

# CLEARING THE PATH FOR PRIVATE HEALTH MARKETS IN POST-CHAULLI QUEBEC

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## **Chaoulli Supreme Court Decision: Catalyst for Conservative Changes**

The *Chaoulli*<sup>1</sup> narrow majority ruling of the Supreme Court of Canada of June 9, 2005 epitomizes the high mark of conservative judiciary activism in an age of Charter rights. As Andrew Petter has shown:

“the ideological assumptions of liberal legalism remove from Charter scrutiny the major source of inequality in our society – the unequal distribution of property entitlements among private parties – and direct the constraining force of the Charter against the institutions of the State best equipped to redress such inequality: governments and legislatures.”<sup>2</sup>

It is within this blunt ideological context that the Supreme Court majority declared that the statutory prohibition of duplicative private insurance for both hospital and medical care<sup>3</sup> was contrary to Quebec’s charter right to life and to right of personal security and inviolability. The very purpose of

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

2 Andrew Petter, “The Wrong Kind of Rights : The Charter Threat to Medicare”, in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems, Promise* (Toronto, J. Lorimer & Co., 2007) 371 at 372.

3 Section 11 of the *Hospital Insurance Act* (R.S.Q., c. A-28) then read: “No one shall make or renew, or make a payment under a contract under which a resident is to be provided with or reimbursed for the cost of any hospital service that is one of the insured services ...” Section 15 of the *Health Insurance Act*, R.S.Q., c. A-29 then read: “No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is

the impugned provisions was to pursue and contribute to the driving force of public healthcare, namely that socioeconomic status of patients should not be a barrier to access to care. The unequal distribution of wealth which is accepted as a core fact of Canadian life should be set aside, says healthcare legislation, when it comes to access to medical care and should not be a controlling factor in the face of medical need. This is why sufficient available human resources and public money for health should be funnelled towards the delivery of care based on this principle as opposed to a parallel private healthcare system.

Justice Deschamps who wrote the majority opinion of the Court downplays the role of the private insurance prohibition when writing that not all provinces had enacted similar provisions. She emphasizes that three Canadian provinces go as far as giving "their residents free access to the private sector."<sup>4</sup> An unqualified comparison of healthcare systems from OECD member States leads her to similar conclusions that the prohibition of private insurance is not necessary.<sup>5</sup> However, the number of provinces has little bearing on market make-up. What the courts' analysis fails to say is that close to 90% of the Canadian population or *markets* were regulated by the prohibition of duplicative private health insurance,<sup>6</sup> while the three prov-

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furnished or under which all or part of the cost of such service is paid to a resident or a deemed resident of Québec or to another person on his behalf."

4 *Chaoulli, supra* note 1 para. 70.

5 *Chaoulli, supra* note 1 para. 74: "Even if it were assumed that the prohibition of private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity. In fact, because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved. The example illustrated by a number of other Canadian provinces casts doubt on the argument that the integrity of the public plan depends on the prohibition against private insurance."

6 Six Canadian provinces, including Québec, had similar statutory provisions: Ontario, British-Columbia, Alberta, Manitoba and Prince-Edward Island. For details, see: Colleen M. Flood & Tom Archibald, "The illegality of private health care in Canada" (2001) 164:6 CMAJ 825. Those six provinces represented 89.8% of the Canadian population in 2005, according to Statistics Canada data, on line: Statistics Canada <[http://www40.statcan.ca/l02/cst01/demo02\\_f.htm](http://www40.statcan.ca/l02/cst01/demo02_f.htm)>.

inces labelled as free marketers represent only 7.6% of the Canadian market in 2005.<sup>7</sup> Far from setting aside the provincial provision as marginal, those numbers show the widespread use of private health market regulation to ensure equitable access to healthcare in Canada.

Mary Anne Bobinski reminded us during this conference that, while the majority of the Supreme Court of Canada in the *Chaoulli* decision fosters individual rights, the judiciaries' cavalier stance over the power of the State to regulate private markets in the name of the public good goes totally unnoticed. Indeed, the prohibition of private health insurance is first and foremost a regulation by the State of the private healthcare markets. Striking down the regulation is nothing short of a direct assault on governments' ability to control markets.

The availability of private health insurance does very little or nothing to provide citizens with the right to purchase such service. Justice Deschamps' introductory framing of the issue, by considering the contested provision to be ruling out Quebeckers from purchasing private health insurance, is rather weak. Without public regulation, the main determinant of access to goods and services is based on the consumer's financial capacity and willingness to purchase it. What indeed is at stake in *Chaoulli* is not the protection of people's security and personal inviolability but the capacity and flexibility of the State to regulate private health markets in the public interest.

Criticisms of the majority ruling have been numerous<sup>8</sup> and this is not the occasion to review them. We must now turn our attention to the aftermath of the decision. The political fallout of *Chaoulli* in Québec shows that the focus of public interest has been shifted and drastically redefined in order to make public regulation more friendly and supportive of private healthcare markets. The series of events following the Supreme Court decision will give us an indication of the new direction of public policy which is to push further a conservative agenda for the future of healthcare in Canada.

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7 Those three provinces would be, according to Deschamps' analysis: Newfoundland and Labrador, New-Brunswick and Saskatchewan. *Supra* note 1 para. 70. The characterization of Saskatchewan, home to Canada's first medicare system, as a free marketer of private healthcare is surprising, to say the least.

8 See for example the collection of over 25 essays on the *Chaoulli* decision in Colleen M. Flood, Kent Roach & Lorne Sossin, *Access to care, access to justice: the legal debate over private health insurance in Canada*, (Toronto: University of Toronto Press, 2005); Marie-Claude Prémont, "L'affaire *Chaoulli* et le système de santé du Québec: cherchez l'erreur, cherchez la raison" (2006) 51:1 McGill L.J. 167.

## 1. The Road to Bill 33

### 1.1 Postponement of Quebec reaction after the 2006 federal elections

The Premier of Alberta, Ralph Klein, had visited Quebec early in 2005 when he declared that he had found “a health care comrade-in-arms in Quebec Premier Jean Charest” for his proposed third-way.<sup>9</sup> The *Chaoulli* decision, which was received with strong positive and negative reactions from different corners of Quebec and Canada, reinforced the common political will of both Alberta and Quebec to increase private sector participation in health-care.

The government of Quebec, after close to seven years of *Parti Québécois* government, was now led by the Liberal Party (since April 2003). Quebec had no option but react to the judiciary statement. It first declared that the notwithstanding clause would not be used to oppose the highest Court’s decision and the Quebec Charter of Human Rights and Freedoms. Quebec Premier Jean Charest and Health and Social Services Minister Philippe Couillard announced in early November 2005 that a white paper presenting the government’s detailed policy proposition would be published in early December 2005 in order to launch a wide public debate and open consultation before a Parliamentary Commission in the spring of 2006.<sup>10</sup>

A few weeks later, on November 28, 2005, Paul Martin’s minority liberal government in Ottawa was defeated by a no-confidence vote at the House of Commons and federal elections were called for January 23, 2006. To avoid the federal election campaign interfering with Quebec politics, Philippe Couillard announced on December 2, 2005 that the white paper publication would be postponed to a date following the federal elections.<sup>11</sup>

In the wake of the sponsorship scandal, the Gomery Commission and the damaged reputation of the federal Liberal Party in Quebec, Ottawa election forecasts were mixed and hopes grew for the Conservative Party of Canada. Quebec Premier Jean Charest had a long history of strong affiliations with the Conservative Party in Ottawa. He had started his political career

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9 Philip Authier, “Charest, Klein see eye to eye on health-care reform” *The Montreal Gazette* (15 Jan. 2005) A-1.

