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ECONOMIC NOTES

HEALTH POLICY SERIES

JANUARY 2023

LIFTING THE BAN ON DUPLICATE PRIVATE HEALTH INSURANCE IN QUEBEC

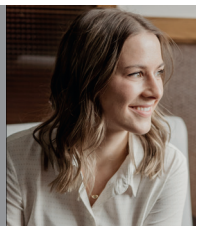
By Maria Lily Shaw

Quebecers are currently in a period of deep reflection regarding the organization of their health care system. The substantial shortcomings of the system having been exposed by the COVID pandemic, the population of Quebec has become far more receptive to allowing the private sector to play a role in health care delivery. But the option of purchasing duplicate health insurance from private companies is currently prohibited in Quebec as well as in several other Canadian provinces. Without this insurance, the private sector stands little chance of any significant expansion. Unless this ban is lifted, it will be impossible for a market in duplicate health insurance to emerge, and access to the services offered in private clinics will remain out of reach to all except those able to afford the full cost of treatment.[1]

In public health care systems such as Canada's, the main function of duplicate health insurance is to provide individuals who desire it with replacement coverage for care already covered by the government's health insurance plan (the RAMQ in Quebec). Individuals are free to choose whether or not to take out such insurance depending on their personal needs. The duplicate policy can then be used as a method of payment for treatment in private health care facilities. As of January 2023, for example, Quebec had more than 600 so-called *non-participating* physicians and specialists[2] offering services outside the public system.

Although one cannot predict the response of insurance companies to a potential lifting of the ban, it is reasonable to assume that this new product might be launched through group insurance offered by employers. Companies could decide to offer such benefits to their employees and, especially in the present context of labour shortages, these could be used as a tool to attract workers.

This Economic Note was prepared by **Maria Lily Shaw**, Associate Researcher at the MEI. The MEI's Health Policy Series aims to examine the extent to which freedom of choice and entrepreneurship lead to improvements in the quality and efficiency of health care services for all patients.

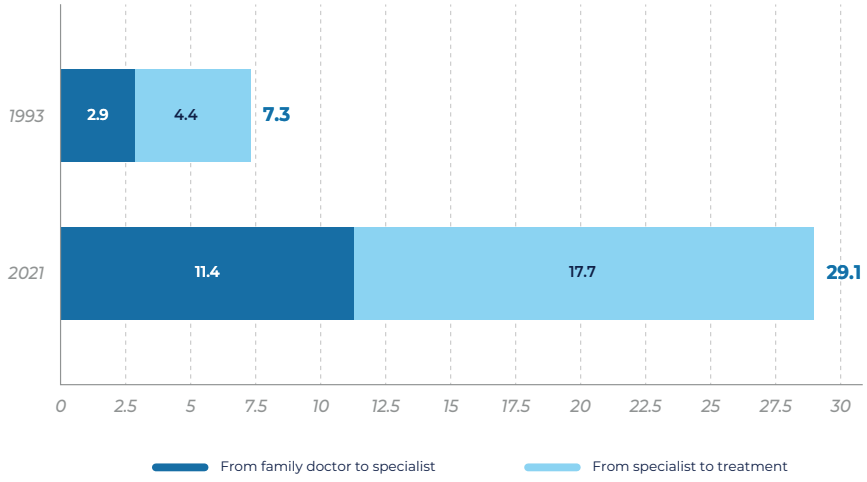


WAITING LISTS ARE EXPENSIVE

The potential benefit of allowing private health insurance to cover services already provided by the public system becomes clear when that system fails to provide care within a reasonable time. As of January 2023, there were over 159,000 Quebecers waiting for surgery. Of this number, 34% had already been waiting over 6 months.[3] Just over half of the patients on the list were waiting for day surgery,[4] i.e., minor procedures that require only a half-day admission to the hospital.[5] In terms of median wait time for elective surgery, 50% of Quebecers on the list waited more than 29 weeks[6] (see Figure 1), three weeks longer than the recommended wait time.[7]

Figure 1

Median wait time for elective surgery in Quebec (in weeks), 1993 and 2021



Source: Mackenzie Moir and Bacchus Barua, *Waiting Your Turn, Wait Times for Health Care in Canada, 2021 Report*, Fraser Institute, 2021, p. iii.

