Extra billing in health care: Prohibit, regulate or laissez-faire?

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3.1. INTRODUCTION

Definitions
Extra billing is the practice of health care providers charging a supplementary fee on top of the tariff agreed upon by health insurance. This tariff may include a co-payment or co-insurance to be borne by the patient.
In Belgium, the term 'ereloonsupplement' (in Dutch) and 'supplément d'honoraires' (in French) is used for a fee charged on top of the official tariff set by basic health insurance.
In France, the term 'dépassement d'honoraires' is used and in Germany, 'Steigerungssatz'.
In the U.S., the term 'balance billing' is used for health care providers billing patients more than what the insurer pays for their services. In Canada, 'extra billing' is the preferred term.

In many countries, extra billing is a controversial issue. In Belgium, some political parties are proposing a prohibition or a strict limitation of extra billing, especially for inpatient care. They are afraid that extra billing jeopardises accessibility of medical care for low-income groups. In France, in 2012, in order to stop excesses, extra billing by physicians has been limited to 150% on top of social security tariffs. In Canada and the U.S., discussion about extra billing continues. In Canada, opponents of extra billing think it will erode Canada's public health care system and give way to a two-tier system.

Driven by the economics of medical practice before the spread of health insurance, doctors applied price discrimination by charging patients according to what they thought each patient could afford. The use of sliding fee scales persisted until widespread health insurance drove a standardis ation of fees (Hall and Schneider, 2008).

The goal of this paper is twofold. First, we provide new detailed estimates on extra billing in Belgium (e.g. total amount of extra billing, split between in- and outpatient care and between the different health care providers). Second, we put forward and discuss several policy issues concerning extra billing that may be helpful for policymakers who decide about different policy options such as 'laissez-faire, regulation or prohibition'.

3.2. THE PRACTICE OF EXTRA BILLING IN BELGIUM

3.2.1. Regulatory framework for supplementary fees in belgium

In Belgium, the legal basis for charging supplementary fees can be found in the Health Care Professions Act, which states that practitioners can set their fees freely. The Code of medical ethics holds that physicians should be moderate when determining their fees and be willing to explain to their patients why they are charging a certain fee.

According to article 50 of the Health Insurance Act, every two years, an agreement is made between the trade unions of the physicians and the 'sickness funds' (representing

their members as social insurees). Physicians can choose to adhere to the agreement ('conventioned' physicians) or they can choose completely not to adhere ('non-conventioned') or partially, for certain well defined days and hours ('partially conventioned'). Partially conventioning is only possible with regard to ambulatory patients.[81] 'Conventioned' physicians get an annual contribution from compulsory health insurance for their future pension (4506 EUR in 2014).

Invariably since 1964, the biannual agreement between physicians and sickness funds has listed situations in which conventioned physicians are at liberty to deviate from the official tariffs set by compulsory health insurance, i.e. for special demands made by a patient (e.g. a private room in a hospital or a consultation late at night).

The agreement also allows conventioned physicians to charge supplementary fees for households whose taxable income exceeds 66709 EUR per year (figure for 2014). However, since it is rather awkward to ask patients for proof of their exact taxable income, physicians have not been using this possibility so far. Dentists no longer have this possibility at their disposal since it has been left out in the biannual agreement between dentists and sickness funds.

As from 1 January 2013, supplementary fees have been forbidden by Belgian government for patients staying at least one night in double and common rooms in hospitals.[82] As from 27 August 2015, supplementary fees are also forbidden for one-day admissions in double or common rooms.

Every hospital has to define a maximum percentage of supplementary fees that can be charged (a percentage of the official tariff of the compulsory health insurance system). Today, maximum percentages for supplementary fees range between 0% and 300%. Today, just one single hospital (Saint Luke hospital in Bruges) has set out different percentages for non-conventioned (300%) and conventioned (100%) physicians. Since there is no limitation by law, hospitals are at liberty to set the maximum percentage of supplementary fees as high as they prefer.

81 First stipulated in the 2009-2010 national convention between physicians and sickness funds.

82 Several associations of physicians filed an appeal in the Belgian Constitutional Court against the abolishment of supplementary fees in double and common rooms. In its judgment of 17 July 2014, the Court stated that the new law respected the equilibrium between an equal access to health care and an equitable income for physicians (with the new law allowing physicians to continue to charge supplementary fees in private rooms).

There are important regional differences in the maximum percentage of supplementary fees charged. In 2014, on average, general hospitals in Flanders applied a maximum percentage of 118%, general hospitals in Wallonia 195% and general hospitals in Brussels 279%.[83] Within the same hospital, there can also be differences between specialties. For instance, in the Saint Augustine hospital in Antwerp, certain specialties (e.g. the gynaecologists) apply the maximum of 200% set by the hospital, while other specialties apply a maximum of 130%.

3.2.1.1. Impact of supplementary fees

Until 1 July 2014, the official admission form a patient has to sign when s/he is being hospitalised stated that the patient had no free choice of physician when s/he was not willing to pay supplementary fees. In the new admission form, defined by the Royal Decree of 17 June 2014, this phrase has been omitted.

In Belgium, according to article 6 of the Patient Rights Act, a patient can freely choose his/her physician. However, physicians are free to refuse treatment, with an exception for urgent treatments (Nys, 2001; Vansweevelt and Dewallens, 2014). As a result, patients refusing to pay supplementary fees, may not be treated by the physician of their choice.

