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Chaoulli's Legacy for the Future of Canadian Health Care Policy

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Chaoulli's Legacy for the Future of Canadian Health Care Policy

Abstract
In Chaoulli, the majority of the Supreme Court of Canada struck down a Quebec law that prohibited the purchase of private health insurance for essential hospital and physician services. The majority found it to be in breach of the Quebec Charter of Human Rights and Freedoms. The Court was split 3-3 on whether it was also in breach of the Canadian Charter of Rights and Freedoms. The decision was initially considered of limited importance by many given that technically it applied only to Quebec. In the six months since the decision was released, however, it has become clear that the legal impact of Chaoulli will be dwarfed by its normative impact on policy debates across the country. Chaoulli has brought Canadian medicare to a fork in the road. At the time of writing, critical decisions are about to be taken across the country. Unfortunately, the level of debate about public and private insurance that has been sparked by Chaoulli reflects the poor account of public and private insurance dynamics in the Chaoulli decision itself. This article discusses the majority judges' poor appreciation of the interface between public and private health insurance across different health care systems and how, subsequently, this lack of understanding has been reflected in media discussions of policy options. The article also discusses likely future challenges in other provinces before moving on to the most critical aspect of all of this-governmental response and what the future holds for Canadian medicare.

Keywords
Health policy; Canada; Quebec

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CHAOULLI'S LEGACY FOR THE FUTURE OF CANADIAN HEALTH CARE POLICY©

COLLEEN M. FLOOD*

In *Chaoulli*, the majority of the Supreme Court of Canada struck down a Quebec law that prohibited the purchase of private health insurance for essential hospital and physician services. The majority found it to be in breach of the Quebec *Charter of Human Rights and Freedoms*. The Court was split 3-3 on whether it was also in breach of the Canadian *Charter of Rights and Freedoms*. The decision was initially considered of limited importance by many given that technically it applied only to Quebec. In the six months since the decision was released, however, it has become clear that the legal impact of *Chaoulli* will be dwarfed by its normative impact on policy debates across the country. *Chaoulli* has brought Canadian medicare to a fork in the road. At the time of writing, critical decisions are about to be taken across the country. Unfortunately, the level of debate about public and private insurance that has been sparked by *Chaoulli* reflects the poor account of public and private insurance dynamics in the *Chaoulli* decision itself. This article discusses the majority judges' poor appreciation of the interface between public and private health insurance across different health care systems and how, subsequently, this lack of understanding has been reflected in media discussions of policy options. The article also discusses likely future challenges in other provinces before moving on to the most critical aspect of all of this—governmental response and what the future holds for Canadian medicare.

Dans l'affaire *Chaoulli*, la majorité des juges de la Cour Suprême du Canada a annulé une loi du Québec qui interdisait de souscrire une assurance santé privée pour les services des hôpitaux et des médecins. La majorité a constaté que cette loi constituait une violation de la *Charte des droits et libertés de la personne* du Québec. Les avis de la Cour étaient partagés—3 contre 3—quand il s'agit de décider si la loi constituait également une violation de la *Charte canadienne des droits et libertés*. Au départ, l'ordonnance fut considérée d'une importance limitée par de nombreux observateurs car, à proprement parler, elle ne s'appliquait qu'au Québec. Cependant, six mois après l'entrée en vigueur de l'ordonnance, il est évident que les effets juridiques de l'affaire *Chaoulli* seront atténués par ses effets normatifs sur les débats concernant les politiques, débats qui ont lieu partout au pays. L'affaire *Chaoulli* a mené l'assurance maladie canadienne à la croisée des chemins. Au moment de rédiger cet article, des décisions capitales sont sur le point d'être prises dans le pays. Malheureusement, le niveau du débat sur l'assurance publique et de l'assurance privée, déclenché par l'affaire *Chaoulli*, reflète la mauvaise perception, dans l'ordonnance *Chaoulli* même, de la dynamique qui régit l'assurance publique et l'assurance privée. Cet article examine la mauvaise appréciation, par la majorité des juges, du rapport entre l'assurance santé publique et l'assurance santé privée, à travers les différents systèmes de soins de santé et la façon dont, par la suite, ce manque de compréhension s'est reflété dans le débat, au sein des médias, sur les options de politiques. Par ailleurs, l'article discute les futurs défis probables dans les autres provinces, avant de passer au volet le plus critique de l'ensemble: la réaction du gouvernement, et l'avenir de l'assurance santé au Canada.

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I. INTRODUCTION

Much has already been written about the *Chaoulli* decision,[1] but its full policy impact has yet to be played out. Initially, the importance of the decision was considered by many to be limited given that technically it applied only to Quebec. Moreover, the Quebec government could choose to respond not by abandoning single-tier medicare, but through

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

reducing wait times to what the court considers a reasonable length.[2] In the six months since the decision was released, however, it has become clear that the legal impact of *Chaoulli* will be dwarfed by its normative impact on policy debates. Prior to *Chaoulli*, advocates of privatization were discounted as either ideologues or speaking from the perspective of their own vested interests—for example, private clinics that would reap financial gains from further privatization of Canadian medicare. Now, however, these positions have the normative imprimatur of legitimacy (indeed superiority) from no lesser body than the Supreme Court of Canada. The debate has swung widely from when discussion of anything other than public funding was akin to heresy to now, when the only option on the table is private health insurance.[3]

All of this has brought Canadian medicare to a fork in the road. At the time of writing, critical decisions are about to be made across the country. Unfortunately, the level of debate about public and private insurance sparked by *Chaoulli* reflects the poor account of public and private insurance dynamics in the *Chaoulli* decision itself. Below, I will discuss the majority judges' poor appreciation of the interface between public and private health insurance across different health care systems and how, subsequently, this lack of understanding has been reflected in media discussions of policy options. I will then discuss the likelihood of future challenges to legislation in other provinces before moving on to the most critical aspect of all of this—governmental response and what the future holds for Canadian medicare.

II. THE COURT'S GRASP OF HEALTH CARE POLICY

In *Chaoulli*, Justice Deschamps, writing for a slim majority (it was a 4-3 decision), dismissed the Quebec government's claim that the law prohibiting private health insurance is necessary to protect the public health care system. The majority found this law to be in breach of the Quebec *Charter of Human Rights and Freedoms* (Quebec

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[2] Bernard M. Dickens, "The Chaoulli Judgment: Less Than Meets the Eye—or More" in Flood, Roach & Sossin, *ibid.* at 19.

[3] See *e.g. Medicare Schmedicare* (International Documentary Television in association with the CBC, 2005), a documentary filmed in private clinics in Montreal, Toronto, and Vancouver that compared the wait times for those who use private health care services as compared to those who use the public health care system; CBC News, The Passionate Eye, "Medicare Schmedicare" (8 December 2005), online: <http://www.cbc.ca/passionateeye/medicare.html>.

Charter).[4] Justice Deschamps did not rule on the challenge to the Canadian *Charter of Rights and Freedoms*,[5] but the other majority judges (Chief Justice McLachlin and Justice Major, writing for themselves and Justice Bastarache) did. These three judges concluded that, in addition to breaching the Quebec *Charter*, the law was "arbitrary" and thus in breach of section 7 of the *Charter* and could not be saved by section 1. The minority found Quebec's law prohibiting private insurance did not breach either the Quebec *Charter* or the *Charter*. Thus, on the critical issue of the *Charter* (and the application of *Chaoulli* to similar laws in other provinces), the court was split 3-3.

The majority did a quick survey of health care systems around the world. Justice Deschamps' judgment reviewed the health care systems in Austria, Germany, the Netherlands, the United Kingdom, New Zealand, Australia, and Sweden. Drawing on the Kirby report,[6] Chief Justice McLachlin and Justice Major outlined the basics of the Swiss, German, and British systems with passing reference to Australia, Singapore, and the United States. Their primary purpose was to demonstrate that public and private insurance co-exist in a number of jurisdictions. They concluded that "many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are *superior to* and *more affordable* than the services that are presently available in Canada."[7] However, they provided no discussion of the factors that led them to such a damning conclusion.[8]

There are many errors in the majority judgment and many errors in their conclusions vis-à-vis health policy.[9] I will focus on three. First, I will contest the characterization of Canada as an oddity in having a goal

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[4] R.S.Q. c. C-12.

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

[6] 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: Standing Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael J. L. Kirby).

[7] *Chaoulli, supra* note 1 at 854 [emphasis added].

[8] 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 1, 296 at 307.

[9] We discuss these in Flood, Stabile & Kontic, *ibid.*

of preventing a flourishing two-tier system. Second, I will contest the conclusion that Canada's system is inferior to other health care systems. Third, and most seriously, I will discuss the majority's failure to distinguish between countries that allow parallel or duplicate private health insurance (such as would be allowed after *Chaoulli*) and those countries in which private insurance plays a role but not for the purposes of enabling those who hold it to jump wait-list queues. In this context, I will discuss the failure of the majority to consider *why* many countries take a range of legal measures to protect their respective public systems from a duplicate private tier. The primary goal of countries that take these measures is to protect valuable capacity (the work time of specialists and other medical professionals) in the public system—a goal that the majority judges completely dismiss.

A. *Portraying Canada as an Oddity*

The majority judges characterize Canada as an outlier from the rest of the world in prohibiting private health insurance for essential hospital and physician services. But they do not note that Canada tied for third place in the OECD in 2003 with respect to the extent to which private insurance plays a role in financing the health care system.[10] The private sector, both in financing and delivery, plays a very significant role in the Canadian system already. Where Canada differs (although only in six provinces including Quebec) is in explicitly prohibiting private health insurance for "medically necessary" hospital and physician services. But one cannot write off the Canadian health care system on this basis alone as akin to that of Cuba or North Korea.[11]

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[10] Organization for Economic Co-operation and Development (OECD), *Health Data 2005,* CD-ROM: *OECD Health Data 2005: Statistics and Indicators for 30 Countries,* (Paris: OECD, 2005). Figures show that in both Canada and France private health insurance accounts for 12.7 per cent of total health spending. Health care financed by private insurance is highest in the United States, at 36.7 per cent, which reflects the fact that private insurance is the dominant form of coverage in this country. The Netherlands, where private insurance is the primary payer for more than 30 per cent of the population, reports the second highest level of financing at 17.2 per cent. According to OECD statistics for 2003, private insurance accounts for less than 10 per cent of total health expenditure in all remaining OECD countries supplying such information.

