

C.D. Howe Institute

Benefactors Lecture, 2006

Chaoulli v Quebec
**and the Future of
Canadian Healthcare:**
Patient Accountability as the
“Sixth Principle” of the
Canada Health Act

Patrick J. Monahan
Dean, Osgoode Hall Law School

Toronto, November 29, 2006

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*C.D. Howe Institute
67 Yonge Street, Suite 300
Toronto, Ontario M5E 1J8
tel.: 416-865-1904; fax: 416-865-1866;
e-mail: cdhowe@cdhowe.org
Internet: www.cdhowe.org*

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Foreword

The Supreme Court's June 2005 judgment in *Chaoulli v Quebec (Attorney General)* opened a new chapter in the debate over Canada's approach to publicly funded health care. The key question in that case was whether restrictions on individual purchase of insurance for healthcare services covered by government plans violated the right to security of the person. In a 4 to 3 vote, the Court ruled that such prohibitions in the province of Quebec violated the Quebec Charter of Human Rights and Freedoms. Where the publicly funded system does not provide timely care, the Court said, forbidding individual purchase of care is unconscionable — "access to a waiting list," in a much quoted declaration from the judgment, "is not access to health care."

The narrowness of the vote, and the fact that the finding applied only to Quebec, on its face, sharpened the edge on the debate that followed. Defenders of medicare in its current form have generally condemned the Court's decision as opening the door to a parallel private system that will give consumers with more money better care and siphon producers from the publicly funded system. Critics of the current medicare model have generally welcomed the decision for upholding individual rights against a state monopoly and acknowledging the limits of a system that must, by its nature, ration a service for which demand will always exceed supply.

No end to these arguments is in sight. Restrictions on private purchase of insurance along Canadian lines exist in no other developed democracy, yet the devotion of many Canadians to this country's unique model runs deep. Constraints on the tax-funded system's ability to supply new providers and services mean that arguments against allowing resources to move into a privately paid system will continue to resonate, even as demographic change, technology, more informed patients — and perhaps even new health threats — further stress publicly funded services. Not surprisingly, governments have been slow to react to *Chaoulli*. Future litigation along similar lines is certain, and judges may play a central role in the future development of health-care in Canada.

For these reasons, the C.D. Howe Institute is pleased that Professor Patrick Monahan, Dean of the Osgoode Hall Law School, has agreed to deliver this year's Benefactors Lecture. Professor Monahan has been deeply involved, both as a commentator and a participant, in the debate over balancing individual rights against the demands of a single-payer, public sys-

tem. The Institute is particularly pleased to note that Professor Monahan wrote, with co-author Stanley Hartt, the 2002 C.D. Howe Institute Commentary, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, which anticipated the *Chaoulli* decision.

In this Lecture, Professor Monahan discusses the issues at stake in the debate over *Chaoulli*, and makes a powerful case that future court decisions will find it hard to overturn the logic that a declared collective interest in restricting private payment cannot override a sick person's right to seek timely care. What remedies future judges will impose will depend on the willingness and ability of governments to provide better and faster services in the publicly funded system. In the end, however, Professor Monahan is confident that the *Chaoulli* decision will have the effect of elevating accountability to patients as a core principle of medicare.

I wish to thank Professor Monahan for the energy and insight he brings to this task. I am also grateful to David Sutherland and IPSCO Inc. for sponsoring this year's Benefactors Lecture. I also add my thanks, and those of my colleagues, to the many reviewers who read and commented on drafts of the lecture. The Institute also gratefully acknowledges the excellent editing of James Fleming and the preparation of the manuscript for publication by Wendy Longsworth and Diane King.

The C.D. Howe Institute's aim in the Benefactors Lecture series is to raise the level of public debate on issues of national interest. In doing so, the Institute hopes to give Canadians information and analysis that they will find valuable in considering public policy challenges. As with all C.D. Howe Institute publications, the opinions expressed here are those of the author, and do not necessarily represent the views of the Institute's members or Board of Directors.

William B.P. Robson
President and Chief Executive Officer
C.D. Howe Institute

There is normally no shortage of critics or controversy surrounding Supreme Court of Canada Charter decisions. Nevertheless, the widespread condemnation by legal and health policy commentators of the Court's June 2005 decision in *Chaoulli v Quebec* was both striking and remarkable. As is by now well known, in *Chaoulli* the Supreme Court ruled that prohibitions on the purchase of private health insurance for services covered by the public health system were unconstitutional, given excessive waiting times in the public system. The Court's decision was variously described as "astounding" (Stewart 2005), as embodying a "Two-tier Magna Carta" (Marchildon 2005), and as a "Charter calamity waiting to happen" (Petter 2005). One respected critic denounced the decision as being "worse than *Lochner*" — *Lochner* being the now infamous and wholly discredited 1905 decision of the US Supreme Court striking down legislation setting maximum work hours in bakeries (Choudhry 2005). Critics saw the decision as striking a potential death knell to medicare, Canada's most cherished social program, and as mandating that the Quebec healthcare system "must be 'two-tier' to be constitutional" (Flood, Stabile and Kontic 2005). There were calls for the use of the Canadian Charter of Rights and Freedom's "notwithstanding" clause to override the Court, and even speculation as to whether a full nine-member panel of the Court could be prevailed upon to reverse the decision.¹

The alarm sounded by legal and health policy experts in relation to *Chaoulli* was in a sense quite understandable.² For one thing, the health policy community had little warning that such a legal outcome was likely or

* I acknowledge with thanks the extensive comments and discussions on earlier drafts of this paper provided by Howard Chodos, Stanley Hartt, Peter Hogg, Michael Kirby, Gareth Morley, Finn Poschmann, John Richards and Bill Robson, as well as by a number of anonymous external reviewers selected by the C. D. Howe Institute. I am also grateful for the able research assistance provided by Jesse Rosenberg, a member of the Osgoode Hall Law School class of 2008. Any errors remain my responsibility alone.

1 As Madame Justice Arbour had retired by the time the appeal was heard in June 2004 and Justice Iacobucci was about to retire, the Court sat in a panel of seven justices rather than nine and split 4 to 3 in favour of striking down the Quebec legislation at issue in the appeal. This prompted speculation as to whether the newly appointed justices (Abella and Charron) might be persuaded to rule differently on the issues raised in *Chaoulli* (see, for example, Russell 2005, 13-14, Petter 2005, 132).

2 It should be noted that it was legal experts who were particularly vocal in their criticism of *Chaoulli*; in contrast, a significant number of health administrators seemed to accept the legitimacy of the decision and the need to reduce wait times. (For example, Torgerson and McIntosh [2006] accept the need to address wait times and discuss ways in which this might be achieved post-*Chaoulli*.) It should also be noted that amongst members of the public there was broad support across all income groups and age groups for the Court decision; in a 2005 poll by Pollara Research, 59 percent of respondents indicated support for the decision with 39 percent opposed (Pollara 2005, 66).

even possible. The constitutional challenge brought by Dr. Jacques Chaoulli, a doctor who wanted to offer private health services, and George Zeliotis, a Quebec patient who had been on a waiting list for hip replacement surgery, had been rejected by both the Quebec Superior Court and a three-member panel of the Quebec Court of Appeal, albeit for slightly different reasons.³ Even though some eyebrows were raised when the Supreme Court of Canada agreed to hear the case, the expectation remained that the Court would ultimately affirm the rulings from the courts, accompanied, perhaps, by some *obiter*⁴ comments on the need to address the problem of waiting lists. Indeed, the Attorney General of Quebec did not even bother to make submissions on the appropriate remedy in the event that the Court were to find in favour of Dr. Chaoulli and Mr. Zeliotis and rule the impugned legislation invalid (Attorney General of Quebec, 2004).⁵ Thus the Court's 4 to 3 decision striking down the impugned provisions in Quebec law was truly a legal and political bombshell, which caught governments and the health policy community completely flat-footed.

