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Canada's Supreme Court and Its National Health Insurance Program: Evaluating the Landmark Chaoulli Decision from a Comparative Perspective

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Abstract

This article proceeds in three modes. The first briefly characterizes my reactions to the Chaoulli decision in June 2005 as a policy analyst and one of the experts in the Quebec trial testifying on behalf of Canada's Attorney General. The second part discusses some of the commentaries of others in connection with this decision. The third-and the main section-deals with the Court majority's use of international evidence in arriving at its decision and argues that the approach taken violated almost every scholarly standard for competent, cross-national policy analysis.

Keywords

Health policy; Canada; Quebec

CANADA'S SUPREME COURT AND ITS NATIONAL HEALTH INSURANCE PROGRAM: EVALUATING THE LANDMARK *CHAULLI* DECISION. FROM A COMPARATIVE PERSPECTIVE[©]

THEODORE R. MARMOR*

This article proceeds in three modes. The first briefly characterizes my reactions to the Chaoulli decision in June 2005 as a policy analyst and one of the experts in the Quebec trial testifying on behalf of Canada's Attorney General. The second part discusses some of the commentaries of others in connection with this decision. The third—and the main section—deals with the Court majority's use of international evidence in arriving at its decision and argues that the approach taken violated almost every scholarly standard for competent, cross-national policy analysis.

Cet article procède en trois modes. Le premier expose brièvement mes réactions à l'arrêt Chaoulli de juin 2005, puisque je suis analyste de politiques et figurais parmi les experts du procès au Québec, témoignant au nom du Procureur général du Canada. La deuxième partie débat de certains commentaires d'autres observateurs en rapport avec cet arrêt. Le troisième—il s'agit de la section principale—aborde le recours, par la majorité de la Cour, de preuves internationales pour arriver à son arrêt, et argue que la démarche adoptée enfreignait quasiment toutes les normes confirmées permettant une analyse compétente et transnationale des politiques.

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I. INTRODUCTION

Canadians hardly needed reminding in June of 2005 that the Supreme Court's decision in *Chaoulli v. Quebec (Attorney General)*,¹ which struck down the Quebec prohibition on private health insurance for publicly insured services, was an important, if unexpected judgment. The immediate reactions were numerous, strongly worded, and varied.² As an American scholar familiar with both Canadian health debates and the limited attention to them in the U.S. media, I was not surprised that the controversy was hardly noted south of the Canadian border. But, as one of the expert witnesses at the trial court level, I was certainly surprised by the decision, initially puzzled by the majority's reasoning, and, after an initial period of quiet reflection, literally flabbergasted by both its misconceptions and misuse of comparative, cross-national evidence.

The structure of this article reflects these three perspectives, each embodying a chronological period and a different professional role. Part II briefly characterizes my initial reactions to the *Chaoulli* decision as a policy analyst familiar with medicare and with the legal and policy disputes surrounding the case at the trial court level. Part III reflects a second phase of reflections. It discusses some of the commentaries of other policy and legal specialists about the character and merits of the decision, as well as the implications for the future of medicare in its provincial expressions. The main focus of the article, however, is on the Court's use of comparative, cross-national evidence. As a specialist in cross-national policy analysis, I argue in Part III and Part IV that the majority's approach to international and comparative

¹ [2005] 1 S.C.R. 791 [*Chaoulli*].

² See David Gratzner, "An End to the Party Line" *Maclean's* (20 June 2005) 22; "The Right to Live," Editorial, *National Post* (9 June 2005) A20; Ingrid Peritz "Praise, Censure for MD's Crusade" *The Globe and Mail* (10 June 2005) A9; L. Ian MacDonald "Canada's Youngest Supreme Writes a Mean Judgment" *Montreal Gazette* (10 June 2005) A23; Sam Shortt "Ruling Won't Improve Health Care" *Ottawa Citizen* (15 June 2005) A15; "Medicare on Trial...Again" *Winnipeg Free Press* (9 June 2005) A15; Antonia Maioni & Christopher Manfredi "A Blow to Champions of Medicare" *Toronto Star* (10 June 2005) A25; "Strong Medicine from High Court for Health System" *Edmonton Journal* (10 June 2005) A16; "A Supreme Shot in the Arm: Right to Buy Private Health Care Should be Extended Here, Too," Editorial, *Calgary Herald* (10 June 2005) A22; and Barry Kay "Private Health Insurance Needn't Have a Huge Impact" *Kitchener-Waterloo Record* (16 June 2005) A9.

