



MACDONALD-LAURIER INSTITUTE

Debunking the Myths

A Broader Perspective of the *Canada Health Act*

Michael Watts

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Executive Summary

Is it illegal under the *Canada Health Act* for provinces to allow private delivery of care, charge user fees or even allow private insurance? Not in the least, but readers would be forgiven for thinking so based on the rhetoric surrounding proposals for health care reform.

The unfortunate result of the disingenuous, poisonous and hyper-partisan commentary around Canada's health care system is that innovative thinking has been stifled and the voices of well-intentioned and thoughtful politicians and experts have been silenced. In the process, many myths have taken root. If legislators falsely believe their actions are significantly restricted by the CHA, they will fail to consider and implement essential changes.

What is the truth?

To begin with, provinces have sole authority over their own health care programs. The federal government's power under the CHA is limited to its ability to withhold portions of the Canada Health Transfer. As public policy expert Gerard Boychuk has written, the *Act* "neither has nor requires provincial consent and is not legally binding on either party".

And not only are the federal government's powers over the provinces on issues such as user fees and extra billing weaker than most believe, it is becoming less and less inclined to use them. There is little evidence the federal government has ever imposed discretionary penalties on the provinces over failures to uphold the *Act*, mandatory penalties have declined dramatically over the years, and what few cases go to dispute resolution also tend not to result in reductions in health transfers.

It is vital to note the areas where the CHA remains silent or, put another way, those subjects over which it provides zero power for the federal government to withhold health transfers to the provinces. The CHA:

- does not dictate how insured health services must be provided;
- is silent on who may provide the services;
- takes no stance on whether a physician may work both inside and outside the provincial public insurance program;
- does not discuss whether fees may be charged for non-insured health services;
- says nothing about whether insured services must be delivered by public entities;
- does not define "medically necessary services"; and
- does not prohibit a province from adding other types of services to its list of insured health services.

Not only does the law allow for major reforms to how health care is delivered, it arguably requires them. Any provincial system that creates a monopoly over the provision of health care and creates barriers to access that jeopardize citizens' Charter rights (such as the rationing of care) is subject to a constitutional challenge.

The landmark case of *Chaoulli v. Quebec (Attorney General)*, which was decided by the Supreme Court of Canada in 2005, provides an excellent example of how the CHA is less restrictive than most people believe it to be. This case, which has significance for the entire country, makes the powerful statement that if a vital health service is not provided by the government, an individual has the constitutional right to pay for the service either directly or through private health insurance. Although the facts of this case focus on a patient's right to have timely access to medical services, there are other implications, such as a patient's right to access medically necessary services that the government chooses not to insure. The majority of the Supreme Court held that Quebec's law prohibiting private insurance for medically necessary hospital and physician services violated the *Quebec Charter*, and that lengthy wait times and delays in obtaining treat-

ment cause patients both physical and mental harm.

Chaoulli has created the foundation to dramatically alter the landscape of the Canadian health care system, essentially standing for the proposition that the status quo no longer is a viable or even a legal option.

Chaoulli was definitive confirmation that the *Charter* provides protection against government inaction, as well as protection for Canadians when government acts in violation of guaranteed rights and freedoms. If governments wish to be the exclusive providers of health care services in a “public” system, they must provide health care in a manner that does not deprive individuals of life, liberty, or security of the person. As Chief Justice McLachlin wrote for the majority in *Chaoulli*, “access to a waiting list is not access to health care.”

In “Medicare’s Midlife Crisis,” its ambitious series of commentaries and research papers, the Macdonald-Laurier Institute is asking Canadians to open themselves to considering major reforms to how our health care system works. The series comes at a time when it’s becoming increasingly clear that Canadians are getting sub-optimal results from a system that is placing an enormous and ever-growing financial strain on provincial treasuries.

The Canada Health Transfer (the source of federal funding for health care) has been renewed, but the rate of increases will be reduced over time. Funding that no longer keeps pace with expenditures combined with Ottawa’s hands-off approach means provinces have increased responsibility to provide the publicly administered, comprehensive, universal, portable, and accessible health care required by the CHA.

In order to make real change, however, we must shed our illusions about what is and what is not possible. Timid politicians and vested interests are content to hide behind the *Canada Health Act* (CHA) when faced with calls for change. But as this paper will demonstrate, the CHA does not pose the barrier to reform that we have been led to believe it does.

In order to provide timely, medically necessary care to Canadians who need it in the future, the provinces will have to act boldly, and to do that they will need to separate *Canada Health Act* myths from reality.

Sommaire Exécutif

Est-il illégal en vertu de la *Loi canadienne sur la santé* (LCS) que les provinces autorisent la prestation privée des soins de santé, qu’elles imposent des frais modérateurs ou même qu’elles permettent le recours à l’assurance privée? Pas le moins du monde, mais les lecteurs doivent être excusés s’ils pensent ainsi, puisque c’est ce que laisse entendre le discours sur les propositions de réformes en matière de soins de santé.

Les arguments trompeurs, nocifs et démesurément partisans qui ont été au centre du débat sur le système de soins de santé du Canada ont eu comme conséquence de décourager une démarche innovatrice et de réduire au silence les politiciens et les experts bien intentionnés et réfléchis. Au fil du processus, de nombreux mythes ont pris racine. Si les législateurs croient à tort que leurs actions sont considérablement limitées par la LCS, ils ne parviendront pas à envisager et à mettre en œuvre les changements jugés essentiels.

Quelle est la vérité?

Tout d’abord, les provinces détiennent un pouvoir exclusif sur leurs propres programmes de soins de santé. Le pouvoir du gouvernement fédéral en vertu de la LCS est limité à sa capacité de retenir certaines portions du Transfert canadien en matière de santé.

Et non seulement le gouvernement fédéral ne dispose pas d’un pouvoir décisif pour punir les provinces sur des questions telles que les frais modérateurs et supplémentaires, contrairement à ce que la plupart croient, mais il est de moins en moins enclin à l’exercer. Rien n’indique vraiment que le gouvernement fédéral a déjà imposé des sanctions discrétionnaires aux provinces parce qu’elles n’avaient pas respecté la *loi*, tandis que les sanctions obligatoires ont considérablement diminué au fil du temps et que les quelques cas ayant été soumis au processus de résolution de conflits n’ont pas entraîné de réductions des transferts en matière de santé.

Il est essentiel de cerner les aspects sur lesquels la LCS reste muette ou autrement dit, les aspects pour lesquels elle n’accorde au gouvernement fédéral aucun pouvoir d’annuler les transferts en matière de santé aux provinces. Ainsi, la LCS :

- ne dicte pas le mode de prestation des services de santé assurés;

- demeure muette sur les prestataires pouvant fournir les services;
- n'indique pas si un médecin peut travailler tant à l'intérieur qu'à l'extérieur du régime public d'assurance provincial;
- n'aborde pas la facturation des services de santé non assurés;
- n'établit pas si les services assurés doivent nécessairement être fournis par des organismes publics;
- ne fournit pas de définition des « services médicalement nécessaires »; et
- n'empêche pas une province d'ajouter d'autres types de services à la liste des services de santé assurés.

Non seulement la loi permet-elle de procéder à des réformes profondes du mode de prestation des soins de santé, mais elle l'exige sans doute. Tout système provincial qui crée un monopole en matière de prestation de services de santé et qui met des obstacles à l'accès à ces soins qui compromettent le respect des droits constitutionnels des citoyens peut donner lieu à une contestation judiciaire.

L'importante affaire *Chaoulli c. Québec (Procureur général)*, relativement à laquelle la Cour suprême du Canada a rendu une décision en 2005, fournit un excellent exemple du caractère bien moins restrictif de la LCS que ce qu'on croit généralement. Cette affaire, qui a des conséquences pour l'ensemble du pays, confirme sans équivoque que si un service de santé essentiel n'est pas offert par le gouvernement, un citoyen a le droit constitutionnel de payer pour l'obtenir, soit directement, soit par l'intermédiaire d'une assurance-santé privée. Bien que les faits dans cette affaire portent principalement sur le droit du patient d'avoir accès à temps à des services médicaux, il y a d'autres implications, telles que le droit du patient d'avoir accès à des services médicaux nécessaires que le gouvernement choisit de ne pas assurer. La Cour suprême a statué, par jugement majoritaire, que la loi québécoise interdisant l'application d'une assurance privée à des services médicaux nécessaires dispensés par les hôpitaux et les médecins violait la *Charte québécoise*, et que les longs délais d'attente et les retards à obtenir des soins constituaient un danger tant physique que psychologique pour les patients.

