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Fallout from Chaoulli: Is It Time to Find Cover?

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Abstract
This article examines the implications of the decision in Chaoulli v. Quebec (A.G.) for Canadian health policy. The author assesses whether governments are likely to strengthen medicare, given past performance and the exit option Chaoulli presents. The article analyzes the consequences of increasing private care and private insurance, concluding this will diminish the publicly funded system. It contrasts Chaoulli -with courts' dismissals of claims for Charter protection of minimal social and economic security, despite the profound effects of the latter on health status. It concludes by noting Chaoulli is one more example of the increasing prevalence of discourse normalizing privatization and individual responsibility in policy justifications.

Keywords
Health policy; Canada; Quebec; Privatization

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FALLOUT FROM *CHAOULLI*: IS IT TIME TO FIND COVER?©

JOAN M. GILMOUR*

This article examines the implications of the decision in *Chaoulli v. Quebec (A.G.)* for Canadian health policy. The author assesses whether governments are likely to strengthen medicare, given past performance and the exit option *Chaoulli* presents. The article analyzes the consequences of increasing private care and private insurance, concluding this will diminish the publicly funded system. It contrasts *Chaoulli* with courts' dismissals of claims for *Charter* protection of minimal social and economic security, despite the profound effects of the latter on health status. It concludes by noting *Chaoulli* is one more example of the increasing prevalence of discourse normalizing privatization and individual responsibility in policy justifications.

Cet article examine les conséquences qu'exercera le jugement rendu dans l'affaire *Chaoulli c. Québec (A.G.)* sur la politique de santé canadienne. L'auteur s'interroge pour savoir si les gouvernements sont susceptibles de renforcer l'assurance santé, étant donné la performance passée et l'option de sortie que présente *Chaoulli*. L'article analyse les conséquences d'une augmentation des soins privés et de l'assurance privée, et conclut que cela affaiblira le système que financent les deniers publics. Il oppose le jugement *Chaoulli* aux déboutés que prononcent les tribunaux dans les procédures relatives à la protection, aux termes de la Charte, du minimum de sécurité sociale et économique, malgré les effets profonds de ces dernières sur le statut de la santé. Pour conclure, l'article note que l'affaire *Chaoulli* représente un nouvel exemple de la prédominance grandissante du discours normalisant la privatisation et la responsabilité individuelle, qui vise à justifier les politiques.

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Chaoulli v. Quebec (AG)[1] is a troubling decision, both because of the majority's problematic interpretation and application of the *Canadian Charter of Rights and Freedoms*,[2] and because of the impact the decision will have on publicly funded health care. While there is much to criticize in the majority's legal analysis, this article focuses on an even greater concern: the implications of the decision for the future of Canadian health policy. I begin by situating the decision in the context of the Canadian health care system, outlining developments since *Chaoulli* in law, politics, policy, and the professions, and then consider how the decision is likely to affect the organization of the health system and access to care. The prevailing focus on acute care in health services and policy fails to take into account the important influence of broader determinants of health on health status, especially social, economic, and environmental factors that are often beyond individual control. This omission is evident in law as well, in the consistent rejection of legal challenges seeking to protect even minimal economic and social supports when government action clearly harms the health and well-being of vulnerable populations. I examine the marked contrast between these cases and the Court's readiness in *Chaoulli* to overturn government policy seen as negatively affecting the health and well-being of a different population—those able to pay privately for health care. I conclude by noting how *Chaoulli* demonstrates the growing influence of discourse that normalizes privatization and self-reliance in policy justifications.

I. SITUATING THE DECISION IN THE HEALTH CARE LANDSCAPE

In order to assess what *Chaoulli* means for the future, it is important to understand the broad outlines of the existing funding arrangements and policy context in health care. The bulk of constitutional jurisdiction over and responsibility for health care rests with the provinces. While the federal government has some areas of

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[1] [2005] 1 S.C.R. 791 [*Chaoulli*].

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

direct responsibility, its power over health care is primarily indirect, exercised largely through its spending power. At present, approximately 70 per cent of total health care expenditures in Canada are paid from public funds, while the remaining 30 per cent are covered by the private sector, a figure that has been increasing slowly for some time.[3] Of the 130 billion dollars spent on health care in 2004, public spending accounted for 91 billion dollars; the remaining 39 billion dollars came from private sources, split almost evenly between private insurance and out of pocket spending.[4] Canada funds hospital and physician services almost entirely (98 per cent) through public monies,[5] as well as First Nations health care, public health programs, and part of the cost of other services such as home care, extended care, prescription drugs, and ambulances.[6] Public expenditures on health care have been increasing steadily in recent years, following an unprecedented five-year period of decreases in the mid-1990s; indeed, they grew more rapidly in constant dollars from 1998-1999 to 2003-2004 than at any time since 1975-1976.[7] Private expenditures on health care by insurers and individuals have been growing even more rapidly than public expenditure.[8] Most private expenditures are for drugs, dental care, and vision care.[9] Looking at Canada in a comparative context, private sector funding accounts for

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[3] Canadian Institute for Health Information, *Exploring the 70/30 Split: How Canada's Health Care System is Financed* (Ottawa: Canadian Institute for Health Information, 2005), online: <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1282_E&cw-topic=1282> at vii [CIHI, *70/30 Split*]. In 1994, private expenditures accounted for 28 per cent of health spending (*ibid.* at 6).

