Introduction: The Courts and Two-Tier Medicare

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Colleen M. Flood and Bryan Thomas

Canadians are greatly concerned by long wait times for health care within their public health care system, medicare.[1] Internationally, Canada's relative performance on this score has fallen in recent years,[2] with Canadians reporting some of the longest wait times across comparator countries. But rather than spurring significant government action to improve health care for *all* Canadians, wait time concerns are sparking constitutional challenges to overturn laws restricting private finance, so some Canadians can more easily "jump the queue." Of course, though these challenges are framed around the rights of patients, they are as much about the rights of physicians—led and financed by private clinics and doctors who stand to profit from an expansion of privately financed care in Canada.

1 Mario Canseco, "Wait Times, Red Tape Are Main Health Care Snags for Canadians" (30 January 2019), online: *Research Co.* <researchco.ca/2019/01/30/health-care-canadians/>.

2 Canadian Institute for Health Information [CIHI], "How Canada Compares Results From The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries" (2017), online: *CIHI* <www.cihi.ca/sites/default/files/document/text-alternative-version-2016-cmwf-en-web.pdf>; CIHI, "Wait times longer for joint replacements and cataract surgeries in Canada" (April 2018), online: <www.cihi.ca/en/wait-times-longer-for-joint-replacements-and-cataract-surgeries-in-canada>.

These court challenges, grounded in the *Canadian Charter of Rights & Freedoms*'[3] section 7 right to "life, liberty and security of the person" and the section 15 right to "equal benefit of the law without discrimination," seek to overturn a variety of laws that exist across Canadian provinces, limiting opportunities for privately financed care. Current laws, which we describe below, restrict (but don't completely eliminate) a two-tier system, wherein doctors can treat patients who are willing to pay for faster access and higher quality care. These laws vary across provinces but include:

i. restrictions that stop a doctor who bills medicare from charging a patient an additional amount (referred to as "extra-billing");
ii. restrictions that force doctors to choose between exclusively billing the public system or exclusively billing privately, forbidding simultaneous billing in both streams (i.e., dual practice);
iii. restrictions on doctors, in the private sector, charging prices for medically necessary care that are higher than those permitted in the public plan; and
iv. restrictions on private health insurance for services that are covered by medicare.[4]

All Canadian provinces have a mix of some or all of these restrictions, enacted to meet the requirements of federal legislation, the *Canada Health Act*,[5] and thereby qualify for a federal contribution to the operation of their respective health care plans. Consequently, a finding of unconstitutionality of one or more of these laws in a province like British Columbia will have an enormous impact across Canada, as similar laws in other provinces may be then quite quickly overturned on the grounds they are not compliant with s. 7 of the *Charter*.

The reason Canada has legal restrictions on private finance is to ensure that health care is, to the extent possible, accessed based on need and not ability to pay. And as Greg Marchildon describes in his

3 *Canadian Charter of Rights and Freedoms*, s 7, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c11 [*Charter*].
4 *Canada Health Act*, RSC 1985, c C-6.
5 *Ibid.*

contribution to this volume, "Private Finance and Canadian Medicare: Learning from History," overcoming the many barriers and interest groups opposed to universal medicare was a hard-won political war waged over many years against medical associations, which fought tooth and nail to prevent a universal public health care system, and against some politicians who were ideologically in favour of maintaining a significant role for private finance. The mix of different laws that exist across the provinces, and the *Canada Health Act* itself, are thus a product of the particular history and context of Canadian medicare, including political accommodations necessary to bring doctors into the public plan (e.g., doctors are not public employees but independent contractors mostly paid on a fee-for-service basis with relatively little governmental control over their clinical decision making).

