Physician Dual Practice in Israel and Canada

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Introduction

Universal health coverage (UHC), as defined by the policies put in place to ensure that all or almost all citizens have access to medically necessary health services, is the norm in most high-incomes developed countries (WHO 2010). It is a truism to say that every country has a UHC system that is unique to its history and political culture. This includes the regulatory regime put in place to protect the principle of access based on medical need rather than ability to pay (Gracía-Prado and González 2011). As a result of its perceived impact on access, the regulation of physician dual practice, or lack thereof, is a contested policy area in jurisdictions with UHC systems.

Physician dual practice in Israel and Canada are compared and contrasted. These countries have been selected in part because they lie at extreme ends of the spectrum in terms of the prevalence of dual practice at least among high-income nations. This comparative study is even more interesting from a policy perspective in that Israel's lack of regulation on dual practice contrasts sharply most high-income countries where dual practice is regulated in some form (Flood and Thomas 2017). It contrast most sharply with Canada's strict regulation of the practice through thirteen provincial and territorial single-payer programs in order to preserve the single-tier dimension of Canadian Medicare. The Israeli experience is particularly poignant for Canada because of current constitutional litigation, which may produce a radical relaxation of the rules regulating physician dual practice.

The typical definition of physician dual practice is when physicians work simultaneously in the public and private sectors (Eggleston and Bir 2006; Gracía-Prado and González 2007). However, in their respective literature reviews of dual practice, Gracía-Prado and González (2011) assumed that the public sector equates to physicians working directly for the government in a publicly owned clinic or hospital. This definition does not entirely fit Israel where the public sector includes non-governmental and non-profit health plans and hospitals. This narrow conception does not at all fit Canada where privately employed (but publicly funded) physicians can work in private or public facilities which are funded publicly to serve patients covered under Canada's provincial and territorial UHC single-payer systems.

To remedy this, we have redefined "public sector" to include publicly remunerated hospitals, facilities and physicians. This includes all physicians who receive almost all their remuneration for providing government financed or mandated UHC services. This definition is a better fit for those countries (e.g. Canada, Belgium, Australia, and New Zealand among others) in which UHC services, while paid for through largely public funds or subsidies, is delivered by private practice physicians received these public payments or subsidies. This more inclusive definition still fits Israel, Spain, Germany and other countries with distinct public and private service-funding streams.

The purpose of the comparison is based on what we think are some profound differences. In countries with UHC, physician dual practice may or not be common depending on the institutional and regulatory environment. When it exists, it may or may not pose serious challenges in the ability of the state to preserve equity of access again depending on the way in which UHC has been structured and regulated. In Israel, dual practice has been allowed for many years and until recently was limited in scope and hence innocuous. However, over the past decade the scope has greatly increased, creating significant challenges for the publicly financed system. In Canada, dual practice is rare among physicians. It is discouraged by federal and provincial government policy and is actually prohibited by some provincial governments and, at least until very recently when the courts have been asked to remove the limitations on dual practice, has not been perceived as a threat to equity of access.

We isolated the key institutional variables in which physician dual practice is embedded in order to compare Israel and Canada. Table 1 organizes these institutional factors into three larger categories based on: 1) the nature and scope of UHC (Marchildon 2014; WHO 2010); 2) supply-side factors which mainly have to do with the nature of physician practice, payment and independence; and 3) demand-side factors which operate mainly through the incentives and disincentives faced by the consumers of physician services. Although Table 1 is descriptive in nature, the categories and factors are robust enough to allow for a more systematic comparison of dual practice across multiple jurisdictions.

Table 1: Institutional Context of Physician Dual Practice in Israel and Canada

Category	**Institutional Factors**	**Israel**	**Canada**
Universal health coverage	Form of universality	Strong form	Strong form – coverage on "uniform terms and conditions" under Canada Health Act
	Population covered	100% of population	100% of population
	Extent of coverage	Same as CA + pharmaceuticals	Medically necessary hospital, diagnostic and medical care (physician) services
	Depth of coverage	Limited user fees	No user fees
Supply-side (doctors)	Status of doctors providing UHC services	Public (mostly employees, minority as contractors)	Private (independent contractors)

	Payment of doctors providing UHC services	Mostly salary and capitation	Fee-for service
	Who pays doctors	Health plans and hospitals	Provincial governments
	Dual practice regulated and how	Largely unregulated	Yes – by provincial government laws on opting in and opting out
Demand-side (patients)	Prevented from obtaining private care	Can get private care via extensive supplemental insurance or out of pocket	Can get private care in other countries or some cities in Canada through out of pocket payment
	Legal devises to reduce incentives to obtaining private care	Just beginning to institute incentives of this sort	Yes – duplicative private health insurance prohibited in 6 provinces and discouraged in 3 provinces (permitted in 1 province)