evidence violated almost every scholarly standard for competent policy analysis.

II. THE *CHAULLI* DECISION: INITIAL SURPRISES AND SURMISES

The narrow 4-3 decision in *Chaoulli* was, for many critics of medicare, judicial confirmation of the program's overall failure to provide timely and proper access to health care. For medicare's supporters, the decision represented a worrisome threat to the program's core values, most notably the principle that access to care should not vary with one's willingness and ability to pay for private health insurance. On this topic, the initial reaction was fulsome, frequent, and strongly felt.³

For external observers like myself, two issues initially struck me as significant about the decision: the vigorous judicial participation in a policy field that, in Canada and much of the OECD world, had typically been reserved to legislatures;⁴ and the reasoning behind the majority's opinion that access to care was so wanting in Quebec that it violated the province's *Charter of Human Rights and Freedoms*.⁵ Writing in *Time Canada* immediately after the decision, I called attention to the court's view that neither "common sense [n]or theory"⁶ was the basis for the majority's decision. I emphasized the majority's claim that "evidence" about how other industrial democracies organize the financing of

³ By the end of the summer, the University of Toronto Press had already published a volume of articles from a conference that substantially, but not entirely, reflected a critical judgment of the Court's majority rulings. 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). This, of course, was a prelude to the Osgoode Hall Law School conference from which many of the articles in this special issue are drawn.

⁴ See Christopher P. Manfredi & Antonia Maioni, "The Last Line of Defence for Citizens: Litigating Private Health Insurance in *Chaoulli v. Quebec*" (2006) 44 Osgoode Hall L.J. 249. This article takes up both the substance and the appropriateness of this judicial "activism." Interestingly, this article's concentration is on the questionable appropriateness of the judicial intervention, not its substantive justification. As will be clear in this article, my argument is that the court was entering an area it should have approached with much more caution and, most importantly, the majority's opinion was poorly reasoned.

⁵ R.S.Q. c. C-12 [*Quebec Charter*].

⁶ *Supra* note 1 at 855.

medical care provided the “empirical” grounds for their opinion.⁷ This was the basis the majority offered for rejecting experts’ conclusions at trial that international evidence about health care financing policies did not provide grounds for overturning the ban on private insurance for publicly financed services. In this article, I do not want to assess the competency of the Court in evaluating the performance of health systems, although I do think it is a question worth exploring. Rather, in Part IV, I directly address the way the Court actually reasoned through the comparative evidence of the experience of other OECD nations.

The background required to question the Court’s use of comparative evidence was not central to the initial responses to the *Chaoulli* decision. It is true that medicare has been unique among OECD nations in banning what Colleen Flood usefully terms “double coverage.”⁸ But, for political leaders like Ralph Klein who have long argued for more private financing and provision of medical care, the Court’s decision to challenge that ban prompted immediate approval, not justificatory curiosity: “Any change that gives Canadians more choice in accessing health care,” he stated on 9 June 2005, was worthy.⁹ The President of the Canadian Medical Association (CMA), Dr. Albert J. Schumacher, described the Court’s ruling as “historical,” one that “could substantially change the very foundations of medicare as we know it.”¹⁰ But the CMA’s focus was on the political consequences within Canada, not the Court’s reasoning about the experience of other national health care programs with private insurance. For those like former Saskatchewan premier Roy Romanow, who have long celebrated

⁷ Ted Marmor, “Supreme Ironies: Despite its Flaws, the Court’s Ruling Could Spur Canada to Fix Health Care” *Time (Canada)* 165:25 (20 June 2005) 35.

