# The Unintended Experiment with Accessory Fees in Quebec

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# Contents

# Summary


- Overuse of low-value healthcare services, providing little or no benefit or even avoidable harm to patients, is a common problem in Canadian healthcare systems, and one that likely contributes to rising health care costs.
- Most countries with universal healthcare systems have introduced some form of cost-sharing initiatives to mitigate overuse, whether user fees, co-insurance, or deductibles, with exemptions for vulnerable populations. Among 29 OECD countries with universal health systems, only eight do not require patients to contribute partially to physician and hospital care costs at the point of service.
- Canada prohibits cost-sharing for medically required services under the Canada Health Act, and the federal government has mandatory penalties for offending provinces.
- Despite this, nearly half of Canadians (and 62% of Quebecers) support the idea of introducing user fees in our healthcare systems.
- Quebec previously allowed doctors to charge "accessory fees" to patients during medical consultations, when they considered that one of the services provided was not covered by the government's fee schedule, or simply insufficiently reimbursed. These fees were abolished in January 2017.
- While these fees were not intended to discourage unnecessary healthcare use, they clearly provided additional convenience to a large number of Quebecers, as evidenced by the reduction in clinic-provided services following their abolition.
- Implementing cost-sharing initiatives along the lines of what is done in the best-performing OECD countries could help reduce the demand for low-value care and free up resources that could be used to finance other more pressing healthcare services for Canadians.

# Introduction

Overuse of low-value healthcare services, providing little or no benefit or even avoidable harm to patients, is a common problem in Canadian healthcare systems (Bouck et al., 2019), and one that likely contributes to skyrocketing health care costs. At the same time, overutilization mobilizes resources, contributes to overloading the health system, and can make it more difficult to meet the more pressing needs of some patients on waiting lists for care. In a country that has fewer resources than most other universal systems (Moir and Barua, 2022), this is particularly problematic. Patients tend to overuse resources that are available instead of using resources appropriate to the level of care they require: four Canadians out of ten (40%) consider that they could have avoided a visit to the emergency department if timely care for their condition had been available (CIHI, 2020).

In order to reduce the use of this unnecessary care and improve the allocation of resources, should patients be required to pay user fees when receiving care covered by their universally accessible health insurance?

Whether deductible, co-insurance, or co-payment, the answer is *yes* in the vast majority of developed countries with universal healthcare systems. This includes Australia, Belgium, France, the Netherlands, New Zealand, Norway, Sweden, and Switzerland—all countries whose healthcare systems are considered among the best in the world, and where access to care is generally faster than here (Barua and Moir, 2022).

By comparison, in Canada, the very idea of introducing user charges for publicly-covered health-care services is anathema to many commentators and pundits, and disallowed for physician and hospital care under the Canada Health Act [CHA]. Indeed, the CHA prohibits cost sharing for insured physician and hospital services, including both user charges and extra billing, and the federal government has mandatory penalties for offending provinces. Specifically, sections 18-21 of the CHA require non-discretionary reductions in the federal transfer to the province to the tune of reported extra-billing and user-fees charged. In addition, the federal government of the day can withdraw the entire money transfer under the criterion of 'Accessibility' if it deems the violation to be of sufficient gravity (defined at the discretion of the federal government) (Tiedemann, 2019).

Yet the population is more divided on the subject. A recent poll showed that almost half of Canadians (48%) agree with the idea of introducing user fees in our health-care systems (Simpsons, 2023). In Quebec, support for this proposal climbs to 62%.

It has to be said, however, that Quebecers are more accustomed than Canadians in other provinces to paying a fee when they receive care, even when this is covered by the government (RAMQ—the public health insurer). Even though the Quebec health-care system is similar to that of other provinces—and that there is first-dollar coverage for physician and hospital services deemed medically required—the payment of "accessory fees" (*frais accessoires*) was long tolerated in Quebec (until they were almost completely abolished in January 2017).

These fees were not co-payments or co-insurance similar as those observed in several European countries. Rather, they were lump sum charges billed by doctors directly to patients during medical consultations, when they considered that one of the services provided was not covered by the government's fee schedule, or simply insufficiently reimbursed—i.e., extra-billing.

In recent years, Quebec and the federal government have clashed over the issue of accessory fees. Although they still exist, these fees are now circumscribed to a few minor services deemed not medically required. However, the final chapter on this issue has not yet been written, as two class action suits are currently before the courts (Fleury, 2022).

The purpose of this essay is to trace the evolution of accessory fees in Quebec's health-care system, examine whether they could be considered as a mechanism for regulating the demand for care and, ultimately, identify a number of lessons to be drawn from the Quebec experience for the development of better public healthcare policies.

## The Rationale Behind User Fees in Healthcare

The economic case for pooling the risks and costs of illness is well established. It is also the basis for the universal health insurance schemes that exist in almost all developed countries, the US being a rare exception.