L'arrêt *Chaoulli* a ouvert la voie à un changement radical du paysage canadien des services de santé, démontrant que désormais le statu quo n'est ni viable, ni même légal.

L'arrêt *Chaoulli* a confirmé sans l'ombre d'un

doute que la *Charte* offre aux Canadiens une protection contre l'inaction du gouvernement et les protège de toute initiative du gouvernement qui pourrait contrevenir à leurs droits et libertés garantis. Si les gouvernements souhaitent être les fournisseurs exclusifs des services de santé à l'intérieur d'un système « public », ils doivent exercer cette fonction d'une manière qui n'a pas pour effet de priver les individus de leur vie, de leur liberté ou de leur sécurité. Comme la juge en chef McLachlin l'a déclaré en s'exprimant au nom des juges majoritaires dans l'arrêt *Chaoulli*, « l'accès à une liste d'attente n'équivaut pas à l'accès à des soins de santé. »

Dans sa grande série de commentaires et de documents de recherche sur la crise du système des soins de santé intitulée « Medicare's Midlife Crisis », l'Institut Macdonald Laurier demande aux Canadiens d'envisager des réformes profondes du fonctionnement de leur système de soins de santé. Cette série est lancée alors qu'il est devenu de plus en plus évident que les Canadiens et les Canadiennes obtiennent des résultats qui ne sont pas à la hauteur d'un système qui impose un fardeau énorme et croissant sur les finances provinciales.

Le Transfert canadien en matière de santé (la source de financement fédéral pour les services de santé) a été renouvelé, mais le taux d'augmentation sera réduit au fil du temps. Un financement n'augmentant plus au rythme des dépenses alors même qu'Ottawa est non interventionniste signifie que les provinces vont devoir assumer plus de responsabilités à l'égard de la prestation des services publics de soins de santé, complets, universels, transférables et accessibles, caractéristiques exigées par la LCS.

Pendant, pour apporter de véritables changements, il faut cesser de s'illusionner sur ce qu'il est possible de faire. Les politiciens et les groupes d'intérêt précautionneux s'empressent d'invoquer la *Loi canadienne sur la santé* (LCS) lorsqu'on réclame des changements au système. Mais, comme ce document va le démontrer, contrairement à ce qu'on nous a laissé croire, la LCS ne constitue pas un obstacle aux réformes.

Afin de fournir, à temps, les soins médicaux nécessaires aux Canadiens qui en auront besoin dans l'avenir, les provinces devront agir avec audace, et pour ce faire, elles devront bien faire la distinction entre les mythes et la réalité en ce qui a trait à la *Loi canadienne sur la santé*.

Introduction

As a brief piece of legislation, with narrowly-tailored applicability and limited enforcement powers, the *Canada Health Act* (CHA or the Act) has taken on enormous proportions in the minds of Canadian citizens and their political representatives. Indeed, it has become a symbol that defines what it means to be Canadian and this symbolic status tends to obscure – or at least distract from – the reality of the Act’s provisions.

Over the years, the Canadian public has been subjected to far too much disingenuous commentary from political actors regarding the CHA. Politicians who have challenged the status quo have frequently found themselves vigorously attacked by the self-proclaimed defenders of Canada’s public health care system. Those bold politicians who have ventured to suggest that innovations or fresh approaches need to be considered have been accused of selling the universal health care system down the river, without due regard to the substance of their suggestions or proposals.

Politicians who suggest innovation in health care are not given a fair hearing.

On January 21, 2002, when the Liberal Party was in power, *The Globe and Mail* reported that Deputy Prime Minister Anne McLellan said she had no problem with the introduction of private hospitals in the country, so long as provinces continue to respect the principles of the CHA.

In 2003, Prime Minister Paul Martin expressed the view that provincial experimentation was acceptable:

In terms of private delivery, I think it has got to be judged on a case-by-case basis which is permitted under the *Canada Health Act*. The fact is a substantial por-

tion of our system is already privately delivered...I certainly would not allow anything that would damage the essential foundations of our healthcare system. But I think that obviously provincial experimentation, best practices, that’s the kind of thing that I’m sure the Health Minister will look at.

In April 2004, Federal Health Minister Pierre Pettigrew, appointed to the post by Paul Martin, offered the following comments:

In recent years, differences of opinion as to how to interpret the [CHA’s] provisions, and inconsistent enforcement of its requirements, has resulted in growing confusion and uncertainty as to what the Act does and does not allow...I do believe we have a responsibility to clarify its practical meaning in today’s terms.

With growing interest among the provinces to experiment with new forms of health care delivery, we need to ensure that the ground rules for doing so are clearly defined, and that these experiments are closely monitored through a public interest lens.

We know the public administration principle of the CHA already provides flexibility on private delivery, but we may need more work to ensure our respective approaches continue to honour the purpose of the Act. (April 27, 2004)

Pettigrew added:

If some provinces want to experiment with private delivery options, my view is that as long as [provinces] respect the single, public payer, we should be examining these efforts and then compare notes between the provinces.

It’s up to the provinces to explore...ways of delivering [health care] but...the public administration [principle] does not say everything has to be state-owned. (Gordon April 28, 2004)

Pettigrew’s point – that there was room to manoeuvre and experiment with innovation even while respecting the CHA – was factually correct and should have been well-understood and ap-

preciated. Despite that, opposition politicians were quick to jump on the comments and the media did nothing to help clarify matters during the ensuing political firestorm. One news report went so far as to suggest that Pettigrew's statement signalled a move in the direction of two-tier medicine, and the newspaper used a front page headline which boldly proclaimed that the Liberals were stealing a page from the Conservative handbook. With an election in the offing, the Liberal PMO of the day found itself on the defensive.

There is room to experiment with innovation while respecting the CHA.

A carefully worded clarification was offered in which the Minister did not revise his interpretation but stressed that the Liberal Party was solidly behind the CHA and not in favour of private delivery of health care services. The media and the opposition saw the stage-managing as evidence of confusion, panic, and backtracking. With that, the attempt to have an honest debate about the CHA was shelved once again.

Since then, no federal politician has dared to go as far as Pettigrew did in 2004. It is not as if none of today's politicians have a view: back in 2001, when they were members of Michael Harris's Conservative government in Ontario, Tony Clement and Jim Flaherty had each mused about being open to the notion of health care user fees. Former Alberta Premier Ralph Klein and his Health Minister Gary Mar invested considerable time in developing a new model for health care (the 2001 Mazankowski report, entitled "A Framework for Reform"), but when their resulting "Third Way" proposals began to cause problems for their federal Conservative cousins during the lead-up to the June 2004 general election, Premier Klein deep-sixed any detail regarding the province's plans until after the election. The result was that critics accused both the provincial and federal Conservatives of having a

hidden agenda to encourage the growth of a private health care system.

Stockwell Day, as leader of the newly created Canadian Alliance, was effectively villainized – entirely disingenuously – by his political opponents over his alleged support for two-tier medicine. After witnessing the political demolition of Day and the reaction to Pettigrew's honest and apparently too frank assessment of the CHA, it is not surprising that Clement, Flaherty, and any other members of Stephen Harper's cabinet who have expressed such views on our health care system in the past have lost their voice.

Once they are retired, however, politicians are less constrained and more candid. In 2011, Stockwell Day authored an insightful commentary on the topic. Day found it ironic that just as caution on the subject was reaching new heights, never had the need for discussion been more evident.

Every elected person understands full well that she risks banishment or ostracization by her party, her constituents, and maybe even family members should she dare touch the Holy Grail of Canada's supposedly "free" health care model. Questioning this apparently infallible doctrine that weakly supports our fiscally failing health care system is a career-ending decision in the minds of even the bravest elected members.

Politicians must engage in sincere debate to introduce crucial health care reforms.

There is plenty of evidence to support Day's analysis. The unfortunate result of the disingenuous, poisonous, and hyper-partisan commentary around Canada's health care system is that innovative thinking has been stifled and the voices of well-intentioned and thoughtful politicians and experts have been silenced. In the process, many myths have taken deep root.

