

CHAULLI: POLITICAL UNDERTOWS AND JUDICIAL RIPTIDES

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Introduction

The Canadian health care system has been the source of concern and rigorous debate over the last decade. Tensions centre on the fact that public spending on health care is outpacing economic growth, raising sustainability concerns. Yet, on the other hand, the public and patients are concerned about access to new drugs and treatments, shortages in the numbers of family doctors and nurses, and wait times.

The Supreme Court of Canada, spurred by lengthy waiting lists, has waded into the debate as to the appropriate role for public and private financing. *Via* the *Chaoulli* decision,¹ the court has plunged into a complex policy arena, and the impact of the decision is being felt throughout the health care system. The majority found Quebec laws prohibiting private insurance for medically necessary hospital and physician services, given long wait times, to be in breach of the Quebec *Charter of Rights and Freedoms*.² Three of the seven judges sitting also found the laws to be in breach of the Canadian *Charter*.³ In essence, the Court said that if the public system was not able to provide timely care, then patients could not be prevented from buying private health insurance.

In this paper I will make two arguments. The first is that poor decision making by the Supreme Court of Canada in the *Chaoulli* decision is feeding into poor decision making at the policy level, which in turn may result in

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1 *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791 [*Chaoulli*].

2 *Charter of Human Rights and Freedoms*, R.S.Q. c. C-12.

3 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

further poor decision making at the judicial level; this merry-go-round has to stop. The second is that the most important problem for all health care systems (whatever the dynamics of public and private financing) is how to improve accountability for decision making. Progressive elements of the legal community have, in response to *Chaoulli*, focused on creating (positive) constitutional rights to health care. Positive rights to health care under the *Charter* seem highly unlikely to be realized in the short term and might not necessarily improve the overall functioning of Medicare for the benefit of all. Instead, I argue that better legal avenues for improving accountability lie in administrative law or tort law.

The Majority's Flawed Approach in *Chaoulli*

First, let me establish that the majority's argument was flawed, particularly with respect to its assumptions, reasoning and conclusions regarding the effects of a parallel private health insurance system on the public system, and its reliance on simplistic international comparisons to reach conclusions about the relative merits of the Canadian system. Much has already been written on this⁴ so I will make the case relatively briefly here.

The public sector monopoly causes waiting lists:

The majority concludes that the public monopoly in health insurance for medically necessary care causes waiting lists and if it were not for the monopoly that people would not suffer and die on wait lists. According to Chief Justice McLachlin and Justice Major: "The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence,

4 Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) [Flood, Roach & Sossin] ; Marie-Claude Premont, "La garantie d'accès aux services de santé: analyse de la proposition québécoise" (2006) 473 *Les Cahiers de Droit* 539; Marie-Claude Premont, "Crunch Time for Public Health Care in Quebec" *The Toronto Star* (17 November 2006) A21; Marie-Claude Premont, "Santé: benins, les frais afferents" *Le Devoir* (1 February 2007) A7; Marie-Claude Premont, "L'affaire Chaoulli et le système de santé du Québec: cherchez l'erreur, cherchez la raison" (2006) 51 *McGill L. J.* 167; Bruce Ryder, ed., "Symposium on *Chaoulli*" (2006) 44:2 *Osgoode Hall L.J.*

results in delays in treatment that adversely affect the citizen's security of the person."⁵

In truth, international evidence demonstrates that many countries with two-tier systems (e.g. with no "monopoly" on public insurance) also struggle with waiting lists, e.g. New Zealand, UK, Ireland, and Australia.⁶ The diagram on the following page, using OECD data, clearly shows this. On the left are countries that experience problems with wait times and these include Australia, Denmark, Finland, Ireland, Italy, the Netherlands, Norway, Spain, Sweden and the UK.

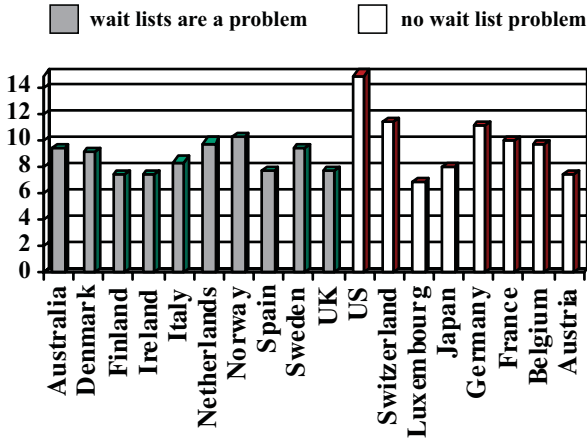
These countries, unlike Canada, do not have a "monopoly" in public health insurance for medically necessary care yet they still wrestle with wait times. Presumably, citizens of those countries who can't afford private options (or who fail to qualify for private health insurance) still suffer and die on those wait lists. If it were the monopoly in health insurance that was causative of wait times then one would expect to see *only* Canada listed as a country with wait times. Yet Canada is not alone – many other countries in the world also struggle with wait times and have done so for a much longer time and frequently to a more significant degree. Thus when Chief Justice McLachlin and Justice Major refer to "people" who would not suffer and die "but for" the existence of a public monopoly⁷ in health insurance we must assume they do not mean *all* people but only those who would otherwise be prescient enough, wealthy enough, and healthy enough to buy and qualify for private health insurance.

5 *Supra* note 1 at para. 106.

6 Colleen M. Flood, Mark Stabile & Sasha Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying and Two-Tier Systems" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 298.

7 *Supra* note 1 at para. 111. Chief Justice McLachlin and Justice Major state: "It is common ground that the effect of the prohibition on insurance is to allow only the very rich, who do not need insurance, to secure private health care in order to avoid the delays in the public system. Given the ban on insurance, most Quebeckers have no choice but to accept delays in the medical system and their adverse physical and psychological consequences."