10 A. Derfel & K. Dougherty, “Medicare battle looms” *The Gazette* (11 November 2005) A-1.

11 Robert Dutrisac, «Couillard reporte le débat sur la santé après les élections» *Le Devoir* (3 December 2005) A-7.

as an MP for the Progressive-Conservative Party in the House of Commons in 1984. He was assigned as Minister of numerous ministries between 1986 and 1993 under the Mulroney government and was leader of the Progressive Conservative Party of Canada between 1993 and 1998. He then moved to Quebec and became the new leader of the Liberal Party of Quebec on April 30, 1998.<sup>12</sup>

We can hypothesize that postponement of the publication of the white paper until after the federal elections would open the door to a better alignment of Quebec and federal health policies. It would allow the Charest government to prepare different plans and be ready to adjust its proposals to the federal elections results, with plan A if the Liberals won the elections and plan B if the Conservatives lead the way. This hypothesis can be neither confirmed nor denied, but we can analyse the results and see if the policy presented in the white paper is in line or not with the federal conservative agenda.

## 1.2 The white paper *Guaranteeing Access*

A minority conservative government was indeed elected on January 23, 2006, and the Quebec white paper *Guaranteeing Access* was published shortly after, on February 16, 2006.<sup>13</sup> I have argued elsewhere<sup>14</sup> that the proposed policy of the Charest government was closely associated with a conservative agenda, as found in the report of the federal conservative Kirby Senate Committee, the Alberta Conservative proposal as well as the electoral platform of the Conservative Party of Canada. The two main proposals of *Guaranteeing Access*, the wait-time guarantee and the introduction of for-profit private healthcare delivery with public funding, are found in the federal election 2006 platform of the Conservative Party of Canada.<sup>15</sup>

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12 See Quebec National Assembly website, online:

<<http://www.assnat.qc.ca/fra/Membres/notices/c/chaj5.shtml>>.

13 Québec, *Guaranteeing Access. Meeting the challenges of equity, efficiency and quality* (Quebec: Ministère de la Santé et des Services sociaux, February 2006),

<<http://publications.msss.gouv.qc.ca/acrobat/f/ documentation/2005/05-721-01A.pdf>>. [*Guaranteeing Access*].

14 Marie-Claude Prémont, "Wait-time Guarantees for Health Services: an Analysis of Quebec's reaction to the *Chaoulli* Supreme Court Decision" (2008) 15 *Health L.J.* 44.

15 Conservative Party of Canada, "Stand Up For Families" *Stand Up for Canada: Federal Election Platform 2006* (Conservative Party of Canada, 2006) 29 at 31.

Reactions to the policy paper were varied and numerous. One hundred and thirty six submissions were tabled before the Quebec Parliamentary Commission. Public hearings were held by the *Commission des affaires sociales* for nineteen days between April and June 2006 where over one hundred organizations and citizens were heard.<sup>16</sup> An analysis of all submissions reveals three categories of interveners before the Commission.<sup>17</sup>

The first group was composed of those with strong support for the public healthcare system, calling for appropriate funding and resources within the public system, as well as better management of current resources. This group was generally critical of the main recommendations of the consultation paper, warning the government about the negative impact on public healthcare if resources were shifted to a private delivery and financing system. Organizations representing this position were mainly unions, academics, not-for-profit, community-based patients and seniors groups.<sup>18</sup>

On the other hand, some believed that a stronger involvement of the private sector could help or even “save”<sup>19</sup> the public healthcare system. Emphasizing a current crisis in public finances and public healthcare delivery, they claimed that the proposals were too timid and should go further in helping the private sector to take over a “deserved”<sup>20</sup> share of healthcare

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16 All memoirs can be accessed online: Assemblée Nationale Quebec, <<http://www.assnat.qc.ca/fra/37legislature2/commissions/Cas/depot-acces.html>>.

17 Analysis done by then Law student, Marie-Ève Léveillé, Faculty of Law, McGill University. Marie-Ève Léveillé, « L'appui à la proposition gouvernementale du Livre blanc *Garantir l'accès*. Analyse des mémoires présentés à la Commission des affaires sociales» (10 August 2006) [unpublished].

18 *Ibid.*

19 See for instance Valentin Petkanchin, & Norma Kozhaya, Institut économique de Montréal, “Pour une réelle ouverture à l'assurance-maladie privée au Québec” (24 March 2006) at 8, online: Institut économique de Montréal <<http://www.iedm.org/uploaded/pdf/memoire170506.pdf>> (“The private sector for health delivery – which will be funded by private insurance – can become a safety valve and rescue the public system when problems arise and wait-lists become unreasonable.”). [translated by author].

20 An example: Groupe santé Sedna, « Mémoire du Groupe santé Sedna : Commission parlementaire suite à la parution du document '*Garantir l'accès*' » (24 March 2006) at 6, online : Groupe Santé Sedna <<http://www.groupesedna.ca/dmdocuments/MemoiredeGroupeSanteSedna24mars2006.pdf>> (“There must be reserved markets made as clear as possible for public delivery and for private for-profit delivery. They could also be commonly shared areas between

delivery and financing. This group was mainly composed of businesses, employers and insurance companies associations.<sup>21</sup> A third group of interveners were divided between themselves and also between recommendations. This was the case of professional organizations (including physicians). For example, the Quebec Medical Association, the *Collège des médecins*<sup>22</sup> and both main medical federations (FMSQ<sup>23</sup> and FMOQ<sup>24</sup>) were in favour of opening of duplicative private insurance, while the Quebec public health Association, the *Collège québécois pour les médecins de famille*, the *Coalition des médecins pour la justice sociale* et the *Médecins pour l'accès* were strongly opposed to private insurance and private for profit delivery. Public institutions and hospital groups were supportive of some proposals, while insisting that caution should be the key word when experiencing with private insurance and private for-profit delivery.<sup>25</sup>

Although nowhere in the white paper do we find a clear discussion of healthcare privatization, the majority of interveners directly addressed this issue and framed their argument against or in favour of privatization in one form or another. Briefs on all sides complained that the Minister's position was too vague and unfocused, without sufficient detailed explanation for the private sector's proposed contribution. The wait-time guarantee which figures as a core argument of the policy paper, as demonstrated by the title *Guaranteeing Access*, did not manage to generate substantial support from interveners. In the end, most submissions opposed the government proposals of introduction of the wait-time guarantee,

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public and private providers.» [translated by author]). The brief was presented by Michel Clair, now CEO of Sedna corporation. Michel Clair was the chair of the Commission which recommended the creation of affiliated specialized medical centres. See Commission d'étude sur les services de santé et les services sociaux, *Emerging Solutions. Report and Recommendations*, (Quebec, 2001), online : Ministère de la Santé et des Services sociaux <<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2001/01-109-01a.pdf>>.