What added to the concern of healthcare administrators and policy experts in the months following the ruling was the fact that *Chaoulli* seemed

3 Chaoulli and Zeliotis raised several grounds of objection to the Quebec ban on private insurance, arguing that it was not within the legislative jurisdiction of the province to ban it, that it constituted cruel and unusual treatment contrary to section 12 of the Canadian Charter, that it violated equality rights under section 15, and that it violated right to life, liberty and security of the person under section 7. At trial, the judge dismissed all the other grounds but found that there was a *prima facie* violation of rights protected by sec. 7; however, he concluded that the impugned legislation conformed with the principles of fundamental justice (and therefore was ultimately consistent with the section) in that it was in accordance with the values underlying the Charter, struck a balance between the interests of society and the individual and was necessary to achieve the government's goal of protecting the single-payer system (Flood et al. 2005, Appendix A, 555-6). The Quebec Court of Appeal wrote three separate decisions on this particular point: Justice Forget agreed with the trial court decision (pars. 60-63); Justice Delisle found that the right to enter into an insurance contract was an economic right not protected by sec. 7, that the threat was not imminent because Chaoulli was not himself ill, and because sec. 7 cannot be used to second guess a societal choice (pars. 24-30); while Justice Brossard held that no infringement occurred in this case because Chaoulli was not ill, although he seemed to hold the door open to a different decision in a future case.

4 *Obiter* or *obiter dicta* are statements in a judicial decision that are not strictly necessary to the resolution of the matter before the court. This contrasts with those elements of the court's reasoning that are necessary to the resolution of the case, called the *ratio*. Though *obiter* in a Supreme Court judgment would be highly persuasive in future decisions, it would not be binding; whereas all lower courts in Canada would be required to abide by the *ratio* of the same judgment.

5 Subsequent to the decision, the Quebec government returned to Court and sought a stay of the decision. In August 2005 the Court issued a stay of the judgment until June 2006.

to portend fundamental change in the ground rules governing Canada's publicly funded healthcare system without any clear road map of what direction such change could or would take. The healthcare system has evolved over many decades as a largely unregulated, tax-financed, pay-as-you-go monopoly. Most important decisions are negotiated behind closed doors between government officials and powerful provider groups with little input from users of the system. Within this context, the rationing of care by government through waiting lists can come to be seen as necessary, natural and inevitable. Indeed, as the dissenting judgment of Justices Binnie and LeBel in *Chaoulli* remarked, the absence of waiting lists could be regarded as more problematic than waiting lists themselves, since this would be evidence of a "substantially overbuilt healthcare system with idle capacity" (*Chaoulli*, par. 221). The lack of any meaningful accountability to patients for waiting times, pre-*Chaoulli*, is reflected in the striking fact that until recently there had been no serious attempt by governments or healthcare providers to measure the extent to which waiting for care represented a significant problem; it was left to private public policy research bodies to attempt to track the extent to which healthcare was being rationed through waiting (Esmail and Walker 2005).

Chaoulli threatened to fundamentally undermine this status quo by mandating that there are legal limits on the extent to which care can be rationed and on the permissible length of wait times. For the first time, patients and users of the system were not to be regarded as mere bystanders but as real stakeholders who could demand accountability for meeting reasonable service standards from those administering the system. What made this all the more novel and potentially disturbing for the health policy community was that these new ground rules were being introduced by the judiciary, who seemed to have no understanding whatsoever of the actual operation of the system and who appeared to have been hoodwinked by a series of allegedly specious arguments advanced by "health policy zombie masters."⁶

Largely overlooked in this academic debate was whether anyone had an answer to the fundamental question of principle that had moved the Court to intervene in the first place. This question was simply whether it was

6 See Barer (2005) who defines a "zombie" as "a seemingly sensible idea about the healthcare system that easily meets the test of surface plausibility but that, when viewed through a critical lens, turns out to have no basis in fact." What makes the idea a "zombie" is the fact that "it cannot be permanently killed, no matter how compelling the evidence." As the Court in *Chaoulli* had allegedly misinterpreted or ignored research evidence, Barer characterized them as servants of "health policy zombie masters" (p. 217).

legally and morally justifiable for the state, on the one hand, to require individuals to access healthcare services only through a universal, single-payer system and then, on the other, to deny them access to needed service when they were sick or dying. In such circumstances, which the Court found to prevail in Canada today, was it legitimate for the state to prohibit individuals from using their own resources to access the care they needed? Could the sick be legally compelled to wait indefinitely for care without legal consequences of any kind, even if it resulted in a serious deterioration of their health or even their death? Yet critics of the decision largely ignored this fundamental question, preferring to focus attention on subsidiary questions, such as whether the Supreme Court had a proper appreciation of the complex operation of health insurance in other OECD countries, or whether the courts had any business interfering in a complex policy area such as medicare.

Given the importance of this issue to the argument that follows, it bears explaining briefly why it cannot be legitimate in a free and democratic society to prevent individuals from utilizing their own resources to protect their health, in circumstances where the publicly funded system does not provide medical care in a timely manner. In these circumstances, the state is essentially forcing individuals to endure pain and even death in aid of the efficient operation of a social program. This offends the basic liberal principle that all persons should be treated “as equals”; that is, as entitled to equal concern and respect. No one citizen may be treated as a mere instrument to improve the welfare of another. Government fails to observe this bedrock moral principle when it imposes a “sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning his sense of his equal worth” (Dworkin 1985, 204). By way of illustration, as a democratic society we believe it would be wrong and immoral to put an innocent person to death, even if by so doing we might increase the health or welfare of others in society. The fundamental defect in such a proposal is that it treats the person to be sacrificed as a mere means to increase the welfare of others in society, rather than as an equal person entitled to the same concern and respect as those who stand to benefit from his or her death.

Nor is this merely a moral principle. The Supreme Court of Canada has indicated that the “ultimate standard” for justifying limits on rights must be the values of a free and democratic society, which values include respect for the “inherent dignity of the human person” (*R. v Oakes*, 136). It is for this reason that any healthcare system which deliberately and systematically imposes pain or even death on innocent individuals in the name of improving healthcare provided to others cannot be justified either morally or legally, since it fails to treat all individuals as equally deserving of concern and

respect. Nor could such a system be regarded as being in accordance with the “principles of fundamental justice” enshrined in section 7 of the Canadian Charter, since any legal regime which treated one person as a mere instrument for the satisfaction of the needs of another must be regarded as odious and fundamentally unjust. It is for this reason that the Supreme Court’s conclusion in *Chaoulli* was correct, both legally and morally.

On one matter the critics of *Chaoulli* have it right: I believe that the case does indeed mark a fundamental watershed in the evolution of Canada’s healthcare policy. Where I part company with the critics, however, is on the nature of that watershed and on its consequences for the future of medicare in Canada. Far from heralding the destruction of Canada’s publicly funded healthcare system, I believe that *Chaoulli* may provide the key to its reform and long-term sustainability. At bottom, what *Chaoulli* does is to introduce a new “sixth principle” beyond the five already enshrined in the *Canada Health Act*⁷ — that being patient accountability. Patient accountability means that those responsible for funding the healthcare system and providing care are ultimately answerable to patients for the timeliness of service provided and, further, that this accountability can be enforced through the legal system. In effect, the Court has affirmed that there are minimum and legally enforceable service standards that must be observed by those who control the provision of healthcare in Canada. This is because, as Chief Justice McLachlin and Justice Major noted in plain language in their judgment, “access to a waiting list is not access to healthcare” (*Chaoulli*, par. 123).

The principle of patient accountability is not simply a call for more funding for healthcare. Rather, as the Federal Advisor on Wait Times concluded in his Final Report, it requires that we “refocus the system to put the patient at the centre of our attention and problem solving” (Postl 2006, 50). Not only will this require changes in management techniques and innovations, but it will also necessitate a “general cultural shift within the health system and among professionals...[that] changes attitudes, assumptions and

7 *The Canada Health Act*, considered the foundation of Canadian healthcare, enshrined five principles: public administration (healthcare insurance must be administered by a non-profit agent of the provincial government); comprehensiveness (the insurance plan must cover all insured health services); universality (all insured persons of the province must be treated alike); portability (requires that Canadians be covered out of province and out of country for emergency services); and accessibility (access must be enshrined in law, not be unreasonably impeded by charges or otherwise, reasonable compensation must be provided to doctors and other medical professionals, and hospitals must be reasonably funded). In recent years, a variety of “sixth principles” have been proposed. A significant example came in British Columbia’s 2006 Speech from the Throne, in which the new principle of “sustainability” was proposed (see British Columbia 2006). However, the precise meaning of the principle was not defined.

patterns of behaviour of the leaders, managers and providers of care...” (Postl 2006, 50).

