The Courts and Two-Tier Medicare

Les tribunaux et le système de santé à deux vitesses

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Abstract

Canada's single-payer healthcare system is at a critical crossroads. A legal challenge underway in British Columbia alleges that legislative restrictions on privately financed care infringe the right to "life, liberty and security" guaranteed under Section 7 of the *Canadian Charter of Rights and Freedoms*. The greatest challenge for the court will be comparing healthcare systems across disparate jurisdictions, with the future of single-tier healthcare system hanging in the balance. If successful, the case may require a major overhaul of Canada's single-payer system – a perilous task politically, if history is any guide, and this may be the system's undoing.

Résumé

Le système de santé canadien à payeur unique est rendu à un carrefour critique. Une contestation judiciaire en Colombie-Britannique allègue que les restrictions législatives sur le financement privé des soins se santé enfreignent le droit « à la vie, à la liberté et à la sécurité » garanties en vertu de l'article 7 de la *Charte canadienne des droits et libertés*. Le principal défi

pour le tribunal sera de comparer les systèmes de santé entre des juridictions disparates, avec en jeu l'avenir du système de santé à payeur unique. Si la contestation obtient gain de cause, cela pourrait donner lieu à une révision radicale du système de santé canadien à payeur unique – une tâche politiquement périlleuse, si on se fie à l'histoire, et qui pourrait mettre en péril le système même.

Introduction

Internationally, Canada's healthcare system has seen a fall in its relative performance in recent years, with Canadians reporting, among other concerns, some of the longest wait times across comparator countries (Canadian Institute for Health Information 2017). However, rather than spurring significant government action to improve healthcare for *all* Canadians, wait-time concerns are sparking constitutional challenges to overturn present legal restrictions on privately financed care, so some can both enjoy the security of a single-payer system and "jump the queue" by using private monies more easily. Although framed around patient rights, the case is equally about the economic rights of physicians: a physician-owned private for-profit clinic (Cambie Surgeries) is at the helm of the most recent constitutional challenge and looks to benefit from further privatization of the Canadian system.

Challenges to laws that limit the potential for a two-tier system are primarily grounded in Section 7 of the *Canadian Charter of Rights and Freedoms* – the right to "life, liberty and security of the person." Challengers are seeking to overturn a variety of laws that exist across Canadian provinces; these laws restrict opportunities for privately financed care (it is important to note that the Canadian system, although restrictive on the possibilities for private financing, largely embraces possibilities for private delivery [Deber 2002]). Across Canada, current laws restrict (but do not completely eliminate) a two-tier system, wherein all Canadians are insured by public medicare, but the use of private funds to buy faster or better care is permitted. These laws vary in their detail across the 10 provinces but include a mix of the following:

1. restrictions that stop a doctor who bills public medicare from charging a patient an additional amount (extra-billing);
2. restrictions that prevent physicians from billing both the public and private systems simultaneously, at least for "medically necessary" care (dual practice);
3. restrictions on physicians in the private sector charging prices for medically necessary care that are higher than those permitted in the public plan; and
4. restrictions on private health insurance for services that are covered by medicare.

All Canadian provinces have a mix of some or all of these restrictions, enacted to meet the requirements of federal legislation, the *Canada Health Act* (CHA), and thereby qualify for a federal contribution to the operation of their respective healthcare plans.

The First Successful Court Challenge

The ruling of *Chaoulli v. Quebec* (2005) was the first successful court challenge in this area. In this case, the court overturned the province of Quebec's restrictions on parallel private insurance for medically necessary care on the grounds that such a restriction, given wait times in the public system, infringed an individual's rights to life and/or security, and as such people should be entitled to buy private health insurance to help navigate their way around the wait times. Building off of *Chaoulli*, interest groups wanting to benefit from the expanding role of private financing in the Canadian system, as well as patients both harmed and distressed by increasing wait times, have launched lawsuits that expand far beyond the *Chaoulli* precedent (*Allen v. Alberta* 2015; *Cambie Surgeries Corporation v. British Columbia (Attorney General)* 2018; *McCreith and Holmes v. Ontario* 2007). The most significant of these is an ongoing case that went to trial in September 2016 in British Columbia (BC) and for which we expect a decision later this year. Launched by Cambie Surgeries Corporation (a private for-profit clinic) and led by its owner, Dr. Brian Day, the challenge is to the constitutionality of BC's *Medicare Protection Act* (MPA) laws that dampen the incentives for physicians who participate in medicare ("enrolled physicians") from sidelining in private practice (Government of British Columbia n.d.). The three laws under the challenge are as follows:

1. a ban on "dual practice," which requires physicians to choose to either bill solely the public system ("enrolled") or "un-enroll" and exclusively bill private payers (that is the patient him- or herself or their private insurer; Sections 14 and 17–18 of the MPA);
2. a law that nullifies any private insurance contracts covering publicly insured care delivered by "enrolled" physicians (Section 45 of the MPA); and
3. a ban on extra-billing so that enrolled physicians cannot charge patients above and beyond what they receive from the public plan (Section 17(1) of the MPA).