21 *Supra* note 17.

22 College of Surgeons and Physicians of Quebec.

23 Fédération des médecins spécialistes du Québec.

24 Fédération des médecins omnipraticiens du Québec. Both medical federations play in Quebec the role occupied in other provinces by their respective provincial Medical Association and members of the Canadian Medical Association.

25 *Supra* note 17.

private health insurance and the contracting out of health services by public hospitals.<sup>26</sup>

On June 8, 2006, on the day following the end of the public hearings, which was also the day marking the end of the twelve months stay obtained by the Government of Quebec from the Supreme Court of Canada for the decision of June 9, 2005,<sup>27</sup> Health Minister Philippe Couillard made a public declaration. He announced that a bill would be shortly presented for first reading before the Legislature and for third reading during the following fall parliamentary session. He declared that the bill would be in line with the policy paper and would allow private duplicative insurance for knee, cataract and hip surgeries only. The provisions limiting private insurance to those three surgeries would be retroactive to June 9, 2006, in accordance with the legal situation created by the Supreme Court *Chaoulli* decision and stay period. One week later, on June 15, 2006, the last day before the summer break-up of the Legislature, Bill 33<sup>28</sup> was indeed submitted before the National Assembly of Quebec.

### 1.3 The four main components of bill 33

The National Assembly of Quebec enacted Bill 33<sup>29</sup> on December 13, 2006<sup>30</sup>, confirming the government's response to *Chaoulli* concerning unreasonable wait times for some services in the Quebec healthcare system. Beneath a benign façade, the bill created fundamental changes in the core principles of healthcare in Quebec, which up until then, had assured that necessary avail-

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26 See three examples of submissions with strong opposition to core proposals: Paul A. Lamarche & André-Pierre Contandriopoulos, « Les propositions du livre blanc: un pas vers l'amélioration de la cohérence du système de santé » (GRIS, Université de Montréal : 24 March 2006) online : Unité de santé internationale <<http://www.usi.umontreal.ca/publication2.asp?no=12819>>; Médecins pour l'accès, « Accessibilité aux soins de santé et délais d'attente déraisonnables : 1001 solutions publiques » (24 March 2006); Fédération des infirmières et infirmiers du Québec, « Garantie d'accès ou garantie de soins? » (31 March 2006).

27 *Chaoulli*, supra note 1, stay of decision granted, 29272 (August 4, 2005).

28 Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*, 2<sup>nd</sup> Sess., 37<sup>th</sup> Leg., Quebec, 2006 (assented to 13 December 2006, S.Q. 2006, c. 43) [Bill 33].

29 It is therefore no more a bill, but a statute. However, we will use both the term "bill 33" and "statute" below.

30 Bill 33, supra note 28.

able financial and human resources be channelled towards the healthcare system devoted to the whole of the population, by minimizing public support to a private system which, by definition, caters only to a small portion of the population.

Some positive changes can be found in Bill 33 with the introduction of centralized waiting lists for specialized and super-specialized services, along with the implementation of service corridors between healthcare hospitals and clinics across regions.<sup>31</sup> However, other features of the statute are far less reassuring for the future of public healthcare. Below are the four main components of the statute which introduce a radical change of public policy relating to private health markets.

### ***1.3.1 Private investor hospitals***

The first major change introduced by the new statute concerns the launching or legalization of “private hospitals,” called “specialized medical centres” in the jargon of the Bill. These centres are allowed to offer those out-of-hospital surgical services currently delivered by public ambulatory care centres (for one-day surgery), by hospitals (for ambulatory and surgical services with an overnight stay) or by the traditional private doctor’s office. These private investor hospitals would be called “surgical facilities” in Alberta.<sup>32</sup>

These new private hospitals fall in two categories. The first one is, in principle, funded exclusively by public money, and could become some sort of a “private extension” of an existing hospital, while at the same time opening another door for other clients. Renewable five year contracts will be signed with hospitals for contracting out authorized surgeries. The centre then becomes what the Bill calls an “associated medical clinic.”<sup>33</sup>

The white paper had suggested that affiliations between hospitals and for-profit surgical facilities would be done on an exclusive basis.<sup>34</sup> No such restriction has been included in Bill 33 and specialized medical centres, as

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31 Bill 33, *ibid.*, s. 7, 8 (introducing s. 185.1 to the *Act respecting health services and social services*).

32 *Health Care Protection Act*, R.S.A. 2000, c. H-1.

33 It was called an «Affiliated Specialized Clinic» in the white paper. *Guaranteeing Access*, *supra* note 13 at 23.

34 *Guaranteeing Access*, *ibid.* at 49 (“Affiliated specialized clinics must provide services exclusively (or mainly) for the needs of affiliated establishments, under conditions defined in the agreement.”).

well as laboratories or medical clinics signing contracts with public hospitals, will be under no restriction to limit their services to patients covered by the long-term contract with the hospital, as long as they provide only publicly insured services. This major change, supported by a strong political will, provides a powerful tool to unleash the delegation of public services by contract on a continuing basis, thus establishing safe markets for private surgical facilities, who in turn will be allowed to develop at the same time other markets. We will return to this.

In the second type of “private hospital” envisioned by the bill, services will be paid for by private money and rendered by non-participating physicians.<sup>35</sup> They will offer authorized surgical services, including surgeries with an overnight stay. In other words, Bill 33 prohibits, for now, participating and non-participating physicians working in the same private surgical centre or sharing the same operating room.<sup>36</sup> That rule is in fact a mirror rule to the one prohibiting double-dipping for individual physicians who cannot be at the same time opted-in and opted-out of the public regime,<sup>37</sup> now introduced at the level of the specialized medical centre. This could be summarized as a prohibition of mixed medical practice, both for individual physicians and private surgical centres. This rule is most important to contain cross-subsidization of privately financed health delivery with public money<sup>38</sup>.

Bill 33 was also the occasion for the introduction of another major structural change in medical delivery in Quebec which went relatively unnoticed, but had been debated for years before between medical corporations (in particular, the *Collège des médecins du Québec* and the *Ordre des pharmaciens du Québec*), and their supervisory professional body, the *Office des professions du Québec*. After years of persistent requests from physicians, the Charrest government proposed a new regulation in 2003 opening the door to physician’s incorporation where private capital not controlled by practicing physicians could reach up to 50%, minus one share.<sup>39</sup> This proposal raised

35 Quebec health legislation prohibits physicians to be paid at the same time by public and private money. A physician may opt-out of the public regime and then becomes a “non-participating” physician. *Health Insurance Act*, R.S.Q. c. A-29, ss. 1, 26-28.

36 *An Act Respecting Health Services and Social Services*, R.S.Q., c. S-4.2, s. 333.3.

37 *Regulation respecting the application of the Health Insurance Act*, R.R.Q. c. A-29, r. 1, s. 28-29.