3.2.1.2. Transparency

Article 8, §2 of the Patient Rights Act states that the patient needs to be duly informed about the financial consequences of a medical intervention in order to be able to give his/her informed consent. This includes information about supplementary fees and information about the 'convention status' of the physician (whether the physician respects the official tariffs set by compulsory health insurance) (Dijkhoffz, 2004). Charging supplementary fees in hospitals is strictly regulated. Every hospital has to provide the patient with a list of the maximum supplementary fees that can be charged (expressed as a percentage of the official tariffs set by compulsory health insurance). The admission form to be signed by the patient allows him/her explicitly to choose supplementary fees not to be charged.

Charging supplementary fees in an outpatient setting is less regulated. Physicians only have to put up a notice in their waiting room with their 'convention status' (stating whether or not they stick to the official tariffs set by compulsory health insurance). They do not have to list the level of supplementary fees charged. Recently, a new law has created more transparency, obliging physicians to specify - in certain circumstances - the

83 Calculation based on the maximum percentage of supplementary fees listed in the 'internal regulation' of every hospital.

supplements charged on the patient bill (when billing electronically and when at the same time billing care reimbursed by social security and care not reimbursed by social security).[84]

3.2.2. New figures on supplementary fees in belgium

Using data from Deutsche Krankenversicherung Belgium ('DKV Belgium'), the market leader for additional health insurance, we have been able to calculate estimates on supplementary fees for outpatient care (cf. footnotes 7 and 8). So far, only for inpatient care reliable estimates on supplementary fees have been published in Belgium. Combining existing estimates for inpatient care with new estimates for outpatient care, based on authors' own calculations, makes it possible - for the first time - to present a reliable estimate of the total amount of supplementary fees charged by health care providers.

In 2012, supplementary fees were 1.2 billion EUR on a total of 8.8 billion EUR private expenditure and 39.6 billion EUR total expenditure on health. Supplementary fees represented 14% of total private expenditure on health, while co-payments represented 21%. The bulk of total private expenditure (60%) comprised payments for care not included in the basic package of the National Institute of Health and Disability Insurance (NIHDI) (cf. figure 1).

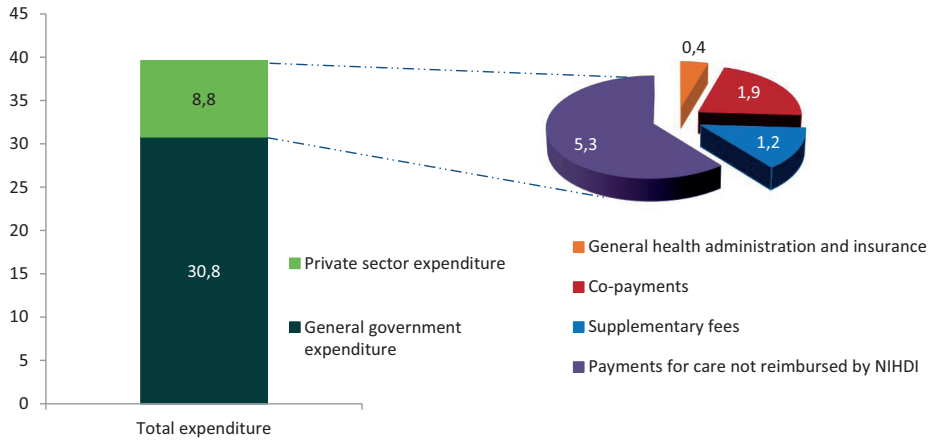

Figure 1. Private expenditure on health in Belgium in 2012 (billion €) (OECD Health Statistics 2015, authors' own calculations; sources: Christian sickness fund, DKV Belgium, NIHDI)[85]

84 Art. 22-23 wet van 17 juli 2015 houdende diverse bepalingen inzake gezondheid, *Belgisch Staatsblad* 17 August 2015.

85 The amounts listed are estimates, after extrapolation of the findings of the Christian sickness fund (for inpatient care) and DKV Belgium (for outpatient care) respectively.

Traditionally, supplementary fees for inpatient care have been in the spotlights. About 75% of all Belgians are carrying additional health insurance covering inpatient care (including supplementary fees). However, less than 5% have comprehensive additional coverage for outpatient care.

Figure 2 shows that the total amount of supplementary fees charged in Belgium in 2012, is estimated at 1.2 billion EUR, with inpatient care accounting for 31% of total amount of supplementary fees and outpatient care for 69%.

Physicians and dentists are responsible for the bulk of supplementary fees in outpatient care. Dentistry is especially well represented. For certain types of dental care the official tariff set by basic health insurance is quite low, resulting in important supplementary fees (e.g. orthodontics and periodontology). Often, dentists use new techniques, the additional cost of which is not always readily reimbursed by basic health insurance. Supplementary fees can be used to finance these new techniques. Today, less than 5% of all Belgians are carrying additional dental insurance. The number of insured is likely to increase since several sickness funds recently have started to offer additional dental insurance products.

Most supplementary fees attributed to the category 'offices of other health practitioners' are charged by physiotherapists. 'Medical and diagnostic laboratories' comprehend medical imaging and clinical biology centres. It is rather rare that supplementary fees are being charged by providers of home health care services.

