

# Courting Trouble: The Supreme Court's Embrace of Private Health Insurance

*Use and misuse of social science evidence by the Supreme Court –  
how should Canadian governments respond?*

by COLLEEN M. FLOOD

*Associate Professor,*

*Faculty of Law, University of Toronto*

*Canada Research Chair in Health Law and Policy*

STEVEN LEWIS

*Centre for Health and Policy Studies, University of Calgary*

*Access Consulting Ltd.*

*Saskatoon, SK*

**I**N A NARROW AND BITTER 4–3 DECISION, THE SUPREME COURT OF CANADA in the *Chaoulli*<sup>1</sup> decision struck down Quebec laws prohibiting the sale of private health insurance on the basis that they violate Quebec's *Charter of Human Rights and Freedoms*. Three of the four judges in the majority also found that the provisions, in light of wait times in the public sector, violate s. 7 of the *Canadian Charter of Rights and Freedoms* – which provides for a right to life, liberty and security of the person. But three other judges, in a blistering dissent, found that the insurance restrictions violated neither the Quebec nor the Canadian charters.

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1. *Chaoulli v. Quebec (Attorney General)* 2005 SCC 35 (hereinafter *Chaoulli*). A copy of the judgment and various related materials is available at <<http://www.law.utoronto.ca/healthlaw/>>.

The Chaoulli decision is confusing and complex but to clarify there are three separate judgments:

1. The majority judgment, written by Justice Deschamps finding the Quebec legislation to be in breach of the Quebec Charter (which is similar to but not exactly the same as the Canadian Charter) ["the Deschamps judgment"] the result of which was concurred with by Chief Justice McLachlin and Justices Major and Bastarache ["the majority judgment"].
2. The judgment written by Chief Justice McLachlin and Justice Major on behalf of themselves and Justice Bastarache which finds the Quebec laws prohibiting private health insurance not only contravene the Quebec Charter but also are in contravention of section 7 of the Canadian Charter ["the McLachlin/Major judgment"]. The significance of this judgment is that it puts in question the constitutionality of measures taken in other provinces to prevent the flourishing of a two-tier system.
3. The minority judgment written by Justice Binne and LeBel on behalf of themselves and Justice Fish finding that Quebec's laws violated neither the Quebec nor Canadian Charter ["the minority judgment"].

In this brief review, we discuss the use and misuse of social science evidence by the court and consider how Canadian governments should respond to this decision.

One of the most concerning aspects of the Deschamps and McLachlin/Major judgments is their treatment of evidence presented by social scientists. The social scientists called all testified about the detrimental effects of allowing a two-tier system. All were dismissed in the harshest of terms and condemned for making arguments based on logic or theory rather than grounded in economic studies or upon the experience of other countries.<sup>2</sup> Indeed, McLachlin C.J. and Major J. conclude that governmental policy was "arbitrary," given in their view the lack of evidence supporting the contention that to allow parallel private insurance would undermine the operation of publicly funded medicare.

Writing for the majority on the Quebec Charter, Justice Deschamps states: "Some patients die as a result of long waits for treatment in the public system when they could have gained prompt access to care in the private sector."<sup>3</sup> This sweeping claim is based on anecdotal evidence from physician witnesses. If this is true, then surely the physicians in question, if they were not able to prioritize the needs of the desperately ill above others, would have brought this to the attention of relevant institutions and the relevant ministries of health. There would be lawsuits brought by the families of those who died.

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2. *Chaoulli*, paragraph 136.

3. *Chaoulli*, paragraph 37.

The McLachlin/Major judgment is on a firmer evidentiary footing in discussing the psychological effects of dealing with anxiety and uncertainty irrespective of final outcome. But as the minority (Justices Binne, LeBel and Fish) succinctly point out, how much of a wait is too long from a constitutional perspective? The McLachlin/Major judgment speaks in such general terms here that there is the possibility that any waiting time could justify a s. 7 Canadian Charter challenge. The patient at the heart of this litigation, George Zelotis, waited a year for a hip operation but remarkably, given that waiting times was the seminal issue in the judgment, the majority does not discuss his case.

