decisions about the provision of services such as imaging technologies or operating-room capacity. Put differently, the comprehensiveness criterion means that, in order for a provincial plan to be fully eligible for federal transfers, medical risk for insured services cannot be individualized through the direct rationing of public health insurance coverage for listed services.

Accessibility – "Reasonable" Access without Financial Charges: The accessibility criterion requires that provincial health insurance plans provide coverage for listed health services "on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services" (CHA, s.12, 1, a). It is important to remember that, as I discuss more fully below, user fees and extra billing are subject to non-discretionary federal penalties outlined elsewhere in the Act, so invoking the accessibility criterion in such cases would be redundant. Thus, the accessibility criterion is best understood as offering an additional opportunity for the levying of federal penalties at the discretion of the federal minister in cases where charges technically do not meet the legal definition of user fees or extra billing but nevertheless impede reasonable access. One clear example is healthcare premiums. It was clearly intended that provincial healthcare premiums would be fully consistent with the CHA; however, the criterion of accessibility requires that access to health services not be denied at the point of service for non-payment of premiums, even if the provincial plan pursues other legal remedies for non-payment of premiums.

In addition, the accessibility criterion requires that physicians be given "reasonable compensation" for providing insured services – with reasonable compensation defined as the necessary result of a process of negotiation between the province and provincial organizations representing health service providers.[12] Similar to the comprehensiveness criterion, this element of the accessibility criterion attempts to ensure that the provincial plan does not individualize medical risk for insured services by limiting the availability of services through undercompensating providers financially for these services – a form of indirect rationing. The basic assumption is that, if services are reasonably compensated, they will be provided at a level that meets needs. A similar requirement does not apply, however, to hospital-related costs; here, the CHA merely stipulates that provincial health insurance plans "must provide for the payment of amounts to hospitals....in respect of the cost of insured health services" – rather than ensuring that such

11 One reviewer notes that there are some very limited exceptions, such as limits on the number of psychological consultations physicians may provide per year per patient. However, this is not the same as a global limit on the overall number of psychological consultations that may be provided or on the number of patients that can receive such consultations. Another reviewer suggests that some provinces have placed global limits on the quantity of services that can be provided, but I am not aware of any specific examples of such limits. Certainly, services might rationed indirectly – for example, by "idling" operating rooms based on staffing considerations – but this is not the same as the direct rationing of health insurance coverage.

12 According to the legislation, this obtains provided there is a mechanism for dispute resolution through independent third-party conciliation or arbitration; see CHA, s.12 (2).

payments are reasonable or adequate, as in the case of physicians' services (CHA, s.12, 1, d.).

Non-Discretionary Penalties for Extra Billing and User Charges

The CHA also sets provisions for mandatory deductions, on a dollar-for-dollar basis, for extra billing and user charges; these provisions are spelled out separately from the five discretionary criteria.[13]

There are two major implications of the non-discretionary penalties on extra billing and user charges. The first is that, to be eligible for full federal cash transfers, the provincial plan must offer "first-dollar coverage." That is, physicians and other medical service providers in the province must accept the public payment as payment in full if the province is not to be financially penalized. The corollary is that the patient is not financially responsible for any portion of insured health services. The second implication is that federal funds cannot be used by the provincial insurance plan to subsidize the private purchase of health services at rates above the provincial fee schedule, either out-of-pocket or through third-party insurance. If a province nevertheless chooses to do so, federal cash transfers will be reduced for every dollar by which the province subsidizes private purchase; in other words, the province must bear full financial responsibility for such subsidization.

Summary: The Canadian Healthcare Model

Given these provisions, what characterizes the Canadian healthcare model? There are three major challenges to any attempt to provide an overall characterization of the model. First, all provinces go above and beyond what the CHA requires in terms not only of the provision of public health insurance, but also of the regulation of the private purchase of health services and of third-party insurance for publicly insured services (Boychuk 2008). Often, what is portrayed as the "Canadian healthcare model" refers not to requirements of the CHA but to various practices undertaken at the provincial level – for example, the banning of third-party insurance for publicly insured health services.