⁸ The terms used to describe what private health insurance had proscribed include a misleading mélange: “complementary,” “supplementary,” “extra,” and, more usefully, “double coverage.” “Double coverage” simply means private health insurance for costs of care that are publicly financed. What Flood makes clear, which will be important in discussing the Court’s reasoning, is that the forms of private health insurance take on significance in connection with their overall impact on who gets what kind of care when. See Colleen M. Flood, Mark Stabile & Sasha Kontic, “Finding Health Policy ‘Arbitrary’: The Evidence on Waiting, Dying, and Two-Tier Systems” in Flood, Roach & Sossin, *supra* note 3, 296; Stefan Greß, “The Role of Private Health Insurance in Social Health Insurance Countries—Implications for Canada” *ibid.*, 278.

⁹ John Cotter, “Provinces Respond to SCOC Striking Down Quebec Private Health Insurance Law” *The Canadian Press* (9 June 2005) (QL).

¹⁰ “Health-care Ruling Called ‘Stinging Indictment’” *CBC News* (10 June 2005), online: CBC News <<http://www.cbc.ca/story/canada/national/2005/06/09/medical-ruling-reaction050609.html>>.

medicare, the decision was a call to political action. After all, the Court did not hold that the ban was unconstitutional itself. Instead, it argued that the “prohibition on obtaining private health insurance ... is not constitutional where the public system fails to deliver reasonable services.”¹¹

The very narrowness of the decision’s grounds was crucial to making sense of the immediate response to the decision: the fear medicare defenders felt, the delight critics expressed, and the policy implications experts imagined. There appeared little doubt that private health insurance would be for sale in Quebec at some point, though later some scholars expressed doubt.¹² But it seemed just as likely that in other provinces the decision would prompt governmental attention to waiting list problems on the scale of Quebec’s in recent years.¹³ In that respect, the decision appeared to warrant less celebration from advocates of private insurance and justified less fear from defenders of medicare. Understood symbolically, it was easy to see why the ideological stakes initially seemed so high on both sides. Such was my impression in the immediate aftermath of the decision.

III. FURTHER REFLECTIONS: THE USE AND ABUSE OF INTERNATIONAL EVIDENCE

The range of reactions to the *Chaoulli* decision has been extraordinarily broad among scholars interested in Canadian medicare. Both the University of Toronto Faculty of Law’s conference entitled “Access to Care, Access to Justice: The Legal Debate Over Private Health Care in Canada” that took place in September of 2005, and Osgoode Hall Law School’s one-day national summit entitled “*Chaoulli*

¹¹ *Supra* note 1 at 860.

¹² For example, there had been initial skepticism from some Quebec lawyers in the Fall of 2005. As communicated to me personally by Antonia Maioni via email, the Quebec government “finally responded to *Chaoulli* and proposed to allow private insurance and this is now ONLY for elective surgery in hip, knee, and cataract [cases]; and the opening of a limited number of ‘public-private partnerships’ in these same three services in which publicly affiliated doctors would perform surgeries covered by public insurance (so the wall between physicians in the public system and those who opt out of it remains in place). Quebec also intends to put into place “wait time guarantees” for certain services.” Email from Antonia Maioni to Theodore R. Marmor (28 February 2006) [on file with the author].