[4] *Ibid.* at 18-19. Canadians paid about $17 billion out of pocket for health services in 2002 (*ibid.* at 7).

[5] *Ibid.* at 6.

[6] *Ibid.* at 18-19. Among provincial and territorial governments, approximately 61 per cent of health expenditures are allocated to programs associated with services covered by the *Canada Health Act*, R.S.C. 1985, c. C-6 [*CHA*]. For instance, hospitals account for 42.3 per cent and physician services account for 19.6 per cent. A further 10.5 per cent goes to institutions other than hospitals, 9.1 per cent to drugs, 5.8 per cent to public health, 1.8 per cent for administration, and 4.9 per cent to capital. See Canadian Institute for Health Information, "Preliminary Provincial and Territorial Government Health Expenditure Estimates, 1974-1975 to 2005-2006" (November 2005), online: <http://www.cihi.ca> at 19 [CIHI, "Health Expenditure Estimates"]. These percentages do not include direct federal expenditures on health care.

[7] *Ibid.* at 2-3. The 2005-2006 forecast is approximately $2 per capita less than the amount that would have been realized if the trend prior to 1993-1994 had continued without the five years of decreases (*ibid.*).

[8] CIHI, *70/30 Split*, *supra* note 3 at vii.

[9] *Ibid.* at 19. Governments bear part of those costs indirectly, through tax revenues foregone.

between one-fifth and one-third of health expenditure in most OECD countries.[10] With 30 per cent of health expenditures being private, Canada falls within that range, although the mix of what is paid for privately and the constraints on practice, practitioners, and patients differ considerably among countries.

A majority of Canadian provinces prohibit duplicative private insurance: private insurance for hospital and physician services that are considered medically necessary and therefore, publicly funded.[11] In keeping with the requirements of the *Canada Health Act*, provinces must cover these services under their public health insurance plans in order to receive full federal cash transfers.[12] Whether or not private insurance is prohibited, provinces have generally adopted measures to prevent subsidy of private practice by public plans.[13] In *Chaoulli*, however, four of the seven judges concluded that Quebec's prohibition on the purchase of private health insurance in circumstances where needed health care services were not available in reasonable time in the publicly insured system breached the Quebec *Charter of Human Rights and Freedoms*;[14] three of the four also held that it breached section 7 of the *Charter*.[15] The three dissenting judges held that neither of the Charters were breached by prohibiting private insurance for health services that were publicly insured.

II. DEVELOPMENTS SINCE *CHAOULLI*

On application, the Supreme Court of Canada granted Quebec a twelve-month stay before the judgment in *Chaoulli* will come into effect.[16] That breathing room will allow the province and the rest of Canada time to formulate their responses. Health care, policy and law

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[10] *Ibid.* at 4.

[11] *Supra* note 1 at 833, Deschamps J.

[12] See *CHA*, *supra* note 6, s. 7.

[13] Colleen M. Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 Can. Med. Assoc. J. 825.

[14] R.S.Q. c. C-12 [Quebec *Charter*].

[15] Deschamps J. limited her decision to finding that the ban breached the Quebec *Charter*. McLachlin C.J.C. and Major J., with Bastarache J. concurring, held that the ban on private insurance breached s. 7 of the *Charter* and also concurred with Deschamps J.'s judgment on the Quebec *Charter*.

[16] *Chaoulli c. Quebec (Procureur général)* (2005) 2005 Carswell Que 5795 (eC).

have not stood still in the interim, however. This section reviews the most germane developments.

A. *Law*

On the legal front, the court was soon faced with another attempt to challenge the delivery and funding of health care in *Cilinger c. Quebec (Procureur général)*.[17] In that case, the Quebec Court of Appeal had rejected a class action against the provincial government, while allowing it to proceed against hospitals, based on allegations of breach of duty for failure to provide timely treatment for women diagnosed with breast cancer.[18] The court denied leave to appeal. Elsewhere in Canada, in *Jane Doe 1 v. Manitoba*,[19] the Manitoba Court of Appeal overturned a summary judgment that required the provincial government to pay for abortions in private clinics. The lower court had held that limiting provincial health insurance coverage for abortions to those performed in public hospitals breached women's *Charter* rights, since abortion, a medically necessary service, could not be accessed in a timely manner in those facilities. The Court of Appeal concluded that the matter was not appropriate for summary judgment, but rather, in light of the complex and evolving *Charter* issues raised and their significant policy implications, required a full trial to allow for development of a more complete evidentiary record.[20] Other lawsuits attacking various aspects of the health care system are underway as well.

B. *Politics*

Moving from law to politics, the federal government continues to vow that there will not be two-tier health care in Canada. Beyond that, prior to the election call, it did little more than point to the 2004 Health Accord and accompanying 41.3 billion dollars in federal money already earmarked for the provinces. In addition, efforts to ensure that provinces develop wait-time benchmarks in five areas culminated in a

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[17] [2004] C.S.C.R. 582.

[18] [2004] R.J.Q. 2943 (C.A.).

[19] [2005] M.J. No. 335 (C.A.), rev'g in part (2004), 248 D.L.R. (4th) 547 (Q.B.) [*Jane Doe 1*].

[20] *Ibid.*

December 2005 announcement of national standards for maximum wait times in those areas.[21] Health care played a muted role in all parties' election campaigns. For their part, provinces are considering their options, although only Alberta greeted the decision with enthusiasm. Quebec announced it would not respond to *Chaoulli* until after the federal election.