38 André Noël, «La mixité en six questions» *La Presse* (19 February 2008) A4.

39 *Physicians – Practice of the profession within a partnership or a joint stock company*,

vigorous public debate following media reports about free rents and alleged kick-backs to private doctor's offices from large drugstore chains in Quebec. The question was raised about who could become shareholders of corporate medical clinics and about conflict of interest for both pharmacists and physicians. The *Office des professions du Québec*, the general professional regulation body of Québec, carried out an enquiry concerning the relationship between physicians and pharmacists, while the proposed by-law was tabled. The *Office des professions* published its report in 2005<sup>40</sup> and, while supporting the possibility for physicians to incorporate, recommended that amendments to the *Professional Code* and *Codes of Ethics* for both physicians and pharmacists be made in order to update conflict of interest regulation.<sup>41</sup> The important issues raised by allowing the medical profession to incorporate postponed the enactment of a general by-law until February of 2007 (in force on March 22, 2007).<sup>42</sup>

However, Bill 33, which was debated and enacted in 2006, opened a window of opportunity for the passage of more liberal rules for shareholders and members of the board of directors of specialized medical centres. In fact, Bill 33 allows up to 50% minus one of the shares and the members of the board of a specialized medical centre to be owned or managed by investors,<sup>43</sup> while the general incorporation by-law which came into force in March 2007 requires all voting shares of a medical practice to be the property of a physician and all managing directors to be physicians as well.<sup>44</sup>

The incorporation of physicians and the development of investor-owned health facilities introduce major pressures for the commercialization and transformation of medical practice. Florence Maury who has analysed similar changes in France writes: "Following the enactment of the statute allowing physicians to practice within a partnership or a company in 1990, health

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G.O.Q. 2003. v. 135, n. 36. 2772. (Draft Regulation, Professional Code, R.S.Q., c. C-26).

40 Office des professions du Québec, *Avis de l'Office des professions du Québec sur la déontologie et l'exercice en société en regard des pratiques commerciales entre les médecins et les pharmaciens* (April 2005), online : Office des professions <[http://www.opq.gouv.qc.ca/fileadmin/docs/PDF/AVIS-OFFICE-MEDECIENS-PHAR\\_2005.pdf](http://www.opq.gouv.qc.ca/fileadmin/docs/PDF/AVIS-OFFICE-MEDECIENS-PHAR_2005.pdf)>.

41 Ibid. See in particular pp. 55-56.

42 *Regulation respecting the practice of the medical profession within a partnership or a company*, R.R.Q., c. M-9, r. 8.1.01.

43 *Supra* note 36, s. 333.2.

44 *Supra* note 42, s. 1.

professions are undergoing a profound metamorphosis. The incorporation is typically followed by the commercialization and the expansion of the employee status for the medical profession...The main pressure for the commercialization of the medical practice is to be found in the incorporation of the physicians."<sup>45</sup> It is important to keep in mind that new for-profit private delivery centres in Quebec were offered from the start the more liberal rule of ownership and control of 50% minus one. This may soon become a major factor in the evolution of medical practice in Quebec.

### ***1.3.2 Growth device for authorized surgeries in specialized medical centres***

The three following components of Bill 33 establish the very conditions which will facilitate market growth for those two types of private hospitals and increase the prospect of loss of control over public policy. This is how we can best understand the meaning of the portion of the Bill that lists the authorized surgeries in private hospitals. Bill 33 limits authorized surgeries in specialized medical centres to three areas: knee, hip and cataract surgery. This should be read as a first step designed to make it more acceptable to more timid or hesitant opponents. What is important is not the length of the list at the time of statute enactment, but the growth device included in the Bill itself. Indeed, section 11 of Bill 33, which introduces a new title on specialized medical centres to Part II of the *Statute on the provision of health and social services*, grants the Minister a regulatory power to determine eligible surgeries and acts to be performed in both types of private hospitals. So the short list which was emphasized during the public debate may become a long list in due course with very little impediment or public debate.

### ***1.3.3 Growth device for duplicative private insurance***

The third component to which we must pay attention concerns the introduction of duplicative private insurance (allowing private insurance for items already covered by public insurance) for the very first time in Quebec since the beginning of public healthcare. This may seem to address directly the Supreme Court's reprimand expressed by Deschamp J., as well as Chief Justice McLaughlin and Justices Major and Bastarache, who write: "The prohibition against private insurance in this case results in psychological and

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45 Florence Maury, « L'exercice en société de la profession médicale » [1997] 25 *Médecine & Droit* 1 [translated by author].

emotional stress and a loss of control by an individual over her own health"<sup>46</sup> and "the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice".<sup>47</sup>

Bill 33 may appear very cautious on this count as it limits the private insurance coverage to the same three surgeries mentioned above.<sup>48</sup> But, for authorized surgeries to be performed by private investor facilities, the length of the list in the bill is not what is important. We must look at the way the list is made and modified. In this case, we find two limitation tools in the Bill, which could easily be converted into two growth devices.

First, privately paid medical services can be performed only by non-participating physicians, which means that privately paid surgeries can only be offered in the second type of specialized medical centres. Changing this rule would require a legislative amendment to allow mixed medical practice in order to better promote private insurance markets. Second, although limited to three services in the Bill, the list of such services can be extended to cover some or all of the authorized surgeries in the private hospitals by simple by-law of the Government, after discussion in the appropriate commission of the National Assembly. Once a regulation allows a surgical act to be performed in the specialized medical centre by regulation of the Minister, the same list or part of such a list of surgeries for private insurance markets, can be included in a separate regulation of the government. The growth device for private insurance markets is therefore linked to a double control: mixed medical practice and regulatory power of the government.

Private insurance contracts allowed by Bill 33 will cover both physicians' income and "hospital" services associated with provided services, including an overnight bed stay<sup>49</sup>. Hospital costs are called in the jargon of Bill 33 "pre-operative, postoperative and rehabilitation support services."<sup>50</sup> The structure of the amendment introduced by Bill 33 unites both private medical and hospital costs within the *Health Insurance Act* and departs from the traditional separation of two separate statutes for hospital costs covered by the *Hospital*

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46 *Chaoulli, supra* note 1 para. 122.

47 *Chaoulli, supra* note 1 para. 153.

48 Bill 33, *supra* note 28, s. 42 (amending s. 15 of *Health Insurance Act*, R.S.Q., c. A-29).

49 See also Bill 33, *ibid.*, s. 20 (which specifies that permits for specialized medical centres will indicate "the number of beds available in the centre").

50 *Health Insurance Act*, R.S.Q., c. A-29, s. 15 (as amended by Bill 33).

*Insurance Act* (enacted in 1960)<sup>51</sup> and medical costs in the *Health Insurance Act* (enacted in 1970)<sup>52</sup>. This structure is related to the two step history of public healthcare coverage. The total prohibition of duplicative hospital insurance by Bill 33 is therefore a misnomer.<sup>53</sup> Bill 33 seems to reinstate a total prohibition of duplicative private hospital insurance on a reading of the amended s. 11 of the *Hospital Insurance Act*. This is a false impression as duplicative private “hospital” insurance is not only allowed but mandatory for all surgeries performed in specialized medical centres staffed by opted-out physicians. Not naming it “hospital insurance” does not stop it from being so.