Critics of Canada's single-payer model often overlook this history and argue that equality in "mediocrity" is not an equality worth pursuing. They assert it is "common sense" that allowing wealthier patients to jump the queue will free up resources for those left behind in the public system—the trickle-down effect being better, if unequal, access for all. And while this assumption may be true in many markets, as Jerry Hurley comprehensively explains in chapter 3, "Borders, Fences, and Crossings: Regulating Parallel Private Finance in Health Care," health care markets do not function like most markets. Market failures, the limited number and high cost of training health care professionals, and the difficulty of attracting medical manpower into remote and rural areas across Canada, mean that there are health-professional shortages in many critical areas *already*. If a two-tier system is permitted to flourish, it seems most likely that more health professionals will move at least some of their time from the public to the more financially lucrative private sphere. And in a country the size of Canada, this will likely prove to be most problematic in places where it is already hard to attract medical labour, such as in the North, rural areas, and small cities.

Canadians need not look far for examples of how fairness in the allocation of health care can be skewed by private financing: this is visible already with the country's patchwork coverage of pharmaceuticals,[6] and for long-term and home care services, as Sara

6 Health Canada, *A Prescription For Canada: Achieving Pharmacare For All* (Final Report) by Advisory Council on the Implementation of National Pharmacare (Ottawa: Health Canada, June 2019).

Allin and colleagues detail in chapter 5, "Experiences with Two-Tier Home Care in Canada: A Focus on Inequalities in Home Care Use by Income in Ontario." The concern then is that permitting a two-tier system will not improve wait times in the public system but in fact worsen them, and there is evidence to demonstrate that where permitted in two-tier systems, medical labour is drawn away from the public to the private tiers. Further, as Vanessa Gruben explains in chapter 6, "Self-Regulation as a Means of Regulating Privately Financed MediCare: What Can We Learn from the Fertility Sector?," a larger privately financed sector in Canada will also mean an even larger role for delivery by for-profit providers with attendant concerns about the quality and safety of care delivered.

Despite these worries, in the face of increasingly long wait times and the struggles Canadian governments have faced in managing these, those Canadians with resources may conclude that equality of access must be sacrificed to ensure their own access to timely care. In the context of a *Charter* challenge, debate over two-tier care could be seen as a contest between the "rights" of patients with resources to access a market without impediment and the interests of patients who continue to rely on the public system. The choice is usually not put so bluntly; instead, most who argue for greater private financing couch it as win-win (i.e., despite inequality, both rich and poor will be made better off). Canada's single-payer system has long enjoyed strong public support and continues to do so despite its problems; perhaps, then, it is no surprise that those seeking to expand the role of private finance and open up broader opportunities for a two-tier system have bypassed electoral politics and have turned to the courts.

The first major judicial attack on restrictions on two-tier care came in 2005, in what is arguably one of the Supreme Court's most controversial decisions ever, *Chaoulli v Quebec*.[7] There, the court struck down a Quebec law banning private health insurance for services covered by medicare. The reasoning was that, were it not for this restriction, patients facing lengthy wait times could obtain quicker care in the private sector. Writing for the majority in *Chaoulli*, Justice Deschamps found that, given unreasonable wait times in the public system, patients' rights in Quebec were unjustifiably infringed by a law prohibiting private insurance for hospital and physician services. Lawyers for the Quebec and Canadian governments had

7 *Chaoulli v Quebec*, 2005 SCC 35 [*Chaoulli*].

argued that restrictions on private insurance were necessary to ensure an adequate supply of doctors' services within the public system, as a large private market would lure the limited number of doctors away from the public to the private sector to receive higher rates of pay and to treat patients requiring less complex care. The majority did not respond directly to this argument, but did rely on a brief and superficial review of international evidence to conclude that most Western European countries (it seemed to the majority) manage to maintain high-performing public systems while permitting a two-tier system.[8]

Although successful, the *Chaoulli* decision did not lead to the runaway private financing of health care in Canada that the applicants hoped for, due to three factors:

i. The impugned law overturned in *Chaoulli* prohibited duplicative private health insurance, but this is only one of *several* laws restricting two-tier care in Quebec and other provinces, including, for example, restrictions on dual practice.[9] Consequently, the impact of *Chaoulli* in opening up two-tier care was not as dramatic as one might have imagined.
ii. The majority decision rested upon the Quebec *Charter of Human Rights and Freedoms*[10] as opposed to the *Canadian Charter of Rights and Freedoms*, and thus technically applied only to Quebec—necessitating re-litigation in other provinces to spread the *Chaoulli* precedent nationwide.[11] The fact of Quebec's long wait times at this time was pivotal to the

