Canadian Policy Research Networks | Réseaux canadiens de recherche en politiques publiques

Commentary

DON'T PANIC:
The Hitchhiker's Guide to Chaoulli, Wait Times and the Politics of Private Insurance

Tom McIntosh[i]

Introduction

The issue of wait times for certain health care services continues to dominate the popular discussion of health care politics and policy. In the past year a number of events have kept wait times front and centre in the public's mind and in the political discourse of the nation:

- June 2005: In what has become known as the Chaoulli decision, the Supreme Court struck down Quebec's ban on private insurance for publicly insured services because of the government's perceived failure to adequately deal with wait times for surgery;
- November/December 2005: A number of provinces announced they would not be able to meet their self-imposed deadline for setting benchmarks for wait times in key areas of concern;
- December 2005/January 2006: During the federal election, both the Liberal and Conservative parties make the development of "care guarantees" a key plank in their election platforms;
- January 2006: Alberta makes news with its hip and knee replacement project which reduces wait times from 47 weeks to 4.7 weeks for most surgeries through a significant reorganization of processes and more efficient use of resources within the public system;
- February 2006: The B.C. government, in its Speech from the Throne, announces a major public consultation on the introduction of a greater role for private sector involvement in health delivery and payment;
- February 2006: The government of Quebec responds to the Chaoulli decision by introducing care guarantees for select surgical procedures and promising to pay for private surgeries if the guarantees are not met and allowing the purchase of private insurance for those procedures as well, but it maintains its ban on so-called "dual practice physicians
- Still to come: Alberta is preparing to announce its so-called "third way" solution to deal with pressures on the public system which is expected to include greater access to private insurance and the removal of the ban on dual practice physicians.

[i] Director, Health Network, Canadian Policy Research Networks, Ottawa; Associate Professor, Political Science and Research Faculty, SPHERU, University of Regina, Regina, SK. Apologies to Douglas Adams.

A great deal has already been said about the implications of the Chaoulli decision, the renewed interest on the part of some governments in opening up a private insurance market to relieve pressure on the public system and the creation of a private system of care accessible to those with the necessary resources. What is both remarkable and disturbing about much of what we have seen of late is the continued insistence on the part of both medicare's defenders and critics that there are simple, "big bang" solutions to the very real problems and challenges the health care system faces in this country. "If", they argue, "we do X, then all will be fine." Such propositions reflect a profound misunderstanding of the complexity of the system and speak more to the entrenched ideological positions to which many analysts and decision makers have retreated. The debate about the kind of health care system we want and how to get there is not well served when leading health care economists blame a constitutional bill of rights for bringing about the death of medicare or when a candidate to head-up a major health care stakeholder group refers to the current system as "Marxist" in its operation.

The reality is much more complicated than that. The good news is that reform is happening: primary care models are being implemented, wait lists are being more effectively managed, new governance arrangements are leading to a better integration of services across the continuum of care. The bad news is that reform is slower than it should be given the resources the system has at its disposal, it is fragmented within jurisdictions and the system lacks the capacity to translate "what works" across jurisdictions in a coherent and coordinated manner. But rather than focus on fixing those things that account for the bad news, commentators, policy analysts and even governments continue to grasp onto single-issue, big bang solutions to fix the system once and for all.

The purpose here is to provide something of a reality check on the issues at hand in the current discussion. What is happening with wait lists and wait times across the country? What is the likelihood that a private insurance market would alleviate pressure on the system? How do these options fit with the kind of health care system we want to build for the future? What emerges from this discussion is the need for a little perspective in the current debate and for all concerned to abandon their instinctive desire to demonize those they disagree with and to believe that only they are the holders of the truth about the future of health care in Canada.

We begin with a look at both the Chaoulli decision and the current situation with regard to wait list management in the country. Then we examine the limitations of private insurance as a cure-all for the system and, finally, provide some thoughts about how reform is actually changing the system in both important albeit incremental ways.