¹³ See e.g. Alan Maynard, “How to Defend a Public Health Care System: Lessons from Abroad” in Flood, Roach & Sossin, *supra* note 3, 237.

and the Restructuring of Health Care in Canada” that took place in October of 2005, displayed not only different ideological sympathies with the decision itself, but hugely different interpretations of what was important to assert. Some thought the decision, whatever its merits, might prompt useful attention to waiting lists and other measures of distress, as already noted.¹⁴ Other commentators were preoccupied with the privileges the decision could provide to higher-income Canadians, or how these high-income earners pursued such avenues of advantage in the years preceding *Chaoulli*. Still others raised different issues, all of which are of interest, but which exceed the scope of this article.¹⁵

For this article, the Court’s use of evidence from other systems of publicly financed medical care is central. My conclusion, after more careful review, is that the majority’s treatment of international evidence was conceptually flawed, empirically superficial, and profoundly misleading. These are strong claims and obviously require elaboration and documentation.¹⁶

The majority contended that the experience of other countries with supplementary insurance “refutes the government’s theory that a prohibition on private health insurance is connected to maintaining quality public health care.”¹⁷ The Court went on to state that “[i]t does not appear that private participation leads to the eventual demise of public health care.”¹⁸ The first of these claims, I will try to demonstrate, is clearly misleading. The second is true, but relevant to a question the trial court rightly did not ask. Every Western European nation with universal or near universal medical care coverage permits private health insurance. That generalization is one no expert in comparative medical care policy would (or did before the trial court) deny.

The misleading conclusions the Court reached were connected to the way the majority framed the question for which international evidence might be relevant. The pressing question in *Chaoulli* was

¹⁴ *Ibid.*

¹⁵ See generally Flood, Roach & Sossin, *supra* note 3.

¹⁶ There is still a strong body of evidence about the distributive effects and inefficiencies of private insurance and clear evidence from places like the United Kingdom and New Zealand that eliminating monopoly in public insurance will not eliminate waiting lists. See Flood, Stabile & Kontic, *supra* note 8 at 298.

¹⁷ *Supra* note 1 at 794.

¹⁸ *Ibid.*

neither whether private health insurance practices exist nor whether the health programs of the OECD world manage to produce tolerable results despite these practices. The question, rather, was whether expanding private insurance—understood as double coverage—fosters higher quality of care for the public programs, increases citizen support for the national scheme, or helps in dealing with the inflationary forces in medical care. But for one witness, there was agreement among the experts that private health insurance does not aid these purposes!¹⁹

Nonetheless, what strikes the outside policy analyst is the peculiarity of the question. Why would anyone sensibly defend or critique the Canadian ban on supplementary coverage on the basis that public programs would otherwise fail to provide a reasonable level of quality or fail to engender political support? Who among the comparative experts consulted claimed that allowing double coverage would lead to such extreme (and extremely unhappy) outcomes? None in fact did. In fact, no scholar I know of would claim that national health financing is incompatible with supplementary private health insurance.

The defensible justification of the ban on supplementary health insurance in Canada is egalitarian and prudent. Parallel financing, ample research has shown, tends to increase overall costs.²⁰ Moreover, the experience of private supplementary insurance in Europe is that parallel financing persistently raises questions of fairness, as illustrated by the controversies over pay-beds in British National Health Service (NHS) hospitals; private insurance coverage of co-payments in France; and the exiting from the public insurance “pool” of those in Germany’s top 10 per cent of income earners.²¹ These problematic features of double coverage are known to scholars of health care, yet they were not noted by the majority. The scholarly findings suggest prudent lessons from other countries, not stories of policy collapse from supplementary

¹⁹ It is a feature of systems with greater levels of private finance that they are more often in turmoil. See Carolyn Hughes Tuohy, Colleen M. Flood & Mark Stabile, “How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations” (2004) 29 *J. Health Pol.* 359.

²⁰ Indeed, the Court cited the article by Tuohy, Flood & Stabile *ibid.*, but failed to note this as part of its findings.

²¹ For the NHS, see especially Rudolf Klein, *The New Politics of the National Health Service*, 3d ed. (New York: Longman, 1995). For French and German discussions, the writings of Jean de Kervasdoué and Heinz Rothgang are useful sources. Conversations with these scholars during the fall of 2005 brought out the persistence of these concerns. But, see especially the support for these claims in Maynard, *supra* note 13; Greß, *supra* note 8.

coverage. Evaluating Canada's ban thus calls for judgment about what is more fair and less costly, not what is simply possible to do.

