

Policy changes and physicians opting out from Medicare in Quebec: an interrupted time-series analysis

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ABSTRACT

BACKGROUND: In all Canadian provinces, physicians can decide to either bill the provincial public system (opt in) or work privately and bill patients directly (opt out). We hypothesized that 2 policy events were associated with an increase in physicians opting out in Quebec.

METHODS: The 2 policy events of interest were the 2005 Supreme Court of Canada ruling on *Chaoulli v. Quebec* and a regulatory clampdown forbidding double billing that was implemented by Quebec's government in 2017. We used interrupted time-series analyses of the

Quebec government's yearly list of physicians who chose to opt out from 1994 to 2019 to analyze the relation between these events and physician billing status.

RESULTS: The number of family physicians who opted out increased from 9 in 1994 to 347 in 2019. Opting out increased after the *Chaoulli* ruling, and our analysis suggested that between 2005 and 2019, 284 more family physicians opted out than if pre-*Chaoulli* trends had continued. The number of specialist physicians who opted out rose from 23 in 1994 to 150 in 2019. Our

analysis suggested that an additional 69 specialist physicians opted out after the 2017 clampdown on double billing than previous trends would have predicted.

INTERPRETATION: We found that the number of physicians who opted out increased in Quebec, and increases after 2 policy actions suggest an association with these policy interventions. Opting out decisions are likely important inputs into decision-making by physicians, which, in turn may influence the provision of publicly funded health care.

In all Canadian provinces, most physicians work as part of a private business. Whether they are solo practitioners or part of larger group practices, physicians can bill the provincial public Medicare system, or work privately and bill patients directly. Engaging in both is referred to as “dual practice,” and evidence exists to suggest that it can negatively affect the accessibility of care in the public system where it is permitted.¹ As a result, most provinces have enacted legal barriers designed to prohibit or discourage dual practice.² In Quebec, British Columbia, Alberta, Saskatchewan and New Brunswick, physicians have to opt out formally from the public system to be able to bill patients for publicly covered services. In Ontario, Manitoba and Nova Scotia, physicians who decide to rely on private billing are not permitted to bill their patients more than the public fee schedule. Given these regulations, it is widely thought that only a small proportion of Canadian physicians choose to work outside of the public funding scheme for medical care. Nevertheless, private out-of-pocket payment to physicians still accounts for hundreds of millions of dollars per year in Canada³ and, in Quebec, the number of physicians who opt out has been steadily growing for the past decade. However, our understanding of how policies and

legal events have affected these rates in Quebec or other Canadian provinces is limited. Over the past 20 years, 2 important policy events directly related to dual practice have occurred in Quebec.

First, in 2005, in its ruling for *Chaoulli v. Quebec*, the Supreme Court of Canada concluded that Quebec's prohibition of private insurance for publicly insured medical services violated Section 1 of the Quebec Charter of Human Rights and Freedoms.⁴⁻⁶ Quebec's government was granted 1 year to adjust its laws to the ruling, during which time there were intense policy debates about the private system.⁷⁻⁹ Many argued that there was a demand for out-of-pocket privately financed medical services, pushing many private investors, physicians and patients to debate the role of private delivery of health services.^{7,10-12} Second, in the years following this ruling, Quebec witnessed substantial interest and investments in private facilities for elective medical interventions. In many specialties with a high volume of outpatient elective interventions (e.g., ophthalmology, dermatology and orthopedic surgery), a certain level of double billing became the norm. Patients were routinely asked to pay out-of-pocket to cover things like eye drops, anesthetics, use of the intervention room and record management — so-called

“frais accessoires” [“incidental expenses”]. Faced with increased public and media scrutiny of the legality of those fees and strong pressures from Ottawa, Quebec started, in January 2017, to enforce a new regulation that clearly outlawed double billing for publicly funded medical services.¹³ Because many clinics had come to rely on these added fees, this clampdown threatened their business model, which may have pushed some physicians to opt out of the public system altogether.