Chaoulli and the Issue of Wait Times: Reality Check #1

In striking down Quebec's ban on private insurance for publicly insured services, the Supreme Court argued that wait times for certain services are so long in some parts of the country that individuals should have access to private insurance that would allow them to get these services in a private, parallel system. Indeed the Court went so far as to baldly state that people are dying on wait lists. The fact that a private, parallel system offering the kinds of services for which people are waiting does not really exist in Canada was ignored by the Court. Thus, the Court's rationale lies almost entirely in its perception that governments have failed to provide adequate access to those services under public

health insurance plans and, as such, has put people's lives in danger. This perceived failure then means that the government of Quebec had failed to limit the impact of the ban in the least harmful manner.

Yet in rendering its decision in the manner it did and in failing to examine the issue of wait times in anything approaching a thorough and dispassionate manner, the Court itself has failed to provide a remedy that is the least harmful to the future of the Canadian health care system. Two things are immediately apparent about the Court's decision. The first is that the decision completely ignores the scientific evidence on wait times. The second is that the creation of a private parallel system of insurance – which will be available only to some Canadians living in some parts of the country – is hardly the least intrusive course of action governments might take in dealing with wait times and may well have the effect of derailing the progress that is being made in a number of key health reform areas by pushing governments to look for mythical 'big bang' solutions to the system's ills.

Although no one would deny that wait times are a serious issue facing the whole of the Canadian health care system – and certainly a major preoccupation of the public and a key source of their own anxiety about the system's future – it should be noted that the Court reached its conclusions about wait times in the absence of any of the scientific evidence about wait times that has been accumulated in Canada over the past decade and a half. Indeed, it is apparent that the Court reached its conclusions based entirely on the anecdotes provided by those who testified. Yet, perhaps because the anecdotes related to the Court in this particular case fit so well with a long-standing public view that wait times continue to grow across the country, the Court felt no need to probe these claims in any depth.

At the same time, the legal representatives of the government of Quebec (and those of the intervenors defending Quebec's legislation) also clearly failed to counter the impression given the Court by marshalling the all too easily obtained evidence that governments are in fact making significant progress on wait times and the length of wait lists.

Last March in Ottawa, a coalition of health care stakeholders convened the second in what is shaping up as an annual symposium called *The Taming of the Queue*. Nearly 150 participants – including researchers, government officials and stakeholder representatives – spent two days examining the effects of efforts across the country to manage wait lists more effectively and reduce wait times in key areas.

The symposium demonstrated that change *is* happening and it is having an effect[1]. There is not a single jurisdiction in Canada that is not actively engaged in dealing with the wait time issues it faces. Progress is slower in some parts of the country than in others, but there is a strong commitment to learning from the experiences of others and applying that knowledge at home.

For example, there is clear evolution from Ontario's Cardiac Care Network to the work of the Western Canada Wait List Project to the creation of the Saskatchewan Surgical Care Network with each building on, expanding and adapting what was learned

[1] Tom McIntosh. 2005. *The Taming of the Queue II: Wait Time Measurement, Monitoring and Management* (Colloquium Report). Ottawa: Canadian Policy Research Networks. [http://www.cprn.org/en/doc.cfm?doc=1274]

about wait list management over time. These initiatives have evolved from simply consolidating multiple wait lists in central registries to developing benchmarks and setting maximum wait times for specific procedures.

In Quebec, local pilot projects are using new information technology to streamline cancer care treatments at a number of sites in the province – something that can eventually be rolled out across the province and likely adapted in other parts of the country. Nova Scotia and New Brunswick are on their way to establishing surgical registries to give a clearer picture of who is waiting and how long. Even Prince Edward Island – with fewer than 150,000 residents – has found new ways of managing the flow of patients by reallocating resources so as to end the practice of so-called 'hallway medicine'.