8 Colleen M Flood, "*Chaoulli:* Political Undertows and Judicial Riptides" (2008) (Special Edition) Health LJ 211.

9 Colleen M Flood & Tom Archibald, "The illegality of private health care in Canada" 154 CMAJ 825.

10 *Charter of Human Rights and Freedoms*, RSQ c C-12 [Quebec *Charter*].

11 Notice as well that the outcome in *Chaoulli* turns on specific findings of fact concerning wait times within Quebec's health care system. Under Canadian federalism and the terms of the *Canada Health Act,* the administration of medicare falls to the provinces. Expanding the *Chaoulli* precedent across Canada will require (*inter alia)* province-by-province litigation establishing that patients are endangered by unreasonable wait times. This point was emphasized in a 2015 decision, when the Alberta Court of Appeal rejected a plaintiff's request for a summary declaration that Alberta's restrictions on two-tier care are invalidated by the *Chaoulli* precedent. See *Allen v Alberta*, 2015 ABCA 277 at 13.

success in *Chaoulli*, and would need to be demonstrated for other provinces.

iii. Quebec's Liberal government at the time responded to *Chaoulli* not by completely striking the ban on private health insurance, as would seem to have been required, but only liberalizing the law with respect to private health insurance for hip, knee, and joint replacement whilst simultaneously establishing wait time guarantees within the public system for those same health services. Although the guarantee was not enshrined in law it seems—as Amélie Quesnel-Vallée and colleagues discuss in chapter 4 ("*Chaoulli* v *Quebec:* Cause or Symptom of Quebec Health System Privatization?")—it was nonetheless effective, at least in part, in quelling the growth of a significant private insurance market and, in turn, a significant parallel private tier, at least in the short term.

Although *Chaoulli* did not singularly ring in a new era of two-tier care in Quebec or across Canada, in our view it had a normative impact, which is to say it helped popularize the idea of private finance and, indeed, cast it not only as a legitimate policy option but as constitutionally mandated when "monopoly" governments fail to deliver timely care. Amélie Quesnel-Vallée and colleagues argue in their chapter that *Chaoulli* was more a *symptom* than a cause of privatization, growing out of the slow encroachment of private clinics in Quebec—an encroachment visible in other provinces, more so today than ever. Another way to see the case in context is that changes in Canadian society, including the growing income inequality and aging baby boomers who are anxious to use personal wealth to access care, are combining to soften up society at large and political institutions for a break from single-payer medicare. Mark Stabile and Maripier Isabelle document rising income inequality within Canada, and hypothesize that it becomes more difficult as a result for publicly funded care to satisfy the median voter.[12] Their model predicts increased political pressures for a greater role for private finance as a by-product of growing income inequality.

Building off of *Chaoulli*, interest groups who want to benefit from the expansion of private finance in the Canadian system, as well

12 Mark Stabile & Maripier Isabelle, "Rising inequality and the implications for the future of private insurance in Canada" (2018) 13:3 Health Econ, Pol'y & L 406.

as patients distressed by increasing wait times,[13] have launched lawsuits in other provinces (Ontario,[14] Alberta,[15] and British Columbia[16]) which expand far beyond the *Chaoulli* precedent. Of most significance, as Martha Jackman explains in chapter 2 ("*Chaoulli* to *Cambie*: *Charter* Challenges to the Regulation of Private Care"), is an ongoing case that went to trial in September 2016 in British Columbia.[17] Launched by Cambie Surgeries Corporation (a private for-profit clinic) and led by its owner, Dr. Brian Day, the challenge is to the constitutionality of laws in British Columbia that

i. ban private health insurance for medically necessary hospital and physician services (as in *Chaoulli*) [s. 45 (1) of the *Medicare Protection Act* (*MPA*)];[18]
ii. ban extra-billing so that doctors cannot charge patients above and beyond what they receive from the public plan [s. 17(1) of the *MPA*];
iii. ban dual practice so that doctors must choose to bill exclusively to the public system ("enrolled") or "un-enroll" and bill exclusively to private payers.[19]