Second, references to provincial practices face the challenge that the provinces vary widely in regard to a number of tenets often thought to be central to the Canadian healthcare model. For example, some provinces (such as Ontario) do not allow physicians to opt out of the public health insurance plan, others (such as Alberta) allow physicians to opt out but require that they do so totally and are thus either wholly opted in or opted out, while still others (such as Newfoundland and Labrador) have no such requirement at all. Similarly, only some provinces (such as Ontario and Alberta) ban private third-party insurance for insured health services (see Boychuk 2008). In short, one can draw

13 See "Extra-billing and User Charges Information Regulations," http://laws.justice.gc.ca/en/ShowFullDoc/cr/SOR-86-259///en (accessed November 15, 2011). Mandatory penalties may be assessed under these sections in response to provincial reporting of extra billing and user charges or at the discretion of the federal minister. With one minor and partial exception, however, penalties have never been levied on the latter basis. The federal minister has no discretion to waive transfer reductions to provinces that self-report extra billing and user fees. Where extra billing and the charging of user fees are not reported as such by the province, however, the federal minister shall – "where information is not provided in accordance with the regulations" – levy penalties "in an amount that the Minister estimates to have been so charged" (CHA, s.18).

Supplementing s.19 of the Act, the "Marleau letter" of 1995 outlines the federal interpretation of the CHA that fees charged by private medical facilities constitute a user charge if the physician services portion of the costs is covered directly by the provincial plan (Canada 2011, 171-3). The corollary is that, if the physician service portion of the costs is not compensated by the public plan, then charges levied by the medical facility are, in turn, not considered user charges.

surprisingly few generalizations from provincial practice that hold for all provinces.

Third, if one reverts, in the face of provincial variation, to the CHA, which constitutes a common denominator across the provinces, the challenge is to differentiate between provisions that are explicitly stated in the Act and system-level characteristics that emerge indirectly as a result of those provisions as they operate in practice. For example, the Canadian model is often referred to as a "single-payer" model, although there is nothing in the CHA that directly establishes or requires it. Nothing in the CHA precludes patients from paying the full cost of medical services directly or by purchasing private insurance to cover those costs – either of which would constitute a multi-payer system.

To the degree that the model outlined in the CHA is taken to embody the Canadian healthcare model, it can be described accurately as one that guarantees access to a non-categorical, non-income-tested, not-for-profit, publicly accountable insurance plan that provides first-dollar coverage for all listed services when prescribed by a plan-recognized practitioner. Premiums are determined on a provincial basis and without restrictions on access to health services if premiums are not paid. In some sense, this model – guaranteed access to public health insurance with certain specific characteristics – is relatively minimalist in comparison, for example, to the outright banning of the private purchase of, or private insurance for, health services. At the same time, the provisions of the Canadian healthcare model are also relatively significant in the degree to which they imply a public insurance model in which medical risk for insured services cannot be individualized except in cases where individuals voluntarily choose to assume that risk.

Emerging CHA Issues

A number of issues have arisen recently that call into question the actual requirements of the CHA, including block fees for integrative health clinics, provincial health deductibles, publicly insured services provided out-of-country, and medical concierge services for publicly insured health services provided in another province. These emerging issues highlight both the scope of the grey zones that exist at the boundaries of the CHA and the federal government's reluctance to exercise its discretion in these areas.[14]

Block/Annual Fees for Integrative Health Clinics

Over the past three years, the healthcare topic that has received the most media attention in Canada – and generated the most concern about the integrity of the CHA – has been the charging of block or annual fees by integrative health clinics.[15] Media reports have alleged numerous violations of the CHA associated with these practices – for example, "dozens of violations of the *Canada Health Act*" (*Managed Care Weekly Digest 2011*); "the Canada

14 A reviewer of this study emphasizes the importance of the fact that, if a provider of insured health services might not be operating in a manner consistent with the requirements of the CHA, Health Canada may bring the issue to the attention of the province or territory for investigation and, if necessary, corrective action. The federal government thus works most often behind the scenes with provinces to resolve issues as they arise, which might contribute to the creation of a public perception of grey zones even where Ottawa is working to ensure compliance with the CHA. The reviewer notes the example of integrative health clinics, where Ottawa and the provinces have been in communication to resolve issues of concern; in all such cases, the provinces have initiated action to address the concern.

15 In media reports, these clinics are often erroneously referred to as "private clinics." However, virtually all physician practices in Canada are private clinics in the sense that they are privately owned and operated on a for-profit basis and many also charge a block fee (often on an annual basis) for non-insured services.