On the other hand, these healthcare systems are subject to well-documented inefficiencies, including the risk of uncontrolled demand for healthcare services by patients who do not have to pay anything to have access to them. As economist and Nobel laureate, Kenneth J. Arrow, acknowledged in the early 1960s, "It is frequently observed that widespread medical insurance increases the demand for medical care" (Arrow, 1963: 961). In other words, in a first-dollar insurance coverage where access to care is free at the point of service, "the cost of [any] individual's excess usage is spread over all other purchasers of that insurance, [and no] individual is prompted to restrain his usage of care" leading to over-consumption of care (Pauly, 1968: 535). This over-consumption could in turn result in higher public spending, more difficult access to care, or both.

To avoid such problems, most countries with universal healthcare systems have opted to introduce some form of cost-sharing at the point of care delivery, in addition to costs borne indirectly via taxes or insurance premium payments, depending on the type of system. These cost-sharing mecanisms by patients generally fall into three categories. Deductibles are an amount up to which individuals are exposed to the full cost of care, after which the insurance applies and covers the expenses. Co-insurance payments are a percentage or fraction of the cost of each unit of care that is to be borne by the individual. Co-payments are fixed amounts paid by the patient for each unit of treatment. Vulnerable patients (children, the elderly, or the disadvantaged) are generally exempt from co-insurance or co-payments. Other patients are often subject to an annual cap (Barua and Moir, 2022).

As shown in Table 1, out of 29 OECD countries with universal health systems, only eight do not ask patients to partially contribute to the costs of physician and hospital care at the point of service, as of 2023. All others require some form of cost-sharing, whether user fees, co-insurance, or deductibles (Table 1).

## Table 1: Cost-sharing for core medical services in Canada and 28 other OECD countries, 2023

| Reference Area | Cost-sharing: Acute Inpatient Care | Cost-sharing: Outpatient primary care physician contacts | Cost-sharing: Outpatient specialist contacts |
|---|---|---|---|
| **Australia** | Free at the point of care for patients treated as public patients in public hospitals. Patients treated as private patients in public or private hospitals have to pay a share of the cost—often paid by their private health insurance (with some services being partly funded via the Medicare system). | Free at the point of care when doctors accept direct payments from Medicare (89% of GP services in 2021-22). Otherwise, patients may be exposed to costs. | Outpatient specialist contacts are fully covered when provided by the public hospital system, and covered generally with a co-payment when provided outside hospitals and financed by Medicare. |
| **Austria** | Co-payment of approx. €13-27 per day (with regional variations and variations according to the insurance status). In some regions family members of the insured person ("Mitversicherte") have to pay a higher co-payment (up to €27), up to 28 days a year. | For most people free of charge for services included in the benefit basket of the social insurance (by using the e-card and paying the e-card service fee once a year). Certain professional groups (e.g. civil servants, self-employed, railway workers) have excess co-payment (10-20%) instead of the e-card service fee. | For most people: free of charge for services included in the benefit basket of the social insurance (by using the e-card and paying the e-card service fee once a year). Certain professional groups (e.g. civil servants, self-employed, railway workers) have excess co-payment (10-20%) instead of the e-card service fee. |
| **Belgium** | Co-payment per day, plus the costs of some non-reimbursable medical products or pharmaceuticals. | Co-payment of €6.50 (US$7.48) or €4.00 (US$4.60) with GMD. reduced to €1.50 (US$1.73) or €1.00 (US$1.15) for patients with preferential reimbursement. Patients pay the full price and are reimbursed afterwards. | Co-payments between €2.50 (US$2.88) and €24.25 (US$27.94) depending on service type and patient status (GMD/preferential reimbursement). Patients pay the full price and are reimbursed afterwards. |
| **Canada** | Free at point of care. | Free at the point of care. | Free at the point of care. |
| **Czechia** | Free at the point of care. | Free at the point of care. Some informal co-payments for gynecology. | Free at the point of care. Some informal co-payments for some specific types of specialists. |
| **Estonia** | Co-payment of €2.5 per day, up to 10 days per episode. Co-payments charged for above-standard accommodation. | Free at the point of care for consultation. Co-payment of €5.00 for home visits. | Co-payment of €5.00 for visits to specialists contracted with the health insurance fund, after a GP referral. Visits without referral are not reimbursed except some specialities as dermatovenerology, psychiatry, ophthalmology, gynaecology. Specialists not contracted with health insurance determine their fees. |
| **Finland** | Co-payment of €41.80 per day in somatic care; €22.80 per day in psychiatric care, up to the annual cap. | Co-payment of €20.90 per visit up to the annual co-payment cap. A single primary care center cannot collect this co-payment more than three times a year. Alternatively an annual co-payment of €41.80. | Co-payment of €41.80 per visit to an outpatient specialist contact in a hospital. For same-day (outpatient) surgery there is a co-payment up to a maximum of €136.90 per procedure. The annual municipal healthcare co-payment cap applies. |