C. *Policy*

Meanwhile, policy papers continue to proliferate, as they have for years now. In Quebec, the Menard Commission Report on improving Quebec's health care system, tabled in July 2005, recommended increasing private sector involvement in health care (at least in service delivery), introducing "loss of autonomy" insurance, and tax increases to pay for medicare.[22] Alberta, having hailed the *Chaoulli* decision, continues to flesh out a "Third Way" option to allow more scope for private health care; with a federal election looming, however, it became reticent about its plans.[23] A focus on wait times characterized much work in the non-government sector. Canadian Policy Research Networks produced their second annual cross-Canada check-up on provincial progress in developing uniform indicators of the need for

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[21] Health Canada, News Release, "First Minister's Meeting on Future of Health Care 2004: A 10-year plan to strengthen health care" (16 September 2004), online: <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html>. The 2004 Health Accord includes commitments by First Ministers to have evidence-based benchmark wait times for cancer, heart, diagnostic imaging procedures (MR/CT scans), joint replacements, and sight restoration (cataracts) by 31 December 2005. Indications at the time of writing in late 2005 are that, while there will be limited progress, the task will be far from complete. See Gloria Galloway "Deal Set on Hospital Waiting Times" *The Globe and Mail* (24 October 2005) A1; Ken Pole, "The Challenge of Wait Times" *Medical Post* 41:37 (1 November 2005), online: <http://www.medicalpost.com/opinions/columns/article.jsp?content=20051031_195857_2488>. In November 2005, the Canadian Institutes of Health Research (CIHR) released reports highlighting the paucity of scientific evidence on which to base wait-time benchmarks for cancer, joint replacements, and sight restoration. See CIHR, News Release, "CIHR Releases Research Results to Inform the Development of Benchmarks for Wait Times" (16 November 2005), online: <http://www.cihr-irsc.gc.ca/e/29902.html>. See also Karen Howlett & Caroline Alphonso "Targets Set for Faster Health Care" *The Globe and Mail* (13 December 2005) A1.

[22] Peter Woodford, "Quebec and Alberta Tiptoe Towards Private Healthcare" (2005) 2:15 Nat'l. Rev. Med. 17 at 17.

[23] "'Third Way' Legislation on Hold in Alberta" (2005) 9:41 Health Edition 4.

procedures and efforts to rationalize and reduce waiting lists.[24] The Wait Time Alliance for Timely Access to Healthcare, an amalgam of national medical specialty societies and the Canadian Medical Association, released a report that, although acknowledging the lack of needed data, nonetheless proposed specific wait-time benchmarks by priority level and procedure in the five areas governments had targeted.[25] It also recommended that governments establish a Health Care Access Fund to pay for care obtained elsewhere when provinces did not meet those benchmarks, a suggestion that sparked its own round of critiques.[26]

D. *Professions*

Reaction to *Chaoulli* from health care providers' professional organizations has been mixed. The Canadian Nurses Association urged Canadian governments to resist pressures to allow more private sector involvement and encouraged its members to advocate for the sustainability of the publicly funded, not-for-profit health care system, noting that despite the frustration of all involved, allowing more private care "is a short-sighted decision that flies in the face of the evidence."[27] The Canadian Medical Association, however, lost little time in endorsing an expanded role for privately funded health care services. At its Annual General Meeting in August 2005, despite a pro forma nod to supporting medicare with a resolution that access to care should be based on need and not ability to pay, delegates voted by a margin of two to one in favour of "the principle that when timely access to care cannot be provided in the public system, the patient should be able to utilize private health insurance to reimburse the cost of care obtained in the

[24] Tom McIntosh, *The Taming of the Queue II: Wait Times Measurement, Monitoring and Management* (Ottawa: Canadian Policy Research Networks, 2005), online: Canadian Policy Research Networks <http://www.cprn.ca/en/doc.cfm?doc=1274> [CPRN, *The Taming of the Queue II*].

[25] Wait Time Alliance for Timely Access to Health Care, *It's About Time! Achieving Benchmarks and Best Practices in Wait Time Management* (Ottawa: Canadian Medical Association, 2005) at 3, 5 [Wait Time Alliance].

[26] See *e.g.* Barbara Sibbald, "Benchmarks for 'scheduled' cases unwise, experts say" (2005) 173 Can. Med. Assoc. J. 742.

[27] Deborah Tamlyn, "Message from the President" (2005) 101:8 Can. Nurse 12 at 12, online: <http://cna-nurses.ca/CNA/documents/pdf/publications/Access_Oct_2005_e.pdf>.

private sector."[28] They voted 198 to six to develop policy principles to "define and guide the relationship between the public and private sectors in delivery and funding of health care in Canada."[29] As Canadian health economist Robert Evans has pointed out, privatizing health care financing and delivery aligns with physicians' economic incentives:

> The loud voices for privatization ... come from those who believe that they could do better, in the form of increased sales or higher prices for their products or services, in a more entrepeneurial environment. It is not clear how many, if any, of these would support a *truly* private system, with no direct or indirect contribution of public funds... . Instead, what seems to be contemplated is a continuation of public support on a large scale, but without limits on private fee setting or delivery, or private insurance—rather like the United States, in fact, before "managed care."[30]

These observations seem particularly salient to the Wait Time Alliance proposal for a government-funded Health Care Access Fund described earlier,[31] since it would not be subject to the supply-side controls on practitioners and services that provincial governments have imposed as a way to constrain health care costs. They are also germane to any assessment of care guarantees, promised during the election campaign, that would provide financial support for patients to obtain treatment in another jurisdiction when unavailable in their home jurisdiction within a medically acceptable timeframe. They have the potential to encourage increased privatization in service delivery, and significantly decrease governments' ability to control the cost of services, since they would be outside the fee schedules governments negotiate or impose on providers and institutions. Evans notes that hospital workers, on the other hand, "whose patients tend to be very ill and/or have very limited resources" (and therefore, limited ability to pay privately), are generally very supportive of public payment systems, although they resist hospital downsizing or cost containment more generally, consistent with an interest in maintaining or increasing their incomes, along with a

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[28] Matt Borsellino, "2005 CMA meeting was one for the ages" *Medical Post* 41:29 (6 September 2005) at 1.