If legislators falsely believe that their actions are significantly restricted by the CHA, they will fail to consider and implement essential changes and the consequences will be significant for Canadians. If Canada is to introduce reforms which are necessary to improve and perhaps even save its cherished health care system, it will be crucial for politicians to stop trying to score political points and engage in a sincere, well-intentioned, and informed political debate. It is some provincial laws which impose the penalties on paying or insuring for insured services, not the CHA, but the political imperative not to remove such impediments arises not from the “devil made me do it” threat of sanctions under the CHA, but from assertions that a parallel private system would draw resources away from the public one and lengthen waiting times. This view is contrary to the majority decision in *Chaoulli v. Quebec (Attorney General)* which accepted evidence that the availability of private health care is more likely to enhance the public health care system than weaken it (*Chaoulli* ¶147-149).

Politics and public resistance are more of a problem than the myths of the CHA.

A clear, legal reading of the CHA – as well as a factual analysis of its actual impact on provinces since its enactment in 1984 – shows that the *Act* is far less restrictive with respect to the ability of the private sector to provide medically necessary health care services (whether publicly or privately paid for) than the *Act*'s reputation would lead people to believe.

It is vital that provincial legislators take a fresh, unobstructed look at what the CHA does and does not allow. The cost of Canadian health care has reached unsustainable levels and the gap between what is medically necessary and publicly insured is widening at an ever-increasing rate. *Chaoulli* lays a foundation for change within the CHA which, in the author's opinion, has yet to be fully explored.¹ The CHA currently does not

address chronic illnesses and aging populations, which are key to the sustainability of Canada's health care system.² The purpose of this paper is to illustrate that the CHA does not pose the barrier to allowing for a greater role in payments by the private sector and citizens that one has been led to believe. One can foresee that, unless the provincial governments implement a legislative, regulatory, and cultural environment which allows Canadians to purchase medically necessary services that the provinces respectively choose not to insure (such as enhanced medical devices, drugs, and/or procedures), the economic pressures being brought to bear on our primarily provincially-funded public health care system will lead to a serious degradation of the quality of care being offered. This, in turn, ultimately will offend a basic principal tenet of medicine: informed consent. Various reasons could be identified for this but, in the author's opinion, one important factor is that society's perspective of the CHA has been cultivated by public sector entities, which have a stake in preserving the status quo: a public health care system that is hospital-centric.³

I. An Ailing Health Care System

Available data paint a stark picture of the financial costs and the quality of outcomes currently attached to Canada's health care system.

Financial Difficulties

Chapter 5 of the 2012 Drummond Report – which was commissioned by the Government of Ontario – includes the following findings related to health care:

Canada has one of the costliest health care systems in the world... Canada spent almost \$193 billion on health care in 2010, or 11.9 percent of [Gross Domestic Product (“GDP”)]. In Ontario, where total health spending was \$75.5 billion, the share of GDP was 12.3 percent, slightly

higher than the national average, but only the fifth highest of any province. ... Of the 34 countries covered in the latest health data from the Organisation for Economic Co-operation and Development (OECD), Canada had the sixth most expensive system in 2009, when it was tied with Switzerland. ... Adjusted for age, Canada definitely has one of the most expensive systems.

Canada has one of the most expensive health care systems in the world.

Canada has the fifth most expensive (per share of GDP) *universal access* health care system among OECD countries and its “health care expenditures are 22 percent higher than the average developed nation that has a universal access health care system” (Esmail 2012, 22). In 2010, the premier of Ontario stated that “Just 20 years ago, 32 cents of every dollar spent on [provincial] government programs were spent on health care. Today, it is 46 cents” (McGuinty). Ontario’s health costs have not been the only ones to increase significantly. According to the Canadian Institute for Health Information (CIHI), Canada’s total health expenditure, expressed as a rate of its GDP, was 7.0 percent in 1975, 8.2 percent in 1985, 9.1 percent in 1995, and 11.9 percent in 2009 (2011). Health care expenditures often have increased faster than the rate of economic growth.⁴ Quite simply, Canada cannot afford to continue spending at this pace. The Office of the Parliamentary Budget Officer (PBO) has projected that the provinces’ and territories’ debts, in relation to GDP, will “increase substantially over the long term from 20 percent in 2010/11 to over 125 percent in 2050/51 and to over 480 percent by 2085/86.” As a result, the PBO estimates that the “provincial-territorial fiscal gap is now +2.9 percent of GDP, indicating that...provincial-territorial governments would need to raise revenue, reduce program spending, or some combination of both (by \$49 billion in 2011/12 and increasing over time in line with

nominal GDP) to achieve fiscal sustainability” (2012).

Quality Concerns

Authors at the Fraser Institute analysed 2011 OECD data and calculated that the following was true of Canada in 2009:

- It ranked below 27 other OECD countries “in almost every indicator of medical resource availability and the output of medical services for which comparable data were available.”
- It ranked below the OECD average for 15 of 20 health care quality indicators.⁵
- It ranked 19 (out of 23 countries) for the number of practising physicians per population.
- It tied for last place (out of 26 countries) for the number of acute care beds per population.

In short, this “analysis suggests that relative to the majority of OECD countries, Canada’s health insurance system does not produce good value for money” (Rovere and Skinner 2012).

Canada’s health insurance system does not produce good value for money.

Chapter 5 of the Drummond Report also cites numerous studies which indicate that Canada does not have enough physicians. “The CIHI concluded that fewer physicians per capita in Canada ‘may lend insight into why Canadians continue to report difficulties in accessing health care when compared to other countries.’ According to the World Health Organization, among the countries in the Commonwealth Fund report, only Australia has fewer physicians per capita” (2012). It is likely a result of the insufficient number of physicians that “new research indicates that Canadians are waiting longer than ever to access ... medically necessary treatment” (Barua and Rovere 2012). In fact, “Canada ranks last or next-to-last on almost all measures of timeliness of care. It is a common misconception

to associate universal or near-universal coverage with long waiting times for care. That is not true either for meeting immediate care needs, as in the United Kingdom, or for specialist care – patients in Germany and the Netherlands have similar rapid access to specialists as US patients” (Davis, Schoen, and Stremikis 2010, 11-12).

Hospitals’ and provinces’ responses to the financial difficulties noted above also have led to (perhaps unintended) degradation in the quality of health services. One example is that hospitals have joined third-party shared services organizations (some covering large metropolises, others covering major portions of the country, and some covering all of Canada) in order to use their combined purchasing power to reduce the costs of, for example, durable medical equipment and pharmaceuticals. Unfortunately, not only does this enable hospitals to contain costs, it also results in business decisions being made for a large number of hospitals which are not related to the clinical decisions that physicians in those hospitals would make. In practice, this means that a shared service organization may have a short list (or possibly even one) product (such as a hip prosthesis) that it purchases for all of the member hospitals, and physicians will have to choose from that short list (or use the only product purchased) when treating their patients, whether or not that is the best clinical choice or even a good clinical choice for the individual patient. The shared service organizations may not consider the added value that a particular product offers but, rather, look simply at cost as the lowest common denominator in their decision-making processes. For example, one brand of intraocular lens may cost more than another, in and of itself, but it may cost less over the lifetime of its use because of its ability to militate against infection or because of its durability. At the provincial level, some provinces have eliminated the consideration of added value from all of their Requests for Proposals. As with shared service organizations, this means that cost has become the major factor in the decision-making process, with no consideration of potential added value which could reduce costs over the lifetime of a product or service. These financial/purchasing decisions made by hospitals and provinces highlight the need for patients to be able to purchase enhanced medical services.

Providers’ Viewpoints

The Canadian Medical Association (CMA) has been outspoken in its criticism, concluding that the “system is failing Canadians, especially vulnerable populations” (2011, 35). At a CMA gathering in St. John’s in August of 2011, the Association stated that: “it’s not money that’s the problem. ‘Yes, Canada faces the pressure of rising demand and limited resources – but so do other developed countries, many of whom are navigating the challenge more successfully while spending less than Canada’” (Allan August 22, 2011). The then-president of the CMA Dr. Jeffrey Turnbull gave a speech at that conference, in which he said that “Canada’s health-care system is failing and in need of immediate transformation” (Radia August 24, 2011).