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## Table 1: Cost-sharing for core medical services in Canada and 28 other OECD countries, 2023

| Reference Area | Cost-sharing: Acute Inpatient Care | Cost-sharing: Outpatient primary care physician contacts | Cost-sharing: Outpatient specialist contacts |
|---|---|---|---|
| **France** | The maximum of 20% cost-sharing. not applicable for diagnostic or surgical procedures whose cost exceeds a certain threshold (€120). Co-payment of €18/day (US$20.85) for acute inpatient care and €13.50/day (US$15.64) in psychiatric facilities. | Co-payment of €1 (US$1.16) per consultation and 30% cost-sharing for patients registered with a treating physician. 70% in other cases. Patients may be exposed to extra-billing, without any reimbursement by the basic coverage. Patients pay the full price and are reimbursed afterwards. | Co-payment of €1 (US$1.16) fee per consultation, plus cost-sharing of 30% with a GP referral or directly for some specialists (gynecologist, ophthalmologist, psychiatrist and neuropsychiatrist). 70% otherwise. Patients may be exposed to extra-billing (allowed for 45% of specialists), without any reimbursement by the basic coverage. Patients pay the full price and are reimbursed afterwards. |
| **Germany** | Co-payment of €10/day, limited to 28 days/year. | Free at the point of care for patients with statutory health insurance and patient with selected PHI contracts. | Free at the point of care for patients with statutory health insurance and patients with selected PHI contracts. |
| **Greece** | Typically covered without cost sharing for patients treated in public hospitals. Cost-sharing (of about 30% of the relevant DRG tariff) and potential extra-billing exist for patients treated in private hospitals. | Free at the point of care for public providers. | Free at the point of care for public providers. |
| **Hungary** | No co-payment. | No co-payment. | No co-payment. |
| **Iceland** | Free at the point of care. | Co-payment of ISK500 (US$ 3.6) per visit to primary care health center, for visits after usual opening hours ISK3100 (US$27). Free at point of care for children up to 18 years and for seniors and disabled persons. | 90% of agreed or determined total price for arrival up to a monthly ceiling of ISK31.150 (US$211). Seniors and disabled persons pay 2/3 of agreed or determined total price with a ceiling of ISK20.767 (US$141). Free at point of care for children 2-18 years old if they have a referral but if not 2/3 of agreed or determined total price with a ceiling of ISK20.767. Free at point of care for children 0-2 years old and children with care assessments. |
| **Ireland** | Free at the point of care for medical card holders and certain other categories. Co-payment of €75 (US$89.71) per day for public patients, capped at €750 (US$897.10) in any period of 12 consecutive months. | Free at the point of care for approximately 40% of the population; while the remainder of the population pays the full cost of a GP consultation as a private arrangement with their GP. | Patients attending an emergency department are subject to a €100 (US$119.76) charge subject to a number of exemptions. Attendances at planned outpatient clinics in public hospitals are free at the point of care for public patients. |
| **Israel** | Free at the point of care. | Free at the point of care. | Co-payment of approximately NIS 25 (US$6.38) once every quarter. |
| **Japan** | A fixed rate of 30% of costs. | A fixed rate of 30% of costs. | A fixed rate of 30% of costs. |

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## Table 1: Cost-sharing for core medical services in Canada and 28 other OECD countries, 2023

| Reference Area | Cost-sharing: Acute Inpatient Care | Cost-sharing: Outpatient primary care physician contacts | Cost-sharing: Outpatient specialist contacts |
|---|---|---|---|
| **Korea** | 20% co-insurance for inpatient care. | 30% co-insurance for people under 65. For those 65 or older, it's ₩1,500 if total cost is ₩15,000 or less; above ₩15,000 won, it's 30% cost-sharing. | Consultation fee and cost-sharing of between 30% and 60% depending on provider type (hospital or clinic), region (urban or rural) and age (general population or seniors). |
| **Latvia** | Co-payment of €5-10 per day from the second day. | Co-payment of €2 per visit (for a person over the age of 65 €1). | Co-payment of €4 per visit if referred by a primary care doctor. |
| **Lithuania** | No co-payment | No co-payment | No co-payment |
| **Luxembourg** | Co-payment of €24.88 per day for the first 30 days of hospitalization per year, from the 13 day onwards for women having delivered. No Co-payment for children aged under 18. A fee of €12.44 applies for day-care hospitalisation. | Co-insurance of 20% for physician visit. Co-insurance of 12% for medical acts and services. No cost-sharing for children aged less then 18 years. | Co-insurance of 12% for visits to specialists. |
| **Netherlands** | Deductible | No cost-sharing for GP care and district nursing care (home care). To visit a GP is completely free (no deductible system). In case the GP performs additional care (for example laboratory tests) the deductible system applies. | Deductible |
| **Norway** | Free at the point of care. | Co-payment of kr 160 (US$15.4) per visit up to an annual ceiling for all user charges of kr 3040 (US$292) in 2023. | Co-payment of kr 375 (US$36.1) up to a annual ceiling for all user charges of kr 3040 (US$292) in 2023 |
| **Poland** | Free at the point of care. | Free at the point of care. | Free at the point of care. |
| **Portugal** | Free at the point of care. | Free at the point of care. | Free at the point of care. |
| **Slovak Republic** | Free at the point of care. | Free at the point of care. | Free at the point of care. |
| **Slovenia** | Co-payment or co-insurance from 10% to 30% of costs. Free at the point of care for certain high risk groups and patients with certain diseases defined by the health care act. | 20% cost-sharing. Free at the point of care for certain high risk groups and patients with certain diseases defined by the health care act. | From 10% to 30% cost-sharing. Free at the point of care for certain high risk groups and patients with certain diseases defined by the health care act. |
| **Spain** | Free at the point of care. | Free at the point of care | Free at the point of care |
| **Sweden** | Co-payment of kr 120 (US$12) per day. In some regions limited to certain amount of days. | May vary between regions. but co-payment of kr 100-300 (US$10-30) in most regions, up to a cap of kr 1300 (US$130)/12 months. | May vary between regions. but co-payment of kr 100-400 (US$10-40) in most regions, up to a cap of kr 1300 (US$130)/12 months. |

