

WAIT-TIME GUARANTEES FOR HEALTH SERVICES: AN ANALYSIS OF QUEBEC'S APPROACH

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The Quebec government's response to the Chaoulli Supreme Court decision regarding unreasonable wait times and private health insurance has been to introduce guaranteed wait time limits for certain health care services. In this paper I examine two documents: the White Paper (Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality), and Bill 33, tabled in June 2006. An analysis of these documents shows that the government is suggesting not one but two separate guarantee mechanisms quite different from one another: a public guarantee on the one hand and a public-private guarantee on the other.

The first one, the public guarantee, is for all practical purposes already in place, even if not in those terms, for tertiary cardiology and radiation oncology services. Results of the use of this mechanism in the past few years have shown dramatic improvement to access to care. I welcome the expansion of the public guarantee for health care services in Quebec.

However, the Quebec proposal also introduces a second type of guarantee, the public-private one, about which I express strong reservations. This guarantee is linked to staunch conservative ideology, as found in Canada and elsewhere, and it is part and parcel of the introduction of private health insurance for medical and hospital services, as well as the delegation of public services to private for-profit enterprises. Its main impact over the medium to long term would be the support of the legalization and expansion of private surgical facilities and, more broadly, the implementation of a parallel system of private medical and hospital care in Quebec. The public interest of Quebecers would be poorly served by such an initiative.

Le gouvernement du Québec a répondu à la décision de la Cour suprême du Canada dans l'affaire Chaoulli en introduisant le mécanisme de la garantie de soins comme solution aux délais d'attente déraisonnables. L'analyse du document Garantir l'accès : un défi d'équité, d'efficience et de qualité, et du projet de loi n° 33 qui a suivi, révèle que ce n'est pas un mécanisme qui est proposé mais bien deux mécanismes distincts de garantie d'accès : une garantie publique et une garantie du type public-privé, qui n'ont de commun que les apparences.

Le premier mécanisme de la garantie publique est déjà pratiquement fonctionnel dans les secteurs de la cardiologie tertiaire et de la radio-oncologie, même s'il n'en porte pas le nom. En effet, une réforme a été engagée dans ces domaines depuis quelques années et donne à l'heure actuelle des résultats probants. Il s'agirait d'un développement prometteur pour le réseau public de santé du Québec.

La proposition québécoise ajoute par ailleurs un autre mécanisme de garantie, que nous avons qualifié du type public-privé, afin de bien le distinguer de la garantie publique. Ce type de garantie pose problème. La filiation conservatrice, son couplage à l'ouverture à l'«assurance privée duplicative» pour les mêmes soins et l'introduction de l'entreprise privée à but lucratif comme délégataire de la prestation de certains soins nous permettent d'anticiper que l'un des principaux effets de la garantie du type public-privé ne serait pas de réduire les délais d'attente dans le réseau public, mais bien d'appuyer, ou de garantir, la création d'un système parallèle de soins privés. Le projet de loi n° 33 déposé à la fin de la session parlementaire en juin 2006 confirme cette approche. L'intérêt public des Québécois serait mal servi par un tel virage.

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1 The Supreme Court of Canada decision in *Chaoulli*

The Supreme Court of Canada rendered its judgement in the *Chaoulli*¹ case on June 9, 2005. Few decisions in its recent history have attracted the same level of media attention as this one. The next day, startling headlines appeared in newspapers across Canada.² In a controversial and close decision, a 4-3 majority had concluded that, given the unreasonable wait times for access to certain health services, the ban on private insurance for services covered under Quebec's public hospital and health insurance legislation³ violated section 1 of the Quebec Charter of Human Rights and Freedoms.⁴

The decision became the subject of numerous commentaries, in law journals⁵ and other specialized publications⁶ as well as in the media.⁷ The purpose of this paper is not to comment on the legal decision itself, but rather to offer an analysis of the Quebec government's response to the decision. Its proposals were contained in its White Paper, *Guaranteeing Access*,⁸ published on February 16, 2006, and in large part confirmed in Bill 33, *An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*, which was tabled in the National Assembly on the last day of the spring 2006 parliamentary session and became law on December 13, 2006.⁹ Quebec's Social Affairs Committee heard from more than 100 organizations and individuals that made written submissions in response to the White Paper.¹⁰ I will from time to time make reference to some of these submissions.¹¹

It is worth noting that the Supreme Court's decision rests on the existence of unreasonable wait times, which threaten the right to life and to personal security, rights guaranteed in section 1 of the Quebec *Charter*.¹² The government had three possible models at its disposal to ensure the right to health care, notably with respect to the problem of wait lists. Before examining the Quebec response more closely, it is useful to consider these three models briefly.

2 Three models of patients' rights protection

Canadians' concerns about the quality and accessibility of health care services are real and demand a response.¹³ Quebec and Canada are not the only jurisdictions that struggle with these problems,¹⁴ which generate vigorous debates both here and elsewhere.¹⁵ Close attention must be paid to the terminology being used, however, as the same word can encompass distinct phenomena, while similar techniques can sometimes be designated in different ways. The expression *Charter of Patients' Rights* offers a striking example of this phenomenon, as the term could refer to an administrative text, a public policy, a legislative text or even a text with constitutional authority. I will briefly review three possible models used by public authorities to ensure the protection of patients' rights.

2.1 The first model: rights written into health care legislation

The model of rights written into the legislative framework of the health care system is already well established in Quebec. Health care legislation outlines the rights of patients within the health care system. For example, sections 5, 6 and 13 of the *Act Respecting Health Services and Social*

*Services*¹⁶ state clearly that everyone in Quebec has the right to medically necessary insured services. Courts have recognized that individuals can request access to these services.¹⁷ We also note that Quebec differs from many countries in the Organisation for Economic Co-operation and Development (OECD) in allowing patients to choose their health professionals and health care institutions.¹⁸

The law also provides several other protections, including confidentiality of personal information and a complaint mechanism to effectively protect patients' rights. This mechanism recently underwent major reforms,¹⁹ and recent recourse to the Quebec Ombudsman, an agency that reports directly to the National Assembly, no doubt augurs well for the protection of citizens' rights.

2.2 The second model: guaranteed access with fixed wait times

Governments can sometimes establish targets to bring wait times under control and set specific maximum wait times for certain types of procedures. Failure to meet the targets can then entitle the patient to seek service from another professional or another institution, whether public or private. Some countries have experimented with different variations on this approach, but the results remain difficult to determine. The White Paper cites the experiences of the United Kingdom and Sweden²⁰ as two examples.

The guaranteed access model with fixed wait times is most often implemented through administrative service agreements between different service providers. These agreements give patients who have been subjected to wait times that exceed the specified standard access through public insurance coverage to health care institutions where such access would not normally be available. The guarantee therefore serves, in some situations, to override restrictions inherent in the public system. I will return to these observations when I discuss the Swedish and British experience with the guaranteed access model in section 4.5.

2.3 The third model: declaration of values, principles and rights

The third model involves increasing public awareness, through administrative or political means, so as to remind health care professionals and users of the values, principles and rights on which the health care system is based. This is the model put forward by Quebec's Conseil de la Santé et de Bien-être (CSBE) in 2005.

In August 2004, Quebec Health and Social Services Minister Philippe Couillard enlisted the CSBE to develop a proposed declaration of rights and responsibilities in the area of health and welfare. The CSBE first held a consultation, and then produced a guide to develop its proposal and prepared reference brochures to inform the public of the issues raised by the proposal. Finally, the CSBE filed its proposal with the minister in July 2005. The proposal was made public in August 2005,²¹ along with some supporting documents, including one that compared the proposal with other approaches that have been used in Canada and elsewhere.²²

In its comparative analysis, the CSBE first took note of the three possible models,²³ highlighting the fact that Quebec already has the equivalent of a charter as outlined in the first model, as the *Act*

Respecting Health Services and Social Services sets out everyone's relevant rights and responsibilities.

Since the mandate it had been given did not include revising the *Act Respecting Health Services and Social Services*, the CSBE faced a choice between the second model, an administrative guarantee of health care within a fixed wait time, and the third, a political declaration. The council opted for the third model, establishing a parallel with the European Charter of Patients' Rights, drafted by the Cittadinanzattiva–Active Citizenship Network.²⁴

The CSBE briefly explained why it did not choose the health care guarantee within a fixed wait time:

The Council's draft declaration does not mention service standards in the form of a right to service within time limits for two reasons. First, we did not want to confuse a political declaration with rights that would stem from administrative agreements. Second, we did not wish to create false expectations by setting out norms that could be recognized as unrealistic and could become overly rigid ... Experience overseas, such as in Britain and Spain, demonstrates that a reduction in wait times for access to medical services or surgery is more sensitive to increased public investment and restructuring by the government than to inclusion into a charter.²⁵

The CSBE has now been replaced by the Commissioner of Health and Welfare by virtue of the *Act Respecting the Health and Welfare Commissioner*,²⁶ enacted June 16, 2005, by the Quebec National Assembly. The Commissioner's functions as set out in the legislation will likely lead this new office to take a different direction from the CSBE, as the Commissioner is charged with evaluating the performance of Quebec's health care system and contributing to the debate on its viability.²⁷

According to the first section of the act, the Commissioner will be appointed by the government and will report to the Minister of Health and Social Services. Under the circumstances, the future of the CSBE's draft declaration appears uncertain.

3 The White Paper's option

3.1 Two types of guarantees

The White Paper *Guaranteeing Access*, made public February 16, 2006, by Premier Jean Charest and Health and Social Services Minister Philippe Couillard, recommends that Quebec adopt an approach involving guaranteed access to certain services with fixed maximum wait times, similar to the second model presented above. The guaranteed access mechanism plays a central role in the government's proposal. It represents a new approach for Quebec that has never been tested in this form. We first need to have a clear understanding of the proposed mechanism so as to better grasp the way it was incorporated into the legislation discussed in section 5. I will outline the major features of the proposal and then, in section 4, look at the ways it may relate to recent Canadian discussions regarding health care system reform.

It is important to understand that the document introduces not one but rather two very different kinds of wait-time guarantees – even though the way they are presented superficially appears to indicate that only minor nuances separate the two. In fact, the two types of guarantees differ in their structure, in their legal impact and in their potential medium- and long-term consequences for the public health care system. I will therefore make a clear distinction between the “public wait-time guarantee” on one hand and the “public-private wait-time guarantee” on the other.