Given this context, patients would see a clear advantage to purchasing duplicate insurance, in that they would be able to obtain more timely treatment from a doctor in the private sector. For some patients,[8] waiting several months can be very costly and may eat into their savings if they are unable to work. And let us not forget the physical pain that many of these people have to endure while waiting for an operation.

Wait times for elective surgery in Quebec are nothing new, and they have increased by more than 20 weeks since 1993. In 1999,[9] a protracted delay before an operation even provided one of the reasons for the Chaoulli case, litigation brought before the Superior Court of Quebec[10] that would drag on for over five years. A final judgment in the case was handed down by the Supreme Court of Canada in 2005.

THE CHAOULLI DECISION: BANNING DUPLICATE HEALTH INSURANCE IS UNCONSTITUTIONAL

The appellants in the case, Dr. Jacques Chaoulli and George Zeliotis (his patient waiting for surgery) challenged the validity of the sections of the law that prohibit insurance companies from selling duplicate health insurance to Quebecers, namely Section 11 of the *Hospital Insurance Act* and Section 15 of the *Health Insurance Act*.[11] They alleged that the prohibition was depriving Quebec residents of access to health services and violating their constitutional rights to life, liberty, and security of the person.

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More precisely, they argued that this prohibition violated the integrity of the person,[12] because it could lead to physical and psychological damage due to the chronic inability of the public system to provide care within a reasonable time. Without this restriction, they contended, patients facing long waits for medically necessary procedures in the public system could get faster care in the private sector, paid for with their duplicate insurance.

The Supreme Court of Canada ruled that Quebec's ban on duplicate health insurance was indeed unconstitutional. Based on the evidence provided, the Court concluded that

there was "no real connection between the prohibition on health insurance and the objective of maintaining a high-quality public health care system."[13] As we shall see, however, this prohibition remains in force in Quebec with but three exceptions.

The judges based their reasoning on the fact that most Western European countries manage to maintain robust public systems even while allowing their populations the freedom to purchase duplicate insurance. There are also Canadian provinces that do not prohibit the sale of such health insurance, at least not formally. The Court stated, "[w]hile it may be assumed that prohibiting private insurance can help preserve the integrity of the system, the variety of measures put in place by different provinces demonstrates that such a measure is far from the only one that a state can resort to."[14] Moreover, in the four Canadian provinces that do allow insurance companies the option of selling duplicate health insurance policies, there is no evidence that their health care systems suffer from any lack of integrity.

THE STATE OF HEALTH INSURANCE IN QUEBEC TODAY

Unfortunately, the Chaoulli decision did not lead to the appellants' hoped-for liberalization of private health insurance. One of the articles challenged, Article 11 of the *Hospital Insurance Act*, has remained essentially unchanged since the Supreme Court's decision. Section 15 of the *Health Insurance Act*, which was also found to be unconstitutional, has been amended to allow insurance companies to offer duplicate health insurance for just three specific procedures:

1. Total hip replacement,
2. Total knee replacement,
3. Cataract extraction with intraocular lens implantation.

According to current regulations, the insurance contract must cover the costs of all pre- and post-operative services as well as all rehabilitation and home support services resulting from the surgery. However, this insurance policy can only be used as a method of payment in so-called "non-participating" specialized medical centres (SMCs),[15] of which there are only 23 in the entire province as of January 2023.[16] The interest of insurers in offering such coverage is thus considerably limited, which explains why no market in duplicate health insurance has yet developed in Quebec, not even for these three operations.

Most Western European countries manage to maintain robust public systems even while allowing their populations the freedom to purchase duplicate insurance.

However, there is potential to expand this short list, because according to Article 15.1 of the *Health Insurance Act* the government has the power to include other medical services if it so wishes.[17] In fact, the prohibition could also simply be lifted entirely, since the *Canada Health Act* (CHA) does not prohibit duplicate private health insurance as such.[18] In other words, the CHA does not preclude provinces from introducing reforms that would allow the emergence of private insurance markets for services already included in their public health insurance plans. Provinces that have chosen to introduce legislation prohibiting the purchase of duplicate insurance actually go beyond what the CHA requires. Quebec does this on the grounds that such measures are necessary to maintain the integrity of the health care system and "to ensure that virtually all existing health resources in Quebec are available to all Quebecers."[19]

BARRIERS TO DUPLICATE HEALTH INSURANCE

Together with some other provinces, Quebec is actively preventing the emergence of a market for duplicate health insurance. These are among the last places in the industrialized world to do so, and they persist in spite of case law such as the Chaoulli decision that has called into question the constitutionality of this prohibition.