Having established that wait times are too long and that Canadians die and suffer harm as a result of a government-imposed monopoly in healthcare insurance, the Deschamps and McLachlin/Major judgments assume that the ability to purchase private insurance will remedy this problem. Moreover the McLachlin/Major judgment concludes that allowing private insurance will benefit “ordinary” Canadians and not just the elite who can afford to fly to the United States and pay out of pocket for private care. Many will be familiar with the literature about the distributive consequences of private insurance and the cream-skimming and risk-rating behaviour of private insurers, and they will be surprised to learn of the benefits of private insurance that were heretofore unknown. The irony is that George Zelotis, the 73-year-old patient with hip and heart conditions, whose unsuccessful efforts to buy private insurance sparked these proceedings, would not, in all likelihood, qualify for private insurance if it were available.

The majority then considers whether or not allowing two-tier private insurance would detrimentally affect publicly funded medicare. Justice Deschamps superficially discusses the healthcare systems in Austria, Germany, the Netherlands, the United Kingdom, New Zealand, Australia and Sweden. Drawing on the Kirby report (Standing Committee on Social Affairs, Science and Technology 2002) the McLachlin/Major judgment provides a quick tour of the benefits of the healthcare systems of Sweden, Germany and the United Kingdom. There is also passing reference to Australia, Singapore and the United States. They conclude that “many western democracies that do not impose a monopoly on the delivery of healthcare have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada.”<sup>4</sup>

Through their comparative analysis of healthcare systems, the Deschamps and McLachlin/Major judgments amply demonstrate why courts should be extremely cautious about wading into these difficult policy choices. The fundamental error is to conflate all healthcare systems with some role for private insurance into one group. In fact, there are at least four distinct ways of financing healthcare,<sup>5</sup> and European

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4. *Chaoulli*, paragraph 140.

countries such as the Netherlands and Germany are better classified not as two-tier systems (which allow parallel private coverage for services ostensibly covered by the public system) but as group-based. In these systems, private insurance does not perform a duplicate role as would be allowed by the *Chaoulli* decision, permitting people to jump queues for treatment. Instead, private insurance is required to provide full coverage for certain segments of the population. For example, in the Netherlands, an individual earning less than \$30,000 (Cdn\$48,886) must contribute to and is eligible for social insurance (like medicare). All others must rely totally on private insurance (Wassem et al. 2004). Moreover, physicians don't have an incentive in the Netherlands to prefer patients with private insurance over those with social insurance, as the fees or tariffs paid are the same. In Germany, wealthier patients can opt to stay in the social insurance scheme or take out private insurance, but private insurance must cover all their needs, and one cannot easily opt back into the social insurance scheme. Private insurers in Europe are often heavily regulated to stop them from cream-skimming and risk-rating. To be clear, this kind of system will not evolve in Quebec as a result of striking down the ban on private health insurance.

Systems that have two-tier systems, such as is likely to emerge in Quebec post-*Chaoulli*, include New Zealand and the United Kingdom. In those countries, private insurance duplicates coverage of services that are provided publicly. Consideration of the specific experiences of these jurisdictions shows that historically, both countries have wrestled with waiting lists that are much longer than those within Canada (Tuohy et al. 2004). The length of waiting times in these two-tier systems strongly refutes the linkage made by the majority between long waiting lists and Canada's public monopoly on insurance. But neither the Deschamps or McLachlin/Major judgments consider evidence of long waiting times in these jurisdictions at all.