I will briefly review the summary information provided in the White Paper. I will also try to anticipate the implications, despite the challenges posed by the limited data available at this time.

The mechanisms proposed in the White Paper would be introduced gradually and adapted over time on the basis of the results obtained and the resources available to the actors involved (p. 46).²⁸ Both types of guarantees have a twofold objective: treatment within defined wait times and personalized patient management (p. 47). These objectives are certainly important for Quebecers in general and for the smooth functioning of the health care system. The two types of guarantees translate into an obligation by the institution where a patient is first put on a wait list to deliver the required treatment within the prescribed wait time or, failing that, to direct the patient to another institution. In either case, the guarantee covers both medical and hospital services. The White Paper specifies that it will be instituted only in cases where the existing wait times are too long (p. 44). It cautions the reader about the complex nature of managing the guarantee mechanism, while highlighting its advantage in offering recourse²⁹ to citizens who feel they have been wronged.

3.2 The public wait-time guarantee

The White Paper proposes to introduce guaranteed access to certain services within wait times set according to medical standards. These services would be guaranteed within the public health system. The targeted services would be set through regulations from the minister of health and social services.³⁰ Instituted gradually, the guarantee would be supported by a reorganization of services, in stages, to the extent that human and financial resources allow (p. 45). Under the plan, such a guarantee would be offered initially for tertiary cardiology and radiation oncology treatments.

Practices and follow-up systems already in place for these services would be maintained. The White Paper drafters are confident that patients would be treated within the prescribed wait times. Two primary mechanisms are mentioned. One is the *Système de Gestion de l'Accès aux Services (SGAS)*, an information system that tracks the demand for tertiary cardiology and radiation oncology services throughout Quebec and provides standardized wait lists according to the priority level of the service requested. The other consists of service corridors that allow patients who have been waiting more than eight weeks to be transferred between radiation oncology centres.

Two observations are in order here. First, the services chosen to benefit from the public guarantee are ones involving critical medical situations. Radiation oncology and tertiary cardiology are areas where a patient's safety could be in serious jeopardy. This situation can be distinguished from cataract surgery or knee or hip replacements, all items reserved for the second type of guarantee. Second, cancer treatment has been the subject of lawsuits that have called public attention to the

problem of wait times in this area,³¹ which could well explain a stronger desire to remedy the situation.

The public guarantee for certain services relies on a substantial reorganization of service delivery within the public system. To a significant degree, the health network has already successfully accomplished this reorganization in regard to the two initial areas of treatment that were announced. It is also important to note that the public wait-time guarantee maintains the strict prohibition on duplicate private insurance³² for private for-profit services, contrary to the second type of wait-time guarantee associated with the introduction of affiliated specialized clinics (ASCs).³³ The White Paper states that the two primary measures required to ensure success for the public wait-time guarantee are already in place: proactive and centralized management of wait lists and effective service corridors between public institutions. We can assume that any other medical treatments added to the public guarantee will likewise first see the implementation of similar measures involving centralized, coordinated management of wait lists and service corridors between institutions in the health care network.

What recourse might be triggered by failure to meet the guarantee? The complaint procedure set out in chapter 3 of the *Act Respecting Health Services and Social Services* is the primary procedure available to patients who are dissatisfied with the management of their wait times for services covered by the public guarantee. Under this complaint procedure, the local or regional service quality commissioner would be involved, as would the Quebec Ombudsman, an agency that replaced the Health and Social Services Ombudsman as of April 1, 2006.³⁴

Patients can also always pursue a remedy through civil law, but this option frequently proves to be much too onerous and lengthy to be worthwhile for patients – all the more so given the inherent difficulties in any legal challenge dealing with public policy and public agencies' liability.

3.3 The public-private wait-time guarantee

Other types of hospital and medical services, also determined by regulation from the minister of health and social services,³⁵ will be covered by a separate type of guarantee: a public-private wait-time guarantee. Divided into three phases, the guarantee is associated with duplicate private insurance and provision of services by private, for-profit institutions. The public-private wait-time guarantee's connection to private payment and for-profit service is key to fully understanding the nature of the mechanism and its impact on the public health care system.³⁶

The public-private guarantee would initially be introduced for a small group of elective surgeries (hip and knee replacements and cataract surgery). In contrast to the *public* wait-time guarantee discussed earlier, the necessary conditions for its implementation are not yet in place within the public network.³⁷

The first phase of the public-private guarantee is public in nature, in terms of both financing and delivery, and continues that way for the first six months a patient is on a wait list following consultation with a specialist. During this period, the institution where the patient is wait-listed maintains responsibility for the follow-up and must schedule the procedure within thirty days of the initial registration. If this deadline cannot be met, the patient is then put on personalized patient management, which includes tight follow-up of the clinical situation in an effort to ensure that the

procedure takes place within the six-month period. The White Paper mentions that the necessary measures to ensure proper monitoring and management of standardized wait lists for the three designated procedures have not yet been put in place. Most likely, the waiting time will frequently go beyond the first phase, thus requiring patients to move to the second phase of the guarantee.

The second phase takes place between six and nine months after the patient is wait-listed. This phase is characterized by its dual nature since, while financing continues to be public, the delivery of surgical services can be transferred to private, for-profit clinics. Thus, if the patient was not treated by the local institution within the initial six-month wait time period, that institution will have to work with its regional health and social services agency to identify another facility that can offer the service: either another institution in the region or another region or an ASC with which the regional agency has entered into an agreement. The Réseaux Universitaires Intégrés de Santé (RUIS) can also be called on to help in the search when a patient must be transferred from one region to another.

Finally, if the treatment cannot be provided within the second phase – that is, within a nine-month period – the guarantee enters its third and final phase. At this point, the original institution could be required to purchase the service from a doctor who operates outside the public system or from an institution outside Quebec or even outside Canada. Both the Quebec-wide health care network and the regional agency would support the local institution in its search. The regional agency that first put the patient on the waiting list would be required to pay for the service from its own budget (p. 48). Thus, agreements between public bodies and private clinics would serve to formalize a system whereby surgical services provided by doctors practising outside the public system would be paid for out of public health funds.

The White Paper notes that the waiting periods could be open to some modification. An integrated information system would have to be put in place to establish standardized management of wait lists (p. 48). The White Paper does not specify, however, how these measures might be implemented nor does it discuss the budgetary allowances that will have to be made for this purpose.

The term *public-private* refers to the duality of public and private dimensions of this guarantee, in relation to both delivery and financing of care. On the delivery side, the introduction of ASCs into Quebec's health network systematizes the presence of private, for-profit organizations to which volumes of service delivery would be allocated and guaranteed by agreement, and thus possibly through the tendering process required by public-sector procurement.³⁸ The White Paper points to the fact that those clinics might be required to hold a hospitalization permit (p. 50). This confirms the introduction of private, for-profit hospitals into the Quebec health care system. The White Paper also indicates (p. 49) that the ASCs should hold an affiliated clinic permit for the procedures targeted by the agreement, thus making it clear that the clinic is free to pursue other activities that may not be covered by the agreement. This dimension of having private, for-profit delivery of surgical care is far from benign and raises numerous questions. It could open up the provision of these services to tendering processes and to international agreements. It may also infringe the conditions set out in the *Canada Health Act*,³⁹ most notably that of public administration.⁴⁰

At the same time, the public-private guarantee introduces a dimension of private financing for the services under the guarantee. Once the nine-month waiting period has expired, public authorities

must contract with privately funded service providers to deliver the required services. Therefore, this third phase of the public-private guarantee introduces mixed public-private financing into the Quebec health care system, contrary to the White Paper's stated goal of "separating the financing of the public and private sectors with as watertight a seal as possible" (p. 45).

The White Paper opens the door to having doctors who participate in the public system and non-participating doctors⁴¹ work under a single roof, or work in clinics controlled by the same company. This private for-profit company could thus recruit both participating and non-participating doctors. The participating doctors would take care of the procedures covered by the agreement in relation to the second phase of the public-private wait-time guarantee, while the non-participating ones would look after three categories of patients: 1) those who pay directly out of pocket; 2) those who are covered by their own duplicate private insurance; and 3) those coming from the public system who have reached the third phase of the guarantee. Such a new phenomenon introduced into the Quebec system would clearly jeopardize the status distinction between participating and non-participating doctors.⁴² It also raises a number of questions regarding cost control and regulation of medical practice, and creates double listing of patients for a single institution, which directly undermines the stated objective of integrated and centralized management of wait lists.

The public-private guarantee also puts private and public financing of health care in direct competition, throughout the wait-time period. According to the terms stated in the White Paper, insurance companies could offer coverage for surgeries or other procedures listed under the public-private wait-time guarantee, allowing their clients to bypass the waiting periods normally tied to that guarantee.⁴³

In other words, a patient with duplicate private insurance coverage could avoid the public regime's waiting periods and have direct access to private clinics where care would be provided by non-participating physicians. The White Paper does not bar a patient with private insurance from going to private clinics that serve two distinct groups of patients, one supplied and paid for by the public system and another financed directly by the patient or through duplicate private insurance coverage. There would be therefore two distinct ways to enter the same institution: patients registered on two separate waiting lists, in competition for the same operating rooms and the same technical staff. Even if the government succeeded in maintaining the distinction between participating and non-participating doctors,⁴⁴ public-private cross-subsidization and loss of priority for patients with the public-private guarantee would become the norm.

What recourses might be triggered by a failure to meet the guarantee? The complaints procedure outlined in the *Act Respecting Health Services and Social Services* would need clarification in order to apply equally to ASCs. Non-participating doctors should also be covered by the legislation.

The most striking difference between the public-private wait-time guarantee and the public guarantee is its potential impact on the public health care system. The public-private wait-time guarantee's boomerang effect is looming: the public system must rely on private organizations to fulfill its own obligations for which it can be held accountable. This type of guarantee amounts to delegation of public services and is accomplished through administrative and contractual

agreements between the public network and the ASCs. Such delegation funnels government finances to the private for-profit sector.

Long-term contractual agreements must be signed to cover the second and third phases of the public-private wait-time guarantee. They amount to built-in recognition of the failure of the first phase of the guarantee and the public dimension of the second and third phases, since the government will need to supply the ASCs or other clinics with non-participating doctors with a specified level of patients or procedures – and follow up with public financing. If patients do not receive treatment within the first phase of the guarantee, their recourse will simply move them on to the second and third phases, where contractual agreements with private ASC companies will come into play.