[29] *Ibid.* See also Sacha Bhatia & Adam Natsheh, "Should Canadian physicians support parallel private health care?" (2005) 173:8 Can. Med. Assoc. J. 901.

[30] Robert Evans, "Health reform: What 'business' is it of business?" in Daniel Drache & Terry Sullivan, eds., *Market Limits in Health Reform: Public Success, Private Failure* (London: Routledge, 1999) 25 at 36 [Evans, "Health Reform"] [emphasis in original].

[31] *Supra* note 25.

concern for the delivery of effective and timely care.[32] Clearly, economic explanations alone are not sufficient. Health care workers are certainly motivated by more than economic incentives—most notably, by concern for patients. However, economic self-interest does play a role in the health care policies particular groups advocate. The alignment between economic incentives and providers' preferred policy solutions is properly taken into account when evaluating the proposals they advance.

III. TAKING STOCK

I turn now to consider what *Chaoulli* will mean for the future of health care. Political scientist Carolyn Hughes Tuohy has pointed out that, although stresses have become more evident, the Canadian health care system overall has been characterized by "extraordinary structural and institutional stability" for years, and that health policy development has brought about only incremental alterations to the basic institutional mix and structural balance.[33] *Chaoulli* has the potential to alter that pattern substantially. Questions about the directions in which Canadian health policy will develop now abound. An immediately pressing one is whether it is time for us all to find cover—private insurance cover?

The one prediction that can be made with certainty after *Chaoulli* is that there will be more litigation. The Court was evenly divided on whether Quebec's prohibition of private insurance breached the *Charter*, with Justice Deschamps expressing no opinion on that issue. The standard propounded by Chief Justice McLachlin and Justice Major, joined by Justice Bastarache—health care of a reasonable standard within a reasonable timeframe—provides a vague threshold at best.[34] How it will apply in different circumstances is far from self-evident. Justice Deschamps' judgment carried the day, but she based her decision only on the Quebec *Charter*. Although provincial health insurance statutes are typically drafted with an eye to satisfying the conditions in the *CHA* that provinces must meet to qualify for full

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[32] Evans, *"Health Reform," supra* note 30.

[33] Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999) at 204. Tuohy summarizes at 33: "[T]he basic structure of Canada's 'internal market,' the balance between public and private finance, and, most significantly, the influence of the medical profession and the importance of collegial mechanisms of decision-making remain essentially unchanged."

[34] *Supra* note 1 at 843-44.

federal cash transfers, *Chaoulli* itself involved only a challenge to Quebec legislation, and not to either the *CHA* or the provincial laws preventing physicians from working in both the private and public systems. Although all provinces limit private sector overlap with services that are publicly insured, as Justice Deschamps noted in *Chaoulli*, not all do so in the same way, potentially raising different issues in different jurisdictions.[35] Apart from the issue of private health insurance, the proliferation of private clinics in Canada had sparked lawsuits attempting to force governments to crack down on alleged violations of the *CHA* and provincial legislation; these challenges will continue.[36] The British Columbia Nurses Union, for instance, had already begun legal proceedings seeking to force the provincial government to enforce its own health insurance legislation and prohibit private clinics from charging patients for publicly insured services. Emboldened by *Chaoulli*, not only were a number of those clinics reportedly considering seeking intervenor status to argue that patients' *Charter* rights override the provincial legislation, and so, the practice should be allowed, but many also have announced ambitious plans to establish for-profit clinics across Canada that would allow private payment regardless of public coverage.[37] *Charter*-based challenges to exclusions from provincial health insurance plans will also continue, claiming not that patients should be free to purchase services or insurance privately, but rather that more, or more timely, or more widely available services must be covered under public health insurance plans, on the basis that both the *CHA* and patients' *Charter* rights are breached when provincial health insurance fails to cover medically necessary services.[38] In sum, we can

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[35] *Ibid.* at 831-33, Deschamps J.

[36] See *e.g. Canadian Union of Public Employees v. Canada (Minister of Health)* (2004), 244 D.L.R. (4th) 175 (F.C.T.D.).

[37] Elaine Carey "Private surgery in the city?" *Toronto Star* (3 December 2005) A24; Myron Love, "*Chaoulli* in Action: Manitoba Private Clinic Buys its Own MRI, Challenging Governmental Policy" *Medical Post* 41:41 (29 November 2005), online: <http://www.medicalpost.com/news/aritcle.jsp?content=20051127_205836_4484>; and Matthew Sylvain, "Private Options Coming East" *Medical Post* 42:3 (24 January 2006), online: <http://www.medicalpost.com/news/article.jsp?content=20060123_205722_4776>.

