fect of the Chaoulli decision, says Dr. Antonia Maioni, director of the McGill Institute for the Study of Canada.

On the surface, the decision itself had little impact, other than the government of Quebec's proposed response to establish wait time guarantees for cataract, knee and hip surgeries, and allow elective surgeries for those 3 to be covered by private insurance and performed by a limited number of affiliated private clinics, Maioni says.

"However, there has been a big shift in the public debate around health care," Maioni adds. "What Chaoulli did was to open up the playing field to legitimize a wider range of alternatives for the direction of Canada's health care system."

> "It's no longer taboo to talk about private financing."

Conference Board of Canada Director of Health Programs Glen Roberts concurs. "It's no longer taboo to talk about private financing."

Skinner argues the debate has already turned in favour of private financing. "The largest impact has been to change the consensus on whether or not the health care system is sustainable. It's changed the consensus on whether it's even just." As importantly, it's affected a shift in provincial government behaviour, Skinner adds. "While they maintain the rhetoric of the Canada Health Act, there's a reluctance to enforce it because they know that on legal grounds they would fail."

But others say that the debate and threat of privatization have served to rejuvenate the national will to save medicare, resulting in significant re-investment in the system, a raft of reforms to reduce wait times, as well as legislative initiatives like Ontario's Commitment to the Future of Medicare Act to protect public financing of the system.

The public system is poised to demonstrate there's no need for a major overhaul, argues Dr. Danielle Martin, chair of the newly formed Canadian Doctors for Medicare.

"We're at the thin edge of the wedge of re-investment into the system," says Martin, a Toronto FP. Wait times are decreasing and people are getting faster access to diagnostics, she says. "In the space of only a year, [that] is pretty impressive."

Still, Martin concedes, the impetus for privatization isn't likely to disappear, whether it stems from patient need and patient demand, or "whether the impetus for privatization is somebody wants to make some money."

That makes it ever more incumbent that physicians "stand with our patients" to save and strengthen the system, she adds. "The threat is never gone. This debate will never go away. In some ways, that's good because ... the medicare project that we've undertaken in this country ... [is] a costly one although not as costly as the alternatives and it requires a big social commitment and so we have to re-commit to it all the time. It's one of those things that we all have to wake up every morning and choose it again."

CMA President Dr. Ruth Collins-Nakai says she welcomes Martin's group and the input of Canadians. "It's wonderful to have different people becoming involved in the debate. It has to be a public debate." — Wayne Kondro, *CMAJ*

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Medical students oppose two-tier, petition CMA

More than 20% of Canadian medical students have signed a petition asking the CMA to support publicly funded and accessible medical services.

The petition was set up by the Student Medical Reform Group following CMA delegates' vote last August to support allowing private health insurance and private-sector health services. The reform group, which started 3 years ago at the University of Toronto, is affiliated with the Medical Reform Group, a voluntary group of socially minded physicians concerned with the social, economic and political factors influencing health care.

As of late May, the petition (www.medicalreform.ca) had garnered 1107 signatures representing every Canadian medical school; there are 8177 medical students across Canada.

"It's pretty significant for a grassroots initiative," says Larissa Liontos, who is in the third year of the MD/PhD program at the University of Toronto.

The reform group hopes the petition will result in the CMA "publically stating they support a universally accessible health care system and that patients' ability to pay won't interfere with their access to care," says Liontos, co-chair of the reform group's Toronto chapter. "Paying out of pocket is counter to accessibility," she added. "We don't want to see our future colleagues going down that road."

The vote has also embodied an inherent conflict of interest since physicians stand to gain from the move, she pointed out. — Barbara Sibbald, *CMAJ*

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CMA proposes options for private–public split

Published at www.cmaj.ca on June 8, 2006.

Canadians and physicians must decide the degree to which they would like to increase private health care financing and delivery in light of the unsustainability of the existing system.

The CMA unequivocally states in its June 7 discussion paper, *It's about Access! Informing the Debate on Public and Private Health Care* (www.cma.ca), that the status quo is not tenable and delineates 4 options Canadians may consider in reforming the system.

Delegates at the CMA Annual Meeting Aug. 21–23 will be asked to use the paper to reconsider the private–public

split. The CMA has traditionally supported a public system.