Table 1 gives an overview of supplementary fees expressed as a percentage of total fees earned.

In a hospital, supplementary fees charged by physicians represent 11.4% of fees earned. In an ambulatory setting, this figure is 9.2% (5.8% for general practitioners and 14.8% for specialists).

Dentists charge substantial supplementary fees for orthodontic treatments (143.7%) because reimbursement by basic health insurance for this kind of treatment is limited.

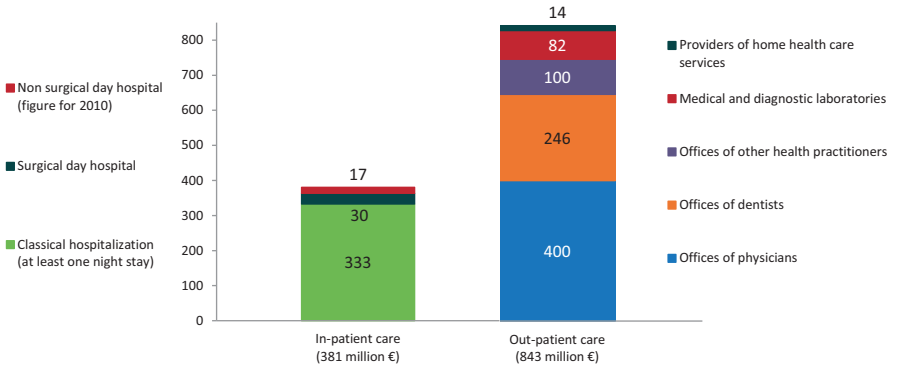

Figure 2. Supplementary fees in Belgium in 2012 (million €) (authors' own calculations; sources: Christian sickness fund[86], DKV Belgium[87,88], NIHDI)

86 For the estimation of supplementary fees charged for inpatient care we have been using the annual study on hospital bills, published by the Christian sickness fund. In 2012, the Christian sickness fund covered 41.6% of the Belgian population (*source*: NIHDI). CM, Negende barometer van de ziekenhuisfactuur, 7 November 2013 (figures for 2012) (http://www.cm.be/binaries/CM-255-NL-9deCM-barometer_tcm375-137079.pdf, accessed 5 October 2015).

87 For the estimation of supplementary fees charged in an ambulatory setting, we have been able to use data from DKV Belgium, the market leader in additional health insurance (covering 16.4% of the Belgian population in 2012). About 20% of what DKV Belgium reimburses, pertains to ambulatory care (people carrying a full cover for ambulatory care and people carrying a cover for pre- and posthospitalisation costs). We have been using information from 1432429 services billed for ambulatory care and sent to DKV Belgium for reimbursement in 2012, 2013 and 2014 (with among others 921000 acts referring to physicians, 118000 to dentists and 189000 to physiotherapists). We calculated supplementary fees as a percentage of reimbursement by basic health insurance plus co-payments. We multiplied these percentages with total reimbursement by basic health insurance plus co-payments to get estimates for total amounts of supplementary fees. Supplementary fee percentages represent a weighted average of a certain (sub) sector. Every (sub) specialism has a supplementary fee percentage. For calculating the average of a group of (sub) specialisms the weight of each (sub)specialism has been taken into account. For outpatient care, OECD's Health Provider classification has been followed.

88 We are aware of the fact that there may be some bias as to the data from DKV Belgium. People carrying additional health insurance might be less price sensitive and health care providers knowing that a patient is additionally insured might charge higher prices. However, additional coverage for ambulatory care is not widespread in Belgium (less than 5% of the population). Providers of ambulatory health care generally do not take into account the possibility that a patient might be carrying additional coverage for ambulatory care. We assume that the upward pressure of additional health insurance on supplementary fees is limited so far as ambulatory care is concerned. Anyway, it might be recommended to consider the percentages of supplementary fees for ambulatory health care presented here as 'upper limit', real supplementary fees maybe being somewhat lower.

Table 1. Supplementary fees as a percentage of 'total fees earned based on the official tariffs, including co-payments' (Belgium) (2012) (authors' own calculations; sources: Christian sickness fund, DKV Belgium and NIHDI[89]

INPATIENT CARE	
Physicians working in hospitals	**11.4%**

OUTPATIENT CARE			
Offices of physicians	**9.2%**	**Offices of dentists**	**24.5%**
1. Gynaecology	6.9%	1. Conservative treatment	11.8%
2. Surgery	19.4%	2. Prosthetic treatment	46.9%
3. Technical acts	4.6%	3. Orthodontic treatment	143.7%
4. Consultations and house calls	8.9%	4. Periodontal treatment	27.1%
- General practitioners	5.8%	**Offices of other health practitioners**	**6.6%**
House calls	1.6%	1. Speech therapists	0.9%
Consultations	9.0%	2. Providers of bandages	28.3%
- Specialists (consultations)	14.8%	3. Physiotherapists	5.6%
Cardiologists	*9.2%*	4. Providers of orthopedic material	15.7%
Dermatologists	*16.1%*	5. Midwives	19.3%
Gerontologists	*9.4%*	**Medical and diagnostic laboratories**	**4.4%**
Internal medicine specialists	*4.7%*	1. Clinical biology	1.6%
Neurologists, psychiatrists and neuropsychiatrists	*7.8%*	2. Medical imaging	6.1%
Oncologists and haemotologists	*4.4%*	**Providers of home health care services**	**0.8%**
Pediatricians	*9.6%*	1. Nurses	0.8%
Other medical specialists	21.0%		