I believe that *Chaoulli* is a key milestone in the journey towards this transformation. The first section of the paper considers the Court’s decision, focusing in particular on the precise nature of the Court’s reasoning. I explain that the Court’s decision does not mandate a particular organization of the healthcare system but, instead, simply indicates that there are legal limits to the length of time that patients can be expected to wait for care in the context of a universal healthcare system. This is explained by contrasting the various lines of argument that were presented by the parties appearing before the Court, as well as by reviewing the reasoning relied upon by the two majority judgments.

I then consider the major criticisms that have been leveled at the majority judgments, both by the dissenting members of the Court and by academic and other critics. I explain that these critics have misinterpreted the majority judgments as somehow mandating an “American-style, two-tier” healthcare system. In fact, as I point out, all the Court has required is that if government wishes to maintain the universal nature of the public healthcare system and continue to preclude a parallel private system it may do so, provided that it ensures timely access to medically necessary care.

Finally, I examine the impact that *Chaoulli* has had thus far on governments and service delivery. While the actual changes implemented to date have been relatively modest, I argue that *Chaoulli* has made significant change — and change for the better — inevitable for the healthcare system. In effect, *Chaoulli* has created a new paradigm for the delivery of healthcare, one that includes the right of patients to timely medical care. Governments and healthcare administrators will now have to keep such rights front and centre as they plan needed reforms, or be forced to do so by the courts.

What does *Chaoulli* Decide?

Much of the controversy that has been generated by *Chaoulli* arises from a particular interpretation of the significance of the judgment. It is thus important to begin this discussion by clarifying precisely what the court did, and did not, decide. In my view, a careful reading of the two majority judgments of the Supreme Court indicates that the Court is not mandating a “two-tier” system of healthcare. Nor, indeed, does the Court specify the precise manner in which the delivery of healthcare services ought to be organized or paid for. What *Chaoulli* does require is that if Canadians are to be required to access healthcare through a single-payer, universal system, then services

must be provided in a reasonably timely manner. The failure to provide such service will mean that legal limitations on the right of individuals to access care outside of the single-payer, universal system will be unenforceable. But whether Canada is to maintain a single-payer, universal healthcare system, or permit the development of a parallel private-payer system alongside the publicly funded system, remains a choice for governments and legislatures even post-*Chaoulli*.

Arguments Before the Court

At issue in *Chaoulli* were two prohibitions in Quebec's healthcare legislation. The first was section 15 of the *Health Insurance Act* (R.S.Q., c. A-29), which prohibited anyone from contracting for private insurance for a service that was available through the public system. The second was section 11 of the *Hospital Insurance Act* (R.S.Q., c. A-28), which prohibited anyone from paying for services that were insured hospital services.

Dr. Chaoulli objected to these provisions on a variety of grounds.⁸ However, the key argument on which the Court's decision would turn was section 7 of the Canadian Charter, which reads as follows:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Dr. Chaoulli and Mr. Zeliotis advanced a number of distinct arguments in support of the conclusion that the impugned prohibitions in Quebec's health insurance and hospital insurance legislation were contrary to section 7 and could not be justified under section 1 of the Canadian Charter.⁹ For his part, Dr. Chaoulli argued that the impugned prohibitions violated his right as a patient to "choose between a public hospital and a private hospital funded exclusively from private moneys" (*Chaoulli* 2004, par. 148). Second, these prohibitions interfered with his right as a physician to "practice his or her

8 See note 3 above.

9 Sec. 1 of the Canadian Charter of Rights and Freedoms provides that the rights guaranteed by it are "subject only to such reasonable limits as are prescribed by law in a free and democratic society." In *R. v Oakes* a test was established to determine whether a limit in a particular case is "reasonable." The government must prove that it is a pressing and substantial objective, that there is a reasonable connection between its objective and the limit established, that the limit on freedoms has been minimized, and that the damage done to freedoms is proportional to the ends sought. In *Chaoulli*, the majority found that the ban on private insurance fails to meet the "minimal impairment" test as the government had not proved that another measure, short of a ban, might better protect patients' rights.

profession without constraint in the private sector” (Chaoulli 2004, par. 142). Counsel for Mr. Zeliotis advanced a different argument, to the effect that the prohibitions may have been necessary when the legislation was originally enacted in the 1970s in order to protect the integrity of the public healthcare system by ensuring that resources and healthcare professionals would not be drained off into a parallel private system. But in Mr. Zeliotis’ submission, these prohibitions were no longer necessary to achieve this purpose and, at most, the legislature was justified in requiring that there be sufficient resources available to the public system, while allowing individuals to “supplement the state’s limited financial resources by obtaining their own resources that the community does not need” (Zeliotis 2004, par. 72).

Both Dr. Chaoulli and Mr. Zeliotis were asking the Court to fundamentally redesign Canada’s healthcare system by holding that the right to purchase private health insurance was constitutionally protected by the Charter. These arguments had not succeeded either at the Superior Court or before the Court of Appeal; in both instances, the courts evinced extreme reluctance to second-guess the political branches in designing an equitable and efficient healthcare system.¹⁰ At the Supreme Court of Canada, both the Attorney General of Quebec and the Attorney General of Canada argued that the Appellants were raising essentially political questions that fell with the realm of “general public policy,” as opposed to the “inherent domain of the judiciary” (Attorney General of Quebec 2004, par. 85). According to the Attorney General of Quebec, the Appellants were challenging the “actual wisdom of government policy” in establishing a universal medical plan, and seeking the constitutional entrenchment of a parallel private system of health insurance. The Attorney General of Canada added that governments are best equipped to make these “complex, sensitive choices the appropriateness of which does not lend itself to judicial debate” (Attorney General of Canada Factum 2004, par. 6).

However, in addition to the Appellants Chaoulli and Zeliotis the Supreme Court appeal attracted the participation of a significant number of Interveners¹¹ who supported the legal conclusion advanced by the Appel-

10 As Justice Piché observed in her judgment in the Superior Court, “the solutions to the problems in the healthcare system are not to be found through legal channels” (see Flood et al. 2005, Appendix A, 558). Justice Delisle in the Court of Appeal concluded that “section 7 of the Canadian Charter cannot be used to judicially second-guess the appropriateness of a societal choice...” (ibid., par. 30, p. 560).

11 Intervener status allows parties other than those directly involved in a case to submit written and oral arguments. To be allowed to do so, the party must demonstrate (i) sufficient interest in the case, (ii) that it has something to contribute that would not necessarily otherwise be brought out, and (iii) that it will not overly complicate the length and

lants but based on a significantly different line of argument. According to this alternative argument, the fatal constitutional flaw in the existing legal regime governing the delivery of healthcare was the attempt to create a legal monopoly over insured health services without providing a guarantee that such services would be delivered in a timely manner. For example, as an Intervener, the Canadian Medical Association (CMA) supported the existing single-payer, publicly funded model of healthcare delivery and rejected the argument that there was a constitutional right to the establishment of a parallel privately funded healthcare system in Canada (Canadian Medical Association and the Canadian Orthopaedic Association 2004, par. 1). Nevertheless, the CMA objected to the prohibitions on access to privately funded care in circumstances where the publicly funded medicare system was not required, and was unable to provide, medically necessary care in a timely manner. According to the CMA, the fundamental issue that was raised was whether it was constitutionally justifiable for governments to legislatively preclude a patient from seeking access to necessary medical treatment, when such treatment was not available in a timely manner in the public system. In the CMA's view, the difficulty with the existing healthcare system was that there was no legal requirement of timely access to medically necessary care, with the result that governments were not being held accountable for the failure to provide medically necessary services in a timely manner in the public system. The CMA summarized its conclusion as follows: "medically necessary healthcare delayed is healthcare denied."¹²

A group of Interveners led by Senator Michael Kirby buttressed this argument by explaining that there were ways in which patients could be provided with a guarantee of timely service within the context of a single-payer, universal healthcare system.¹³ Senator Kirby and his colleagues had been members of the Standing Senate Committee on Social Affairs, Science and Technology, which had conducted a three-year study of the healthcare system and issued a comprehensive six-volume report in 2002 (see Standing Committee on Social Affairs, Science, and Technology 2002). The Senate Committee had strongly supported the single-payer, publicly funded model of healthcare delivery in Canada. However, the Committee also had antici-

footnote 11 cont'd

expense of the proceedings. Intervener status in important public interest cases has been gradually becoming more common.