The McLachlin/Major judgment describes as merely "theoretical" the concern that a private-pay tier will undermine the public system. But the experiences of other jurisdictions demonstrate that this is a concern through the various measures they take to counteract it. For example, the McLachlin/Major judgment discusses how there is a small amount of private insurance in Sweden but fails to mention that physicians are prevented from working in both the public and the private sectors. Swedish physicians must choose one or the other, and the inability to operate largely in the public system with a top-up from the private sector provides a brake on the extent to which the private sector can develop at the expense of the public system. Similar measures are taken in other two-tier systems, namely those of Luxembourg, Greece and Italy (Colombo and Tapay 2004). This is also what many provinces in Canada do as well (Tuohy et al. 2004). Are all these governments misguided as to the problems of a parallel private

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5. Tuohy et al. (2004) identify four basic models of structuring the relationship between public and private financing; parallel public and private systems; co-payment; group-based; and sectoral.

sector? If not, then surely it is not “arbitrary” to take the next step and simply ban private insurance for essential hospital and physician services.

What went wrong, then? How could the majority of the Supreme Court have reached this outcome? There are, in our view, two reasons.

The first reason has to do with the quality of evidence about public and private interactions across healthcare systems. It is impossible to run a randomized, controlled trial to show irrefutably the effects of two-tier insurance. Indeed, it is a feature of systems with greater levels of private finance that they are more often in turmoil (Tuohy et al. 2004). Nonetheless, there is still a strong body of evidence about the distributive effects and inefficiencies of private insurance and clear evidence from countries such as the United Kingdom and New Zealand that eliminating a monopoly in public insurance will *not* eliminate waiting lists.

The second reason has to do with presentation of policy evidence in an adversarial environment. In an often-quoted essay, Lorne Fuller (in Winston 2002) argues that judges are good at determining bi-polar disputes and struggle much more with polycentric issues.<sup>6</sup> That is usually why, at least in theory, courts will be cautious about wading into complex policy areas. Indeed, on issues of resource allocation, courts have evinced a strongly deferential position, most notably on the part of the Supreme Court in the *Auton* decision concerning funding of a controversial treatment for autistic children.<sup>7</sup> But in a courtroom, a judge is as likely to be swayed by the direct testimony of physicians or patients as by systemic research, particularly where the research is neither clear nor overwhelming and has to counter a judge’s own strongly held intuition or liberal values. In our society, there is a powerful presumption that competitive private markets are inherently efficient and virtuous. The intuition of many people, underscored by the liberal values enshrined in the Charter, is that allowing private markets will alleviate pressure on the public system. Those in health policy need to understand that judges will not necessarily share the presumption that healthcare is a public good rather than a market commodity. The court will start from the perspective of the rights of an individual, and although accepting that rights are not inviolable, will not easily be persuaded that government policy that treads on such rights is necessary.

## Political and Legislative Responses

Now that the spectre of accelerated privatization looms large, provincial governments have several strategic options to pursue. The issues are by no means straightforward, and the battle is likely to be fought in three arenas, each with its own dynamics.

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6. Also see L.A. Chayes (1976), “The Role of the Judge in Public Law Litigation,” in the *Harvard Law Review* 98: 1281.

7. *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 SCR 657

The first dimension is democratic. Medicare was forged in the political arena in Saskatchewan and prevailed over fierce opposition. The pro-medicare camp still commands the political high ground, and it should capitalize on this advantage. Though it is plausible to infer that some governments in Canada would be content to see medicare fade away as an icon and political litmus test, it is still risky in most parts of the country for a politician to declare that a tax-funded, single-tier system is a bad idea. Insisting that all candidates for provincial or federal office disclose their views would seem to be an important tactic. The central questions are:

- Should better-off Canadians be able to purchase faster service from doctors and hospitals?
- Would you support a two-tier system if the result is that waiting times in the public sector worsen?
- As a matter of principle, do you support the development of a private and parallel system for physician and hospital services? Do we have too much or too little private care now?

Sorting out the politics is necessary, but not sufficient. The second dimension is to solve the problems of quality and access, the latter of which created the pretext for *Chaoulli* and which also portends future Charter challenges now that the court has left the door ajar. The purpose here is to improve the public system so that even well-heeled people lose interest in the private option.