*When the CHA was written,
the focus was on acute care.*

The CMA has noted that the CHA was drafted at a time when society was focused on acute care. As a result, the current system is “very good at providing ... short-term care for illness or injury ... [b]ut for the elderly and others with long-term, or chronic, illness our system is much less effective” (CMA 2011). “Very often ... the acute treatment doesn’t really deal with the long-term nature of [a] chronic condition” (2011, 11). “Now most people die of the effects of chronic disease and our system is still based around the acute” (11). “[W]hen our health care system was created, when we founded [M]edicare back in the early 60s, patients on average only lived to their late 60s. Now people in Canada are going to be living into their 80s. So we have a large geriatric population that has issues of chronic disease that needs to have their issues better addressed. The system has not changed but the patients have” (13). The CMA also has acknowledged that there are many who are in favour of “[e]xtending the scope of the [CHA] to include long-term care, home care, pharmacare, and rehabilitation

services while enforcing the existing principles” (20). Since the CHA is not tailored to dealing with an aging population or chronic illness, Canada’s health care system is becoming more difficult to sustain and the gap is widening between what is truly medically necessary (from a clinical point of view) and what is publicly insured.

Provinces must cease viewing the CHA as an obstacle to reform.

Conclusion

Immediate transformation only can occur if provinces cease viewing the CHA, and Ottawa’s enforcement role, as an obstacle to reform. If provinces opt to maintain the status quo because provincial legislators are responding to a political perception that changing the current system is contrary to their political interests, then the problems relating to the sustainability and access to our current publically funded health care system will have to reach a critical point before action is taken. The evidence accepted by the majority in *Chaoulli* established that the availability of private health care is more likely to enhance the public health care system than weaken it:

147 After reviewing a number of public health care systems, the Standing Senate Committee on Social Affairs, Science and Technology concluded in the Kirby Report that far from undermining public health care, private contributions and insurance improve the breadth and quality of health care for all citizens, and it ultimately concluded, at p. 66:

The evidence suggests that a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled

countries to achieve broader coverage of health services for all their citizens. Some countries like Australia and Singapore openly encourage private sector participation as a means to ensure affordable and sustainable health services.

148 Nor does it appear that private participation leads to the eventual demise of public health care. It is compelling to note that not one of the countries referred to relies exclusively on either private insurance or the public system to provide health care coverage to its citizens ...

149 In summary, the evidence on the experience of other western democracies refutes the government’s theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care.

II. Interpreting the Law

Overview of Provincial versus Federal Powers

It is undisputed that provinces have the sole authority to create, manage, and reform their individual health insurance programs. Aside from a few discrete areas which are beyond the scope of this paper (such as food and drug regulations), the federal government’s authority is limited to its ability to withhold portions of the Canada Health Transfer (CHT) from provinces, under the *Federal-Provincial Fiscal Arrangements Act*. This ability stems from the federal spending power (which is inferred from sections 91(1A), 91(3), and 106 of the *Constitution Act, 1867*) and from the discretionary and mandatory penalty provisions set forth in the CHA (which are discussed further, below).

As one legal scholar succinctly stated: “Because compliance with the terms and conditions of the *Act* is entirely voluntary (the only penalty being the withholding of federal funds), the legislation

is constitutionally unobjectionable” (Jackman 2000, 98). Additionally, “the CHA does not create a legally binding set of obligations on either the federal or provincial level of government ... the legislation is not justiciable; as federal legislation, it neither has nor requires provincial consent and is not legally binding on either party. The federal government can change the legislation at any time while the provinces are in no way breaking the law if they implement practices contrary to the CHA” (Boychuk 2012). As a result, the CHA “provides considerable latitude for provinces to experiment with reforms, especially given that the *Act* embodies a much less restrictive model than either its critics or its supporters often portray” (Boychuk 2012).

The CHA leaves far more room for change than most people believe.

What the CHA Requires

From a legal point of view, the provisions of the CHA leave far more room for movement and change than most people believe. A plain legal reading shows that the provinces must meet five program criteria and two conditions in order to receive funding (CHT) from the federal government (CHA s. 7). Additionally, the provinces must not allow two specific conditions to arise, or the CHT will be reduced.

THE FIVE CRITERIA

The five criteria required by the CHA are: public administration (section 8); comprehensiveness (section 9); universality (section 10); portability (section 11); and accessibility (section 12).

Essentially, the public administration requirement means that a provincial health insurance plan “must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province.” Comprehensiveness means that a pro-

vincial health insurance plan “must insure all insured health services provided by hospitals, medical practitioners, or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.” Universality means that a provincial health insurance plan “must entitle one hundred percent of the insured persons⁶ of the province to the insured health services provided for by the plan on uniform terms and conditions.” Essentially, portability means that a provincial health insurance plan: (1) must not impose any minimum period of residence in excess of three months before residents of the province are eligible for coverage by the plan; (2) must provide coverage for any minimum period of residence in another province to those insured persons who move to another province; and (3) must pay for the cost of insured health services provided to residents who are temporarily absent from the province (with pay rates to reflect the rates in the province where the resident is travelling, or to reflect the rates in the home province, if the resident is travelling outside of Canada, and where prior consent of the home province may be required for non-emergency services). Finally, the accessibility requirement effectively means that a provincial health insurance plan must provide for: (1) insured health services “on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services” by insured persons; (2) payment for insured health services (per a legally-authorized tariff or system of payment); (3) reasonable compensation for all insured health services rendered by medical practitioners or dentists; and (4) payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services. Provincial premiums, if not paid by a resident, must not lead to restrictions in access.

An analysis of what is “medically necessary” or “medically required” is key to interpreting the CHA and provides great opportunity for the provision of health care services by the public sector. (See the discussion of *Flora v. Ontario*, below.) To clarify, per section 2 of the CHA, publicly insured health care services include “medically necessary” surgical, surgical-dental, nurs-

ing, physiotherapy, radiotherapy, pharmaceutical, laboratory, radiology, and other diagnostic services provided in hospitals for the purpose of maintaining health, preventing disease, or diagnosing or treating an injury. “Medically required” services provided by physicians also are “insured services” under the CHA.⁷ The CHA does not provide a definition of “medically necessary” or “medically required” and the courts have not developed a universally applicable definition either. As a result, it has been at the discretion of provincial governments under provincial health insurance legislation (often in consultation with medical associations) to determine what is included under the umbrella of “medically necessary” services. Health care services which otherwise would qualify under the CHA but which are not insured by a particular province are, by the legislature’s or regulator’s omission, not “medically necessary.” In my view, the legislature’s decision as to what publicly funded health services “insured” persons are entitled to receive is an appropriate decision for our provincial legislatures to make. This point is well enunciated in *R. v. Cambridge Health Authority*, British Court of Appeal, ex p B [1995] 1 WLR 898:

They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. ... Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the Court can make.

However, having made a decision to not insure certain medically necessary services based on a requirement to allocate scarce “tax” resources, the legislature should not prohibit Canadians from paying or insuring health services that the provincial legislature chooses not to publicly insure (see the discussion of *Flora v. Ontario*, below).

THE TWO CONDITIONS

Section 13 of the CHA requires that the provincial government shall (1) provide information to the federal Minister of Health “of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this *Act*” and (2) recognize the Canada Health Transfer in any public documents, or in any advertising or promotional material, relating to insured health services in the province. Basically, the federal government requires sufficient information to determine if any discretionary or mandatory penalties should be administered and it requires public recognition of its fiscal contributions to the provinces.

There is no history of discretionary penalties imposed for non-compliance with the CHA.

DISCRETIONARY PENALTIES

Pursuant to sections 14 to 17 of the CHA, the Minister has the discretionary power to withhold CHT from a province that fails to meet any of the five criteria or the two conditions discussed above. In 1999, Canada’s Auditor General “found that the federal government has never imposed discretionary financial penalties on provinces and territories for non-compliance with the five criteria of the CHA. In its interactions with provinces and territories, the federal government has attempted for the most part to adopt a non-intrusive approach to compliance, based on discussion, negotiation, and persuasion” (Desautels 1999, Chapter 29). The Auditor General cited six cases where such resolutions were brokered. “Four of these cases took 14 to 48 months to resolve, while the remaining two went on for as long as five years without penalty” (Desautels 1999, Chapter 29). Other cases were not resolved at the time of the report but no penalties had been imposed. It appears that no penalties were levied between 1999 and 2011 either. Health Canada’s 2010-2011 *Annual Report* on the CHA includes a

section entitled “History of Deductions and Refunds Under the *Canada Health Act*.” The section sets forth a description of mandatory deductions over the decades but there is no mention of any discretionary deductions (2012).

MANDATORY PENALTIES

Pursuant to section 18 of the CHA, a province will not qualify for a full cash contribution for a fiscal year if payments are permitted by the province, under the provincial health care insurance plan, “in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.” Section 2 of the CHA defines “extra billing” as “the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.” In other words, doctors and dentists must accept the provincial payment for the service as payment in full.

