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Increasing Access Through Privatization? Bill 33 and the Introduction of Private Clinics and Duplicative Insurance in Québec

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Abstract

On 15 June 2006, Bill 33: *Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*, was tabled at the Québec Legislature. It served as the government's response to the Supreme Court of Canada's 2005 ruling in *Chaoulli vs. Québec (Attorney General)*, which had ruled that Québec's ban on duplicative health insurance was not consistent with the *Québec Charter of Human Rights and Freedoms*. Bill 33 implemented centralized waiting lists and introduced specialized private medical centres and duplicative private health insurance. The stated objectives were to reduce wait times and abide by the SCC ruling. However, the scope of the reform was strictly limited to three services: hip and knee replacement, cataract extraction, and intraocular lens implantation. It also placed regulations on the ability of physicians to practice in the private sector, suggesting that the government sought to achieve these reforms while attempting to maintain the integrity of the public system and change as little as possible. Minimal evaluations of Bill 33 have been conducted by the government, with no further evaluations planned. However, analysis of the current Québec health care landscape indicates that despite the stated aspirations of Bill 33, it has not made a substantial impact on reducing wait times. At the same time, it has not contributed to the growth of a private insurance market in Québec, as many of its detractors feared. The implications of the Chaoulli decision and Québec's response provide key lessons for government and stakeholders in responding to legal challenges on health equity and parallel health system.

Le 15 juin 2006, le projet de loi 33 : Loi modifiant la Loi sur les services de santé et les services sociaux et d'autres dispositions législatives, a été déposé à l'Assemblée législative du Québec. Il s'agissait de la réponse du gouvernement à la décision rendue par la Cour suprême du Canada en 2005 dans l'affaire Chaoulli c. Québec (Procureur général), qui avait jugé que l'interdiction de l'assurance maladie duplicative au Québec n'était pas conforme à la Charte des droits et libertés de la personne du Québec. Le projet de loi 33 a mis en place des listes d'attente centralisées, des centres médicaux privés spécialisés et a introduit l'assurance maladie privée duplicative. Les objectifs déclarés étaient de réduire les temps d'attente et de se conformer au jugement de la CSC. Cependant, la portée de la réforme était strictement limitée à trois services : remplacement de la hanche et du genou, extraction de la cataracte et implantation de lentilles intraoculaires. Elle a également imposé des règlements sur la capacité des médecins à exercer dans le secteur privé, ce qui laisse entendre que le gouvernement a cherché à réaliser ces réformes tout en essayant de maintenir l'intégrité du système public et de changer le moins possible. Des évaluations minimales du projet de loi 33 ont été effectuées par le gouvernement, et aucune autre évaluation n'est prévue. Cependant, l'analyse du paysage actuel des soins de santé au Québec indique que, malgré les aspirations déclarées de la Loi 33, celle-ci n'a pas eu d'impact substantiel sur la

réduction des temps d'attente. En même temps, elle n'a pas contribué à la croissance d'un marché de l'assurance privée au Québec, comme le craignaient nombre de ses détracteurs. Les implications de la décision Chaoulli et la réponse du Québec fournissent des leçons clés pour le gouvernement et les parties prenantes dans la réponse aux défis juridiques sur l'équité en santé et le système de santé parallèle.

Key Messages

- Bill 33 introduced regulations for private specialized medical centres, duplicative insurance, and centralized wait lists for select surgical procedures.
- Impact analysis has shown that the reforms have not made a significant impact on reducing wait times, nor did they increase the market for duplicative private health insurance.
- An analysis of the Chaoulli decision and Québec's response via Bill 33 are critical to provide a comparative perspective of the 2020 *Supreme Court of Canada Decision in Cambie Surgeries Corporation v. British Columbia (Attorney General)* and future debates on health system privatization.

Messages-clés

- *Le projet de loi 33 a introduit une règlementation des centres médicaux privés spécialisés, l'assurance duplicative et les listes d'attente centralisées pour certaines procédures chirurgicales.*
- *L'analyse d'impact a montré que les réformes n'ont pas eu d'impact significatif sur la réduction des temps d'attente. Par ailleurs, ces réformes n'ont pas non plus augmenté le marché des assurances privées duplicatives.*
- *Une analyse de la décision Chaoulli et de la réponse du Québec par le biais du projet de loi 33 est essentielle pour fournir une perspective comparative de la décision de la Cour suprême du Canada de 2020 dans Cambie Surgeries Corporation c. Colombie-Britannique (Procureur général) et des débats futurs sur la privatisation du système de santé.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Bill 33, an *Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* was passed through the Québec legislature on 13 December 2006. The legislation implemented centralized wait lists, created legislation on private specialized clinics, and regulatory protocols permitting duplicative private health insurance.