[11] The comparison seems to originate from the following opinion piece: David Gratzer, "Wanted: Credible Health Care Analysis" (1998) 7:2 Fraser Institute Canadian Student Review, online: Fraser Institute <http://oldfraser.lexi.net/publications/csr/1998/september/health_care_analysis.html>.

Where Canada does not differ from other countries is in trying to suppress through legal means a flourishing private sector for essential care. As I will discuss further, below in Part II.C, many countries use a range of other indirect methods apart from expressly prohibiting private health insurance in order to protect their public systems. As a result of the majority's misunderstanding of the prevalence of this policy objective, the consequences of *Chaoulli* are much worse than originally envisaged; it provides the basis for some governments (at the time of writing: Quebec, Alberta, and British Columbia) to consider removing the prohibition against doctors working in both the public and private sectors simultaneously. In my view, this law performs a much more important role in protecting the public system than the laws banning private health insurance which were the subject of the *Chaoulli* decision. Indeed, the latter is almost a red herring as evidenced by the fact that some provinces (New Brunswick, Newfoundland & Labrador, Nova Scotia, and Saskatchewan) do not ban private insurance and yet still do not have a flourishing two-tier system. Why is this? It is because unless a significant number of doctors work in the private sector, for at least part of their time, there are no private services to insure.[12]

The majority judgment written by Justice Deschamps acknowledged that laws such as those prohibiting physicians working simultaneously in both the public and private sectors are taken in various jurisdictions to protect the integrity of the public insurance systems. This is both heartening yet bewildering given that, on the one hand, she appears to endorse these laws, and yet, on the other hand, she completely rejects Quebec's arguments as to why it is necessary to protect the public tier from private insurance. The same arguments justifying the measures she seems to approve of also justify the law banning private health insurance. If these arguments are rejected in the context of a challenge to a law prohibiting private health insurance for essential care, it is at least possible that it may also be rejected in the context of challenges to other laws, such as those preventing doctors working simultaneously in both the public and the private insurance sectors.

Chief Justice McLachlin and Justice Major in their analysis of section 7 of the *Charter* fail to mention that other provinces and a

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[12] Colleen Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 Can. Med. Assoc. J. 825.

number of European countries take measures (short of prohibiting private health insurance) to severely limit the scope of a duplicate private tier. By ignoring this fact Chief Justice McLachlin and Justice Major are much more readily able to dismiss the Quebec government's claim that it is a legitimate policy objective to protect public medicare from the emergence of a duplicate private tier. They do this by characterizing Canada's aspirations in this regard as odd compared to other countries. If they had acknowledged that a number of other countries take legal measures to protect their public systems from a duplicate private tier, it would have been much more difficult to describe Quebec's law prohibiting private health insurance as "arbitrary."[13]

B. *Portraying Canadian Medicare as Inferior*

Chief Justice McLachlin and Justice Major reach the damning conclusion that other jurisdictions that "do not impose a monopoly" have "delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada."[14] For health policy experts, this is a breathtaking conclusion. The intractability of comparing different health systems is well accepted.[15]

First, with regard to "affordability," presumably they are not speaking from an individual perspective, as further privatization must result in more direct costs to individuals either through private insurance premiums or out-of-pocket payments and thus decreased affordability. I assume therefore they are referring to the overall

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[13] Chief Justice McLachlin and Justice Major further discount governmental arguments (and the evidence of expert witnesses) about the detrimental effect of a private tier on a public system and seem to accept that there is no downside to allowing a private tier.

[14] *Chaoulli, supra* note 1 at 854.

[15] For example, in 2000 the World Health Organization completed its first study of health systems and ranked Canada as thirtieth out of 191 member states. But the controversial analysis has been roundly criticized because it focused on just five factors, which caused the study to discount Canada's excellent health outcomes. Our health care system was downgraded due to the high overall educational levels of Canadian citizens, on the basis that education is a significant determinant of health status. In other words, because Canadians are more highly educated than, for example, the citizens of France, our otherwise excellent performance on health care outcomes like infant mortality and life expectancy was severely discounted. See Raisa Deber, "Why Did the World Health Organization Rate Canada's Health System as 30th? Some Thoughts on League Tables" (2004) 2:1 Longwoods Review 2.

affordability of the system as measured by total spending as a percentage of GDP. Here it is true that Canada is clustered in the top ten of OECD member countries in terms of total health care spending,[16] but it is not out of line with other countries of comparable wealth. As the wealth of a country increases, so does the total percentage of its wealth devoted to health care—in this regard Canada is exactly where it should be in terms of total health care spending.

The fact that Canada spends more on health care than some other countries does not reveal much. It is important to note that setting aside drug spending, the vast majority of total health care spending is for the remuneration paid to health professionals. Indeed, Canada pays its professionals higher rates than some other jurisdictions, yet many still feel that we do not pay these professionals enough. Thus, the fact that we spend more on health in Canada than the United Kingdom or New Zealand does not itself mean that the money is wasted (or at least no more than in any other system[17]). All it means is that we remunerate our health professionals at rates consistent with our total level of wealth. Chief Justice McLachlin and Justice Major also failed to note that countries with higher rates of private spending (Canada already records high rates of private spending compared to many other countries) record higher levels of overall (public and private combined) spending.[18] For example, the U.S. government already pays more *public* funds per capita than the Canadian government despite leaving over 14 per cent of the U.S. population uninsured.[19] By extrapolation, it is obvious that allowing more privatization of the system will increase, not decrease, overall spending or "affordability."

Chief Justice McLachlin and Justice Major boldly state that other countries deliver "superior" medical services than are presently delivered in Canada. Again, it is hard to know what they really mean by

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[16] *Supra* note 10. In 2003, Canada tied Greece for seventh place in the OECD in terms of total health care spending measured as a percentage of GDP.

[17] See Alan Maynard, "How to Defend a Public Health Care System: Lessons From Abroad" in Flood, Roach & Sossin, *supra* note 1, 237.

[18] Francesca Colombo & Nicole Tapay, "Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems" (2004) 15 OECD Health Working Papers at 15, online: <http://www.oecd.org/dataoecd/34/56/33698043.pdf>.

[19] 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>.

this. One assumes that they do not mean the quality of individual services delivered to patients by clinics and hospitals since there is no evidence to support this. So, one must assume that in the context of the facts of *Chaoulli* they are referring to the problem of wait times and that the "superiority" of other jurisdictions relates to the fact that either there is no waiting or their wait times are shorter than those recorded in Canada. But in support of this conclusion they make no reference to wait times in other countries. Had they done so, they would have found that Canada is far from alone in its struggle with wait times and that many other countries also struggle with this problem—including those that allow private health insurance for essential services.

A recent review of wait times in OECD countries irrefutably demonstrates that many countries with two-tier systems (in which citizens may purchase private insurance to cover essential hospital and physician services) also struggle with waiting lists. As Figure 1, below, shows, other countries within which waiting lists are a significant policy concern include Australia, Denmark, Finland, Ireland, Italy, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom.[20] The Deschamps and the McLachlin/Major judgments each refer favourably to these countries but do not discuss wait times. This oversight is difficult to understand when waiting for care is at the heart of the constitutional challenge before the Court. It is also surprising that they did not consider that a number of the countries that do not have wait-time problems have other access problems. For instance, the United States does not have a waiting list problem but records 45.8 million people as uninsured.[21] France has very high out-of-pocket payments at the point of service that likely deter those on low incomes from accessing care.[22]

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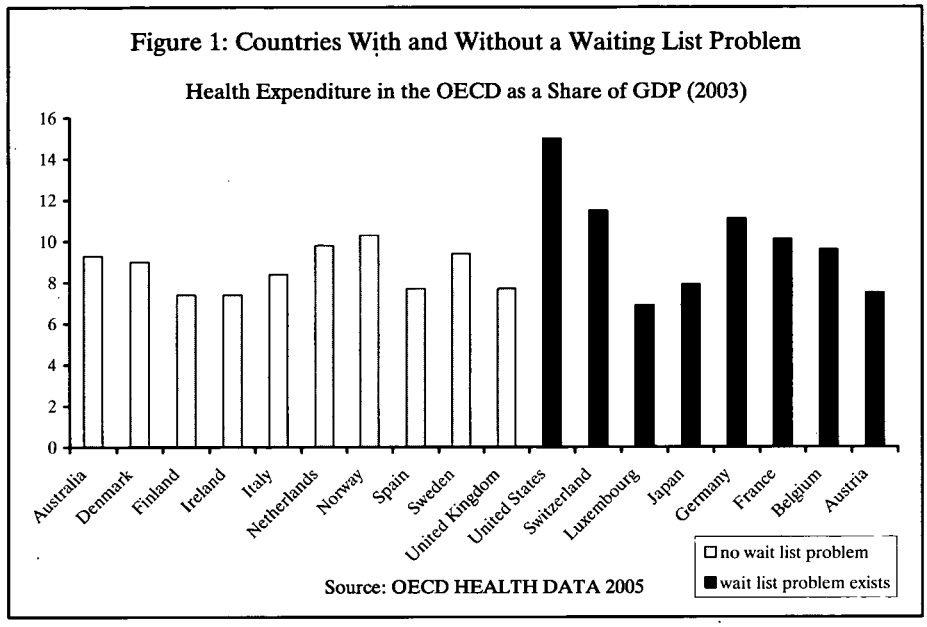
[20] See Luigi Siciliani & Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery Across OECD Countries" (2003) 7 OECD Health Working Papers, online: <http://www.oecd.org/ dataoecd/31/10/17256025.pdf>.