More privatization, however, may be problematic, the paper states, noting that reform of the system may be all but impossible without a significant increase in the number of physicians.

Drawing on international data and feedback from some 2800 Canadian doctors, the paper sketches 4 possible scenarios for the evolution of the Canadian system:

1. **Status quo**
2. **Medicare plus:** Including an evaluation of the basket of insured services, more cost-sharing arrangements (e.g., premiums), allowing physicians to opt out, and allowing Canadians to buy private insurance for some services and to get paid care elsewhere if wait times are exceeded (safety valve)
3. **Medicare complemented:** Including a safety valve for more procedures, an expanded range of privately funded services (and private insurance for the same), and allowing physicians to deliver medically necessary services under both publicly and privately funded systems
4. **Medicare plus parallel private:** Public services for all, but Canadians will have the option of private insurance for a full range of hospital and medical services.

None of the scenarios completely meet all the paper's 10 recommended guiding principles for the future of health care, CMA President Ruth Collins-Nakai said during the paper's release.

"At some point Canadians have to decide whether or not they want to continue with a tax-supported collective health care system or whether they wish to go with a more private, individual-rights type of system and ignore the collective. That's what it comes down to. Or whether they want something that is somewhere between those 2 extremes."

An Ipsos Reid poll released in conjunction with the paper seems to indicate Canadians have already made that choice. Of the 1000 adults polled (accurate ± 3.2%, 19 times out of 20), 30% preferred scenario 3 and 29% preferred scenario 2, 26% the status quo and only 15% scenario 4.

The enhanced medicare scenario consistently garnered the best rating for overall impact (81%), timely access (78%), comprehensiveness (79%) and equity (74%). Scenario 4 had the lowest overall ratings.

Scenario 3 and 4, which advocate an extended role for private financing, will significantly alter the 70:30 public–private funding split that has characterized Canadian medicare financing for the past 3 decades.

The new advocacy group, Canadian Doctors for Medicare, criticized the CMA for even considering scenario 4. Its Chair, Dr. Danielle Martin, says a "duplicate system is basically anathema to Canadians." The paper itself concludes that in countries with a parallel private system, access is increased for a very small number of people but "significantly compromises access for everybody else."

Martin says it's incumbent on the CMA to make it clear that it does not support a duplicate system. "Ultimately, the CMA is going to have to lead on this issue. ... We'd like to see that commitment made without any equivocating."

The Canadian Association of Internes and Residents went one step further, calling on the CMA to reject private health insurance outright. President Dr. Jerry Maniate says given the existing human resource shortages, "there is a serious risk that channeling these resources into a parallel privately funded system would, instead of reducing, actually increase wait times for the majority of Canadians, who could not afford private insurance."

The Fraser Institute, a think tank group, chided the CMA for failing to articulate options that are available other than the 4 scenarios. Director of Health and Pharmaceutical Policy Brett Skinner said the paper's authors overlooked "the most successful model" in the world, the one used in Switzerland, in which all health care is delivered privately, while the system is funded entirely by mandatory public insurance (much like auto insurance in Canada).

Skinner also said the relatively low level of public support for a duplicate system that was evident in the poll was strictly a function of Ipsos Reid having surveyed healthy Canadians, rather than those who are severely ill or who had recent experience with medicare.

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The CMA has opened the doors for discussion on 3 public–private scenarios for Canada's health care system.

The discussion paper was developed in response to resolutions at the August 2005 CMA Annual Meeting that endorsed private health insurance and private-sector health services for patients who don't get timely treatment through the public system. A CMA "blueprint" on the private–public split was promised for February 2006. Collins-Nakai said a paper was presented to the CMA board in February, but they wanted the discussion paper to coincide with the 1-year stay in the Chaoulli Supreme Court decision (see page 17).

With this paper now slated to guide discussion at the CMA Annual Meeting in Charlottetown, Collins-Nakai indicated the physician community appears as split as Canadians on the question of privatization.

Paper coauthor Dr. Robert Hollinshead, a Calgary orthopedic surgeon, said that split is a function of the fact that specialists are "extremely frustrated over the pace of reform." He added, "We see the potential that

the private system, if it was publicly funded, could help deal with these very long waiting lists."