Health Expenditure in the OECD as a Share of GDP (2003)



Source: OECD HEALTH DATA 2005

The freedom to purchase private insurance will reduce the burden on the public system because the public system will no longer have to treat people who are privately insured:

Madame Justice Deschamps, in reference to arguments about the impact of liberalizing private health insurance on the public plan, notes that “[o]nce again, I am of the opinion that the reaction some witnesses described is highly unlikely in the Quebec context.Furthermore, because the public plan already handles all the serious cases, I do not see how the situation could be exacerbated if that plan were relieved of the clientele with less serious health problems.”⁸

This statement exemplifies the implicit assumption on the part of the majority that medical need is fixed and with the emergence of a private tier that a subset of that need would be carved off from the public system and transferred to the private sector. If true this would result in a win/win situation as the wealthy would have their needs met in the private-pay system, leaving more room for those left behind in the public system. But this is a false conclusion because medical “need” is not fixed and will expand in a

⁸ *Supra* note 1 at para. 66.

private system – what was once not a need but merely a want or desire or expectation is transformed into a “need” by market actors who will benefit as a result. Doctors in unregulated private markets have strong incentives to transform what truly are only wants – for example the desire for plastic surgery, or the desire for a second or third MRI “just to be sure” – into a need. The resources of the health care system are not then deployed to treat those most in need as a priority, but to treat as a priority the needs and wants of those able to pay more.

Fulfillment of more wants rather than needs in a health care system is not a problem if there are unlimited numbers of doctors, nurses, and other health professionals to meet both critical need, less acute needs, and things that are objectively more wants than needs. But there are significant limitations in terms of the number of physicians, nurses, and other health care professionals we presently have in the system (it costs significant public dollars to train a physician and it takes many years). If a private tier is expanded then more of this limited resource would necessarily be deployed to the private tier, treating less acute needs and wants. Of course, to an extent, that is why wait times have become an issue – planning for the training and deployment of medical manpower has not kept up with the increases in demand. In the face of a limited resource, lobbying is growing on the part of the middle class and wealthy, who want to use their purchasing power to secure this limited resource, and on the part of some physicians who have market power and want to have a two-tier system so they can increase their own incomes. The obvious solution is to train more health professionals but doctors are not like widgets, gidgets or health policy pundits in that, as mentioned, it takes years to train them and it costs a lot of (public) dollars. Other solutions, such as revisiting scopes of practice (allowing, for example, nurses to perform many of the tasks of family doctors) would also free up capacity but is often strongly resisted by the medical profession who want to protect its professional monopoly.

The ability to purchase private insurance will have no detrimental effect on the public system as evidenced by the experience of jurisdictions with two-tier systems:

The majority praises European health care systems, relying primarily on a summation of how they work from the Kirby Report,⁹ but they do not

9 Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role: Health Care Systems in Other Countries*, vol. 3

truly come to grips with financing dynamics. Could Canadian Medicare do with a dose of Europe? Maybe, but let me illustrate why this is far more complex a question than it is portrayed by using the example of France.

The World Health Organization, in a study published in 2000, ranked the French health care system first in the world; Canada ranked a lowly thirtieth.¹⁰ This result is repeatedly used by privatization advocates to prove how poor the Canadian system is and how much more superior are systems that have two-tier health care systems.¹¹

A cursory review of health outcomes suggests that this apparently abysmal performance on Canada's part – at least relative to France – is very strange indeed. As the following table shows, France and Canada record similar health care outcomes and, indeed, Canada performs better on many other important indicators, such as infant and maternal morbidity. So why did Canada perform so badly in the WHO study?

As Deber explains, Canada's poor ranking is explained by the fact that the WHO study discounted Canada's performance with respect to health outcomes because Canada spends more money on education, the latter being assumed to be a determinant of health.¹² In other words, the French spend less on education so their good health care outcomes, it is argued, are more directly attributable to their health care system. The methodology employed to reach this conclusion is highly suspect and has been subject to heavy criticism. But the political heft of such a study survives such criticism as the details of comparative performance measurement do not sell as well as a story that clearly portrays Canada's system in a bad light.

(Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby) [Kirby Report]; *supra* note 1 at paras. 141-149.

10 World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: World Health Organization, 2000).

11 Brian Day, "Putting Patients First: The Only Solution for Canada's Health Care System" (Paper presented to the AGM of the Canadian Medical Association, Vancouver, 22 August 2007), online: <<http://www.brianday.ca/>>; John Carpay, "Taking Ontario's health monopoly to court" *The National Post* (3 May 2007) A18.

12 Raisa Deber, "Why Did the World Health Organization Rate Canada's Health System as 30th? Some Thoughts on League Tables" (2004) 2:1 Longwoods Review 2; Philip Musgrove, "Judging health systems: reflections on WHO's methods" (2003) 361 *The Lancet* 1817.

**Common (Crude) Indicators of Health Status:
Canada and France (2004) (Source: OECD data, 2007)**

Health Status Indicator	France	Canada
Life expectancy at birth (years)		
Male	76.7	77.8
Female	83.8	82.6
Total population	80.3	80.2
Life expectancy at age 65 (years)*		
Male	17.1	17.2
Female	21.4	20.6
Infant Mortality (deaths per 1,000 live births)	5.3	3.9
Perinatal Mortality (Deaths per 1 000 total births)	10.9	6.2
Maternal Mortality (Deaths per 100 000 live births)**	7.4	6.9
Potential years of life lost (Years lost, /100 000, age 0-69)*		
Male	5376	4296
Female	2542	2669
Total population	3949	3487

The majority in *Chaoulli* unfavorably compares the Canadian system to European systems like that of the French. Chief Justice McLachlin and Justice Major state that other countries deliver “superior” medical services.¹³ They seem to assume that if the law regarding private health insurance was liberalized, the Canadian system would acquire the positive attributes of European systems like France – but this chain of logic is not made of steel but dust.