The majority posed the wrong questions, I believe, when dealing with comparative evidence. As a result, they were unable to legitimately reject the twin arguments that if ability and willingness to pay is a criterion of access, parallel systems increase costs and allocate access to care unfairly. What is even more puzzling is that the majority was willing to reject the decisions of two Quebec courts in a major case that but for one vote would have gone the other way. On this reading, one ought to be concerned with this kind of judicial expansion of both claimed expertise and vigour amidst substantial disagreement.

It may be that the problems of the *Chaoulli* decision for medicare defenders were the arguments the government's lawyers offered, not the merits of the case for banning supplementary coverage.²² To the extent the government justified its defence by threats of medicare's demise or its loss of quality, it made a serious mistake. There was and is no reason to believe that parallel systems cannot maintain adequate quality, prevent runaway inflation, or survive in recognizable form.²³ But that does not mean the ban on supplementary insurance in Quebec was unjustified: it was justified on grounds of advancing equality of access and helping to maintain broad interest in the quality of care available to most Quebec citizens.

The central policy point to make about parallel health insurance is rather simple: such systems are likely to be more expensive overall, are certain to be less fair, and alone will not do very much about the length of waiting lists. After all, "[w]here will the specialists and physicians come from to staff a privately paid tier if not from the public sector? The majority does not address this fundamental question."²⁴ If

²² It no doubt should be stipulated that the parallel financing that is the subject of my article is supplementary, private insurance to finance costs in services covered by the public plans, whether in Canada or elsewhere—what Flood terms "double coverage." See Flood, Stabile & Kontic, *supra* note 8.

²³ The United Kingdom has had queue-jumping through private insurance since 1948, but the NHS remains primarily a place where care is free at the point of service, and the overwhelming proportion of the population relies on it for care. That the British government is today trying to "purchase" care from private suppliers from Europe and the United States is itself worthy of attention. The official justification of that policy is the attempt to reduce the capacity of the privately insured to gain unfair advantage. More access on NHS medical grounds will, according to this view, *reduce* the ability of the wealthier to "jump the queue."

²⁴ Flood, Stabile & Kontic, *supra* note 8 at 310.

Dr. Chaoulli is serving a privately financed patient, he can not at the same time treat a publicly financed one. This point, so obvious to the outsider, has prompted less immediate attention than I would have expected.²⁵

If this point was clarified, it would produce greater understanding about why restricting private coverage is an expression of firm and important Canadian beliefs about how access to care ought to be provided.²⁶ And, as a consequence, the Court's decision would be a landmark one in a quite different sense.

IV. FINAL THOUGHTS: THE USE AND ABUSE OF COMPARATIVE EVIDENCE

As mentioned, the first part of this article conveys what I had written within hours of reading the decision.²⁷ But in the following weeks, there was literally a deluge of commentary among critics, defenders, and explicators of the *Chaoulli* decision. Those commentaries prompted further attention to two questions: (1) why introducing private funding and delivery might not reduce waiting lists (and times); and (2) precisely what was wrong with the majority's interpretation of the comparative evidence on which it relied.

The answer to the first question is that, in the short run, the supply of caregivers is largely fixed. That means private financing will redistribute attention to some over others, not increase the availability of care itself.²⁸ The majority, as François Béland has noted, did not take

²⁵ It did prompt the attention of Professor François Béland of the University of Montreal in "The Supreme Court Missed a Good Opportunity" *Law and Governance* (June 2005), online: Longwoods Publishing <<http://www.longwoods.com/product.php?productid=17234&page=1>>.

²⁶ This claim about clarity is not meant to cast doubt on the proposition that there are other more important constraints on queue-jumping in Canada than the ban in six provinces on private insurance financing of publicly insured services. See Colleen M. Flood, "Chaoulli's Legacy for the Future of Canadian Health Care Policy" (2006) 44 *Osgoode Hall L.J.* 273. In that article, Flood makes a good case that preventing physicians from working both in the private and the public sectors is more important. That some other policy promotes the same value does not detract from the claim that the ban serves the same purpose, even if less powerfully.