Saskatchewan, Nova Scotia, New Brunswick, and Newfoundland and Labrador do not formally prohibit insurance companies from offering

Table 1

Provincial regulation of duplicate health insurance

	Are private insurance contracts for publicly insured services allowed?	Can private insurance cover all or part of the fees of non-participating doctors?
British Columbia	No	No
Alberta	No	No
Saskatchewan	Yes	Yes
Manitoba	No	No
Ontario	No	No
Quebec	No	No
New Brunswick	Yes	Yes
Nova Scotia	Yes	Yes
Prince Edward Island	No	No
Newfoundland and Labrador	Yes	Yes

Source: Colleen M. Flood and Tom Archibald, "The illegality of private health care in Canada," *Canadian Medical Association Journal*, Vol. 164, No. 6, March 2001, p. 826.

duplicate private health insurance[20] (see Table 1), a practice that is well established in several high-income OECD countries with universal public health care systems.

In these four provinces, the patients of non-participating doctors are allowed to substitute private coverage for public coverage. However, despite the long waiting lists[21] (see Figure 2), the duplicate health insurance market has not developed in these four provinces either, for several reasons.

To begin with, there are other regulatory barriers that limit the public's ability to use duplicate insurance, including the prohibitions on open billing and on mixed medical practice. In Nova Scotia, for example, non-participating physicians can only bill their patients for amounts less than, or equal to, what the physician would receive from the public plan. To do otherwise is illegal.[22] There is therefore no financial incentive for doctors in Nova Scotia to practise in the private sector.

New Brunswick, Newfoundland and Labrador, and Saskatchewan all allow physicians to bill patients for more than they would receive in the public system. Patients can then use duplicate private insurance as a method of payment to cover all, or part, of the costs of services rendered by non-participating physicians, regardless of the amount of the bill. This allows doctors in three of Canada's ten provinces to charge the fees they wish, creating a medical practice environment more conducive to private sector development of a duplicate health insurance market.

The prohibition could simply be lifted, since the *Canada Health Act* does not prohibit duplicate private health insurance.

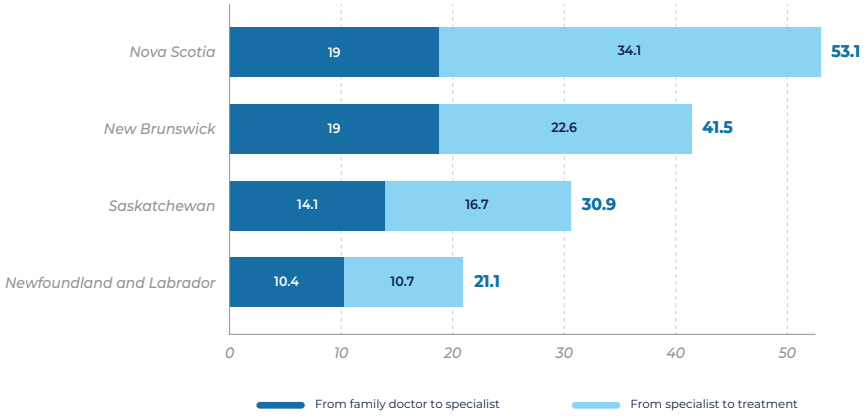
But despite this greater freedom in billing, all three provinces maintain another regulatory barrier to the emergence of a duplicate insurance market, namely a prohibition on mixed practice. Six of the ten Canadian provinces have legislated prohibitions on physicians being paid from both public and private funds for care covered by the provincial plan.[23] This constitutes a brake on the development of private medicine: private clinics cannot recruit doctors (participating or not) on a part-time basis, since

participating doctors cannot resort to private practice without first formally withdrawing from the public system. The prohibition on mixed practice thereby restricts the emergence of a duplicate insurance market by limiting the potential for service provision and reducing the number of doctors who can accept such insurance as a form of payment.

Since the ban on mixed medical practices also exists in Quebec, even if the province were to lift the current bans on duplicate private health insurance, policies with private insurers could still only cover the services of non-participating physicians.