#### ***1.3.4 Wait-time guarantee or connecting tool to feed private healthcare markets***

The implementation of all three previous components introduced by Bill 33 allows us to see how a wait-time guarantee may work in real life, and in particular within the Canadian public healthcare system. We saw that the wait-time guarantee was the core policy of the Quebec white paper, which corresponds to the electoral agenda of the Federal Conservative Party.

The fourth component of the statute, the wait-time guarantee, has relatively little visibility in the statute itself. It is limited to section 17 of Bill 33 which introduces a new section 431.1 to the *Act respecting Health Services and Social Services*. However, its real meaning is to be found in the connection mechanism it provides between both delivery and funding of public hospitals and new private investor surgical facilities called specialized medical centres, whether staffed with participating or non-participating physicians.

The wait-time guarantee, the details of which may easily change, is to be implemented by administrative policies. It envisions that compliance with the guarantee may result in publicly insured patients being sent to private investor surgical facilities of both types, including those staffed with non-participating physicians,<sup>54</sup> The wait-time guarantee is actually working as a feeding pump between the new private investor healthcare markets and public healthcare, both in terms of delivery and financing.

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51 *An Act to establish Hospital Insurance*, S.Q. 1960, c. 78.

52 *Health Insurance Act*, S.Q. 1970, c. 37.

53 Bill 33, *supra* note 28, s. 41 (which modifies s. 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28).

54 Bill 33, *ibid.*, s. 17 (introducing new section 431.2 to *An Act respecting Health Services and Social Services*, R.S.Q., c. S-4.2).

The Government of Quebec did stress those aspects of the bill which limited the first step towards duplicative private health insurance and the extent of cross-subsidization of public and private healthcare systems. A proper reading of the changes set in motion and the overall structure set in place through the connection of the four components described above give us a different reading. Such drastic changes in the course of healthcare delivery and financing could only be done in incremental steps anyhow. The overall power of the four components lies in their interconnection which generates a feeding mechanism for the evolving growth of viable private health markets. The structure set in place by Bill 33 lays the corner stone on which private healthcare delivery and funding can gradually expand and efficiently (for private markets) connect to public health services, creating the two-tier healthcare system which public policy previously constrained for medical and hospital services.

## 2. The Road Opening up After Bill 33

### 2.1 The Proposed by-law expanding the list of authorized medical treatments in specialized medical centres

Even before all sections of Bill 33 came into force on January 1, 2008, a proposed regulation to lengthen the list of surgeries authorized in the specialized medical centres was published on November 14, 2007 in the *Gazette officielle du Québec*<sup>55</sup>, inviting anyone to submit comments within 45 days of its publication, in accordance with sections 10 and 11 of the *Regulations Act*<sup>56</sup>. The proposed regulation is actually divided into two lists of surgeries. Part I of the list includes 38 medical treatments which must be provided in specialized medical centres, unless related to the mission of a public hospital. Part II presents 15 medical treatments which could be provided in a medical office when performed under local anaesthesia, but must be done in a specialized medical centre or within the mission of a public hospital when provided under general or area anaesthesia.

The regulation was enacted on July 9, 2008 (Ministerial Order 2008-08). The media reported in mid-June 2008 that the proposed list of 53 surgeries was contested by the Fédération des médecins spécialistes as being too

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55 *Specialized medical treatments provided in specialized medical centre*, G.O.Q. 2007, v. 139, n. 46. 2959. (Draft Regulation).

56 R.S.Q., c. R-18.1.

short and restrictive and that a new version of the regulation would open up authorized surgeries in specialised medical centers even further.<sup>57</sup> We will, for the time being, limit our comments to the published proposed regulation which gives us a solid indication about the orientation developing after Bill 33. We will emphasize two main points.

The first point relates to the quick expansion of the list of authorized medical treatments in the private investor hospitals. Although services were limited to three treatments in Bill 33, another 53 different medical treatments will be added shortly after the coming into force of the Bill. The warning about the importance of the growth device in Bill 33 is therefore materializing so quickly that we will not even experience a period of time where medical treatments in private clinics will be limited to the three treatments mentioned in the statute. Moreover, the list of authorized medical treatments in private investor facilities is a potential list for duplicative private insurance by means of a simple by-law of the government, therefore feeding the growth of private health financing markets.

The second main point is related to the active target pursued by public regulation in carving out dedicated markets for private health enterprises. Two mechanisms can be identified in the proposed regulation which together will provide safe private markets for private investor centres for the delivery of health services.

The first one is directed at public hospitals which could lose their public delivery mission following the implementation of such a regulation. Section 1 of the regulation prohibits institutions to carry out procedures listed in the two parts of the list unless these procedures are related to their mission. An institution's mission may be redirected in order to make room for the private sector and provide lucrative private markets. The mission can be indicated in the permit issued by the minister.<sup>58</sup> The institution itself can specify how the mission is to be focussed, with the approval of the regional health authority under which it operates.<sup>59</sup> The proposed regulation opens the door to administrative decisions whose effect would be to transfer procedures from public hospitals to private investor delivery clinics. Simple administrative

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57 A. Lacoursière, "Plus d'opérations dans les cliniques privées", *La Presse* (14 June 2008) A14.

58 *An Act respecting Health Services and Social Services*, *supra* note 36, s. 440 (as amended by Bill 33).

59 *Ibid.*, s. 105.

decisions may therefore carve out particular markets according to the regional health markets supply and demand.

The second mechanism for carving out specific markets for private investor owned delivery is found in the draft regulation which reserves exclusive markets for out-of-hospital surgeries with an overnight stay to private investor specialised medical centres. Section 3 of the proposed regulation divides up the market for private delivery of surgical services between centres with participating doctors and centres with non-participating doctors. Any procedure that requires an overnight stay can be performed only by non-participating physicians. This means that centres with non-participating doctors can become private investor hospitals directly competing with public hospitals, while the two types of specialized medical centres would not be in competition with one another. The draft regulation would define a clear and exclusive market for the duplicative private insurance industry, granting a monopoly for out-of-hospital surgeries requesting over 24 hour stays.

We must also note that the draft regulation radically modifies the wait-time guarantee for procedures requiring an overnight stay as put forward in the white paper. Let's remember that the stated objective for setting-up specialized medical centres was to help the public system meet demand for services when wait times become unreasonable. The purpose of the long term contracts with specialized medical centres staffed with participating physicians (which is called an associated medical clinic in Bill 33) was to be understood as relieving the burden on the public system and reducing wait lists. During the parliamentary Commission hearings that preceded the enactment of Bill 33, Health Minister Couillard said on many occasions that wait times for hip and knee surgery were among those that deserved special attention with the wait time guarantee.