²⁷ As noted, *Time (Canada)* published what I wrote on 10 June 2005. *Supra* note 7.

²⁸ Another good point here is that:

[t]he Court's complete failure to cite, follow, or even attempt to distinguish its own precedents led it to make a fundamental legal error: it posed the wrong question. The question was not whether Quebec had convincingly demonstrated that a ban on private insurance was necessary to maintain the integrity of public health insurance. Rather,

on the question of how less waiting time for patients like Mr. Zeliotis could reduce the waiting time of others. Instead, they decided that the burden of proof was not on the plaintiffs to show that private insurance “cures” the waiting list problem. Further, as Béland puts it, the court “completely avoid[ed] examining the possibility that introducing private insurance would lengthen waiting lists in the public sector.”²⁹

The answer to the second question led me to compose months later the last part of this article. Since I provided testimony, my general conclusion may be relevant as a considered answer to what the comparative evidence on health policy demonstrated. In fact, as Professor Hamish Stewart noted, the trial court relied to some degree on my report.³⁰ As such, it may be useful to simply repeat my conclusion, cited by the dissent in *Chaoulli*:

Doubts about the plaintiff's assumptions are not only based on theoretical concerns. There is also considerable empirical basis for such skepticism. My studies of health care and financing systems in OECD countries provides real world demonstrations of the dynamics that might well occur in Canada In France, for example, there is continuous dispute about the role of cost sharing by patients in restraining demand for services in a fair and effective way. ... The result is less the reduction of medical care use (whether justified or not), but the substitution of one source of payment for another. This multiplication of sources of finance weakens rather than strengthens the capacity of a society to decide democratically what health care its citizens should be entitled to in health care and how scarcity should be apportioned.³¹

The critique thus far has concentrated on the argument the majority used to reject expert views that international evidence provided

the question was whether Quebec had a ‘reasoned apprehension of harm’ that opening the door to private insurance would pose this threat.

Sujit Choudry, “Worse than *Lochner*?” in Flood, Roach & Sossin, *supra* note 3, 75 at 86.

²⁹ *Supra* note 25. This comment was made with reference to *Chaoulli*, *supra* note 1 at 827, 838.

³⁰ Hamish Stewart, “Implications of *Chaoulli* for Fact-Finding in Constitutional Cases” in Flood, Roach & Sossin, *supra* note 3, 207 at 211.

³¹ Theodore R. Marmor, Expert Witness Report (November 1998) at 5 [on file with the author].

some support for the Quebec government's ban on supplementary health insurance. Now I turn to a more fundamental concern: the extent to which the majority understood how to use comparative evidence at all.³²

What is striking is how cavalier the majority was about how to evaluate comparative policy analysis. There was almost no attention in the majority opinion to the logic of comparative analysis or to the limits of reasoning from such findings. There are but two defensible scholarly designs of comparative policy studies: a "similar system" and a "most different system" approach. The more similar the nations selected for study, the more plausible that the forecasts based on the experiences of nations A to F would resemble what nation G should expect from a similar policy initiative. Nothing in the majority's opinion suggested an awareness of this understanding. Equally, where many different nations have a common reaction to a given policy, this suggests an especially powerful reason to anticipate the same result from a new nation implementing that initiative. Such generalizations will be rare, given the diversity of national experiences, but will be important for policy forecasting. The majority in *Chaoulli* were silent on the methodology of using very different systems for comparative analysis. Indeed, in terms of international comparative evidence, there was no methodological discussion of any kind. Instead, the majority pontificated about their use of what they called "studies," especially the comparative findings published by Senator Kirby in the six-volume report entitled *The Health of Canadians—The Federal Role*.³³

³² In fact, there are at least four distinct ways of financing health care. Actually, "[d]ouble-cover or complementary private health insurance in Canada is different from alternative private health insurance in Germany or the Netherlands and from supplementary health insurance [in] Belgium, France and Germany, the Netherlands and Switzerland. ... [T]he majority of the Supreme Court fail to grasp this distinction." Greß, *supra* note 8 at 291-92.