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**Table 1: Cost-sharing for core medical services in Canada and 28 other OECD countries, 2023**

| Reference Area | Cost-sharing: Acute Inpatient Care | Cost-sharing: Outpatient primary care physician contacts | Cost-sharing: Outpatient specialist contacts |
|---|---|---|---|
| **Switzerland** | Co-insurance of 10% after deductible, subject to annual cap. | 10% cost-sharing after general deductible, with an annual cap. | 10% cost-sharing after general deductible, with an annual cap. |
| **United Kingdom** | Free at the point of care. | Free at point of care. | Free at point of care. |

Source: OECD Data Observer.

Research has shown that user charges tend to reduce the use of medical services and medications, and may lead to higher preventive behavior and some efficiency gains (Rostamkalaee, Koohi, Jafari, and Gorji, 2022). But is there a link between the presence of a cost-sharing mechanism and waiting times, and therefore timely access to care? While this does not seem to be the case for primary care, the presence of cost-sharing for specialist consultations tends to be associated with lower waiting times, although the link is weak. On the other hand, the correlation between the presence of a cost-sharing mechanism and better performance for access times to elective surgery is both strong and significant, suggesting a positive impact of cost-sharing on access to such care (Barua and Moir, 2022).

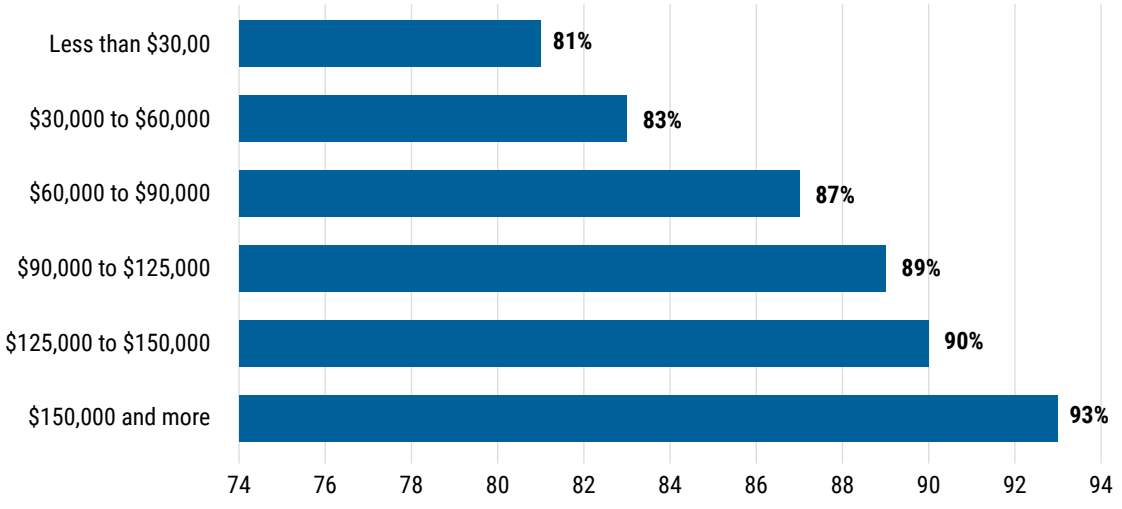
The introduction of a user contribution raises the issue of barriers to access to care that could result from it, and above all, the effect on patients' health. The literature is equivocal on this subject. Some studies, including the famous RAND health insurance experiment, conclude that the reduction in consultation visits resulting from a cost-sharing mechanism has a negligible impact on patient health, both clinically and socially (Aron-Dine, Einav, and Finkelstein, 2013). Others indicate that it could be detrimental to certain groups of populations, although the evidence is once again mixed (Chandra, Gruber, and McKnight, 2014; Hitoshi, 2014). To address this risk, most cost-sharing countries have implemented annual payment limits and exempted at-risk populations. This is as true for countries where universal coverage is provided by a mix of public and private insurers (France, Netherlands, Switzerland) as it is for those where the government acts as the universal health care insurer (Norway, New Zealand, Sweden) (Barua and Moir, 2022).

Again, Canada is one of the exceptions to the general rule among OECD countries of making patients contribute at the point of access for physician and hospital services (such fees are common for complementary services, not deemed medically required as defined by the Canada Health Act, like prescription drugs, dental care, and long-term care). Canada is also consistently at the tail end of developed countries in terms of delivering timely access to care, including waiting to see a specialist or undergo elective surgery (CIHI 2016, CIHI

2020). It also ranks very low compared to other developed countries in terms of equitable access to care, as demonstrated by a number of studies (Dahrouge, Hogg, Muggah, Schrecker, 2018; Devaux, 2015). Indeed, "despite Medicare virtually eliminating financial barriers to accessing physician services in Canada, individuals with higher income are more likely to access a physician, particularly a specialist, and are less likely to report unmet needs for care than those with lower income" (Marchildon and Allin, 2023: 59) (see figure 1). This inequity in access is illustrated in a recent analysis of the Commonwealth Fund longitudinal data that found that lower income Canadians systematically report longer wait times to see their primary care provider, compared to those with higher income (Martin, Siciliani, and Smith, 2020). Hence, rationing by waiting lists does not guarantee equality of access in the publicly funded healthcare systems in Canada.