One cannot assume that the introduction of a two-tier system would have no negative effects in Quebec (or Canada) simply because other systems, like France, appear to have public and private tiers that superficially

13 *Supra* note 1 at para. 140: “The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada.”

co-exist comfortably.¹⁴ There are such huge and significant differences between, for example, the French and Canadian health care systems that one cannot cut and paste one aspect of the French system on to the Canadian system and assume it will work. Some of the profound structural differences between the two systems are, for example, that the French system is primarily funded through social health insurance and not, like Canada, through tax-financing. This different form of public financing leads to profoundly different forms of institutions and dynamics and different kinds of relationships within the system that have built up over the course of the last 50 years. The other important difference is the *role* that private health insurance fulfills within the French health care system. Private health insurance is provided in France primarily through non-profit insurers and their main role is to cover the extensive co-payments that are required to be paid at point of service within the public system (approximately 30% of the total fee is required to be paid at point of service). In order to cover these out-of-pocket costs, over 90% of French citizens hold private health insurance (which, I might add, reduces any incentive resulting from a co-payment to reduce consumption and explains why the French too are very worried about the long-term financial sustainability of their system). In order to help those without means get the care they need the French government has now started to provide public funding to help the poor cover the co-payments.¹⁵

14 Simone Sandier, Valerie Paris & Dominique Polton, *Health Care Systems in Transition: France* (Copenhagen: WHO Regional Office for Europe on behalf of European Observatory on Health Care Systems and Policies, 2004) at 7, online: European Observatory on Health Systems and Policies <<http://www.euro.who.int/observatory/CtryInfo/CtryInfoRes?COUNTRY=FRA&CtryInputSubmit=>>>; Agnès Couffinhal & Valérie Paris, *Cost Sharing in France: Working Paper* (Paris: Institute for Research and Information in Health Economics, 2003) at 1, online: IRDES <<http://www.irdes.fr/english/wp/CostSharing.pdf>>.

15 People earning less than EUR \$652 per month, or \$771 CAD, as well as 3.8 million other people previously covered through less extensive private insurance programs, are now eligible for waiver of the co-payment requirement. The people most commonly covered are the unemployed and single parents. Thomas C. Buchmueller & Agnes Couffinhal, *OECD Health Working Papers No. 12: Private Health Insurance in France* (Paris: Organization for Economic Co-operation and Development, 2004) at 15, online: OECD <http://www.oecd.org/document/25/0,2340,en_2649_33729_2380441_1_1_1_1,00.html>.

The majority in *Chaoulli* assumes that the only substantial difference between the Canadian system and European systems is the existence of private health insurance – hopefully I have persuaded you that there are a number of fundamental differences between Canadian and European systems such that liberalizing the law on private health insurance would not result in the transformation of the Canadian system into, for example, a French-style system. Moreover, private health insurance takes on very different roles in many European countries from what the court imagines. In striking down the law prohibiting private health insurance the majority effectively endorses a system in Canada where everyone is covered by public health insurance but those who wish can buy private health insurance to jump queues. This is a particular kind of system – which is *not* French or German or Dutch or Swiss – but one that would more closely replicate systems existing in the UK, Sweden, New Zealand, Ireland, Australia, etc. In those latter two-tier systems, private insurance **duplicates** coverage of services that are also publicly insured (hip, knee, cataract, diagnostic, etc.), and physicians are free to collect payment for the delivery of medically necessary care from both the public insurer and from private sources (private health insurance, out-of-pocket payments). Closer scrutiny at this group of countries would have revealed that they have all had substantial problems with wait times. Why would Canada wish to emulate these?

The Policy Impact of *Chaoulli*

I hope with this brief tour of the *Chaoulli* decision to have persuaded you that the majority had a poor grasp of the structure and dynamics of different health care systems. Notwithstanding, the fact of the Supreme Court's ruling in favor of private health insurance has now legitimized the view (previously largely discounted) that a two-tier system is the "solution" for the problems that bedevil Canadian Medicare, particularly wait times. Arguably, as a result of *Chaoulli*, we are now witnessing private health insurance (and privatization more broadly) being more frequently put forward as a legitimate policy option in a number of provinces.

Apart from the steps taken in Quebec in the wake of *Chaoulli* – which Marie-Claude Premont writes eloquently of in this volume – proposals for privatization are percolating in New Brunswick, Alberta, and British Columbia. "Privatization," however, can take many forms with different effects and it is not clear what the thrust of these privatization proposals truly is. In particular, it is not clear whether the goal is to enable greater private-for-profit *delivery* in an effort to spark greater efficiencies *within* the public system or

whether the goal is to introduce in the short or long term a greater role for private *financing* for medically necessary hospital and physician services in order to allow those with means to achieve preferential treatment. In terms of access to care, the former is a lot less problematic than the latter (i.e. provided the care is fully publicly-funded, even if privately-delivered, patients will still receive care on the basis of need and not ability to pay). However the development of private for-profit clinics and hospitals is of course necessary before a fully-fledged privately-financed system can prosper, for if there are no sites for delivery of private care then there is no opportunity to spend private dollars. In other words, there is a concern that the development of for-profit clinics, even if fully publicly-funded, is but a stepping stone towards a flourishing two-tier system that will facilitate the wealthy to pay more to get preferential care.

Apart from initiatives to introduce more private for-profit delivery and to liberalize the law relating to private health insurance, other actors are seeking to challenge complementary laws that limit the extent to which the private system is cross-subsidized by the public system and thus the ability of a privately-financed system to flourish. For example, the Canadian Medical Association (CMA), an intervener in the *Chaoulli* case, has recently released a “vision” paper, stating that physicians should be able to work in the public health care system and be paid for the delivery of medically necessary care in a private system as well.¹⁶

The advent of the CMA proposal supports my claim that the *Chaoulli* decision has legitimized privatization possibilities, for which there is no basis in research evidence, such that the CMA feels justified in putting forth this nakedly self-interested proposal. Although the *Chaoulli* decision pertained to liberalizing the law relating to private health insurance, it is now being used as a lever to challenge other laws – in particular the law that is, in my view, more important in terms of protecting the public system. Here I am referring to the various provincial laws that effectively inhibit doctors from working in the public system and then *in addition* billing privately for medically necessary care. A physician may practice privately if she so chooses to but she cannot also be paid from the public purse for the delivery of medically necessary care or, if she is able to, the price of the service able to be paid is pegged

16 Canadian Medical Association, *It's Still About Access!* (Ottawa: Canadian Medical Association, 2007) at 44, online: CMA
<http://www.cma.ca/index.cfm/ci_id/45471/la_id/1.htm>.

to the public tariff. A number of provinces do not employ a law, akin to the impugned law in *Chaoulli*, banning private health insurance, yet there is still no flourishing private system for hospital and physician services in those provinces.¹⁷ This is largely, in my view, due to other complementary regulations that prevent physicians providing medically necessary care in both the public and private systems (they must pick one or the other) and/or that regulate the maximum tariff payable for privately financed care (eliminating or reducing the financial incentive to care for private patients in preference to public patients).