³³ Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: The Story So Far* (Interim Report), vol. 1 (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2001) (Chair: Michael J.L. Kirby); Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Current Trends and Future Challenges* (Interim Report), vol. 2 (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby); Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Health Care Systems in Other Countries* (Interim Report), vol. 3 (Ottawa: Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby); Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Issues and Options*

Before turning to the use of the report's findings, it would be helpful to briefly review the criticism others have made of the Court's analysis of the comparative evidence. Professor Colleen Flood argues that the majority in *Chaoulli* did not understand the different forms and functions of private health insurance abroad, and further, that they failed to recognize that other regimes possessed functional substitutes for Canada's ban on private insurance for publicly financed medical services.³⁴ This claim is certainly true and important. Professor Flood also makes a different and contestable claim by questioning whether the Quebec *Charter's* ban is even the most significant instrument of control on private medical care in Canada. Other scholars applaud the minority opinion that, unlike the trial court, the Court was not in a position to reconsider international evidence. They call attention to the limited time the Court had for a hearing, the inappropriate inclusion of evidence not central to the trial court's deliberations, and the condescending treatment of the experts that were cross-examined at trial. I want to note, but not comment further on any of these arguments, however much I find them compelling.

The central decision facing the Court about comparative evidence was whether it should defer to the trial court's evidentiary findings, which embodied conclusions of all but one of the expert witnesses. Precisely what evidence, then, did they use? The answer is, not much. The majority relied on the work of the *Kirby Report*, but that in turn raises the issue of whether it was worthy of reliance. In fact, the

(Interim Report), vol. 4 (Ottawa: Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby); Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Principles and Recommendations for Reform—Part I* (Interim Report), vol. 5 (Ottawa: Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby); and Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Recommendations for Reform* (Interim Report), vol. 6 (Ottawa: Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J.L. Kirby) [*Kirby Report*].

³⁴ *Supra* note 26. Others have pointed out the distributive features of double insurance coverage and the advantages it confers on private providers of care: "The summary of world experience with private health insurance; then, is that where it exists it functions primarily as a mechanism for providing preferred access to care—shorter waiting times and particularly specialist services—for those with higher incomes. It is also a source of additional income for the providers who serve, and are paid, by that clientele." Robert G. Evans, "Preserving Privilege, Promoting Profit: The Payoffs from Private Health Insurance" in Flood, Roach & Sossin, *supra* note 3, 347 at 365.

report's review of the experience of other industrial democracies with universal access to medical care was rather superficial.³⁵ The Senate Committee responsible for the report put together snippets of information into short national portraits of the United Kingdom, France, Belgium, the Netherlands, Australia, Sweden, and the United States. Those short portraits are typical of a class of studies that substitute superficial description for substantial understanding of how complex policy systems actually work. Moreover, the Senate Committee complemented this superficial treatment with what can only be described as rudimentary reflections on the accuracy of their portraits. They held video conferences with a series of national experts, talking by telephone and then recording their conclusions about how the experts' systems worked. As an alternative to knowing nothing about the experience of other nations, this is admirable. As serious analysis of comparative performance of quite different regimes, this is totally inadequate.

It is fair to note, on the other hand, that reliable comparative policy studies in this field are rare. Much of what passes for comparative understanding are hit-and-run observations communicated by phone, fax, and lightning visits.³⁶ But that does not absolve the majority from criticism for using weak studies to draw strong conclusions. Put another way, the *Kirby Report* provides little authority in two senses: (1) the bases for the Senate Committee's deliberations were, as stated, superficial; and (2) the majority invoked the *Kirby Report* even though the report did not reach the same conclusion as the majority did about the implications of international experience for Canadian reform.