3.3. POLICY ISSUES CONCERNING EXTRA BILLING

3.3.1. Additional health insurance

In hospitals in Belgium, the bulk of supplementary fees is covered by additional health insurance. About 75% of Belgians carry an additional cover for hospital costs. Because of this high percentage, additional hospitalisation insurance is said to have an inflationary effect on supplementary fees. People carrying additional health insurance may be less price-sensitive and health care providers, knowing that a patient is additionally insured, may charge higher prices. There certainly is an interaction between supplementary fees and additional health insurance, since the first additional health insurance - covering

89 Total private expenditure on hospitals represents 8.5% of total expenditure on hospitals. Total supplementary fees represent 35.6% of total private expenditure on hospitals.

private hospitalisation costs - came on the market in Belgium in 1964, the same year universal health insurance was established (creating the possibility of - legally - charging supplementary fees).

Contrary to hospital costs, and with 69% of total supplementary fees in Belgium being charged in an ambulatory setting, it is remarkable that less than 5% of Belgians are carrying full additional coverage for outpatient costs. Since full additional coverage for ambulatory care is not widespread in Belgium, providers of ambulatory health care generally do not take into account the possibility that a patient might be carrying additional coverage for ambulatory care. Therefore, so far as ambulatory care is concerned, we assume the upward pressure of additional health insurance on supplementary fees to be limited.

Additional health insurers may try to reduce upward pressure on prices by certain measures such as deductibles, co-insurance and price negotiations with providers.

In Belgium, there is no tax deductibility for premiums paid for additional health insurance. For individual and group contracts alike, there are no fiscal incentives.

3.3.2. Patients facing financial problems

According to the Belgian Health Interview Survey (2013), 26 % of households say that private expenditure on health is (very) hard to bear (32 % if the reference person is > 75 years old). In 2013, 8% of Belgian households had to postpone medical care for financial reasons (Demarest, 2015).

Debt as a result of private health care costs and debt as a result of energy costs are said to be among the most important risk factors for sinking into poverty in Belgium (Vranken *et al.*, 2009).

Government has implemented a number of specific measures to improve accessibility for high risk and low income people, such as preferential reimbursement for low income groups ('Verhoogde Tegemoetkoming'/'Intervention Majorée') and yearly subsidies for chronic patients (e.g. for incontinence material). In 2001, a maximum billing system ('MAF') has been introduced. This measure improved the out-of-pocket maximum, already introduced in 1994 under the social and fiscal exemption mechanism for certain vulnerable categories, by extending the scheme to all households and to other types of user charges. MAF ensures that, according to the family's net income, each household has an annual out-of-pocket maximum for all 'necessary health care expenses' (Corens,

2007). As soon as expenses reach the set ceiling, any further health care costs are covered in full by the health insurance fund for the remaining part of the year.

However, only care reimbursed by basic health insurance is taken into account for the calculation of the MAF. Supplementary fees and room charges for private rooms in hospitals but also supplements for medical material that is not reimbursed by basic health insurance are not covered by the MAF system.

Patients who have no additional health insurance coverage, need to pay for supplementary fees out-of-pocket. About 25% of the Belgians are not carrying additional health insurance. Some of them choose not to because they have sufficient financial resources to do without insurance. A large group however may be too old, too sick or too poor - or a combination of the three - to buy an additional coverage.

3.3.3. Inpatient versus outpatient setting

Unlike France where additional health insurance is providing a large coverage for both inpatient and outpatient costs, additional coverage in Belgium is focusing on inpatient costs only ('hospitalisation insurance'). Less than 5% of the Belgians are carrying a full additional cover for outpatient costs. However, since 69% of total supplementary fees in Belgium is being charged in an ambulatory setting, ambulatory supplementary fees might in certain circumstances constitute a financial barrier for low income groups.

A further restriction of supplementary fees in hospitals, might result in a compensatory increase of ambulatory supplementary fees. Physicians may also transfer certain procedures to an ambulatory setting. So far, ambulatory supplements are only scarcely regulated.

3.3.4. Increase of social security tariffs and supplementary fees

A supplementary fee is a fee charged on top of the social security tariff and expressed as a percentage of that tariff. When the tariff is being increased, the supplementary fee automatically follows suit. For instance, when a tariff increases from 1000 to 1200 EUR, a 200% supplementary fee results in 2400 EUR instead of 2000 EUR. It is sometimes argued that in 1964, at the start of the current Belgian health insurance system, social security tariffs were relatively low and physicians could charge supplements to patients that could afford to pay more. As a consequence, some consider supplements as a part of the regular physician fee and social security tariffs as the physician fee for socially deprived patients (Van de Voorde *et al.*, 2014). Of course, this argument ought to be reconsidered, when social security tariffs increase and do reflect the full price.

In 2013-2015, several hospitals in the region of Namur have increased their maximum percentage of supplementary fees, from 100% to 200%.[90] These increases may be inspired by the desire to align with hospitals in the rest of Wallonia but of course they are not building stones for the financial sustainability of the supplementary fee system.

3.3.5. Reform of the hospital financing system

Federal Belgian government has decided that the hospital financing system needs to be reformed. On 26 September 2014, the Belgian Health Care Knowledge Centre has published an extensive report on the reform (Van de Voorde *et al.*, 2014). For this report, the Centre has intensively been consulting with all stakeholders.