[21] Carmen DeNavas-Walt, Bernadette D. Proctor & Cheryl Hill Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, (Current Population Reports) (P60-229) (Washington: U.S. Government Printing Office, 2005), online: U.S. Census Bureau <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

[22] Paul Dourgnon & Michel Grignon, "Le tiers-payant est-il inflationniste?" (2000) CREDES Working Paper at 27, cited in Agnès Couffinhal, Valérie Paris & CREDES, "Cost Sharing in France" (2003) CREDES Working Paper at 4-5, online: <http://www.irdes.fr/ english/wp/CostSharing.pdf>. Note that when a patient is hospitalized, the patient is only



C. *Comparing European Apples and Oranges*

There is another difficulty with both the Deschamps and the McLachlin/Major judgments: their summative roundup of the experiences in other health care jurisdictions fails to distinguish between different systems that combine public and private insurance, assuming that the only purpose of private insurance is to "top-up" the quality of health care offered in the public system.

It is a fundamental error to treat all health care systems with some role for private insurance as the same. There are a number of distinct ways of financing health care, all with different consequences for equity and efficiency.[23] Below, I will discuss three different systems of public and private insurance. First, I will discuss group-based systems

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responsible for the co-payment fee, as the hospital is paid directly by the sickness fund for its share of the treatment.

[23] Carolyn Tuohy, Colleen Flood & Mark Stabile have identified four basic models of structuring the relationship between public and private financing: parallel public and private systems; co-payment; group-based; and sectoral. See Carolyn Hughes Tuohy, Colleen M. Flood & Mark Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations" (2004) 29 J. Health Pol. 359.

where private insurance is purchased by the wealthy but, in contradistinction to what the *Chaoulli* decision endorses, is not used primarily, if at all, for the purposes of jumping wait-list queues. Second, I will discuss co-payment systems, such as those in France, where private insurance is used to cover higher out-of-pocket payments imposed in the public system. Third, I will discuss duplicate insurance or two-tier systems where the primary purpose of private insurance is to allow those who hold it to jump wait-list queues. Countries that have these kinds of systems include New Zealand, Ireland, Australia, and the United Kingdom among others, and it is these countries that the Court should have closely examined. In this context, I will also discuss countries (*i.e.* Sweden) that ostensibly permit the purchase of private insurance for the purposes of queue-jumping, but take other measures, such as preventing physicians from working simultaneously in both the public and private sectors, that effectively preclude the development of a two-tier system.

1. Solidarity in a Group-Based System

The Court refers favourably to the Netherlands and Germany, but these countries are not operating two-tier systems in the sense the majority in *Chaoulli* has in mind, where individuals are allowed to buy parallel or duplicate private coverage to jump queues in the public system. The Netherlands and Germany each have what I would characterize as a group-based system. In group-based systems private insurers do not perform a duplicate role—as would be allowed by the *Chaoulli* decision—allowing people to jump queues for treatment. Instead, private insurance provides full (as opposed to duplicate) coverage for the wealthier segments of the population that buy it.

To elaborate, an individual earning less than 33 thousand euros (48 thousand Canadian dollars) in the Netherlands must contribute to and is eligible for social insurance that is similar in its progressive nature to Canadian medicare, although it is not financed primarily out of general taxation revenues but rather through employer and employee contributions. Dutch citizens earning more than 33 thousand euros are not insured by the social insurance scheme but can buy private insurance, and most do. The private insurance they purchase, however,

does not "top up" coverage in the public system as would be allowed by *Chaoulli*; it covers all the needs of those who elect to buy it.[24]

To reiterate and underscore the fact that buying private insurance does not allow queue-jumping or preferential treatment, regulation requires that Dutch specialists be paid the same fee by private insurers as by the social insurers.[25] Moreover, it is part of the ethical code of Dutch physicians not to treat patients with social insurance or private insurance differently.[26]

To be clear, (in case you are wondering why anyone would purchase private health insurance) wealthier individuals are not publicly insured. If they do not buy private insurance, then they are uninsured. In short, through different means the Dutch system achieves exactly the same progressive outcome as Canadian medicare where access to essential care is determined on the basis of need, not ability to pay. Private health insurance has a role, but only as a way of financing the system, not as a way of enabling those with means to get faster or better care. *Chaoulli*, though, finds that there is a constitutional right for those with means to buy their way to the front of wait-list queues.

2. Co-payment Systems

Co-payment systems also provide public coverage but impose large co-payments or user charges and, therefore, allow the purchase of private health insurance to help defray those out-of-pocket costs. This occurs in the U.S. medicare system (for those over sixty-five years of age) and in France. In France, the co-payments range from 20 per cent on hospital care, 35 per cent (usually) on prescription drugs, and 30 per cent for private physician visits (majority of physicians in France practise privately and provide day treatments or day surgeries). The co-payments

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[24] For a discussion, see Jurgen Wasem, Stefan Greß & Keike G.H. Okma, "The Role of Private Health Insurance in Social Health Insurance Countries" in Richard B. Saltman, Reinhard Busse & Josep Figueras, eds., *Social Health Insurance Systems in Western Europe* (London: Open University Press, 2004) 227.

[25] This is similar to the mechanism employed in the provinces of Nova Scotia, Ontario, and Manitoba to protect public medicare, namely preventing physicians charging more privately than they may publicly for the same essential services.

[26] The Dutch Professional Guidelines for Doctors, found in the *Individual Health Care Professions Act*, states at Article II.2 that doctors have to treat patients equally in equal cases. See Hans Akveld & Herbert Hermans, "The Netherlands" in H. Nys, ed., *International Encyclopaedia of Laws: Medical Law*, looseleaf (The Hague: Kluwer Law International, 2003).

are intended to promote patient responsibility in using health care resources, but they may also have the adverse effect of limiting access to services for those who cannot afford to pay the out-of-pocket costs. So, although France does not appear to have a wait-list problem, this may be due to the fact that some people cannot pay the high out-of-pocket costs required to access the system (in other words, they don't get into the system to wait). In addition to co-payments, access in France is also limited by the requirement that patients pay a health care professional upfront for a service and submit the bill twice: once to their social security insurer for partial reimbursement, and then to their private insurer to recover the co-payment.[27]

In France, citizens buy private health insurance to cover the costs of co-payments and user charges imposed in the public sphere. The level of private insurance varies; the best coverage is usually linked to type of employment and income. As a result, the lowest income earners in France have the least private insurance coverage and the highest co-payments.[28] To remedy this problem in part, public complementary insurance was put in place for the most poor in 2000.

As in a number of other countries, France requires the fees charged by a doctor in the private sector to be set by a government committee (doctors in the public system are paid on salary) in order to prevent the loss of doctors from the public to the private sector.[29] From 1980, the rules were modified, allowing any privately practising doctor to become what is known as a Sector 2 doctor and to bill above the government-set tariff. But concerns about fairness, access, and the failure of price competition to manifest itself resulted in a change in the policy in the early 1990s.[30] The new policy dramatically reduced the

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[27] Couffinhal, Paris & CREDES, *supra* note 22.

[28] The only study that has explicitly measured equity in the finance of the French health care system was undertaken in the early 1990s. See Eddy van Doorslaer & Adam Wagstaff, "Equity in the Finance of Health Care: Methods and Findings" in Eddy van Doorslaer, Adam Wagstaff & Frans Rutten, eds., *Equity in the Finance and Delivery of Health Care: An International Perspective* (Oxford: Oxford University Press, 1993) 20.

[29] In France there is a plurality of health care delivery methods—either through public or private hospitals or by self-employed private physicians. The public and private sectors for the most part deliver different types of care, and social insurance covers both public and private care. The private sector is not meant to be a second tier.

[30] Since 1980, doctors in France have been able to extra-bill (or charge a "dépassement") by choosing to be a Sector 2 doctor. However, by 1990, only 68.2 per cent of doctors were applying the negotiated tariff (57 per cent of specialists). There was no proof of improved quality being offered

number of doctors able to qualify to practise in Sector 2. Currently, about 24 per cent of French doctors in the private sector are able to bill at fees higher than the public tariff, but this percentage will decrease since only a very limited number of new doctors are able to earn the right to be classified in Sector 2 each year.[31] Thus, France also takes measures to protect the integrity of its public system and mitigate the loss of doctors from the public to the private sector. Why would France do this if there are no adverse ramifications in allowing privately paying patients to buy their way to the front of queues?

3. The Right Comparison: Countries with Duplicate or "Top-Up" Private Insurance

Both the Dutch and German group-model and the French co-payment model are very different from the kind of system likely to emerge in post-*Chaoulli* Canada.

In order to mimic the European models touted by the majority as superior to the Canadian system, the entire funding base of medicare would have to change from tax funds to social insurance premiums. Moreover, the other extensive social welfare programs of Northern European countries would need to be implemented. If we were to follow the French model, large user charges and out-of-pocket payments would have to be introduced at point of service (in France they are about 30 per cent of the specialist fee[32]) and government subsidies put in place to help the poor to cover those costs. If we were to replicate either the German or Dutch model, wealthier citizens would either be excluded (the Dutch model) or given a once-in-a-lifetime opt-out (German model) from the public system and would have to pay for insurance covering all their health care needs. Unlike these models, *Chaoulli* envisages all Canadians retaining public insurance, and then allowing

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by the Sector 2 doctors and the market provided little control over competitive pricing as the Sector 2 fees were 45 per cent higher than the conventional tariff. See Jean-Pierre Poullier & Simone Sandier, "France" (2000) 25 J. Health Pol. 899 at 902-03.