Pursuant to section 19 of the CHA, a province will not qualify for a full cash contribution for a fiscal year if the province has permitted user charges under the health care insurance plan of the province.⁸ Section 2 of the CHA defines “user charge” as “any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.” For example, if a province required all patients seeking treatment at an emergency room to pay a \$20 co-pay, that would constitute a user fee.

Sections 20 and 21 of the CHA set forth the mandatory deductions which should be made by the federal government in relation to any extra-billing or user charges that are imposed in a province in a given year. These are dollar-for-dollar deductions. In 1999, Canada’s Auditor General reported that “Mandatory financial penalties have been used on a number of occasions to discourage provinces from continuing to allow extra-billing and user charges. For example, from 1984 to 1987 approximately \$245 million was withheld from the cash contribution to seven provinces. ... From 1992 to 1995, some \$2 million was deducted from transfer

payments to one province that permitted extra-billing. Under the federal policy on private clinics, a total of approximately \$6 million has been withheld since November 1995 from four provinces where patients were charged a ‘facility fee’ for medically necessary services. One province is still not complying with the federal policy on private clinics and is being penalized in the amount of \$4780 per month” (Desautels 1999, Chapter 29). These numbers are supported by Health Canada’s 2010/11 *Annual Report*, which states: “Since the passage of the *Canada Health Act*, from April 1984 to March 2011, deductions totalling \$9,238,332 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the *Act*. This amount excludes deductions totalling \$244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated.”⁹

The CHA does not dictate how insured health services must be provided.

Perhaps the most interesting factor to consider is the reduction in mandatory penalties that has occurred over the years. In the *Toronto Star* on April 20, 2011, Thomas Walkom writes, “Most of the time, Ottawa prefers not to confront recalcitrant provinces. Still, between 1984 and 2006, the federal government levied penalties averaging about \$400,000 a year. Since Harper came to power, however, federal [M]edicare penalties have shrunk to about \$84,000 annually.” Documents which were provided to the author in response to Freedom of Information requests shed some light on mandatory penalties, as well as on Ottawa’s increasing tendency to try to reach agreement over issues related to extra-billing and user charges. One example of a mandatory penalty is seen in Nova Scotia’s submission to Health Canada regarding the actual amounts

of extra-billing and user charges imposed by the province during the period from April 1, 2003 through March 31, 2004. Although no extra-billing occurred in the 2003/04 fiscal year, the province charged \$15,967 in user charges for insured services (therapeutic abortions) provided by physicians at the Morgentaler Clinic. In 2005, however, the same issue (albeit in a different province) was handled in a different manner. The federal Minister of Health corresponded with the New Brunswick Minister of Health and Wellness, raising concerns about the province's "coverage for abortion services considered to be medically necessary." The federal Minister expressed concern that New Brunswick might not be in compliance with the requirement that medically necessary services be covered whether they are provided in a hospital or in a facility providing hospital care. After stating that several years of discussions had not resolved the issue, the federal Minister chose to "move to the resolution stage of the *Canada Health Act* Dispute Avoidance and Resolution (DAR) process agreed upon by the provinces and the federal government in April 2002." Although documents showing the results of the DAR process were not provided to the author, it is clear that a resolution was reached, as there were no deductions from (or refunds of) the federal government's CHT contributions to New Brunswick from fiscal years 2004/05 through 2010/11 (Health Canada 2012).

In April 2004, appearing before the Standing Committee on Health, federal Health Minister Pierre Pettigrew acknowledged that changes were in order when he described the federal approach to establishing penalties as "slapdash". "I believe we need to review existing CHA dispute avoidance mechanisms to make them more transparent and inclusive and to ensure enforcement is more consistent and evidence-driven" (April 27). Pettigrew also suggested "that provinces should be involved in shaping a fairer process" (Laghi April 24 2004).

What the CHA Does Not Require

It is vital to note those areas where the CHA remains silent or, put another way, those subjects over which it provides zero power to withhold

CHT from the provinces.¹⁰ Each of these items opens numerous possibilities for those provinces that wish to pursue innovative means to bolster and improve their health care systems.

- The CHA does not dictate how insured health services must be provided.
- It is silent as to who may provide the services (for example, it does not discuss how health care services in a hospital should be divided up between physicians, registered nurses, and other health care providers).
- It does not require physicians either to opt in or opt out of the public health system.¹¹ Furthermore, the *Act* does not take a stance as to whether a physician may work both inside and outside the provincial public insurance program.¹²
- The *Act* does not discuss whether fees may be charged for non-insured health services.¹³
- It says nothing about whether insured health services must be delivered by public entities (or not-for-profit entities) only.
- As aforementioned, the CHA does not define "medically necessary" or "medically required." (Generally, provinces have a list of approved services and physicians have some discretion within the list.)
- It does not prohibit a province from adding other types of health services (services other than hospital services and physician services) to its list of insured health services. (For example, a province could reduce the use of costly hospital services by investing in preventative medicine, pharmaceuticals, home health care, and other services which would cost less and, evidence suggests, provide more appropriate care and achieve better results for a vast number of patients.)

A little further examination of one of these items – the definition of "medically necessary" – may serve to illustrate how focusing on the areas where the CHA is silent can enlighten the provinces as to the great flexibility they have when it comes to reforming their health care systems. In 1997, the National Forum on Health published a report which, among other things, delved into the many issues related to the *Act's* failure to define "medically necessary." Among other things, the report stated that:

The *Act* requires public insurance of hospital and medically necessary physician services but does not require public funding of anything else. ...

In practice, the health care system has defined services as either medically necessary or not to identify which services will be paid for by the public purse, and which will be left to private insurance of individual consumers. This has two predictable consequences: the public system will pay for some services that are inefficiently or ineffectively deployed, while other potentially very useful and – on the grounds of common sense – necessary services will not be publicly funded. ...

[I]t is clear that many [uninsured] services are medically necessary by any common-sense definition. ...

An unintended consequence of the *Canada Health Act* definition of medical necessity is an incentive to provide services either in hospital or by a physician to guarantee publicly funded status. This is another problem with the arbitrary definition: a preference emerges for inefficient deployment of resources in order to ‘play the game’ mandated by the *Canada Health Act*.

... many of the problems associated with the definition of medical necessity arise from the traditional fee-for-service reimbursement mechanisms for physicians. When the state pays for services on an itemized basis, it is essential to define which items are reimbursable and which are not. The judgment about whether something is medically necessary in the end has very little to do with its anticipated health benefit per se. It has everything to do with whether physicians are paid for their efforts.

Chaoulli v. Quebec (Attorney General)

The landmark case of *Chaoulli v. Quebec (Attorney General)*, which was decided by the Supreme Court of Canada in 2005, provides an excellent example of how the CHA is less restrictive than

most people believe it to be. This case, which has significance for the entire country, makes the powerful statement that if a vital health service is not provided by the government, an individual has the constitutional right to pay for the service either directly or through private health insurance. Although the facts of this case focus on a patient’s right to have timely access to medical services, there are other implications, such as a patient’s right to access medically necessary services that the government chooses not to insure. The majority of the Supreme Court held that Quebec’s law prohibiting private insurance for medically necessary hospital and physician services violated section 1 of the *Quebec Charter of Human Rights and Freedoms (Quebec Charter)*. Three of the seven judges also found these laws to be in breach of section 7 of the *Canadian Charter of Rights and Freedoms (Charter)*, while one expressed no opinion on the application of section 7 of the *Charter*.

The Chaoulli decision essentially proposes that the status quo is no longer a legal option.

Chaoulli has created the foundation to dramatically alter the landscape of the Canadian health care system, essentially standing for the proposition that the status quo no longer is a viable or even a legal option.¹⁴ Each of the courts which heard the *Chaoulli* case, including the Superior Court of Quebec, the Quebec Court of Appeal, and the Supreme Court of Canada, agreed that lengthy wait times and delays in obtaining treatment cause patients both physical and mental harm, and are a violation of their rights under the *Charter*, although the two lower courts dismissed the action on other grounds.