As physicians who have opted out are not available to deliver services for publicly insured patients, any trend toward more privately delivered care will have obvious implications for delivery of publicly funded health care in Canada. Furthermore, international evidence suggests that dual practice is associated with challenges to equity and efficiency.^{14–16} Therefore, we analyzed the association of these 2 policy events with physicians’ decisions to opt out in Quebec.

Methods

Study setting and data

Quebec is Canada’s second-largest province, with about 8.5 million residents in 2020. As in other provinces, hospital and physician services are publicly funded under provincial health insurance, and delivery is provided, for the most part, by private physicians who charge the provincial plan on a fee-for-service basis. It is not permissible under the *Canada Health Act* to charge patients additional fees for services paid for through the public plan.² However, physicians may choose to opt out of the public plan and charge whatever amount they wish directly to patients. To do so, they need to notify the agency responsible for paying physicians from the public plan — Régie de l’assurance maladie du Québec (RAMQ) — of their intent and wait 30 days for their new status to be valid.¹⁷ Physicians can opt back in without delay through a simple notification.

Most provinces lack reliable data about physicians who have opted out. Quebec is an exception: the *Quebec Official Gazette* publishes a monthly list of physicians who have opted out on the first Saturday of every month.¹⁸ The first list of each year includes the previous year’s cumulative list. Using these annual reports, we compiled the number of family physicians (omnipraticiens) and specialists who opted out from 1994 to 2019. We also acquired the annual total number of physicians licensed to practise in Quebec from Scott’s Medical Database¹⁹ to calculate the proportion who had opted out each year in a sensitivity analysis.

Statistical analysis

We used interrupted time-series analysis to estimate long-term trends in opting out from the public system in Quebec and to assess the impact of the 2 policy interventions on opting out.²⁰ We set the policy intervention dates as the year in which each took place (2005 and 2017, respectively) and estimated their effect for family and specialist physicians in separate models. We also conducted a sensitivity analysis using the proportion of all practising family and specialist physicians as the outcome. As observations may have been correlated over time, we used

generalized least squares models with the number of physicians who opted out in each group as the outcome and incorporated a 1-year autoregressive structure. All models were fit using R statistical software.

Ethics approval

Because this study relied exclusively on publicly available data, it did not require approval by an ethics review board.

Results

According to the 2019 list of physicians who opted out, most are family physicians, and most are located in the greater Montréal and greater Québec areas. Among specialists, the highest proportion of physicians who have opted out were dermatologists (14%), plastic surgeons (10%), orthopedic surgeons (4%) and ophthalmologists (4%).

Family physicians

As shown in Figure 1, the number of family physicians who opted out increased from 9 in 1994 to 347 in 2019, representing 3.2% of all family physicians in the province in 2019. Prior to the Chaoulli ruling, the number of family physicians who had opted out increased by about 2.2 (95% confidence interval [CI] 0.5 to 4.0) physicians per year. Immediately following the ruling, we found no statistically significant change in the number of physicians who opted out (estimate –12.5, 95% CI –27.1 to 2.1). However, after 2005 we observed a large and sustained increase, with 18.9 additional physicians opting out each year (95% CI 16.5 to 21.3). In contrast, we found no statistically significant change in opt-outs by family physicians after the clampdown on accessory fees in either the immediate or long term (level estimate 4.9, 95% CI –18.8 to 28.7; trend estimate 2.5, 95% CI –8.2 to 13.2). The increase we observed suggests that by 2019 there were 284 more family physicians who had opted out than would have been expected if pre-Chaoulli trends had continued. The percentage of family physicians who opted out showed a similar response (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201216/tab-related-content).

Specialist physicians

We found that the number of specialist physicians who opted out in 1994 was 23, which rose to 150 in 2019 (Figure 2). The percentage who opted out was lower than for family physicians (1.4% in 2019). In 2005, after the Chaoulli ruling, there was an increase in the level of opted-out specialist physicians of 9.3 (95% CI 1.6 to 17.1) physicians. We observed a larger rise in the number of specialist physicians who opted out after the 2017 clampdown on accessory fees: 52.0 (95% CI 37.8 to 66.2) physicians. However, we found no statistically significant change in the trend for either policy intervention (ruling trend estimate 0.08, 95% CI –1.12 to 1.29; clampdown trend estimate 2.10, 95% CI –4.2 to 8.4). Taken as a whole, our model suggested an additional 69 specialists opted out by 2019 than would have been expected based on preclampdown trends. As with family physicians, our sensitivity analysis of the proportions showed substantively similar results (Appendix 1).