For some, the fact that change has been so slow and is still uneven across the country will be taken as a sign of failure. But such criticism ignores the complexity of the problem and the challenges involved in getting so many actors – health professionals, unions, professional and regulatory bodies, governments, regional health authorities and others – to row in a single direction.

At the same time, the symposium acknowledged that future challenges are at least as big if not bigger than those already met. Setting appropriate benchmarks for wait times (how long should person X wait for service Y?) and dealing with human resource issues involved (getting the right mix of health professionals in the right place at the right time) are not problems that will be tackled in a day.

More recently, the Health Council of Canada profiled the success of the Alberta Hip and Knee Replacement Project in their ability to reduce the wait time for knee replacements from 47 weeks to 4.7 weeks. This was accomplished through the better use of existing resources, the use of case managers and the streamlining of processes for the patients move from diagnosis to treatment to post-operative care.

Thus, contrary to the impression given by the Court, governments have not ignored the issue and there is ample evidence that the solutions being adopted across the country are having an effect. One must ask oneself, then, whether the kind of 'crisis' portrayed by the Court is in fact upon us – a crisis so severe that it demands a fundamental reordering of public policy with regards to the creation of a parallel private system supported by the private purchase of insurance for services already insured in the public system.

Had the Court considered (or been given the opportunity to consider) the available evidence on wait times, it is not readily apparent that it would have reached the conclusion it did. Indeed, given the Court's unwillingness to substitute its judgement for that of governments in other health care related decisions, it may well have been the case that the Court could have satisfied itself that the demonstrable progress constituted a solid basis for leaving this particular policy question to the policy makers.

The Limits of Private Insurance: Reality Check #2

Though there is a great temptation to view the Chaoulli decision as 'the beginning of the end' of Canada's publicly financed health care system, it is far too early to sound the death knell quite yet. There is no doubt that it is a troubling decision for those who defend a single-payer, publicly administered system, but Chaoulli is still a long way from

being the body-blow many initially thought it to be. Nor is it the victory that those who want to create a larger role for private payment in the system have long wanted.

First, for the time being at least, the decision only applies to the province of Quebec. Second, as the Court itself notes, the Canadian Charter and the Quebec Charter are two different documents and a violation of the latter does not necessarily translate into a violation of the former. Third, the Chaoulli decision was rendered by only seven of the nine judges (two of the judges being recent appointments who had not heard the original arguments) so any subsequent case dealing with legislation in other provinces will likely be heard by the whole of the Court and, given its split on Chaoulli, it is unclear how it would rule. Fourth, the Court will, in all likelihood, be faced with having to deal with the scientific evidence on wait times in any subsequent case and that could change matters considerably. Fifth, and perhaps most important, not all provinces actually ban the purchase of private insurance and medicare has managed to survive quite well in spite of this[2].

It is no small irony that by the time Dr. Chaoulli won his victory in the Supreme Court, the patient that prompted the challenge had already received the medical service (a hip replacement) in the public system in which he had been waiting. Yet, let us assume that the patient was still waiting for surgery when the Court rendered its decision. And, further, let us assume that there was insurance for sale for surgery immediately following the decision. Would this have made any difference to the patient? The answer is 'no'.

First, it is difficult to purchase insurance once it is apparent that you need it. One can not buy fire insurance while one's house is burning. Once you have a diagnosis you have what the insurance industry calls a pre-existing condition the treatment of which would be exempted from any insurance you subsequently purchased. So, in order to make private insurance for surgical procedures profitable for the companies that would offer it, it would have to be widely purchased by the population but used by only some small percentage of the population at any given time. It is not clear how many 25 to 35 year olds would be willing to pay such premiums given that they would be unlikely to need a new hip for at least another 35 years.