4 Where do concepts presented in the White Paper originate?

4.1 The Senate proposal and the national health care guarantee

This section will review past recommendations, in Quebec and elsewhere, that might help us establish the history that led to the plan set out in the White Paper. The Senate committee led by Senator Michael Kirby (the Kirby Committee) published six reports over the course of its work between 1999 and 2002. The committee's sixth and final report brought together all its recommendations for a reformed Canadian health care system.⁴⁵ Part 3, entitled "The Health Care Guarantee" and consisting of chapters 5 ("Timely Access to Health Care") and 6 ("The Health Care Guarantee"), are of particular interest for this analysis.

It is important to situate the Kirby Committee's report in relation to the progress of the *Chaoulli* court case. The report was made public after the Quebec Court of Appeal unanimously upheld⁴⁶ the decision of the Quebec Superior Court,⁴⁷ which rejected the request by appellants Chaoulli and Zeliotis to invalidate the prohibition on private insurance for health and hospital services covered by the Quebec public health insurance plan. On the other hand, the Kirby Committee's report *preceded* the decision by the Supreme Court of Canada, which accepted the appellants' petition and reversed the previous decisions.⁴⁸ The Supreme Court's decision triggered the current public debate in Quebec and across Canada concerning health care reform and introduction of duplicate private health insurance.

Part 3 of the Kirby Report focused on the problem of wait lists. It stressed the absence of reliable data on the subject and gave examples of Canadian experiences where a simple reorganization of the way the lists are managed made a real difference.⁴⁹

It is important to note that even before the unexpected Supreme Court decision, the Kirby Committee anticipated that the courts would strike a blow against the current system: "The Committee believes that the courts are likely to rule unconstitutional current laws that effectively prevent Canadians from paying privately, in Canada, for health care services that are publicly insured."⁵⁰ Having foreseen that the courts would strike down the legislative prohibition of private health insurance, the Kirby Committee recommended adopting a wait-time guarantee as a way of solving the problem.⁵¹

The hypothesis that rights protected by the Canadian *Charter of Rights and Freedoms* were being violated made its first appearance in the Kirby Committee's fourth report.⁵² Analysis by law firms⁵³ and the C.D. Howe Institute,⁵⁴ made public in May 2002, in the weeks following the Quebec Court of Appeal judgement, influenced the committee's thinking. The committee relied on the C.D. Howe Institute's document in predicting that the courts would invalidate the private insurance prohibition.⁵⁵ The final report explained this:

In the context of health care, then, the Charter might not require governments to ensure that a certain level of health care is available in the publicly funded system, but the Charter could be employed to stop governments from taking restrictive measures that deny individuals from having the freedom to seek health care on their own in Canada when the publicly funded system fails to provide such care in a timely manner.⁵⁶

The Kirby Committee concluded its analysis by saying that governments should not wait passively to be penalized by the courts and should immediately tackle the problem of wait lists.

We now turn our attention to the solution presented by the Kirby Report: the adoption of a national health care wait-time guarantee.

The report highlighted the lack of reliable information with regard to wait lists and mentioned some wait list management experiences in Canada that had led to promising results. It emphasized the difficulty of drawing definitive conclusions from international experiences with adoption of a wait-time guarantee, noting that these experiences were recent and limited to a handful of countries. It nevertheless concluded that the available data suggested that such a guarantee would help reduce wait times.⁵⁷

The Kirby Report further noted that the approach applied in Sweden "appears to do more to improve patients' freedom of choice than constitute a mechanism to regulate waiting times."⁵⁸ It made the same comment with regard to the Danish experience, where the guarantee essentially serves to extend patients' freedom to choose clinics in a parallel private network where they can receive treatment at public expense.⁵⁹

The Kirby Committee recognized that governments must take financial responsibility for their failure to implement efficient wait list management systems and must therefore, for now, use public funds to allow patients who wait too long to find care elsewhere.⁶⁰ It added that other Canadian reports had also proposed adoption of a wait-time guarantee, including the Mazankowski Report in Alberta,⁶¹ made public in December 2001, and the Canadian Medical Association's report, published in June 2002.⁶²

The Kirby Report stressed that, given the threat of judicial remedy, the health care wait-time guarantee should be adopted without delay:

Nonetheless, it is important to consider the consequences that would follow from a refusal on the part of the provinces to adopt the health care guarantee ... Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts.⁶³

The Kirby Committee's unexpected cautionary note concerning the democratic institutions of Canadian provinces highlighted the threat that a national health care wait-time guarantee adopted by Ottawa would pose to provincial jurisdiction. The committee's way of proceeding reflected a questionable interpretation of the Canadian Constitution in keeping with its political views.⁶⁴

Further along in the report, the committee tried to mitigate its forceful suggestion by expressing hope that provinces will voluntarily adopt the guarantee: "[The Kirby Committee] passionately hopes that it will not be necessary for unilateral action to be taken by the federal government."⁶⁵

Finally, the Kirby Committee concluded by insisting that the wait-time guarantee recommendation was closely linked to the other recommendations in the report.⁶⁶

4.2 The federal Conservative Party's proposal

The public-private wait-time guarantee proposed by the Quebec White Paper presents a similar approach to the one in the Kirby Senate Committee report.

The threat of federal government implementation of a national health care wait-time guarantee, mentioned in the Kirby Report, has taken on a much more urgent dimension following January 23, 2006, when the Conservative Party of Canada, led by Stephen Harper, came to power. There is an obvious link between the Quebec proposal and the Conservative Party's election platform, which seeks to implement a national health care wait-time guarantee, associated with an opening to mixed public and private delivery of services.⁶⁷

The Liberal Party platform also included a promise to adopt a national health care guarantee,⁶⁸ but a key point distinguishes the two proposals. The Liberal proposal was essentially based on specialized public centres of excellence, while the Conservative proposal relied on a combination of services provided by public institutions and private for-profit organizations.

To summarize, the mechanisms proposed by the White Paper trace their lineage as follows: the public guarantee is associated with the federal Liberal platform, while the public-private wait-time guarantee is in line with the Kirby Report and the federal Conservative platform. The introduction of duplicate private insurance for procedures covered by the public-private guarantee is an additional element, which the White Paper justifies by the Supreme Court decision in *Chaoulli*.⁶⁹

4.3 The difference in relation to the Romanow proposal

The Commission on the Future of Health Care in Canada (2001–2), known as the Romanow Commission after its commissioner,⁷⁰ received its mandate directly from the Canadian government. The time frame of the commission's work overlapped with that of the Kirby Committee, and it too studied the problem of wait times.⁷¹ In its final report, it rejected the hypothesis that this was a simple problem of perception and acknowledged that the situation was dire, even if the data are incomplete and not always reliable. It also shelved the suggestion advanced by some that Canada open parallel private health care institutions.

The Romanow Report outlined two recommendations to respond to wait times: use new federal funds for diagnostic services and ask the provincial governments to implement centralized wait list management, after adopting standardized criteria to establish the situation's urgency.⁷² The Romanow Commission concluded that public, transparent and scientific centralized management of the lists offered the best hope for a marked improvement in wait times.

The Romanow Report did not reject the idea of a health care guarantee and even suggested that it be given consideration, but it did not go so far as to actually recommend it.⁷³ The report discussed the advantages of the guarantee in the context of the peace of mind offered to patients and the positive influence a guarantee can have on regional health authorities. On the other hand, the Romanow Report raised two concerns relating to a health care wait-time guarantee. The first involves the absence of objective, reliable criteria on which to base the targets. The second is the inflexible competition between life-saving and elective surgeries that the guarantee may set in motion. The guarantee could introduce an inequitable and unscientific method for prioritizing patients.

It is important to note a fundamental distinction between the type of guarantee considered in the Romanow Report and the one proposed in the Kirby Report and the Conservative Party platform. The big difference hinges on whether or not there are private for-profit institutions within the health network that can act as guarantors. For the Romanow Report, the guarantee acts as a target for equitable delivery within the public system, while for the Kirby Committee and the Conservative federal government, the guarantee becomes a mechanism that allows public resources to be directed towards private health care organizations on which the public network must rely to respond to needs. Thus, the full meaning of a health care wait-time guarantee becomes clear only when considered along with all elements with which it interacts.

4.4 The Alberta Conservative position

The report of the working group on the future of the health care system mandated by Alberta Premier Ralph Klein and led by Don Mazankowski was made public in December 2001.⁷⁴ It was enthusiastically received among Conservatives and businesspeople, but was almost unanimously denounced by community groups, unions and spokespersons for the public health care system.⁷⁵ The conservative tone of the Mazankowski Report was clear: it recommended the introduction of duplicate private insurance, the delisting of certain public services, the delivery of targeted surgical procedures by private for-profit clinics and the implementation of medical savings accounts. The very first recommendation of the Alberta report for revamping the health care system involved implementation of an a 90-day wait-time guarantee for certain services, with the introduction of private for-profit clinics built in:

If regional health authorities are unable to provide service within 90 days, they would have to consider other options for getting the service from another region or within a reasonable distance. Services could be arranged from either a public or private sector provider. If they are unable to arrange services within 90 days, government would arrange for the services in another jurisdiction and the costs would be charged to the region where the patient lives.⁷⁶

The resemblance to the public-private wait-time guarantee proposed in the Quebec White Paper is striking, apart from the choice of procedures and wait-time targets. Although the connection with private insurance is not clearly stated in the Mazankowski Report, this connection comes up implicitly in the Alberta government's move to delist certain insured services and to allow private payment for enhanced services.⁷⁷ Further, Mazankowski's proposal predated the Supreme Court's decision in *Chaoulli*,⁷⁸ and Alberta subsequently put forward a proposal that would not risk incurring penalties on federal transfers under the *Canada Health Act*. The Kirby Report clearly emphasized the link between its proposed guarantee and Alberta's.⁷⁹

On February 28, 2006, on the heels of the Supreme Court decision in *Chaoulli*, the Klein government published a newly radicalized policy paper in its push to reform the health care system.⁸⁰ Proposals in the new report are described as the second phase of the reform effort started back in 2001 following publication of the Mazankowski Report. Alberta's 2006 approach is strikingly similar to Quebec's, although it differs in the notable absence in the policy paper of any mention of a health care wait-time guarantee along the lines of the federal Conservative Party's proposal. It is unclear why this aspect of the Mazankowski Report was abandoned in Alberta's new policy, but the most likely explanation is that the privatization of certain health care services is spelled out so forcefully and clearly that there is no longer any need for a supplemental mechanism to buttress the approach.

