FAILING ON THE FUNDAMENTALS: THE CHAOULLI DECISION

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Many Canadians spend their lives in unnecessary pain. George Zeliotis, a 73 year-old retiree from Montreal, needed hip replacement surgery in 1996. He remained on a wait list for one year in a badly bottlenecked public health care system. Zeliotis finally tried to buy insurance to pay for the procedure in a private health clinic but learned that Quebec law prohibited him from using private insurance to pay for "medically necessary" services. His only other option, paying out-of-pocket for private surgery in the United States (or elsewhere) was far beyond his financial means.

Dr. Jacques Chaoulli is a physician who has unsuccessfully tried to have his home-delivered medical practice recognized and to obtain a licence to operate an independent, private hospital.

Mr. Zeliotis and Dr. Chaoulli joined forces to challenge the provisions of Quebec's *Health Insurance Act* and *Hospital Insurance Act* that bar the use of private insurance. They argued that the provisions were unconstitutional and invalid under both the *Quebec Charter* and the *Canadian Charter*. Their position was that forcing patients to wait for extended periods without recourse violates their rights to life and personal security. The crucial question posed to the courts was whether the prohibition is justified by the need to preserve the integrity of the public health care system.

The result is one of the most contentious Supreme Court of Canada (SCC) rulings in recent history, and challenges Canadians to rethink their much-treasured ideal of a public health care system. At the very least, the result will instigate a new course of public debate and policy development in Canada.

Although the analysis differed radically at each level of court, there was one common thread: every judge hearing the case agreed that if patients are suffering from a life threatening or painful condition, with extended delays in obtaining services, without recourse, then their rights are being violated. This violation extends not only to death and physical harm resulting from long wait times, but to the resulting mental stress and anguish as well.

Twice the Quebec courts rejected Zeliotis's and Chaoulli's claim. In 2000, the Honourable Justice Piché of the Superior Court of Quebec found that while they had demonstrated a deprivation of the right to life, liberty and security of the person under s. 7 of the *Canadian Charter*, the purpose behind the prohibition was to ensure equality in Quebec's public health care system by discouraging the development of a parallel private health care system. The deprivation was thus in accordance with the principles of fundamental justice. The Quebec Court of Appeal dismissed Chaoulli's appeal in 2002. Justices Delisle and Brossard held that s. 7 was not invoked, since the right affected is an economic one, and not fundamental to an individual's life. Justice Forget agreed with the reasoning of the Superior Court, justifying the deprivation under the principles of fundamental justice. Neither level of court considered arguments under the *Quebec Charter*.

On June 9, the SCC overturned the Quebec courts. The divided and complex judgment may have opened the door to private health insurance in Quebec and – perhaps – in the rest of Canada.

A slim 4-3 judge majority held that a prohibition on private insurance violates the right to life under s. 1 of the *Quebec Charter* when a patient cannot get reasonable access to services in the public health care system, and that this prohibition cannot be justified without cogent evidence that substantiates the proportionality of the prohibition with the avowed policy goal of protecting the integrity of the public system. The majority cited the existence of private tiers within predominantly public health care systems such as France, Switzerland and the UK, not as a suggested course for Canada, but as evidence that other, less drastic measures exist to preserve meaningful access to health care.

Justice Deschamps's judgment found a violation of the *Quebec Charter* but refused to determine whether the *Canadian Charter* had been violated. Three justices of the majority (Chief Justice McLachlin and Justices Major and Bastarache) found a violation of s. 7 of the *Canadian Charter*. In considering that the prohibition was not in accordance with the principles of fundamental justice, these three judges concluded that the Quebec government was arbitrary in its choice of means of allocating medical services – a prohibition on insurance for private medical services – as so many other medical systems met these needs in so many other ways.

A strong three-judge dissent vehemently disagreed, arguing that it is not the role of the courts to settle such a long-standing public debate. The dissenting judges, Binnie, LeBel and Fish, found that while wait lists may result in violations of the *Canadian Charter* and the *Quebec Charter* in individual cases, the current health plan is not arbitrary and works toward a valid legislative goal, and thus does not violate any principles of fundamental justice. The minority assailed the majority's reliance on evidence of other OECD countries as a simplistic and unsophisticated evaluation, which has been consistently rejected by commentators, Commissions and legislatures.