Some stakeholders hold that supplements already have been heavily restricted over the last years. They believe that further regulation might encourage a further shift from hospitals towards private practices resulting in a dual health care system. Another group of stakeholders fears that supplementary fees in private rooms will further increase. They suggest to further restrict supplementary fees. Some stakeholders propose to just stop charging supplementary fees altogether. Others suggest to limit supplementary fees to a maximum percentage.

Some stakeholders consider charging supplementary fees in private rooms in hospitals to be a strange and unacceptable system, since different prices are being charged for the same care.

Conclusion of the report is that stakeholders have very divergent opinions on the further restriction of supplementary fees. For the moment, a reform of the supplementary fee system seems to be 'out of scope'.

3.3.6. Income for health providers

For certain groups of self-employed physicians in Belgium and France providing inpatient care, extra billing constitutes a substantial part of their income (cf. Table 2). Extra billing represents respectively 35% and 32% of total income of Belgian and French surgeons. In ambulatory care in Belgium, 9.2% of total income of all physicians is provided by extra billing.

90 For instance, Centre Hospitalier Régional Sambre et Meuse, Clinique Maternité Sainte Elisabeth, Clinique Saint Luc and Centre Hospitalier Universitaire Dinant Godinne.

Table 2. Share of supplementary fees in the income of self-employed physicians providing inpatient care in France and Belgium in 2010

	France	Belgium
Specialism	**% of gross income**	**% of gross income**
Stomatology	45.6%	15.9%
Surgery	31.9%	34.7%
Gynaecology	29.5%	34.9%
Ophthalmology	25.3%	10.1%
Oto-rhino-laryngology	20.8%	12.3%
Anaesthesia	16.7%	31.5%
Paediatrics	16.7%	21.1%
Psychiatry	16.6%	4.2%
Gastro-enterology	11.6%	11.5%
Radiology	4.0%	13.4%
Cardiology	4.0%	15.0%
Pneumology	4.0%	5.8%

Source: Drees, 2012 (FR); Swartenbroekx *et al.*, 2012 (BE).

In the Netherlands, price discrimination by physicians was legally banned in the 1990's. Before, in hospitals different fees were charged to members of sickness funds on the one hand and privately insured people at the other hand. In the 1960's for a 'first class' private patient staying in a single hospital room the fee for an inpatient treatment by a medical specialist could be tenfold the fee for the same treatment for a 'third class' sickness fund patient staying on ward. During several decades of fee regulation by Dutch government the differences in fees gradually converged to zero, without seriously reducing the income of medical specialists. In 2012, Dutch medical specialists earned more than their colleagues in neighbouring countries Belgium, Denmark and Germany (Kok *et al.*, 2012).

3.3.7. Revenue for hospitals

In Belgium, hospitals also do benefit from supplementary fees. In most hospitals, physicians have to cede a certain percentage of their supplementary fees to the hospital to help finance its overhead costs. E.g., hospitals have been raising the maximum level of supplementary fees from 100% to 150% of official tariffs to generate money for the construction of new hospital facilities.

However, self-employed physicians contribute more to the hospital's overhead costs with revenue from reimbursement by basic health insurance than with revenue from supplementary fees. In 2010, physicians overall contributed 41% of their total revenue from reimbursement by basic health insurance to financing hospitals (Belfius, 2011). Revenue from supplementary fees contributed for a varying but substantially lower

percentage. For example, while 31% of the revenue of gynecologists generated by reimbursement by basic health insurance is transferred to the hospital, only 15% of their revenue from supplementary fees goes to the hospital (Swartenbroekx *et al.*, 2012).

The University Hospital of Antwerp explains on its website what is being done with the proceeds of the supplementary fees. Proceeds of supplementary fees are being used 'to finance new medical techniques that are not yet reimbursed by government, to keep the hospital's budget in balance and to finance professional literature, training abroad and special equipment for the physicians' (UZA, 2012).

3.3.8. Competition between hospitals and physicians

If a hospital wants to attract a physician with a top reputation, offering the possibility to charge substantial supplementary fees, may constitute an important element in convincing the physician to switch hospitals. As a result, supplementary fee percentages tend to evolve to the same level within the same region or city. Most hospitals in Brussels apply a maximum level of supplementary fees of 300% of the official tariffs. Over the past few years, all hospitals in Antwerp have been increasing the maximum level of supplementary fees to 200%.

However, this mechanism does have an inflationary effect on supplementary fees and on the premiums of additional health insurance covering these supplementary fees. Another problem is that in most occasions the hospital and not the physician is charging the supplementary fee, leaving no room for appraisal by the physician and resulting in hospitals almost always - for every patient - charging the maximum percentage.

3.3.9. Extra comfort for patients

Patients willing to pay extra may be offered convenient consultation hours and comfortable private rooms in hospitals. In Belgium for instance, a general practitioner can charge supplementary fees for special demands made by the patient, e.g.: home calls at night or during the weekend when the physician is not on call, consultations after 9 pm or during the weekend, explicitly demanded by the patient. However, does a private room in a hospital still represent 'luxury' in an era when in the rest of the economy private rooms have become the norm? Imagine the receptionist in a hotel asking you whether you would prefer a private room or a room to be shared with a stranger. Anyway, while it is understandable that a patient needs to pay extra to the hospital for the use of a luxurious private room, it is difficult to understand why s/he should pay extra to the physician for staying in a single room.