Furthermore, if Alberta's clear and pressing goal is to promote a parallel private health care system, no additional effort has to be devoted to improving the public system.⁸¹ The deeper the gap between the two systems, the more attractive the private system will become and the more people will be willing to pay for additional insurance. On April 3, 2006, Prime Minister Harper wrote to Premier Klein to express his concerns about the reform policies outlined in the February 28 paper. In the letter he emphasized that the policy proposed by Alberta could contravene the requirements of the *Canada Health Act*.⁸² Harper reminded Klein that establishing a health care guarantee in collaboration with all the provinces was a priority of his government and noted his surprise that the Alberta plan made no provision for such a guarantee. He specified that he preferred the proposals for new health care delivery methods that had been put forward by Alberta a few years earlier. Harper indicated clearly that he favoured Quebec's approach, which he believes other provinces, including Alberta, should follow in planning their own reforms.⁸³

4.5 Reviewing foreign models

The White Paper briefly examines health care wait-time guarantees adopted in the United Kingdom and Sweden.⁸⁴ Since these foreign experiments fed into the government's considerations, they are worth revisiting. However, it can be risky to draw lessons from experiments with guaranteed wait times in other countries – including the United Kingdom⁸⁵ and Sweden⁸⁶ – since there are important structural differences between their health care systems and those of Quebec and other Canadian provinces. The White Paper emphasizes the point that these mechanisms can be extremely complex to manage and must be constantly reviewed and modified as necessary and appropriate.⁸⁷ Still, identifying the context of the reforms within which these countries introduced a guaranteed access model can be a very useful exercise.

Britain's national health care system, the National Health Service (NHS), was introduced in 1948 and underwent major reforms during the 18 years of Conservative government (1979–97) led by Margaret Thatcher and then, after 1990, by John Major. Under Conservative rule, internal markets were used as a way of separating the purchase and delivery of health care. The reform was designed to introduce incentives into the system through enforced competition as a way of controlling costs. The results of this exercise have been the subject of much criticism and ongoing debates, while the problems faced by the NHS have persisted. Wait lists grew and so-called two-tier health care expanded,⁸⁸ taking the form of a growing parallel private delivery sector and a surge in duplicate private insurance.

After the Labour Party came to power in 1997, its leader, Tony Blair, proposed new reforms based on collaboration between the various sectors of the system already in place. Under his proposal, the parallel private sector was to become further integrated into the public financing of the NHS, while expenditures of public funds would be significantly increased. Starting in 2000, health care networks were instituted, leading to the creation of a new level of regional management for the NHS through groups known as primary care trusts (PCTs). These groups were given budgets for negotiating care contracts. The contracts, signed with private-sector health care providers, typically covered a five-year period and made provision for guaranteed levels of clinical procedures.⁸⁹ Integration of the public and private delivery sectors meant that patients could freely access a multiplicity of service providers. NHS regulations were modified to guarantee this freedom of choice. Since January 1, 2006, patients have been able to choose among four service providers, normally including one from the private sector. With its eighteen-week pathway, the NHS plans to eliminate almost all restrictions on the choice of institution.⁹⁰

It was in this context that the health care wait-time guarantee was introduced by the Blair government in 1998 and then modified in 2002 and 2004. A policy for implementing the eighteen-week maximum wait time, part of the 2004 plan, was recently put into action.⁹¹ The British guarantee thus clearly plays a role in ensuring the movement of patients between the public NHS sector and the private health care delivery sector that was strengthened under the Conservative government.

In Sweden, the national treatment guarantee, as described in the White Paper, sets a maximum wait of ninety days for a consultation with a medical specialist and another ninety days to receive the appropriate treatment.⁹² It was first introduced in 1991 by the conservative government of Carl Bildt, which was replaced in 1994 by a social democratic coalition government. Growth in the parallel private health care sector was strictly limited by maintaining the prohibition on mixed medical practice. The privatization of health care in Sweden has primarily been seen in the growth of publicly funded private hospitals since the early 1990s. The hospitals (like St. Göran's Hospital in Stockholm) were first converted into public companies, which were then transferred to private owners.

Since January 1, 2003, Swedes have been able to be treated in the county of their choice by the provider of their choice. However, the counties try to influence patient choice by charging a lower fee for a visit to a general practitioner than for a hospital visit and a higher fee if the patient is treated elsewhere than in his or her home county.⁹³

The British and Swedish experiments suggest that a guaranteed access mechanism works in tandem with the growth of duplicate private insurance or private for-profit health care delivery markets, in a context of increased public financing. Where the guaranteed access mechanism includes a service corridor between the public and private delivery systems, it allows patients with only public coverage to have access to private institutions whose development may either follow or precede implementation of the wait-time guarantee.

Thus, one effect of the guarantee mechanism is to allow patients access to a parallel private system. Duplicate private insurance cannot develop without a sustainable parallel private system, which itself needs favourable conditions to grow. As with the chicken and the egg, public health care system reforms may favour the development of private insurance first, or private delivery first, or both at the same time. A public-private wait-time guarantee as proposed in the Quebec White Paper sets in motion a careful step-by-step, synchronized movement of both these elements. It is important to understand that Quebec does not currently have a duplicate private insurance market for medical and hospital care, nor a parallel private health care system to speak of, since very few doctors in Quebec – fewer than one half of one per cent – have opted out of the public system.

5 From policy to legislation

5.1 The minister's precautions

Health care policy was a major preoccupation in the Quebec National Assembly at the end of the spring 2006 parliamentary session. Apart from the nineteen days of hearings held by the parliamentary Social Affairs Committee to study the White Paper, there were intensive negotiations concerning the renewal of agreements between the Quebec government and the two large doctors' unions, one representing general practitioners (Fédération des Médecins Omnipraticiens du Québec – FMOQ) and the other representing specialists (Fédération des Médecins Spécialistes du Québec – FMSQ).⁹⁴ During the night of Monday, June 12, to Tuesday, June 13, the legislature adopted special emergency legislation⁹⁵ imposing conditions for renewing the agreement with the specialists.⁹⁶ The next day (Wednesday, June 14), Health and Social Services Minister Couillard held a press briefing⁹⁷ to announce the signing of an agreement with the FMOQ, which essentially lifted the cap on physicians' fees.⁹⁸

On June 9 – the day after the parliamentary committee studying the White Paper finished its deliberations, and also the day the Supreme Court's stay of application of its ruling in *Chaoulli* expired – Couillard officially announced that a bill would be introduced soon. He made a point of saying that the ban on private insurance would continue, with a limited opening for the three procedures mentioned in the White Paper – hip, knee and cataract surgery. The minister expected the bill to be passed by the fall of 2006, with the provisions to come into force retroactively as of June 9, 2006, the day the Supreme Court decision took effect. He stated clearly that the legislation would be retroactive so as to prevent insurance companies from starting practices that would later be retroactively banned.

The bill that came out of the White Paper and the *Chaoulli* decision was given first reading a week later, on Thursday, June 15, the last day of the parliamentary session before the summer break.⁹⁹

The government announced that same day that a small parliamentary committee would be appointed to study the bill's contents from September 14 to 16.

The introduction of Bill 33, and its passage into law in December 2006, allows us to complete our analysis of the Quebec proposal with a brief commentary on its embodiment in legislation. The bill did not contain any major surprises, and was generally in keeping with the proposals contained in the White Paper and the discussions by the parliamentary committee, except for the regularization and promotion of existing private surgical practices. The bill in question introduced the three main mechanisms described above: the public and public-private wait-time guarantees, restricted duplicate private insurance, and the delegation of health care services to private for-profit enterprises.

5.2 Implementation of a public mechanism for managing wait times

Bill 33 implements, in sections 7¹⁰⁰ and 8,¹⁰¹ the proposal outlined in the White Paper of a centralized mechanism for wait list management by hospitals for specialized and superspecialized services. Centralized management of wait lists is recognized as an effective and necessary way of responding, at least in part, to the problem of unreasonable wait times.¹⁰² One can celebrate the inclusion of such a mechanism, which falls under the responsibility of the director of professional services, who must ensure that the head of each clinical department looks after its proper functioning. In addition, the executive director of the hospital must regularly report to the board of directors on the efficacy of this mechanism.¹⁰³ Section 17 of Bill 33 also adds a new section 431.2 to the *Act Respecting Health Services and Social Services*, which authorizes the minister to intervene and take whatever measures may be necessary to implement particular access mechanisms whenever the usual procedure would risk incurring unreasonable delays.

The point of centralized management is to improve access to health services within a reasonable and appropriate period of time. Centralized management should allow for significant improvement in access to certain services without it being necessary to add to the productive capacity of the system. Studies show that some resources remain underused, even where there is a significant wait time, because of poor management.¹⁰⁴

Centralized management, however, would not be complete without determining what constitutes a reasonable wait. This second aspect of the management mechanism represents a significant challenge. If government authorities can sometimes agree on a target as a maximum wait time for a procedure, this does not mean that the same wait time should necessarily apply to every patient needing the same procedure. For example, a hip replacement within six, nine or fifteen months, according to the target set by the administrative norm, could be reasonable for a patient who can continue to function more or less normally, but it could be unreasonable for a patient who is in extreme pain and for whom moving around has become impossible.¹⁰⁵

The challenge of setting reasonable wait times should be the subject of discussions and consensus among medical experts. These wait times should normally be written into administrative standards. Bill 33 remains silent on this point.

5.3 Private for-profit hospitals by another name

Over the years, private surgical clinics have appeared in a legal grey area and outside public scrutiny. There are two types of such clinics, depending on whether or not the doctors who work in them are participating or non-participating. In either case, major surgical procedures are performed, such as hip or knee surgery. Some of these procedures, such as hip replacements, may require overnight stays. Functioning as a simple private office and yet providing in-patient care without a hospitalization permit, these clinics have until now operated at the legal margins.¹⁰⁶

Surgical clinics whose doctors participate in the public system present additional problems when they charge patients fees for medical services covered by the Régie de l'Assurance Maladie du Québec (RAMQ), the provincial government health insurance plan. Directly or indirectly, these clinics collect three types of payment to finance their surgical services: 1) fee-for-service payments to the doctor, paid by the RAMQ; 2) additional user fees to pay for health professionals and surgical facilities, paid by the patient; and 3) payments for drug substances used (including drugs and anesthetics), paid directly by the patient, with some of these payments partially reimbursed by the Quebec prescription drug insurance plan. The additional fees could be considered "extra-billing" in the sense prohibited by the *Canada Health Act*.¹⁰⁷

Faced with this situation, public authorities have two options. Without carrying the analogy too far, I will compare the situation to illegal drugs or prostitution to make a point. Some people maintain that drugs and prostitution clearly need to be outlawed and their proliferation needs to be resisted. Others believe that these phenomena are practically impossible to eradicate, and their legalization would acknowledge this fact while allowing better control over their harmful effects and abuse. Of course, unlike drugs and prostitution, the operation of private surgical clinics is not a criminal offence. Nevertheless, the analogy clarifies the choice that Quebec faces: either a clear ban on the medical practice in question – which is marginal in relation to the profession as a whole – or its regularization, with conditions established for its growth.