The dissent further rejected the majority's assessment of private insurance, emphasizing expert evidence heard by the trial judge that a parallel private system would further decay the public system by increasing wait times and draining public resources. In an unusual and rather direct reproach to her dissenting colleagues, Justice Deschamps referred to this as "indicative" of a type of "emotional reaction". The dissenters, however, referred to this as appellate acceptance of findings of fact by a trial judge.

Media commentators have been quick to pronounce that this decision will inspire a barrage of similar lawsuits across the country, and that it represents the death knell for universal health care in Canada. A closer look reveals that these outcomes are hardly inevitable, nor are they what the Court intended. It is more likely that governments will finally have to act to find other means of allocating scarce medical resources in the face of growing demand.

Justice Deschamps – again in rather biting, direct language – addressed this argument head on:

> For many years, the government has failed to act; the situation continues to deteriorate.This is not a case in which missing scientific data would allow for a more informed decision to be made. The principle of prudence that is so popular in matters relating to the environment and to medical research cannot be transposed to this case. Under the Quebec plan, the government can control its human resources

> in various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services (s.30 HEIA) or by implementing less restrictive measures, like those adopted in the four Canadian provinces that do not prohibit private insurance or in the other OECD countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebeckers' right to security. The government has not given reasons for its failure to act. Inertia cannot be used as an argument to justify deference.

What has happened here is that a policy treated as a shibboleth by many Canadians, and by all Canadian politicians, has been subjected to the SCC's legal analysis and found wanting. While there has been much talk on addressing the "wait list problem", action has been slow in coming, and getting to the roots of addressing wait lists is anything but simple. The decision is not, however, quite the cataclysm that some people appear to believe, assuming that the governments seize upon the findings as an opportunity to put things right concerning access.

Because of the Court's 3-3 split on the *Canadian Charter* question, the effect of the judgment is limited to Quebec. While the common language of the majority judgments may invite similar lawsuits in other provinces, it is far from certain which way the full SCC bench would go in the future. Justice Deschamps's concurring judgment is careful to point out that the language of the *Quebec Charter* has a potentially broader scope and a different burden of proof – or persuasion – than that of the *Canadian Charter*, and thus may lead to a different application.

Further, if the Court hears this issue again, it will likely be in front of the full complement of nine judges, now that Justices Charron and Abella have filled the two vacancies that existed at the time of hearing. The balance of any future decision depends on these three opinions, and it is difficult to predict on which side they may fall. Further, the findings concerning government "inertia" and "failure to act" were based on evidence which, at this point, may be "historical", given how long the case took to go through the courts, the year-long deliberation at the SCC, and the recent infusions of significant additional resources in the Health Care Accord. In the meantime, at least some governments have already moved to address wait lists and access. Nevertheless, as the concurring judgment of Justices McLachlin and Major stated, "access to a waiting list is not access to health care." So wait list policies must be seen by the public to be fair and effective.

What can be said with certainty about the Chaoulli decision is that it challenges Canadians to radically rethink their health care system, and with it, a piece – some would say the central piece – of their national identity. Since the 1960s, Canada has worn its uniquely world-class and universal medicare proudly on its sleeve. The success of this moral enterprise has been exemplary. It has also, however, ingrained itself so deeply into the Canadian consciousness that any mention of deviating from a purely single-tier, publicly funded and not-for-profit system inspires strongly polarized public controversy – an "emotional reaction", if you will, at least in part. Medicare has achieved a sanctity that places it beyond question, doubt and, at least until last week, rigorous analysis for many Canadians.

In reality, Canada's public health care system needs major reforms. Wait times are increasing, doctors and nurses are in constant shortage, and there is scarcely enough money to fund hospitals and new infrastructure. The federal government has committed $41 billion in additional financing to the health care system over the next ten years, but Canadian Medical Association president Dr. Albert Schumacher has said the increase has "just kept

us from bleeding to death". Too much emphasis has been placed on maintaining the current system without taking more reform-based steps towards improving it.