[31] Thomas C. Buchmueller & Agnes Couffinhal, "Private Health Insurance in France" (2004) 12 OECD Health Working Papers at 10, online: <http://www.oecd.org/dataoecd/35/11/30455292.pdf>; World Health Organization, "Highlights on Health, France 2004," online: <http://www.euro.who.int/eprise/main/who/progs/chhfra/system/20050131_1>.

[32] Buchmueller & Couffinhal, *ibid.* See also Couffinhal, Paris & CREDES, *supra* note 22 at 14.

those with means to spend relatively marginal amounts of money to achieve preferential treatment and queue-jumping. This would produce in Canada what is best described as a duplicate or top-up private insurance system.

Post-*Chaoulli*, the Canadian system may more likely come to resemble the systems in New Zealand, the United Kingdom, Australia, Ireland, Sweden, Spain, Luxembourg, Greece, and Italy. It is these countries that the majority should have considered in detail rather than countries like the Netherlands, Germany, and France which are too dissimilar in fundamental respects to be comparable. In the former countries, private insurance duplicates coverage of services that are publicly insured. In a number of them, particularly in those where wait time is a significant problem, physicians work in both the public and private sectors, "topping-up" their public sector incomes with private payments. Examination of countries with duplicate public insurance shows that, like Canada, they have also wrestled with chronic waiting lists.[33] An article I co-wrote with my colleagues at the University of Toronto that was quoted by Justice Deschamps in support of the different configurations of public and private insurance also included data showing that reported waiting lists in the United Kingdom and New Zealand were, respectively, three and five times longer than waiting lists reported by the Fraser Institute in Canada.[34] This research was not commented on, nor was it rebutted.

It is true that, recently, wait times in New Zealand and the United Kingdom appear to have been reduced. But there are two critically important factors to consider before leaping to any adverse conclusions about the relative merits of the Canadian system. The first is that reduction in waiting lists in the United Kingdom is due to the injection of large amounts of public funding into the National Health Service, not an expansion of the role of private health insurance. The Blair government has also tried to ameliorate the effects of allowing duplicate private health insurance in the United Kingdom through new contracts with consultants that limit the amount of time they can spend in the private sector.

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[33] For a discussion, see Tuohy, Flood & Stabile, *supra* note 23.

[34] *Ibid.* at 374.

In New Zealand, wait times have been reduced by managerial fiat; now an individual cannot be put on a public waiting list unless the system is able to meet his or her needs within six months. If the system cannot cope, the patient is sent back to her family doctor to "manage" her needs until the public system is able to meet them or the patient pays for the service privately—a de facto queue has formed for the waiting list.[35] But these "waiting lists" for the real waiting lists are not centrally recorded and cannot readily be used to criticize government performance. This latter experience illustrates that it is easier to ration more harshly in a system where the political elites, themselves holding private health insurance, are not subjected to the rationing process—a phenomena completely discounted by the majority.

4. Measures Taken in Countries that Allow Two-Tier to Limit Private Insurance

Many countries that prima facie allow top-up or duplicate private health insurance, *i.e.* they do not have a law explicitly prohibiting it, have other laws to limit the deleterious effects of the private tier on the public system. For example, Chief Justice McLachlin and Justice Major discuss the small amount of private insurance in Sweden, but they fail to mention that physicians there are prohibited from working in both the public and the private sectors. Swedish physicians must choose one or the other, and this inability to operate primarily in the public system with a top-up from the private sector provides a brake on the extent to which the private sector can develop at the expense of the public system. Similar measures are taken in other two-tier systems, namely Luxembourg, Greece, and Italy.[36] Why would these countries take these measures if, as the majority concludes, there is no basis for concern in allowing a private tier? In Canada, similar laws exist in every province except for Newfoundland & Labrador.[37] Presumably, in

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[35] Robin Guald & Sarah Derrett, "Solving the Surgical Waiting List Problem? New Zealand's 'Booking System'" (2000) 15 Int'l J. Health Plann. Mgmt. 259, online: Wiley InterScience <http://www3.interscience.wiley.com/cgi-bin/fulltext/77002023/PDFSTART>; New Zealand National Party, Press Release, "Patients Struck Off Second Waiting List" (18 April 2006), online: Scoop <http://www.scoop.co/nz/stories/PA0604/S00299.htm>.

[36] *Supra* note 18 at 24, n. 38.

[37] Flood & Archibald, *supra* note 12.

Newfoundland & Labrador the potential private market is insufficient to flourish even in the absence of laws suppressing it.

Chief Justice McLachlin and Justice Major conclude that Quebec's law prohibiting private health insurance fails to accord with the principles of fundamental justice on the basis that it is "arbitrary." They reach this conclusion based on their cursory review of the dynamics of other jurisdictions, from which they conclude that public and private insurance co-exists in certain countries and infer that the former remains viable. They dismiss arguments about the detrimental effects of a private tier on the public system merely on the basis that in other countries public and private insurance co-exist. But as I have shown, the dynamics of public and private insurance and regulation is far more complex than they allow for, and many jurisdictions take measures to try to achieve the same goal as in Quebec, namely protecting the public system from a private sector.[38]

5. The Problem of Capacity Being Transferred from the Public to the Private Sectors

Why do countries have laws such as those preventing physicians from receiving both public insurance and private payment for the delivery of essential services? The key issue is one of capacity: the time specialists and medical professionals spend working in the public system. If specialists are free to work simultaneously in the public and private systems, then a disproportionate amount of their time will be spent in the private sector—a problem that will be exacerbated by the differences in fees paid by the respective sectors.[39] In other words, to the extent that prices are higher in the private sector and where specialists are free to do so, they will devote an increasing proportion of their time to private patients who are likely to have less acute or serious needs than those patients left behind in the public system. This is not, as the

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[38] The dissent however was more sensitive to the complexity of health care financing in their treatment of evidence from other jurisdictions. They criticize the majority's treatment of this evidence in *Chaoulli*, *supra* note 1 at 891-94.

[39] U.K., Select Committee on Health, *Memorandum by Professor David Light: Testimony on its Inquiry into Consultants' Contracts* (App. 8 to *Health—Third Report*) (London: House of Commons, 2000), online: <http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/586/586ap17.htm>.

majority judges variously allege, merely a "theoretical"[40] argument or one based only on "human reactions"[41] or "common sense"[42] as opposed to evidence.

Evidence in support of these preventive laws includes the fact that many countries have similar laws. Why take these measures if there is no concern about capacity? There is more direct evidence. New Zealand has a two-tier system in which specialists are free to work in both the public and private spheres. It has had a chronic problem with waiting lists (although, as mentioned before, these are now not reported centrally).[43] The New Zealand Medical Council reported that in 2000, New Zealand specialists spent only 48.9 per cent of their time working in public hospitals. They devoted most of the remaining 51.1 per cent of the time to their private practices.[44] The consequences for public sector waiting lists and the public sector itself in Canada would be enormous if specialists were allowed to devote only 50 per cent of their time to working in public hospitals even when allowing for significant increases in productivity (*i.e.* physicians working more efficiently or longer hours). Inevitably, wait times in the public system would lengthen. Moreover, there would be profound and lingering effects (*i.e.* the amount of time that specialists would spend training junior doctors in the public system).

There is also judicial recognition in other countries of the relationship between waiting lists and duplicate private insurance systems. *The Commerce Commission v. The Ophthalmological Society of New Zealand*[45] involved a New Zealand funding authority seeking to

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[40] See *Chaoulli, supra* note 1 at 852, where McLachlin C.J.C. and Major J. say: "In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts."

[41] *Ibid.* at 828, Deschamps J.

[42] *Ibid.* at 853, McLachlin C.J.C. and Major J.

[43] The extent to which New Zealand wait times apparently seem to have fallen is due to a managerial sleight of hand rather than any substantive reform. The New Zealand booking system now requires that a patient not be put on a wait-list unless the system has the resources to meet the need within six months. If not, then the patient is referred back to his or her family doctor to "manage" the care until when (if ever) the system is able to meet the patient's need or the nature of the need changes so that it requires prioritization—in other words the patient gets much worse.

[44] Medical Council of New Zealand, *The New Zealand Medical Workforce in 2000* (Wellington: Medical Council of New Zealand, 2000) at 14, online: <http://www.mcnz.org.nz/portals/0/publications/workforce%202000.pdf>.

[45] (2004), 10 TCLR 994 (H.C.).

reduce long wait times for cataract surgery in the public sector by contracting Australian ophthalmologists to perform 225 operations during January 1997. The New Zealand High Court found that the group of ophthalmologists and their Society breached section 27 of the *Commerce Act*[46] (New Zealand's competition legislation) by being party to an arrangement designed to hinder Australian doctors from performing routine cataract surgery in New Zealand. The judgment includes excerpts from correspondence that make very clear the connection between long wait times in the public system and surgeons' personal income. In a letter to the funding authority, one of the doctors involved describes the marked reduction in public wait times for cataract surgery that would occur as a result of the proposed extra surgery and how that would detrimentally affect his private practice:

> Whilst this will have a devastating effect on my private practice with a markedly reduced number of private cataract referrals and cataract operations at Southern Cross Hospital over the new year or more as more people opt for public hospital surgery, my ongoing commitment to the Public Hospital Service now and in the future is however such that I am still prepared to assist just as I did when I performed the extra 66 outpatient clinics seeing 700 extra new patients over the last 2 years when it would have clearly been financially more advantageous for me not to have done this.[47]

The New Zealand High Court concludes that this particular surgeon knew of the impact that shorter waiting times in the public system would have on his private income and, despite his protestations to the contrary, had worked actively to thwart efforts to employ Australian surgeons to reduce public sector wait times.