In Bill 33, which became law on December 13, 2006, the Quebec government chose the second option by inserting a new title, "Specialized Medical Centres," in the *Act Respecting Health Services and Social Services*.¹⁰⁸ Whether or not the doctors involved participate in the public system, specialized medical centres (SMCs) need to have an operating permit.¹⁰⁹ Their authorization by the government is associated with various forms of regulation, such as an accreditation procedure.¹¹⁰ An SMC must appoint a medical director¹¹¹ and is authorized to perform hip, knee or cataract surgery or any other specialized medical treatment determined through regulation by the minister.¹¹² The permit issued to an SMC specifies the number of beds available for patients.¹¹³

Bill 33 provides that if an SMC is owned by a legal person or partnership, a majority of voting rights must be held by doctors who are members of the Collège des Médecins du Québec.¹¹⁴ No producer or distributor of health-related goods or services that could be required by an SMC's patients at any point in their treatment may hold shares in that SMC.¹¹⁵ The intent is to exclude pharmacists, pharmaceutical companies, orthopedic equipment suppliers and providers of private health-related insurance (either drug coverage or the new possibilities available in health care that will be discussed in section 5.4), among others. Through this provision, the establishment of a Quebec equivalent of American health maintenance organizations (HMOs) would be

proscribed.¹¹⁶ If an SMC is under sole ownership, the owner must again be a doctor who is a member of the Collège des Médecins du Québec.

Unlike the formulation in the White Paper analyzed in section 3.3, Bill 33 makes it impossible for doctors participating in the public system to share the human resources, equipment and medical and surgical facilities of a private clinic with non-participating doctors. The new section 333.3 of the *Act Respecting Health Services and Social Services* inserted under Bill 33 clearly indicates that an SMC must employ either participating or non-participating doctors, but not both. Thus, an SMC would be publicly or privately financed, subject to some exceptions, discussed later.

With the common characteristics of the two types of SMC in mind, I will now describe their differences. Only an SMC with non-participating doctors can be paid through the new private insurance coverage authorized by Bill 33. An SMC with non-participating doctors must provide all the care associated with the surgery or treatment in question, from preoperative through postoperative services, rehabilitation and home care. If the SMC itself cannot provide these services, it needs to ensure their provision by another facility whose financing is exclusively private.¹¹⁷

By contrast, an SMC with participating doctors can sign an exclusive agreement with a public institution¹¹⁸ and thus become an “associated medical clinic” (AMC),¹¹⁹ which corresponds to what the White Paper calls an affiliated specialized clinic (ASC). The only extra fees that these clinics can charge patients are the same ones that are authorized in public institutions.¹²⁰

Thus, depending on the treatments that it offers, an SMC with non-participating doctors could well be the equivalent of a for-profit hospital. Such an SMC is authorized to practise surgery, provide in-patient care and be remunerated by patients or their insurers for some of these services. SMCs with non-participating doctors could thus become the basis for the development of a parallel private health care network.

While SMCs with doctors who participate in the public system are integrated into the public health care network, they still constitute a new form of privatization of health care delivery. Remuneration of doctors in these SMCs may contain new elements that are distinct from the fee-for-service, salary or mixed payments that doctors have hitherto received from the RAMQ. This phenomenon is similar to the establishment of publicly financed private hospitals in Sweden,¹²¹ although the arrangements for ownership differ significantly. As I noted in my discussion of the White Paper's ASCs,¹²² an SMC that becomes an associated medical clinic¹²³ institutionalizes the contracting-out of public services to a for-profit organization. The new section 349.3 of the *Act Respecting Health Services and Social Services* specifies the content of the agreement that must be signed, with the minister's authorization, between a regional health and social services agency and an institution under its jurisdiction, on the one hand, and an AMC on the other. Such agreements are for a maximum five-year period, subject to renewal.

5.4 The prohibition of duplicate private insurance

The Supreme Court's *Chaoulli* decision targets two sections that prohibit duplicate private insurance for medical and hospital care: section 11 of the *Hospital Insurance Act* and section 15 of the *Health Insurance Act*. I have explained elsewhere why Quebec should renew the prohibition of duplicate private insurance and how it could do so, to the extent that it presents a credible response to the problem of unreasonable wait times.¹²⁴ Bill 33 shies away from the approach of maintaining a total ban on duplicate private insurance. At the same time, however, it does not throw the door wide open, as some witnesses before the parliamentary committee proposed – notably the Action Démocratique du Québec (ADQ),¹²⁵ Dr. Jacques Chaoulli¹²⁶ and others.¹²⁷ The White Paper suggested allowing duplicate private insurance for knee, hip and cataract surgery, and Bill 33 confirmed this approach. These types of surgery – which may require in-patient care – are to be financed through new duplicate private insurance allowed by the Quebec government. They must be performed outside public institutions by non-participating doctors. Hence, the government's introduction of duplicate private insurance has an impact on health insurance and also, indirectly, on hospital insurance.

In short, Bill 33 amends section 15 of the *Health Insurance Act* by authorizing insurance contracts for all services “required for a total hip or knee replacement, a cataract extraction and intraocular lens implantation or any other specialized medical treatment”¹²⁸ determined by the government, in conformity with the new section 15.1 of the *Health Insurance Act*. The new section 15 specifies that the private insurance contract must also cover preoperative and postoperative services, rehabilitation and home support. The new section 15.1 outlines a mechanism for broadening the opening to duplicate private insurance beyond the three specified surgeries. Any addition to the three procedures specified in section 15 must be drawn from the list of procedures that the minister has previously authorized to be performed in SMCs.¹²⁹ The government may exercise this regulatory power only after a study by a parliamentary committee.¹³⁰

In terms of hospital insurance, there is an amendment to section 11 of the *Hospital Insurance Act* that could appear to be a restatement of a total ban on private hospital insurance. The section is brought up to date with an extension of the ban to (noninsured) employee benefit plans. In addition, the last paragraph provides for fines of \$50,000 to \$100,000 for any contravention, and double that for a second offence. These extraordinary fines seem to be a steep increase over the \$100 fine previously found in section 15 of the act. This impression, however, does not reflect reality. As we saw earlier, Bill 33 provides for the introduction of SMCs. While not technically considered hospitals, SMCs perform some of the same functions as hospitals with regard to the surgical procedures carried out there. These equivalent “hospital” services would not come under the *Hospital Insurance Act*, and hence are not covered by the ban on duplicate private hospital insurance.

The amendments to these two acts represent significant changes to the legal structure of health insurance in Quebec. First of all, the introduction of duplicate private insurance for some health services covered by the public system, in and of itself, required that the legislation covering the public insurance system be adapted to the presence of duplicate private insurance systems. This is why the new formulation for section 15 of the *Health Insurance Act* and section 11 of the *Hospital Insurance Act* not only deals with private insurance in general; it also specifically authorizes or bans (as the case may be) coverage of the same services by employee benefit plans. Private

insurance often becomes important and substantial only when it takes the collective form of employee benefit plans, as happened with prescription drug insurance even before the introduction in 1997 of mandatory private insurance as part of the overall Quebec prescription drug insurance plan.¹³¹

The distinction between hospital care, covered by the *Hospital Insurance Act*, and medical care, covered by the *Health Insurance Act*, can be explained by the historical development of public health insurance coverage in Quebec and Canada. The introduction of private health insurance for surgical procedures that can be performed in an SMC holding a permit for in-patient care renders this distinction inoperative. Regulation of services in an SMC that are equivalent to hospital services now falls under the *Health Insurance Act*. In sum, despite appearances to the contrary, the prohibition of private hospital insurance has also been partially breached for all services carried out in an SMC with non-participating doctors. The instrument of this major change is the amended *Health Insurance Act*.

5.5 Introduction of a public-private wait-time guarantee confirmed

The structure established under Bill 33 confirms the introduction of a public-private wait-time guarantee as outlined in the White Paper. This guarantee is organized around the public guarantee and based on the establishment of the two types of SMCs. Guaranteed levels of health care will be directed towards SMCs with participating doctors. Institutions in the public sector can also direct patients towards SMCs with non-participating doctors, once the wait time has exceeded the administrative standard for reasonable wait times for the procedure in question.¹³² SMCs with non-participating doctors are in direct competition with the public system for all authorized procedures, and especially for those covered by duplicate private insurance, which in and of itself places these services under a public-private wait-time guarantee. The White Paper put forward the idea of capping fees charged by non-participating doctors, but this idea was not incorporated into Bill 33.

Conclusion:

Why should the reform of Quebec's health system be based on a conservative agenda?

Bill 33, like the White Paper, puts forward two types of wait-time guarantees: a public guarantee and a public-private guarantee. I have tried to outline the origin and sources of inspiration of each of these formulas. The inspiration for the public-private wait-time guarantee clearly appears to be conservative, and it promotes an increased role for private industry in the health sector, in terms of both financing and delivery. The duplicate private insurance industry in the health sector is normally based on a separate health care delivery system, as the OECD's international study reminds us.¹³³ No such separate system currently exists in Quebec or in Canada. Before the government can allow a significant market in medical and hospital care to develop for the duplicate private insurance industry, it needs to provide favourable conditions for the growth of such a separate system. This can be done through the legalization of some existing private surgical procedures. Hence, the promotion of ASCs in the White Paper and by the current Conservative federal government, and their presence in Bill 33 in the form of the two types of SMCs, could well

be the cornerstone of this agenda, in conjunction with a targeted opening to duplicate private insurance, both for the specified medical services and for the equivalent hospital services where those services require in-patient care.

This target is undoubtedly compatible with a conservative political program. It is, however, in dire conflict with the strengthening and consolidation of the public health care system, and with an appropriate response to the problem of wait times within Quebec's public system.

