The Chaoulli case: Two-Tier Magna Carta?

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There has been much speculation about the impact of the recent Supreme Court decision on Chaoulli. Even if those who are most friendly or most hostile to Canadian medicare are exaggerating the impact of the decision, its impact will be large. While the decision does not strike down any existing single-payer medicare system in any province, including Quebec, it is certainly capable of becoming the magna carta for two-tier (even multi-tier) medicare through future judicial interpretation and extension.

Much has been said in recent years by the critics of medicare about the monopoly of single-payer health care in Canada. This claim demands closer examination.

In the first place, medicare refers to quite a narrow range of health services – mainly hospital and physician services that are provided on a universal basis and without direct payment by the patient. These services constitute only about 43 per cent of total health care expenditures in the country. Almost all other health care including home care, nursing home care, prescription drugs, vision care and alternative medicines are outside the medicare basket. In other words, the so-called monopoly covers less than one-half of Canadian health care and does not at all apply to mixed and private sectors of health care sectors in which private insurance, user fees and direct payment are the rule rather than the exception. It is these mixed and private sectors – comprising over 50% of health expenditures – that are responsible for much of the growth in health care expenditures over the last decades.

In the second place, we have always permitted two small exceptions to our single-payer medicare regimes – one private, the other public. On the private side, no one is prohibited from purchasing private health services as long as they pay out-of-pocket for those services from providers who have chosen to be non-participating members of a provincial medicare scheme. On the public side, workers' compensation health benefits predate medicare and were legally excluded from the operation of the Canada Health Act and provincial medicare laws.

Of the two exceptions, the public tier of workers' compensation has been more problematic in terms of its damage to the principle of universality by allowing a segment of the population preferential access to medicare services, occasionally through non-participating physicians and private facilities. In contrast, the private exception based upon private out-of-pocket payments never really developed in Canada because provinces discouraged or prohibited the purchase of private health insurance for medicare-type services. I would also argue that the generally high quality of the Canadian medicare has also prevented a large private market from developing. At any rate, the very few who wanted such services could purchase them in the United States where a ready market for privately purchased services has always existed because of the truncated nature of public health insurance in that country.

This brings us to the nub of the Supreme Court decision. Opponents of Canadian-style medicare, including Dr. Jacques Chaoulli, have long argued that the inability to purchase private insurance for medically-necessary health services has prevented a viable second tier from emerging capable of competing with publicly-administered medicare for customers.[1] They often point to examples such as Australia where public and private hospital and physician services co-exist conveniently ignoring the fact that the Australian government has had to provide a huge public subsidy in the form of a 30% deduction for private insurance premiums to keep the private system in business.

Proponents of medicare have long argued that the provinces need to discourage, or even prohibit, any major exception to single-payer medicare in order to preserve the universality of a system, with access based solely on need, by not permitting a separate "upper" tier of care based on ability to pay. They did so because they wanted to prevent major exceptions to the principle that access should be based on urgency of need. They also did so to prevent a parallel private system from robbing the financial and human resources needed to run a top-notch public system. To protect their single-payer systems, different provinces have selected different and various means to discourage a second private tier. These include: not allowing non-participating physicians to charge more than the medicare fee schedule; refunding patients only the medicare portion of fees paid to non-participating physicians; and in the case of six provinces (British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and Quebec) prohibiting private health insurance for medicare services.

With Chaoulli, the Supreme Court has decided that Quebec's prohibition on private health insurance is contrary to the Quebec Charter of Human Rights and Freedoms in a situation when the individual's lengthy wait for medicare services seriously compromises the health of that individual. The court provides little guidance, however, in helping governments, health organizations and physicians know at what point a waiting time is too long. Moreover, little consideration appears to be given to the fact that many provincial governments and health organizations, through initiatives such as the Western Canada Wait List Project and the Saskatchewan Surgical Care Network, have focused their efforts at understanding and shortening wait lists. Indeed, although the degree of success varies across and within provinces, considerable progress on tackling waiting time has been made in many parts of the country.