The application of the Court’s decision in *Chaoulli* is not limited to Quebec but affects all Canadian provincial health care systems. Canadian provinces which fail to deliver timely health care services can no longer deny patients the opportunity to spend their own money to pur-

chase health care insurance plans that cover hospital and physician services which already are included in a province's public insurance plan. Arguably, *Chaoulli* imposes obligations on provinces to provide "insured" medically necessary services in a timely manner and prohibits the governments from imposing barriers on Canadians from paying for medically necessary services that the government chooses not to provide or that they do not provide in a timely manner. For example, the provincial governments' slow and restrictive adoption of medical technologies, drugs, appliances, and procedures and the provinces' defining the scope of "medically necessary" insured services would be a violation of section 7 of the *Charter* if the provincial government also tried to prohibit insured persons from paying for those non-insured services. Such measures couched in the rhetoric of "cost containment", while prohibiting individual choice of private payment, should no longer be acceptable in a post-*Chaoulli*, patient-centric Canada.

For example, Adolfo Flora cited *Chaoulli* to challenge a denial of critically-needed, medically necessary treatment by the Ontario Health Insurance Plan (OHIP). Mr. Flora required a liver transplant in order to survive but he was not deemed to be a suitable transplant candidate pursuant to Ontario transplant guidelines. He sought treatment in England and, after a successful transplant that saved his life, he sued the government of Ontario for reimbursement of the cost of his foreign surgery. Although Mr. Flora's lawsuit was unsuccessful, the courts' decisions provide important guiding language for future challenges. For example, the Ontario Superior Court of Justice stated that health care treatment decisions by physicians, specifically those that deny care, constitute state action which attracts *Charter* scrutiny. The "government is not permitted to shield itself from constitutional review by hiding behind its private delegates or the algorithms that determine its policies on the bases of what private actors do" (*Flora v. Ontario*, [2007] O.J. No. 91 at ¶166 [*Flora*].) Mr. Flora lost his suit because, according to the Ontario Superior Court of Justice, the OHIP regulation at issue in the case did not prohibit an individual from accessing or arranging for his or her own out-of-province health care treatment,

whereas the Quebec legislation in *Chaoulli* entirely prohibited access to urgently needed care (¶174). Perhaps the most crucial language in the *Flora* decision is where the Superior Court observed that the Supreme Court of Canada's jurisprudence has established a certain amount of protection or freedom from state interference in the manner in which individuals arrange their health care:

The legislative prohibition against private health insurance in *Chaoulli* violated s. 7 of the *Charter* because through it, the state impinged on s. 7 rights in an arbitrary fashion. ... In *Chaoulli* ... the state took action to prohibit something. The prohibition in [*Chaoulli*] meant that the individual was not allowed to take his or her desired course of control over his or her own health without suffering consequences imposed by the state. ¶202, 204

This observation suggests that, despite the negative decision in *Flora*, in respect of Mr. Flora being reimbursed for his treatment in England, it does bolster the argument that if the government chooses not to insure a medically necessary service, then the government should have no right to prohibit the person from paying for the medically necessary but uninsured service. This last point is certainly consistent with a patient-centric model of providing care to our citizens. In respect of Mr. Flora, one can accept the fact that he was not entitled to be reimbursed for the care he received in England while questioning why Mr. Flora could not have paid for and received treatment in Ontario where he could have drawn upon the support of his family and friends. This last point is consistent with Cancer Care Ontario's announcement on July 28, 2006 that if a requested cancer drug was not on the Ontario's formulary, then Ontario hospitals should develop guidelines to allow patients to pay for the non-formulary drugs. Based on the above, Ontarians should have greater freedom to choose where and how they obtain uninsured health care treatment and, consequently, the door is open to significant opportunities for new private health care initiatives.

Stein v. Québec (Régie de l'Assurance – maladie) is a Quebec case similar to *Flora*. In *Stein*, the is-

sue was the determination by an administrative board not to reimburse the patient for costs incurred for treatment outside the province (for a procedure that was not available at all in Quebec – whether single-payer paid or user-paid). As one author notes, the circumstances and findings in *Stein* support the argument that provinces cannot avoid providing quality care merely because of their parsimony or the backwardness of their medical technology:

If the government does not insure a medically necessary service, then it should not prohibit the person from paying for the service.

The Court found that it was patently unreasonable to refuse coverage for these treatments, which saved or at least prolonged the patient's life. The Court stated that "to maintain that it was reasonable to make *Stein* continue to wait for surgery in Montreal when the danger to his wellbeing increased daily is irrational, unreasonable, and contrary to the purpose of the *Health Insurance Act*, which is designed to make necessary medical treatment available to all Quebecers." (Goldring 2005, 6)

As the Supreme Court of Canada stressed in *Chaoulli*, "the *Canada Health Act* does not prohibit private health services" (¶16). In her concurring majority opinion, Justice Deschamps acknowledges the existence of a significant private sector role in health care in Canada, writing:

In reality, a large proportion of health care is delivered by the private sector. First, there are health care services in respect of which the private sector acts, in a sense, as a subcontractor and is paid by the state. There are also many services that are not delivered by the state, such as home care or care provided by professionals other than physicians. In 2001, private sector

services not paid for by the state accounted for nearly 30 percent of total health care spending. (¶17)

The majority of the Court, composed of Chief Justice McLachlin, and Justices Major and Bastarache, (Deschamps concurring) held that prohibitions against the purchase of private health insurance in Quebec violated section 1 of the *Quebec Charter* and that such a violation could not be justified under section 9.1 of the *Quebec Charter*, which provides:

in exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order, and the general well-being of the citizens of Quebec. In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law.

The majority further held that the prohibition against private insurance "impermissibly limits the right to life, liberty, and security of the person protected by section 7 of the [Canadian] *Charter*" and such limitation was not demonstrably justified as reasonable under section 1 of the *Charter* (*Chaoulli* ¶102).

Lengthy delays for care is tantamount to failure to provide essential health care.

The Court held that, by prohibiting individuals from purchasing private health insurance to cover medically necessary services, the state created a virtual monopoly over the public health care scheme (*Chaoulli* ¶106). The Court reviewed extensive evidence of a provincial health care system failing to meet the needs of its citizens for essential health care services, as a result of lengthy delays and wait times for care. The majority agreed that the prohibition against private insurance allowed or contributed to such delays. The majority held that these delays in access to medically necessary health care treatment, and resulting pain, suffering, and potentially death,

infringe Canadian patients' rights to life, liberty, and security of the person, and therefore violate section 7 of the *Charter* (Weinrib 2005, 63). This statement by the Court alone marks a critical watershed in Canadian health law and policy. Despite disagreement among the panel of judges with respect to the justifiability of *Charter* violations in this case, the importance of this pronouncement by the Court to the future of health care in Canada cannot be understated. McLachlin C.J.C., for the majority, writes "where the public system fails to deliver adequate care, the denial of private insurance subjects people to long waiting lists and negatively affects their health and security of the person" (*Chaoulli* ¶152). The majority ultimately held that, where the state creates a virtual monopoly over the provision of necessary services, it must do so in accordance with basic principles of reasonableness and fairness (Weinrib 2005, 61).

Chaoulli was confirmation that the Charter provides protection against government inaction.

Chaoulli was definitive confirmation that the *Charter* provides protection against government inaction, as well as protection for Canadians when government acts in violation of guaranteed rights and freedoms. When Canadian governments have a monopoly over the supply of an essential service, they must meet obligations in the supply of that service (Kirby 2005). If governments wish to be the exclusive providers of health care services in a 'public' system, they must provide health care in a manner that does not deprive individuals of life, liberty, or security of the person. The legislative barriers to access insured health care services privately, combined with lengthy waiting lists, deprived reasonable and necessary access. As McLachlin C.J.C. wrote for the majority in *Chaoulli*, "access to a waiting list is not access to health care" (¶123).

Arguably, the Supreme Court's decision in *Chaoulli* applies to every provincial health care

system in Canada, but is particularly relevant for those that ban private health care insurance. The Court's decision imposes legal obligations on all provincial health care systems to provide timely and quality health care or risk infringing the *Charter*. Obligations under the *Charter*, particularly when explicitly articulated by the Supreme Court, apply to all of Canada. Stanley Hartt argues that making distinctions between the *Quebec Charter* and the *Canadian Charter* for purposes of limiting the scope of *Chaoulli*'s implications "does not represent a strong legal argument that the reasoning in *Chaoulli* would not apply in another province," and that those who seek to make such distinctions are "grasping at straws" (Hartt 2005, 510). Provinces with analogous prohibitions against private insurance for health care, which fail to deliver timely and quality health care, and provinces without such a prohibition but with lengthy delays and care of questionable quality and restricted access to care through other measures, are open to constitutional challenge following *Chaoulli*. Moreover, *Chaoulli* is principally a case about access to health care. Accessibility is a core, enshrined principle of the CHA.