In the United Kingdom, too, specialists are free to work simultaneously in the public and private sectors. In recognition of the concern that consultants are spending too much time treating private patients and not enough for the public sector, the U.K. government has recently tried to introduce productivity measures in the public sector.[48] In its evidence to the Select Committee on Health, the Department of Health stated that there was a statistical correlation between those specialties with the longest waiting lists and those with private practice

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[46] (N.Z.), 1986/5.

[47] *Supra* note 45 at 1013.

[48] Alan Maynard & Karen Bloor, "Reforming the Consultant Contract Again?" (2004) 329 Brit. Med. J. 929.

earnings making up a substantial part of consultants' incomes.[49] The Committee ultimately recommended that physicians be prohibited from working in the public and private sectors at the same time.[50]

A recent study conducted in 2005 in Australia also clearly demonstrated that the higher the proportion of private activity in any particular sector, the longer the wait in the public system.[51]

Within Canada itself there is clear evidence of the detrimental impact on public sector waiting lists from allowing a private tier in which physicians can work simultaneously in both the public and private sectors. A 1998 study in Manitoba of cataract surgery which, for a period, was provided by cataract surgeons who were free to work in both sectors, showed that waiting times were, unsurprisingly, lowest of all for private-pay patients (about four weeks). They were higher for services provided by surgeons who practised only in the public sector (ten weeks). But they were highest of all (twenty-three weeks) for publicly financed services provided by surgeons who practised simultaneously in both sectors.[52] It is extremely worrying that this evidence was before the majority judges but they nonetheless dismissed the views of expert witnesses on the ground that they did not "present economic studies."[53] One assumes that this evidence was discounted because it did not directly speak to the law banning private health insurance; it does of course speak to the rationale behind the law for banning private health insurance.

Chief Justice McLachlin and Justice Major found that the Quebec government had acted "arbitrarily" in precluding the purchase of private health insurance. If there were really no substance to the concerns of a private sector operating in tandem with a public sector,

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[49] U.K., Select Committee on Health, *Health—Third Report: Minutes of Evidence—Volume II (HC 586-II)*, App. 8 (London: House of Commons, 2000), online: <http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/586/586ap17.htm.>

[50] U.K., Select Committee on Health, *Health—Third Report: Summary of Conclusions and Recommendations* (London: House of Commons, 2000) Recommendation (o) at 3, online: <http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/586/58613.htm>.

[51] Stephen J. Duckett, "Private Care and Public Waiting" (2005) 29 Aust. Health Rev. 87.

[52] Carolyn DeCoster, Leonard MacWilliam & Randy Walld, *Waiting Times for Surgery: 1997/98 and 1998/99 Update* (Winnipeg: Manitoba Centre for Health Policy and Evaluation, University of Manitoba, 1998), online: Manitoba Health Centre for Health Policy <http://www.umanitoba.ca/centres/mchp/reports/pdfs/waits2.pdf>.

[53] See *Chaoulli, supra* note 1 at 853, McLachlin C.J.C. and Major J.

why do the governments of Sweden, Luxembourg, Greece, and Italy (not to mention all the provinces in Canada except for Newfoundland & Labrador) effectively prevent physicians from working both sides of the fence (*i.e.* by being paid from the public purse while "topping up" their incomes by supplying the same medically necessary care to private-pay patients)? Why has the U.K. government tried to introduce measures into consultants' contracts to make sure they spend more time treating public hips and knees?[54] Are all these governments "arbitrary" in their policy choices? This seems unlikely. If one accepts those laws as justifiable because of concerns about capacity, then Quebec's law prohibiting private health insurance could be similarly justified.

III. THE IMPACT OF *CHAOULLI* ON PUBLIC DEBATE AND POLICY

In the realm of public debate, *Chaoulli* seems to have unleashed the idea that Canadians can have their private insurance cake and medicare too. On the positive side, *Chaoulli* has opened the door for politicians and citizens to openly discuss the possibility of a greater role for private health insurance without running the risk of being called heretics. On the negative side, *Chaoulli* has enabled those who favour privatization to promote a greater role for private financing without having to explain the logistics of such a system.[55] The message of those advocating privatization is that medicare clearly does not work, a private system can only make things better, and the provinces should be free to experiment with combining the two.

A. *Supporters of Medicare*

Those who support a single-payer, publicly funded system in Canada have lost credibility by conflating the issues of private *financing* and private *delivery*. For example, some proponents of medicare rail against P3 hospitals in Ontario, which would be fully publicly funded (thus raising no equity concerns), or private cancer clinics, which are also fully publicly funded. The leader of the NDP, Jack Layton, has

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[54] Maynard & Bloor, *supra* note 48.

[55] John Ibbitson "Klein's Non-Partisan Health-Care Warnings" *The Globe and Mail* (22 November 2005) A1.

further clouded the debate by saying that his party is opposed to any public funding flowing to private clinics.[56] He has however been challenged on the grounds that he himself attended the Shouldice clinic, a private for-profit hospital that specializes in hernia operations but which is fully publicly funded.[57]

One has to distinguish between financing and delivery, and then between delivery by not-for-profit and delivery by for-profit firms. There are legitimate concerns about the quality of care delivered by private for-profit institutions in some settings, but not in all. In my view, the issue of not-for-profit versus for-profit *delivery* is not as critical as the issue of access to care as embodied in the distinction between public and private *financing*. Financing and delivery become conflated in the issue of private clinics (*i.e.* private MRI clinics) that supply both publicly and privately financed care. That these clinics are condoned is extremely problematic. They starkly illuminate the problem of physicians having an incentive to build up their more lucrative private practices rather than treat public patients. Similarly, there are concerns with the advent of private clinics that charge annual fees to patients (*e.g.* the Copeman clinic plans to charge 2,300 dollars annually) but argue they are in compliance with provincial laws by billing the public sector for "medically necessary" physician services.[58] The annual fees, ostensibly, are to cover non-insured services but may well be used to indirectly subsidize physicians who work there (treating far fewer patients than usual) providing of public health care.

Nonetheless, vocal opposition to all things private simply clouds the issues of what is really at stake in *Chaoulli*: the raw prospect of a two-tier system (such as exists in New Zealand, Ireland, and the United Kingdom) and the prospect of longer waiting lists in the public system.

Because the most vocal opponents of privatization in Canada have been fighting the battle of private *delivery*, they have been caught off balance, ill-prepared to fight the battle against private health *insurance*. The opposition to all things private makes it easy to discount them as zealots, just as the proponents of privatization used to be

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[56] See Bill Curray "Not Opposed to Private Health Care, Layton says" *The Globe and Mail* (5 December 2005) A5.

[57] See Steven Chase "Layton Defends His Mid-'90s Visit to Private Hernia Clinic in Toronto" *The Globe and Mail* (13 January 2006) A4.

[58] See the Copeman Health Care Centre, online: <http://www.copemanhealthcare.com>.

written off as zealots. Phillipe Couillard, Health Minister of Quebec stated:

> I believe there is a place for private health care in our public system ... . There appears to be a perversion of the debate here in Canada and particularly in Quebec. There are some people who associate any intrusion of private delivery of the health-care system with some kind of social backwardness.[59]

Coulliard's remarks are misleading, however, as there is already extensive private delivery in the Canadian health care system. But *Chaoulli* is not about delivery, it is about financing. Notice how Couillard carefully avoids talking about private insurance, private financing, two-tier systems, or queue-jumping—which is actually what *Chaoulli* requires—and speaks in the far more reasonable rhetoric of private delivery, even though at the time he spoke his government was contemplating reform of financing.

B. *Newspaper Commentary*

Media commentary has grossly oversimplified the debates about public and private health insurance. The poor grasp of health policy reflected in the judgment of the Court has been replicated in the media and particularly in relation to the experiences of other jurisdictions. I will provide three examples here, all from one national newspaper, *The Globe and Mail.* I acknowledge that this limited sampling does not provide a scientific basis for proving the media's poor grasp of health policy and I do not claim to do so. I only hope to demonstrate through a few examples the potential scope of the problem.

The first is a commentary by Lysiane Gagnon, who states that in its approach to public financing of health care, "Canada is in a league with Cuba and North Korea."[60] She neglects to note not only that Canada ranks third in the world for the percentage of total spending paid for by private health insurance but that the Canadian system allows a significant amount of autonomy and freedom in delivery. By comparison, physicians in the United Kingdom, New Zealand, and Ireland (not to mention Cuba and North Korea) are salaried state

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[59] Cited in "How Quebec Deals with Its Health Plight," Editorial, *The Globe and Mail* (16 November 2005) A20.

[60] Lysiane Gagnon' "A Pill Quebec Won't Swallow" *The Globe and Mail* (14 November 2005) A15.

employees, and their hospitals are owned by the state. By effectively dismissing the medicare system as akin to a system in a communist country, she denigrates its larger objective of providing access to necessary care on the basis of need and not wealth, which Canada does through a plurality of financing and delivery mechanisms.

Gagnon goes on in the same piece to point out that the Quebec Minister of Health has said that Quebec should find inspiration in countries like France, the United Kingdom, and Sweden that allow two-tier systems. She notes "only a diehard ideologue, or someone who hasn't traveled much, can argue that countries like France and Sweden, whose institutions were built by a succession of socialist governments, have an unfair system."[61] Gagnon is likely unaware that in Sweden physicians are prevented from working both sides of the fence, *i.e.* in both the public and the private sectors, and so as a consequence the private insurance sector is very small. She is also probably unaware that private health insurance in France is primarily used to pay for large out-of-pocket costs and that many doctors are prevented from billing (privately) above the government-set tariff. Gagnon, whilst travelling in Sweden and France, likely did not explore the complexities of public, private, and social health insurance.