12 For a similar line of argument see Factum of the Intervener, *Cambie Surgeries Corporation et al.* 2004.

13 See Factum of the Interveners Senator Michael Kirby et al. 2004. I disclose that I acted as co-counsel for the Interveners Senator Michael Kirby et al.

pated the *Chaoulli* litigation by concluding that Canadians' rights under section 7 were likely to be violated if timely access to publicly funded healthcare was denied while, simultaneously, Canadians were effectively prohibited from obtaining care in Canada privately.¹⁴

In order to protect the integrity of the universal healthcare system from such a constitutional challenge, the Committee had recommended the adoption of a healthcare guarantee, which would ensure that Canadians receive timely access to medically necessary healthcare services. The concept underlying the healthcare guarantee is to mandate that healthcare professionals set evidence-based maximum wait times for various procedures. Once this maximum wait time is reached, a patient would be entitled to immediate care, paid for out of public funds, even if that care had to be provided in another province or another country. The rationale for the healthcare guarantee was that, under medicare, governments have assumed responsibility for being the monopoly supplier of an essential service — healthcare. This meant that governments have an obligation to meet reasonable service standards, as defined by maximum wait times and the care guarantee (Standing Committee on Social Affairs, Science and Technology 2002, Vol. 6, Chap. 5: 117-120).

Senator Kirby and his colleagues did not suggest that the Supreme Court could or should directly impose the healthcare guarantee on governments. Rather, the point of their intervention before the Supreme Court was to counter the claim made by governments and other defenders of the status quo that any alteration in the Canadian healthcare system would automatically lead to US-style healthcare. The healthcare guarantee was evidence of the fact that there were other viable options available to governments that were consistent with the maintenance of a universal, single-payer system. Thus, the Court could require legal accountability for excessive and unjustifiable waiting times in the public system without fear of having embraced an American-style, two-tier system.

The Majority Opinions

The arguments raised by the CMA, Senator Kirby and other Interveners provided the foundation for the two Supreme Court judgments that found the impugned provisions to be unconstitutional. Turning first to the judgment of Chief Justice McLachlin and Justice Major, with whom Justice Bastarache concurred, the justices framed the issue before the Court in precisely these

¹⁴ Standing Committee on Social Affairs, Science and Technology 2002, Vol. 6, Chap. 5, p. 108. In coming to this conclusion, the Committee had relied on the legal analysis advanced by Hartt and Monahan 2002.

terms: in their view, the key difficulty is that the government and legislature has established a monopoly in the provision of healthcare services and then failed to deliver care in a timely fashion:

By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s.7 of the Charter...The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person. Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so (*Chaoulli* 2005, pars. 105-06).

Later in the judgment, Justices McLachlin and Major note that the question in the case is not whether single-tier healthcare is preferable to two-tier care. They further note that the prohibition on obtaining private health insurance might well be justifiable in circumstances where healthcare services are reasonable as to both quality and timeliness. But these prohibitions cannot be sustained where care is not being delivered in a reasonable and timely manner: "if the government chooses to act, it must do so properly" (*Chaoulli* 2005, pars. 108 and 158).

Similarly, Madam Justice Deschamps frames the question before the Court as being "whether Quebecers who are prepared to spend money to get access to healthcare that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state"¹⁵ (*Chaoulli*, par. 4). Justice Deschamps acknowledges that the government has the right to discourage the emergence of a parallel private healthcare system, but that the issue raised is excessive waiting times:

...when my colleagues ask whether Quebec has the power under the Constitution to discourage the establishment of a parallel private health

15 It should be noted that Justice Deschamps based her analysis on sec. 9.1 of the Quebec Charter of Human Rights and Freedoms and therefore did not find it necessary to rule on the question of whether the prohibitions in Quebec law were inconsistent with the Canadian Charter. Nevertheless the reasoning and analysis in her judgment are equally applicable to the Canadian Charter and, indeed, mirror precisely the analysis and conclusions of Chief Justice McLachlin and Justice Major. Senator Michael Kirby has also noted that it would be highly anomalous and the "ultimate in two tier healthcare" if Canadians living in one province have a right to timely health care but those elsewhere in the country can be forced to suffer pain or even death while waiting for care (see Kirby 2006).

care system, I can only agree with them that it does. But that is not the issue in the appeal. The appellants do not contend that they have a constitutional right to private insurance. Rather, they contend that the waiting times violate their rights to life and security. It is the measure chosen by the government that is in issue, not Quebecers' need for a public health care system. (*Chaoulli*, par. 14.)

A variety of arguments were raised in support of the prohibitions on access to private care. One such argument was that the prohibitions were necessary in order to prevent the emergence of a parallel private system, since such a parallel system would then drain off human resources from the public plan as many physicians and other healthcare professionals left the public plan. This could lead to increased waiting times in the public plan and diminish the quality of care available to those who were not in a position to afford private insurance.

There were a number of clear answers to this argument. First, governments themselves had created shortages in the public healthcare system by a variety of measures, including limiting the supply of doctors, capping specialists' incomes, or restricting the number of operating room hours available to surgeons as a means of rationing the number of procedures a surgeon can perform (see Kirby 2006). Having rationed the supply of medical personnel and services in this way, governments can hardly then argue that these government-induced shortages serve as a justification for preventing individuals from utilizing their own resources to protect their health. Government is perfectly entitled in maintaining the existing prohibitions aimed at suppressing the emergence of a parallel private healthcare system and, indeed, on taking steps to control costs, provided that it ensures that medically necessary care is available in the public system in a reasonably timely manner. What the government cannot do is attempt to have it both ways: it cannot legally require Canadians to access healthcare through a single-payer public system and then, by suppressing or rationing the availability of care, deny the services needed when Canadians are sick. As noted above, this was precisely the argument advanced by Justices McLachlin and Major as well as by Justice Deschamps.

Further, where the government seeks to justify a measure as a "reasonable limitation" under section 1 of the Charter, it is common for the courts to consider whether a similar limit has been enacted in other countries with analogous political and legal systems. In the event that other analogous jurisdictions have *not* enacted the prohibition(s) in issue, this is usually regarded as evidence that the measure cannot be "demonstrably justified in a free and democratic society" since there are other alternatives available to achieve the desired objective(s). In *Chaoulli*, both the majority judgments

pointed out that very few jurisdictions have attempted to totally ban individuals from using their own resources to access medically necessary care and yet jurisdictions without such bans had properly functioning universal healthcare systems. While all jurisdictions were struggling with similar problems — an aging population, paying for expensive new technology and drugs, and training enough healthcare workers — other jurisdictions had managed to deliver services in at least as timely a manner as Canada, and often in a timelier manner, without banning individuals from utilizing their own resources to protect their health. Thus, it can hardly be maintained that the prohibitions in question represent a minimal impairment of the rights of individuals who are forced to wait for medically necessary care in circumstances that can cause severe physical and psychological harm and even death.

It is well accepted generally that where the state confers a monopoly on the provision of a necessary service, whether it be electricity, telephone or postal service, the monopoly provider is required to meet minimum service standards. The Supreme Court is simply extending this same reasoning to the healthcare field, and requiring that where the state chooses to establish a monopoly over the provision of certain medically necessary services, those responsible for providing the service must meet minimum requirements of timeliness.

Dissenting Judgment

When members of the Supreme Court of Canada disagree with each other, they normally do so in measured and polite tones. Not so in *Chaoulli*, where Justices Binnie and LeBel issued a blistering dissent in the combative style more commonly associated with the US Supreme Court. The dissenters charge that the majority judgments had proceeded on the basis of wholly political rather than legal argument. First, even conceding that waiting may constitute a problem for “some Quebecers in some circumstances” (*Chaoulli* par. 207, emphasis in original), the dissenting justices claimed that there was no systematic evidence about the extent of wait times and, in any event, it was beyond the expertise of judges to determine what was a reasonable wait for care. “How many MRIs does the Constitution require?” they ask rhetorically (*Chaoulli* 2005, par. 163).

Second, they point out that there was extensive evidence at trial supporting the conclusion that a “US Two-Tier system of health coverage” would have a negative impact on wait times in the public system. For example, there was evidence from other jurisdictions suggesting that parallel pri-

vate insurers would “skim the cream” by siphoning off high-income patients while shying away from patients that constitute a higher financial risk, with the result that the public system would carry a disproportionate burden of patients considered high risk. Even if this evidence was contested or controversial, the trial judge, who had concluded that the creation of a parallel private system would harm the public system, had accepted it. In Justices Binnie and LeBel’s view, the Supreme Court of Canada ought to defer to governments and legislatures, as well as to the trial judge, on these complex policy matters.