Legislative Language: Confusion and Clarity

The legislative language is quite confusing. In BC, physicians who are "enrolled" in the public system have the following two options: they can "opt in" (bill the government directly) or they can "opt out"; by opting out, they may bill patients directly, but not more than the public plan permits, and then the patient him- or herself can claim this sum from the public plan. On the other hand, physicians who are "unenrolled" are free to bill patients for services at whatever rate the market will bear in private clinics, and patients cannot claim any part of this sum from the public plan.

Cambie then is a much broader challenge than *Chaoulli*, which was restricted to a challenge to a ban on private insurance alone. The goal of *Cambie* is to make it economically attractive for physicians to work in a two-tier system, and to achieve this, it seeks to overturn the law restricting not only private insurance but also dual practice. If *Cambie* is successful in challenging the ban on dual practice, they will also incidentally be able to overturn the ban on extra-billing, as these provisions are bundled together under the same law (the reader will recall that this then would allow all physicians to not only bill the public plan but also bill an extra amount from patients, raising very significant access concerns). *Cambie*, in its closing arguments, says that it accepts the constitutionality of the ban on extra-billing but nonetheless still seeks to have the entire law struck down, leaving it to the government to respond with a more tailored legislation that bans extra-billing while allowing wholly private billing by enrolled physicians. In other words, *Cambie* suggests the formation of a new law that bans extra-billing but permits physicians to bill the public plan for medically necessary services and in addition provide private services and bill these entirely to the patients and/or their private insurers.

In terms of the challenge to extra-billing, it is relevant to note that the *Cambie* challenge was launched in response to the BC government's move to investigate Cambie Surgery Centre for extra-billing of patients – it demanded patients pay up to CA$17,000 per treatment and also billed the public system at the full medicare rate (Ministry of Health, Billing Integrity Program, Audit and Investigations Branch 2012). Nonetheless, perhaps because extra-billing is so clearly in contravention of the CHA, the *Cambie* claim has become more nuanced on this point over the course of the multiyear trial, focusing on the restrictions on private insurance and dual practice. Despite muting their attack on extra-billing in their final arguments, *Cambie* still asks that the court issue a "suspended declaration of invalidity" over *all* of the relevant laws, requiring the government to enact a response within a fixed period of time – presumably legislation that liberalizes dual practice while presumably maintaining restrictions on extra-billing. However, should the BC government fail to enact response legislation during the period of suspension, the entire suite of protections – including the ban on extra-billing – would be deemed invalid. Needless to say, this is a high-stakes game, given the challenges governments face in enacting structural reforms to health systems, an issue we return to in the Conclusion.

Cambie, if successful in whole or in part, has the potential to rapidly accelerate the privatization of healthcare financing across Canada for two reasons. First, the national impact of the *Chaoulli* ruling was limited because the majority did not reach a consensus on whether Quebec's restrictions on private insurance breached the *Canadian Charter*; writing for the majority, Justice Deschamps argued that judicial restraint favoured disposing of the matter under the *Quebec Charter* alone, and thus the technical legal ambit of that judgment was limited to Quebec alone. Second, the *Cambie* ruling has broader implications because, in addition to challenging restrictions on private health insurance at issue in *Chaoulli*, the litigation also challenges restrictions on dual practice and extra-billing – measures used in

other provinces. More fundamentally, if BC laws banning dual practice or extra-billing are overturned in whole or in part, this would strike at the heart of the CHA. To forestall this, provincial governments will have to demonstrate that wait times in their provinces are "reasonable" or that there are measures in place to ensure that Charter rights (to life and security of the person) are not unduly infringed, for example, a wait times guarantee and/or a patient ombudsman that patients can appeal to if waiting too long.

Surviving the *Charter* Challenge

In determining whether existing BC laws restrictive of the two-tier healthcare system can survive a *Charter* challenge, what will be crucial is how a court treats evidence of Canada's approach to the public–private mix relative to other jurisdictions (Flood and Thomas 2020). In short, a court is more likely to be persuaded that Canada's legislative restrictions on a two-tier system are justified for the protection of medicare if there is evidence of a similar approach in other countries (Flood and Thomas 2018). In the 2005 decision of *Chaoulli*, the majority found that Quebec (and the other provinces that similarly restrict private health insurance) is alone among comparator healthcare systems in prohibiting parallel private health insurance, and this finding grounded their ultimate conclusion that the prohibition was arbitrary and infringed the *Quebec Charter of Human Rights and Freedoms*. However, the court's approach to comparative analysis was remarkably brief and superficial, failing to note that private health insurance *serves very different purposes* across jurisdictions.