Cambie, then, is a much broader challenge than *Chaoulli*, reflecting their claim that in order to have a flourishing two-tier system in Canada—to make it much more economically viable for doctors to provide these services—it may be necessary not only to overturn

13 CIHI, "Wait times for joint replacements and cataract surgery growing in much of Canada" (28 March 2019), online: <www.cihi.ca/en/wait-times-for-joint-replacements-and-cataract-surgery-growing-in-much-of-canada>.

14 *McCreith and Holmes v Ontario* (5 September 2007) (Statement of Claim filed at ONSC).

15 *Allen v Alberta*, 2015 ABCA 277.

16 *Cambie Surgeries v British Columbia (Attorney General)* (23 November 2018), Vancouver S090663 (BCSC) [*Cambie*].

17 *Ibid.*

18 RSBC 1996, c 286 [*MPA*].

19 The language is quite confusing in the BC legislation. Physicians who are "enrolled" in the public system have two options: they can "opt in" (bill the government directly) or "opt out" (bills patients directly but not more than the public plan permits; the patient can then claim this sum from the public plan). Physicians who choose not to participate in the public plan ("unenrolled") are free to bill patients for services at whatever rate the market will bear, in private clinics.

restrictions on the sale and purchase of private health insurance but also to facilitate a two-tier system by striking down restrictions on dual practice and extra-billing. If the ban on extra-billing were struck down altogether, then all enrolled physicians would be entitled to bill what they wanted to the patient or her insurer on top of what they bill the public system. However, *Cambie*, in its closing arguments, say that they do not seek to fully strike down the ban on extra-billing and, indeed, grant that enrolled physicians should not be entitled to tack on private fees to medicare services, as this would create a financial barrier to accessing a public service. But they insist that enrolled physicians—that is, those billing the public plan—should also be allowed to treat private patients provided medicare funding is *not* involved. As written, the *MPA* bans enrolled physicians from extra-billing and wholly private billing in one fell swoop. *Cambie* asks that these sections be struck altogether, leaving it to government to respond with more tailored legislation that bans extra-billing while allowing wholly private billing by enrolled physicians.

It is worth noting that the *Cambie* challenge itself has come about as a defence to a determination that doctors at the Cambie clinic in Vancouver were breaking the law by extra-billing. Nonetheless, perhaps because extra-billing is so clearly in contravention of the *Canada Health Act*, the *Cambie* claim seems to have become more nuanced on this point over the course of the multi-year trial, focusing on the restrictions on private insurance and dual practice. Despite muting their attack on extra-billing in their final arguments, *Cambie* still asks that the court issue a "suspended declaration of invalidity" over all of the provisions, requiring government to enact response legislation within a fixed period of time—legislation that, in their claim, must liberalize dual practice but could maintain restrictions on extra-billing. However, should government fail to enact response legislation during the period of suspension, the entire suite of protections—including the ban on extra-billing—would be deemed invalid. Needless to say, this is a high-stakes game, given the challenges governments face in enacting structural reforms to health systems.

Cambie, if successful in whole or in part, has the potential to rapidly accelerate the development of two-tier care across Canada and if the BC laws banning dual practice or extra-billing are overturned, in whole or in part, this would strike at the heart of the *Canada Health Act*. To forestall this, provincial governments will have to demonstrate that wait times in their provinces are

"reasonable" or that there are measures in place to make sure that section 7 rights (life, liberty and security of the person) and section 15 rights are not infringed unreasonably, a topic we return to in the conclusion.