If the state fails to provide reasonable services, it cannot constitutionally prohibit citizens from obtaining private care.

To the extent that *Chaoulli* has altered the meaning of accessibility under the CHA, this new and improved accessibility applies not only to Quebec, but to all Canadian provinces as a condition of receipt of public funding. Furthermore, under section 7 of the *Charter*, every Canadian citizen has the right to life, liberty, and security of the person, and the right not to be deprived of these rights. Therefore, any provincial health care system that creates a monopoly over the provision of health care and creates barriers to access that jeopardize citizens' section 7 rights is subject to a constitutional challenge. Certainly,

the Court's statements that prohibitions against private insurance cannot be sustained where care is not being delivered in a reasonable and timely manner, and the principle that when the "government chooses to act, it must do so properly" (*Chaoulli* ¶158) cannot reasonably be interpreted as applying only to Quebec.

Although waiting lists for health care services were, as noted above, the focus of the constitutional challenge in *Chaoulli*, the scope of the application and implications of the Court's decision in *Chaoulli* extends far beyond waiting lists. Rather, *Chaoulli* establishes an obligation on governments generally to provide insured medically necessary services in a reasonably timely manner and prohibits the government from imposing barriers on Canadians from paying for medically necessary services that the government chooses not to provide or that they do not provide in a timely manner. In perhaps the most critical paragraph of the Court's decision, the majority states that a prohibition on obtaining private insurance "is not constitutional where the public system fails to deliver reasonable services" (¶158). As Lorraine Weinrib writes, "the *Chaoulli* judgment makes clear that the state is bound by the *Charter* when it establishes and administers a public health care system. At a minimum, the state must deliver health care in a way that does not seriously breach the right to life, liberty, and security of the person" (2005, 6-7). If the state fails to provide such care, it cannot constitutionally prohibit citizens from obtaining the care privately (*Chaoulli* ¶123-124).

The above point has been identified by insurance companies in Canada and there are now insurance products being offered that specifically insure medically necessary services that are not insured by the provinces' health insurance plan.

III. Change Is Coming, Whether Provinces Like it or Not

Future Reductions to the Canada Health Transfer

The current Canada Health Transfer, which resulted from federal-provincial negotiations, is set to expire in 2014. In December of 2011, the federal government announced a unilateral renewal of the CHT.¹⁵ On January 19, 2012, the Office of the Parliamentary Budget Officer provided further details when it issued *Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability*. In this publication, the PBO articulated the following:

Present Through 2017

- The CHT will continue to grow at 6 percent annually through 2016/17.
- This rate of increase is only marginally lower than PBO's projected growth in provincial-territorial government health spending over 2007–2016 (6.1 percent average annual growth).

2017 Through 2025

- Starting in 2017/18, the CHT will "grow in line with a 3-year moving average of nominal GDP growth" (with a guaranteed minimum increase of 3 percent per year).
- PBO projects that CHT cash transfers will grow an average of 3.9 percent annually from 2017/18 through 2024/25.
- This rate of increase is significantly lower than PBO's projected growth in provincial-territorial health spending over the same period (5.1 percent average annual growth).

2025 Onward

- The CHT will be reviewed again in 2024. "However, beyond 2024/25, PBO assumes

that the CHT escalator formula (i.e., the 3-year moving average of nominal GDP growth) will be maintained indefinitely.”

- PBO “projects that growth in provincial-territorial health spending will further outpace growth in CHT cash transfers over 2025/26 to 2040/41 (5.3 percent versus 3.8 percent average annual growth) if the new escalator is maintained beyond 2024.”
- If the new CHT escalator formula is maintained, PBO projects that the share of federal CHT cash payments in provincial-territorial health spending will decrease substantially from 20.4 percent in 2010/11 to average 18.6 percent from 2011/12 through 2035/36, then 13.8 percent over the following 25 years, and 11.9 percent “over the remainder of the projection horizon. This would ultimately bring the level of federal cash support to historical lows [11.1 percent on average] observed under the 1996/97 to 2001/02 period of CHST (Canada Health and Social Transfer) Funding.”

A Hands-Off Approach by the Federal Government

The federal government’s unilateral renewal of the CHT has been described as a “take-it-or-leave-it deal” which has “no-strings-attached” and which “reflects a growing hands off approach to healthcare in federal politics” (Tsang and Neves 2012). Some analysts view this in a negative light. Adrian Tsang and Justine Neves state that “[u]nder the new plan, Stephen Harper threatens to narrow the already limited input that the federal government has in a domain where it makes substantial annual investments. Ottawa has in a sense become a hands-off funder, while leaving responsibility to the provinces to continue to provide essential health care services that Canadians have come to expect on terms guaranteed by the *Canada Health Act*” (2012). Rather than viewing this approach as a threat, however, it is possible to see it in a very positive light.

Increasing financial pressures on the provinces, combined with decreasing control measures taken by the federal government, create a situation that is very similar to the environment that surrounded social assistance payments and programs in the early 1990s. In 2011, the Mac-

donald-Laurier Institute published a paper concerning how legislators could apply the welfare reform lessons of the 1990s to the health care predicament that exists today (Clemens 2011). Without repeating the entire contents of that paper, it is important to note that (1) welfare dependency had reached unsustainable rates (10.7 percent of the population in 1994); (2) the federal government reduced funding to the provinces for social support programs; and (3) the provinces implemented numerous reforms to make the system sustainable (and, arguably, to improve welfare programs as well). The reforms varied from province to province, as each strove to deal with its unique challenges. In hindsight, reforming the provincial welfare systems was an extremely wise thing to do, which may, in fact, have prevented the collapse of the systems.

The provincial welfare reforms were not limited to a simple reduction in benefit levels. One reason for this is that there “was an increasing understanding that when welfare benefits surpass comparable income available from low-paid work, incentives were created to enter or remain on welfare” (Clemens 2011, 4). Therefore, provinces focused on creating new incentives for people to enter the work force.

Provinces spend health care dollars on acute and long-term care with little allocated to prevention.

A similar strategy is needed in regards to the provision of health care services. Provinces overwhelmingly spend the funds they allocate to health care services on acute care and long-term care with little allocation of funds to health and wellness promotion or management of chronic illnesses (which can be provided in the community).

In addition, provincial governments will need to develop incentives to improve the value patients receive for the dollars the provinces are spending for their insured patients’ care.

When measuring value, both outcome and costs must be measured over the full cycle of care, not for discrete interventions or procedures ... The cycle of care involves not just treatment but rehabilitation, long-term management of a medical condition to minimize recurrences. The care cycle also encompasses assessment of risk of disease and steps to prevent occurrence or progression. Value must be understood as the outcomes and costs over the whole cycle, not just for the individual components. (Porter and Teisberg 2006, 99-100)

Any significant shifts in health care policy, however, will require significant political will, as well as substantial public consultation and engagement, in light of health care's status as the proverbial third rail of Canadian politics.

Conclusion

This paper is not intended to provide a blueprint on how to repair provincial health care systems. However, it is imperative that provincial legislators have a clear understanding about what services are required (and, just as importantly, not required) by the CHA. If legislators recognize the flexibility afforded by the CHA and can contemplate reforms with a certainty that provincial actions will not be impeded by arbitrary federal interventions, they will find that there is enormous room for innovative changes that could address not only the provinces' financial difficulties in insuring health care but also the significant quality concerns related to the health care system in this country.

In 2004, an opportunity for an intelligent, thoughtful, responsible, and substantive discussion of an issue that is consistently rated as one of the top priorities of Canadians slipped away when political actors on all sides opted to score points (or play defence) rather than behave like true policy-makers and thought leaders.

If there is to be any hope for responsible action to deal with the health care challenge, we know that real change must and can come from the provinces. Provinces should investigate and address the costly and inefficient incentives that have been created by their own provincial health insurance plans. It is not in the federal govern-

ment's jurisdiction (or on its agenda) to engage in or foster (or hinder) any reformation plans. This paper has outlined a number of areas for potential action, each of which is ripe with possibilities for experimentation of the sort that are not governed at all by the CHA. Most of the obstacles to reform which people perceive to exist in relation to the CHA are not real. Rather, a close look at both the language of the CHA and its historical application shows that the *Act* allows for a great amount of freedom to experiment and improve the provincial health care systems. Given the "hands-off" approach suggested by the current federal government, one could argue that it might be reasonable to expect benign federal approval of such innovations. More importantly, given the current financial realities, changes must be made in order for provinces to sustain the provision of publicly administered, comprehensive, universal, portable, and accessible health care to their residents.