3.3.10. Waiting time

Since health care providers can increase their income by engaging in extra billing, they might be motivated to provide extra consultation or operation time. This could result in avoiding or decreasing waiting lists.

In Germany, patients are covered either by statutory health insurance (SHI) or by private health insurance (PHI). Due to a 20%-35% higher reimbursement of physicians for patients with PHI, it is claimed that patients with SHI are faced with longer waiting times when it comes to obtaining outpatient appointments. Lungen *et al.* (2008) have shown that patients carrying SHI face waiting times for an appointment that are 3.08 times longer than patients carrying PHI. Other studies confirm their findings (Roll *et al.*, 2012; Farnworth, 2003). Countries facing waiting lists have developed a whole set of remedies to tackle this problem. In Spain, bonuses for specialists who achieved waiting-times reductions (that accounted for two to three per cent of their salary) may have contributed to the steady reduction in waiting times (Siciliani and Hurst, 2005). In the Netherlands, extra billing is forbidden.[91] However, the Dutch regulatory authority has stated that in future it might be possible for an intermediary to pay extra to a provider in order to get faster treatment, as long as other patients are not pushed aside (Nederlandse Zorgautoriteit, 2009).

3.3.11. Accessibility of care

In health care, the term 'equity' often is used in the sense that every person should have access to health care on the basis of need and not ability to pay (Richards, 2008). According to Weale and Clark the principle of equity means that all should have access to high quality, comprehensive care without financial barriers to access (Weale and Clark, 2009).

Sometimes, new medical technology is only available for patients who are willing and able to pay supplementary fees. Dentists for instance use new techniques, the additional cost of which is not always readily reimbursed by basic health insurance. Supplementary fees can be used to finance these new techniques. Patients who are not able to pay these supplementary fees, may not have access to the new dental materials that are being used.

3.3.12. Access to time-consuming and/or complex procedures

Sometimes, the official tariff agreed by health insurance, does not meet the expectations of physicians. When a fee for a certain service is perceived to be too low, physicians may refrain from performing that service. Waiting lists may arise or better-remunerated

91 Cf. art. 35, lid 1 Mededingingswet.

alternatives may be suggested to the patients. When two different procedures are available for the treatment of the same medical problem, a time-consuming and complex procedure (golden standard) at the one hand and an easier, faster procedure on the other hand, physicians may choose to perform the latter if reimbursement for the time-consuming and complex procedure is perceived as being (too) low. Two examples.

Autologous reconstruction of the breast after amputation for breast cancer - a DIEP-flap reconstruction - currently is reimbursed by compulsory health insurance in Belgium at a rate of 1527 EUR. A DIEP flap is a type of breast reconstruction in which blood vessels called deep inferior epigastric perforators (DIEP), and the skin and fat connected to them are removed from the lower abdomen and transferred to the chest to reconstruct a breast after mastectomy (Blondeel, 1999). A recent study of Damen *et al.* (2011) revealed that in the Netherlands actual total cost for a unilateral DIEP-flap reconstruction was 12,848 EUR, with actual surgery costs amounting to 6346 EUR. With Belgian and Dutch prices for health services generally not diverging very much, there may be an important gap in Belgium between the fee agreed by health insurance and the real cost of the DIEP-flap reconstruction, a procedure taking more than 6 hours with several surgeons. Generally, plastic surgeons charge 200% or 300% supplementary fees to fill the gap. These supplementary fees are generally reimbursed by additional health insurance. About 75% of the Belgian population carries an additional coverage for hospital costs. Access to a DIEP-flap reconstruction may be financially difficult for patients who do not have such coverage.

Mohs surgery is used to treat skin cancer. During the surgery, after each removal of tissue, while the patient waits, the pathologist examines the tissue specimen for cancer cells, and that examination informs the surgeon where to remove tissue next. Mohs surgery is the treatment of choice for certain types of skin cancer because of its high cure rate and maximal conservation of tissue (Gloster *et al.*, 1996). Analysis of the existing literature on Mohs surgery relative to surgical excision confirms that Mohs surgery is a cost-effective treatment. It is lower in cost than surgical excision, which often includes an ambulatory surgical centre facility fee and a subsequent re-excision procedure (Tierney and Hanke, 2009). In Belgium, reimbursement by compulsory health insurance of surgery for skin cancer amounts to 441 EUR (2014). Supplementary fees - e.g. 100% or 200% - play an important role as an incentive for dermatologists to effectively choose for the time-consuming procedure of Mohs surgery and not for the one-time broad surgical excision.

Reconstruction of the breast after breast cancer can be performed either with own tissue or with a breast implant. Since reimbursement by basic health insurance in Belgium of a breast reconstruction with own tissue is quite limited - as opposed to a

reconstruction with an implant - a breast reconstruction with an implant is more likely to happen when no supplementary fees can be charged. The same goes for Mohs surgery for the treatment of skin cancer. In the absence of supplementary fees a one-time broad surgical excision may be preferred by the surgeon (and the hospital) instead of the time-consuming step by step approach of Mohs surgery. The divide between those having access or not to (new) time-consuming and complex medical procedures paid for with supplementary fees, runs pretty much along the same line as the divide between those who have an additional cover and those who have not.