Health Act is being violated regularly" (Attaran 2011); "at least five provinces…are turning a blind eye to private clinics that break the law […] defy[ing] the federal *Canada Health Act*" (Walkom 2011).

Despite these claims, such practices fall into a CHA grey zone in two senses. First, they might constitute extra billing or user charges requiring non-discretionary federal penalties, but they do not necessarily do so. Second, regardless of their technical status, while the federal government has the discretion to interpret such fees as constituting an indirect financial barrier to accessibility under the criteria of the CHA and, not surprisingly, has been asked to investigate such practices and apply penalties,[16] it nevertheless has not issued any interpretations or directives on this issue.

In all provinces except Quebec, all physicians in their private practices are allowed to charge annual fees for non-insured services (Glauser 2011). The central issue in regard to annual fees is whether non-paying patients are expressly denied access to insured services. However, ascertaining whether or not this is the case can pose significant challenges. The issue is not whether all patients in the clinic receiving insured services have paid the annual fee. For example, a clinic's patient list might be filled – a matter determined by the physician – with patients who are paying the registration fee without the clinic's actually denying care to prospective patients who are unwilling to pay the fee.

Two situations are most likely to establish that the practices necessitate non-discretionary penalties. One is where two patients with identical health needs attempt to receive insured services from a private clinic, but the clinic refuses to provide services to the patient who has not paid the annual fee while simultaneously providing services to the patient who has agreed to pay the fee, or otherwise indicates explicitly that it will render the publicly insured services only if the fee are paid. The other situation is where an enrolled patient discontinues paying the annual fee and subsequently is removed from the clinic's patient list and, as a result, is denied access to insured services. In the absence of evidence of such practices, however, annual block fees do not constitute extra billing as defined by the CHA.

In response to the persistence of annual block fees in both British Columbia and Alberta, requests for federal interpretation of application of penalties continue. The most recent round of such calls emerged when, in 2006, British Columbia's health minister ordered an investigation into whether the Copeman Healthcare Centre in Vancouver "was operating within provincial public health-care laws" (Lang 2008b). In 2007, "the BC Medical Services Commission completed its audit…and concluded there is no problem with it services, finding no evidence of extra billing or enhanced services related to the fees." The audit was reported to have "cleared it of any allegations that its membership fees violate the *Canada Health Act*" (Montgomery 2009). Similar concerns that membership fees contravened the CHA arose in Alberta when a Copeman Healthcare Centre opened in Calgary in September 2008 (see Lang 2008a,b,).

While the issue was apparently settled, at least on a temporary basis, information released in response to a freedom of information request by the BC Health Coalition later revealed that the Medical Services Commission audit "simply referenced Copeman's written policy stating no preferential access to its physicians and no charges for access to insured services" but did not attempt to contact the centre, book an appointment, or interview prospective patients "who had notified the Commission that they had been denied access because they were unwilling or unable to

16 The fact that the federal government has been asked to investigate such practices does not imply that it has the statutory authority to do so.

pay Copeman's fees."[17] The issue thus remains unresolved. The BC Health Coalition continues to call for investigation by the federal minister on the basis that these practices, in fact, do constitute extra billing (see BC Health Coalition 2010), but Ottawa continues to refuse to provide an interpretation in this area.

Similar demands for a federal investigation into such practices have arisen more recently in Ontario. Following an attempt by Sentinelle Health Group in Ottawa to recruit federal Members of Parliament as patients into its integrative health practice, which charges a significant annual fee, Health Canada issued a public commitment in October 2010 to investigate this practice. The media reported that Health Canada was "questioning whether Sentinelle's membership fees violate the *Canada Health Act*."[18] Media reports of the basic details of the letter from Sentinelle to MPs revealed that the fees were in keeping with legal physician fees as determined by the Ontario Ministry of Health and Long-Term Care. The Sentinelle letter clearly identified the uninsured services to which the fees were attached and clearly outlined that patients could elect to pay for uninsured services on a fee-per-service basis and that a membership fee that covered a basic set of uninsured services was not required (see Ontario 2011a; see also Goar 2010).