The White Paper wisely states that a new policy needs to be implemented gradually and progressively, so as to maintain the coherence of the health system and make sure that adequate financial and human resources are available for the change. The public guarantee proposal meets this condition, as the areas for which the guarantee is proposed are already in a position to respond appropriately to the establishment of prescribed wait times, within the public system.

Bill 33 does try to maintain the maximum degree of separation between public and private systems.¹³⁴ In time, however, the numerous exceptions, along with the development of the public-private wait-time guarantee,¹³⁵ could cause the weak barriers to crack. Knowing the conservative origins of the public-private wait-time guarantee gives us a better idea of its goals and allows us to predict its effects.

In conclusion, it is worth coming back to the definition of duplicate private insurance: "The main characteristic of duplicate [private health insurance] is that it provides people already covered by public health systems with a private alternative coverage for the same sets of services."¹³⁶ To the extent that purchase of duplicate private insurance coverage represents duplication or overlap in relation to services already covered by the public system, it makes sense only if it provides access to higher-quality care. Quality can be measured by the facilities in which care is provided, the reputation of the health professionals who deliver the services, or the length of time it takes to provide access to services.

A targeted and coordinated opening of the door to duplicate private insurance and for-profit private delivery kicks off a dynamic that moves resources from the public health care system to a developing private delivery system. It may feed an opening gap between the two systems that would make the private system more attractive than the public one. Subjecting the public system to prescribed wait times, even before the measures needed to meet those wait times are in place, will force the public system to transfer patients on a continuous basis to a parallel private network. In this scenario, public funds will support the growth of this private network, allowing it to meet its goals. Hence, such a public policy can certainly appear advantageous for that business sector. Whether it is a wise policy for Quebec's public finances and patients, however, remains questionable.

Endnotes

¹ *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791.

² Hyperbolic headlines were especially common in English Canada: A. Coyne, "A Final Chance to Fix the System," *National Post*, June 10, 2005, p. A-1; A. Coyne, "Destroying Medicare's Myths," *National Post*, June 10, 2005, p. A-20; A. Duffy, "Ruling Cuts Through Myth to Deadly Truth," *National Post*, June 10, 2005, p. A-8; A. Duffy, "Health Care's Main Malady," *Ottawa Citizen*, June 10, 2005, p. A-3; A. Heller, "Medicare Shockwave Felt South of Border," *Ottawa Citizen*, June 10, 2005, p. A-6; "A Supreme Shot in the Arm: Right to Buy Private Health Care Should be Extended Here Too," *Calgary Herald*, June 10, 2005, p. A-22; D. Martin, "Fast Relief from Health-Care Lineups a Credit Card Away," *Calgary Herald*, June 10, 2005, p. A-7. Here are some examples of headlines in Quebec dailies: V. Marissal, "Le pavé dans la mare," *La Presse*, June 10, 2005, p. A-1; A. Dubuc, "Quand une loi est absurde," *Le Soleil*, June 10, 2005, p. A1; P. Gravel and R. Dutrisac, "Santé: la Cour suprême ouvre la porte au privé," *Le Devoir*, June 10, 2005, p. A-1. There was media coverage outside Canada as well: C. Krauss, "Canadian Court Chips Away at National Health Care," *New York Times*, June 9, 2005; C. Guly and M. Farley, "Ruling May Threaten Canada's Healthcare System," *Los Angeles Times*, June 10, 2005.

³ Section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28; section 15 of the *Health Insurance Act*, R.S.Q., c. A-29.

⁴ R.S.Q., c. C-12.

⁵ C.M. Flood, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access," (2005) 33 *Journal of Law, Medicine & Ethics* 669; Harvard Law Review Association, "Due Process, Right to Medical Access, Supreme Court of Canada Holds that Ban on Private Health Insurance Violates Quebec Charter of Human Rights and Freedoms," (2005) 119 *Harvard Law Review* 677; M. Jackman, "The Last Line of Defence for [Which?] Citizens?: Accountability, Equality and the Right to Health in *Chaoulli*," *Osgoode Hall Law Journal* (forthcoming); M.-C. Prémont, "L'affaire *Chaoulli* et le système de santé du Québec: cherchez l'erreur, cherchez la raison," (2006) 51 *McGill Law Journal* 167.

⁶ C.M. Flood, L. Sossin and K. Roach, eds., *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005).

⁷ In Quebec alone: P. Garant, "Décision de la Cour suprême sur le système de santé: un choix politique ou judiciaire?," *Le Devoir*, June 11, 2005, p. B-5, and *Le Soleil*, June 10, 2005, p. A-15; H. Brun, "En toute légitimité, le Parlement doit avoir le dernier mot," *Le Soleil*, June 10, 2005, p. A-15; M.-C. Prémont, "Régime public universel de santé du Québec: l'urgence d'agir suite au jugement de la Cour suprême," *Le Devoir*, June 16, 2005, p. A-7; H. Brun et al., "Privatisation des soins de santé au Québec: il n'y a pas d'ordre de la Cour suprême," *Le Devoir*, November 17, 2005, p. A-7, and in English as "Quebec Medicare Plan is Not What the Supremes Ordered," *Montreal Gazette*, November 17, 2005, p. A-29.

⁸ Ministère de la Santé et des Services Sociaux (Quebec), *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality* (Quebec City: Government of Quebec, 2006). Retrieved April 9, 2007, from <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-721-01A.pdf>

⁹ S.Q. 2006, c. 43.

¹⁰ Hearings began on April 4, 2006, and ended on Wednesday, June 6, 2006. In all, 108 individuals, groups and organizations appeared before the committee and made submissions.

¹¹ I presented an earlier version of this paper during the first day of the Social Affairs Committee's hearings: M.-C. Prémont, *La garantie d'accès aux services de santé: à quel modèle se vouer?* (March 24, 2006). Retrieved April 11, 2007, from www.assnat.qc.ca/fra/37legislature2/commissions/cas/depot-acces.html

¹² In her majority opinion, Justice Deschamps wrote, "Not only is it common knowledge that health care in Quebec is subject to waiting times ..." (*Chaoulli v. Québec [Attorney General]*, para. 39). Citing the testimony of Dr. Daniel Doyle regarding the risks faced by patients suffering from cardiovascular disease, she added, "In such cases, it is inevitable that some patients will die if they have to wait for an operation" (para. 40). And further: "If the evidence establishes that the right to security of the person has been infringed, it supports, *a fortiori*, the finding that the right to the inviolability of the person has been infringed" (para. 43).

¹³ See the documents prepared by the Réseau de Recherche en Santé des Populations et l'Assurance Privée, especially D. Contandriopoulos and H. Bilodeau, *Satisfaction et inquiétude: l'ambiguïté de l'opinion sur le système de santé* (February 2006). Retrieved April 11, 2007, from www.santepop.qc.ca/chaoulli/precis_f.asp

¹⁴ Problems with health care wait times have been noted in all but eight OECD member countries: Germany, Austria,

Belgium, the United States, France, Japan, Luxembourg and Switzerland. This does not necessarily mean that all citizens in these countries enjoy access to health care within a reasonable time. See L. Siciliani and J. Hurst, "Explaining Waiting-Time Variations for Elective Surgery across OECD Countries," *OECD Economic Studies*, no. 38 (2004/1), pp. 95–124.

¹⁵ C.M. Flood and T. Epps, "Waiting for Health Care: What Role for a Patient's Bill of Rights?," (2004) 49 *McGill Law Journal* 515, 554.

¹⁶ *Act Respecting Health Services and Social Services*, R.S.Q., c. S-4.2.

¹⁷ *Poirier v. Hôpital du Haut-Richelieu*, [1982] S.C. 511.

¹⁸ *Act Respecting Health Services and Social Services*, s. 6.

¹⁹ *An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*, S.Q. 2005, c. 32 (Bill 83).

²⁰ Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, pp. 38–39.

²¹ Conseil de la Santé et du Bien-être (Quebec), *Declaration on Rights and Responsibilities in Health and Well-Being (Draft)* (Quebec City: Author, 2005). Retrieved April 12, 2007, from <http://www.csbe.gouv.qc.ca/site/download.php?8f53febaf026130d2d6fe0e989d6e942>

²² Conseil de la Santé et du Bien-être (Quebec), *Analyse sommaire des déclarations, des lois et des chartes des droits en matière de santé et de bien-être* (Quebec City: Author, 2005). Retrieved April 12, 2007, from <http://www.csbe.gouv.qc.ca/site/download.php?4f2cd21dbe3215ce856ba9ad7a460b34>

²³ *Ibid.*, pp. 9, 10.

²⁴ Cittidinzattiva–Active Citizenship Network, *European Charter of Patients' Rights*. Retrieved April 12, 2007, from www.activecitizenship.net/projects/project_europe_chart.htm

²⁵ Conseil de la Santé et du Bien-être (Quebec), *Analyse sommaire*, p. 13.

²⁶ *An Act Respecting the Health and Welfare Commissioner*, R.S.Q., c. C-32.1.1.

²⁷ *Ibid.*, s. 14.

²⁸ Page numbers in parentheses in the text refer to the White Paper (Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*), which outlines the proposed plan.

²⁹ The White Paper does not specify the type or nature of the recourse.

³⁰ Many people and organizations expressed reservations about this discretionary executive power. As a result, the minister stated before the parliamentary committee that an addition or modification should be made through legislative means.

³¹ *Stein v. Tribunal administratif du Québec*, [1999] R.J.Q. 2416 (a case involving cancer surgery cited in the Supreme Court's *Chaoulli* judgement); *Cilinger v. Centre hospitalier de Chicoutimi*, [2004] R.J.Q. 3083 (a case involving women suffering from breast cancer who were unable to obtain radiation therapy within a reasonable wait time of eight weeks).

³² The Organisation for Economic Co-Operation and Development defines duplicate private insurance as "private insurance that offers cover for *health services* already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service. It does not exempt individuals from contributing to public health insurance" (Organisation for Economic Co-Operation and Development [OECD], *Private Health Insurance in OECD Countries*, OECD Health Project [Paris: OECD, 2004], p. 31).

³³ The White Paper presents a summary description of the concept of affiliated specialized clinics (Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 49).

³⁴ *An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* (Bill 83), sections 249–268.

³⁵ Before the parliamentary committee, the minister stated that these additions too would be made through legislative means.

³⁶ On several occasions, the minister stated before the Social Affairs Committee that application of the access guarantee did not necessarily mean opening the door to duplicate private insurance.

³⁷ "However, the conditions that would permit the introduction of a service guarantee in these fields remain to be put in place" (Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 47).