Physician Dual Practice in Israel

Israel has a tax-based national health insurance (NHI) system and the government specifies the benefits package to which all Israelis are entitled. That benefits package includes hospital care, physician services, pharmaceuticals and more. Every citizen is free to pick among four competing non-profit HMOs (health maintenance organizations – like Kaiser in the US). The HMOs receive capitation payments from the government that take into account the age mix of their members. In return, the HMOs must provide their members with the full range of services that the government specified in the benefits package (Rosen, Waitzberg and Merkur, 2015).

All of Israel's citizens are covered by NHI. In addition, 85% have voluntary supplemental insurance through their health plan and 50% have voluntary commercial insurance from a for-profit insurance company. One of the main reasons for purchasing voluntary insurance is to be able to choose one's surgeon (Rosen, 2016).

The majority of the hospitals are operated either by the government or by a non-profit organization. However, there is also a small and growing for-profit hospital sector; it accounts for only 3% of the acute care beds, but about 10% of the operating rooms and about a third of the elective operations.

Almost all the physicians work for a hospital or a health plan on a salaried or capitated basis. However, a growing number also work on a fee-for-service basis out of their own private clinics or in a private hospital.

Overall, Israel spends between about 7.5% of our GDP on health. About 40% of Israel's health expenditures are financed privately; this includes payments for services not in the benefits package (e.g. adult dental care and long-term care), co-payments for certain goods and services

in the benefits package (e.g. pharmaceuticals), voluntary insurance premiums, and various out-of-pocket payments.

Dual practice is allowed in Israel. The main form of dual practice involves a physician, employed in a salaried position in a government or non-profit hospital, who also works of a fee-for-service basis in a private hospital in the late afternoon and/or the evening. This is most prevalent for surgical specialties. Physicians in non-private hospitals who also want to work privately are formally required to get permission to do so from the directors of their non-private hospital. However, such permission is inevitably granted and has become a mere formality, enshrined in custom, so that the physicians simply inform the hospital directors of their intentions to engage in dual practice. The costs of the medical care provided in the private hospitals are usually covered by voluntary (i.e. private) insurance. The patients opt for private hospital care to reduce waiting time, choose the surgeon, and get more personal attention. In Israel, unlike many OECD countries with universal coverage (Flood and Thomas 2017), there are no limits on the number of hours that public sector physicians can engage in private practice nor on the amount of income that they can earn from their private practices.

The physicians' right to work privately, subject to the approval of the directors of their non-private hospitals, is stipulated the collective bargaining agreement between the Israel Medical Association and the major employers of physicians. This situation is somewhat unique among public sector employees and unions in Israel.

Dual practice of this sort has grown substantially over the past decade and it has led to several problems, including:

1. *Reduced afternoon availability of senior physicians in the non-private hospitals*
   While there are no systematic data on this issue, it is widely acknowledged that many board-certified specialists leave the governmental and non-profit hospitals (which are their main places of employment) at some point in the afternoon to continue work at a private hospital or clinic. This is believed to be particularly problematic in those cities which have private hospitals. The perceived result is an increase in the burden on the house staff (interns and residents) and reduced capability to handle complex situations for which experienced, board certified clinicians are uniquely qualified.

2. *Reduced public confidence in the publicly-financed health system*
   The availability in private hospitals of shorter waiting times, more choice of surgeon and more private attention has reduced the public's appreciation of care in the non-private hospitals. Moreover, stories in the media about the limited availability of specialists in the afternoons raise questions about the quality of care in non-private hospitals. These concerns are further encouraged by the private insurance companies and their agents, eager to sell coverage for care at private hospitals.

3. *Pressure on public sector wage levels, to compete with the private hospitals*
   Physician wages in the public sector have increased substantially in recent years (reference). One of the acknowledged causes of this increase has been the need to compete with the private hospitals for medical manpower. While this is a welcome development for physicians, it is not necessarily good for the general public. The increased wages in the public sector put significant financial pressure – in turn - on the public hospitals, the health plans that pay the hospital bills, the government that makes the capitation payments to the health plans, and the taxpayers who ultimately fund national health insurance. If they are unable or unwilling to expand funding to accommodate the higher physician pay levels, then service levels and patient care can suffer.