Madame Justice Deschamps, who penned the majority judgment, refers specifically to the existence of laws that prevent doctors being funded by the public insurance system and privately for the delivery of medically necessary care, and suggests that given the existence of these laws it is not necessary to also have the law banning private health insurance. But this critical feature of the majority judgment is glossed over by those now seeking to clear the path for a two-tier system.

It is important to protect within the public system the key resource of physician labour; if physicians are completely free to practice in the public system and top-up their incomes in the private sphere, and if those with means are completely free to purchase preferential treatment, then no one should be surprised to see physicians spending a significant proportion of their time being paid *more* to treat less needy patients in the private sector. For example, in New Zealand, which permits doctors to practice in the public and private systems on an unregulated basis, the Medical Council reported in 2000 that specialists are spending less than 50% of their time working in public hospitals; the rest of the time they are attending to private patients in private clinics/hospitals.¹⁸ A more recent report shows a surprising increase in this figure and it is not *prima facie* clear from the latest report what has driven this change.¹⁹

17 Colleen M. Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 *Canadian Medical Association Journal* 825.

18 Medical Council of New Zealand, *The New Zealand Medical Workforce* (Wellington: Medical Council of New Zealand, 2000) at 14, online: Medical Council of New Zealand

<<http://www.mcnz.org.nz/portals/0/publications/workforce%202000.pdf>>.

19 This new figure is 74%: Medical Council of New Zealand, *The New Zealand Medical Workforce in 2005* (Wellington: Medical Council of New Zealand, 2005) at 14, online: Medical Council of New Zealand

Some countries (France, Sweden, etc.) use legislation, regulation and policy to try to suppress the extent of a private tier in order to protect the public system from being drained of personnel. The majority judgment of Justice Deschamps does not refer to these functionally equivalent laws in other jurisdictions but, as mentioned, she at least acknowledges the importance of the Canadian versions. In contrast, the McLachlin/Major judgment lauds other jurisdictions that appear to have a greater role for private insurance without stopping to delve into the regulations that buffer the public system from the adverse effects of a private system, particularly the siphoning of personnel from the public to private spheres.

Advocates of privatization now recognize that Canadian laws inhibiting doctors from supplying two-tier care (laws that require opting in and out of the public health insurance scheme) are far more important in terms of preventing the flourishing of a parallel private tier than the ban on private health insurance. The Quebec government, in the aftermath of *Chaoulli*, considered overturning this law too *even though the Chaoulli decision did not require this*. Significant lobbying and efforts on the part of health law, health policy, and health services research scholars helped persuade the Quebec government that the research evidence simply did not support liberalizing of the opting in/opting out laws and that the *Chaoulli* decision did not require it.²⁰

So far the Quebec government has held fast to this position but this achievement may prove to be a fragile one given the election of the Action démocratique du Québec (ADQ) as official opposition. ADQ in its official party manifesto claims that “[a]fter the Supreme Court ruled that our current health care system undermines the dignity of citizens, the Health Minister chose to maintain the system as it now stands, without grasping the op-

<<http://www.mcnz.org.nz/portals/0/publications/>

The%20New%20Zealand%20Medical%20Workforce%20in%202005.pdf >.

20 Marie-Claude Premont & André-Pierre Contandriopoulos, “Un plan santé à surveiller” *La Presse* (17 February 2006) A19; Marie-Claude Premont *et al.*, “Quebec Medicare Plan Is Not What the Supremes Ordered” *The Gazette* (17 November 2005) A29; Marie-Claude Premont *et al.*, “Privatisation des soins de santé au Québec : il n’y a pas d’ordre de la Cour suprême” *Le Devoir* (17 November 2005) A7; Marie-Claude Premont, “Régime public universel de santé du Québec : l’urgence d’agir à la suite du jugement de la Cour suprême” *Le Devoir* (16 June 2005) A7.

portunity for change offered by the *Chaoulli* ruling.”²¹ The platform also trots out the fallacy that Canada is comparable to Cuba and North Korea in terms of its health insurance monopoly (neglecting to note that Canada is tied in third place in the OECD vis-à-vis the importance of private insurance for the financing of its system).²² With reference to its commitments, the ADQ lists a number of key promises that include treatment within a reasonable time period, giving priority to the development of a truly mixed health system and, of most concern, allowing doctors to practice in both the private and public sectors.²³ Moreover, the appointment of Claude Castonguay to head a commission looking at the future of Medicare is a signal that further inroads to privatization could follow.²⁴ Castonguay’s recommendations include liberalizing the law preventing doctors providing medically necessary care in both the public and private systems. To date, the Quebec government has not accepted this recommendation but a groundwork of ideas, pro-privatization, is being laid by legitimate actors that could subsequently result in policy change.²⁵

Further Court Challenges to Medicare

As proposals for privatization are bubbling up across Canada so too are *Charter* challenges based on *Chaoulli*. There are claims being launched in Alberta and Ontario.

21 Action démocratique du Québec, *Au Québec on passe à l'action* (Montreal : Action démocratique du Québec, 2007), online: ADQ <<http://www.adq.qc.ca/accueil>>.

22 Organization for Economic Co-operation and Development, “Health Data,” online: OECD <http://www.oecd.org/department/03355,en_2649_34631_1_1_1_1_1,00.html>.

23 *Supra* note 21.

24 The Commission was headed by Claude Castonguay, a former Liberal Minister. The two other members of the Commission are Ms. Joanne Marcotte, representing the ADQ, and Michel Venne, for the Parti Québécois. See Chantal Hébert, “Quebec set to pry lid off medicare” *The Toronto Star* (4 June 2007) A16, online: thestar.com <<http://www.thestar.com/printArticle/221191>>.