Bill 33 required each hospital to implement a central management mechanism for wait lists for designated specialized services, with a guarantee of access to privately purchased specialized services in cases of "unreasonable" waiting times. The Bill did not stipulate explicit wait time guarantees, but in practice, the government did set a target of 90% of elective and semi-elective surgeries being performed within six months (Segall, Takata and Urbach 2020). These wait times are publicly reported through the *Système d'information sur les mécanismes d'accès aux services spécialisés* (SIMASS).

Bill 33 also defined specialized medical centres (SMC) as independent centres operated by a licensed physician and equipped and allowed to perform only specified orthopedic and ophthalmologic procedures. SMCs can only employ physicians who are non-participating in the public system (practicing completely outside the public system) and are subject to 5-year permits from the Ministère de la santé et des services sociaux (MSSS).

Finally, Bill 33 also introduced a provision permitting duplicative private insurance for specified specialized procedures (cataract, hip and knee surgeries) performed in an SMC.

2 HISTORY AND CONTEXT

Bill 33 was catalyzed by the Supreme Court of Canada (SCC) ruling of *Chaoulli v. Québec* in 2005, which challenged the constitutionality of Québec's health care legislation vis-à-vis private health insurance for services that are covered under the public plan. Dr. Jacques Chaoulli and patient George Zeliotis contended that the prohibition of private health insurance in Québec deprived patients of timely access to health services (*Chaoulli v. Québec (Attorney General)* 2005, par. 3). They argued that these prohibitions violated patient rights to life and security of the person; and life, personal security and inviolability under Section 7 of the *Canadian Charter of Rights and Freedoms* (hereinafter "*Canadian Charter*") and Section 1 of the *Québec Charter of Rights and Freedoms* (hereinafter "*Québec Charter*"), respectively. The case had previously been dismissed by the Superior Court of Québec in 2000 and by the Québec Court of Appeal in 2002, (R.J.Q 1205-1215 2000) upon which it was brought to the SCC (*Chaoulli v. Québec (Attorney General)* 2005).

The Québec government reacted to the 2005 SCC ruling by applying for a stay of at least six months before the SCC decision could take effect, citing that immediate implementation could disrupt the delivery of health services (*CBC* 2005). Over the following year, the Québec government held a series of public and stakeholder consultations which resulted

in the release of a white paper entitled *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency, and Quality* (hereinafter "*Guaranteeing Access*") on 16 February 2006 (Government of Québec 2006). In the white paper, the government committed to five principles in guiding health and social services, namely: *1*) universality and equity of the public health system; *2*) integration of services as a preferred organizational method; *3*) maintaining and improving the quality of services; *4*) availability of human resources in the public sector; and *5*) increased productivity and better control of the costs of the health system (Government of Québec 2006). The legislative amendments in Bill 33 largely arise out of the recommendations of the *Guaranteeing Access* report.

3 GOALS OF THE REFORM

3.1 Stated

The aforementioned five principles in the *Guaranteeing Access* report were emphasized in the introduction of Bill 33, seemingly as a means for the Québec government to respond to the SCC's judgment while attempting to balance the mounting concerns around the integrity of the public health system (Quesnel-Vallée et al. 2006).

Bill 33 has three explicit goals that include the introduction of: *1*) centralized management of wait times in hospitals for specialized health services; *2*) new nomenclature and regulation of private specialized medical centres staffed by physicians who opted out entirely from the public system (meaning they cannot treat any non privately paying patient) and that offer high-demand procedures as well as associated medical clinics that could contract out physicians from the public health system; and *3*) permission to offer duplicative private insurance for a restricted set of procedures covered publicly (*An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* 2006).

3.2 Implicit

In response to the SCC ruling, the Québec government could have chosen to invoke the notwithstanding clause (Section 33) of the *Canadian Charter* to maintain the prohibition against private insurance, declaring that it applies despite Section 52 of the *Québec Charter* (Gaudreault-Desbiens and Panaccio 2005). Instead, the provincial Liberal government chose to use the Chaoulli ruling as an opportunity for reform, notably as the federal Conservative party was making the issue of private health care services the centre of its 2006 election campaign (Manfredi and Maioni 2018).

However, while the decision to allow any form of duplicative private insurance was highly contentious, the fact that it applied only to a limited set of procedures suggests that it may have been a strategic decision. It indeed appeared to respond directly to the highly criticized link established by the Supreme Court, which insinuated a relationship between duplicative insurance and wait times. The decision was ultimately benign in its potential

impact on the privatization of the system because the limited set of procedures eligible for duplicative insurance limited the development of a parallel private market (Prémont 2006; Prémont 2007).