[38] See *e.g. Jane Doe 1*, *supra* note 16; Lisa Priest "Transplant Patient to Invoke Charter" *The Globe and Mail* (7 December 2005) A17 (*Charter* challenge to Ontario's refusal to pay for out-of-country liver transplant for a cancer patient); and Ingrid Peritz "Morgentaler Lashes out at Tories on Abortion" *The Globe and Mail* (17 January 2006) A8 (class action suit in Quebec challenging its decision to only partially cover fees for abortions in private clinics).

anticipate (and indeed, are already seeing) many lawsuits about what *Chaoulli* means, its application in the rest of Canada, and its implications for expanding public health insurance.

IV. HEALTH POLICY: THE SHAPE OF THINGS TO COME

Beyond more litigation, *Chaoulli* may herald an end to provincial governments' monopsony power as single payer for most hospital and physician services, as well as a beginning to private insurance that duplicates public system coverage. Will it provide the impetus for radical change to the Canadian health care system, or can the publicly funded system be reinforced and *Chaoulli* accommodated without such a major break? The answer will depend on political will. In broad terms, the response may take one of three directions: resistance, acquiescence, or welcome. Examining and assessing policy developments and government initiatives in the past can assist in predicting future directions. To date, with the exception of Alberta, governments' rhetoric across Canada would certainly indicate that they intend to reinvigorate the publicly funded system. Will that be the reality? Given past government performance, the answer is not as clear as the fervent avowals of support for the public system might lead one to believe.

Since the passage of the *CHA*, the federal government has never withheld cash transfers to any provincial government because it was failing to comply with the act's five conditions to qualify for full federal cash transfers—portability, accessibility, universality, comprehensiveness, and public administration—although it has done so on occasion when provinces have permitted extra billing or user fees.[39] That would not be problematic if provinces were complying with those five statutory requirements. However, blanket assertions of adherence to the *CHA* are difficult to credit due to long-standing troubling practices. These include Quebec's refusal to pay out-of-province physicians in accordance with their home province pay scales (contrary to the requirements of portability), numerous allegations of charging privately for services covered by public insurance, and providing quick access to services for

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[39] Office of the Auditor General of Canada, "Health Canada: Federal Support of Health Care Delivery" in *2002 Status Report*, c.3, online: 2002 Reports of the Auditor General of Canada <http:// www.oag-bvg.gc.ca/domino/reports.nsf/html/20020903ce.html>.

private payment (challenging comprehensiveness and universality), and a long list of others. Even so, federal inaction on cash transfers would not be problematic if breaches were being resolved and compliance ensured as a result of negotiations between the federal government and the province concerned. But that has not occurred either.[40] Why is this? The federal Auditor General reported in 2002 that Health Canada was reluctant to pursue suspected non-compliance vigorously, in part out of a concern that provinces will simply choose to absorb the cost of penalties imposed.[41] Reluctance to disrupt federal-provincial relations must also play a major role. With this record, there is good reason to doubt the federal commitment to protecting and upholding the publicly funded health care system and the terms of the *CHA* in practice.

What of the provinces? Despite statements strongly supporting single-tier health care provided on the basis of need and not ability to pay, the possibilities opened by *Chaoulli* have to be sorely tempting. Governments are faced with rising health care costs and demands to provide a constantly expanding array of services, technologies, and drugs. Robert Evans has argued clearly and persuasively for years that the least demanding response for those with the responsibility to pay rising health care costs, like governments, is not to contain them (a politically unpopular move, not only with patients, but also with providers who derive their income from services rendered), but to transfer those costs to other payers, be they individuals or private insurers.[42] By doing so, governments avoid the painful political fallout from "denying" care and can reduce their own health care costs. Health care costs overall, however, are not reduced, and in fact, are quite likely to increase, both because of the cost of paying for multiple plan "administrations," and because the bargaining power of a single payer

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[40] There were indications of a willingness to act on this front in mid-2005 when the federal government and New Brunswick appeared set to take their disagreement over whether the province's refusal to fund abortions in private clinics breached the *CHA* to a dispute resolution panel under the Social Union Framework Agreement. However, no panel had been appointed by the time the federal election was called, and the new Conservative government has not yet responded to queries about whether it will continue to press that issue. See Richard Rolk "Tories Don't Know if They'll Force Province to Pay for Abortions at Morgentaler Clinic" *New Brunswick Telegraph-Journal* (17 January 2006) A4, cited in "News Shorts" (2006) 10:3 Health Edition 3 at 3.

[41] *Supra* note 39 at 9-12.

[42] "Tension, Compression and Shear: Directions, Stresses and Outcomes of Health Care Cost Control" (1990) 15 J. Health Pol. 101.

will have been lost.[43] Even before *Chaoulli*, provincial governments had undertaken a number of initiatives to limit the services for which they were responsible, and to shift costs to private sources. Examples include de-listing services from public health insurance plans, discharging patients from hospitals to home "sooner and sicker" with responsibility to pay for their own drugs and other care, and encouraging private clinics that provide both insured and uninsured services with blurred distinctions between the two.[44] In Alberta, private clinics are permitted to package "enhanced" services that patients can purchase as alternatives or additions to those publicly funded. It recently ended many of the restrictions on what procedures private clinics can perform and how much they can charge for uninsured services, doing away with much of the regulatory oversight.[45] Governments are also increasingly reluctant to expand public health insurance by adding new services.