Whether there is a market for this kind of insurance in Canada is an empirical question that needs some serious investigation, but on the face of it, it is not clear whether such specialized insurance would be widely attractive to citizens or hugely profitable for companies. Recent work by Emory and Gerrits, which models demand for private insurance in Alberta, puts that demand at about 28% of the population and notes that this purchase will not free up any substantial resources for reinvestment in the public system. They also note that in their comparator system, Australia, the parallel private insurance market is supported by state tax incentives designed to encourage purchase of private insurance.[3]

As Emory and Gerrits note, the purchase of private insurance in the face of a public alternative will only happen if that private insurance guarantees better quality care.

---

[2] Newfoundland and Labrador, Nova Scotia, New Brunswick and allow individuals to purchase insurance for those services covered by the public system, but there has never been a significantly large enough demand to create a parallel private system within any of those jurisdictions.

[3] Emory, Herb and Kevin Gerrits. 2005. The Demand for Private Health Insurance in Alberta in the Presence of a Public Alternative. Paper presented at the Health Services Restructuring: New Evidence and New Directions conference, Queen's University, November 2005. [http://www.irpp.org/indexe.htm]

Providing that higher quality of care, either in terms of better outcomes or in terms of better "frills" like private rooms or more access to post-surgical rehabilitation, would become a cost driver within the health system.

Second, even if someone has surgical insurance there would need to be a place to have the surgery. Presumably, the purchase of private insurance would not allow the patient to jump the queue in a publicly financed hospital and to receive services ahead of those who have only public insurance. To allow this would be to allow the publicly financed hospital system to subsidize the private insurance industry and would erode the notion that patients should be dealt with in terms of their severity of need not their ability to pay.

So, it seems fair to suggest, that before there can be a private insurance market there has to be a private hospital sector to provide those services that have been privately insured. Now it is the case that there are private surgical clinics in Canada that are providing some surgical services paid either by private insurance or direct payment by patients. And indeed the Quebec response to Chaoulli rests on the province's ability to access those services for people who wait longer than they should.

But, again, whether there is a business case to be made for the construction and staffing of private hospitals that would offer services such as hip replacements or cancer surgery (two of the five priority areas for wait list management according to the federal and provincial First Ministers Agreement of September 2004) is an empirical question. Those private facilities that do exist in Canada tend to provide services that are relatively standardized and easy to replicate and they rely on a high volume with a low complication rate to make a profit. The Shouldice Clinic in Ontario has done this successfully with regard to hernia operations and there may be some potential to do this with other procedures such as hip and knee replacements, but it is unlikely that it will apply in the near future to cancer surgeries. Furthermore, if such facilities were asked to internalize all of the costs associated with their operations (e.g. the cost of shifting cases where complications arise back to the public system or the cost of bidding up the cost of scarce human resources) then it is not clear that such facilities could continue to be profitable. And there is certainly an argument to be made for the fact that a private facility should not be able to shift cases that become difficult back to the public system at no cost to its own profit margin[4].

Dual-Practice Physicians: Reality Check #3

But in making the general business case for a parallel private system, the challenge will not be whether it can be financed by private insurance but whether it can overcome a far more important restriction; namely, whether it can successfully challenge the ban on physicians practicing in both the public and private systems.

Right now provincial health insurance plans expressly forbid doctors from offering services privately that they also offer under the public insurance plan. A physician can not say to a patient, in effect, "I can offer you this service in two weeks under the public insurance plan, but if you (or your private insurance company) pay me

[4] It is worth noting that in estimating the likely cost of private insurance in Alberta Emory and Gerrits assume the cost of private facilities where one could use one's private insurance to be zero – something that is clearly not the case. If private insurers have to build a parallel private facility system then the cost of the insurance will rise considerably and as the cost rises the demand will no doubt fall.

$X I can offer it to you immediately." Doctors must practice 100% within the public insurance plan or 100% outside of it[5].