4. *Regional and specialty imbalances in the physician supply, as more physicians choose locations and specialties with more private practice opportunities*
   The private hospitals are concentrated in the large cities in the center of the country. This acerbates the already-difficult challenge of encouraging physicians to live and practice in peripheral regions. In addition, the private practice opportunities are concentrated in the surgical specialties; they are particularly limited for such specialties as family medicine, pediatrics, internal medicine, and pathology, making it harder to attract young physicians to these specialties.

5. *Reduced health system equity, as not everyone can access private care*
   Private hospital care is less available in the peripheral regions, which have a relatively high concentration of low-income people. Moreover, paying for private hospital care out-of-pocket is usually unaffordable for low-income people, many of whom also lack the private insurance which is the most common way to pay for such care.

6. *Reduced revenues and profitability in the public hospitals, as they lose market share to the private hospitals.*
   As noted above, the private hospitals have grown to the point where they now account for a substantial share of elective surgery – the most profitable segment of the hospital market. Moreover, they tend to avoid patients with multi-morbidity, who tend to be higher risk and more expensive. This leaves the non-private hospitals with fewer patients overall and a higher concentration of non-profitable patients.

In recent years, several steps have been taken to restrain dual practice and address its adverse effects. These include:

Requiring physicians in non-private hospitals to sign in and out using a digital time clock
This was put into place as part of the 2011 collective bargaining agreement between the Israel Medical Association and the main employers (the Ministry of Health, the largest health plan, and the largest non-profit hospital). This originally caused a significant uproar among front-line physicians, some of whom saw it as demeaning. The uproar has subsequently died down, with physicians apparently learning to live with the time clock. Moreover, some physicians have

simply decided to forego some of their public sector hours (and income) in order to work second shift in private hospitals.

Limits on self-referrals by physicians from their public hospital practices to their private practices
Self-referrals of this sort are generally perceived in Israel as being particularly inappropriate. They were outlawed in a 2015 law, which indicated that a physician may not see any patients in their private practices whom they saw in their public practices in the past 4 months. Note, however, that while this measure has symbolical and perhaps ethical significance, its practical impact on the overall scope of private practice is probably quite limited.

Reducing surgical waiting times in non-private hospitals
As one of the main reasons patients turn to private hospitals is to reduce their waiting times, it seems reasonable that reducing waiting times in the public sectors should reduce demand for care in private hospitals., Accordingly, the government has launched a major, well-financed, initiative to reduce those waiting times.

1. *Strengthening the public hospitals*
   In recent years, government has taken a series of coordinated steps to strengthen the public hospitals. These include approving and funding an expansion in the number of advanced (and expensive) diagnostic devices, such as MRIs.

2. *Constraining the growth of private insurance, inter alia by promoting standardized insurance contracts*
   This regulation, which was adopted in 2015, seeks to reduce demand for private hospital care by constraining one of the key facilitating factors – the private insurance programs that pay for private hospital care.

3. *Limiting the extent that private insurers and individuals can pay physicians directly for private care*
   In 2015, a regulation was promulgated requiring that – with limited exceptions[1] - private insurers (whether commercial or supplemental) and individuals must include within their payments to private hospitals the payments for physician services provided within those hospitals. In other words, the insurers and individuals would not make direct payments to physicians working in private hospitals. The objective here is to constrain private physician fees by reducing the market power of the private physicians and enhancing the market power of the private insurers.

In addition, efforts are underway to establish a "full-timer program" in which physicians in non-private hospitals are given significant bonuses for working additional hours and committing not to work in the private sector. Initiated by the Ministry of Health and cautiously supported by the Ministry of Finance, this approach is widely supported by the heads of the non-private

[1] The law/regulation does provide for an exception in the case of a limited number of physicians whose names must be specified by the insurers.

hospitals. However, some officials in the Ministry of Financed and the Civil Service Administration are strongly opposed – either due to concerns about ripple effects for wages throughout the rest of the public service or due to concerns about whether these high, and highly targeted, payments constitute appropriate public management practice.

Some policy analysts have proposed giving patients the right to choose their physician or surgeon within the non-private hospitals, without the need to pay any additional fee. This would eliminate one of the main reasons why patients currently seek care in private hospitals. Others in the health system have countered that this approach is not feasible – either because the senior physicians would not agree to it or because it would lead to a situation where too many patients would demand to be cared for by a limited number of particularly prestigious physicians.

It remains to be seen how these various recently approved, and currently contemplated, initiatives will affect the scope and nature of dual practice in Israel.