The nature of the draft by-law has changed this reading, as it makes it impossible to cover these two procedures under an associated medical clinic agreement since only non-participating physicians would be allowed to offer such out-of-hospital surgeries. It is indeed difficult to make sense of a regulation which appears contrary to the objectives explicitly outlined by the Minister and the white paper for the enactment of Bill 33. However, its meaning becomes clearer when we realize that the main underlying goal, although far from being transparent, is to create a feasible and hospitable climate for the growth of private health markets. These observations put in question the objectives put forward by both Bill 33 and the draft regulation, which pursue objectives foreign to those advanced by the government.

According to Health Minister Couillard and the *Collège des médecins*, the only objective of the proposed by-law is to formalize practices already performed outside hospitals and it will not change in any substantial way current medical practice. This is not our understanding of the impact of the draft by-law when analysed as suggested above. On the contrary, if the overall structure proposed in the regulation were to be implemented, we can foresee the potential for a major shift as to how surgical procedures will be dispatched amongst private and public health facilities and where they will be performed in the medium to long term.

## 2.2 The rush for outsourcing surgeries

Bill 33 opens the road for investor owned private surgical facilities under long-term contracts with public hospitals. Before the statute's full potential can be realized, specialized medical centres must be up and running and proper permits obtained. Moreover, the specialized medical centres sections of the statute and the by-law for their permits<sup>60</sup> did not come into force until January 1, 2008.

However, Quebec has been known for some time as a welcoming land for private clinics where fees were charged to both the public system and patients<sup>61</sup> leading to practices contrary to Quebec legislation.<sup>62</sup> One such clinic received front page media coverage when it opened five brand new operating rooms only one month after the enactment of Bill 33. The clinic, called RocklandMD<sup>63</sup>, was staffed with both participating and non-participating physicians.

A few months later, the media revealed that Sacré-Coeur Hospital in Montreal was negotiating with RocklandMD in order to contract out one-day surgeries.<sup>64</sup> The contract was signed on December 13, 2007, that is be-

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60 *Regulation respecting the issue of permits under the Act respecting health and social services*, R.R.Q., c. S-4.2, r.0.2.2.

61 James Ferrabee, "Going Private", *National Post* (5 May 2005) FP-23.

62 Régie de l'assurance maladie Québec, *Rapport d'enquête : Facturation de frais à des personnes assurées par le Centre de chirurgie Rockland MD et par la Clinique Opmedic de Laval*, (29 March 2007), online : RAMQ ,<[http://www.ramq.gouv.qc.ca/fr/publications/documents/depliantscitoyens/rapport\\_enquete\\_rocklandmd\\_opmedic.pdf](http://www.ramq.gouv.qc.ca/fr/publications/documents/depliantscitoyens/rapport_enquete_rocklandmd_opmedic.pdf)>.

63 Kathleen Lévesque, «Un premier bloc opératoire privé s'ouvre à Montréal» *Le Devoir* (22 January 2007) A1.

64 «Sacré-Coeur veut confier des opérations à une clinique privée» *Cyberpre-*

fore sections about specialized medical centres and affiliated medical clinics in Bill 33 came into force. Health Minister Couillard strongly supported such an initiative which represents, according to him, a good example for the evolution of healthcare delivery as a part of the solution to lower waiting lists in the public system.<sup>65</sup>

The initiative was strongly contested by the local unions which emphasized that operating rooms at the hospital were closed while the hospital paid for access to one operating room at a private clinic. The hospital claimed that a lack of human resources, and in particular, a shortage of nurses was the main reason for the contracting out. On February 27, 2008, the union presented a petition before the Superior Court claiming that the contract signed between the hospital and RocklandMD should be declared null as contrary to Quebec regulation, and in particular, the sections relating to public tendering. This is an interesting case which reveals in another form the conflicting policies between potential solutions for the public system and the commitment to contribute with public money to the growing share of private healthcare delivery markets.

### 2.3 The Castonguay Report

The Charest government was elected for a second mandate as a minority government on March 26, 2007. For the first time since 1973, a third political party outside the *Parti Québécois* and the Liberal Party of Quebec became the Official opposition at the Legislature, under Mario Dumont as the leader of *Action démocratique du Québec* [ADQ].<sup>66</sup>

Quebec finance Minister Monique Jérôme-Forget delivered the budget speech for 2007-2008 in May 2007, and she announced the creation of a task force of three members to present recommendations for the adequate funding of healthcare. She set out avenues to be explored by the task force:

“One of the avenues the government intends to explore in light of the creation of the first affiliated clinics stemming from the Chaoulli

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sse (8 August 2007), online: Cyberpresse <<http://www.cyberpresse.ca/article/20070808/CPACTUALITES/70808021/6050/CPACTUALITES>>.

65 Radio Canada, «Hôpital du Sacré-Coeur-Rockland MD. Couillard approuve l'initiative» (8 August 2007), online: Rockland, MD. <[http://www.rocklandmd.com/images/nouvelles/nouvelles\\_couillard.pdf](http://www.rocklandmd.com/images/nouvelles/nouvelles_couillard.pdf)>.

66 The ADQ was created in 1994. It describes itself as a centre-right political party of Quebec.

decision is the role the private sector could play in improving access to health care and reducing wait times. Faced with the ever-growing presence of the private sector, the government, while reiterating its commitment to maintain a strong public health care system, believes that it must examine how this increasing presence can be targeted and coordinated so that it contributes more effectively to improving health care delivery."<sup>67</sup>

The liberal government entrusted the committee's chair to Claude Castonguay who is a well known figure in the history of healthcare and pharmacare in Quebec while spending most of his active professional life in the insurance industry. Two other members were nominated respectively by the ADQ and the *Parti Québécois*. The report, *Getting Our Money's Worth*,<sup>68</sup> was released on February 19, 2008, with a dissenting minority report from the PQ nominee Michel Venne on a few points, which on his own admission, did not impact his general support for the main recommendations.

Following the Report's release, the media presented a united view. Quebec Health Minister Philippe Couillard and his government had promptly rejected the three-member task force's main conclusions<sup>69</sup>. A chorus of media headlines said that the Report's most important and innovative recommendations had been peremptorily put aside. These were the introduction of a deductible based on both health services consumption and income and a 0.5% to 1% increase of Quebec sales tax.<sup>70</sup>

The government did indeed reject the recommendation of a deductible or some type of user fee as proposed by the Report. However, since the measure would be contrary to the *Canada Health Act* and would even clash with the Harper government's health policy, this dismissal was to be expected. Time was not ripe for such plan. Nor should anyone be surprised that the minority Liberal government turned down the Quebec sales tax increase

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67 Finances Quebec, *2007-2008 Budget: Meeting the challenge of Health Funding* (May 24, 2007) at 19, online: Finances Quebec <<http://www.budget.finances.gouv.qc.ca/budget/2007-2008a/en/documents/pdf/ChallengeHealth.pdf>>.

68 Quebec, Task Force on the Funding of the Health System, *Getting Our Money's Worth* (February, 2008), online: <[http://142.213.166.134/en/rapport/pdf/RapportENG\\_FinancementSante.pdf](http://142.213.166.134/en/rapport/pdf/RapportENG_FinancementSante.pdf)> [Castonguay Report].