Figure 2

Median wait time for elective surgery (in weeks), select provinces, 2021



Source: Mackenzie Moir and Bacchus Barua, *Waiting Your Turn: Wait Times for Health Care in Canada, 2021 Report*, Fraser Institute, 2021, p. iii.

In addition to the regulatory aspects, in Saskatchewan there is another reason that duplicate health insurance has not emerged. Since 2010,[24] the province's government has routinely subsidized surgeries delegated to the private sector in order to reduce waiting lists and pressure on public hospitals. Thus, at the time of receiving the care required, a patient could be sent to either a public hospital, or to a specialized private clinic at no additional cost. This way of doing things is good for both the patient and the taxpayer, since operations performed in private clinics can cost up to 45% less[25] than in public facilities, but it also reduces the demand for duplicate health insurance. Since patients are potentially already satisfied with the waiting times, the insurance companies do not see any point in offering a product to compete with the government's quasi-monopoly on coverage.

Finally, there are demographic reasons for the absence of duplicate private insurance. The number of inhabitants in these provinces may be insufficient to interest insurance companies in offering such coverage. Even if 45% of the population in each of these provinces chose to buy duplicate health insurance (equivalent to the rate in Australia which has the highest enrolment among OECD countries),[26] this would still represent only 1.5 million people[27] compared with more than 11 million people in Australia.[28]

Despite the factors currently discouraging development of a market for duplicate health insurance in those provinces that do not prohibit it, the other provinces should still follow their lead in allowing such markets to develop in the future. Were the care situation in the public system to deteriorate, or individual health care preferences to change, the absence of bans in the four provinces named above would play an important role in allowing the freedom for duplicate insurance to emerge once warranted.

Other barriers limit the ability to use duplicate insurance, including the prohibitions on open billing and on mixed medical practice.

Given its long waiting lists, which have shown no sign of improvement in recent years, Quebec in particular would be well advised to lift its prohibition. Let us not forget that the Chaoulli decision established that these waiting lists endanger patients' welfare.

Overseas, there are many countries with universal public health care systems that do not

prohibit the purchase or sale of duplicate health insurance. These include Sweden, Ireland, Portugal, Germany, the UK, the Netherlands, Denmark, and Australia.[29] Australia is a particularly salient example for Quebec, as it has introduced measures to encourage its population to take out such insurance.

AUSTRALIA: AN EXAMPLE TO FOLLOW

Duplicate health insurance has been allowed in Australia since the 1970s.[30] In September 2022, 45% of Australians had duplicate health insurance,[31] and according to a 2021 survey the Australian population was quite satisfied (73.7%) with their insurance coverage.[32]

While the proportion of Australians with duplicate health insurance is quite high today, this has not always been the case. The proportion actually declined for several years, mainly due to the introduction of Medicare,[33] before rebounding starting in 1999 (see Figure 3). This was the point at which the government introduced, almost simultaneously, three separate measures meant either to reduce the amount of premiums paid by policyholders in the short and long terms, or to encourage certain groups of individuals to take out duplicate health insurance.[34]

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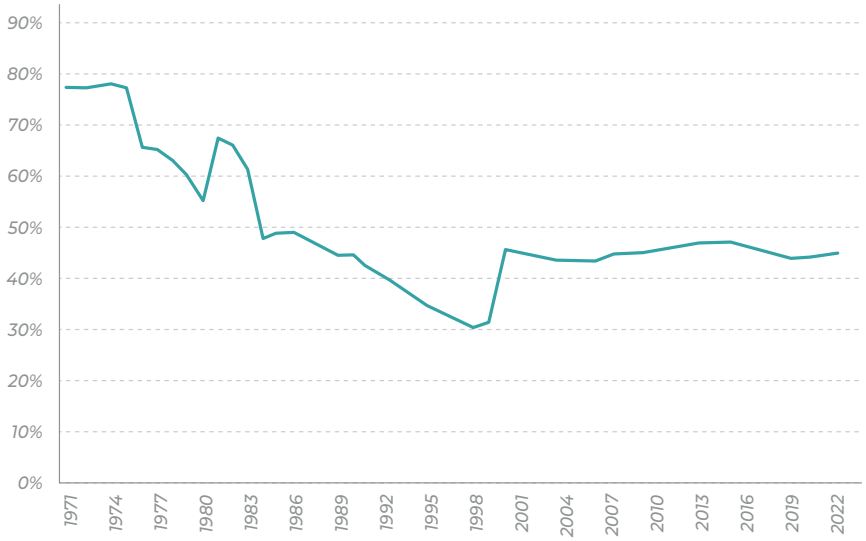
The first measure was a discount of up to 32.8%[35] on the cost premiums for duplicate health insurance policies, a tax expenditure that reached more than $6.7 billion in 2021-2022.[36] Citizens who purchase such insurance are reimbursed for part of the cost of the premium, either through the insurer, who will apply the discount directly, or through a refundable tax credit. The amount of the rebate received by the insured depends on their age, marital status, and income.