25 QC, Task Force on the Funding of the Health System, *Report of the Task Force on the Funding of the Health System: Getting our Money’s Worth* (Quebec City: Government of Quebec, 2008) at 261, online: Task Force on the Funding of the Health System <<http://www.financementsante.gouv.qc.ca/en/groupe/index.asp>>.

i. *William Murray et al. v. The Queen et al.*

This emerging challenge in Alberta centres on William Murray, a 57-year-old who was diagnosed with severe osteoarthritis in his left hip requiring either replacement or resurfacing. Mr. Murray requested a resurfacing procedure using the Birmingham prosthesis (the Birmingham Procedure) as this was less invasive and required removal of much less bone than the traditional hip replacement procedure. His request was denied because of an alleged policy decision by the Calgary Health Region (CHR) which limited access to the Birmingham Procedure to patients below the age of 55. According to the statement of claim, Mr. Murray then sought to have the surgery through a private surgical facility. Allegedly the facility had agreed to perform the surgery but subsequently cancelled the surgery because of pressures from the CHR. After further complications, Mr. Murray then travelled to Quebec to have the Birmingham Procedure in a private clinic, incurring costs of over \$22,000.

The statement of claim articulates two strands of argument, the first of which – similar to *Chaoulli* – seeks to gain greater access to private treatments and the second of which – similar to claims in *Eldridge*,²⁶ *Auton*,²⁷ etc. – seeks to ensure greater fairness *within* the delivery of the public health care system.

The first line of argument is that the *Alberta Health Care Insurance Act*²⁸ prohibits the provision of commercial insurance for basic health services to residents of Alberta for which there is public coverage. The claim is that this effectively prevents residents from accessing health care outside the government-run system. It is alleged that the lack of coverage and the refusal

26 *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86. The case centred around a section 15 challenge to a refusal by a hospital to provide translation services for the deaf. The Supreme Court of Canada found a *Charter* violation because access to hospital services must be equally available to all and the absence of interpretation for the deaf deprived deaf individuals of access.

27 *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 S.C.R. 657. The applicants used a section 15 argument to challenge a refusal by the province to fund a specific autism treatment. The Supreme Court of Canada held that a particular autism treatment was not a benefit provided by law (as the therapists in question were not included in a list of designated providers); thus no *Charter* violation occurred.

28 *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20.

of service delivery (the Birmingham Procedure) by the CHR amount to a breach of section 7 of the *Canadian Charter of Rights and Freedoms* in so far as they deprived Mr. Murray of his right to life, liberty and security of the person in a manner inconsistent with the principles of fundamental justice. The statement of claim does not, however, *only* challenge the specific law prohibiting private health insurance but also asks for a declaration that all provisions of the Act which create a “virtual monopoly” be declared unconstitutional and of no effect.

The second line of argument is grounded more in the fairness of the decision to limit access to the Birmingham Procedure on the grounds of age *within* the public health care system. In this regard, the arguments will rest on section 15 of the *Charter* (equal protection and equal benefit of the law without discrimination based on age) and the claim that such rights have been breached by the establishment of an age limit in the delivery of the Birmingham Procedure within the public health care system.

This case is particularly interesting for although the claimants portray the age cut-off for the Birmingham Procedure as criteria developed by the CHR, it in fact appears to be a criterion developed by Alberta orthopaedic surgeons as a clinical guideline, and that is why it was not possible for Mr. Murray to obtain the procedure in a private clinic. Clinical guidelines apply whether treatment is provided within a public or a private facility. If it were a decision by the government or a governmental agency that the Birmingham hip procedure was not a publicly-insured service for those over the age of 55 (i.e. not medically necessary), then there would be no reason in the Canadian model why it could not be provided in the private sector. In other words, it may be tough sledding for the applicants if it is proven that the age cut-off was generated not as a mere resource allocation decision but as a clinical criterion because in the latter case, even if private insurance were available, the procedure would still not be provided in a private hospital. This claim is also interesting in that the plaintiff’s initial claim for a declaration overturning all provisions that create a “virtual monopoly” be declared unconstitutional is a very broad one indeed. We will have to see as the claim develops whether or not the applicants will specifically challenge the law preventing doctors from working in both the public and private sectors at the same time, which – as I argued earlier – is a critical piece of regulation protecting the integrity of the public system.

ii. McCreith et al v. Attorney General

A similar case in Ontario centres on claims by Ms Holmes and Mr McCreith, who are challenging the framework regulating access to private health care in Ontario, which allegedly endangers lives by precluding or discouraging private treatment in Ontario.²⁹

The applicants claim that on 2 January 2006, Lindsay McCreith experienced an onset of seizures and was diagnosed with a brain tumour. The attending specialist diagnosed the tumour as benign based on a CT-scan and refused to order an MRI. Subsequently the family physician requested an MRI but Mr. McCreith was told he would have to wait for another four months. In light of the long wait times, the family enlisted the services of Timely Medical Alternatives Inc., and this company arranged for an MRI in Buffalo, New York. The MRI confirmed the presence of a tumour. On the basis of the MRI, McCreith's family doctor in Ontario referred him to a neurologist who examined him on 8 February 2006 and who in turn referred him to a neurosurgeon, but there was a three-month wait for the first appointment. Consequently McCreith returned to Buffalo and, using his own savings, paid for surgery. The tumour proved to be malignant and was removed. The Ontario Health Insurance Plan (OHIP) has, to date, refused McCreith's request to be reimbursed for the cost of the treatment on the grounds that he did not, as the regulations require, acquire pre-approval before undergoing the treatment.

Shona Holmes, the second applicant, had a history of endocrine problems and in March 2005 began to experience headaches and vision disturbances as well as anxiety attacks, high blood pressure and fatigue. She encountered significant wait times – approximately four months for a consultation with a neurologist and six months for a consultation with an endocrinologist. Her family doctor was apparently unable to fast-track her despite the fact that she was beginning to lose vision in both eyes. Consequently she went to the Mayo clinic in Arizona in June 2005; at this time she had lost 50% of vision in her right eye and 25% of vision in her left eye. She obtained a diagnosis and recommendation for surgery, but upon returning to Ontario was disappointed to find that her Ontario neurosurgeon recommended further testing that would delay the surgery recommended by the Mayo clinic for at least a

29 Lindsay McCreith and Shona Holmes and the Attorney General for the Province of Ontario (Statement of Claim filed at Ontario Superior Court of Justice 5 September 2007).

further month and probably longer. Consequently she returned to Arizona and had surgery on 1 August 2005, incurring costs of \$95,000. OHIP has, to date, refused Ms Holmes' request for reimbursement on the grounds that, as required by the legislation, surgery was not recommended by an Ontario neurosurgeon prior to her obtaining treatment in Arizona.