4 FACTORS THAT INFLUENCED HOW AND WHY THE ISSUE CAME ONTO THE GOVERNMENT'S AGENDA AND HOW THE FINAL DECISION WAS MADE

The Kingdon framework notes that government agenda-setting ("how and why the issue came onto the agenda") involves three key components: problems, policies, and politics coming together to open a "policy window" (2003). The policy window that opened and led to Bill 33 arose directly from the "problem" that the SCC ruling posed for the Québec government. In considering proposals, the government could have opted for the notwithstanding clause, but instead elected to impose more regulation of the private system, as well as impose wait times guarantees in the public system. Many argued that this decision was motivated by politics favouring further privatization of the system, though this was, not surprisingly, strongly denied by the government in power, who instead argued that this was an opportunity for strengthening the public sector's timely delivery of care.

In order to shed some light on how the final decision was made, we will employ the 3I (Interests, Ideas, and Institutions) framework (Kingdon 2003).

4.1 Interests

During the consultation stages of Bill 33, it was evident that stakeholders including individuals, policymakers and interest groups had been dissatisfied with wait times for elective procedures in the public system (Contandriopoulos et al. 2012). The provincial Liberal government in power at the time also engaged in several public-private partnerships, which was seen as a politicization of health care (Manfredi and Maioni 2018).

4.2 Ideas

Chaoulli v. Québec pegged ideas of equity and protection of the public good against freedom of choice and limits to individual liberty (Quesnel-Vallée et al. 2006).

There was consensus among policymakers that protection of the public health system was important (Government of Québec 2006). Regulations that would restrict the growth of private insurance were therefore favoured given the concern that privatization could weaken the public system and open the floodgates to a two-tier health system where those with greater resources would have better access to services (Flood 2007).

However, some voices pushed for faster access to services in a parallel private system for those with the capacity to pay or with private insurance. A prevailing argument was

that this might alleviate the burden on the public system as well (Quesnel-Vallée et al. 2006). Such an outcome, however, was based on likely faulty assumptions given the level of rationing in Québec with regards to health human resources. What's more, polls-based reports of public support for the privatization of the health care system display logical and methodological weaknesses, indicating that these polls may not provide an accurate depiction of public opinion (Contandriopoulos and Bilodeau 2009).

Finally, Québec was already a "hot spot" for the private health market compared to other provinces, notably in the areas of private diagnostic imaging and insurance for these services, physicians opting out of the system, and user fees—which were flourishing before the Chaoulli case (Quesnel-Vallée, McKay and Farmanara 2020), suggesting that these ideas were pervasive enough to motivate both the behaviour of physicians and patients.

4.3 Institutions

The Chaoulli decision set a precedent concerning the involvement of judicial systems in health services design and delivery, as noted by the dissenting justices of the SCC. The latter also expressed discomfort about the risk of turning administrative targets such as wait time guarantees into legislated rights (*Chaoulli v. Québec (Attorney General)* 2005).

In *Guaranteeing Access*, the Québec government set clear targets to timely access to care, which included guaranteed private financing or out-of-province coverage after a waiting period of nine months (Government of Québec 2006). However, the recommendations from the plan were not codified in Bill 33, therefore reducing the risk of judicial intervention if the benchmarks were not met.

5 HOW THE REFORM WAS ACHIEVED

5.1 Policy instruments

Bill 33 is a legislative policy instrument, based on the health system administration principles outlined in the *Guaranteeing Access* report. It allowed for the implementation of the reforms through its amendments to integral pieces of health care legislation in Québec and led to the creation of additional regulations that extended the private delivery of health services.

While Bill 33 initially only allowed for the private insurance funding of total hip or knee replacements, cataract extractions and intraocular lens implantations carried out in specialized medical centres, it was followed in 2009 by Bill 34 and related regulations (*Regulation Respecting the Specialized Medical Treatments Provided in a Specialized Medical Centre* 2008), which expanded the number of elective surgical procedures that eventually could be allowed in the specialized medical centres (including mastectomies, hysterectomies, and bariatric surgeries) (*An Act to Amend Various Legislative Provisions Concerning Specialized Medical Centres and Medical Imaging Laboratories* 2009).

5.2 Implementation plans

The three explicit goals of Bill 33 had varied methods of implementation.