In the end, however, the federal government did not release publicly any conclusions from whatever investigation actually took place. In February and April 2011, media reports alleged that Ontario was "turning a blind eye to private clinics that break the law" (Walkom 2011).[19] Similar public concerns also emerged in Quebec with regard to annual fees charged by integrative health clinics. In early January 2011, federal Liberal health critic Ujjal Dosanjh called on the federal health minister to investigate, arguing that the fees "contravene the *Canada Health Act*" (Fidelman 2011). Federal inaction was not particularly surprising in this case given that the practices contravened Quebec provincial law, which prohibits doctors who bill services to the public plan from charging annual fees; indeed, the provincial health insurance plan had already launched its own investigation (Glauser 2011). Nevertheless, the issue remains squarely on the public agenda in that province.[20]

In summary, the issue of annual fees charged by integrative health clinics has been a political agenda item for more than half a decade now, and has garnered considerable recent media and public attention in at least the four most populous provinces. But the federal government has provided little clarity on this issue despite the considerable discretion it wields. As a result, the status of such practices with respect to the provisions of the CHA remains highly contested.

Provincial Health Deductibles

Similar confusion regarding CHA status enveloped proposals by the Quebec government for a provincial "health deductible" in its March 2010

17 "Health Coalition questions Medical Services Commission's ability to protect patients from illegal user charges," *MarketWire*, June 29, 2011.

18 "Western medicare advocates call for federal investigation of Copeman Healthcare Centre," *Canada Newswire*, October 28, 2010.

19 The Ontario government announced in June 2011 that it would be "stepping up efforts to investigate potential illegal fees that healthcare providers charge to patients for [insured] services" by expanding proactive investigations and spot checks as well as providing a complaints hotline (Walkom 2011).

20 See Fidelman (2010); and "Doctors seek ruling on extra fees," *Gazette* (Montreal), March 16, 2011.

budget.[21] The government defended the proposed health deductible by arguing that it was not a user fee and that it would not impede access to health services in the province. As carefully outlined in the budget, the characteristics of the deductible ensured that it would not hinder either accessibility or universality: "Unlike user fees, a health deductible would not hinder access to healthcare and would make it possible to exempt the most disadvantaged. It would not infringe on the right to healthcare or the principle of equality between citizens. It would not be collected at the service outlet, but instead the following year through the income tax return" (Quebec 2010, 29). Under this formulation, the Quebec government maintained firmly that the deductible was not a "user fee." As well, the budget's discussion of "The Health Deductible and the *Canada Health Act*" carefully established that the intent was not to impede accessibility: "Québec is of the opinion that a health deductible would not restrict the accessibility of the health-care system. What is sought is an orienting effect, not a moderating effect: the purpose is to encourage delivery of the right care at the right place" (ibid., 26).[22]

Despite these claims, media reports cast the proposed health deductible as a user fee and as "violating" the CHA. The *Globe and Mail*'s initial reporting of the proposal quotes a spokesman for Canadian Doctors for Medicare as saying "[t]here's no doubt that user fees violate the spirit of the *Canada Health Act*, which is quite clear that user fees cannot be charged." The report concluded: "the act...clearly states that when user fees are charged and collected they can be deducted from the federal funding a province receives from Ottawa," and it lumped the proposal for health deductibles with "[a]ll efforts to change the founding principles of the health act" (Séguin 2010). In another report, the president of the Quebec Federation of Medical Specialists was quoted as stating that "the user fee would have almost certainly prompted a legal challenge on the grounds that it violated the *Canada Health Act*" (Peritz 2010). Others argued that the deductible "might seem to contravene the *Canada Health Act*" and, also misinterpreting the enforcement mechanisms of the CHA, "[b]ut by burying the fee in the provincial income tax, Quebec is hoping to win any court challenge" (Simpson 2010).

While the deductible was clearly constructed such that it could not be reasonably interpreted to constitute a "user charge" in formal CHA terms and thus require the non-discretionary federal application of penalties, claims about accessibility – a matter about which the CHA grants discretion to the federal health minister – appear far less clear cut. The *Toronto Star* reported that "[t]he Quebec government admits that its planned fee...could fly in the face of the *Canada Health Act*" (Hébert 2010). Given Quebec's firm assertion that the deductible did not constitute a user fee, the provincial finance minister's public speculation that the health deductibles might contravene the CHA appeared to be an implied reference to the discretionary criterion of the CHA presumably with respect to accessibility.[23] A health deductible reasonably could be considered to challenge the CHA's discretionary

21 The budget very cautiously proposed that the government "study the advisability of introducing a health deductible within a few years" (Quebec 2010, 27). The budget also announced a new "health contribution," essentially a flat, earmarked annual premium that would be collected through the tax system, with a low-income exemption and proposed contribution rates per adult of $25 in 2010, $100 in 2011, and $200 in 2012.