McCreith and Holmes are seeking standing as public interest litigants and will challenge sections 14(1), 14(2), 15(1), 15.1(1), 15.1(2) and 15(2) of the *Health Insurance Act (HIA)*,³⁰ sections 10(1) and 10(3) of the *Commitment to the Future of Medicare Act, 2004*³¹ and sections 3(3) and 3(3.1) of the *Independent Health Facilities Act, 1990*³² on the grounds that they violate the right to life and security of the person as guaranteed by section 7 of the *Charter*. Sections 14(1) and 14(2) of the *HIA* prohibit purchasing private insurance for any services that are insured by Ontario's public scheme (OHIP) (this law is similar to that challenged in *Chaoulli*) and section 15(1) requires physicians to bill OHIP directly for any insured services.³³ Section 10(1) of the *Commitment to the Future of Medicare Act* prohibits physicians (who did not opt to be grand-fathered at the time this provision was introduced in 2004) from charging or accepting private payment for insured services. This stops doctors opting out to the private-payment system.³⁴ The applicants argue that these provisions deny Ontario residents access to essential medical services in a timely manner, inflict unnecessary physical and psychological suffering and increase the risk of complications, permanent impairment and death.

There are many issues raised by this constitutional challenge. The facts as set out in the statement of claim raise the question of whether or not claims in private law (medical malpractice) might not be possible against the various physicians involved in Mr. McCreith's care, particularly the early decision that no further follow-up was required. Questions also arise regard-

30 *Health Insurance Act*, R.S.O. 1990, c. H.6.

31 *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5.

32 *Independent Health Facilities Act*, R.S.O. 1990, c.I.3.

33 *Supra* note 30.

34 It is difficult to understand why this particular piece of legislation was thought necessary, given that the number of physicians who had opted out prior to this time was very low. Even for those physicians who are grand-fathered and are permitted to practise privately, s. 10 of the *Commitment to the Future of Medicare Act* precludes charging a higher tariff to private-pay patients than the tariff payable by OHIP, thus dampening the financial incentive to "go private."

ing the decisions made by Ms Holmes' treating physicians, particularly those that effectively resulted in delayed treatment as her vision was failing. If such private actions were launched a further question that arises is whether or not the physicians involved would be able to argue in response a defence of limited resources.³⁵

The other issue of interest is the challenge to Section 10 (1) of the *Commitment to the Future of Medicare Act* – passed in 2004 – that prohibits all doctors from providing medically necessary services for private payment (except those who were permitted to be grandfathered and had opted to the private sector prior to 2004). This goes further than laws in other provinces that require doctors to opt into the public insurance scheme or opt out; the law in Ontario effectively conscripts physicians to the public service. Other provinces simply make it less lucrative by foreclosing the possibility of the sale and purchase of private health insurance for medically necessary care and/or by regulating the tariffs that are able to be charged in the private system. The Ontario government may have a more difficult time defending this challenge given that the Ontario government will have to provide compelling evidence that this provision is necessary to protect the public health care system.

Striking down s. 10 of the *Commitment to the Future of Medicare Act* would not in my view have a substantial effect on the health care system. However striking down other laws, such as that which requires doctors to opt in or out of the public health insurance system or the law regulating the price able to be charged privately, most certainly would. Should these latter two laws survive constitutional challenge then this will, in my opinion, be sufficient to protect the public system from siphoning off large chunks of the physician labour supply. Similarly, striking down the law preventing the sale of private health insurance (as happened in *Chaoulli*) will be a pyrrhic victory if these other laws withstand the challenge; no large privately-financed sector will come to pass in Ontario. Nonetheless, success even in a limited fashion will be a strongly symbolic political victory for those in favour of privatization, which will bolster their lobbying at the political level to “open” up the system so that wealthier individuals can use private dollars to obtain prefer-

35 *Law Estate v. Simice* (1994), 21 C.C.L.T. (2d) 228, [1994] B.C.J. No. 979 (B.C. S.C.); *Bateman v. Doiron*, [1991] N.B.J. No. 714, 8 C.C.L.T. (2d) 284 (Q.B.); *Dillon v. LeRoux*, [1994] B.C.J. No. 795, [1994] 6 W.W.R 280 (B.C. C.A.).

ential treatment – even if there are adverse effects for those left in the public insurance scheme.

The statement of claim lodged on behalf of McCreith and Holmes assumes that the existence of a parallel private tier would have solved their problems and those of others waiting for treatment in Ontario. If a parallel private tier was available in Ontario then *perhaps* both McCreith and Holmes could have jumped queues for treatment, but on the other hand, perhaps not. In countries with parallel private tiers that exist on top of a universal system, the private sector generally does not provide complex, expensive treatments such as those sought by both McCreith and Holmes. Even if available in Ontario they would still have to find the private resources to pay for these treatments or have private insurance coverage (even if affordable, not all will be necessarily available). The assumption seems to be that somehow the Canadian version of private health markets would have cheaper prices than those available in the US, but there is no evidence to support this.

So What is the Solution?

Progressive health care lawyers tend to think the solution is more *Charter* challenges but challenges which are more inclusive and embrace s. 7 positive rights.³⁶ However, in my view the major problem in public Medicare is not a lack of rights in the health care system but a lack of accountability; the establishment of constitutional “rights” to public funding for medical services will not necessarily improve accountability. Let me elaborate by focusing on the issue of wait times. Quite quickly the issue of wait times began to emerge as a significant issue for Canadians after the cuts made in the mid-1990s, and yet governments for a long time did little to respond. Why did they not respond? There are a number of reasons but the main one I think relates to fractured accountability. As Duncan Sinclair, Joanna Erdman and I have written elsewhere, accountability for the health care system is *the* question regardless of the configurations of public and private

36 Lorne Sossin, “Towards a Two-Tier Constitution? The Poverty of Health Rights” in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 161; Martha Jackman, *Discussion Paper No. 31: the Implications of Section 7 of the Charter for Health Care Spending in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002).

financing.³⁷ Who is accountable for the health care system? In Canada it is, presumably, the provincial governments but voting every 3 or 4 years at the polls hardly assures the nuanced accountability required to ensure an efficient, equitable and timely health care system. And in Canada this basic problem of accountability is worsened by the fragmentation of responsibility between the federal and provincial governments. Who is responsible for long wait times? Not us, say the hospitals and doctors, we don't have enough resources. Not us, say the provinces, we don't get enough funding from the federal government. Not us, says the federal government, we don't have direct control of the system and so can't reform it to eliminate wait times.

