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Delisting Medical Imaging in Private Settings from Public Coverage in Québec

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A Provincial/Territorial Health Reform Analysis

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Abstract

On December 19, 1981, the Québec government passed a bill allowing notably for the determination of public coverage of services based on location of delivery, opening the door to subsequent delisting of medical imaging (mammography, ultrasonography, computerized axial tomography scans and magnetic resonance imaging) when performed out of the hospital. Rationing and increased governmental regulatory powers were the explicit aims of this reform, with cost-efficiency an implicit aim. This reform occurred in the national context of decreased federal transfers for health, a severe recession, and on the provincial front, physicians in Québec had been without a contract since November 1979. The reform was achieved with regulatory instruments, with full implementation (delisting of public coverage of mammograms, ultrasonography, and thermography when outside of hospital) a year later. While the reform was never formally evaluated, it likely achieved its aim of cost-containment, but at the price of access in the public system, and at the risk of threats to horizontal and vertical equity.

Le 19 décembre 1981, le gouvernement du Québec a adopté une loi permettant au gouvernement de prescrire par décret « les cas, conditions ou circonstances » selon lesquels des services considérés par ailleurs comme médicalement requis ne seraient pas publiquement assurés. De fait, cette clause a ouvert la porte à la désassurance publique ultérieure de l'imagerie médicale (mammographie, échographie, informatisés tomographies axiales et l'imagerie par résonance magnétique) lorsqu'elle est effectuée hors de l'hôpital. Les objectifs explicites de cette réforme incluaient la rationalisation des services de santé et l'augmentation des pouvoirs de réglementation gouvernementaux. Cette réforme s'est produite dans le contexte national de la diminution des transferts fédéraux pour la santé, ainsi que d'une grave récession; au niveau provincial, les médecins du Québec étaient sans contrat de travail depuis novembre 1979. La réforme fut réalisée grâce à des instruments politiques réglementaires, avec la mise en œuvre complète (retrait de la couverture publique de la mammographie, l'échographie, et la thermographie quand à l'extérieur de l'hôpital) effectuée un an plus tard. Bien que la réforme n'ait jamais été évaluée explicitement, il est probable qu'elle ait atteint son objectif de maîtrise des coûts. Cependant, les effets pervers de la réforme pourraient inclure notamment l'exacerbation de temps d'attentes dans le système public, ainsi que des menaces à l'équité horizontale et verticale.

1 DESCRIPTION OF THE HEALTH POLICY REFORM

On 19 December 1981, the Québec government passed Bill 27, *An Act to amend various legislation in the field of health and social services*. Among a number of other amendments, this bill notably increased the power of government to publicly delist certain services on the basis of location of practice (in hospital, or later in an "approved facility"). This was achieved by amending Section 69 of the Act (pertaining to power of government to modify the Act by way of regulations) by inserting subparagraph b.1, which allows the government to "prescribe the cases, conditions or circumstances in which the services contemplated in Section 3 [of the *Health Insurance Act*, RLRQ c A-29; chiefly '(a) all services rendered by physicians that are medically required;'] are not considered insured services for all insured persons or those insured persons it indicates." Prior to that amendment, the government could only determine by way of decree *which* services could be insured, and *how* often they could be delivered (as per subparagraph "(b) determine among the services contemplated in section 3 those which are not to be considered insured services, and how often some of those contemplated in subparagraph c of the first paragraph or in the second paragraph of section 3 may be rendered in order to remain insured services").

This reform greatly facilitated the legislative process to determine the public insurability of services delivered out of hospital, as changes to regulations by way of decrees are considered a quasi-unilateral administrative action by government and are not subject to public debate in the Québec National Assembly (Lauzière 2012). The reform was implemented a year later in December 1982 with a decree modifying the *Regulation respecting the application of the Health Insurance Act* (RLRQ, c A-29, r 5) delisting public coverage of mammography, ultrasonography and thermography when performed out of hospital. This legal provision was later used to delist CAT scans (in 1988) and MRIs (in 1995) from public coverage when delivered outside of a hospital.

2 GOALS OF THE REFORM

2.1 Stated

The explanatory notes in the preamble to the Act state notably that: "It enables the Minister to rationalize the provision of health services and social services by health establishments. The bill provides for a rearrangement of the regulatory powers of the Government and concordance adjustments. (Gazette Officielle du Québec 1982)."

2.2 Implicit

'Rationalize' evokes a rational restructuration of practices or organization to achieve greater efficiency. This stated goal suggests that cost-containment of governmental spending on health was an implicit aim of the reform. Limiting the public coverage of medical imaging

to services delivered in hospital facilities constitutes a passive form of cost-containment, and insulates the government from increases in costs that could stem from the development of this market in the private sector. Furthermore, regarding the specific case of medical imaging, there may have been concerns with the cost-benefit ratio of these new technologies, though these may have been most salient with the later changes to the regulation concerning CAT scans and MRI (MQRP 2012).

3 FACTORS THAT INFLUENCED HOW AND WHY

3.1 The issue came onto the government's agenda

In 1977, the Canada Assistance Plan (CAP), a federal-provincial cost-sharing arrangement for social assistance programs, was replaced by the Established Programs Financing (EPF). The EPF block grants were no longer tied to actual costs and effectively led to a decrease in federal funding (Evans 2000). For instance, in 1982-83, federal transfers to provinces decreased by 14.4% from the previous financial exercise (Rusk 1983). These cuts occurred in the midst of a severe recession that lasted from July 1981 to October 1982, characterized by double-digit inflation and unemployment rates (Walkom 1982). Furthermore, physicians in Québec had been without a contract since November 1979 (CMAJ 1982). The first version of the proposed legislation would have allowed the government to settle key contract negotiating issues by way of decree (Malarek 1981).