22 The latter is in reference to the proposal that the amount charged could be adjusted depending on where the service was consumed – for example, in a hospital as opposed to in a doctor's office or a walk-in clinic.

23 He asserted, that if health deductibles did turn out to contravene CHA principles, "[m]aybe it's time Canadians sit down and examine that legislation" (quoted in Hebert 2010).

criterion relating to accessibility, which requires that services be insured on "a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (CHA, s.12, 1, a). The question then remains whether the application of such a charge would impede reasonable access, with this determination presumably resting to some degree on the amount of the deductible.

Interestingly, while the federal government itself refused to clarify the issue or to give any indication of how the federal health minister would interpret the measure, the leader of the official opposition stated most clearly that "he did not see the measure as a breach of the *Canada Health Act*" (Hebert 2010). For its part, the federal government, in a public statement issued by a Health Canada official, stated that "the department wants to examine the Quebec proposal more closely before commenting" (Johnston 2010). In any event, such a determination was rendered moot since the Quebec government retracted the proposal in September 2010, and in the absence of a federal interpretation of the accessibility criterion, the incident failed to clarify this grey zone in CHA requirements.

Publicly Insured Services Provided Out-of-Country

Another recently emerging issue is the question of the public financing of health services received out-of-country – most typically in the United States – and, relatedly, recent private initiatives to offer third-party insurance for such services.[24] The issue of publicly insured services provided out-of-country results from some of the same dynamics that gave rise to the *Chaoulli* case: public expectations of high-quality and timely services. In cases where such services are not domestically available, pressures to allow patients to seek them elsewhere, with provincial healthcare plans covering at least part of the cost, seems to be a natural development.

Recent important developments in this regard include a ruling of Ontario's Health Services Appeal and Review Board that the Ontario public health insurance plan must pay the full costs that had been incurred by a publicly insured patient for surgical services received in the United States. These services had been available in the province without any waiting time, but the expertise available in Ontario was deemed to be inadequate given the complexity of the operation. In other high-profile cases, however, provincial health insurance plans have denied or resisted providing coverage (Priest 2010; Hasham 2011). Such cases raise questions about whether provincial health insurance plans should cover such services at all, using what criteria, and whether they should cover the full costs or up to some limit – such as the CHA stipulation that such services be covered up to the provincial rate schedule, adjusted for other relevant factors (see below) – although partial coverage of actual costs raises issues analogous to those relating to user fees and extra billing.

The CHA itself creates a loophole in regard to non-discretionary cash reductions for extra billing and user charges. Under the portability criterion, the CHA stipulates that provincial plans must pay for insured services for insured persons who are temporarily out of the country, not in full, but "on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital

24 For example, the MyCare Insurance Program offers third-party insurance to Canadian citizens for second opinions, difficult-to-diagnose conditions, and access to treatment (for serious illnesses) at the Mayo Clinic. To be eligible, however, applicants must be insured under a provincial public health insurance plan; see http://www.mycare.ca/mayoclinic/ (accessed November 14, 2011).

services, to the size of the hospital, standards of service and other relevant factors" (CHA, s.11, 1, b, ii). At the same time, the portability criterion allows, but does not require, provinces to demand prior approval for elective services received out-of-country "if the services in question were available on a substantially similar basis in the province" (CHA, s.11, 2).

In other words, the CHA allows provincial plans to pay less than the full cost of health services received abroad – thus allowing extra billing and user charges for which patients either pay out-of-pocket or are insured by a third party. By not requiring provincial plans to demand prior approval for elective services, the CHA allows provinces to make such payments to any insured resident receiving health services outside Canada regardless of whether substantially similar services are available in Canada. This creates a significant potential for provincial health insurance plans to pay for services that are subject to what otherwise would be considered extra billing and user fees if those services were provided domestically.

Currently, the prospect of provincial plans' subsidizing elective health services received abroad, but not in full, might seem remote. Indeed, all provinces currently have "prior approval" stipulations that, in many cases, are combined with a provincial commitment to offer full payment for the service, thus allowing no room for extra billing or user charges (Canada 2011).