In most OECD countries with universal healthcare systems, the presence of cost-sharing is the norm, and ultimately seems to have positive effects for patients in gaining access to certain services. Could Quebec's experience with accessory fees serve as inspiration for the implementation of cost-sharing mechanisms in the rest of the country? A brief historical review is in order to understand the context in which these fees were introduced, and how they have evolved over time.

**Figure 1: Proportion of Canadians who reported that they have a regular doctor or place they usually go to for medical care, by household income level, 2023**




Source: Canadian Institute for Health Information [CIHI] (2024; March 21).
Primary health care: International survey shows Canada lags behind peer countries in access to primary health care.

## Debates Surrounding the Legality of "Accessory Fees"

Before the regulatory change abolishing them came into force in January 2017 (MSSS, 2017), the term "accessory fees" did not exist anywhere in Quebec laws or regulations. Yet, these fees had been present since the very creation of the Quebec universal health insurance plan, in 1970, under agreements with physicians' associations. At the time, these agreements allowed additional charges to be billed to patients who were not treated in hospitals, for odd-sized bandages or the provision of a birth-control device, over and above the amounts reimbursed for an office visit by the Régie de l'assurance maladie du Québec (RAMQ)—the province's public insurer. Further exceptions were added in the late 1980s to allow charges for drugs and anesthetics. Again, these could not be applied to fees that were covered during treatment in hospital, but could be charged for services in a medical office or clinic (Protecteur du citoyen, 2015).

The practice of charging accessory fees then spread (see Table 2 for a list of key dates in the saga of accessory fees in Quebec). In 2007, a report commissioned by the Quebec Ministry of Health estimated that accessory fees in medical clinics had grown significantly due to the marketing of new devices and medicines, the resulting rise in operating costs, and the relocation of certain examinations and procedures outside hospital settings (Protecteur du citoyen, 2015). In 2008, the task force on the funding of Quebec's healthcare system, chaired by former Health Minister Claude Castonguay, recommended eliminating accessory fees at the point of service and re-evaluating physician fee schedules, identifying potential expense reductions. More importantly, it also recommended the implementation of a deductible, the amount of which would have varied according to the number of medical visits made during the previous year, for families with revenues above a certain level. Among its stated goals were to "orient the utilization of medical services in the direction considered the most appropriate," to "make citizens aware of the cost of the health care system," and to "give them an incentive to stay healthy" (Castonguay, Marcotte, and Venne, 2008: 225).

In 2011, the Collège des médecins du Québec published a document on billing fees to insured patients in which it stated that it no longer had control over the situation (Auditor General, 2016). Then in 2012, the Fédération des médecins omnipraticiens du Québec (FMOQ), the family physicians' union, nevertheless presented ancillary fees as "part of an insured service" or "intimately associated" with it. According to this definition,

a doctor could not claim compensation for these expenses (Desrosiers, 2012). Examples given were the maintenance of a medical record or supplies needed to provide a service, such as examination gloves, sutures, or needles to repair a wound.

### Table 2: Important dates related to the issue of accessory fees in Quebec

| | |
|---|---|
| **1970** | Creation of the Quebec universal healthcare system. Agreements between the government and the physicians' associations allow additional charges to be billed to patients outside hospitals, for odd-sized bandages or the provision of a birth-control device. |
| **1987** | Various additional accessory fees may be billed to patients, particularly with regard to medications and anesthetics used in medical offices. |
| **1997** | Creation of the Public Prescription Drug Insurance Plan, a universal and mixed program that incorporates user fees (co-insurance and deductible) without contravening the Canada Health Act. |
| **2000** | The FMSQ (physicians' union) is demanding before the Clair Commission an expansion of the range of accessory fees that doctors practicing in medical offices can charge their patients. |
| **2005** | The Chaoulli judgment is rendered which states that the ban on purchasing private insurance for medically required care contravenes article 7 of the Quebec Charter of Human Rights and Freedoms. |
| **2007** | The Chicoine report, commissioned by the Quebec Ministry of Health, is released. It argued that accessory fees in medical clinics had grown significantly due to the marketing of new devices and medicines, the resulting rise in operating costs, and the relocation of certain examinations and procedures outside hospital settings. |
| **2008** | The task force on the funding of Quebec's healthcare system, chaired by former Health Minister Claude Castonguay, recommended the elimination of accessory fees at the point of service and the implementation of a deductible. |
| **2010** | RAMQ reminds the province's medical associations that fees not explicitly provided for in agreements with the government are considered "illegal," in accordance with ***Loi sur l'assurance maladie***. |
| **2011** | Class action brought by a group of patients against the government of Quebec, due to accessory fees. A second will follow in 2014. |
| **2015** | Publication of a report by the Ombudsman which argues that some accessory fees charged to patients are "out of all proportion to their actual costs." |
| **2016** | The Auditor General publishes a report study in which it states that accessory fees charges in medical clinics are "ambiguous, confused and misunderstood" and that "the legal framework does not allow this billing to be adequately controlled." |
| **2016** | Letter sent to the Quebec Minister of Health by his federal counterpart, Jane Philpott, reminding him that incidental fees contravene the provisions of the Canada Health Act. |
| **2017** | Entry into force of the Regulation abolishing accessory costs related to the provision of insured services and governing transportation costs for biological samples (January). |