Significantly, Justices Binnie and LeBel did not provide a response to the principled argument that if governments wish to establish a monopoly over the provision of certain medically necessary services, it thereby comes under an obligation to provide care in a timely manner. It is certainly true, as the dissenting justices suggest with their rhetorical question regarding MRIs, that the determination of reasonable waiting times requires a difficult exercise of judgment. But the fact that such a determination is difficult does not mean that governments and healthcare administrators should thereby be relieved of any obligation to provide care in a timely manner. By way of analogy, the fact that it may be difficult to determine what constitutes an acceptable speed for driving on city streets does not mean that governments are thereby justified in abolishing speed limits in residential areas. Of course, just as speed limits on the roads are fixed by traffic experts rather than the courts, the determination of acceptable wait times must be made by qualified medical professionals rather than judges; what the courts can mandate is simply that there must be enforceable limits on waiting time determined by qualified medical professionals, if the state wishes to establish a universal, single-payer delivery model and prohibit individuals from accessing private care.

Academic Criticisms

The academic criticisms that were advanced in the period immediately following *Chaoulli* broadly followed the two lines of argument advanced by the dissenting Supreme Court justices.

First, it was argued that the decision was fundamentally legally flawed in the sense that it was a departure from previous jurisprudence and represented illegitimate “judicial activism” in a complex area of social policy. There were even suggestions that the decision evidenced a kind of “class bias” in favour of the rich, who were thought to be the primary beneficiaries of a move to a “two-tier” system of private insurance (Choudhry 2005, 93-

96). The result in *Chaoulli* was contrasted unfavourably with two earlier Supreme Court of Canada decisions, one in which the Court had refused to order the British Columbia government to fund therapy for autistic children,¹⁶ and the second in which the Court dismissed a constitutional challenge to a workfare scheme in Quebec.¹⁷ Although it was conceded that “it was impossible to say whether a class bias, unconscious or otherwise, is at work...as they say in politics, the optics are bad” (Choudhry 2005, 95).

A second line of criticism focused on the negative consequences that would follow from the introduction of an “American-style, two-tier” health-care system in Canada. For example, Roy Romanow points to scholarly accounts that the single-payer system drastically reduces administrative costs and is cheaper than the American system (Romanow 2005, 525). Economist Robert Evans argues that excessive reliance on private insurance will cause costs to greatly escalate (Evans 2005, 361-2). Concerns were raised that due to our international trade commitments, specifically under NAFTA, *Chaoulli* may irrevocably destroy public healthcare (Epps and Schneiderman 2005). It was argued that adding a second tier of private care would, at least in the short term, draw resources away from the public system as doctors take many years and a great amount of money to train (Flood, Stabile and Kontic 2005, 310-312). An intangible cost of a parallel private healthcare system might be that doctors will not be available to train their counterparts if they spend time in the private system (Flood Draft 2005, 11-12). Perhaps the most philosophically troubling allegation is that by opening the door to more private healthcare, the system will allow those with money and influence to turn their attention away from the public system, leaving it to wither and die (Marmor 1998; Roach 2005, 200; Flood 2005, 20).

The response to these various lines of criticism is simply that they involve a misunderstanding of what the case actually decides. First, *Chaoulli* does not establish that Canadians have a right of access to any medical services they made need or desire. All that *Chaoulli* decides is that Canadians have a right not to be prevented from solving the access problem on their own, if the medicare system does not provide them with timely access. This is why the constitutional claims for autism therapy considered in *Auton* or the welfare benefits sought in *Gosselin* were quite different, since in those cases there were no government prohibitions on accessing the care or services, and the claimants were simply seeking to compel government to provide them with funding.

16 *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004.

17 *Gosselin c. Quebec (Procureur général)*, 2002.

As for the fears about the negative consequences of a parallel private system, as I have already explained *Chaoulli* does not mandate a particular form of healthcare delivery; post-*Chaoulli* it remains perfectly open to governments and legislatures to discourage the emergence of a parallel private healthcare delivery system. But governments cannot do so in a way that ignores the interests of patients and users of the system. If governments wish to prohibit individuals from using their own resources to access healthcare services, they must meet legally enforceable minimum standards with respect to the timely delivery of care in the public system.

Suppose, however, that governments determine that ensuring the availability of medically necessary services in a reasonably timely manner in the public system is too costly or difficult? In these circumstances, individuals must be permitted to purchase private health insurance in accordance with the ruling in *Chaoulli*. But does this mean that service timeliness and quality within the public system will necessarily deteriorate, as suggested by Justices Binnie and LeBel?

It would seem that the answer to this question will turn on the manner in which governments elect to respond to the risks identified by Justices Binnie and LeBel. Consider, for example, the risk that if private insurance is permitted, medical resources might be drained away from the publicly funded system, resulting in increased wait times for those who cannot afford private insurance. Faced with this risk, governments would be expected to take such actions as they regarded appropriate and necessary to maintain the quality and timeliness of service in the public system. For example, Michael Kirby has proposed that, in a scenario in which private health insurance were permitted for services available in the public system, all doctors be required to work within the public system up to the existing income caps or to some other publicly mandated level. Only after the mandated level of service had been satisfied within the public system could a doctor accept a private-pay patient. Since all specialists would be required to work up to their capped income in the publicly funded system, there would be no reduction in the supply of services to the publicly funded system. Indeed, waiting lists within the public system ought to be reduced, since patients treated privately would no longer remain on the publicly funded waiting list (Kirby 2006, p. 71-72).

This is merely one option amongst many. The point is that governments cannot justify continuing to impose pain or even death on innocent patients through prohibiting them from taking measures to protect their own health, merely on the basis that lifting the ban on private health insurance will create policy challenges. These same policy challenges exist in other jurisdictions that do not have a similar ban on utilizing one's own resources to pro-

protect one's health. *Chaoulli* decides that if government wishes to establish a monopoly on the provision of medically necessary care, then it must be legally accountable to patients for the timeliness of medical care provided.

Far from destroying medicare, this requirement of patient accountability adds an essential element that was previously missing from the principles established by the *Canada Health Act*. Pre-*Chaoulli*, governments were apparently free to ration access to healthcare without legal limitation, and those sick or dying individuals who were forced to bear the costs of such excessive rationing were deprived of all legal recourse or remedy. What *Chaoulli* decides is that such a state of affairs is constitutionally unacceptable in a free and democratic society that places a proper value on individual human dignity.

Chaoulli requires only that in making a choice between a single-tier and a two-tier healthcare system, governments respect the constitutional rights of Canadians. If governments choose to maintain Canada's single-payer, universal healthcare model, they must ensure that there are clinically valid and legally enforceable limits on waiting times for medically necessary care. If governments are unable or unwilling to put such accountability mechanisms in place, Canadians cannot be prohibited from utilizing their own resources to protect their health. But this will have been a choice ultimately made by governments and legislatures, rather than the courts. Moreover, as explained above, in this event there will undoubtedly be ample policy tools and options available to government to ensure that waiting lists within the public system do not grow.

It has now been over a year since *Chaoulli* was handed down, and governments and health policy administrators have begun to respond to the decision. I turn now to a consideration of those responses, in order to discern the impact that the decision is likely to have on the evolution of healthcare policy in Canada.

Redefining Healthcare Post-*Chaoulli*

In recent years, both pre- and post-*Chaoulli*, the Canadian public and legislators have identified wait times as a significant political and legal problem. Approximately half of Canadians believe that current hospital (and clinical) wait times for surgical procedures are unacceptable and that Canadians wait an unreasonably long time for access to healthcare services (Postl 2006, 18). Consistently, Canadians identify long wait times as the number one barrier in accessing health services (Health Council of Canada, 2005, 1).