Overall, the Israeli experience suggests that when the genie of dual practice is allowed out of the bottle, it can quickly grow to substantial proportions. This has made it quite difficult to get the genie back into the bottle.

A major question is why this rapid growth has taken place in Israel, but not in many other countries with UHC and dual practice. One possible explanation is the relatively high prevalence of private insurance in Israel which has played a major role in financing the expansion of dual practice. Another possible explanation is that, unlike many other countries, Israel has not limited the extent to which its physician can engage in private practice. Yet a third explanation is that physician income levels in the public hospitals may have been relatively low in Israel, fueling the appetite for supplementary/alternative income sources.

Physician Dual Practice in Canada

Canada has a tax-based UHC system that provides all Canadians with medically necessary hospital, diagnostic and physician services – commonly referred to as Medicare – free at the point of service. The federal government sets broad national standards through the Canada Health Act while the ten provincial and three territorial governments administer their own single-payer and single-tier UHC systems. Provincial governments raise most of the revenue required for their Medicare expenditures although the federal government covers 20% of all provincial health expenditures (and roughly 30% of provincial Medicare spending) through the Canada Health Transfer.

Outpatient prescription drugs, over-the-counter drugs, dental care, vision care and social care are not part of UHC coverage. For these goods and services, Canadians rely on a combination of private health insurance – largely through employment benefit plans – out of pocket payment, and targeted provincial and territorial government subsidies, services and coverage. Most

Indigenous Canadians rely on federal government's Non-Insured Health Benefits (NIHB) program for these goods and services.

Overall, health care accounted for 10% of Canada's gross domestic product in 2014. Public sources paid for 70% of health expenditures while private sources were responsible for 30% based on estimates for 2016. Out of pocket expenditures only slightly exceed private health expenditures for goods and services not covered by federal, provincial and territorial governments (CIHI 2016).

Canadian Medicare is based on a single-tier model of care. All acute care, whether provided by hospitals run by public arm's-length bodies known as regional health authorities or by independent (almost all non-profit) boards, operate within the rules of Medicare. The same applies for the majority of primary care and specialized surgical care – largely ambulatory – as well as diagnostic services, despite their private-for-profit character.

Most physicians in Canada are, by definition, independent private professional contractors. They work in a hybrid system in which they remain privately employed even if all, or almost all, of their revenue is derived from public funds. This is because all (or almost all) the patients they serve are Medicare beneficiaries of the single-payer Medicare plans administered by provincial and territorial governments. Every provincial and territorial resident has a health card and number providing access to all medically necessary hospital, diagnostic and physician services free at the point of service. The private practice, public payment nature of the Canadian system was even used as the main title in a history of the medical profession and UHC in Canada (Naylor 1986).

The vast majority of primary care physicians serve Medicare patients in clinics that they own and operate. Most specialists including hospital-based doctors are also independent contractors. Many have legally incorporated their professional practices as professional business corporations in order to minimize taxation. Although the ownership and control of hospitals depends on the organizational structure in each province and territory, physicians are rarely salaried employees of these hospitals or the provincial or regional health authorities which own hospitals in most Canadian jurisdictions, a situation that contrasts sharply with Israel and most Western European countries including Britain (Marchildon 2015).

Due to the constitutional division of powers, the provincial governments have primary responsibility for health care in Canada. However, when it comes to Medicare, the federal government has used its fiscal spending power to influence the way in which this responsibility is exercised. The *Canada Health Act* sets out five broad standards, known as criteria, which provincial governments must comply in order to receive their full share of an annual federal contribution through the Canada Health Transfer (Marchildon 2013). The most pertinent criteria are: 1) the standard of universality imposed by the *Canada Health Act* that patients must have access to Medicare services on "uniform terms and conditions"; and 2) the criteria of accessibility without financial barriers which is backed up by mandatory (dollar for dollar) transfer withdrawals from provincial governments which permit physician extra billing.

The ten provincial governments have established different legal, regulatory and policy regimes to meet these two criteria. As Flood and Thomas (2017) point out, provincial governments have a mix of laws on duplicative (Medicare) private health insurance and physician extra billing. Most have enacted laws that require doctors to either opt-in to the provincial Medicare schemes or opt-out. If they choose the latter, they are then prevented from billing the provincial government for Medicare patients. Some of these provincial laws also prevent opted-out doctors from charging any patient for Medicare services.