So, as it stands, any physician offering surgical services in a private hospital that are also offered by him/her in a publicly financed hospital would be in violation of the regulations under which provincial health insurance plans operate. And this is why there is no significant market for private insurance in those jurisdictions where it is legal – there is not sufficient demand to make it economically viable for any significant number of physicians to choose to fully abandon the public insurance system. Again, it is worth noting that the Quebec government has stated that it intends to preserve its ban on dual practice physicians which will likely inhibit the significant growth of private surgical facilities in the province.

There could be a case made that such restrictions are themselves unconstitutional, serving as a restriction of a physician's freedom of association or other constitutionally protected right. Governments would, presumably, argue that they have the right to determine the conditions under which they offer physicians a billing number in the public insurance plan; that enjoining physicians from working, in effect, for the competition is a reasonable condition to enrolment and that, even if there is a violation of a physician's rights, such a violation is surely reasonable given the public policy objectives of publicly provided health insurance. Whether such arguments would withstand a court challenge is open to debate.

Thus, in the present context, it is unlikely that Chaoulli or Quebec's response to it will change the health care landscape significantly in the short term. But the medium and longer term are less clear and fraught with a number of "what if" scenarios that could turn the system in a variety of directions. Because the creation of medicare absorbed virtually all of the private capacity that the health care system had developed before medicare there is very little (but not nothing) on which to build a parallel private system. And if governments are successful in saying, first, that private insurance companies can not access publicly financed and administered facilities to provide services and, second, that physicians will have to continue to choose between being either "in" or "out" of the public insurance plan, then the building of that parallel system will be far harder to accomplish.

Of course, there are some governments in Canada that might be open to the idea of allowing privately insured services to be delivered in hospitals financed by their government and might also be open to allowing physicians to move back and forth between public insurance and private insurance. Indeed, the government of Alberta has hinted that the restriction on dual practice physicians will be lifted as part of its "third-way" health reforms expected to be unveiled early this year and it has further stated that it may be willing to live with the idea of its reforms violating the Canada Health Act.

But whether governments are open to allowing the creation of a parallel private system within their province – which leads to the spectre of 10 separately regulated

[5] Two provinces, Manitoba and Ontario, go so far as to ban physicians from operating outside of the public system in any way. That is, if they offer services that are publicly insured then they must do so through the public health insurance system. The only exception is for those physicians that offer some services that are publicly insured and some that are not – but in such a case, such as a plastic surgeon, any service that is publicly insured can not also be offered on a private basis. They can charge patients directly for a cosmetic breast enhancement, but post-mastectomy breast reconstruction must be billed to the provincial insurance plan if that is a publicly insured service.

private systems operating in parallel to 10 separately administered public systems – is a political question more than it is merely a legal one. And how it plays itself out will be within the political arena. But what is of concern here is that some governments might choose, for political or ideological reasons rather than for "healthcare" reasons, to facilitate the building of a parallel system and, in doing so, frustrate the progress that they themselves have made in reforming the system they administer.

At the same time, the biggest incentive for provinces to resist a parallel public system is that they have begun to make progress on some of the promises they have made over the past decade. How would the private system respond to the desire to move to a model of primary health care based on team practice? How well would it fit into attempts to better coordinate a continuum of care from the community through the primary health care team to the hospital and back to the community in the form of home care, rehabilitation or long term care? Would private facilities be offered access to single electronic health records and, if so, what privacy concerns would be raised by putting that kind of information into the hands of what could be corporate entities with a mandate to sell care to individuals? These are questions that will undoubtedly be faced as we go down this road and there are no easy answers to any of them.

They are raised not because they pose insurmountable challenges to a private parallel system, but because they point to a more important issue – the health care debate has not, at least for some of us, not just been about how we contain costs within the system, but also about what kind of system we want. It is about a belief that a system centred entirely on doctors, hospitals and the treatment of illness is not the goal for which we should aim and that public policy should not reinforce that as the sine qua non of health care. Rather the whole point about primary health care, about community care, about thinking through the continuum of care and dealing with the social and economic determinants of health has been not only about cost but about a vision to which the health system should aspire.