As described earlier, in 2002, the Standing Committee on Social Affairs, Science and Technology had issued a multi-volume report that identified wait times as a potential threat to the continued legal and political viability of the single-payer, publicly funded model of healthcare delivery. The Committee strongly supported the maintenance of this universal single-payer system, and advocated the creation of a “healthcare guarantee,” which would guarantee every Canadian the right to timely access to medically necessary healthcare.¹⁸

In September 2004, just months after *Chaoulli* had been argued, but before the Court’s judgment was issued, First Ministers signed an Accord entitled, “Ten Year Plan to Strengthen Healthcare” (Canada, 2004). The Accord did not provide for any legally enforceable limits on acceptable waiting times. Nevertheless, First Ministers did agree that “access to timely care across Canada is our biggest concern and a national priority” (Canada 2004, 2). First Ministers committed to establishing “evidence-based benchmarks” for medically acceptable wait times in five key areas by December 2005,¹⁹ to achieving meaningful reductions in wait times in those areas by March 31, 2007, and to setting multi-year targets for “priority benchmarks” by December 31, 2007. A Wait Times Reduction Fund of \$5.5 billion was established, and a total of \$41 billion in federal funding was committed over 10 years.

There is no doubt that, while these commitments focusing on five priority areas were relatively narrow and limited, they nevertheless represented important steps forward. Previously, including in course of the *Chaoulli* appeal itself, governments had often minimized the problem of waiting times and resisted efforts to systematically measure the extent to which healthcare was being rationed through waiting. But the 2004 Accord demonstrated real political will to begin to address the problem. Nevertheless, the 2004 Accord continued to operate on the basis of the traditional paradigm, one in which governments and provider groups control the healthcare delivery system without any direct accountability to individual patients.²⁰ Thus,

18 The Committee indicated that timely access meant “service is being provided consistent with clinical practice guidelines to ensure that a patient’s health is not negatively affected while waiting for care” (see Standing Committee on Social Affairs, Science, and Technology, 2002, Vol. 6, p.99). As described above, if the patient could not obtain “timely access to medically necessary healthcare” in his or her home province, then the provincial or federal government would be required to pay for those services to be provided to the patient in another jurisdiction.

19 The priority areas identified were cancer, heart, diagnostic imaging, joint replacement and sight restoration.

20 The 2004 Accord did make reference to agreement on “continued accountability and provision of information to make progress transparent to citizens”, but there were no mechanisms put in place at that time.

for example, if governments failed to meet their commitments in the Accord, there were no mechanisms whereby patients could hold governments and healthcare providers to account. Ultimately, the 2004 Accord reflected a series of non-binding political commitments that could not be enforced by individuals. Needless to say, pre-*Chaoulli* there was no opportunity for individuals to require governments to undertake commitments beyond the very limited ones identified in the 2004 Accord.

What *Chaoulli* does is fundamentally alter these ground rules by making governments accountable to individuals who are in need of care. This accountability is not defined by, or limited to, particular agreements that governments may choose to enter into with each other. Thus, for example, the fact that governments may have identified five areas as priorities for the reduction of wait times does not limit or exhaust government's obligations, on the assumption they wish to maintain a universal, single-payer delivery model. Justices McLachlin and Major made reference in their judgment to a 2001 study which found that 18 percent of the estimated five million people who visited a specialist for a new illness or condition reported that waiting for care "adversely affected their lives" (par. 117). This includes significant adverse psychological effects which "need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety" in order to trigger the protections of section 7 of the Charter (pars. 116-118).

How have governments responded to this new requirement of patient accountability in the months following the release of *Chaoulli* in June 2005? Recognizing that the Court itself granted a 12-month stay of its ruling and that, therefore, the issue of waiting times need not be solved overnight, governments have made incremental progress in some areas but achieved mixed results in others. What is clear, however, is that there is an increasing recognition that the principle of patient accountability must come to the forefront if there is to be significant progress in reducing wait times and, in this way, preserve and strengthen Canada's public, universal system of healthcare delivery.

Of particular significance is the fact that during the 2005-06 federal election campaign, Conservative leader (and now Prime Minister) Stephen Harper pledged to establish a Patient Wait Times Guarantee, based on the recommendations in the Standing Committee on Social Affairs, Science, and Technology Report (Conservative Party of Canada 2005). The Wait Times Guarantee would ensure that patients receive essential medical treatment within clinically acceptable waiting times. If this is not available in their own area, the patient must be given the option of receiving treatment at another hospital or clinic, even outside of their home province. Recognizing that

implementation of the Wait Times Guarantee would require provincial cooperation, Mr. Harper pledged to work with the provinces to ensure its adoption. When the Conservatives formed a minority government following the January 23, 2006, election, a patient wait times guarantee formed one of the government's top five priorities, as set forth in Speech from the Throne on April 4, 2006.²¹

The government indicated that it hoped to negotiate the terms of a wait times guarantee with the provinces within a year. However, in the months immediately following the Throne Speech, only a single province — Quebec — made any significant movement towards accepting a wait times guarantee. In February 2006, Quebec issued a consultation document entitled “Guaranteeing Access: Meeting the challenges of equity, efficiency and quality” (Quebec 2006a), which set forth the broad direction of the province's response to *Chaoulli*. First, and significantly, the government indicated that it could not agree with those who had demanded that the government invoke the Charter's notwithstanding clause to override the Court's decision. In a principled and thoughtful introductory message, Premier Charest indicated that the notwithstanding clause had been invoked in the past in order to protect the French language or the collective identity of Quebec. The *Chaoulli* decision implicated the relationship between the individual and the state and the fundamental rights of Quebecers. Accordingly, the Premier indicated, to invoke the notwithstanding clause in these circumstances would have meant “failing in our State duty” (Quebec 2006a, 2).

The government response to *Chaoulli* was premised on an intention to preserve the “universality and equity of the public health system” and the principle that “access to health services must be based on people's needs and not their ability to pay” (Quebec 2006a, 39). Within this framework the government proposed:

- a “guarantee of access to services,” whereby patients would be guaranteed treatment within defined periods. The access mechanism would be triggered when the patient was placed on a waiting list, and if the service could not be provided within the maximum period applicable the patient must be provided with the service in another establishment in Quebec or elsewhere.²² The

21 The April 2006 Speech from the Throne, entitled “Turning a New Leaf,” included the following commitment: “The Government will engage the provinces and territories on a patient wait times guarantee for medically necessary services. This guarantee will make sure that all Canadians receive essential medical treatment within clinically acceptable waiting times.”

22 If the service has not been provided within six months patients will be referred elsewhere in the province or to a new group of private clinics that will be affiliated with existing

access guarantee would initially apply to a limited number of services²³ but it was envisaged that this list would gradually be expanded;

- Private insurance would be permitted, but limited to certain procedures which were also covered by the care guarantee.²⁴ Insurance coverage must cover the entire care episode and thus include rehabilitation and home support;
- A “watertight seal” would be maintained between doctors opting in or out of the public systems, whereby a doctor who participated in the public system could not opt out for certain services only. There would also be a ceiling on the number of doctors authorized to practice in the private sector, in order to ensure that resources necessary for practice in the public sector remained available.

On June 15, 2006, Quebec’s Minister of Health, Dr. Philippe Couillard, tabled Bill 33 in the National Assembly, legislation embodying the principles set forth in the Consultation Paper.²⁵ Amongst other things, Bill 33 proposes to enact a new section 15 of the *Health Insurance Act*, to replace the provision of that statute that was ruled invalid in *Chaoulli*. The amended provision would permit private insurance for the insured services identified in the Consultation Paper, and provides the possibility of adding additional insured services to this permitted list through government regulation, following consultation with a committee of the National Assembly.

While the Quebec care guarantee is limited in scope and application, it nevertheless represents a real and meaningful patient-centred response to the *Chaoulli* decision. However, as of this writing (September 2006), no other province has indicated a willingness to make legally enforceable commitments regarding the timeliness of service in the public system. This is not to deny the fact that all provinces are making significant efforts aimed at reducing wait times, often with dramatic success. Of particular note is the 2005 Alberta pilot project, involving three health regions, targeted at reducing

footnote 22 cont’d

public hospitals; if service has not been received within nine months patients will be referred to full private clinics or outside the province, at public expense.

23 The covered services would initially be radiation oncology and tertiary cardiology (including cardiac surgery, hemodynamics, angioplasty and electrophysiology), elective hip, knee and cataract surgeries, as well as cancer-related surgery (see Quebec 2006, 45).

24 Private insurance would be permitted for elective hip, knee and cataract surgery, procedures which are subject to the care guarantee.

