

## **Canada should not allow two-tiered practicing for medically-necessary services**

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### **The Current State of Canadian Health Care**

In 2009, Dr. Brian Day, owner of a for-profit surgery clinic in Vancouver, launched a constitutional challenge against the condition of the Canada Health Act (CHA), which specifies that medically-necessary services cannot be delivered on a [for-profit basis](#). Dr. Day claimed the condition [violates section 7](#) of the Canadian Charter of Rights and Freedoms (i.e., the right to life, liberty, and security of the person). He [argued](#) the CHA prevents individuals from accessing the care they need, as prolonged waiting for medical procedures often puts individuals at an increased risk of adverse outcomes. Dr. Day's case went before the Supreme Court of British Columbia. While the Supreme Court of BC has yet to issue a ruling, the case has sparked a heated debate about Canada's health care system; specifically, focused on whether or not the introduction of a two-tier system would be beneficial.

Currently, Canada has a universal single-payer system. Medically-necessary services are [publicly funded](#) and doctors are prohibited from charging user fees and extra-billing. However, certain services including pharmaceuticals, optometry and dentistry are paid out of pocket or funded through private insurance. One of the biggest critiques of the current system is that wait times for elective surgeries and primary care services are [continually increasing](#). In 2016, [36% of respondents](#) in the Health Care in Canada survey reported wait times as the largest issue facing the health care system, a 16% increase from 2007. Findings from the 2016 Commonwealth Fund survey reveal that Canada ranks last out of 11 countries when it comes to getting a same-day or next-day appointment to see a doctor or nurse. Additionally, Canada [ranks second last](#) for access to medical care outside of the emergency room on evenings and weekends.

### **About Two-Tiered Health Care**

A two-tier system allows two health care service options for medically-necessary procedures: public and private. Countries such as Australia and the United Kingdom (UK) operate using a two-tiered health care system. The majority of health care is [publicly funded](#) under universal care in both countries, but all patients preserve the opportunity and in some cases are encouraged to seek private treatment at their expense. Individuals accessing private services pay through private insurance plans or out of pocket. Physicians are able to [practice](#) in both the public and private systems. Implementing a two-tier system can, theoretically, create competition between service providers and foster innovation in care delivery and treatment. Proponents of a two-tier system also identify that introducing a private system could solve Canada's current wait time issues.

### **Canadians Value the Equity and Universality in the Current Health Care System**

The ability to access care based on need and not ability to pay is [highly valued](#) in Canada. Canadians often cite our universal health care system as a point of pride. In fact, findings from the [2012 General Social Survey](#) revealed that pride for our health care system was among the top four contributors to national pride. The General Social Survey finding on health care and

national pride indicates that Canadians value fairness and equity. These two principles represent the underlying foundations of health care decision-making and delivery in Canada.

Fairness and equity have been enshrined into the Canadian health care system since the days of Tommy Douglas and his fight to establish universal health insurance. The implementation of Medicare in Saskatchewan paved the way for the development of universal health insurance across the country. The CHA was introduced following the Medicare movement in 1984. Under the act, all insured persons are entitled to receive medically-necessary services at no cost. The CHA contains five criteria provincial governments must meet in order to receive federal funding for health care. Accessibility is a vital criterion of the act. According to [section 12](#) of the CHA, “insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one may be discriminated against on the basis of such factors as income, age, and health status”. The implementation of a two-tier health care system has the potential to weaken accessibility to care. Specifically, a two-tier system may have detrimental consequences for health human resources and quality of care in the public system.

Canadians value the equity, accessibility, and universality of their current universal single-payer system. Creation of a two-tier health care system in Canada challenges these values as it could substantially impact the quality and accessibility of the parallel public system without alleviating the long wait-times. We propose that a two-tiered system for medically-necessary services in Canada would not be feasible given the current state of our health care system. Health care in Canada is under provincial jurisdiction to manage each province’s differing needs.

### **Two-Tiered Health Care Influences Physician Labour Supply in the Public System**

A large concern with moving to a two-tiered health care system is that the best performing specialists and practitioners may choose to practice more in the private system, thus weakening health care outcomes in the public system. For instance, in the UK [increased monetary compensation](#) was one of the main driving factors for consultants choosing to practice a portion of their time in the private sector.