³⁸ The minister stated before the Social Affairs Committee that ASCs would be able to perform a variety of surgical procedures at the same time, on the basis of a list that would form part of the agreement.

³⁹ *Canada Health Act* (An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services), R.S.C. 1985, c. C-6.

⁴⁰ Ibid., s. 8.

⁴¹ Under the terms of Quebec's *Health Insurance Act* (R.S.Q., c. A-29), doctors have the choice of practising within the terms of the public plan and receiving public insurance funding, or opting out of the plan and foregoing public funding. Doctors in the first category are referred to in this paper as "participating doctors"; those in the second category are referred to as "non-participating doctors." The vast majority of Quebec's doctors are participating doctors.

⁴² *Health Insurance Act*, sections 26, 28, 30, 36. *Regulation Respecting the Application of the Health Insurance Act*, R.R.Q., 1981, c. A-29, r. 1, sections 28–30.

⁴³ This is essentially duplicate private insurance as categorized by the OECD (*Private Health Insurance*, p. 31).

⁴⁴ To prevent this confusion, the Working Group on Quebec's Health Care System proposed that the principle of strict separation of public and private medical practice be extended to clinics and institutions (Working Group on Quebec's Health Care System, *Accès aux soins de santé: confirmer la solution publique pour le Québec*, brief presented to the Social Affairs Committee, Montreal, March 31, 2006).

⁴⁵ Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role (Final Report)*, Vol. 6: *Recommendations for Reform* (2002). Retrieved April 13, 2007, from <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm>

⁴⁶ *Chaoulli v. Quebec (Attorney General)*, [2002] R.J.Q. 1205 (C.A.).

⁴⁷ *Chaoulli v. Quebec (Attorney General)*, [2000] R.J.Q. 786 (S.C.).

⁴⁸ The decision was rendered on June 9, 2005 (*Chaoulli v. Quebec [Attorney General]*, [2005] 1 S.C.R. 791).

⁴⁹ Notable examples in the Kirby Report (Standing Senate Committee, *Health of Canadians*, vol. 6) include one from Ontario (s. 6.3.1, "Cardiac Care Network of Ontario") and another from the west (s. 6.3.2, "The Western Canada Waiting List Project").

⁵⁰ Standing Senate Committee, *Health of Canadians*, vol. 6, chapter 5.

⁵¹ Ibid., s. 5.3: "Thus, in the Committee's opinion, the failure to deliver timely health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services."

⁵² Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role (Interim Report)*, Vol. 4: *Issues and Options* (2001). Retrieved April 13, 2007, from <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/rep-e/repintsep01-e.htm>

⁵³ R.A. Skolrood, *The Charter of Rights and Health Care Reform*, Lawson Lundell, Barristers and Solicitors, July 16, 2002 (Paper presented at the CLE Charter Conference, B.C., May 30–31, 2002).

⁵⁴ S.H. Hartt and P.J. Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, C.D. Howe Institute Commentary, The Health Papers, no. 164, May 2002. Retrieved April 13, 2007, from http://www.cdhowe.org/pdf/commentary_164.pdf

⁵⁵ The Kirby Committee's final report adopted the C.D. Howe Institute's analysis: "The Committee finds the Hartt and Monahan analysis compelling" (Standing Senate Committee, *Health of Canadians*, vol. 6, s. 5.3).

⁵⁶ Ibid., s. 5.3.

⁵⁷ Ibid., s. 6.3.

⁵⁸ Ibid., s. 6.4.1.

⁵⁹ Ibid., s. 6.4.2.

⁶⁰ Ibid., s. 6.5; the recommendation is formulated as follows: "For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public. When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). This is called the Health Care Guarantee."

⁶¹ Premier's Advisory Council on Health for Alberta, *A Framework for Reform* (December 2001).

⁶² Canadian Medical Association, *A Prescription for Sustainability*, June 6, 2002. The prescription recommended that people who waited longer than the prescribed wait time could go outside the province or the country to receive treatment and have it paid for out of public funds.

⁶³ Standing Senate Committee, *Health of Canadians*, vol. 6, s. 6.6.

⁶⁴ Ibid., s. 6.6: "A second consequence would be that it would fall to the federal government to consider enacting its own legislation to enforce the health care guarantee. The federal government could, for example, consider setting national maximum waiting times on its own for various procedures, at the expiration of which the health care guarantee would come into effect. When a patient exceeded the maximum waiting time, the federal government could

then pay the cost of treating the patient in another jurisdiction, including in the United States, and deduct the cost from the cash it transferred under the [Canada Health and Social Transfer] to the province in which the patient resides.”

⁶⁵ Ibid., s. 6.7

⁶⁶ Ibid., s. 6.7. Chapter 17 (s. 17.5) of the Kirby Report explains that the concept of public administration of health care does not include health care delivery, which can be carried out by private for-profit health care providers without violating the *Canada Health Act*.

⁶⁷ Conservative Party of Canada, *Stand Up for Canada* (2006), pp. 30–31. Retrieved April 14, 2007, from <http://www.conservative.ca/media/20060113-Platform.pdf>

⁶⁸ Liberal Party of Canada, *Securing Canada's Success* (2006), pp. 10–18. Retrieved March 10, 2006, from http://www.liberal.ca/images/dir/PDFs/platform_e.pdf

⁶⁹ Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 51. I have explained elsewhere why I believe that this position does not flow from the Supreme Court's decision (Prémont, “L'affaire *Chaoulli* et le système de santé du Québec”).

⁷⁰ Commission on the Future of Health Care in Canada (Romanow Commission), *Building on Values: The Future of Health Care in Canada* (2002). Retrieved April 14, 2007, from http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf

⁷¹ Ibid., pp. 137ff.

⁷² Ibid., recommendations 25 and 26, p. 138.

⁷³ Ibid., p. 144: “Considering Care Guarantees.”

⁷⁴ Premier's Advisory Council on Health for Alberta, *A Framework for Reform*.

⁷⁵ For a supportive view of the Mazankowski Report, see the response by the Canadian Taxpayers Federation, a conservative lobby group: *Mazankowski Report Offers Hopeful Prescription For Ailing Health Care System* (2002). Retrieved April 14, 2007, from http://www.taxpayer.com/main/news.php?news_id=712. For a critical view of the report's conservative orientation, see, for example, the Canadian Health Coalition's website, where a number of critiques are assembled under the heading *Mazankowski Report Analysis* (2002). Retrieved April 14, 2007, from www.healthcoalition.ca/maz.html

⁷⁶ Premier's Advisory Council on Health for Alberta, *A Framework for Reform*.

⁷⁷ The concept of “enhanced medical goods and services” was introduced in May 2000 with the passage of Alberta's *Health Care Protection Act*, R.S.A., c. H-1. Quebec's White Paper also contains this concept: “For various situations ... it would still be possible to take out private insurance to cover other additional fees for the provision of medical goods and services beyond what is medically necessary and insured by the public system. For example, supplementary private health insurance could cover services whose cost exceeds that allowed by the public system, such as highly sophisticated prostheses” (Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 50).

⁷⁸ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791.

⁷⁹ See Standing Senate Committee, *Health of Canadians*, vol. 6, s. 6.5.

⁸⁰ Alberta Government, *Health Policy Framework* (2006). Retrieved April 14, 2007, from http://www.health.gov.ab.ca/healthrenewal/policy_framework.pdf/

⁸¹ This conclusion emerges from my discussions with colleagues in the health law field outside Quebec, and especially in Alberta.

⁸² A copy of Harper's letter to Klein is available online. Retrieved April 14, 2007, from <http://www.healthcoalition.ca/harper-klein.pdf>

⁸³ An example of newspaper coverage of what Harper said is *Le Devoir's* article “L'Alberta devra respecter la Loi sur la santé,” March 2, 2006, p. A-2: “I encourage all provinces to follow Quebec's example. I encourage Alberta and the other provinces to have the same targets.”

⁸⁴ Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 38: “Two countries provide useful examples of mechanisms set up to improve access to healthcare: the UK and Sweden.”

⁸⁵ J. Appleby, A. Harrison and S. Dewar, “Patients Choosing their Hospital: May not Be Fair and Equitable,” *British Medical Journal*, 326 (2003), pp. 407–8. Retrieved April 14, 2007, from <http://www.bmj.com/cgi/content/full/326/7386/407?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=appleby&title=patients+choosing&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT,HWISS,HWFIG,HWDSUP>. See also: N. Hawkes, “Patients Get Right to Choose Hospital for their Treatment,” *Times Online*, January 2, 2006. Retrieved April 14, 2007, from <http://www.timesonline.co.uk/tol/news/uk/article784264.ece>. C. Johnston, “£3 billion for NHS Patients to Have Private Treatment,” *Times Online*, May 13, 2005. Retrieved April 14, 2007, from

www.timesonline.co.uk/article/0,,8122-1610989,00.html

⁸⁶ M. Hanning, "Maximum Waiting-Time Guarantee – An Attempt to Reduce Waiting Lists in Sweden," *Health Policy*, 26 (1996), pp. 17–35; D. Ray, "Getting Better Value for Money from Sweden's Healthcare System," OECD, *Economics Department Working Papers*, no. 443 (2005).

⁸⁷ Ministère de la Santé et des Services Sociaux, *Guaranteeing Access*, p. 39.

⁸⁸ La Documentation française, *Le système de santé britannique* (2005). Retrieved April 14, 2007, from www.ladocumentationfrancaise.fr/dossiers/assurance-maladie-europe/grande-bretagne.shtml

⁸⁹ Department of Health (United Kingdom), *Growing Capacity: Independent Sector Diagnosis and Treatment Centres* (2002). Retrieved April 14, 2007, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005842

⁹⁰ Department of Health and National Health Service (United Kingdom), *Tackling Hospital Waiting: The 18 Week Patient Pathway – An Implementation Framework*. Retrieved April 14, 2007, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134668

⁹¹ *Ibid.*, p. 30.

⁹² Organisation for Economic Co-Operation and Development, *OECD Economic Surveys: Sweden* (Paris: OECD, 2005), p. 119. A summary is available online. Retrieved April 14, 2007, from www.oecd.org/document/22/0,2340,en_33873108_33873822_34965462_1_1_1_1,00.html

⁹³ *Ibid.*, p. 116.