3.3.13. Quality of care

In a theoretical study, Glazer and McGuire (1993) have shown that restrictions on extra billing come at a price as doctors have an incentive to reduce the quality of their services. A physician can be regarded as making two choices to maximise profit, the price for the price-paying patients (patients willing to pay extra), and the quality for the fee-only patients (patients not willing to pay extra). Physicians' equilibrium choice of quality and price depends on the level of fee set by the regulator. When the fee is low enough, no patients will be taken at the fee only. When the fee is high enough, no patients will be charged extra. When the fee is set in the range between the minimum fee, necessary to induce physicians to take some patients at the fee only, and the optimal fee, high enough to avoid patients being billed extra, some patients are served for the fee but the quality to the fee-only patients is less than or equal to the quality for the price-paying patients. Glazer and McGuire hold that quality is set at a higher level for both patients paying the price and those not paying a supplemental price when price discrimination is permitted. The reason is that when discrimination is prohibited, physicians can only extract rents by setting quality. They do so by reducing quality, and therefore saving on costs.

Kifmann and Scheuer (2011) applied the findings of Glazer and McGuire to Medicare in the U.S. They studied the effects of 'balance billing', i.e. allowing physicians to charge a fee from patients in addition to the fee paid by Medicare. In contrast to Glazer and McGuire, they did not find that allowing balance billing is generally superior as balance billing allows physicians to increase their rents.

An empirical study of the effects of Medicare restrictions on extra billing in the late 1980s and early 1990s has been performed by McKnight (2007) She found that these restrictions reduced out-of-pocket medical expenditure of Medicare beneficiaries by 9%. With the exception of a significant fall in the number of follow-up telephone calls, her study showed little evidence that physicians changed their behavior in response to the extra billing restrictions.

An important question is whether extra billing creates extra value for the patient? In health care, 'value' can be defined as the health outcome achieved for the money spent. While most hospitals in Brussels charge 300% supplementary fees, three times the official tariff, hospitals in more rural areas charge 100%. Is the value offered in Brussels' hospitals indeed twice the value offered in hospitals that are 50 or 100 kilometers away from Brussels (the cost of living being only slightly higher in Brussels)?

In the 1990's the effect of the choice of a private room in a hospital on the care provided has been analysed for certain diagnoses (normal delivery, caesarean section, cataract operation, cholecystectomy, spinal fusion, lung cancer and myocardial infarction). The conclusion was that, apart from epidural anesthesia during childbirth being more frequently applied for patients staying in a private room, no other medical acts had been provided in private rooms versus common rooms in Belgian hospitals (Calcoen and Cormans, 1995). A review of the literature by van de Glind *et al.* (2007) - that included no studies about the Belgian situation - found that private rooms have a moderate effect on patient satisfaction with care, noise and quality of sleep, and the experience of privacy and dignity. Conflicting results were found for hospital infection rates and there was no evidence on recovery rates and patient safety.

3.3.14. Transparency

There are problems with extra billing as to transparency. Sometimes it is not clear for the patient when supplementary fees can be charged. In Belgium for instance, a regulatory framework has created transparency on supplementary fees for inpatient treatment, but this is not the case for ambulatory care.

There is little or no transparency about the extra value offered for the extra - supplementary - money paid. In Germany, supplementary fees exceeding 130% of the official tariff need to be motivated (in writing). In France and Belgium, such motivation is not obligatory.

3.3.15. Financial sustainability

Between 1998 and 2010, in Belgian hospitals, total bill for the patient for a 'classical' hospital stay (including minimum one night) has increased with 1.6% per year while total amount of supplementary fees has increased with 6.6% per year (both figures after adjusting for inflation) (CM, 2011). The share of supplementary fees in the total bill for the patient has increased from 20% to 35%.

In 2013, 23% of all 'classical' hospital stays were in a private room (CM, 2014). This percentage is likely to increase over the next years, since newly built hospital facilities typically provide 50% private rooms. With a majority of the Belgian population carrying an ad-

ditional hospitalisation insurance covering supplements in a private room, the demand for a private room is exceeding the offer.

Most supplementary fees are covered by additional private health insurance. When supplementary fees continue to rise, insurance premiums will need to follow suit. At a certain point in time, customers might no longer be ready to pay (ever) increasing insurance premiums to finance (ever) increasing supplementary fees.

3.4. PROHIBIT, REGULATE OR LAISSEZ-FAIRE?

How can it be explained that extra billing did survive the standardisation of fees driven by (universal) health insurance? When studying methods of payment used in public health care programs worldwide, Marmor and Thomas (1972) found that the methods for paying physicians are extraordinarily diverse but share a remarkably close resemblance to what physicians were used to before the programs began. The system of supplementary fees that enables physicians to charge more to richer patients is indeed a continuation of the former practice of physicians using sliding fee scales depending on the income of the patient.

The practice of extra billing can be prohibited (e.g. the Netherlands) or (almost) completely left alone ('laissez-faire') (e.g. Belgium and France). In between, a continuum of more or less restrictive regulation can be opted for.

3.4.1. Is a prohibition of extra billing feasible?

An argument that is often used in the discussion about extra billing is that official tariffs are too low and need to be compensated by the possibility to charge supplementary fees. Following this reasoning, an option could be to increase official tariffs so as to meet the sum of official tariffs plus supplementary fees. To that purpose, 1.2 billion EUR would need to be transferred from supplementary fees to official tariffs in Belgium. A 4% increase of government spending on health care could cover this transfer.