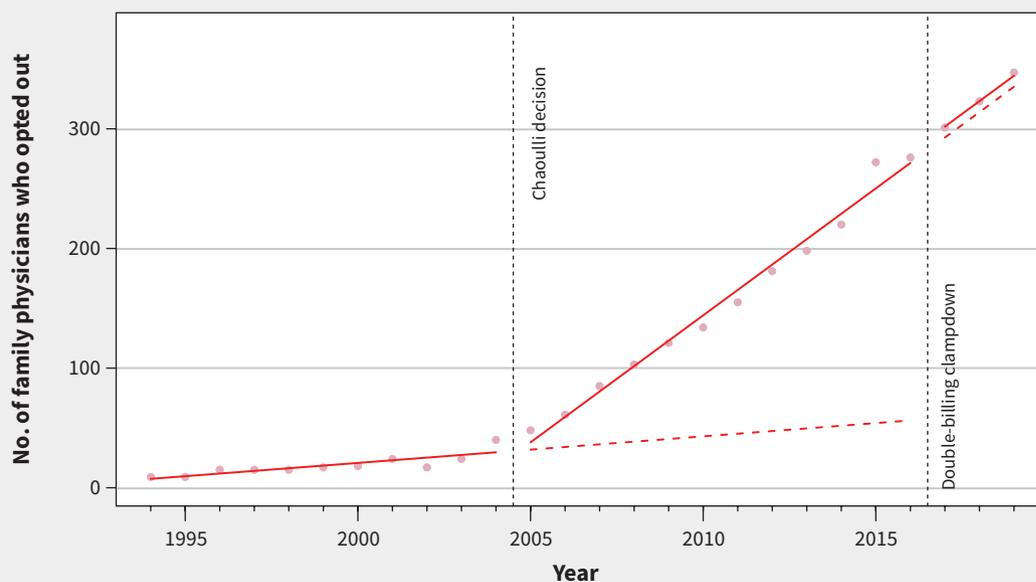


Figure 1: Number of family physicians who opted out of the public medical coverage program in Quebec between 1995 and 2019. Broken vertical lines show dates when the *Chaoulli v. Quebec* decision was made by the Supreme Court of Canada and when the clampdown on double billing began in Quebec. Fitted lines show the results from our interrupted time-series analysis, and broken red lines show the counterfactual projections absent any changes.