The FMOQ document also pointed out that the Health Insurance Act and the preamble to the physicians' billing manual allow certain expenses to be billed under agreements, such as drugs and anaesthetics, or the insertion of an intrauterine device (IUD). Even if these charges are "clearly ancillary to the service provided," the government and doctors' unions would have used an "economic rationale" to allow them to be billed, i.e., that the RAMQ's reimbursement to doctors did not cover the cost of the services. This unofficial definition of what constitutes an incidental expense could have led some to believe that they were still exceptional.

Yet a few years before, in 2010, RAMQ had reminded the province's medical associations that fees not explicitly provided for in agreements with the government were considered "illegal," in accordance with the Health Insurance Act (RAMQ). Between 2011 and 2013, moreover, RAMQ intervened several times with the Minister of Health and Social Services to propose legislative and regulatory changes (Vérificateur général, 2016).

Although the Canada Health Act prohibits extra-billing for insured services, it can be concluded that in Quebec the definition of accessory fees and whether they can be billed to patients was open to different interpretations, depending on the parties involved.

The public debate surrounding accessory fees—accompanied by the filing of two class action lawsuits in 2011 and 2014—set the stage for public interventions by two of the Quebec government's watchdogs, the Quebec Ombudsman in 2015 and the Auditor General in 2016. (In the first case, the government had to compensate the patients; in the second case, a partial settlement was reached, but the case is still pending.)

Both the Ombudsman and the Auditor General pointed out, as others have before them, that the issue of accessory fees is linked to rising clinic operating costs. They also reported that, in some cases, the fees billed to patients as compensation for some drugs administered are "out of all proportion to their actual costs" (Protecteur du citoyen, 2015), and that some doctors "interpret quite broadly the fees they may charge as an attempt to alleviate a problem in financing operating costs" (Vérificateur général, 2016). Examples found over the years include a charge of $40 for a 4 $cm^2$ plaster (Protecteur du citoyen, 2015), $30 for drops that cost only a few dollars (Krol, 2018), or charges of $125 to $200 for an IUD, compared with a purchase cost of $50. In the latter case, this was the range of charges suggested by the medical specialists' union (Fleury, 2022).

The Auditor General further concluded that billing in clinics was "ambiguous, confused and misunderstood" and that "the legal framework does not allow this billing to be adequately controlled." The RAMQ's billing manuals are highly complex—they include over 11,000 procedures—and patients cannot be expected to know what is billable and

what is not. He also pointed out that neither the Ministry of Health nor the RAMQ had an overall view of the fees billed in medical clinics, and that the Quebec government's $50 million estimate "is not based on any analysis." He also noted "differences of opinion" between RAMQ and the medical federations, which can "fuel confusion among the public and among physicians."

Some procedures reimbursed to doctors by the public plan were subsidized to account for clinic operating costs that doctors do not incur in hospital, while others were not. The payment made by the government to the doctor for a given procedure can therefore vary depending on where it is performed, and also on whether it is performed by a family doctor or a specialist. When the bonus for a procedure performed in a clinic was deemed insufficient, the patient could be billed for additional costs, in addition to the reimbursement received from the government.

Accessory fees for the same care could also vary greatly from one clinic to another, even in contexts where no competition existed between medical clinics (Labrie, 2015). For example, a patient will pay nothing for a breast biopsy carried out in hospital. In a clinic, the doctor was reimbursed 28% more for a specialist, or 48% more for a family doctor. The patient could also receive an additional bill of between $51 and $100, which varied from one clinic to another, according to information gathered by the Auditor General. In the case of a colonoscopy, there was no surcharge if the service was performed in a clinic, but doctors were billing the patient an additional $300 to $500 to compensate for equipment and operating costs, which he or she did not have to bear in hospital.

Consequently, a confrontation with Ottawa was inevitable. For the past 35 years, almost all health care payments withdrawn from the provinces by the federal government have been in retaliation for the payment of user fees by patients for insured services (Boychuk, 2008). The Auditor General's spring 2016 report was followed in September by a letter from the federal Minister of Health threatening to cut federal transfers if accessory fees were not abolished in Quebec to comply with the CHA (Shingler and Montpetit, 2016). At the time, the Quebec government was already working on an amendment to the Health Insurance Act to prohibit the billing of these fees, except in the specific case of transporting laboratory samples. The regulatory change came into effect in January 2017 (see Table 3 for the list of fees that can no longer be charged to patients and those that remain).[1]

Although the accessory fees were applied rather unpredictably and unevenly, their abolition was not without consequences. In the first few months following the announcement,

1 The Quebec government eventually recovered the amounts deducted by Ottawa in 2017 and 2019 for accessory fees billed to patients, after making the necessary changes.