Shifting responsibility for health services and costs out of the public realm will have significant effects. Many of these have been catalogued and analyzed extensively elsewhere; what follows is a brief summary of the most salient.[46] First, as explained previously, without the discipline of a single payer and administration, overall health care costs will increase. Second, those who pay privately for diagnostic services will "queue jump" back into the public system, with the result that ability to pay (in the private system) will be a factor affecting access to services (in the public system). Third, limited personnel will be drawn

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[43] *Ibid.*; Robert Evans, "Preserving Privilege, Promoting Profit: The Payoffs from Private Health Insurance" in Colleen 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) 347 at 361-65 [Evans, "Preserving Privilege"].

[44] Joan Gilmour, "Regulation of Free-Standing Health Facilities: An Entrée for Privatization and For-Profit Delivery in Health Care" [2003] Health L.J. (Special Ed.) 131 at 138-39.

[45] "Critics say province has removed restrictions on private clinics" *CBC Edmonton* (20 July 2005), online: CBC News <http://www.cbc.ca/edmonton/story/ed-health-klein20050720.html>. Prior to a recent provincial Order-in-Council, enhanced services (for which patients pay privately) were covered by Schedule 2 of the *Health Care Protection Act*, which provided that procedures had to be government-approved and limited profit margins (*ibid.*).

[46] See Joan Gilmour, "Creeping Privatization in Health Care: Implications for Women as the State Redraws Its Role" in Brenda Cossman & Judy Fudge, eds., *Privatization, Law and the Challenge to Feminism* (Toronto: University of Toronto Press, 2002) 267 at 284-86, and references cited therein [Gilmour, "Creeping Privatization"]; Robert Evans *et al.*, *Private Highway, One Way Street: The Deklein and Fall of Canadian Medicare* (Vancouver: University of British Columbia Centre for Health Services and Policy Research, 2000).

to work in the private sector where fees charged are not subject to government control or caps. Patients in the public system will be left waiting longer for the fewer and less available personnel. Fourth, private clinics can be expected to "cream skim" both more lucrative procedures and lower cost, less complicated patients. If complications result from private treatment, patients will be sent back to publicly funded facilities for treatment at public expense. Fifth, practitioners, hoping to attract clients to pay more privately for services that are also publicly funded, will have little incentive to ensure that patients can readily access services of high quality through the public system; in fact, quite the opposite will occur. It will be in their interests if the public system is, or appears to be, slow or otherwise inferior in quality. Sixth, governments' and health administrators' ability to manage caseload and direct resources, including personnel, to particular types of care will be weakened. Private clinics and care will concentrate on what people who can pay want, and that will most easily provide a high return to providers—hip replacements, executive physicals and gold-plated family practice, MRIs (whether medically necessary or simply to assuage the concerns of the "worried well"), and so on. They will not focus on more complex, chronic, or less lucrative care, such as attending to the treatment needs of older people who are failing, suffering from pneumonia, heart failure, and strokes.

Depending on how widely its invitation to privatization is read, *Chaoulli* has the potential to accelerate these developments. The result will be more limited availability of publicly funded services and a public health care system diminished on a number of fronts. However, in *Chaoulli*, Chief Justice McLachlin *et al.* concluded that ending the ban on duplicative private insurance would "permit ordinary Canadians to access health care in circumstances where the government is failing to deliver."[47] That result is far from assured. Recall the issue in *Chaoulli*: access to private health insurance. Insurance plans provide a pre-set package of coverage and services at a price and subject to conditions of eligibility that an insurance company offers. Even though private health insurance can be controlled to a greater or lesser extent by regulation, as it is in other jurisdictions (for instance, requiring community rather than individual risk ratings), the "faster access to better health care services"

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[47] *Supra* note 1 at 850, McLachlin C.J.C. and Major J.

that it is supposed to offer will be limited. First, it will be limited to those who can pay for it. In *Chaoulli*, Justice Deschamps acknowledges this forthrightly: "the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state."[48] Many will not be able to afford it. Second, there will be individuals whose pre-existing health conditions are sufficiently serious that they are not a good business risk for insurance companies. They may be precluded from obtaining private health insurance. These two factors are interrelated. Systems with a large private financing component are highly regressive, requiring people at lower incomes to contribute a larger share of their incomes.[49] As Evans has pointed out, this result is magnified because needs for care are consistently inversely correlated with income: that is, the wealthy are healthier, and need and use fewer services.[50] This observation applies to private health insurance too: premiums reflect individuals' risk status (their expected use and cost of care), and will tend to be higher—requiring a higher percentage of income—in lower income classes. Both these factors mean that for many ordinary people private health insurance will not be a realistic possibility. One will either need to be wealthy and healthy enough to qualify, or the insurance market will have to be heavily regulated.

If duplicative private health insurance is allowed, most who obtain it will do so through employment, as is presently the case with extended health benefits plans.[51] Realistically, what is included in the package of insured services will be the choice of the employer, not of the individuals.[52] Plans are likely to include services particularly popular with baby boomers and highlighted in the media, such as knee and hip replacements, and MRIs. However, as Jonathan Oberlander has

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[48] *Ibid.* at 806-07.

[49] This result is not so marked if private insurance is just a "top-up" to a well-functioning and extensive public system, because then fewer poor people buy private insurance (Evans, "Health Reform," *supra* note 30 at 33).

[50] Evans, "Preserving Privilege," *supra* note 43 at 355; Evans, "Health Reform," *supra* note 30 at 32.