Indeed one of the most disturbing elements of the recent debate about private health insurance and its relation to wait times is the way in which both the proponents and opponents of private insurance have abstracted the surgical procedure out of the continuum of care. In many ways the surgery is not the most important part of what cures the illness. A successful hip replacement operation is, these days, pretty routine stuff. What makes the treatment successful is the pre- and post-operative care and support that goes along with the surgery. And the importance of these elements of the treatment has been lost as we have made a fetish out of the surgical event itself.

The Ever-Changing Politics of Health Care Reform

As was noted above, the Chaoulli decision, although unlikely to fundamentally alter the health care landscape in the short-term, has already had a large impact on the ongoing debate over health care reform in this country. In the first instance, it has reignited the debate over the management of wait lists and waiting times across the country (not that this issue was ever really far from the public's radar screens). In the second instance, it has added new importance to the debate over public versus private delivery of care and public versus private payment for services (the distinction between payment and delivery being often obscured in the heated rhetoric that dominates much of the debate).

In September 2004 the First Ministers agreed to report on progress on the issue of wait list and wait time management in five key areas: cardiac surgery, joint replacement, diagnostic imaging (esp. MRIs), sight restoration (cataract surgery) and cancer. In exchange the federal government agreed to new funds to provinces for progress in these areas. But as the *Taming of the Queue* symposium revealed this commitment on the part of First Ministers comes after years of work by provinces to understand what wait lists are, to define what it means to "wait"[6], to find ways to centralize, first, the compilation of wait lists[7], and to begin to experiment with how to manage the lists.

Indeed, managing the lists is a key challenge. Creating central surgical or diagnostic registries allows the system to see, relatively accurately, how many people are waiting for any given procedure at any one time. But, how does one determine where someone should be on the list – should they be first or one-hundredth? To do this in a manner consistent with the principle that treatment should allocated on the basis of need governments have worked both individually and collaboratively[8] on designing standardized, objective assessment tools that would be administered by doctors in order to determine the severity of the patient's condition and, thus, their placement on the list.

Using a standardized assessment tool allows governments to create transparent surgical registries where patients can see where they are on the list and to know why they occupy that space – and not surprisingly, individuals understand perfectly well that a person whose condition is judged more severe on the basis of an objective test should receive care ahead of them.

The next step in wait list management is harder still. There is now a widespread consensus that centralized lists are the only kind that makes sense. And there is a growing acceptance that if lists are going to be managed then doctors are going to have to accept that their clinical judgement needs to be supplemented (but not completely replaced by) objective assessment criteria that are transparently applied. But once lists are being managed in this way there remains the very difficult question – how long should patient X, with severity level Y, have to wait for procedure Z?

In other words, once you centralize the list and implement ways to manage the list transparently, then you are faced with the question of how long someone should be on the list before you conclude that there is a failure in the system that needs attention. This is the challenge of setting "benchmarks" or standards for the system's performance in moving people onto and off of the list. And this is what the province's agreed to report on in December 2005 and where much of the discussion and debate was centred at the Taming of the Queue symposium.

---

[6] While one might assume that 'waiting' is self-evident, the reality is a little more complex. Does a person's wait begin when they first see their family physician (which might reveal a surgical need)? Or does it begin when they first see a specialist? Or when their condition is confirmed by testing? Or when their surgeon places them on a list for surgery? How one answers these questions can greatly affect the answer to the seemingly simple question "how long did you wait?"

[7] Wait lists can exist in many places. They can be kept by individual physicians, by hospitals, by health regions, by provincial health departments. And individuals can be on multiple lists for the same procedure resulting in the appearance that there are more people waiting for procedures than in fact there are. Centralizing lists into a single common registry by procedure is generally thought to be a first step in actually beginning to manage the lists.

[8] Most notably in the Western Canada Wait List Project (WCWLP) which brought both provincial governments and regional health authorities together to work on list management issues.