25 See Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*, 37th Legislature, second session, first reading June 15, 2006.

wait times for hip and knee replacements. It involved opening up central assessment clinics and region-wide waiting lists, for an integrated “continuum of care” approach. The central assessment clinics meant that the patient could avoid the multiple waiting lists that were otherwise the norm (i.e. the wait list to see a specialist, then a wait list to get an MRI, before joining the orthopedic surgeon’s wait list to get the actual surgery). The pilot project also dedicated specific operating rooms to perform the surgery and \$20 million in additional funding. The outcome of the pilot project was spectacular. Wait times for hip/knee surgery, measured from referral by a family doctor to actual surgery, were reduced from 82 weeks to 11 weeks. There were also higher rates of patient satisfaction due to centralized intake and the use of case managers. Those responsible for the pilot project indicate that this model could be generalized to the whole province (and beyond) and that access to all appropriate joint replacements in the province could be made predictable within one to two years (Torgerson and McIntosh 2006, 14-15).

In December 2005, the provinces and territories also established common benchmarks for the five priority areas identified in the 2004 Accord. Further, government decision-makers are in the process of identifying the organizational changes,²⁶ as well as the changes in the culture and expectations of health professionals,²⁷ that will be necessary in order to achieve significant reductions in wait times. Of particular significance is the Final Report of the Federal Advisor on Wait Times, issued on June 30, 2006 (Postl 2006). The Final Report identifies six different strategies that, if pursued in concert by all the participants in the healthcare system, could result in significant reductions in wait times.²⁸ At bottom, Postl identifies the key to change as being the development of a patient-centred model, whereby the goal becomes one of ensuring that the recipient of care is the first priority of caregivers and care systems. Postl optimistically concludes that, while there are certainly many challenges associated with reducing wait times, it is possible to dramatically reduce waits through innovation and system change such that “Canadians could potentially have same day access to primary

26 According to Postl (2006), these include: the adoption of patient-centred models which incorporate centralized navigation of the system by patients, the incorporation of queuing theory used in other industries, and the adoption of new business practices.

27 Postl (2006) identifies the need for team-based approaches to system management, training programs for healthcare professionals in key roles and an emphasis on service-oriented approaches as key elements.

28 These strategies are: ongoing research to support benchmarking and operational improvements; adoption of modern management practices and innovations; accelerated implementation of information technology; cultural change amongst health professionals; development of regional surge capacity; and public education (see Postl 2006, 9).

health care, one or two week access for appointments with medical specialists, and almost no waiting for tests and surgeries" (Postl 2006, 40). The patient-centred philosophy advocated by Postl is summarized by the Health Council of Canada's argument to the effect that the interests of patients must "trump" those of healthcare providers, administrators and governments:

"...the objectives of a national approach to improving wait times are basic and speak to Canadians' core needs and values. Citizens want to feel confident that when they need it, they will get access to care within a time frame that does not significantly compromise their health or well-being — and they want a system that is fair, providing the sickest people with the fastest access to care without compromising access for those whose needs are less urgent but no less real. These principles of the importance of individual access to care and equity at the system level should guide all decision-making around wait-list management and must trump the interests of providers, administrators and governments." (Health Council of Canada, *Ten Steps to a Common Framework for Reporting on Wait Times*, June 24, 2005.)

What of the fact that *Chaoulli* was a 4 to 3 decision of the Supreme Court of Canada, with one of the members of the majority (Justice Deschamps) relying on the Quebec Charter to strike down the Quebec legislation, and declining to rule on the issue of whether the impugned legislation also violated the Canadian Charter? In this sense, the six members of the Supreme Court who dealt with the issue split 3 to 3 on whether the Quebec legislation violated the Canadian Charter. Could it therefore be argued that the principle of patient accountability which I have outlined in this paper applies only in the province of Quebec, and that a future Supreme Court will refuse to extend this principle to the other provinces and territories?

In fact, I do not believe that this outcome is either legally or politically sustainable. First, while it is true that Madam Justice Deschamps relied upon the Quebec Charter, rather than the Canadian Charter, to rule the impugned provisions to be invalid, the arguments she utilized were largely identical to those adopted by Chief Justice McLachlin and Justice Major in their Charter analysis, and were diametrically opposed to the position of dissenting Justices Binnie and LeBel. Thus, while her judgment was technically limited to the Quebec Charter, it is legally implausible to read her reasoning as supporting a different conclusion under the Canadian Charter.

More fundamentally, post-*Chaoulli*, it is simply not sustainable politically for political leaders outside of Quebec to suggest that their citizens lack basic rights to timely care that are available only in Quebec. In fact, the political discussions that have occurred over the past year have implicitly accept-

ed that the result in *Chaoulli* applies across the country, rather than in a single province.²⁹ There is strong popular support for *Chaoulli* in all provinces and across all income and age groups (Pollara 2005, 66) and, with the aging of the population, political pressure and demand for timely medical care will only increase rather than diminish.

Nevertheless, if the provinces fail to provide legally enforceable guarantees of timely access to medical care within the near future, legislative prohibitions on accessing private healthcare analogous to those considered in *Chaoulli* will be vulnerable to constitutional challenge in other provinces. There is already litigation underway in the provinces of Alberta³⁰ and Ontario³¹ which will test whether the constitutional principles identified in *Chaoulli* apply outside Quebec. I expect that courts that are asked to consider such challenges will confirm that *Chaoulli* does apply across the country and that, therefore, Canadians cannot be denied access to timely care within the context of a universal, single payer system. However I also expect that, for a time, courts will want to grant political leaders a degree of latitude in terms of their response to this new challenge, provided that there is clear evidence that they are willing to work within a new, patient-centred paradigm. Where this is not the case, the courts can be expected to make it clear to gov-

29 Thus in the discussions in the health policy community in recent months, healthcare administrators have accepted that they are bound to respond to *Chaoulli* and have discussed the ways in which this is occurring in all provinces and territories (see Torgerson and McIntosh 2006 and Postl 2006).

30 See *William Lloyd Murray v Alberta et al.*, Statement of Claim filed in the Court of Queen's Bench of Alberta, August 4, 2006. In *Murray*, the claimant had requested a less invasive form of hip replacement surgery. According to his Statement of Claim (which allegations have not yet been proven in court), he was denied access to this procedure through the publicly funded healthcare system on the basis that he was over 55 years of age; he alleges that, in the case of one hip, he paid personally to have the requested procedure performed in Alberta, while in the case of the other hip he was altogether denied the opportunity to have the procedure performed in Alberta, even at his own expense. He is bringing a class action on his own behalf and on behalf of those over age 55 who may have been similarly denied access to this form of hip replacement surgery through the publicly funded system in Alberta.

31 See *Adolfo Flora v General Manager, Ontario Health Insurance Plan*, Ontario Superior Court, Divisional Court, Court file No. 86/03. In *Flora*, the claimant was refused funding by OHIP for a form of liver transplantation that was not then being performed in Ontario. He subsequently paid for the surgery to be performed in England at a cost of approximately \$450,000, and was refused reimbursement by OHIP and the Health Services Appeal and Review Board. He has appealed this decision to the Divisional Court, relying in part on the argument that the denial breaches his right to life under sec. 7 of the Charter, as recognized in *Chaoulli*. The appeal was argued in the spring of 2006 and as of this writing a decision by the Court was pending.

ernments and administrators that they must respond diligently and in good faith to the new responsibilities identified in *Chaoulli*.

Conclusion

It has been over a year since the Supreme Court handed down its decision in *Chaoulli* and, on the surface at least, little seems to have changed. Millions of Canadians are still waiting far too long for medically necessary care (Statistics Canada 2006). While the province of Quebec has introduced legislation providing for a care guarantee along with limited recourse to private insurance for certain procedures, there have been no legislative changes federally or in the other provinces.

In fact, however, *Chaoulli* means that major change in the Canadian healthcare system is inevitable. The Supreme Court has determined that excessive rationing of the supply of healthcare services cannot be justified legally or morally. The federal government has fully embraced the decision and made a care guarantee one of its signature priorities. At long last, excessive rationing of healthcare services has become unacceptable in this country, just as deficit financing by governments suddenly became politically verboten in the mid-1990s after decades and hundreds of billions of dollars of government deficits.

That is not to say that reforming the healthcare system will be easy, quick or any less politically charged than before. Healthcare administrators will face rising demand on their limited resources as the population ages, even as they seek to increase the timeliness of their services. Governments will face further court challenges if they move slowly, or not at all, on wait times. And would-be patients may find that progress toward shorter wait times moves at a glacial pace.