Similarly, Jeffrey Simpson stokes confusion around the sustainability and affordability of medicare. In a number of columns, he argues that the rate of spending on the health care system is unsustainable and privatization is the solution.[62] He does not advocate complete privatization, but rather for medicare to continue with a supplementary role for private health insurance—the New Zealand, U.K., Irish (and *Chaoulli*) model. However, he does not acknowledge a well-known truth of health spending, namely that 10 per cent of patients account for well over 70 per cent of total spending costs—they have chronic needs or catastrophic conditions.[63] Supplementary or

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[61] *Ibid.*

[62] Jeffrey Simpson "Why Health-care Posturing Won't Amount to a Hill of Beans" *The Globe and Mail* (9 November 2005) A19; Jeffrey Simpson, "So, ask Mr. Harper this health question" *The Globe and Mail* (13 Jaunary 2006) A17; and Jeffrey Simpson "Squaring Off Against the Arithmetic of Health Care" *The Globe and Mail* (24 August 2005) A17.

[63] See Noralou P. Roos *et al.*, "Does Universal Comprehensive Insurance Encourage Unnecessary Use? Evidence From Manitoba Says 'No'" (2004) 170(2) Can. Med. Assoc. J. 209 at 210. A 1999 survey of residents in Winnipeg reveals in this article that 70 per cent of the population in the lowest use group consume just 10 per cent of health care dollars, whereas just 10 per cent of

complementary private insurers will not cover these people and their health care needs unless they are forced to do so by governmental regulation: in other words, the public system must continue to absorb the costs of complex and costly care. Unless Simpson is prepared to advocate complete privatization either of certain expensive classes of services or of health care for certain groups of people (i.e. the wealthy), the introduction of private insurance to allow individuals to jump queues for hip operations and cataract surgery will not improve the sustainability of the public system. More than likely, the effects of a private tier will be inflationary vis-à-vis the public tier as there is always pressure to cover services publicly that are available privately. This may be a good thing from the perspective of rapid adoption of new technologies, et cetera, but one cannot say it is a good thing from the perspective of overall costs.

A third and final example is demonstrated in an editorial in *The Globe and Mail* published in December of 2005 which stated:

> In two months, Quebec will launch a fierce debate about private care. It has no choice. The Supreme Court of Canada said in June that people are suffering and dying because of waits in the public system, and that Quebec is violating its own rights charter by not letting them buy private health insurance for essential care. The court gave Quebec until June 9 to allow private insurance.[64]

This editorial mischaracterizes what *Chaoulli* requires. Quebec laws are only unconstitutional given unacceptable wait times in the public system. The most obvious solution—and one that would benefit all Quebeckers and not just those able to afford private insurance—is to reduce wait times in the public system. Characterizing *Chaoulli* as requiring private insurance plays to the agenda of those politicians and

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the population consume 74 per cent of the dollars. See also Evelyn L. Forget, Raisa Deber & Leslie L. Roos, "Medical Savings Accounts: Will They Reduce Costs?" (2002) 167(2) Can. Med. Assoc. J. 43 at 145. The study determines that over a three-year period between 1997 and 1999, the lowest-using 50 per cent of the population only accounted for 4 per cent of costs whereas the highest-using 1 per cent of the population accounted for 26 per cent of spending on hospital and physician care. The top 10 per cent spending decile accounts for more than 70 per cent of health care costs annually. Both studies show that only the public system can accommodate the catastrophic costs category because the costs associated with this kind of care far exceed the ability of any one individual to absorb them privately.

[64] "Private Health Care. Let's Talk About It," Editorial, *The Globe and Mail* (7 December 2005) A26.

interest groups who argue that there is no other choice now but to allow private insurance.

IV. UNCERTAINTY AND FUTURE LITIGATION

Lamenting *Chaoulli* is to some extent crying over spilt milk; it will likely be many years before the Court is able to revisit its conclusions. But in the interim we can expect litigation across the country. Litigation will be instituted by those hoping to break open restrictions on the private sector: private clinics, for example.[65] There are reports of cases being developed in Ontario given that, at present, the Liberal government of Ontario seems set to defend one-tier medicare—at the time of writing, no action has been filed. There is also speculation that litigation will be launched in Manitoba should the province try to prevent private clinics from providing "medically necessary" MRI services.[66]

What we can expect to see are *Charter* challenges to laws similar to that of Quebec's that ban private health insurance. This is because in reality, the ban on private health insurance is probably not as important as the other laws across the country suppressing a developing second tier. In a 2001 article in the Canadian Medical Association Journal, Tom Archibald and I documented the myriad pieces of provincial legislation that cumulatively provide disincentives for a flourishing duplicate private tier. We concluded:

> [I]n Canada, the absence of a private system is not due to the illegality of private health care per se. Private insurance for the kinds of medically necessary hospital and physician services that the public service is meant to cover is illegal in only 6 provinces. However, there has been no development of a significant private sector in New Brunswick,

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[65] Those with vested interests in the private sector already have begun discussions on how to "better" the Canadian health care system in light of the *Chaoulli* decision. For example, the Canadian Independent Medical Clinics Association (an organization that represents private health care clinics) recently hosted a conference in Vancouver on 11 & 12 November 2005, called "Saving Medicare: Strategies & Solutions." The conference had a registration fee of over one thousand dollars and speakers included Reform party founder Preston Manning, Senator Michael Kirby, Dr. Jacques Chaoulli, Ian McPherson (the CEO of New Zealand private health insurer Southern Cross) and Charles Auld (former CEO of U.K. based General Healthcare Group), as well as members of the legal community and doctors currently operating private clinics in British Columbia.

[66] See 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/article.jsp?content=20051127_205836_4484>.

> Newfoundland, Nova Scotia or Saskatchewan, all of which permit private insurance coverage without any restriction on the extent of the coverage, although as noted Nova Scotia is the only province among these 4 that caps the fees of all physicians (whether opted in or out) at the public plan rates. Rather, the lack of a flourishing private sector in Canada is most likely attributable to prohibitions on subsidization of private practice from the public plan, prohibitions that prevent physicians from relying on the public sector for the core of their incomes and turning to the private sector to top up their incomes.[67]

Given this, we are likely to see challenges not only to laws prohibiting the sale of private insurance for essential services but to other laws which, in my opinion, are of greater significance in protecting the private tier. For example, we can expect to see challenges to the laws in Ontario, Nova Scotia, and Manitoba that preclude a physician from charging more privately than is paid publicly for a "medically necessary" service. We can also expect to see challenges to the laws in Alberta, British Columbia, New Brunswick, Quebec, Saskatchewan, and Prince Edward Island that effectively prevent the public sector from subsidizing the privately financed sector, in such ways as by providing that patients who opt for the services of a private physician cannot receive public funding to pay for them.

Of course, what is not known is how a court will approach a challenge to laws that more indirectly undercut a private tier than a ban on private health insurance. The difficulty for challengers will be that these laws, such as those that provide disincentives to physicians to practise privately, indirectly achieve the goal of suppressing a private sector. Still, it is conceivable that a court might accept that even these more indirect prohibitions could be considered legitimate targets for challenge. They prima facie seem to be about the economic rights of doctors, and given that economic or contractual rights are not protected by section 7, it will be much more difficult to build the nexus to an infringement of life, liberty, and security of the person as was done in *Chaoulli*. But regardless of the merits of these kind of claims and their likelihood of success before the courts, some provincial governments may preempt the needs for such challenges by voluntarily changing their laws using *Chaoulli* as a justification.

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[67] Flood & Archibald, *supra* note 12.

V. GOVERNMENTAL RESPONSE

There are a number of possible governmental responses to the *Chaoulli* decision; we have seen and are seeing different approaches across the country.

A. *Reduce Wait Times*

The first (and best) response is to rise to the challenge and improve wait times within the province in question so that if put to the test, the province in question will be able to demonstrate at trial that the wait times are reasonable and thus any law prohibiting the flourishing of a private tier is not in contravention of section 7 of the *Charter*. To date, that has been the Ontario government's response through its Wait Time Strategy.[68]

This approach of measuring and reducing wait times is one endorsed, at least in theory, by the federal government. Specifically, the federal government has agreed to invest 4.5 billion dollars over a six-year period in the Wait Times Reduction Fund to assist provinces and territories to train and hire more health professionals and otherwise build health capacity.[69]

Wait times are beginning to be managed better, and if success could be claimed on that ground then the law prohibiting private health insurance would no longer be constitutionally suspect.[70] *Chaoulli* would then have achieved what many claimed to be the ultimate goal of those (including the Canadian Medical Association and members of the Senate) who intervened in support of the constitutional challenge. These interveners supported the *Chaoulli* challenge on the grounds that the court needed to provide the equivalent of a spur-in-the-side to lazy governments by telling them that they are not entitled to preserve a "monopoly" on public health insurance if they do not eliminate

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[68] Ontario, Ministry of Health and Long-Term Care, "Wait Time Strategy Overview" (8 December 2004), online: <http://www.health.gov.on.ca/transformation/wait_times/strategy_overview.pdf.>

[69] Health Canada, "New Federal Investments on Health: Commitments on 10-Year Action Plan on Health" (16 September 2004), online: <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/bg-fi_inv_e.html>.

[70] Patrick J. Monahan, "Wait Times Key to Saving Medicare" *The Toronto Star* (17 November 2005) A27.

unreasonable wait times.[71] This would certainly be the best and most optimistic interpretation of the *Chaoulli* decision. On the other hand, as I discuss further below, it is equally plausible that some governments will be more than happy to give up their "monopoly" on health care.