On the heels of the Chaoulli decision, though, came reports that not all provinces were going to have publicly available benchmarks for all five of the priority areas by the December deadline.[9] This admission on the part of governments, though subsequent reports suggest that the level of compliance will be higher than first indicated, only serves to strengthen the perception endorsed by the Supreme Court – that wait lists are too long, that people are dying and that the most viable option is to build a parallel private system open to those who can afford private insurance. What has not been understood is how difficult the process of benchmarking has proven to be and how much progress has actually already been made[10].

What is worrisome is that the combined pressure of the Chaoulli decision and the delay in the unveiling of benchmarks in the five priority areas will push governments, willingly or otherwise, to focus their attention not on reforming the current system but rather on a 'big bang' solution that will appear to the public and the media like real action. And such a 'big bang' may be to look to a private parallel system as an answer regardless of the complications noted above or without some of the other challenges that will have to be faced. The government of Quebec should be lauded for resisting the temptation to put all of its eggs in the private insurance/parallel system basket. Its response to Chaoulli – the partial lifting of the ban on private insurance, the announcement of care guarantees and the retention of the ban on dual practice – are far less than it could have done had it chosen to actively facilitate the development of a parallel private system. That is not to say that they will not potentially have some problems. Care guarantees are tricky things. Set the bar too high and you set up the system to fail which will only undermine public confidence. Set it too low and the public sees no noticeable change in the timeliness of access. The question of whether Quebec's guarantees can be met by the system remains open, but there is some reason for optimism given the progress they have made on managing wait lists in the past. And not only do we need to monitor whether the care guarantees are being met, we need to be concerned with how we regulate those privately provided surgeries that will occur in terms of both cost to the system, but also in terms of the quality. There will be valuable lessons that will come out of what Quebec is proposing to do – the question is whether the system has the capability to learn them.

Unfortunately, somewhere in the course of the health care debate, both the defenders of medicare and its critics have too often couched their positions in terms of 'grand plans' to reform the system from top to bottom and all at once. There can be little doubt that the public's weariness about hearing about the wonders of primary health care stem in part from the fact that proponents of such reform have been less than honest about how damnably long it would take to get real primary health care teams up and running; about the fiercely defended turf that had to be crossed in order to get things moving in the right direction. And certainly the public's suspicion of those who blithely

---

[9] "Ottawa warning about wait-time benchmarks", *Health Edition*, Vol. 9, No. 37, pp. 1-2; "Benchmarks for wait times up in the air", *Health Edition*, Vol. 9, No. 40, pp. 1-2; "Not all wait-time benchmarks to be ready by end of year", *Health Edition*, Vol 9., No. 42, pp. 1-2.

[10] See, for example, Jack Tu, "Challenges for Developing National Benchmarks for Waiting Times" presentation to The Taming of the Queue II Symposium (Ottawa, March 15 & 16, 2005) [http://www.cprn.org/en/doc.cfm?doc=1296] and Tom Noseworthy and Claudia Sanmartin, "Maximum Acceptable Waiting Times: A Critical Input to National Benchmarks" presentation to The Taming of the Queue II Symposium (Ottawa, March 15 & 16, 2005) [http://www.cprn.org/en/doc.cfm?doc=1295].

claim that more private dollars will fix all that is wrong with medicare stems from a similar uneasiness with so simple a solution that does not admit that there are real challenges: what about the loss of good jobs?; should a private hospital be allowed to only skim off those services it deems profitable?; will private facilities resist the temptation to 'sell' ever increasing levels of service regardless of demonstrable medical need?, how do we insure that privately delivered services are of high quality?, etc. We spend over $140B on health care every year in this country and it is a highly decentralized, risk-averse system with powerful interests within it and it has both fierce defenders and fierce critics. This is not a system well designed for simplistic, big-bang solutions from either side in the debate.