The paper sketches the experience of the other 30-member countries in the Organisation for Economic Co-operation and Development (OECD) in terms of the public–private characteristics of their health care systems. It states that, "Contrary to popular belief, Canada relies heavily on private spending and private health insurance as a means of financing health services." Canada's public spending as a share of total health care expenditures is below the OECD average (70.9% compared with 73.5%).

The only countries where private health insurance accounts for a larger share of total health care expenditures are France (12.7%), Germany (12.6%), the Netherlands (15.2%) and the US (35.1%).

Canadians also spend more on private health insurance than the OECD average (11.4% v. 6.3%) although out-of-pocket payments are less (15.8% v. 17.7%).

The paper indicates that it may well be impossible for Canada to adopt any alternative to the status quo without significantly increasing the number of physicians and hospital beds. It states that "All 12 countries with parallel private systems have a higher ratio of practising physicians to population than Canada." Canada had the lowest ratio of physicians to 100 000 population at 2.1; the highest is 4.4 in Greece.

Collins-Nakai acknowledged that the health human resource (HHR) shortage must first be resolved, but believes a welcome-mat for ex-pat Canadians would help redress the deficiency. She also indicated a national HHR strategy must be developed to ascertain the appropriate physician ratio that Canada needs for each of the 4 scenarios.

Maniate from CAIR says the paper has a "misplaced focus on introducing private insurance [that] deflects attention from the fundamental importance of [HHR]." —Wayne Kondro and Barbara Sibbald, *CMAJ*

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No "simple solutions" to emergency log-jam

The Canadian Association of Emergency Physicians (CAEP) calls it "counter-productive." Several of its findings seem counter-intuitive. Yet, the authors of the first national, comprehensive study on emergency department (ED) overcrowding in Canada say there's no evidence that many institutional reforms and responses, such as senior physician flow shifts, have any impact on reducing the nation-wide log-jam.

Other responses, like fast tracking patients with minor injuries or illnesses, have proven to reduce ED length of stay and wait times, according to the report, *Emergency Department Overcrowding in Canada: What are the Issues and What Can Be Done*, prepared for the Canadian Agency for Drugs and Technologies in Health. Other measures may yet prove to be beneficial, like "ambulance diversion strategies, short stay units, staffing changes and system-wide complex interventions."

But there's no evidence that triaging patients has any impact on overcrowding or wait times, according to a scientific literature review led by Dr. Brian Rowe, a clinician and holder of a Canada Research Chair in Emergency Airway Diseases at the University of Alberta.

Nor is there any evidence of efficacy for "float nurse pools, senior ED physician flow shifts, home or community care workers assigned on-site to the ED, over-census on wards, establishment of orphan clinics, 'coloured' codes to decongest ED, and 'overload' units for in-patients." Some of those procedures, however, may simply be too new to have been evaluated.

In a parallel element of the study, a survey of 243 ED directors in Canadian hospitals indicated that 85% believe a lack of beds is the cause of overcrowding. The majority also believed that other contributory causes include increased complexity and acuity of patient systems, the occupancy of stretchers and length of stay of admitted patients in EDs.

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There's no evidence that triaging patients has any impact on overcrowding or wait times.

The directors generally agreed that overcrowding has a major impact on the stress levels of nurses, along with their recruitment. Stress caused by overcrowding is lower among physicians (65%) than nurses (82%).

In short, ED overcrowding is "system-wide. It's profoundly complex. It has multiple causes and there are no clear, simple solutions," Rowe said.

In so saying, the report tempts policy-makers to ignore the fact that there's been a crippling 40% cut in hospital beds generally over the past decade, argues CAEP President Dr. Andrew Affleck. "When you cut 40%, you're going to have a lack of beds, particularly when you have an aging, elderly, complex patient population."

National Emergency Nurses Affiliation president Janice Spivey says it's vital that bed capacity be restored if "we're ever going to tackle the ED backlog."

Spivey also argued there's a need to ensure that medical equipment such as MRIs and CT scans are available beyond the typical 9-5 workday and that programs be put in place to ensure there'll be an adequate supply of properly-trained emergency nurses to handle the expected influx of patients as the population ages. The roster of available nurses is so limited that the system can't handle staff nurses' illness or injury without forcing people into lengthy, multiple work shifts.

But the survey of ED directors doesn't identify human resources as a problem.