In determining whether existing BC laws restrictive of two-tier health care can survive a *Charter* challenge, what will be crucial is how a court treats evidence of Canada's approach to the public-private mix relative to other jurisdictions. In short, a court is more likely to be persuaded that Canada's legislative restrictions on two-tier are justified for the protection of medicare if there is evidence of a similar approach in other countries. In *Chaoulli*, the majority found that Quebec (and the other provinces that similarly restrict private health insurance) is alone among comparator health care systems in prohibiting parallel private health insurance, and this finding grounded their ultimate conclusion that the prohibition was arbitrary and unconstitutional. However, as hinted earlier, the court's approach to comparison was remarkably brief and superficial, failing to note that private health insurance *serves very different purposes* across jurisdictions.

For example, in a number of countries, private health insurance is not primarily used for the purposes of queue-jumping but, instead, provides coverage for user charges and extra-billing charges that are mandated or permitted within the public system. Zeynep Or and Aurélie Pierre's discussion in chapter 9, "The Public-Private Mix in France: A Case for Two-tier Health Care?," well illustrates this problem. In France, private health insurance is mainly needed to cover the copayments that all patients must pay for all health care, and further, this "private" health insurance is heavily subsidized, if not directly paid for, by the state (the latter being for low-income individuals). Moreover, one finds a completely different flavour of "two-tier" in Germany, where self-employed individuals have the option of withdrawing *completely* and *almost irreversibly* from the country's social health insurance scheme and securing coverage in a regulated private health insurance market (see Achim Schmid and Lorraine Frisina Doetter's chapter 8, "The Public-Private Mix in Health Care: Reflections on the Interplay Between Social and Private Insurance in Germany.") In other jurisdictions, such as the Netherlands, private health insurance is mandatory, heavily regulated to ensure comprehensiveness and accessibility, and, again, is not primarily used for the purposes of jumping queues in the public

system; mandatory and regulated private insurance *is* the universal "public" system.[20]

To the extent that these French, German, and Dutch systems are "two-tier," it is not in the sense being pursued in the *Cambie* litigation. Indeed, Canadians in favour of expanding private finance are pursuing something altogether different: retaining medicare coverage for all, while allowing those with the financial means to "go private" when confronted by long wait times for specific episodes of care. In this regard, what they hope for is more similar to systems like that of Ireland, New Zealand, England, and Australia, the first three of which at least have historically struggled with long wait lists *despite* the existence of a two-tier option. The Irish experience with a two-tier system, as Stephen Thomas and his colleagues explain in chapter 11, "Embracing and Disentangling from Private Finance: The Irish System," has been so destabilizing that it is driving major reform to strengthen and protect the Irish public health care system. Despite this, advocates of privately financed care insist on the logical fallacy that because some high-performing European systems allow "two-tier care"—a concept defined so loosely as to be almost meaningless—there is no drawback in Canada's abandoning its hard-won commitment to single-tier care. This kind of magical thinking has gained increased popularity in political discourse. Thus the fair resolution of upcoming constitutional challenges will depend on how courts understand comprehensive evidence of comparative health policy, including how the BC health system truly compares in regulating two-tier care relative to other health care systems.

We had two major objectives with this book. Our first objective is to test whether Canada is in fact (as contended by those in favour of privatization and endorsed by the majority in *Chaoulli*) an aberration in the Western world in having legislative provisions that dampen the potential for a two-tier system. We explain the extent to which OECD countries employ different mixes of regulation and policies to limit two-tier care and show how countries that do not directly ban two-tier care through law may achieve a comparable effect through other policies. We also explore the impacts of two-tier in those countries that have more fully embraced it in the sense

20 Colleen M Flood & Bryan Thomas, "A successful Charter challenge to medicare? Policy options for Canadian provincial governments" (2018) 13:3 Health Econ, Pol'y & L 433.