The *Kirby Report's* approach to comparative policy learning is a poster child example of what not to do.³⁷ According to the majority,

³⁵ Note the supporting interpretation by Colleen M. Flood and Steven Lewis: "Through their comparative analysis of health care systems, [the majority] amply demonstrate[s] why courts should be extremely cautious about wading into these difficult policy choices." "Courting Trouble: The Supreme Court's Embrace of Private Health Insurance" (2005) 1 *Healthcare Pol'y* 26 at 28.

³⁶ Richard Freeman, Ted Marmor & Kieke Okma, "Comparative Perspectives and Policy Learning in the World of Health Care" (2005) 7 *J. Comp. Pol'y Analysis* 331.

³⁷ For instance, consider the Senate Committee's claim that "[a] number of health trends that affect young people in Canada are of great concern. These include, for example, overweight and obesity, eating disorders, incidence of smoking, illiteracy and low levels of psychological well-being" in *Kirby Report*, vol. 4, *supra* note 33 at 35. This is sufficiently vague that it could apply to any industrial democracy in the world, a commonsensical observation that has no obvious policy implication.

however, the report “discussed in detail the situations in several countries, including Sweden, Germany, and the United Kingdom”³⁸ and that supposedly provided the grounds for substantial cross-national policy learning. In fact, the sketches of the financing and administration of health care in Sweden, Germany, and the United Kingdom had no coherent rationale. Nor did the findings about how these systems appeared to operate rest on convincing sources of evidence. The *Kirby Report* represented nothing more than a review of the published literature on the formal features of these national schemes, and it sought to arrive at a more nuanced understanding by video conference discussion with a limited set of national experts. How that is an improvement on the expert reports—and trial cross-examination of those experts—is a mystery, at least to me.

Further, the majority proceeded from the evidence in the *Kirby Report* to a conclusion about the reform of medicare that was not reflected in the Committee’s conclusions. The report’s international discussion was surely superficial, but they did not draw from such portraits reform conclusions. The majority, by contrast, used (or misused) the international evidence in their justificatory argument.

V. CONCLUDING REMARKS

The aim of this article was to evaluate the *Chaoulli* decision from the standpoint of a scholar of comparative studies in health care, reasonably familiar with Canadian medicare developments over the past four decades. With regard to the majority’s use of international experience in reaching its conclusions, my conclusion is three-fold. First, the approach to posing comparative policy questions was obtuse, ill-considered, and prejudicial. Second, the majority had no defensible grounds for its conclusions other than the assertion that the findings of the *Kirby Report* confirmed their a priori beliefs. Third, the Senate

³⁸ *Supra* note 1 at 855. It is useful to contrast the Court’s appeal to the authority of the Senate Committee’s “findings” about other national experiences with their cavalier dismissal of ““common sense” arguments, amounting to little more than assertions of belief.” (*Ibid.* at 852). If the Senate Committee findings were descriptive portraits that did not constitute evidence for the conclusions drawn, they hardly warrant such treatment. Nor is there support for the remarkable claim that “the experience of these countries suggests that there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system.” (*Ibid.*). How could that conclusion be drawn from mere descriptive portraits of a number of countries where the impact of private health insurance was not the focus of the investigation?

Committee's findings in the report were largely descriptions of financial and administrative arrangement, not the product of a research design structured to discover the effects of private health insurance on medical care systems where double coverage is proposed.

Whatever one's preference for what the Court should have done, it is crucial to concentrate on what it failed to do correctly, as the Court is likely to be taking up cases of this kind in the future. Not only did it reveal massive ignorance of the conventions of comparative scholarship, but the Court also appears to have engaged in what some people term "decision-based evidence": the opinion seems to have preceded the analysis. These critical assessments, then, are directed towards cautioning those who might turn to the *Chaoulli* decision for guidance on what cross-national research on medical care might offer Canadian jurisprudence.