several clinics offering endoscopy and colonoscopy services closed their doors, and some specialists decided to disaffiliate from Quebec's public system, saying they were unable to absorb the rising operating costs (Lacoursière, 2016; Gentile, 2017). Some services ceased to be offered in medical clinics or were significantly reduced, such as administrating vaccines or performing vasectomies (Daoust-Boisvert, 2017). The overall range of medical services that can be offered in clinics has been maintained, but the range of services actually provided by physicians—even with a billable supplement—has been reduced. For instance, the number of publicly-funded vasectomies performed in doctors' offices decreased by almost 40% between 2014 and 2018 (Archambault, 2018). According to the Ministry of Health (MSSS), the average waiting time for a hospital consultation in this category of care is 304 days in Quebec (Sabourin, 2023). These negative effects of the ban of accessory fees on the supply of certain medical services reported in the media have also been confirmed by academic research (Contandriopoulos and Law, 2021; Labrie, Benomar, Chênevert, Bouffard, and Groulx, 2023).

## Table 3: List of fees that can no longer be charged to patients and those that remain in the Quebec healthcare system, since the ban on accessory fees took effect in January 2017

| | Fees that can no longer be charged to patients since the abolition of accessory fees in January 2017 | Fees that may be charged to patients because they are not accessory fees or because they relate to health services not covered by the public insurance plan |
|---|---|---|
| **Samples and laboratory tests** | • Blood or biological tissue samples (secretions, urine, stool, etc.) taken in a participating doctor's office | • Blood or biological tissue samples (secretions, urine, stool, etc.) taken outside a participating doctors' office<br>• Laboratory analyses done by a professional not paid by the public insurer (RAMQ)<br>• Laboratory examinations carried out by a company located outside a participating physician's office<br>• Transport of biological samples (other than blood) taken in a participating doctor's office<br>• Transport of biological samples (with blood) taken in a participating doctor's office |
| **Procedures and interventions** | • Joint infiltration (e.g. cortisone)<br>• Intra-articular facet infiltration<br>• Surgeries covered by the public insurer (RAMQ)<br>• Vasectomy<br>• Skin procedures or surgeries with or without anesthetic (abscess, tumor, cyst, wound, superficial or deep fistula, sweat glands, with or without graft, wound debridement, repair of skin lacerations, etc.)<br>• Endoscopy (gastroscopy, uroscopy, rhinoscopy, laryngoscopy, arthroscopy, colonoscopy, bronchoscopy, etc.)<br>• Medications and anesthetic agents used in the provision of an insured medical/surgical service<br>• Liquid nitrogen for cauterization of various skin lesions: warts, nipples, keratosis, etc.<br>• Immobilization "taping," plaster, and splint<br>• Installation of an IUD (The patient obtains her IUD in a pharmacy except when related to an abortion procedure where it is then provided. Hormonal IUDs are insured by the Quebec Public Prescription Drug Insurance Plan.) | • Surgeries not deemed medically required and therefore not covered by the public insurance plan (e.g. cosmetic surgery) |
| **Physical examinations and tests** | • Simple examinations (strep test, urine [stick], blood sugar, etc.)<br>• Physical examination carried out by a participating doctor<br>• Allergens for sensitivity testing<br>• Allergen injection as a desensitization treatment (The patient obtains the allergen in pharmacy) | • Physical examination performed by a physician for employment purposes or insurance |

continued on next page

## Table 3: List of fees that can no longer be charged to patients and those that remain in the Quebec healthcare system, since the ban on accessory fees took effect in January 2017

| | Fees that can no longer be charged to patients since the abolition of accessory fees in January 2017 | Fees that may be charged to patients because they are not accessory fees or because they relate to health services not covered by the public insurance plan |
|---|---|---|
| **Vaccination** | • Vaccination for children<br>• Vaccination under the Quebec Immunization Program (e.g.: flu vaccines for people with certain chronic illnesses) | • Vaccines not covered by the Quebec Immunization Program (e.g.: shingles, flu vaccines for people who are not considered at risk). The patient must obtain them from a pharmacy.<br>• Traveler's visit and vaccinations |
| **Radiology** | • Simple x-ray (thorax, bones, spine, head, etc.) in the imaging laboratory medical<br>• Mammography<br>• Ultrasound performed by a radiologist<br>• Guidance ultrasound in the office (for puncture, search for liquid, or pre-abortion pill) | • Ultrasounds of all kinds carried out by a doctor certified in ultrasound, other than a radiologist<br>• Scan<br>• Magnetic resonance imaging (MRI) |
| **Optometry and ophthalmology** | • Eye drops of any kind (mydriatic, anesthetics, and others)<br>• Biometry of the eye, retinophotography, ultrasound of the eye, optical coherence tomography (OCT), eye biopsy, cataract extraction (conventional or laser) | • Retinal photo (Optomap)<br>• Corneal surgery to correct refractive problems (Laser) |
| **Dentistry** | • Maxillofacial surgery; morphology of the mandibles for maxillary surgery facial<br>• General anesthesia for children with major teething problems<br>• Anesthetic agents for insured customers, particularly children under 10 years old (e.g.: nitrous oxide) | The dental care program is a restricted program. The majority of dental care services received by the population are therefore not covered by the public insurance plan.<br><br>The regulations do not apply and accessory fees may then be charged. |
| **Pharmacy** | • Test carried out in pharmacy for measuring INR (anticoagulation therapy)<br>• Blood sample or other biological sample taken by the pharmacy nurse | • Placing medications in a pillbox at the patient's request when their condition does not correspond to the coverage criteria provided for in the agreement between the Minister and the Quebec Association of Proprietary Pharmacists (clinically not required). |
| **Administration** | • File opening in a participating doctors' office<br>• Copy of file, photocopy, copy of CD, transfer of file, fax for the purposes of providing an insured service<br>• Prescription of temporary absence from work during consultation for acute problem (e.g.: for feverish condition), unless it involves filling out a form for insurance<br>• Clinical services linked to insured medical services (teaching by the nurse, telephone support, results given by telephone, staff salary, dressing change, removal of stitches, rental of device or technical platform) in the office of participating doctors | • Insurance report (physical examination)<br>• Report for the Public Automobile Insurance Plan (SAAQ) for the driving license (physical examination)<br>• File copy, photocopy, CD copy, file transfer, fax related to an uninsured service<br>• Missed appointment (without cancellation within 24 hours) by the patient (permitted according to the criteria of the College of Physicians of Quebec) |