A complete ban on supplementary fees could lead to a two-tiered system consisting of a public system at the one hand and a private system at the other hand with private practices being only accessible for people willing to pay the full price out-of-pocket (or through additional health insurance). However, the success of these private practices would highly depend upon the functioning of the public sector. In the absence of waiting lists and concerns about the quality delivered in the public sector, private practices might not be very successful (Flood, 2006).

3.4.2. From laissez-faire to a more regulated system of extra billing?

From the previous section, it is clear that extra billing has some disadvantages. Extra billing can have an impact on access to new medical techniques and on access to time-consuming and complex procedures. There is an impact on waiting times. There is a lack of transparency about the supplementary fees charged and about the extra value offered for the extra money paid. There is a strong interaction between extra billing and additional health insurance. The last 10-20 years we have seen a sharp increase of supplementary fees charged in countries such as Belgium and France. A further increase might endanger the financial sustainability of the system of extra billing.

Regulation could provide a solution for the issues raised, i.e. equal access to health care, transparency and financial sustainability:

- restricting supplementary fees to a maximum limit (cf. Germany and France[92]);
- stimulating physicians to use a sliding scale when charging supplementary fees (according to the degree of difficulty and the time needed);
- having physicians and not hospital administrations decide upon the supplementary fees charged in hospitals;
- providing patients with information on the supplementary fees charged, also for outpatient care;
- implementing the German practice of a justification in writing might be considered for supplementary fees exceeding a certain limit[93];
- ensuring that treatment options are equally accessible for patients not able to pay supplementary fees (cf. breast reconstruction with own tissue, Mohs surgery).

Changes in regulation will need to be supported by the health care providers. As producers of a crucial service in industrial countries, and a service for which governments can seldom provide short-run substitutes, health care providers have the overwhelming political resources to influence decisions regarding payment methods (Marmor and Thomas, 1972).

92 On 23 October 2012, physicians' trade unions and health insurance agreed on a limit for supplementary fees of 1.5 times the official tariffs set by compulsory health insurance. Before, supplementary fee percentages could be as high as 500%.

93 For personal services, according to the degree of difficulty and the time needed, private patients can be charged up to 130% on top of the official tariff. For technical services, supplementary fees are limited to 80% and for laboratory tests 15% is the limit. When the medical problem is particularly difficult and time consuming, supplementary fees can attain 250% for personal services, 150% for technical services and 30% for laboratory tests. These higher supplementary fees need to be justified in writing. Exceptionally, these limits can be exceeded on the condition that a written contract is made with the patient ('Honorarvereinbarung'). (Verband der privaten Krankenversicherung. PKV-Info. *Die Gebührenordnung für Ärzte, ein kleiner Leitfaden.* http://www.dkv.com/downloads/die_gebuehrenordnung_fuer_aerzte_ein_kleiner_leitfaden.pdf, accessed 7 October 2015)

Health care providers are not likely to support a drastic change in the regulation of supplementary fees (such as a prohibition of extra billing), unless there is a compensation (e.g. in the form of an increase in government financing).

Normally, patients' willingness to pay supplementary fees should depend upon the value they get for the extra money spent. Supplementary fees can buy comfort, e.g. a private room in a hospital or a consultation at a convenient time, possibly a reduction in waiting time and access to well-reputed physicians. Patients paying supplementary fees might expect better quality to be offered. However, to the extent that patients cannot judge the quality of services, the efficiency of extra billing may be questionable (Kifmann and Scheuer, 2011). In the meantime, the willingness to pay supplementary fees for non-medical amenities such as shorter waiting times for non-urgent treatments, could be considered a consequence of the right to 'autonomy', namely people's right to spend their money as they choose.

3.5. CONCLUSION

Extra billing can be dealt with in three ways: prohibit, regulate or laissez-faire.

In the Netherlands, extra billing has been completely prohibited. U.S. Medicare[94] and private health insurers in Germany have regulated and restricted extra billing. In Belgium and France health care providers have a considerable freedom to charge supplementary fees.

Regulation sits on a continuum between a total ban and complete liberty. In the Netherlands, for instance, regulation eventually led to a prohibition of extra billing. Recently, new rules in Belgium (a ban on supplementary fees in double and common hospital rooms) and France (a limitation of supplementary fees to 150% on top of official tariffs) have been introduced to try to contain some of the negative effects of extra billing.

Governments can impose more regulation. Health care providers and payers can make agreements to voluntarily restrict extra billing. Creating more transparency about the practice of extra billing and the value created for the extra money paid, might also have a self-regulating effect.

94 Fees set by Medicare for physicians who have not enrolled in the participating provider program are 95% of the fees set for participating physicians. Total billed charges for non-participating physicians have been restricted to 115% of fees set by Medicare. Since the fee for non-participants is 95% of the fee for participants, physicians have effectively been permitted to balance bill their patients only 9.25% above the Medicare participating physician fee since 1993 (9.25 = [95 * 1.15 – 100] / 100) (McKnight, 2007.)

If extra billing is to be restricted or forbidden, special attention is to be given to the effect on the comfort of patients (e.g. waiting lists) and the income of health care providers (and hospitals).

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