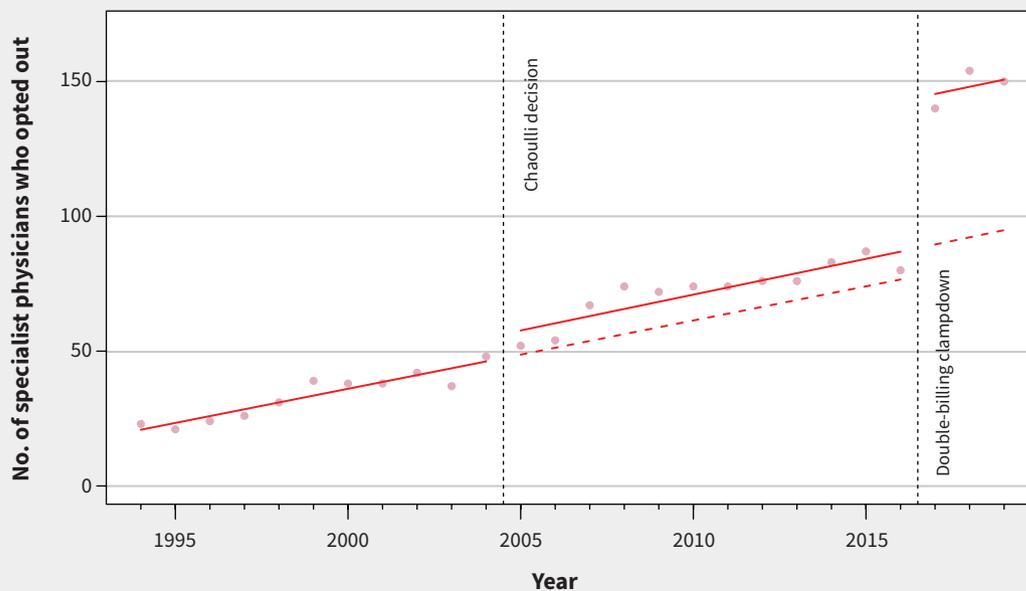


Figure 2: Number of specialist physicians who opted out of the public medical coverage program in Quebec between 1995 and 2019. Broken vertical lines show dates when the *Chaoulli v. Quebec* decision was made by the Supreme Court of Canada and when the clampdown on double billing began in Quebec. Fitted lines show the results from our interrupted time-series analysis, and broken red lines show the counterfactual projections absent any changes.

Interpretation

We found that 2 policy events, the 2005 *Chaoulli v. Quebec* ruling and a 2017 legal clampdown on double billing by physicians in Quebec, were associated with an increased trend toward opting out by family physicians and specialists, respectively, in the province. Following the *Chaoulli v. Quebec* ruling, private family practice appeared to grow, whereas its effect on specialist private practice was insubstantial. Because the ruling itself had very little, if any, impact on the practice of family medicine, our findings are consistent with the hypothesis that shifts in social views prompted by judicial and policy debates can affect physicians' decisions to opt out. The 2017 clampdown on double billing was associated with a rise in specialist physicians deciding to opt out, with little effect on family physicians. Because double billing was likely an integral part of the business model for some specialist clinics, it would have made more financial sense to opt out than to continue to work within the public system after the clampdown on double billing.

Our findings suggest that important policy events are associated with physicians' choices about opting out. The observed trends in Quebec might have policy implications for governments throughout Canada depending on the aftermath and likely appeal in the *Cambie v. British Columbia* case. One component of this challenge is specifically targeting British Columbia's restriction on dual practice. Lessons learned in Quebec can help regulators understand that policy responses can affect practice decisions made by each physician. Furthermore, our finding that although the proportion of physicians choosing to opt out of working in the public sector is small, it is rapidly increasing in Quebec. Most provinces do not mandate public release of these data, which prevents the analysis of trends in other jurisdictions, although anecdote suggests there could be a substantial number of physicians who have opted out in British Columbia.

Limitations

We observed the effects of uncontrolled policy interventions in 1 province. There are limitations associated with such a design. However, we are unaware of any policy or event that occurred in either 2005 or 2017 that would explain the observed shift in opting out among physicians in Quebec. We are also unaware of another province that publishes comparable data on opting out that could have been used as a control. Better data collection across Canada would help in this regard, particularly as other provinces have different rules in place. In addition, the short period between our second event of interest and most recent data limited our ability to detect changes in the slope and level in the 2017–2019 period. Specifically, it may not be long enough to detect any changes for family physicians. The exact number of physicians who have opted out at any given time during a given year could be slightly different from the numbers we used because Quebec requires only 1 month of notice to opt back in. Physicians may strategically time these shifts to allow work in both the public and private sectors. Finally, data availability limited our ability to analyze whether physician or practice characteristics were associated with the decision to opt out.

Conclusion

Our analysis showed that the number of physicians in Quebec who opted out is low but has increased steadily over the last 25 years. Our results support the idea that the societal debates related to the *Chaoulli v. Quebec* ruling, as well as the policy interventions to curb illegal double billing, were associated with increased rates of opting out. Increasing numbers of physicians opting out of work in the public system might threaten the capacity of provinces to deliver timely services and uphold the principles of the *Canada Health Act*. Provinces should not assume that working within the public health sector is inherently attractive to physicians and should note that policy interventions are important inputs into decision-making by physicians. Other provinces and territories should monitor and disclose similar data for comparison.

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