Yet, post-*Chaouli* a new paradigm is in place. Governments and, increasingly, the health policy community now understand that unless they establish enforceable limits on waiting times for medically necessary care, they will be required to provide individuals with the opportunity to pay privately for their healthcare services. Far from destroying medicare, this reality will prompt a serious and meaningful patient-centred debate over the future shape of medicare.

How will that shape evolve? Two viable reform options present themselves: an improved, sustainable version of the single-payer, universal system that now exists, with performance benchmarks and improved timely access to services across the system; or introduction of a privately funded option that would be available to patients who exceed maximum acceptable

wait-time benchmarks within the publicly funded system (see Canadian Medical Association 2006, 17-24). The choice between these options will ultimately be made by governments and legislatures, rather than the courts.

For too long, meaningful debate over reform to the *Canada Health Act* and its associated regimes in the provinces has been regarded as off limits and even politically incorrect. Yet, as the Romanow Commission (Canada 2002, 3) observes, no statute or policy should be immune from review and rethinking. The fact that we will now be required to seriously debate the foundations of the public healthcare system on the basis of evidence and outcomes, rather than ideology and rhetoric, cannot help but improve the quality as well as the equity of the healthcare provided to all Canadians.

References

- Attorney General of Canada. 2004. "Factum of the Respondent (*Mis en Cause*) Attorney General of Canada." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.
- Attorney General of Quebec. 2004. "Factum of the Respondent Attorney General of Quebec." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.
- Barer, Morris. 2005. "Experts and Evidence: New Challenges in Knowledge Translation." In Colleen M. Flood, Kent Roach and Lorne Sossin, eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 216-219.
- British Columbia. 2006. *Speech From the Throne*. 38th Parliament, 2nd Session. February 14, 2006. Accessed online at <http://www.legis.govbc.ca/38th2nd/4-8-38-2.htm>.
- Cambie Surgeries et al. 2004. "Factum of the Interveners." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. 2005. SCC 35
- Canada. 2002. *Commission on the Future of Health Care in Canada: Final Report*. Ottawa. November.
- . 2004. "Ten Year Plan to Strengthen Healthcare." September.
- . 2006. *Speech from the Throne: Turning a New Leaf*. 39th Parliament. April 4.
- Chaoulli, Jacques. 2004. "Factum of the Appellant Jacques Chaoulli." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.
- Choudhry, Sujit. 2005. "Worse than *Lochner*?" In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 76-100.
- Canadian Medical Association. 2006. *It's About Access! Informing the debate on public and private health care: discussion paper* (CMA Task Force on the Public-Private Interface, June 2006) accessed online at: http://www.cma.ca/multimedia/CMA/Content_images/Inside_Cma/Media_Release/pdf/2006/about_access_e2.pdf
- Canadian Medical Association and the Canadian Orthopaedic Association. 2004. "Factum of the Interveners." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.
- Conservative Party of Canada. 2005. *Harper Pledges Patient Wait Times Guarantee*. Accessed online at <http://www.conservative.ca/EN/1091/33313>. December.
- Dworkin, Ronald. 1985. "Why Liberals Should Care about Equality," in *A Matter of Principle*. Harvard University Press: 205-213.
- Epps, Tracey, and David Schneiderman. 2005. "Opening Medicare to Our Neighbours or Closing the Door on a Public System? International Trade Law Implications of *Chaoulli v Quebec*." In Colleen M. Flood, et al., eds., *Access to Care —*
-

-
- Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 369-392.
- Esmail, Nadeem and Michael Walker. 2005. *Hospital Waiting Lists in Canada (15th Edition)*. Vancouver: Fraser Institute. October.
- Evans, Robert G., 2005. "Preserving Privilege, Promoting Profit: The Payoffs from Private Health Insurance." In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 347-368
- Flood, Colleen. 2005. "Chaoulli's Legacy for the Future of Canadian Health Care Policy." *Osgoode Hall Law Journal*. 44:2: 273-310
- , Mark Stabile and Sasha Kontic. 2005. "Finding Health Policy Arbitrary: The Evidence on Waiting, Dying, and Two-Tier Systems." In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 296-320.
- Hartt, Stanley, and Patrick Monahan. 2002. *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*. C.D. Howe Institute Commentary No. 164, May.
- Health Council of Canada. 2005. *A background note on Benchmarks for Wait Times*. Toronto: Health Council of Canada. November.
- . 2005. *10 Steps to a Common Framework for Reporting on Wait Times*. Toronto: Health Council of Canada. November.
- Kirby, Michael, et al. 2004. "Factum of the Interveners." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.
- . 2006. "The Only Two Options for Funding the Wait-Time Guarantee." *Policy Options*, 27:6, 66-73. July-August.
- Marchildon, Gregory P. *The Chaoulli Case: Two-Tier Magna Carta?* Accessed online at <http://www.longwoods.com/view.php?id=&aid=17190&cat=120>
- Marmor, Theodore. 1998. Witness Statement in the matter of *Chaoulli c. Québec (Procureur général)*. 2000 CarswellQue 182 (Que. SC)
- Petter, Andrew. 2005. "Wealthcare: The Politics of the Charter Revisited." In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 116-138.
- Pollara 2005, *Health Care in Canada Survey 2005*. Accessed online at <http://www.pollara.ca>
- Postl, Brian. 2006. *Final Report of the Federal Advisor on Wait Times*. Accessed online at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2006-wait-attente/index_e.pdf. June.
- Québec. 2006a. *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency, and Equality*. Quebec: La Direction des communications du ministère de la Santé et des Services sociaux.
-

- Québec. 2006b. *An act to amend the Act respecting health services and social services and other legislative provisions*, Bill 33, National Assembly of Quebec, 37th Legislature, 2nd Session, June 15, 2006.
- Roach, Kent. 2005. "The Courts and Medicare: Too Much or Too Little Judicial Activism?" In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 184-204
- Romanow, Roy. 2005. "In Search of a Mandate?" In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: University of Toronto Press: 521-530
- Russell, Peter. 2005. "Chaoulli: The political versus the Legal Life of a Judicial Decision." In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 32-55
- Standing Committee on Social Affairs, Science and Technology. 2002. *The Health of Canadians: The Federal Role: Final Report on the State of the Health Care System in Canada*. Ottawa: Senate of Canada. October.
- Statistics Canada. 2006. *Access to Health Care Services in Canada: January to June 2005*. Ottawa: Ministry of Industry. January.
- Stewart, Hamish. 2005. "Implications of *Chaoulli* for Fact-Finding in Constitutional Cases." In Colleen M. Flood, et al., eds., *Access to Care — Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. Toronto: University of Toronto Press: 207-215
- Torgerson, Renée, and Tom McIntosh. 2006. *The Taming of the Queue III — Wait Time Measurement, Monitoring, and Management: Where the Rubber Meets the Road*. (Conference Report) Ottawa: Canadian Policy Research Networks. March
- Zeliotis, George. 2004. "Factum of the Appellant George Zeliotis." Submitted to the Supreme Court of Canada in the matter of *Chaoulli c. Quebec (Procureure générale)*. Docket No. 29272.

Court Decisions and Statutes

- Auton (Guardian ad litem of) v British Columbia (Attorney General)*. (2004) SCC 78, 3 S.C.R. 657.
- Canada. 1982. Charter of Rights and Freedoms. Schedule B to the *Canada Act 1982*, (U.K.) 1982, c. 11.
- Canada Health Act* (R.S., 1985, c. C-6).
- Chaoulli c. Quebec (Procureure générale)*. (2005) 1 S.C.R. 791.
- Chaoulli c. Quebec (Procureure générale)*. (2005) CarswellQue 5795 [stay of judgment].
- Chaoulli c. Québec (Procureur général)*. (2002) R.J.Q. 1205 (Que. CA).
- Chaoulli c. Québec (Procureur général)*. (2000) R.J.Q. 786 (Que. SC).

Adolfo Flora v. General Manager, Ontario Health Insurance Plan, Ontario Superior Court, (Divisional Court), Court file No. 86/03.

Gosselin c. Quebec (Procureur général). [2002] 4 S.C.R. 829.

William Lloyd Murray et al. v Alberta et al., Statement of Claim filed in the Court of Queen's Bench of Alberta, August 4, 2006.

Quebec. *Health Insurance Act* R.S.Q., c. A-29.

Quebec. *Hospital Insurance Act* R.S.Q., c. A-28.

R. v Oakes, 1986 1 S.C.R. 103.

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