Given this lacuna of finger-pointing and shifting of responsibility, coupled with the deep malaise that has settled into the Canadian psyche regarding the perceived decline of Canadian Medicare, it is probably not surprising that there is now greater receptivity to the argument that the system is completely broken. The solution, it is argued, is to privatize. Privatization will cure basic problems in the health care system and more particularly give patients choices beyond the governmental monopoly in health care. Privatization is a tempting solution for many governments as it **diminishes** accountability – the wealthy can exit to the private tier and there are fewer powerful people to hold governments' feet to the fire for improvements in public Medicare.

Whilst a constitutional right to *private* health care will, if anything, further undermine accountability within the public health care system, will a constitutional right to *public* health care improve it? Pragmatically this question is moot as, based on the *Chaoulli* ruling and the subsequent case of *Flora v. Ontario Health Insurance Plan*³⁸ in Ontario, it seems unlikely that the courts will in the short- to medium-term find **positive** rights to health care, for example rights under s. 7 to public funding of treatment.

Adolfo A. Flora, a high school teacher in Toronto, was diagnosed with liver cancer in 1999. After consulting with Ontario physicians, Mr. Flora was deemed unsuitable for a liver transplant and he was given six months to live. Mr. Flora, unwilling to accept the prognosis, commenced exploring

37 Colleen M. Flood, Duncan Sinclair & Joanna Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004) 30 Queen's L.J. 156.

38 *Flora v. Ontario (Health Insurance Plan, General Manager)* (2007), 83 O.R. (3d) 721, [2007] O.J. No. 91 (Sup. Ct. (Div. Ct.))[*Flora*].

alternatives. He found the Cromwell Hospital in London, England in March of 2000 and one month before his 51st birthday he underwent both chemoembolization and a living-related liver transplant, incurring a cost of \$450,000. The treatment involved removing a portion of a living donor's liver. Once treated, Mr. Flora sought to have his costs reimbursed by the Ontario Health Insurance Plan (OHIP) pursuant to s. 28.4(2) of Ontario Regulation 552 of the *Health Insurance Act*.³⁹ This request was denied by OHIP on the basis that the treatment was not, as required by the regulations, generally accepted in Ontario as appropriate for a person in such medical circumstances. Before the Ontario Superior Court, Flora argued that the relevant regulations precluding his claim should be struck down as inconsistent with s. 7 of the *Charter*. Epstein J. rejected this claim and distinguished the facts of the case at bar from those of *Chaoulli*, noting that the latter dealt with a governmental prohibition on private health insurance which allegedly deprived an individual of the opportunity to avoid life-threatening delay in obtaining treatment. In this instance, however, the government had not taken such measures, as section 28.4 of the Regulation does not in any way restrict an individual from securing his or her own health care or arranging his own treatment with *private* funds.⁴⁰

Although the *Chaoulli* decision deals with the right to be free from government interference when purchasing private insurance (a negative right), it establishes the connection between deprivations of the basic necessities of life and fundamental rights. Lorne Sossin has argued it is possible that although *Chaoulli* itself seems regressive in protecting only the rights of those who qualify for and can afford to buy private insurance, it may nonetheless serve as a catalyst for progressive change.⁴¹ *Flora* suggests that *Chaoulli* is not having the effect hoped for by Sossin and others – at least not yet – and we must wait for another more compelling case to see whether s. 7 will ever evolve to embrace rights to publicly-funded treatment. But even if an applicant were successful in a s. 7 claim for public funding of treatment, I am not convinced that the establishment of positive rights would necessarily improve accountability.

What is important for the future sustainability of public Medicare (both fiscally and politically) is that decisions are made on a principled basis and

39 *Supra* note 33.

40 *Supra* note 38 at para.174.

41 See generally Flood, Roach & Sossin, *supra* note 4.

decision makers are accountable for the often difficult hard-choices that have to be made or, in other words, that a fair process is followed. Although it is feasible that *Charter* challenges could be employed as a medium to improve processes for decision making (through the s. 1 analysis) within the public health care system, a less intrusive and more accessible jurisprudential tool would be administrative institutions and administrative law more broadly. Through claims for fairness in the processes of decision making and review using the standard of reasonableness, the legal system could improve the overall standards of decision making within the health care system. One example here is the case of *Stein v. Quebec (Regie de l'Assurance-maladie)*⁴² where the court found that it should be very deferential to resource allocation decisions in health care made by public administrators but nonetheless found that the Quebec insurance authority had been "patently unreasonable" in not compensating Mr. Stein for cancer treatment in New York, given the severity of his condition and the wait for treatment in Quebec. Also, it seems likely from the claims of McCreith and Holmes in Ontario that an overhaul of administrative decision making (in terms of having some form of patient ombudsman or such like to whom individuals could turn to have their disputes more expeditiously resolved) would have gone a long way to addressing many of their concerns.⁴³

In my opinion, administrative structures and administrative law are likely to prove a much better route by which to improve decision making in the public health care system, benefiting all Canadians. To date, administrative law has not been widely employed in the health care system. Part of the reason for this may be the very problem of fractured accountability in the health care system which may make it difficult to identify a particular decision maker and a particular decision to which administrative law can attach. Thus to the extent that a system evolves to ensure accountability of its decision makers by clearly identifying lines of responsibility, administrative law

42 *Stein v. Quebec (Regie de l'Assurance-maladie)* [1999] R.J.Q. 2416, [1999] Q.J. No. 2724 (Sup. Ct.).