And there is no doubt that there are real problems that have to be solved. However wrong the Supreme Court was in its understanding of what is wrong with the wait list situation, it is certainly right that wait lists remain a key challenge for the system. But in looking at what has gone right in the area of wait list management one is struck with one unassailable fact – the solutions that have worked and are continuing to work (the centralization of lists, the creation of registries, the development of standardized assessment tools, the still relatively nascent work on benchmarks) are not 'big-bang', all-at-once solutions. They are relatively small, incremental approaches that build successively from one to the other and, cumulatively, shift the system toward different ways of doing things. They are, however, decidedly un-sexy and, most emphatically, not the stuff of headlines.

Moreover, many of these steps are also quite local in their first incarnation. They are the innovations of a small group of health authorities or of a single province. In the whole range of issues that constitute the "health reform debate" in Canada, almost of all of the interesting progress toward those elusive goals of 'primary health care' or 'improving quality outcomes' exist on the ground in still relatively isolated cases in specific communities or parts of the country. What we have not yet learned is how to translate and transfer the knowledge that exists on the ground in those places to other parts of the system elsewhere. And that is what is so compelling about events like the Taming of the Queue – the opportunity for governments, policy makers, managers and stakeholders to share what they know about what is working (or not) in their part of country in the expectation that it can be replicated (in some form or another) in other communities, regions or provinces. But symposia are not enough to insure that good practices are translated across jurisdictions.

Governments can best respond to the Court's concerns about wait lists by applying the Taming of the Queue lessons. Our focus should be on learning how innovations in Edmonton's Capital Health Authority can be made to work in St. John's or Victoria, rather than on worrying about losing the best and brightest practitioners to a private system. That the Health Council of Canada has chosen to highlight these kind of innovations in both of its annual reports to date is encouraging. But governments should ensure that the system has the capacity and resources to innovate locally and replicate nationally. The system needs the capacity and ability to share knowledge effectively about what works and what does not (and, to be sure, some experiments will not pan out), and to translate that knowledge across jurisdictions. This takes a commitment to let go of the cant and rhetoric that has dominated much of the health care debate in recent years. It

requires a willingness to find those 'neutral, non-politicized spaces' that allow jurisdictions to learn from one another in a constructive manner.

All of that being said, there is still an upside to the Chaoulli decision: it appears to have sparked renewed interest and concern about the role of private payment for services and the private delivery of services within the Canadian system. The decision of the government of B.C. to undertake a wide scale consultation with its own residents about the role of the private sector in health care is, again, something to be lauded. If it does this right it will learn a great deal about what British Columbians want from the system, what they are willing to pay to achieve it and what trade-offs they will and will not accept. Citizens, CPRN has learned from experience, have a much better understanding of what would work for them, their families and their fellow citizens than they are often given credit for. They also have a great ability to see through the cant and rhetoric of entrenched positions and to articulate policy goals rooted both in their values and their understanding that choices – sometimes hard ones – have to be made.

The fall-out from the Chaoulli decision, in conjunction with things like the Menard Report out of Quebec, has provided Canadians with an opportunity to have, finally, a real and serious debate about the relative weight of public and private delivery and finance. By striking down the Quebec legislation (and only the Quebec legislation) the Court has provided an important opportunity for the country (and its leaders) to get its head straight about what it wants the system to look like in this respect. This requires that political leaders especially be very clear in their public pronouncements about the system's future – something none of them, on either side of this debate, have been in recent years. Whatever the Court's shortcomings in terms of its understanding of issues like wait lists (and it should be remembered that it got it wrong because no-one bothered them with the evidence), the political fall-out of the decision in Chaoulli is an opportunity to clarify a debate the confusion and rhetoric surrounding which has itself stymied progress in health reform across the board.

Canadian Policy Research Networks Inc.
600-250 Albert Street
Ottawa, ON K1P 6M1
Tel: (613) 567-7500 – Fax: (613) 567-7640
Web site: www.cprn.org