5.2.1 Wait times

Bill 33 required each hospital to implement a central management mechanism for wait lists for specialized services and increased monitoring by the MSSS of the time patients were spending on wait lists. With regards to waiting times guarantees, Bill 33 also provided powers to the MSSS to grant access to privately purchased specialized services in cases of "unreasonable" waiting times. While the Bill did not stipulate explicit wait time guarantees or give any detail on what "unreasonable" meant (*An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* 2006), in practice, the government has set a target of 90% of elective and semi-elective surgeries being performed within six months (Segall, Takata and Urbach 2020). These wait times are publicly reported by regional health agencies through the SIMASS in 2007. SIMASS is a software that allows for the centralized management of waiting lists for specialized services, and publicly reports the wait times of non-urgent surgical procedures (Government of Québec 2005).

5.2.2 Specialized medical centres and associated clinics

Bill 33 defines SMCs as independent centres operated by a licensed physician and equipped and allowed to perform only specified orthopedic and ophthalmologic procedures. SMCs can only employ physicians who are non-participating in the public system (practicing completely outside the public system) and are subject to 5-year permits from the MSSS. Also, Bill 33 introduces a framework for the creation of clinics associated with hospitals to provide specialized services. However, unlike SMCs, these clinics operate only upon referral from a hospital centre and employ physicians practicing in the public system (*An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* 2006).

5.2.3 Introducing duplicative private insurance

The introduction of duplicative private insurance in Bill 33 was limited to the specified specialized procedures. Additionally, for the procedures to be eligible for coverage, they had to be performed in an SMC (*An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions* 2006).

6 EVALUATION

The Québec government did not lay out a comprehensive evaluation plan for Bill 33. In this section, we highlight the few evaluations this reform. These suggest that the impact

of the intended reforms remains ambiguous—with marginal improvements at best realized.

Despite SIMASS, improvements in wait times have been insignificant, with the maximum benchmark of six months being met in around 80% of cases for hip and knee surgery, and 86% of cases meeting the 112-day benchmark for cataract surgery (Canadian Institute for Health Information 2017). These performance indicators are similar to those before the reform, with slight increases in the wait times for elective orthopedic procedures and decreases in wait times for cataract surgery (Labrie 2015).

Concerning the introduction of duplicative health insurance, the narrow scope of procedures permissible under Bill 33 created the legal opening for private insurance to satisfy the SCC ruling without incentivizing the insurance market towards large-scale adoption, thus preserving the public system (Cohn 2010). Thus, more than two years after the bill was passed, the insurance industry indeed reported that no policies had been sold (CBC 2009).

SMCs similarly failed to garner uptake. As of September 2019, 57 specialized medical centres were licensed. However, the majority perform plastic surgery and other cosmetic procedures, with only a few of the centres providing essential medical services and the originally prescribed ophthalmological and orthopedic procedures (Government of Québec 2019).

Finally, a worrying trend regarding family physicians opting out of the public system in greater numbers following this policy reform was noted, which could be attributed to the impetus created by this bill (Contandriopoulos and Law 2021). However, an alternative interpretation for this trend is that the Chaoulli case and the movement of physicians out of the system share common roots, not that the former caused the latter (Quesnel-Vallée, McKay and Farmanara 2020).

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

By way of conclusion, we present Table 1 which summarizes the strengths, weaknesses, opportunities, and threats of Bill 33, with the perspectives that emerged in stakeholder briefs and media discourse during the review of Bill 33 indicated in brackets.

Table 1: SWOT Analysis

Strengths	Weaknesses
• Reduced burden on the public system (*government*, *users*). • Centralized wait lists improve the cohesiveness of hospital services and monitoring (*government*, *users*, *administrators*.) • Increased accessibility for private services thanks to private insurance (*users*). • Increased patient choice (*users*). • Maintained separation between public-private dual practice (*users*, *government*). • Restrictive provisions discourage the emergence of a viable private market (*users in favour of the status quo*, *government*).	• The absence of clear wait time guarantees reduces trust accountability in the public system (*users*). • Restrictive provisions discourage the emergence of a viable private market (*physicians*, *private clinics*).
Opportunities	**Threats**
• Centralized wait lists could reduce wait times (*users*, *government*, *administrators*). • Cost-savings for the government if more private purchasing of services occurs (*users*, *government*). • Financial incentive for physicians through the introduction of a for-profit parallel system (*physicians*, *government*).	• Threat to horizontal and vertical equity if reform results in faster access for those able to pay (rather than based on need) (*users*). • Increased spending on health care (*government*, *users*). • Competition between public and private systems will drive up costs for the public sector vying for scarce human resources (*government*, *users*, *administrators*). • Weaker regulatory oversight of private clinics could put patients at risk (*government*, *users*). • Risk of lack of consistency in wait list management across health care providers and regions (*government*, *users*, *administrators*).

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9 FOR MORE DETAIL

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