Many Canadians are already aware of this unfortunate reality. In 2002, the Romanow Report on the Future of Health Care in Canada identified wait lists as "one of the most serious concerns" in the health care system. The 2002 Kirby Report on the Health of Canadians identified the need to look beyond public funding to overcome this problem and sustain a world-class health care system, suggesting 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 for all their citizens."

The most common criticism of allowing for this expanded private role is the potential emergence of two defined tiers of care. Instead of rigorous equality of access to medical care, there is a concern that those who can afford private insurance will receive better, faster care. The further worry is that the profit motive will draw doctors and resources away from an already-strained public system, leaving those who cannot afford insurance with worse care and longer lines. Canada, however, is currently the only OECD country that does not allow private insurance. The majority of the SCC in Chaoulli selectively canvassed parallel systems in Sweden, Germany, the UK, France, Switzerland, Australia and New Zealand wherein a range of non-essential health services can be administered by private clinics and insurance. These systems, although all implemented very differently, all still provide a solid base of publicly funded care while employing additional means of accommodating growing demands within a reasonable time.

In fact, Canadian approaches are far from uniform in their commitment to "pure" public health care, and provinces have increasingly turned to providing services privately as health care needs have outstripped available funding. While seven provinces including Ontario have adopted statutory measures designed to discourage private insurance similar to Quebec's, three other provinces – Saskatchewan, New Brunswick and Newfoundland – allow some measure of private insurance. Private health care clinics for non-core services have quietly proliferated in all provinces, creating what some commentators have referred to as "de facto privatization". Hospitals have also been permitted to outsource ancillary services such as building maintenance, food preparation and laundry for years.

These are the kinds of changes that tend to make Canadians uneasy. However, the Chaoulli decision is anything but a call-to-arms for privatized health care. If there is one common thread amongst all of the Court's divided opinions, it is the acknowledgement that Canada's public health care system needs to remain the cornerstone of whatever solution is developed. Indeed, the scope of the Court's actual holding is quite narrow, and finds restrictions on private insurance unconstitutional only when a waiting period jeopardizes the right to life or security of the person. These private solutions would be limited to defined circumstances, and are meant to augment, not replace, public health. Senator Kirby, commenting on the judgment, said that it is anything but a green light for a two-tiered system; it is rather meant to inspire governments and service providers to find a real solution, and fundamentally to reorganize the existing public health care system. There are many innovative ways to achieve this if Canadians keep an open mind.

For example (as indicated in Roger Martin's study *Aligning the Stars: Using Systems Thinking to (Re)Design Canadian Healthcare*), in 1999, Cancer Care Ontario turned to an open-bid process as a last resort to reduce an unacceptable wait list crisis that was directly harming the recovery prospects of cancer patients. CCO struck up an agreement with Canadian Radiation Oncology Services (CROS), an investor-owned company that

had health care professionals use radiation therapy equipment in hospitals after-hours and on weekends when it otherwise sat idle. CCO paid CROS a flat fee equal to what OHIP paid the public system for identical care. No patient paid out-of-pocket. The agreement also stipulated that CROS must provide quality care, treat 1,000 patient per year and do so without poaching staff from existing public clinics. In the first six months of its existence, CROS treated 503 patients at a cost to the Ministry of Health and Long-Term Care that was a fraction of what would have been paid for identical treatment in the United States, where the wait list of patients had previously been referred. Some studies have put this fraction as being $1.8 million versus $9.3 million – a savings of $7.5 million. CROS faced significant public controversy. There is a view that the Ministry succumbed to an emotional public reaction, despite the success of the program, and CROS's contract was not renewed in 2003.

The SCC decision forces Canadians to seriously consider, and then implement, innovative solutions. If anything, the judgment in the Chaoulli case serves as a warning to government and service providers to stop speaking in platitudes. Canada built its public health care system to be world-class. Today, it arguably serves more to fuel national pride, which is becoming more fiction than reality. The SCC has told Canada it needs to look beyond its past glory to regain its unparalleled reputation.

What is desperately required is creative thinking and a holistic approach to the entire health care system. To preserve it, enhance it and build on its very foundations, we owe it to each other – in every sense of that phrase – to look to the fundamentals, and not to fear creative, innovative and original thinking such as Canadians engaged in 40 years ago in the creation of our current health care system.

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