B. Charter-*Proof through Legal Reforms*

The other response open to provinces is to improve safety-valve mechanisms—to provide ways for patients who have been waiting for treatment to have their case reviewed and treatment expedited if necessary either within the province, in another province, or in the United States (in essence, a care guarantee).[72] Each member of the Supreme Court agreed that an adequate appeal mechanism was an important determinant as to whether the Quebec laws prohibiting private health insurance were constitutional. In other words, a province may be able to protect its laws from *Charter* challenge if it provides some sort of timely and independent means to assess when someone has had to wait too long for care and to provide a remedy. This remedy could take the form of ensuring immediate treatment within the province or paying for treatment in another province or country. So far, there has been little movement on the part of any province to embed such protections. In the buildup to the January election in 2006, the Liberals had pledged 75 million dollars in funding to allow patients to travel from one province to another in the event that wait times are too long in a patient's home province. The new Conservative government also promised a care guarantee, its key difference from the Liberal party platform being that it would not prohibit care to be purchased in private clinics or in other countries.[73] To avail themselves of these funds, it would seem essential that provinces put in place some form of mechanism for determining whether a patient has waited too long. How

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[71] *Ibid.*

[72] For a discussion on appeal mechanisms in the province of Ontario, see Caroline Pitfield & Colleen M. Flood, "Section 7 'Safety Valves': Appealing Wait Times Within A One-Tier System" in Flood, Roach & Sossin, *supra* note 1, 477.

[73] See Conservative Party of Canada, "Harper Pledges Patient Wait Times Guarantee," online: Conservative Party of Canada <http://www.conservative.ca/EN/1091/33313>. See also Health Canada, "Wait Times in Canada," online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index_e.html> which confirms the 10-year plan to strengthen health care.

the new Conservative government—committed to provincial autonomy on the one hand and a care guarantee on the other—will practically implement guarantees is anyone's guess. To date the new federal government has made no move to fulfill this election promise, and in its first budget, it allocated no new funds to health care to achieve it.[74]

C. *Capitulate and/or Celebrate and Allow Private Health Insurance*

The third option available to provinces is to celebrate *Chaoulli* and allow the introduction of a supplementary private tier.

In *Chaoulli* the key problem was characterized by the applicant as the government monopoly on health insurance for essential services. Supporters of *Chaoulli*, such as Stanley Hartt, have said that government, as a monopolist, must either improve its performance or "get out of the way" so that people can look after themselves.[75] The characterization of government as monopolist as opposed to the provider of a unique public good belies the fact that many governments, for fiscal, political, or ideological reasons, may be more than happy to give up the ongoing battle to maintain one-tier medicare. If the most vocal and politically connected members of the electorate shift to the private insurance sector this will likely alleviate some of the pressure on provincial governments to perform well. It would likely make it easier for governments to harshly ration services in the public sector, particularly those covered by private insurance (*e.g.* hip and knee surgery).[76] Governments may also be tempted by the idea (even if it is not borne out in practice) that creation of a second tier would reduce the work that has to be done by the public sector. Some governments will be tempted by the idea, not for fiscal reasons but for pure ideological reasons, namely that choice and the market should be allowed to operate freely in health care regardless of merit or consequences.

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[74] Canada, Department of Finance, *The Budget Plan 2006: Focusing on Priorities* (Ottawa: Department of Finance, 2006), online: Department of Finance <http://www.fin.gc.ca/budget06/pdf/bp2006e.pdf>.

[75] Stanley H. Hartt, "Arbitrariness, Randomness and the Principles of Fundamental Justice" in Flood, Roach & Sossin, *supra* note 1, 505.

[76] Within New Zealand there is indirect evidence of a loss of political support for public spending on services also covered by private insurance. See *supra* note 35. See also *supra* note 43 for commentary on the New Zealand wait-list booking system.

D. *Quebec's Choice*

These possible choices in response confront the government of Quebec most directly since its laws were the subject of *Chaoulli*. It asked for an eighteen-month stay in order to be able to better prepare itself or respond to the overturning of the law prohibiting private health insurance. The Court granted twelve months.[77]

To understand Quebec's response on this issue, some context is important. Quebec has long allowed private clinics to flourish within the province (in contravention of the *Canada Health Act*[78]), and it appears that in these clinics physicians are providing "medically necessary" services in both the public and private sectors. For example, a *Montreal Gazette* article[79] reported that two Westmount medical clinics are charging patients substantial fees for quick access to day surgery and other procedures; the doctors at the Westmount Square Surgical Centre and MD Specialists also bill the Quebec medicare board for those procedures. The federal government has failed to stop this.[80]

To the extent that a supplementary private tier is already tolerated in some measure in Quebec, *Chaoulli* may well be viewed as an opportunity to expand the boundaries of that tier, to legitimize existing practice, and perhaps to put some other rules of the game in place. Indeed, *Chaoulli* may have been greeted behind closed doors by the Quebec government with relief rather than chagrin.

The initial signs suggested that the Quebec government would use the *Chaoulli* decision as support for further privatization of the Quebec system in ways not required by the terms of the decision.

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[77] *Jacques Chaoulli et George Zeliotis c. Procureur général du Québec et Procureur général du Canada* (*Qc*) (4 August 2005), Supreme Court of Canada Rehearing – 29272, online: Supreme Court of Canada Bulletin of Proceedings <http://scc.lexum.umontreal.ca/en/bulletin/2005/05-08-12-bul.wpd/05-08-12-bul.wpd.pdf>. The judgment reads: "The motion for a partial rehearing is granted. The Court's judgment is stayed for a period of 12 months from the date such judgment was issued, namely June 9, 2005."

[78] R.S.C. 1985, c. C-6.

[79] Aaron Derfel "Montreal Leads the Country in Offering Private Health Care" *The Montreal Gazette* (12 February 2005) A1.

[80] 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>. Health Canada has recently addressed enforcement issues. See Health Canada, News Release, "Canadian Public Health Care Protection Initiative" (3 November 2005), online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/media/notices-avis/prop_e.html>.

Premier Jean Charest is reported as saying in the National Assembly that he had received an "order" from the Supreme Court of Canada to make room for the private sector in the health care system. It was reported that Quebec is proposing to allow doctors to practise both in the publicly financed system and in a parallel, privately financed system in which private insurance companies would play a role. As six Quebec law professors point out in an opinion editorial in the *Montreal Gazette*, the Court issued no such order and, of course, it is open for the Quebec government to respond by reducing wait times for all, rather than by opening a private tier.[81]

On 16 February 2006 the Quebec government released its proposed response to *Chaoulli*.[82] The Quebec proposals include a broad range of initiatives, but from the perspective of a direct impact on wait times the most pertinent reform proposal is the implementation of two different types of care guarantee.

The first care guarantee is with regard to radio-oncology, cancer surgery, and advanced cardiac care. The proposal read that the guarantee will provide for a three-month maximum wait, then the public sector will pay for care in a private clinic or outside of Quebec. No private insurance may be purchased to cover this kind of care. The irony is, of course, that in countries with duplicate private insurance, private insurers don't insure this kind of care—it is too expensive and not profitable enough. In other words, even if it were lawful to sell it and buy it, the market would not materialize for it in Quebec.

The second kind of care guarantee covers hip, knee, and cataract surgery—in these cases the guarantee is that after a six-month wait then the government will pay for treatment in a private clinic. If a patient is still waiting after nine months, then the government will pay for care out-of-province. The proposal provides that for these kinds of care (hip, knee, and cataract surgery) patients can now buy private insurance—for *these services only*. So the impugned law at the heart of the *Chaoulli*

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[81] Henri Brun *et al.* "Quebec Medicare Plan is Not What the Supremes Ordered" *The Gazette* (17 November 2005) A29.

[82] Quebec, Ministère de la Santé et des Services sociaux, *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency, and Quality* (Consultation document) (Quebec: La Direction des communications du ministère de la Santé et des Services sociaux, 2006), online: <http://publications.msss.gouv.qc.ca/acrobat/f/ documentation/2005/05-721-01A.pdf>.

decision will be liberalized, but only to the extent of allowing the sale of private insurance for hip, knee, and cataract surgery.

The Quebec government is planning a very measured set of proposals that contains a variety of disincentives for a two-tier system to flourish. The proposals cut across the gambit of possible public/private solutions to the *Chaoulli* decision that I outlined earlier. They are what I would characterize as a Goldilocks solution—a sophisticated response to the *Chaoulli* decision, balancing the demands of the Court with the reality of health policy.

First, the introduction of wait-time guarantees within the publicly financed health care system is a public fix to a public problem, the best response one could hope for to the *Chaoulli* decision. However, in order to get wait times down, it will require significant changes within the system, changes that many players have long been resisting (*i.e.* centralization of waiting lists—out of doctors' desk drawers and into regional or provincial management, creating more capacity by changing scope of practice, et cetera).

Second, the proposals provide for a much more significant kind of reform in terms of public funding and private for-profit delivery. Rather than taking on the difficult political task of changing practices within public medicare—and challenging many vested interests—the easier response is to bring in more capacity by allowing publicly financed delivery by private for-profit clinics. This is what I would call the middle ground, and it follows the response to wait times made by Tony Blair's government in the United Kingdom—the system remains publicly funded but extra capacity is injected into the system by allowing private clinics.

This is, of course, a much more preferable option in terms of access than allowing a duplicate private tier as was endorsed by the Supreme Court of Canada. It tries to ensure improved access for all Quebeckers, and allowing delivery by private clinics might get around some of the embedded stickiness associated with expanding public hospitals—if you expand capacity in a public hospital, it is virtually impossible to reduce it later when needs change. However, there are still many concerns with this option. The experience in the United Kingdom suggests we need to be attentive to the following possibilities:

— the bifurcation of responsibility between public hospitals and private clinics with the former getting the tough cases and the latter the easier cases, often at higher rates of remuneration;

— problems associated with the training of junior doctors in hospitals when the easiest kinds of care are no longer performed in public hospitals;

— the reality that bringing on extra capacity will most likely result in extra public spending and result in additional concerns for provincial governments around sustainability;

— and, finally, that in the absence of new resources or greater efficiencies, money spent on wrestling with wait times may well be at the expense of other needs.