[51] CIHI, *70/30 Split, supra* note 3 at 7. This is consistent with other OECD countries surveyed that have significant levels of private health insurance.

[52] While theoretically open to negotiation between employer and employee, in practice that is not likely to occur outside a unionized environment or with very senior levels of employee.

observed in commenting on the situation in the United States, where private health insurance already plays a major role in funding health care, American employers "are much more likely to select insurance on the basis of price than on the basis of quality."[53] The much-vaunted ability to control one's own health care that is said to come with private health insurance[54] will not be controlled by the choices of the individual, but rather of the employer, and it will not be particularly free or unfettered, but highly price-dependent. Also, the availability of private insurance will not end conflicts over whether health care services are "medically necessary" or not, or "experimental" and unfunded or not. One look at the many lawsuits in the United States challenging refusals of coverage by managed care plans and health insurers shows that decisions about private coverage will be contentious as well. Private health insurance is not a panacea.

The preceding section has traced one possible set of responses in the aftermath of *Chaoulli*—essentially, a continuation and intensification of governments' efforts to shift responsibility for the cost and provision of health care to others. There are other approaches governments could take that would evince a genuine commitment to preserving and strengthening the public system, and trying to preserve equity and fairness in the provision of health care. There are real and serious problems with unmet need and under-capacity that need to be addressed. Avenues to explore include identifying, developing and disseminating best practices in wait-time management and service delivery;[55] re-organizing health service delivery to optimize use of existing resources and personnel, unfettered by restrictions on scope of practice and workplace organization determined to be unnecessary;[56] carefully controlling the rise of private clinics to ensure services

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[53] "The US Health Care System: Road to Nowhere?" (2002) 167 Can. Med. Assoc. J. 163 at 167.

[54] See *e.g. Chaoulli, supra* note 1 at 850, McLachlin C.J.C. and Major J.

[55] Candidates include Ontario's consolidated list for cardiac care, Saskatchewan's management of surgical wait-lists, and the Western Canada Waiting List project. See CPRN, *The Taming of the Queue II, supra* note 24.

[56] Relative to personnel, greater and better use could be made of nurse practitioners and physician assistants; relative to workplace organization, Alberta recently reported success in reducing wait times for hip and knee replacements by streamlining assessment processes and dedicating surgical facilities and funds to those procedures. See Dawn Walton "Alberta Slashes Wait Times on Some Surgeries" *The Globe and Mail* (20 December 2005) A1.

provided are publicly funded and meet needs identified in and by the public system; and finally—the most intractable problem—determining how to decide what should and should not be publicly funded.[57] All are important to providing quality care in the public system.

V. BROADER DETERMINANTS OF HEALTH

The focus on acute medical care militated not just by the facts that gave rise to *Chaoulli*, but by the gravity and immediacy of many acute medical problems, coupled with the structure of medicare, squeezes out consideration of the effects of broader determinants of health and the importance of working to ameliorate the conditions that cause poor health. Social, economic, and environmental factors affect health status profoundly.[58] Research has established that not just absolute disparities, but especially, the scale of relative income inequities and social and economic differences within a society are very significant determinants of population health.[59] Even with relatively comprehensive insured medical and hospital services having been in place for decades, there is a stubbornly persistent "health gap" between rich and poor: well-off Canadians live longer and healthier lives than low-income Canadians.

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[57] This would require assessment both of how decisions about new services should be made and of whether existing coverage should be continued. As Timothy Caulfield points out, coverage decisions initially reflected existing lists of services physicians provided, and then in the expansionary economic climate of the times, were expanded to include what physicians requested: "Wishful Thinking: Defining 'Medically Necessary' in Canada" (1996) 4 Health L.J. 63.

[58] Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Final Report*, vol. 6, part VI "Health Promotion and Disease Prevention," chapter 13, "Healthy Public Policy: Health Beyond Health Care" (Ottawa: Standing Senate Committee on Social Affairs, Science and Techonology, 2002) at 239-40 (Chair: Michael L. Kirby) [*Kirby Report*]. The report notes that, while the health care system is clearly an important contributor to good health, the estimated impact of the health care system on the health status of the population is 25 per cent:

> The remaining 75% of the health of the Canadian population is determined by a multiplicity of factors outside the health care system. These ... include: biology and genetic endowment; income and social support; education and literacy; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender; and culture.

[59] See *e.g.* Richard Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996); Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians* (Ottawa: Health Canada, 1999) at 184-85.

Despite having accepted the accuracy of this observation and having committed to reducing inequities in society for some time, governments have not translated that commitment into action. Rather, government policy has in many instances worsened economic and social insecurity and inequality. As Joan Gilmour and Dianne Martin note:

> Far from reflecting the clear identification of reduced access to social and economic resources for those least well off as having a significant negative effect on health status, the changes [governments] actually implemented for the most part have been consonant with a government agenda of restructuring and privatization. Through these processes, governments have drastically reduced their economic role, cutting back on social spending and increasingly promoting private self-reliance.[60]