About the Author



Michael is a partner at Osler, Hoskin & Harcourt LLP and Chair of the firm's National Health Industry Group. Michael's practice focuses on providing legal, regulatory, and governance advice to the firm's public and private health care sector clients in order to ensure that their health care initiatives comply with federal and provincial legislation. Michael has been recognized by Lexpert and recently identified by Best Lawyers as Toronto's Health Care 2014 Lawyer of the Year.

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Endnotes

- 1 See the *Health Care Protection Act* (Alberta), Regulation 208/2000 under the *Health Care Protection Act* (Alberta), and Regulation 244/90 under the *Hospitals Act* (Alberta), which allow individuals to be charged for the provision of enhanced health services.
- 2 In fact, Canada does not have a single health care “system.” Each of the 10 provinces and three territories has its own legislation and regulations governing publicly-insured health care services in their jurisdictions. Additionally, a vast number of health care services are not publicly-insured and, therefore, must be paid for by patients or their third-party insurers. However, for the sake of brevity, the author shall use the word “system” throughout this paper to refer to the general quality of, provision of, and payment for health care in this country.
- 3 Public-sector unions “enjoy advantages that their private-sector rivals only dream of. As providers of vital monopoly services, they can close down entire cities. And as powerful political machines, they can help to pick the people who sit on the other side of their bargaining table” (The Economist January 6, 2011).
- 4 “Over the [most recent]10-year ... period, government health spending growth outpaced revenue growth in most of the provinces where taxes were increased”; “Provincial government health spending has grown at an average annual rate of 7.4% over the 10-year trend period examined in this report (1999/2000 to 2008/2009). At the same time, the average annual growth rate for total available provincial revenue has been only 6.5%. Provincial government health spending has also grown faster than provincial GDP, which grew at an average annual rate of only 6.4% over the same period” (Skinner and Rovere 2009).
- 5 Using health care quality “indicators” as defined by the OECD (2013).
- 6 Section 2 of the *CHA* defines an “insured person” as a resident of the province other than:
(a) a member of the Canadian Forces; (b) a ranking member of the RCMP; (c) an inmate in a penitentiary; or, (d) a resident of the province who has not completed a minimum period of residence (not to exceed three months) as may be required by the province for eligibility.
- 7 In some cases, “extended” health care services, such as home care, nursing care and ambulatory care may be publicly funded but this is not required by the *Act*.
- 8 There is an exception “in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.”
- 9 The *Act* required such refunds during the first three years after its enactment.
- 10 Bear in mind that “everything which is not forbidden is allowed” is a basic tenet of common law.
- 11 A Canadian physician may choose to give up his or her rights to bill the public plan and, instead, practice in the private sector. Several provinces reduce the financial incentive to do so by regulating that opted-out physicians cannot bill more than they would receive if they were working within the public plan. Other provinces allow opted-out physicians to set their fees at any level but the patients of opted-out physicians are not entitled to any public funds to subsidize the cost of buying the private services and, indirectly, this reduces physicians’ financial incentives to opt out of the public plan.

- 12 The major concern of many health scholars is that some provinces may allow physicians to provide medically necessary insured services both within the public system and the private sector. In the *Toronto Star* on March 1, 2006, Thomas Walkom writes, “The problem, as University of Toronto law professor Colleen Flood points out, is that at any given time there are only a limited number of doctors. If physicians are busy with their private-pay patients two or three days a week, they don’t have as much time for their [Medicare patients]. And that, in turn, means that waiting times within the public system will rise. ‘Countries that allow the free movement of physicians between the private and public systems, like the United Kingdom, New Zealand, Australia, have big problems with waiting lists,’ Flood said yesterday. ‘So why would this help?’” In *The Globe and Mail* on March 2, 2006 an editorial ran containing the following: “In a major comparative study in 2004, University of Toronto health-law expert Colleen Flood, who holds the federal research chair in health policy and law, compared health systems in five Western nations, including two that permit parallel private care. The result? Perhaps because specialists in New Zealand and England can practise in both sectors, public-sector waiting lists there did not decline. In fact, Dr. Flood concluded that specialists ‘may even have an incentive to maintain long waiting lists in the public sector to generate demand for services on a private basis.’ She added chilling estimates: If 10 per cent of Canadian specialist capacity were diverted to the private sector, the public wait for hip replacements could rise to 146 days from 126; the wait for knee replacements could rise to 205 days from 177; and the wait for cataract surgery could rise to 93 days from 80.”
- 13 The only issue would be if non-paying patients were denied access to insured services. If that did not occur, this would not constitute extra-billing.
- 14 Since the decision was issued, *Chaoulli* has been cited by at least 110 cases, which shows *Chaoulli*’s potential to significantly alter the health care landscape in Canada.
- 15 The pending legislative amendments may be found in Bill C-38, at section 392 et seq. See http://www.parl.gc.ca/content/hoc/Bills/411/Government/C-38/C-38_1/C-38_1.PDF#page=311 (accessed May 24, 2012).



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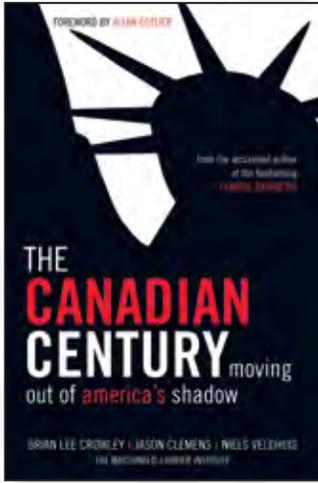
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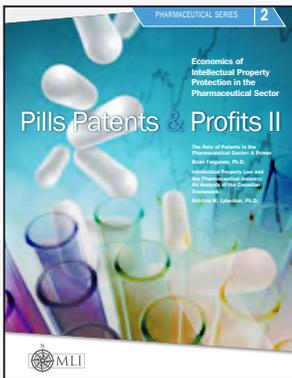


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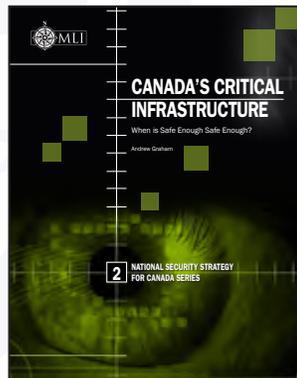
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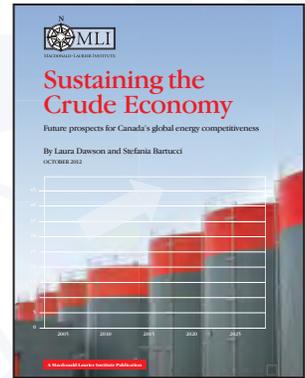
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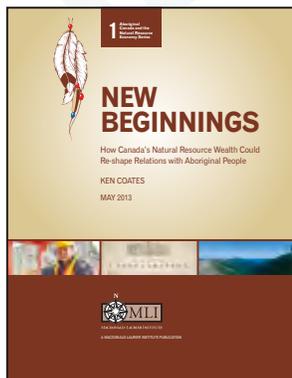
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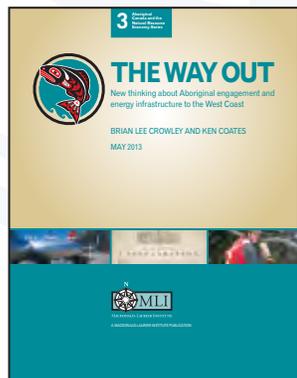
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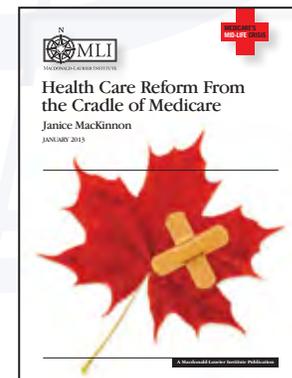
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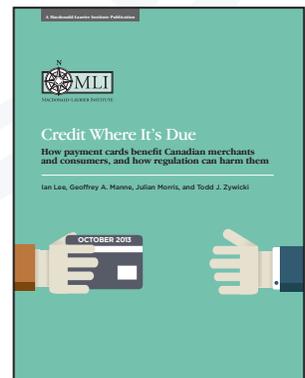
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