⁹⁴ At the same time, the specialists' union carried out a vigorous advertising campaign in Quebec's major daily newspapers. See P. Breton, "Campagne des médecins spécialistes: l'électrochoc publicitaire coûtera 1,4 million," *La Presse*, May 25, 2006: "The advertisement published yesterday threw Health and Social Services Minister Philippe Couillard into a rage. The ad shows a woman uneasily feeling her chest. 'Cancer scares you,' it reads. 'So does the health system. The lump under your arm is getting bigger, the clinic is overflowing, your diagnosis is delayed. You're afraid it's too late.'"

⁹⁵ *An Act Respecting the Provision of Health Services by Medical Specialists*, S.Q. 2006, c. 16 (Bill 37).

⁹⁶ The minister explained that in addition to improved working conditions for the doctors, leading to increased health costs, he was also pursuing the objective of an increased supply of services. Section 4 of the act provides for an envelope of \$50 million, allocated to shortening waiting lists and increasing the hours of operation of operating rooms.

⁹⁷ Gouvernement du Québec, *Le gouvernement du Québec s'entend avec la fédération des médecins omnipraticiens du Québec*. Retrieved April 14, 2007, from communiqués.gouv.qc.ca/gouvqc/communiqués/GPQF/Juin2006/14/c4605.html

⁹⁸ Maximum compensation for a general practitioner was increased if his or her roster of patients included a minimum of 200 vulnerable patients.

⁹⁹ *Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*, Quebec, 37th Legislature, 2nd session, Bill 33 (First Reading, June 15, 2006). Bill 33 became law on December 13, 2006, and is now cited as S.Q. 2006, c. 43.

¹⁰⁰ Bill 33, s. 7, adds s. 185.1 to the *Act Respecting Health Services and Social Services*.

¹⁰¹ Bill 33, s. 8, amends s. 189 of the *Act Respecting Health Services and Social Services* to make the head of a clinical department in any hospital centre responsible for ensuring that the rules and procedures of the central access management mechanism are observed.

¹⁰² *Ibid.* See M.M. Rachlis, *Public Solutions to Health Care Waitlists* (Ottawa: Canadian Centre for Policy Alternatives, 2005).

¹⁰³ Bill 33, s. 7.

¹⁰⁴ Rachlis, *Public Solutions*.

¹⁰⁵ The European Court of Justice explained this nuance in a recent decision that challenges the concept of unreasonable wait times. The court was asked to decide whether a wait of one year for hip replacement surgery represented an undue delay for a patient suffering from acute arthritis. The British National Health Service's maximum wait time target was 15 months, and the patient was asked to accept a wait time of 12 months. The court decided that the establishment of wait times had to be based on two dimensions: on the one hand, objective, nondiscriminatory criteria, and on the other, a personalized assessment of the patient's situation: "Thus, in order for a system of prior authorisation to be justified even though it derogates from a fundamental freedom of that kind, it must in any event be based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities' discretion, so that it is not used arbitrarily ... It follows that, where the delay arising from such waiting lists appears to exceed in the individual case concerned an acceptable period

having regard to an objective medical assessment of all the circumstances of the situation and the clinical needs of the person concerned, the competent institution may not refuse the authorisation sought on the grounds of the existence of those waiting lists, an alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated” (Court of Justice of the European Communities, *The Queen, on the application of Yvonne Watts v. Bedford Primary Care Trust*, Case C-372/04, judgement of May 16, 2006, paras. 116, 120).

¹⁰⁶ Health and Social Services Minister Philippe Couillard characterized the situation as “legally hazy” in the parliamentary committee and in a press briefing when Bill 33 was released.

¹⁰⁷ Federal authorities have expressed their concern with this practice, judging that it could contravene the ban on extra-billing for insured persons in sections 7, 12 and 18 of the *Canada Health Act*: “Following media reports, in March 2000, the Régie de l’Assurance Maladie du Québec (RAMQ) inquired into allegations that a private clinic was imposing operating user fees on patients of up to \$400 relating to procedures for which the doctors were billing the RAMQ. Health Canada made it known to the Ministère de la Santé et des Services Sociaux that imposing charges for the delivery of insured health services to insured persons was a concern in relation to the *Canada Health Act*. In February 2005, Health Canada and Quebec officials met to discuss this question, and the confidential nature of the RAMQ’s inquiries was once again invoked. The Quebec officials mentioned that there had been no recent complaints, but that they were not in a position to confirm that the problem had been resolved” (Santé Canada, *Système de soins de santé, Loi canadienne sur la santé: Administration*, retrieved June 10, 2006, from www.hc-sc.gc.ca/hcs-sss/medi-assur/administration/index_f.html).

¹⁰⁸ *Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* (Bill 33), s. 11.

¹⁰⁹ *Ibid.*, s. 18, amending s. 437 of the *Act Respecting Health Services and Social Services*.

¹¹⁰ *Ibid.*, s. 11, adding a new s. 333.4 to the *Act Respecting Health Services and Social Services*.

¹¹¹ *Ibid.*, s. 11, adding a new s. 333.5 to the *Act Respecting Health Services and Social Services*.

¹¹² *Ibid.*, s. 11, adding a new s. 333.1 to the *Act Respecting Health Services and Social Services*.

¹¹³ *Ibid.*, s. 20, amending s. 440 of the *Act Respecting Health Services and Social Services*.

¹¹⁴ *Ibid.*, s. 11, adding a new s. 333.2 to the *Act Respecting Health Services and Social Services*.

¹¹⁵ *Ibid.*, s. 11, adding a new s. 333.2 to the *Act Respecting Health Services and Social Services* (paragraph 3).

¹¹⁶ The HMOs have established “managed care” organizations in the United States: “A managed care organization is a health care distribution system that signs an agreement with a third-party payer, most often an insurance company, to provide all required health care services to a given population for a specified period of time. The organization takes clinical and financial responsibility for the health care services needed by this population in return for a predetermined sum of money ... Organization, follow-up and control of the manner in which these services are provided are a function of economic and quality objectives established by the third-party payer” (L. Lebel and H. Blouin, *L’approche managed care: le concept, ses impacts, son potentiel au Québec*, Association des hôpitaux du Québec, collection de la reconfiguration du réseau, no. 8 [1996], p. 1).

¹¹⁷ The new s. 333.6 of the *Act Respecting Health Services and Social Services* says “from another private resource.” It would be helpful to have more clarity as to what this expression means. In addition, s. 2 of Bill 33 adds s. 78.1 to the *Act Respecting Health Services and Social Services*, according to which the cost of any health service provided in a public institution that is accessory to a treatment provided in an SMC with non-participating doctors may be claimed from the SMC by the government.

¹¹⁸ S. 5 of Bill 33, amending s. 108 of the *Act Respecting Health Services and Social Services*, provides for an exception: an agreement of this kind with an SMC with non-participating doctors is allowed only if it receives prior authorization from the minister.

¹¹⁹ S. 12 of Bill 33 adds new sections 349.1 through 349.9 to the *Act Respecting Health Services and Social Services* under the heading “3.1 – Functions related to the services offered by associated medical clinics.”

¹²⁰ Bill 33, s. 12, adding a new s. 349.5 to the *Act Respecting Health Services and Social Services*.

¹²¹ See above, section 4.5.

¹²² See above, section 3.3.

¹²³ Three kinds of organizations may become AMCs: SMCs with participating doctors, private health facilities and laboratories (Bill 33, s. 12, adding s. 349.1 to the *Act Respecting Health Services and Social Services*).

¹²⁴ Prémont, “L’affaire Chaoulli et le système de santé du Québec.”

¹²⁵ Action Démocratique du Québec, *Commentaires de l’Action démocratique du Québec sur le Document de consultation du gouvernement intitulé “Garantir l’accès: un défi d’équité, d’efficience et de qualité,”* brief presented to the Social Affairs Committee, March 30, 2006, p. 28: “The debate has always focused on this general prohibition and

the Supreme Court's decision can in no way be interpreted as allowing the prohibition of purchasing private insurance for some medical services to be preserved in part ... The Quebec government is thus getting ready to contravene the Supreme Court's decision in a way that is inconsistent with the Constitution."

¹²⁶ J. Chaoulli, *Garantir l'accès: un défi d'équité, d'efficience et de qualité*, brief presented to the Social Affairs Committee, March 2006, p. 27: "The Supreme Court ordained that ... I did not have the burden of proving that the authorization of private insurance would reduce wait times in the public system. Still less do I have that burden before the parliamentary committee for the purpose of asking legislators to lift this prohibition for all services covered by the public system." And on p. 32: "It is clear that the government's response goes squarely against the decision of the Supreme Court of Canada, and thus against the interests of patients." Retrieved April 15, 2007, from <http://www.bibliotheque.assnat.qc.ca/01/mono/2006/04/899760.pdf>

¹²⁷ For example J. Castonguay, C. Castonguay and C. Montmarquette, *La pérennité du système de santé: un enjeu de finances publiques*, brief presented to the Social Affairs Committee by CIRANO, March 2006; Institut Économique de Montréal, *Pour une réelle ouverture à l'assurance-maladie privée au Québec*, brief submitted to the Social Affairs Committee, March 24, 2006.

¹²⁸ Bill 33, s. 42, amending s. 15 of the *Health Insurance Act*.

¹²⁹ Bill 33, s. 11, adding s. 333.1 to the *Act Respecting Health Services and Social Services*.

¹³⁰ Bill 33, s. 42, amending s. 15 of the *Health Insurance Act*.

¹³¹ *Act Respecting Prescription Drug Insurance*, S.Q. 1996, c. 32; R.S.Q., c. A-29.01.

¹³² Bill 33, s. 17, s. 11, adding s. 431.2 to the *Act Respecting Health Services and Social Services*, 4th paragraph. See also Bill 33, s. 4, amending s. 95 of the *Act Respecting Health Services and Social Services*, making it possible to reach an agreement with an SMC with non-participating doctors, with the minister's authorization.

¹³³ OECD, *Private Health Insurance*.

¹³⁴ In addition to the examples already cited, see Bill 33, s. 10, adding s. 263.2 to the *Act Respecting Health Services and Social Services*, according to which non-participating doctors are not allowed to use public facilities, unless they have received prior authorization from the minister.

¹³⁵ P. Lamarche and A.P. Constandriopoulos, *Les propositions du livre blanc: un pas vers l'amélioration de la cohérence du système de santé?*, Groupe de Recherche Interdisciplinaire en Santé de l'Université de Montréal (GRIS), brief presented to the Social Affairs Committee, March 24, 2006.

¹³⁶ OECD, *Private Health Insurance*, p. 33.