First, the best defence to a s. 7 challenge will be to fix waiting lists and restore Canadians' confidence in the timeliness of medicare. Provinces must implement consolidated, standardized, province-wide wait list management systems: no more lists held in physicians' offices and opaque prioritization processes. Ottawa could and should insist on this as an addendum to the recent Accords. The next step will be to amend the *Canada Health Act* to mandate such measures (Flood and Choudhry 2004). Ironically, the *Chaoulli* decision now provides the leverage that governments need to implement such measures rapidly, regardless of the opposition they may face (Lewis 2005).

Second, the majority of the Supreme Court criticized the fact that there was no real appeal mechanism in Quebec for people languishing on waiting lists. Every province should establish highly accessible tribunals or patient commissioners to review cases swiftly and fairly (Pitfield 2003; Defining the Medicare Basket Project 2003). There should be some discretion to grant relief to individuals where the psychological effects of waiting are extreme, to head off further challenges under s. 7, or even to approve treatments that do not, strictly speaking, meet the usual eligibility criteria. Canada is a wealthy country, and erring on the side of generosity and compassion in delivering healthcare while pursuing reforms to eliminate waste and excess in the

system, seems a reasonable compromise.

Third, there is great confusion about the evidence on public versus private, both in the minds of both the majority of Supreme Court justices and of Canadians. The *Chaoulli* decision makes inevitable further Charter challenges to similar laws in other provinces, but the question of whether they will or should succeed remains contested. The composition of the Supreme Court is changing with the addition of two new justices. A reconstituted court may come to a different conclusion. In anticipation, federal and provincial governments, in conjunction with health policy analysts, must marshal the best possible evidence on public–private financing and the detrimental effects on the public system of a second, private tier. At the very minimum, the forces in favour of privatization should not prevail because the best evidence was not presented to the relevant court.

Fourth, provincial governments need to create a thick firewall between the public and the private system. They should insist that providers choose one or the other, exclusively. It should also be made clear that public hospital capacity will be available to private patients on a purely discretionary basis, and that there will be no subsidization of this private option from the public purse. Ensure that they enforce the spirit and letter of the Alberta legislation that prohibits patients from getting faster public-sector service as a result of getting a private-sector diagnosis.

Fifth, if for whatever reason, the public system is compromised by a growing departure of doctors and other key personnel to the private sector, provinces should consider a two-tier tuition system to mirror the two-tier healthcare system. Currently, medical school tuition can run as high as \$47,000 annually (at Dalhousie) for international students. All health sciences students should be given the option: commit to practising in the public system for a defined period of time and pay low tuition fees, or make no such commitment and pay the actual costs of the education. Public policy should not exclude students who want to retain the option of going private, but nor should it subsidize them.

Beyond these short-term measures, more systematic change is required. We need to revisit Canada's approach to health human resources (HHR). It is, we contend, wiser to produce a modest oversupply than a modest undersupply. Scarcity breeds wait times, tilts bargaining power heavily in favour of providers, leads to bidding wars among jurisdictions that drive up costs without adding service and tempts Canada to engage in the unseemly practice of raiding personnel from developing nations. Aside from physicians, it is relatively inexpensive to produce healthcare personnel. And even though educating physicians is costly, European countries have for years produced more than they needed, with an estimated 100,000 unemployed in 1995 (Orellana 2001) and more recent rates estimated at 3–4% in Sweden, 7–8% in Greece, 5–10% in Spain and as high as 20% in Italy (Avgerinos et al. 2004). Involuntary unemployment is unfortunate, and we are aware of the pitfalls inherent in merely adding more

fee-for-service doctors to a system already vulnerable to supply-induced demand. On the other hand, shortages drive up salaries and compromise public confidence. Conceivably, a modest surplus combined with payment reforms, policies to prevent the over-concentration of personnel in large urban centres and other measures could create competition for quality, increase willingness to locate in underserved areas and impose some semblance of market discipline on wages and salaries. As an initial step, economists and planners should undertake modelling exercises that project the costs and consequences of switching from a “just enough” approach to HHR to a “just a little too much.”