43 Catherine Régis, "Enhancing Patients' Confidence in Access to Health Care: The Ontario or Québec Way?" (2004) 12 Health L.J. 243; Catherine Régis, "Physicians Gaming the System: Modern-Day Robin Hood?" (2004) 13:1 Health Law Review 19; Catherine Régis & Jean Poitras, "Aspects psychologiques et juridiques des excuses en médiation médicale" (2003) 1:3 Revue de prevention et de règlement des differends 51.

can reinforce the process but it will be tougher sledding for administrative law *alone* to enhance accountability.

Another hope is in the prospect of actions in private law, particularly mass tort claims. One example of such a claim is that of *Cilinger*,⁴⁴ a case presently working its way through the Quebec courts. Anahit Cilinger was diagnosed with breast cancer in October 1999 and was still awaiting the appropriate treatment in January 2000. Frustrated with the outcome in care, Ms. Cilinger sought treatment in Turkey, her native homeland, at an approximate cost of US \$12,000.⁴⁵ She then initiated a class action on behalf of herself and other women with breast cancer who were unable to receive the requisite radiation therapy within eight weeks of surgery.⁴⁶ The claimants argue that twelve Quebec hospitals are in breach of their statutory obligations and therefore liable for “leaving their patients waiting beyond what is medically recommended.”⁴⁷ The Quebec Superior Court has ruled on whether this class action claim will be able to proceed under article 1003 of the *Quebec Civil Code*.⁴⁸ In his ruling, John Bishop, S.C.J. accepted that the necessary components are present within the claim to be deemed a class action. Interestingly, however, whilst the judge in this case was prepared to certify the class action to proceed against the twelve public hospitals, he was not willing to accede to the petitioners’ request to join the Government of Quebec as a party. This latter decision was appealed to the Quebec Court of Appeal where it was upheld.

The *Cilinger* claim against the hospitals will likely spur timely treatment in the case of cancer services, not just for the individuals involved but for all future patients in the public health care system. The mere fact of the litigation itself may spur improvements regardless of the outcome of the case. Moreover, although the Quebec government was not joined to the class action, it seems the adverse media coverage surrounding this case and that of the *Stein* decision has resulted in the Quebec government putting in place

44 *Cilinger v. Centre hospitalier de Chicoutimi*, [2004] R.J.Q. 3083, [2004] J.Q. no 2058.

45 Mike King & Allison Hanes, “Quebec breast cancer patients suing hospitals: Class-action lawsuit takes aim at delays in radiation treatments” *The National Post* (11 March 2004) A4.

46 Lorian Hardcastle, “Comment: Cilinger C. Centre Hospitalier de Chicoutimi” (2006) 14:3 *Health Law Review* 44.

47 *Ibid.*

48 Art. 1260 C.C.Q.

wait time targets for cancer services – a result that benefits all Quebeckers and not just those rich enough or well enough to buy and qualify for private health insurance.⁴⁹

Conclusion

Privatization arguments, masked as means of improving Canada's tired monopoly in health insurance, are in truth arguments against redistribution. Privatization advocates claim that timely treatment is desirable – but not for all – only for those able to afford private payment and/or able to afford and qualify for private health insurance. More insidiously, claims for a two-tier system are effectively claims by those with means for a greater share of limited public resources, in terms of a greater share of the time of physicians, nurses and other health professionals who are trained at significant public expense. One could imagine various scenarios where two-tier system proposals could be rendered more just (e.g. by imposing a significant tax on privately-purchased services to at least compensate for the cost of training more health care professionals), but these are not the kinds of proposals made by privatization advocates.

Despite the dearth of research supporting benefits from a two-tier system, a majority of the Supreme Court has effectively endorsed this model. It is hard not to see the effect of this decision as one undermining equality in one of the most important social and political spheres in modern Canadian society, namely Medicare. In legitimatizing two-tier health care as an acceptable policy option, the court provided an infinitely stronger base for privatization, a cause which has always been popular amongst particular interest groups. Proposals for two-tier medicine are now being more frequently proposed at multiple levels in the system by important actors (e.g. the Canadian Medical Association, the Castonquay Commission in Quebec). The Court's simplistic understanding and assessment of the structure and dynamics of public/private health care systems are thus being further replayed at multiple policy levels. The *Chaoulli* precedent may also be used to overturn other important laws protecting the public health care system (e.g. the law requiring doctors to opt out of the public insurance system in order to bill privately for medically necessary care). Courts may think decisions like *Chaoulli* could inspire a "dialogue" with governments that would result in more nuanced regulatory approaches; but this assumes governments

49 *Supra* note 42.

have a vested interest in maintaining one-tier Medicare when in fact politically there are upsides for government in moving to two-tier systems. It is tempting for governments to embrace two-tier as it would lessen overall accountability for performance of the public health care system and thus pressure upon governments. The well-heeled will get more timely treatment, public resources (publicly-trained medical manpower) will be redistributed to the wealthy and middle-class from those in greater need, and taxes need not increase.

Progressive constitutional and health law and policy scholars have responded to *Chaoulli* with a glass-half-empty/glass-half-full approach. Optimistically, some have argued that *Chaoulli* could be used to ground positive rights to publicly-funded health care. However, the majority are emphatic that *Chaoulli* was not about right to public payment for care, and in subsequent cases (*Flora* in Ontario) the courts have been clear there is no free-standing constitutional right to public payment for health care under s. 7 of the *Charter*.⁵⁰ Moreover, claims are proceeding in both Alberta and Ontario that seek to further challenge the regulatory structure protecting public Medicare from two-tier medicine. This time the claims are more sophisticated, and are attacking a range of different regulations and not merely those that prohibit private health insurance.

I have argued here that progressive scholars would do better to turn to other legal tools besides the *Charter* to improve the performance of the public health care system. In particular I have made (briefly) the case for administrative law and tort law as potentially better tools to improve performance of public Medicare for all Canadians. Meanwhile of course the battle to save public Medicare will need to be fought in court-rooms across the country. The strongest evidence will need to be collated about the impact of private insurance/payment on public systems for success to be assured. It will be imperative that courts are persuaded regarding the intricate regulatory frameworks governing the intersection of public and private existing in all countries that aspire to ensure access to health care on the basis of need and not ability to pay.

50 *Supra* note 38.