However, an Alberta government planning document outlines a series of proposed changes to encourage the public subsidization of privately purchased or privately insured services received out-of-country (Alberta 2010). The proposed strategy has two prongs.

First, since Alberta's prohibition on third-party insurance for publicly insured services goes well beyond the requirements of the CHA and effectively "limits choice in accessing publicly-funded health services...outside Alberta (e.g., Mayo Clinic)," the document recommends allowing private insurance options for a limited range of publicly insured health services and the implementation of new regulations that "could enable...the operation of private insurance."

Second, the document recommends that the Alberta government consider incentives for out-of-country services, noting that "flexibility in out-of-country...funding can be an avenue to relieve pressures or address sustainability." The most obvious policy change in the direction of flexibility in out-of-country funding would be to remove or waive the prior-approval requirement for such services. The document's reference to the possibility that such changes might "relieve pressures or address sustainability" suggests that its authors consider the incidence of out-of-country health services to be potentially quite significant.

To the degree that the changes suggested by the Alberta government document actually would relieve pressure on the health service delivery system or materially reinforce its sustainability, the implication is that accessibility to services in-province is currently inadequate or under significant pressure. Such measures – essentially allowing the functional equivalent of extra billing and user fees for publicly funded services so long as those services are received out-of-country – might relieve demand pressures on services provided in-province, thus increasing the accessibility of services for patients who remain in-province without raising the costs borne directly by the provincial insurance plan although they would not necessarily have such an effect. Indeed, for a variety of reasons, they could further reduce accessibility to services for individuals who are unwilling or unable to shoulder the financial burden of the differences between compensation provided by the provincial insurance plan and the actual costs of services received out-of-country.

Thus, not only might Ottawa regard such a practice to be equivalent to allowing extra billing and user charges, and thus subject to the same penalties as if the services were provided domestically, it might also consider the practice subject to penalties under the CHA's discretionary

criterion of accessibility. At the same time, such a practice would not be subject automatically to non-discretionary penalties for extra billing and user charges unless reported as such by the province.

The private offering of third-party insurance for out-of-country services is, at least for now, a reality. Although the take-up rate for such insurance is not high, the prevalence of high-profile cases in which services of adequate quality or reasonable timeliness are not available domestically but public insurance coverage has been denied for out-of-country provision could have important implications for take-up rates in the future. In turn, the existence of third-party insurance for out-of-country services undoubtedly will increase political pressure to explore the possibility of the public subsidization of these services, particularly if it can be argued credibly that such subsidization would reduce pressure on, and increase accessibility to, health services domestically. An increasing rate of publicly-funded health services being received out-of-country would likely generate political pressure to address issues of quality and timeliness.

The open question, however, is where the balance between funding out-of-country service and improving access to service domestically is drawn. While to some degree these pressures are likely to be generated by patients, the Alberta case suggests that the impetus might come from provincial governments, which could see the provision of such incentives as a means to relieve pressure on, and shore up the sustainability of, provincial health services. Moves in such direction undoubtedly would generate considerable public debate, certainly implicating the CHA, in an area that, again, constitutes a significant grey zone in terms of the requirements of the Act.

Medical Concierge Services for Provincially Insured Services Provided Out-of-Province

Another recent phenomenon has been the emergence of medical concierge services whereby the patient typically purchases a given number of hours of expert consultation and research assistance for health service alternatives tailored to his or her specific health needs but the concierge service does not provide any of the health services directly.[25] While these services are clearly consistent with CHA provisions, concerns could well arise in future about publicly funded services received in another province and facilitated by medical concierge services.[26]

As is the case for out-of-country services, provincial plans are required to cover the costs of health services received by insured persons in other provinces. In this case, the CHA requires that "payment for health services is at the rate that is approved by the healthcare insurance plan of the province in which the services are provided" (CHA, s.11, 1, b, i).[27] Thus, in essence, the costs of the services must be provided in full by the provincial plan – so there is no possibility of extra billing or user fees. Similar to the case for out-of-country elective health services, prior approval may be required where "the services in question were available on a substantially similar basis in the province" (CHA, s.11, 2). While all provinces currently require prior approval for services received out-of-country, many do not require prior approval for services provided out-of-province in Canada.