E. *Private Insurance*

The final plank of the Quebec government's proposals that I will discuss is removing the law prohibiting private health insurance. It is interesting that the Quebec government is not proposing to defend this law given its proposals for wait time guarantees. Senator Kirby and the Canadian Medical Association argued before the Supreme Court that wait time guarantees would be the only way for the Quebec government to be able to legitimate the law prohibiting private health insurance. So why liberalize the law given that wait-time guarantees are promised?

We will have to see how the Court responds to this proposal, which is the inverse of what may have been expected. Where wait-time guarantees are in place, the Quebec government could arguably defend itself from constitutional challenge, and where they are not, it has to remove the laws prohibiting private health insurance.

From the perspective of those on waiting lists for other kinds of care, there is every reason to be concerned—as attention and resources are devoted to reducing wait times in these specified areas, in all likelihood, there will be fewer resources and less incentives to deal with other needs. Thus, if anything, there is an even stronger argument on the side of those left out of Quebec's wait-time guarantees that they should have a constitutional right to private health insurance. Of course, as I have discussed earlier, this right is largely meaningless for those presently on waiting lists—no private insurer will cover a patient who has a condition.

On a very positive note, the Quebec government appears persuaded, at least to some degree, by those who reacted strongly to early suggestions that the laws prohibiting doctors working in both the public and the private sectors should be liberalized. The Quebec government says it will keep this law. Currently, there are only one

hundred Quebec doctors who have chosen to opt out of the public system and practise privately—far more than in any other province. We will have to see whether the demand for private insurance will significantly increase the size of the private market and with it the enticement for doctors to move from the public sector to the private sector, or whether, as I have argued here, that the effect will not be significant unless and until doctors are able to work simultaneously in the public and private sectors. In any event, the Quebec government also stated that it would consider restricting the number of doctors opting out if the numbers become too high and deplete public system resources.

F. *Alberta's Stance*

Although not required to respond to the *Chaoulli* decision, the Klein government of Alberta released its proposal for reform on 28 February 2006.[83] Ralph Klein, the premier of Alberta, copying the Blair government in the United Kingdom, named his initiatives for health policy reform "the third way." But Blair's third way and Klein's third way have several degrees of separation between them. The Blair government's initiatives are not about expanding the role for private insurance or private payment; indeed, its reforms in health care have been characterized by an unprecedented increase in the investment of public funds.[84] The Blair third way involves the use of greater incentives for performance and a greater role for competition between providers in order to harness the drive and efficiency of the private sector in the public delivery of health services to achieve equitable goals.[85] Blair's

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[83] Alberta, Ministry of Health and Wellness, News Release, "Alberta health care renewal focuses on balance" (28 February 2006), online: Government of Alberta <http://www.gov.ab.ca/acn/200602/19506B2146229-0A7D-942D-E9B71DD4FD88C882.html>.

[84] In 2000 the Blair government pledged to increase government spending in the National Health Service up to a level on par with the national average of the European Union, which the Blair government estimated to be 8 per cent of GDP. In 2002 the government committed to increase investment by 7.5 per cent per year, which will result in the share of GDP being spent on healthcare rising to 9.4 per cent in 2007. This means spending in 2007-2008 will reach 92 billion pounds, up from 69 billion pounds in 2003. See Sheila Leatherman & Kim Sutherland, "Quality of Care in the NHS of England" (2004) 328 Brit. Med. J. (U.S.) 144; Rebecca Coombes, "Brown Confirms a 7.1% Rise in NHS Spending Next Year" (2004) 329 Brit. Med. J. 128.

[85] Penelope Dash, "New Providers in UK Health Care" (2004) 3285 Brit. Med. J. 340; Julian Le Grand, "Further Tales from the British National Health Service" *Health Affairs* 21:3 (May 2002) 116; and British Medical Association, "The New 2003 National Consultant Contract for

third way is about improving productivity in the public system, not dismantling the public system or undermining equity goals by greater reliance on private financing.

Overall, the platform of proposals put forward by Alberta are sophisticated and speak to many important issues in health care system reform; I do not discount them. However, the key measure of concern from the perspective of the one-tier/two-tier debate, impeded within this larger plan, was a proposal to liberalize the law allowing physicians to work simultaneously in the public and private tier. This proposal is not required by the terms of *Chaoulli* given that the decision spoke to a different law (the law preventing the purchase of private health insurance) and that *Chaoulli* does not require the province of Alberta to respond. It is also of note that, in its proposals, Alberta did not provide for any form of wait-time guarantee in the public system—in other words there would be no entitlement to timely treatment in the public sector, which coupled with a flourishing private tier would allow medicare to decline and waiting lists to grow. The public backlash to Klein's third way proposal was strong and immediate. This backlash ultimately resulted in the government deciding not to proceed with the proposal as initially drafted. On 20 April 2006, Health Minister Iris Evans announced that the legislation would be tabled pending further public consultation.[86] Klein may have left his run on Canadian medicare too late as some members of his own caucus were not supportive of his health care reforms. As a result, Klein "all but lost the leadership vote" at the Conservative Party convention on 31 March 2006.[87]

Klein's proposals saw medicare balanced on a knife edge. Fortunately, because of political forces destabilizing Premier Klein at the end of his long and successful career, he was not able to bed down those reforms in Alberta. That it should have come so close, however, is directly due to the fallout of the *Chaoulli* decision.

England–a Summary by the BMA's Central Consultants & Specialists Committee" (September 2003), online: <http://www.bma.org.uk/ap.nsf/Content/CCSCContractSummary>.

[86] Alberta, Ministry of Health and Wellness, News Release, "New health bill process invites Albertans' input (20 April 2006), online: Government of Alberta <http://www.gov.ab.ca/acn/200604/19746B9640965-0AAF-E3D0-465A26C4954F3D02.html>.

[87] Graham Thomson "Disappointed the 'Third Way' Crashed and Burned? Blame Ralph" *The Edmonton Journal* (22 April 2006) A19.

VI. CONCLUSION

I will conclude, in the spirit of media soundbites, with the top ten reasons why Canadians, despite what their politicians, the media and a majority of the Supreme Court are telling them, should not embrace private health insurance for essential hospital and physician services:

10. Countries in which private spending is high spend more in total on health care, not less. The United States already spends more public dollars per capita than Canada does but leaves 48 million Americans uninsured.

9. We have a shortage of doctors and nurses. Most developed countries do. Wealthier provinces are luring doctors from poorer provinces. This problem will be exacerbated with the introduction of private insurance coverage for services that are presently publicly insured like hip operations. Doctors will move their business into the private tier. They will do work that is elective in nature for the not-so-needy, leaving those with greater need to wait even longer for care in the public system.

8. A two-tier system is one in which one can buy private insurance to jump queues and doctors are free to work part of their day in the public system doing public hip operations for public-pay patients and part of the day in the private system doing hip operations for those who pay privately. This is what is being mooted by the Quebec and Alberta governments as a good idea. That it is not a good idea is demonstrated by countries that already have two-tier systems, like the United Kingdom, New Zealand, and Ireland, where there are very long public waiting lists. Why copy them?

7. In countries that have two-tier systems, only a relatively small percentage of the population holds private health insurance (*e.g.* 11.4 per cent of U.K. citizens), and their doing so is closely associated with their wealth. In other words, the vast majority of Canadians would not benefit from being able to buy private health insurance since either they will not qualify for it or they will not be able to afford the premiums.

6. From the perspective of a private insurance company, if you are on a waiting list you do not have insurable risk. You do not have a risk of disease or illness, you *have* the disease or illness—current needs that must be met. If you cannot pay cash, the public system is the only option. Zeliotis, the patient at the heart of the Supreme Court's decision in *Chaoulli*, exposes the fallacy in the idea that private health insurance will fix our waiting list problems. Zeliotis, sixty-five years old and with

pre-existing heart and hip conditions, simply would not qualify for private health insurance, at least not for those conditions.

5. Do not buy into the suggestion that Canadian medicare is in league with communist states like Cuba and North Korea. We are third in the world in terms of the private health insurance contribution to the financing of our system. Physicians and hospitals are not employed and owned by the state. We already have a significant level of private financing and private delivery, higher than many other developed countries. The real question is whether privatizing insurance for essential services will make our system better or worse.

4. NAFTA requires that we must compensate U.S.-based private insurers for denying them access to Canadian "markets" if we subsequently change our mind about the benefits of two-tier insurance.[88]

3. Many countries (*e.g.* Sweden) and nearly all provinces protect the public system by way of laws preventing doctors being paid both publicly and privately for essential services. These laws require that doctors either work wholly in the public sector or wholly in the private sector. Quebec and Alberta are considering changing this law even though the Supreme Court decision in *Chaoulli* does not require this.

2. Governments and health care providers can fix waiting lists. Together they have been able to achieve extraordinary improvements, for example, in cardiac care treatments in Ontario and with respect to orthopaedic services in Alberta.[89] There is now little or no waiting for diagnosis and treatment; most of these gains have been achieved by better coordination of existing resources and our talent. We can and will do it in other areas. Victory is within our grasp.

1. And the top reason why we shouldn't allow private health insurance for essential services? Access to essential care should be based on need and not on ability to pay. If resources are constricted, we should revisit what is or is not essential, not allow a two-tier system for what indeed *is* essential. We should operate a health care system, not a wealth care system.

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[88] For a full discussion, see Tracey Epps & David Schneiderman, "Opening Medicare to Our Neighbours or Closing the Door on a Public System? International Trade Implications of *Chaoulli v. Quebec*" in Flood, Roach & Sossin, *supra* note 1, 369.

[89] Kelly Cryderman "Waits for Hip, Knee Surgery Cut By 90%: Pilot Project Yields 'Phenomenal Results'" *The Edmonton Journal* (19 December 2005) A1; Dawn Walton "Alberta Slashes Wait Times on Some Surgeries" *The Globe and Mail* (20 December 2005) A1.