69 Don Macpherson, "Straight into the shredder. Rarely has a government report been rejected so quickly as Castonguay's" *The Gazette* (21 February 2008) A19.

70 Castonguay Report, *supra* note 68 at 269.

proposal, given its election promise not to increase the tax burden on the middle class. In addition, while the Quebec health minister initially rejected the idea of allowing doctors to practice in both the public and private systems, as recommended by the task force, he soon gave a nuance to this position, saying that Quebec could consider this option in due course.<sup>71</sup>

Contrary to what the media has presented, none of these measures and their proposed implementation for the fiscal years of 2008-2009 or 2009-2010 – the deductible, the sales tax and the mixed medical practice – capture the full meaning of the Castonguay Report. The Report must be read as laying down a selection of policies for which the timing and sequence of their implementation is as important for their political viability as the recommendation itself. There is no rush to do it all at once; doing so would be political suicide.

The Report's central recommendations reflect the goals underlying Bill 33 and would push forward the statute's underlying objectives of furthering a fundamental restructuring of the public healthcare in Quebec. We have explained how Bill 33 and the proposed by-laws seek to create a favourable environment for private financing and delivery of healthcare. To further enable private financing of healthcare with increased accessory fees in specialized medical centres, for example, the government needs first to prepare the ground by encouraging the private delivery of healthcare by private capital corporations, the specialized medical centres of both types.

This goal is at the heart of the Castonguay Report, and will indeed be implemented, as confirmed by Health Minister Couillard 13 days after the release of the Report on February 19, 2008 when he launched five projects directly deriving from the Report. The other measures will follow in due course when the time is ripe<sup>72</sup>.

The next step in clearing the path for private health markets in post-Chaoulli Quebec lies in the creation of internal markets within the public system.<sup>73</sup> The Castonguay Task Force recommends that regional health

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71 On April 4, 2008, Health critic for the ADQ, M.P. Éric Caire, presented for first reading Bill 392 which introduces mixed medical practice in Quebec: *An Act to again amend the Health Insurance Act*. Online: Assemblée nationale <<http://www.assnat.qc.ca/eng/38legislature1/Projets-loi/Publics/08-a392.pdf>>.

72 The complete list of recommendations is presented in Appendix 1, Castonguay Report, *supra* note 68 at 261-270.

73 Current Quebec Finance Minister had published a paper on the internal markets in Canada in 1995: Monique Jérôme-Forget & Claude E. Forget, «Les mar-

authorities become “purchasers” of health services in a market where public providers compete with one another and with private providers. Already, the legal framework for private health providers is undergoing major changes with the establishment of specialized medical centres and corporate delivery of health services, as outlined above. The groundwork has been laid for the development of internal markets and will be pursued. Health providers’ budgets must be allocated on the basis of service-procurement calculation methodology in order to feed contracting out of service delivery to private providers.

The Castonguay Report invites the Ministry of Health and Social Services to withdraw completely from the provision of health services. Its mission should be reduced to umpiring the new market-based competition, through the “establishment of the health policy and objectives, the definition of insured services, the establishment of national standards, the allocation of resources [...] to the regional agencies, the establishment of performance indicators, and evaluation and approval through the designated bodies.”<sup>74</sup> Increased autonomy would be granted to the health and social services centres and health clinics in order to manage the health system through contracts negotiated on a one by one basis, as opposed to public policy and regulation. The health service pricing becomes the traffic control of both money and patients across a system which connects public hospitals with investor owned private hospitals and other public and private providers. The proposed measures, the Report explains, turn the patient into a source of income, which should increase health services delivery and efficiency according to the expression “patient-oriented” funding.<sup>75</sup> The Report does not explain, however, that in such a scenario the patient also becomes a potential source of loss when more complex and costly care than the average patient is required.

The Report ignores the documented flaws of internal markets and price-based funding in Britain, for example, where these measures – introduced in the 1990s by Prime Minister John Major – have led to cherry picking of patients and lower quality in a number of areas.<sup>76</sup> Nor does it say anything

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chés internes dans le contexte canadien» (1995) 1:3 Choix IRPP: Réforme de la santé 1, online: IRPP <<http://www.irpp.org/lastrak/index.htm>>.

74 Castonguay Report, *supra* note 68 at 158.

75 *Ibid.* at 177.

76 Carol Propper, Simon Burgess & Denise Gossage, “Competition and Quality: Evidence from the NHS Internal Market 1991-1999” *CMPO Working Paper Series*

about the repercussions that these policies have had within the European Union, where the rules of the single European market are taking precedence over public services rules. “Possible tensions between the economic objectives of European Union internal market regulations and the social objectives of the health sector.”<sup>77</sup> have been documented by the European Commission on Health & Consumer Protection Directorate-General, for instance. Hence, the Report completely ignores the likely impact of the recommendations in the context of international trade rules that are already binding on Canada under the North American Free Trade Agreement and the World Trade Organization, similar to those experienced in Europe.<sup>78</sup>

These questions are crucial for the future of the public health care system, and yet the voluminous Report fails to deal with them. The Report certainly delivers a stirring call to adapt the system to globalization – in both the preface and the conclusion. But in the roughly 280 pages in between, there is an eloquent silence about what such an adaptation really means for public healthcare in Quebec and Canada.

As we saw for Bill 33 and its incumbent by-laws, the orientation and interpretation of post-Chaoulli public policy become clearer when it is understood that it is busy preparing the ground for sustainable private health

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*No. 03/077* (May 2003), online: Department of Economics, University of Bristol <<http://www.bristol.ac.uk/compo/publications/papers/2003/wp77.pdf>>. See also a cost study in France concerning bias in comparison between the public and private sectors, and confirming recruitment pattern differences in standardized disease related groups: B. Vincke, P. Fender & H. Allemand, « Hétérogénéité de recrutement entre les secteurs hospitaliers public et privé au sein du GHM 164 » (2001) 32:4 *Revue Médicale de l'Assurance Maladie* 333.

77 European Commission, *The Internal Market and Health Services; Report of the High Level Committee on Health* (Dec. 17, 2001) at 4, online: European Union <[http://ec.europa.eu/health/ph\\_overview/Documents/key06\\_en.pdf](http://ec.europa.eu/health/ph_overview/Documents/key06_en.pdf)>.

78 Following the ruling of the European Court of Justice in 2006 in the case of British patient Yvonne Watts (*The Queen, on the application of Yvonne Watts v. Bedford Primary Care Trust and Secretary of State for Health*, European Court of Justice, C-372/04, 16 May 2006) about the obligation for the NHS to reimburse the cost of hospital treatment provided in France, the European Union Health Commissioner said: “The internal market applies to health services. People can shop around.” to which the *Financial Times* added: “Opening the market could provide lucrative opportunities for private providers to lure clients from across Europe.” Andrew Bounds & George Parker, “EU healthcare must brace for revolution” *The Financial Times* (4 September 2006).

markets. Other recommendations of the Report also make this clearer. This may be the case for the proposed cut-backs of public health budgets which provides additional opportunities for private health financing. This recommendation may seem justified when labelled under the general restriction of public health budget increases tied to the growth rate of Quebec economy. Reliable data shows that public health expenses in Canada have actually been increasing at the same rate as the gross domestic product over the last few decades.<sup>79</sup> The full meaning of the Castonguay Report recommendation to cut back public spending to adjust it to the same rate as the Quebec economy suddenly takes a different meaning when at page 37 of the Report the link is made to the growth of government revenues as opposed to GDP. We can easily anticipate what this new benchmark<sup>80</sup> means when governments are competing on lower taxes, in terms of the potential for private markets growth. We can also read a clear promotion of private health markets in the Report recommendation for the transfer of the management of long-term care institutions [CHSLD] and some public hospitals to for-profit health corporations.