In Australia, [Cheng and colleagues](#) investigated how earning a higher private sector wage influences a medical professional’s time allocation between the public and private systems. Knowledge on time allocation between both systems is important because the ability to have a private practice and earn a higher wage could cause health care professionals to spend more time in the private system compared to the public system. Overall, increasing the wage in both systems simultaneously was not enough to cause professionals to increase the number of hours that they choose to work weekly and thus specialist hours (public or private) are finite. Increased pay in the private system was found to [result in](#) specialists being more likely to allocate proportionally more time to the private system versus the public system. Similar [results](#) of incentives influencing physician movement to the private system to the detriment of the public system were found in Norway. Thus, a two-tiered system has the potential to incentivize the best specialists to allocate less time to the public system because of the freedom to charge higher fee for service and earn more in the private system.

## **Two-Tiered Health Care Could Reduce Health care Quality in the Public System**

Medical professionals may have incentive to decrease the public system quality due to the ability to increase earnings per patient and have a greater influence on the profits made in the private system. [For example](#), dual practitioners can benefit directly from longer public wait times as it will drive increased volume to private practice and increase their charge on a per patient basis. Dual practitioner preference for their private practice may also lead to a [weakening of the public system](#) due to lower quality of services and increased absenteeism. There is substantial evidence that in the absence of a regulatory body or a penalty process for poor public physician performance, dual practice can lead to the [deterioration of public system quality](#).

‘[Moonlighting](#)’ involves medical professionals working as dual practitioners referring patients from their public practice to their private practice. Regulators argue that ‘moonlighting’ may lead to physicians undertreating their patients in the public system to encourage patient switching to the private system where professionals have the potential to earn more. [Biglaiser and Ma](#) investigated whether ‘moonlighting’ negatively influences the health care quality in the public system. ‘Moonlighting’ physicians were defined as being driven primarily by financial incentives whereas ‘dedicated’ physicians were defined as being driven primarily by maximizing patient outcomes. The study found that ‘moonlighting’ physicians decreased their quality of care in the public system in the absence of penalty systems for low quality health care. Furthermore, decreased ‘moonlighting’ physician efforts in the public sector [led to](#) other ‘dedicated’ physicians lowering their efforts in the public sector. Placing an income ceiling in the private sector substantially decreased this deleterious behaviour by all medical professionals.

As mentioned earlier, the opportunity for dual practice is attractive to medical professionals for financial incentives, as well as qualitative factors such as increased physician autonomy. Countries that allow dual practice are therefore at a [competitive advantage](#) for attracting top medical professionals and subsequent improved national health care outcomes. As a result of this presented tradeoff, the direct effect of national health care regulators allowing two-tiered medical practicing on medical outcomes and health care quality in the public system is not perfectly clear. However, if the decision is made to allow for dual medical practicing in Canada, care needs to be taken to have a limit on earnings in the private practice to prevent excessive ‘moonlighting’ and decreased quality of care in the public system.

## **Two-Tier Health Care System Leads to Increased Wait Times in the Public System**

Advocates of two-tiered health care argue that the implementation of a two-tiered system would significantly [reduce the long wait times](#) that currently exist; little evidence exists to support this argument. In theory, a dual system would remove only those individuals who can afford the services (i.e. the most affluent members of society) from waiting lines and allow them to pay for health care out-of-pocket in private clinics. Ideally, this should allow for faster access to care for individuals in both public and private streams. However, wait times historically have been found to increase for the majority of the population that still accesses the public system for health care.

Evidence of extended public system wait times following two-tier health care implementation was found in both Australia and the UK. [Duckett](#) found that even with parallel streams, wait

times for public patients became longer in Australia when more hospital care was provided in the private sector. Additionally, in regions of the country that have the highest number of private patients, [wait times](#) for public patients were the largest. The UK faces similar problems surrounding wait times. A study examining public and private health insurance in the UK, found that there was a positive correlation between the amount of private care used and wait times in the public domain. A greater number of private-pay patients was associated with [longer waiting lists](#) in the public domain.

Although some Canadians are inclined to introduce a health care system similar to the ones implemented in Australia and the UK, data from Canada also fails to support that the adoption of a two-tier health model improves access to care. The [Manitoba Centre for Health Policy and Evaluation](#) found that cataract surgery wait times were lowest in private clinics, but much higher for services provided by surgeons practicing in the public sector only or in both sectors. Overall, research suggests that allowing patients to pay for services privately will fail to address the issue of long wait times for the majority of Canadians seeking health care.