Figure 3

Proportion of the Australian population with duplicate health insurance



Note: The data for 2022 is from March of that year.
Source: Government of Australia, APRA, Data and statistics, *Quarterly private health insurance statistics*, consulted June 9, 2022.

The second measure is intended to encourage younger people to take out and maintain duplicate health insurance. People who take out health insurance early in their adult lives will avoid paying a 2% annual surcharge for 10 years starting at age 31.[37]

The final incentive measure is a surtax on individuals with a taxable income of more than $90,000 for a single person, or $180,000 for families,[38] who do not maintain a duplicate health insurance policy. This consists of a surcharge of between 1% and 1.5% of taxable income, which is then used to fund government-provided health care.[39] In addition to this surcharge, duplicate private insurance offered to the Australian population also contributes to funding the activities of the health care system. In fact, over the past ten years private insurers have accounted for an average of 8.3% of total health spending in Australia, or $18 billion in 2020-2021.[40] The duplicate insurance market therefore represents a way of increasing the

overall financial resources devoted to the health care system without using public money.

Australia's actions are a clear indication that policy-makers have recognized the significant contributions of the private sector to the health care system. In fact, support for private insurance has endured since the 1990s when the newly elected government said that it "see[s] the private sector as a vital complement to the long-term viability of Medicare and the public hospital system."[41] The Australian public still agrees with this today, with 56% of citizens believing that if the private health system were abolished, the public health care system would not be able to meet the additional demand, not even if the funding currently provided to the private health system were transferred to the government-run sector.[42] This popular opinion is supported by a study that concluded that incentives have indeed reduced pressure on the public health care system. A significant proportion of patients (15%) were redirected from the public to the private sector due to enrolment in duplicate health insurance.[43]

The policies the government has chosen to enact ensure equality of access as they allow middle-class Australians to purchase duplicate insurance, thus ensuring that it is not a product reserved for the wealthy.

CONCLUSIONS AND RECOMMENDATIONS

As policy-makers prepare to implement their plan to reform Quebec's health care system, one key element remains absent: lifting the ban on the sale of duplicate health insurance contracts.

As the situations in Saskatchewan, Nova Scotia, New Brunswick, and Newfoundland and Labrador illustrate, however, simply lifting this prohibition will be insufficient for the development of a duplicate health insurance market. They must foster a regulatory environment that makes the sale and purchase of such insurance attractive, i.e., other barriers to market development, such as the prohibition on mixed practice, must also be removed. This would increase the pool of physicians who could accept duplicate health insurance as a form of payment, as well as the number of clinics where patients could use their insurance policy, since this form of payment would no longer be restricted to non-participating SMCs.

In other words, the health care system must be restructured to introduce competition among health care providers and reduce the monopoly power currently held by the government. Failing this, no alternative health care system will ever be able to emerge, and Quebecers may never witness a true expansion of the supply of health care, or any real improvement in their access to care.

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If the ban is lifted, it will be essential to make the purchase of duplicate insurance tax-deductible, as Australia has done, or to make company expenses for the purchase of such insurance policies for their employees tax-deductible. These steps are necessary to make duplicate health insurance more accessible and to encourage people to buy it. Otherwise, this type of insurance will remain useful to only a small segment of the population, discouraging the development of a competitive market.

Finally, as the Chaoulli case has shown, in the context of the recurrent inability on the part of the public system to deliver medically required care within a reasonable period of time, banning duplicate private health insurance jeopardizes both the physical and mental health of the population. Moreover, these limitations restrict the patient's freedom of choice, and every citizen's freedom of contract. It is therefore high time to provide Quebecers with a health care system that meets their needs by allowing them to purchase duplicate health insurance, as so many other industrialized OECD countries have done.

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