One of the most intriguing and insidious recommendations in this regard may be the introduction of a deductible calculated on the basis of the number of medical visits the previous year and capped on the basis of household income.<sup>81</sup> Although, as mentioned above, this could not be implemented in the near future, it offers an interesting signal as how fiscal policy may itself contribute to private market growth in a more subtle way than traditional methods like private insurance deductions or direct public subsidies for private insurance acquisition on a means' test basis.

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79 See Bob Evans' paper in this issue. See also: François Béland, "Arithmetic failure and the myth of the unsustainability of universal health insurance" [2007] 177 CMAJ 54.

80 The trick is actually not new. It is also used in the 2005 report of the Task Force on the sustainability of the Québec Health Care and Social Services system, known as the Ménard report after the name of the chair. Québec, Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, *Pour sortir de l'impasse: la solidarité entre nos générations* (2005), online: Quebec <<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/Rapportmenard.pdf>>. The same method is also used in the white paper *Guaranteeing Access*, *supra* note 13.

81 *Getting Our Money's Worth*, *supra* note 68 at 222-235.

We may first note that such a personal deductible provides a clear tax break for corporations who would not contribute a penny to such a new source of health financing. Simulation of different options provided in Table 18 of the Report shows that with family revenues in excess of \$125,000 and a total of seven medical visits for the family, the new tax could quickly exceed \$2,000 per year. Urgent visits to the hospital, such as accidents or for serious disease, would not be added to the calculation in order not to discourage necessary health access. The Report claims that such a tax structure would better orient patients to the best facilities and would act as an “orientating ticket” as opposed to a consumption “moderating ticket.” We will not comment here on the mediocrity of the impact analysis of such a fiscal policy.

We must mention that with a fiscal penalty nearing or in excess of the average cost per person for public insurance in Quebec (medical and hospital),<sup>82</sup> we can anticipate that this financial structure would be a powerful incentive to purchase at lower prices out-of-pocket medical services or parallel private insurance for families with higher income, who could find cheaper rates for minor or elective visits which would otherwise be penalized under the proposed scheme. At a cost of \$360 per medical visit in the public system,<sup>83</sup> no one would even need private insurance to avoid it. Direct out-of-pocket payment to an opted-out physician becomes indeed an attractive option. Such insidious fiscal policy in favour of private markets could hardly be surpassed.

### 3. Conclusion

Post-Chaoulli events in Quebec on the political, administrative, legislative and regulatory scenes point in the same direction: public policy is now tuned to preparing the ground for the development of sustainable private health

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82 Total average per person public health expenses for medical and hospital insurance was in Quebec around \$2,500 in 2005. See Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2007* (Ottawa, Ont.: Canadian Institute for Health Information, 2007) at 31 (Table 7).

83 Based on the Castonguay report, *supra* note 68 at 233 (Table 18) proposed scheme which gives the example of a family of 2 adults and 1 child with a family income of \$150,000, making 7 visits to the medical clinic, which would translate into a deductible of \$2505, which is a user fee of \$360 per visit as opposed to an average medical visit of \$65.

markets in both service delivery and health financing. This reading might seem at odds with official pleas and public discourse, claiming strong loyalty to the public healthcare system. Such claims must be put in their proper perspective. Indeed, no viable or sustainable private health markets can thrive without a strong public healthcare system where most non-profitable medical situations averted by private health markets could be directed.

While the general support given to the public system by conservative ideology is true, it is conditional on the possibility to carve out of the public system profitable private markets. The details of public policy fine-tuning in post-Chaoulli Quebec can be best understood with this in mind. The wait-time guarantee, for instance, in spite of all its rhetorical appeal, may work out to be a decoy for the naïve, while true reshuffling of public health money, of patients and of health professionals will take place. The official presentation of public policy renewal for both delivery and financing of healthcare does not stand when analysed in a systemic fashion.

Analysts have contended for years that it was paramount to distinguish funding from delivery of healthcare services in order to maintain a rational and objective debate about the evolution of the Canadian healthcare system. The assumption behind this position was to defend the idea with which we all agree, that private funding of healthcare services is inconsistent with access equity. The complementary assumption was that nothing was wrong with private for-profit delivery, as long as public funding was maintained. This argument has gained increasing acceptance across Canada and most provinces now have moved some steps towards acceptance of investor-owned delivery, be it with the incorporation of the medical practice or the legalization of for-profit medical delivery clinics. Further steps may come in due course.

Private for-profit delivery of health services does require substantial public funding to flourish. It also requests the privilege or «right» to serve other clienteles, including those supplied by mixed opted-in and opted-out physicians, in order to take full advantage of their market situation. Private health markets may also include a special category of patients, partly financed by the public regime and paying additional accessory fees. This pattern is promoted by the Castonguay Report which recommends accessory fees for the operation of the specialized medical centres, or an annual fee from patients to register to at health clinics. The same pattern emerges in Alberta when surgical facilities may charge additional fees for enhanced medical services. The wait-time guarantee, the pumping mechanism across the public-private divide, proves that while it may be useful to distinguish funding from delivery, the two are intimately linked in the real-life private health market set-

ting. The different components of post-Chaoulli in Quebec prove that while it is useful for the argument's sake, to separate funding from delivery, in the practical reality of private health market development, both are intertwined and feed each other. Similarly, the public-private divide will not stay divided for long if this reengineering of Canadian healthcare is pushed further.

Following *Chaoulli*, we can now clearly see that «strategy» and «gradual move» are the key words for public policy evolution in Canadian politics, both in Quebec and in the rest-of-Canada. Contrary to the assertion of legal analysts following *Chaoulli* that only Quebec will be impacted, no single Canadian province is immune from such redefinition of public policy for healthcare. Actually, most have already made inroads in that direction. The pace, the rhetoric used and the sequence of the steps may very well vary, but the majority point in the same direction: clearing the path for growth of private health markets.

Paradox has fooled many Canadians. The revered *Canada Health Act* was thought to be the one tool to save the public healthcare system Canada has known for the last 40 years. And indeed *Canada Health Act* is still going strong, with commitment from both defenders of medicare and the conservative federal government, even though the Harper government is determined to prepare the ground for private health markets. How could the paradigm be shifting?

Little attention has been given by Canadian analysts to the role played by the provinces beyond the mechanistic application of the five *Canada Health Act* principles. The Supreme Court of Canada in the *Chaoulli* decision may have damaged the provincial power to regulate private markets. Others have recognized the new window of opportunity for private health market growth and use it.