3.2 The final decision was made

There was substantial resistance from the medical profession to the original proposition by the government to regulate their conditions of practice by way of decree (Malarek 1981), leading to the amendment of the bill (CMAJ 1982). In contrast, changes to insured benefits by way of decree appeared not to have been contentious with neither physicians nor the public and this component of the legislation passed without amendments. Furthermore, as it predates the *Canada Health Act* (1984), this reform did not generate a reaction from the federal government.

4 HOW THE REFORM WAS ACHIEVED

4.1 Policy instruments

Regulatory instruments. Modification of the *Health Insurance Act*, RLRQ c A-29, adoption of the *Regulation respecting the application of the Health Insurance Act* (RLRQ, c. A-29, r.5).

4.2 Implementation plan

Mammograms, thermography and ultrasonography were delisted from public coverage when performed out of hospital in 1982 by the same government. Later delisting occurred under different governments and cannot be attributed to the same implementation plan.

4.3 Communication plan

Difficult to assess. A thorough and systematic assessment would require primary research beyond the focus of this publication. This reform occurs in a 'hole' in electronic coverage of the Québec National Assembly electronic records (the period 1962-1989 is not currently covered) debates are only available on-site, in Québec City. As far as newspaper coverage is concerned, there is very little in the *Globe and Mail*, aside from the physician strike (and this is the only pan-Canadian newspaper with both a continuous existence and full electronic coverage since the late 19thcentury). Finally, in searching microfilms of *La Presse*, the main francophone newspaper, the only coverage pertained to the physician protests and strike.

5 HISTORY OF THE REFORM

- 1970: ➢*Health Insurance Act*, RLRQ c A-29
- 1977: ➢Canada Assistance Plan (CAP) leads to decreases in federal transfers for health.
- 1979: ➢Contract negotiations with physicians fail in Québec.
- 1981–1982: ➢National recession
- 1981: ➢Modification to the *Health Insurance Act*, RLRQ c A-29. ➢ *The Regulation respecting the application of the Health Insurance Act* (RLRQ, c. A-29, r.5) is adopted.
- 1982: ➢Decree modifying the *Regulation respecting the application of the Health Insurance Act* (RLRQ, c. A-29, r.5) to delist from public coverage mammograms, thermography and ultrasonography when performed out of hospital.
- 1984: ➢*Canada Health Act*
- 1988: ➢Computerized axial tomography (CAT) scans outside of hospitals are added by decree (D.1823-88) to the list of publicly uninsured services.
- 1995: ➢Magnetic resonance imaging (MRI) outside of hospitals is added by decree (D.386-95) to the list of publicly uninsured services.

6 EVALUATION

6.1 Process of evaluation, conducted/planned

None found.

6.2 Impact evaluation

None conducted.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT Analysis of the Reform

Strengths	Weaknesses
• Cost-containment of public expenses	• A consequence of this policy has been the development of a private provision and insurance duplicative market (see Opportunities), which in the absence of a centralized waiting list, allows for faster access on the basis of capacity to pay or supplementary private insurance status, thereby violating both horizontal and vertical equity.
Opportunities	**Threats**
• Allowed subsequent governments to exclude computerized axial tomography (CAT) scans and magnetic resonance imaging (MRI) from public coverage when performed outside of hospitals. • Publicly delisting services on the basis of location of delivery allowed for these services to be legally covered by supplementary private insurance (the Québec Health Insurance Act otherwise prohibits 'duplicative' private health insurance for services already covered by public insurance).	• The development of a parallel system of private provision (see Opportunities) may lead to competition between the public and private market for scarce human resources. • Exacerbation of limited access and delays in diagnosis in the public system because of insufficient infrastructure (due to limited public investments) and/or personnel (due to competition coming from the private sector) • Potential for conflicts of interest among the medical profession due to the opportunity of an additional revenue stream (while Québec legislation prohibits dual public-private practice, the delisting circumvents this legislation) (MQRP 2012)

Opportunities (cont'd)	Threats (Cont'd)
• With revenue streams ensured by private supplementary health insurance, out-of-pocket payments and third party payments (primarily workers' compensation board and the SAAQ, Québec's public automobile insurance plan), Québec is currently the Canadian 'leader' in private provision of diagnostic imaging services, with 31 facilities currently in operation (CIHI 2012). • Increased access (primarily in terms of waiting times) for those accessing the private provision and insurance markets • Leveraging private infrastructure investments to improve access to the public sector by funding care regardless of setting (as was done with mammograms for the screening program in Québec; or in Ontario with the incorporation of private infrastructure to the public system	• Lack of quality control of tests in private facilities (MQRP 2012) • This reform predates the *Canada Health Act* (1984). However, its later extensions and similar legislation in Alberta, Nova Scotia and British Columbia have led to concerns being repeatedly voiced from the Federal Government from 2000 to 2005 that these private facilities contravene the *CHA*, at least in principle, if not in strict legal terms (Madore 2005). Since 2006, however, no further comments or action have been undertaken by the federal government regarding this issue (while the growth of facilities has increased, notably in BC, see CIHI 2012). This could lead to the erosion of the public perception and perhaps future confidence in the protections offered by the *CHA*.

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9 FOR MORE DETAIL

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