Source: MSSS (2017).

Nonetheless, apart from two class action suits that are still in progress—the first was settled, but a third class action was subsequently filed—the saga of ancessory fees seems to be over in Quebec.

In 2023, the federal government opened a new front, namely that of billing for medically necessary services even when they are not insured, such as in-clinic medical imaging or telemedicine. However, Quebec should be able to explicitly delist these services from the basket of publicly-covered health services, making them no longer 'medically necessary' by definition and thus avoiding a confrontation with the federal government under the definitions of the CHA (Clemens and Esmail, 2012; Emery and Kneebone, 2013).

# Discussion and Conclusion

The accessory fees that were charged to patients for several decades in Quebec did not fall into any categories of cost-sharing traditionally used by other OECD countries, as discussed above. They were not a deductible amount to be paid prior to the application of public insurance coverage, as they were billed beyond the coverage. Nor were they a percentage of coverage, since they were paid in addition. Nor can they be considered a co-payment, since their amount could vary for the same service offered under the same insurance. They were also not formally exempted for vulnerable patients, nor were they subject to any cap. The rationale behind co-insurance or co-payment is also to share the cost of care to encourage more informed decision making on the part of patients; accessory fees have often been billed in excess of these costs.

Unlike deductibles, co-insurance and co-payments, which are deliberate choices of public policy, the generalization of accessory fees—initially an exceptional measure—is rather an unforeseen consequence of decisions made during the implementation of Quebec's universal plan.

Have accessory fees nevertheless helped regulate or optimize demand for care in Quebec, or improved access to it, as economic theory and research suggest? To our knowledge, no study has attempted to answer this question directly. The use of accessory fees has nonetheless reduced financial pressures on the Quebec taxpayers. Insofar as certain physician operating costs borne by the physician when he or she rendered service in the clinic, particularly with regard to supplies and equipment, were covered at least in part directly by patients.

Given the current state of Quebec's healthcare system, the demographic changes underway, and the pressure this will add in the future, the need to reduce the provision of low-value care which provides little or no benefit or even avoidable harm to patients (and to limit spending increases as much as possible) is no less important today than it was when the universal health insurance plan was introduced over 50 years ago. The same is true for the healthcare systems of other provinces.

This is where the idea of a co-insurance or co-payment, with an annual ceiling and an exemption for vulnerable populations (along the lines of what is done in the best-performing universal plans), could provide a solution—serving both as a mechanism for regulating demand for low-value care, and enabling more care to be taxpayer financed in total. For

example, more non-emergency surgeries, which are subject to exceptionally lengthy waits in Canada, could be performed (Labrie, 2023a).

Although the idea of the patient paying part of the cost of medical and hospital care is controversial in Canada, the practice remains the norm in the country for the cost of outpatient prescription drugs, whether the patient is covered by private or public insurance plans. Vulnerable populations, however, are generally exempt, or are subject to more modest payments (Barua and Moir, 2022).

Perhaps the accessory fees in Quebec were not designed to discourage use of the healthcare system for unnecessary, low-value services. However, these fees clearly provided additional convenience to a large number of Quebecers, as evidenced by the reduction in clinic-provided services following their abolition. While they may not have been valuable in terms of informing demand, they certainly were valuable in terms of expanding access to services for patients in clinic. Moving patients with simpler health needs out of hospital into clinics is also valuable from a risk-containment perspective (Labrie, 2023b).

There should definitely be a rational discussion space for public policies like cost-sharing initiatives that align the right incentives to improve the performance of our public healthcare systems (Baicker and Levy, 2015). Beyond the resources that could be freed up to finance other more pressing health care services with such initiatives (Skinner, 2016), we could also expect gains in terms of improved access and welfare (Whatley, 2022). Unfortunately, the ability of provinces to implement cost-sharing initiatives in Canada is effectively prohibited by the Canada Health Act.

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