The ability to facilitate access to publicly insured services provided in another province appears to generate significant potential for the growth of medical concierge services. To the degree that such

25 See, for example, http://www.medicalconcierge.ca/public/main.html (accessed November 14, 2011).

26 To the degree that medical concierge services facilitate publicly subsidized health services received out-of-country, they might generate some of the same issues outlined above in the discussion of out-of-country services.

27 This provision holds unless an alternative arrangement is agreed to by the provinces in question.

services facilitate quicker access than in-province services, and if patients could not reasonably be expected to gain access without the aid of such a service, the fees charged might be considered to be the functional equivalent of extra billing or user charges. However, since such fees are not charged directly by the health service provider, they would not be regarded technically as extra billing or user fees under the CHA. In this sense, one could argue that the link between the CHA and medical concierge services is tenuous, with no federal intervention required at this time.[28]

If services can be received more quickly in another province, one could argue that patients traveling outside their home province rationalizes the fit between demand and supply of services across provinces. In this sense, such practices could encourage a more efficient use of health service resources. Although they also might have important implications for demand pressures on the province in which the service is delivered, they might relieve demand pressures on services in the funding province. Again, however, such practices could reduce accessibility to services for individuals who are unwilling or unable to shoulder the financial burden of the medical concierge service required to coordinate obtaining health services out-of-province.

The potential for the widespread receipt of publicly insured services in other provinces initially might seem remote, but in fact such policies have been under consideration, notably in Alberta, where a discussion document notes that, as with out-of-country services, "flexibility in...out-of-province funding can be an avenue to relieve pressures or address sustainability" (Alberta 2010). The implied policy changes required to provide such incentives are less clear, however, than in the case of out-of-country elective services, where the prior-approval requirement could simply be dropped. Indeed, the Alberta public insurance plan, like that in other provinces, currently does not require prior approval for elective health services received in another province.[29] One possibility for greater flexibility in out-of-province funding could be to cover "high-cost items not included in reciprocal agreements" and that typically require prior approval (Canada 2011, 99).

As is the case with third-party insurance for out-of-country health services, medical concierge services are, at least for the time being, a reality in Canada. To some degree, it seems plausible that the advent of medical concierge services themselves could increase the incidence of the provision of publicly funded health services in another province as they give their clients information on such an option. Should the incidence of such services increase by a significant degree, such developments likely would also generate considerable public debate about whether such practices in fact constitute a grey zone with respect to the CHA, and increase demands that the federal government clearly state its position on their consistency with the CHA.

Conclusions

Proponents of healthcare reform in Canada should defend a more vigorous federal delineation of the provisions of the *Canada Health Act*, rather than its repeal or suspension. The CHA provides significant latitude for provincial experimentation, but the political negativity-bias that has arisen from Ottawa's unwillingness to take a clear public stance regarding the consistency of various experiments with the CHA constitutes a significant political

28 This position was noted by one of the reviewers of this study.

29 This provision applies so long as those services are not specified as excluded in an existing interprovincial reciprocal hospital billing agreement; see Canada (2010, 92).

barrier to reform. Of course, public opinion is a crucial constraint, to which proposed reforms would be subject even in the absence of the CHA; however, the lack of clarity around CHA requirements has magnified these constraints.

Should provinces or other actors wish to pursue reforms or new practices to improve or expand the range of available heath services, enhance the effectiveness or timeliness of services, or increase cost effectiveness, they should not be hampered politically by a lack of clarity regarding consistency with CHA criteria. Rather, they should be able to make such decisions with relative certainty regarding consistency (or lack thereof) with CHA criteria and how the issue of CHA consistency will play out in public debates.

To help provide such certainty and clarity, the federal government should stop avoiding these public debates and instead clearly and publicly state its position on issues such as the proposed Quebec health deductibles or patient block fees as they arise.

Paradoxically, this might well place the CHA on a firmer political footing. The negativity-bias generated by a lack of clarity has contributed to the sense that the CHA places a straitjacket on reform, which has resulted in calls for its suspension or repeal. Greater clarity and expanded political latitude for reform might well dull such calls.

Moreover, to the degree that providing such clarity seems to be a key step in establishing the context for a meaningful public dialogue on healthcare in Canada, the federal government should provide certainty and clarity in regard to the grey zones that currently exist at the boundaries of the Act – something that is clearly missing from current debates.

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