### **Two-Tiered Health Care Could Modify Patient Distribution in the Public System**

Medical professionals in a two-tiered system are afforded the opportunity of being [selective](#) on which patients they treat in their private practice. Allowing a two-tiered system could thus encourage the medical practice of ‘cream-skimming’. This practice involves medical professionals selecting the easiest surgical procedures that have the best clinical outcomes and are the cheapest to perform for their private practice. The private system is often [characterized](#) by short wait times or even idle capacity. Thus, health authorities frequently attempt to transfer patients to the private sector to alleviate long wait times in the public system.

When health authorities implemented private practice to alleviate wait-time pressures in Spain, ‘cream-skimming’ occurred among the participating medical professionals. ‘Cream-skimming’ caused the most severe and expensive procedures to be treated in the public health care system to the benefit of the private system. Furthermore, ‘cream-skimming’ was [more prevalent](#) as variability in patient illness severity increased. As mentioned earlier, wait times in the UK and Australia increased following implementation of a two-tiered system. Longer wait times in these countries may indicate that a higher proportion of severely ill patients remained in the public system. Despite the best intentions of health authorities to alleviate wait times and improve patient outcomes through implementation of a two-tiered system, ‘cream-skimming’ by medical professionals could result in more severely ill patients waiting longer and increased per capita health care costs for the public system.

### **Process to Improve the Existing Health Care System**

The Canadian health care system must transform care pathways, rather than altering its overall funding model to address the issue of wait times and to improve delivery of care. Transforming care delivery would preserve the principles of fairness and equity that are valued highly by Canadians. Access to care would remain based on need, not ability to pay. Current infrastructure and resources need to be used more efficiently and more outpatient community health care

centers must be established to shorten waiting lists and enhance health care delivery. Canada must learn from past pilot projects and innovative models in other countries.

Scotland successfully implemented a program to improve wait times without outsourcing services to the private system. The country introduced a new initiative in 2011, titled “[18 Weeks Referral to Treatment Standard](#),” which focused on systematic redesign and strategy transformation. The country improved referral and diagnostic pathways, introduced a centralized intake system for referrals, and improved operating room efficiencies. As a result, [92% of patients](#) were treated within the designated 18 weeks at the end of 2011. Barriers to care were significantly reduced demonstrating that improving access to care can be achieved without introducing a parallel private-pay system.

Evidence of changing care delivery models to decrease wait times and improve patient outcomes also exists in Canada. The Alberta Bone and Joint Health Institute (ABJHI), in partnership with the Alberta Orthopedic Society, implemented a pilot project aimed at designing a [new care pathway](#) for individuals waiting for hip and knee replacements. With the exception of family doctor and in-hospital services, all other services were provided in or through a new hip and knee clinic with a multidisciplinary team. [Wait times](#) for consultation with a specialist and for surgery dramatically decreased, and overall patient health significantly improved. For example, patients reported less pain after surgery and a greater ability to perform normal daily activities. The success of the ABJHI project shows that it is possible to make systemic improvements while working within the current one-tiered system.

## Conclusion

Tommy Douglas stated in 1961: “The time is surely past when people should have to depend on proving needs in order to get services that should be the inalienable *right of every citizen of a good society*. It is all very good and well to say that there is no stigma or humiliation connected with having to prove need. This is always said by people who know that they are in no danger of having to prove need”.

Ultimately, choosing to implement two-tiered health care for medically-necessary services has been shown to impact physician and patient participation in the public system. Physicians may spend a greater amount of time in the private system because of the ability to earn more, potentially decreasing clinical outcomes and increasing wait times in the public system that remains accessed by the majority of the patient population. We acknowledge that health care policy is incredibly complicated and an argument could be made for successful two-tiered health care given changes in health care regulation. However, Douglas’s statement from 1961 still echoes the sentiments of many Canadians today. Equal access to health care in Canada should remain a right for all and the ability to pay should not determine who receives superior care.

Given that Canada’s wait times trail other Commonwealth countries, the Canadian government should not delay in implementing change in the current universal single-payer system. The government should restructure the way in which it provides basic care. Hospitals that provide a full range of services are no longer the best option. Based on recurrent local and international success, we propose that the government should increase integrated practice units that specialize

in a particular condition across Canada as they improve care efficiency and have consistently reduced wait times. Furthermore, with the incidence of chronic diseases growing annually, Canada should continue to move towards community-managed care similar to Australia to alleviate strain on hospital resources. Changing the funding model in Canada will not be the immediate solution to the current persisting health care issues. The Canadian government should instead aim to implement proven best practices while maintaining the current universal single-payer system.

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