Romanow (Commission on the Future of Health Care in Canada 2002), Kirby (Standing Committee on Social Affairs, Science and Technology 2002), Mazankowski (Alberta Premier's Advisory Council on Health 2002), Fyke (Commission on Medicare 2001) and Clair (Maioni 2001) have all emphasized the need to accelerate changes to the division of labour. Doctors are doing what nurses can ably do (Horrocks et al. 2003). Highly educated, high-priced surgeons are performing routine, high-volume procedures that technicians perform elsewhere – notably, cataract surgery – while their advanced knowledge and cognitive skills are underused. Primary healthcare reform is by common consensus moving at a glacial pace; even more discouragingly, ambitious, comprehensive models (Ontario Health Services Restructuring Commission 1999) have been diluted into physician-extender compromises. The result is a sub-optimal use of skills and often-demoralized personnel.

As many have also argued, we must tie funding to both organizational innovation and meeting performance standards. We must create incentives to speed up the adoption of comprehensive primary healthcare. We must withhold funding from jurisdictions and institutions that do not have wait time management systems or that fail to follow up with patients on the long wait time tail. We must also renegotiate agreements with medical associations and repatriate the power to establish comparative earning power among physician categories. If there is a shortage of family doctors, it is partly because new graduates are leaving family medicine residencies unfilled; the same holds true for geriatrics. Meanwhile, plastic surgery and dermatology residencies are oversubscribed, and there is already an oversupply of neurosurgeons. If the medical associations' internal collective bargaining process does not value what the public system needs, others must be at the table to bring about change.

## Conclusion

The prime minister of Canada, among others, has downplayed the Chaoulli decision, arguing that it will not fundamentally affect medicare. It is true that technically the reach of the decision is confined to Quebec, but it will have repercussions far beyond those borders. First, because the court is split on the critical issue of the application

of the *Canadian Charter of Rights and Freedoms* to laws prohibiting private insurance, the question will likely soon be tested in the provinces of Alberta, British Columbia and Prince Edward Island, which have similar laws. Second, there is the prospect that other provincial laws that effectively suppress a private-pay sector will be subject to a Charter challenge. Justice Deschamps, writing the majority judgment on the Quebec Charter, seemingly approves of legislative provisions in other provinces that stop short of expressly prohibiting private insurance. However, Chief Justice McLachlin with Justices Major and Bastarache, who find Quebec's insurance provision to be in breach of the Canadian Charter, do not comment on these other measures. This leaves open the possibility that provisions such as those that exist in Ontario, Nova Scotia and Manitoba (which prevent physicians' from charging privately more than they would receive from the public plan) may also be subjected to a Charter challenge.

More importantly, the *Chaoulli* decision, a ruling of the Supreme Court of Canada, will have a strong normative effect on the future tenor of the public-private debate. We are already starting to see the effects of this in editorials in the major newspapers. The ground has shifted, and the forces in favour of privatization have achieved a significant victory. They can now add an enormously strong plank to their heretofore rather weak arguments: they have been legitimated by the Supreme Court of Canada. The new role that the courts may play in healthcare is of crucial importance not only to the courts, but to the Canadian public and their governments. For years, health policy analysts have battled the "zombie" ideas of user-pays, private insurance and two-tiers (Evans et al. 1995). There is now a new venue for the debate, and health policy analysts cannot ignore it.

The Supreme Court decision, however misguided, has brought medicare to a new crossroads. We have proposed political, policy and legislative antidotes to the potential consequences of the *Chaoulli* judgment. Our preference is for politics and policy. Medicare's future should be deliberated in the political arena. Better that 32 million Canadians determine the structure and fate of medicare than seven (or nine) judges – a prescription shared by the dissenting minority.

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