It should be clear that medicare is, in effect, a highly local system depending on the management and decisions of individual physicians, hospitals and regional health authorities. It is up to these organizations, under a publicly administered framework provided by the provincial government, to balance the many priorities, from urgent to elective care, and from sickness care to illness prevention and health promotion in the publicly administered system. My concern is that the court's concern with one waiting list problem in one city in one province is going to end up dictating priority setting by health organizations and governments throughout Canada, even further tipping the balance in favour of downstream illness care and away from prevention and promotion efforts that will keep us all healthier (and a less costly burden to our fellow citizens) in the long run.

So, what next?

In the face of this decision, those governments that support medicare should act now rather than waiting for the inevitable offensive driven by the powerful interests supporting the radical privatization of Canadian medicare. Individuals and groups within those provinces can strengthen the resolve of these governments by expressing their support for universal medicare, their opposition to allowing a private upper-tier of care, and initiating their own litigation to support the principles of medicare. And they can demand action of their governments now.

Those provinces which have prohibited private insurance should consider amendments that clarify the reasons for prohibition and the merits of a single-tier system of medicare. The legislative debates will force everyone to make their positions and assumptions clear and will provide an opportunity for medicare-friendly governments to set out the evidence supporting a single-tier system. Once enshrined in law, each government's legislative intent will have to be taken into consideration in future court rulings.

The provinces that have not previously prohibited private insurance have at least two options open to them. They can examine and explain the combination of measures they have used in place of an outright prohibition on private health insurance to protect the integrity of their single-payer systems, and the extent to which their circumstances may differ from the provinces with express prohibitions. They can then amend their own medicare legislation to make clear their legislative intent to continue to preserve the integrity of their single-payer systems. To push the envelope, one of these provinces could carefully draft a new law prohibiting private health insurance for the express purpose of having it tested in the courts even while making the broader political point that the decision of best to preserve the single-payer system should be within the purview of democratically elected governments.

The federal government could take some long overdue action to enforce the Canada Health Act. There is a reason that Montreal has the largest number of private MRI clinics in the country – a market has been created because of the extremely long waiting lists in the public sector and the willingness of participating physicians to encourage their more well-off patients to jump the medicare queue by getting a private MRI. If the federal government had forced this issue into the public domain years ago through a (temporary) reduction in its transfer payments, the Quebec government might have better ensured timeliness of care through the public system and not relied so surreptitiously on its private release valve. In more general terms, while it is up to individual provinces to decide on how best to administer (and protect) their single-payer systems, the federal government needs to continue to ensure that it is effectively discouraging major exceptions to the fundamental principles of public administration, universality, comprehensiveness, portability and accessibility.

Finally, I would like to offer some unsolicited advice to Premier Klein of Alberta given his recent comments. If he truly believes that the founding principles of medicare are

fundamentally flawed, then this court decision should finally give him the courage of his convictions. If he truly believes that Albertans endorse his vision, then he should replace medicare with a two-tier system. He can bypass the Canada Health Act by simply refusing federal health transfers in the future. Albertans could then pay directly out-of-pocket or indirectly through private health insurance for a portion of their medicare services. Access for the majority would be based mainly on "ability to pay", while access for the very poor (often defined as those on welfare) would be determined by a safety net type medicare program. Where the working poor fit into this picture is a little harder to determine. In the 1960s, this option was called 'Manningcare' because Premier Ernest Manning was convinced of its merits compared to the universal medicare model. Personally, I would be confident that medicare would prove itself more efficient and effective in the comparison, just as it has done relative to the United States. Whether a majority of Albertans would go along with this trip back to the past is more questionable but it is a decision which all Canadians now face because of the Chaoulli decision.

We all know that the demand for health care services is potentially limitless. After a protracted debate, we long ago decided, that at least for medicare services, rationing should be based upon urgency of need rather than ability to pay. Though the majority of Canadians continue to support that decision and the founding principles of medicare, the Supreme Court is nonetheless forcing us to go back to the drawing board again.

[1] J. Edwin Coffey and Jacques Chaoulli, *Universal Private Choice: Medicare Plus* (Montreal: Montreal Economic Institute, 2001).

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