All provincial governments allow physicians to opt out of Medicare (Flood and Archibald 2001). However, three provinces (Ontario, Manitoba and Nova Scotia) limit the amount they charge private (non-Medicare) patients (Flood and Thomas 2017). To get at the details of these regulations, it is useful to examine the regulatory approach in a single province. For example, in British Columbia (BC), dual practice is discouraged through the *Medicare Protection Act* which governs the provision of medically necessary physician services as defined under the *Canada Health Act*. Section 17(1) states that any doctor who has opted to accept Medicare patients – and therefore has a provincial Medicare billing number – cannot charge Medicare patients directly for their medical services nor any facility or other fee related to that service. Of course, doctors who are opted out of the Medicare plan – called unenrolled doctors in the BC law – can charge non-Medicare patients as long as the medical services are provided in a private clinic. Moreover, there is no cap or restriction on the fees actually charged by an unenrolled BC doctors or by a clinic in which the services are performed entirely by unenrolled doctors (Plaintiffs opening statement 2016).

Conclusion and Policy Implications

This study illustrates how much easier it is for a single-tier UHC system to prevent physician dual practice in the first place than for UHC systems that have highly developed parallel tiers of private care. In Israel, the reality of a parallel private tier makes it extremely difficult to prevent dual practice from undermining the objectives of equitable access objectives of UHC. Moreover, without constant vigilance and policy interventions, it is difficult to prevent the growth of physician dual practice. As long as there is a parallel private tier of hospital care, there will likely be powerful incentives for physicians working in the public tier to also work in the private tier. While most effectively countervailed by substantial public incentives and bonuses, these measures add to the cost of providing UHC to the entire population.

At the same time, Canada can draw some important policy lessons from the experience in Israel. At this time, the challenge to the current provincial Medicare rules restricting dual practice in the *Cambie Surgeries* court case in British Columbia, may lead to the end of legislated single-tier Medicare. If a separate private tier becomes the norm in Canada, then Canadian governments can learn much from the range of regulatory and policy instruments Israel has used to mitigate the worst effects of dual practice. In particular, reducing waiting times should be seen as more than a measure to improve quality and patient responsiveness

but also a reform that preserves the integrity and underlying values of Canadian Medicare. Here too, it is possible to learn from additional research on the experience of other countries which have chosen a middle-ground – allowing dual practice, but limiting the extent to which any particular physician can engage in it.

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Appendix A: Additional Forms of Physician Dual Practice in Israel

The public discourse in Israel has focused on the "main form" of dual practice in which physicians work in both private and non-private hospitals, hence that has been the focus of this article. For completeness, it is important to briefly mention three other forms of dual practice. In one of them, a board-certified specialist working in a non-private hospital also works (typically in the late afternoon and/or evening) for one or more of Israel's four non-profit health plans. Payment for this work can be either on a fee-for-service basis or on an hourly basis; in either case, the physician's income per hour worked tends to be much higher than his/her income at the non-private hospital. Thus, as in the "main form" of dual practice, here too medical manpower is drawn away from the non-private hospital and competitive pressures are created to increase pay in those hospitals. It differs from the "main form" of dual practice in that the work in the health plans is funded progressively via the national health insurance system and hence the equity concerns are much less pronounced.

In another form of dual practice, which is limited to Jerusalem's non-profit hospitals, the hospitals operate an in-house Private Medical Service (PMS). In the PMS, patients are allowed to choose their physician (most often – their surgeon), in return for an additional fee – usually covered by private insurance. The hospitals' experienced physicians are allowed to work in the PMS, subject to hours and conditions determined by the hospital. This arrangement entails significant equity issues, and the contribution to a two-class system of care is even more obvious and jarring than when the premium level of care is provided in a separate facility. However, unlike with the main form of dual care, in this form the experienced physicians remain in the non-private hospital and hence can more easily be called in to help with the care of a non-private patient whose health status has deteriorated. Accordingly, heads of many of the governmental and non-profit hospitals have called for extending the PMS option from the Jerusalem hospitals to their own hospitals. However, due to concerns about inequity, the courts and lawmakers have blocked this proposed extension.

Yet another form of dual practice is present in the government and non-profit hospitals themselves. In this form, the hospitals will pay some physicians at a premium rate for work in the afternoons and evenings (using either fee-for-service or an enhanced hourly rate). This is done for those specialties and procedures for which backlogs have emerged. The hospitals sell these services to the health plans – either at the usual rates or at special, higher rates. The main advantages of this form of dual practice are that it keeps the senior physicians in the non-private hospitals, and that it does not discriminate between rich and poor patients. However, the health plans tend to limit its scope, and the pay levels for the physicians – while higher than in the standard non-private system – remain well below the levels available in the for-profit hospitals.