advocated by the claimants in *Cambie*—that is, maintaining universal health care but permitting people to buy faster or higher quality care. For example, as explored by Stephen Thomas and colleagues in chapter 11, "Embracing and Disentangling from Private Finance: The Irish System," the difficulties of access to care in Ireland suggest that two-tier certainly does not solve the problem of wait times in that country. Likewise, Fiona McDonald and Stephen Duckett, in chapter 10, "Embracing Private Finance and Private Provision: The Australian System," unpack the Australian experience with two-tier care, explaining the significant (and regressive) tax subsidies that flow to those purchasing private insurance. Moreover, they discuss the regulatory mandate in Australia that forces higher-income individuals to buy private health insurance—a feature that reportedly results in many Australians acquiring "junk" policies, thus fulfilling the legislative requirement but not providing substantive coverage.

Apart from understanding the regulation and impact of two-tier care in different jurisdictions, our second objective in writing this book is to anticipate how the BC provincial government—and ultimately all Canadian governments—might respond in the event that the *Cambie* challenge succeeds. They will, in the wake of a successful challenge, have the opportunity to pass alternative laws and policies that are constitutionally compliant.[21] As Canadian governments consider their options here, a deeper understanding of how other jurisdictions *actually* regulate the public-private divide will help them make better policy choices. The debate over the adoption of regulations more permissive of private finance often stumbles over assumptions about the experiences of other countries and the translation of foreign experiences to the Canadian context. Indeed, comparative health policy is generally fraught with misdirection and superficiality.[22] For example, as Bryan Thomas discusses in

21 The example of Quebec's shrewd legislative response to *Chaoulli* was mentioned above; for more information, see the detailed description by Quesnel-Vallée, McKay, and Farmanara in this volume. On dialogue theory generally, see Kent Roach, *The Supreme Court on Trial: Judicial Activism or Democratic Dialogue* (Toronto: Irwin Press, 2001).

22 Ted Marmor, Richard Freeman & Kieke Okma, "Comparative Perspectives and Policy Learning in the World of Health Care" (2005) 7 J Comparative Pol'y Analysis: Research & Practice 331; Ted Marmor & Claus Wendt, "Conceptual frameworks for comparing healthcare politics and policy" (2012) 107 Health Pol'y 11.

chapter 12, "Contracting Our Way Around Two-Tier Care? The Use of Physician Contracts to Limit Dual Practice," the English system is portrayed as allowing two-tier care and having lower wait times than the Canadian system.[23] However, in translating the English experience to the Canadian system it is critical to appreciate that English physicians are generally full-time salaried employees, whereas Canadian physicians bill medicare on a fee-for-service basis.[24] Indeed, having doctors work on a salary within pubic hospitals is a feature of many systems that appear two-tier (e.g. New Zealand, Australia, Ireland) so that, at least within public hospitals, care remains free for patients. Requiring physicians to be paid a salary and to work normal hours also puts a natural constraint on their ability to practice privately. In contrast, if Canadian provincial laws banning dual practice and private insurance were overturned, it seems more likely that the lure of the private sector will result in greater diversion of physicians from the public system than occurs in England—threatening its sustainability.

With constitutional challenges to medicare underway, now is the time for Canadians to think carefully about the potential impact of two-tier care, looking beyond shallow comparisons to other systems. With this book, we look to advance the research base, fusing understandings of constitutional law with evidence and analysis from health policy research. In particular, we ask for a careful consideration of the historical, economic, political, and geographical factors particular to the Canadian health care system that impact the viability of transplanting foreign approaches to the Canadian context. We hope this research is of use to the courts as they consider these constitutional challenges, to policy-makers as they revamp medicare and respond to a court decision that allows private financing of medically necessary care, and to Canadians as they grapple with the sometimes counterintuitive world of health policy.

23 Brian Day, "30 Years of health care dysfunction," *National Post* (1 April 2014) online: <nationalpost.com/opinion/brian-day-30-years-of-health-care-dysfunction>.

24 Séan Boyle, "United Kingdom (England): Health System Review" (2011) 13 Health Systems in Transition 1 at 117–119.