To see evidence of this, one need only consider the 20 per cent reduction in welfare rates in Ontario in the mid-1990s, or the Quebec government's welfare reform initiative that reduced benefits people under the age of thirty could receive from 424 dollars per month to 173 dollars per month if they did not participate in job training programs. Both these decisions were challenged in court. In *Masse v. Ontario (Ministry of Community and Social Services)*, the court declined to inquire into what it termed a "policy/political" decision in any substantive way, stating: "the intractable economic, social and even philosophical problems presented by public welfare assistance programs are not the business of the Court."[61] The Quebec decision *Gosselin v. Quebec (Attorney General)*[62] was appealed to the Supreme Court of Canada. It held that there was no breach of individuals' rights to life, liberty, and security of the person, and no breach of equality rights when the state reduced welfare payments to levels grossly inadequate to support life.[63] In both these cases, courts declined to interfere with the government action, essentially holding that whether welfare recipients received sufficient support to survive or not was a policy decision for governments to take. The contrast with *Chaoulli* is striking. In that case,

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[60] "Women's Poverty, Women's Health: The Role of Access to Justice" in Penny Van Esterik, ed., *Head, Heart, and Hand: Partnerships for Women's Health in Canadian Environments*, vol. 1 (Toronto: National Network on Environments and Women's Health, 2003) 353 at 358.

[61] *Dandridge v. Williams* (1970), 90 S. Ct. 1153 at 1163, cited in *Masse v. Ontario (Ministry of Community and Social Services)* (1996), 134 D.L.R. (4th) 20 at 42 (Ont. Gen. Div.), O'Driscoll J., leave to appeal refused, [1996] O.J. No. 1526 (C.A.) (QL).

[62] [1999] R.J.Q. 1033 (C.A.).

[63] [2002] 4 S.C.R. 429.

the majority saw no difficulty in overturning the government's policy choice. Finding that the prohibition against private health insurance resulted in "psychological and emotional stress and a loss of control by an individual over her own health,"[64] a "difficulty" that met the threshold requirement that it be "serious," Chief Justice McLachlin, and Justices Major and Bastarache held that it breached section 7 of the *Charter*, and hence, it could not stand.[65]

Effective action to improve the broader determinants of health is important, not just to the future of the health care system, but to our future health. It is a tremendously difficult challenge. As the *Kirby Report* pointed out, "Despite the available evidence, no jurisdiction in Canada and no country in the world has designed and implemented programs and policies firmly based on a population health approach."[66] Practical obstacles include the difficulty in associating cause and effect because of the multiplicity of factors that influence health status (often over long periods of time), the resulting lack of short-term political gain that would make action more attractive to politicians, and the difficulty of coordinating activities across many levels of government and areas that influence health status. Additionally, the commitments needed extend beyond government to non-government entities and individuals. However, acknowledging that the goal is difficult to achieve does not excuse inaction, or worse yet, regressive policies. Even without a complete picture of all the factors that affect population health status and how they interact, we do know with certainty that people who are poor on the whole live shorter lives and suffer a disproportionate share of illnesses and disabilities. We have the ability to provide a measure of real economic and social security to all Canadians and to ameliorate the conditions of their lives. Preserving access to a comprehensive range of health services that are publicly insured is one crucial component to preventing the health of those already most disadvantaged in society from deteriorating even further. This is threatened by introducing private parallel health insurance. However, access to health service alone is not enough to address the health gap between those who are better off and worse off in society. We also need to tackle the social and

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[64] *Supra* note 1 at 850.

[65] *Ibid.*

[66] *Supra* note 58 at 251.

economic conditions that significantly contribute to ill health. Unfortunately, as this brief review of the law makes clear, legal challenges attempting to force governments to do so, in even minimal ways, have had little success.

VI. CONCLUSION

Returning to *Chaoulli*, the decision has the potential to accelerate the privatization in health care that is already underway. Governments now have to make a fundamental decision about how far they will use the decision to shift not only their responsibility to pay for health care costs to others, but also, to shift the fallout—the blame for ending single payer health care and the diminished public health care system that will ensue—onto the Court. Early indications from Quebec, the target of the litigation, are that the provincial government may allow private insurance considerable scope.[67] So alarming have its initial pronouncements been that they prompted a quick collective response from a number of Quebec legal experts pointing out that such extensive changes would go significantly beyond what *Chaoulli* requires, especially if they include physicians who have not opted out of the public system.[68]

Public discourse in Canada has long been strongly supportive of our health care system, with its assurance that access to insured services is based on need, and not on ability to pay. However, in recent years a contrary discourse has arisen, emphasizing individual choice about and responsibility for the health care services one uses and for one's own health status. This has been coupled with claims that the health care system is too expensive to be sustainable. These themes of unaffordability and individual responsibility are relied on to justify shifting costs from the public to the private realm.[69] That discourse, which presents increasing privatization as the only sensible policy choice, flies in the face of the understanding that has long marked Canadian society: that in important ways, health care is a collective responsibility, and that efforts to reform the system should be directed

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[67] Rhéal Séguin "Quebec Moves Ahead on Plans for Private Health Insurance" *The Globe and Mail* (11 November 2005) A9.

[68] Henri Brun *et al.* "Privatisation des soins de santé au Québec: Il n'y a pas d''ordre' de la Cour suprême" *Le Devoir* (17 November 2005) A7.

[69] See generally Gilmour, "Creeping Privatization," *supra* note 46 at 267-68.

to initiatives that benefit all Canadians. It is strengthened by continual media reports that foster a climate of fear about the health system's capacity to meet people's needs. These are powerful forces to resist. Rallying to make the case for publicly funded health care is essential. Governments' support for medicare will be strongly affected by the public reaction they anticipate to their policy choices. In light of the disappointing response from the Court in *Chaoulli*, mobilizing political pressure is critical.