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Health care: are we moving closer to a two-tiered system?

On June 9, 2005, the Supreme Court of Canada handed down a highly controversial decision. In its Chaoulli ruling, the Court struck down a provision in the Quebec *Health Insurance Act* and another in the *Hospital Insurance Act* banning private insurance for services covered under public plans. The justices ruled that this ban ran counter to the Quebec *Charter of Human Rights and Freedoms.*

On February 16, the Quebec government announced its response to the Court's decision. First of all, it refused to resort to the "Notwithstanding" clause, which would have allowed it to ignore the ruling; second, it proposed to establish two categories of access guarantees. The first concerns needs for radiation oncology, tertiary cardiology and cancer-related surgery that can only be met under public insurance plans. The second concerns medical procedures designated by the Minister (elective hip and knee replacements and cataract surgery, for the moment), for which the ban on private insurance coverage would be lifted for people who choose to obtain these services from doctors who have opted out of the Quebec health insurance plan. Other services could be added to this list in future, however.

Public health insurance: fairness for all

Barely forty years ago, you had to pay to consult a doctor and to be treated in a hospital. In the 1960s, the government created a hospitalization insurance plan, offering free universal access to hospital services and care. Health Minister Claude Castonguay subsequently introduced a health insurance plan offering a similar guarantee for medical care. In fact, the machine used to print invoices from health insurance cards was nicknamed a "Castonguette"! Henceforth, hospital and medical care were financed by income taxes and managed through a public healthcare system. Doctors, who were afraid of becoming public servants, reluctantly accepted the health insurance plan. They managed to keep their status as "entrepreneurs," and their services are reimbursed by the state at negotiated rates. Some of them, nonetheless, preferred not to join the public insurance plan. Today there are about one hundred physicians who have opted out of the public system. They practise in private offices, mainly in plastic surgery, but recently we have seen general practitioners and at least one orthopedic surgeon move over to the private sector.

About ten years ago, the shift to ambulatory care reduced hospital stays to a strict minimum, and some surgery and healthcare services moved outside the hospital setting. But a problem became apparent: drugs were provided free of charge only while patients were hospitalized. To overcome this problem, Health Minister Rochon pushed through a drug insurance plan –a necessary step to maintain universal access to health care in the new context of ambulatory care.

The technological evolution of health care, the more rapid development of new therapies and the rampant consumerism in our modern society have led to exponential growth in demand for health care. Public insurance plans are having trouble keeping up. Indeed, healthcare spending accounts for 43% of the provincial government's program spending, up from 32% twenty years ago. Our public healthcare system is overwhelmed, and this has led to longer waits for treatment and difficulties in obtaining access to general practitioners and specialists. This is why some people were asking for the right to buy private healthcare insurance. The Supreme Court felt that their demands were acceptable, in cases where the public system cannot offer medically acceptable wait times for insured services. Minister Couillard has therefore proposed to introduce the concept of maximum wait times in the management of the health system. The title of his white paper, in fact, is *Guaranteeing access: Meeting the challenges of equity, efficiency and quality.*

According to one expert,[1] most wait times in the health system are due not to a lack of resources, but rather to problems of efficiency. For instance, he recommends that routine minor surgery be done in specialized clinics, and that there be a single waiting list per jurisdiction, rather than multiple lists for each operation and each surgeon. For-profit clinics are not part of the solution. Furthermore, the experiences with the Pan-Am clinic in Winnipeg (bought out by the government) and the Trillium Queensway clinic in Toronto in fact tend to show that non-profit clinics can be both efficient and innovative.

Private clinics affiliated with the public system

We need to ask whether public/private partnerships (PPPs) are part of the solution. This calls for the utmost caution, however. Is there ever a case for the public healthcare system calling on complementary services provided by private companies? Minister Couillard thinks so, and suggests that medical clinics offering specialized care should be built, equipped and run by private-sector partners. Health and social service centres (CSSSs) could sign service contracts with these private clinics. This approach would not be something new, in itself, since many physicians already perform medical procedures in private clinics. What is new is the contractual arrangement, which amounts to outsourcing of services. For the public, the services would remain free, except for a number of costs that are already charged in some cases — bandages, for instance. Can the Minister guarantee that services at these clinics will be completely free?

The merits of this solution are open to question. After all, nothing is stopping CSSSs from setting up out-patient clinics of this nature. Is it red tape that is preventing them? Does the government want to avoid having to make the investments involved in creating such clinics? Is it looking for ways to reduce the cost of delivering these services? But above all, we have to ask what profit margins such clinics will be looking for, and what quality standards will apply. The OIIQ recommends that these clinics be run on a non-profit basis and considers that the possibility of increasing the number of medical acts should be sufficient incentive for doctors. Moreover, the Order would like the nurses in these clinics to remain CSSS employees and be seconded to the clinics under a service contract, so as to preserve their working conditions. Most countries, even socialist countries like Sweden, have a mixture of public and private services in their health systems. It is the rules established by the government that help to protect the public interest.

The crisis caused by the Chaoulli decision has focused the debate on access to surgery and away from the fact that there are already inequities in access to care. It is difficult for low-income people or those without private insurance to obtain many medically required professional services. Just think of x-rays, ultrasounds and MRIs, all of which are more readily accessible in the private sector, or physiotherapy, psychology, clinical nutrition, etc. In this context, it is only natural that this ruling has rekindled our fears of a widening gap between rich and poor. Our public healthcare system is an invaluable collective asset, a guarantee of fairness for all. Should we be relieved that the government is planning to open the gates only partway to private insurance? Or are we allowing a Trojan horse into the system? ●

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President

1. RACHLIS, M.M. *Public Solutions to Health Care Wait Lists*, Canadian Centre for Policy Alternatives, December 2005. http://www.policyalternatives.ca/documents/National_Office_Pubs/2005/Health_Care_Waitlists.pdf