For example, private health insurance in a number of countries is not primarily used for the purposes of queue-jumping, but instead provides coverage for user charges and extra-billing charges that are mandated or permitted within the public system. In France, for example, well over 90% of the population have private health insurance, and it is used mainly to cover the mandatory co-payments that all patients must pay for all healthcare, and, further, this "private" health insurance is heavily subsidized if not directly paid for by the state, the latter being for very low–income individuals (Or and Pierre 2012). Moreover, one finds a completely different flavour of "two-tier" in Germany, where self-employed individuals have the option of withdrawing *completely* and *almost irreversibly* from the country's social health insurance scheme (akin to our public medicare) and securing coverage in a regulated private health insurance market (Schmid and Doetter 2020). In other jurisdictions, such as the Netherlands, private health insurance is mandatory for all citizens, heavily regulated to ensure comprehensiveness and accessibility, and again it is not primarily used for the purposes of jumping queues in the public system; mandatory and regulated private insurance *is* the universal system in the Netherlands (Flood and Thomas 2018).

To the extent that these French, German and Dutch systems are "two-tier" models, they are not two-tier in the sense being pursued by the Cambie clinic. Indeed, Canada's champions of privately financed care are pursuing something altogether different from what we observe in many European countries: retaining medicare coverage for all, while granting those with the financial means the option to "go private" when confronted by long wait times

for specific episodes of care. In this regard, the more apt comparators are systems such as those of Ireland, New Zealand, England and Australia, the first three of which have historically struggled with long wait lists *despite* the existence of a two-tier option (Vinberg et al 2013). The Irish experience with the two-tier system has been so destabilizing that it is driving major reform to strengthen and protect the public healthcare system (Thomas et al. 2020). Despite this, advocates of privately financed care insist on the logical fallacy that because some high-performing European systems allow "two-tier care" – a concept defined so loosely as to be almost meaningless – there is no drawback in Canada's abandoning its hard-won commitment to single-tier care. This kind of magical thinking has gained increased popularity in political discourse. Thus, the fair resolution of upcoming constitutional challenges will depend on the courts carefully reviewing comprehensive evidence of comparative health policy while acknowledging the deep complexity of the health policy choices that governments face given the particular context and history of the Canadian healthcare system. The claim made by the applicants in *Cambie*, that liberalizing hard-won laws protecting public medicare will improve public medicare by transforming it into a European-style system, has the allure of an easy fix – but is a mirage.

Given the problems rife across Canadian healthcare at the moment and high public concern about wait times and a lack of determined governmental response, there will be many who are sympathetic to the *Cambie* challenge, believing that perhaps this kind of disruptive approach may kick-start real reform across the system. The applicants in the *Cambie* case are seeking to persuade the court that they need not deeply consider the policy consequences of a decision to overturn laws protecting public medicare. Their argument is that having proclaimed laws limiting two-tier care as unconstitutional, it will then fall to the government to respond with a new set of laws, and the court should not worry exactly what those laws or policies may be, provided they are constitutionally compliant, what is known in constitutional parlance as "dialogue theory" (Hogg and Bushell 1997). On its face this sounds feasible – that the courts overturn laws and that governments respond by bringing forth new laws that are constitutionally compliant to achieve their objective. But this stance assumes that provincial governments will be motivated to protect public medicare: some provinces may in fact welcome the courts forcing a two-tier model upon Canadians without having to bear adverse messy political ramifications. Some provincial governments may view two-tier care as a way to relieve the political pressure on them to improve public medicare and to further placate doctors desirous of even more autonomy and more ways of earning extra income.

Thus, the "dialogue" *Charter* theory assumes that governments are motivated to protect the laws that have been found to be unconstitutional and that new laws can be introduced with relative ease (Kent 2001). Given the fierce battles that occurred between doctors and governments surrounding the birth of public medicare (also mentioned in Marchildon 2020), it is naïve to assume that provincial governments will necessarily respond to a loss in the *Cambie* case by taking bold steps to tackle wait times or will carve out a small niche for

the two-tier system while protecting a healthy core of public medicare. Moreover, although (some) physicians, private clinics and private insurers form a natural and economically motivated alliance pushing for the expansion of privately financed care, effective coalition-building on the opposing side – demanding the protection and improvement of universal healthcare and insisting upon management of wait times – is infinitely more challenging. Indeed, the recent struggles to bring about universal pharmacare illustrates this problem with (to date) strong and intense opposition from private insurers and drug companies, drowning out the more diffused voices of the uninsured and underinsured or those who are insured but still pay some of the highest prices in the world for pharmaceuticals.

Still, there is hope that if the courts overturn laws that are vital to the CHA, the federal government will lean in to provide more meaningful reform, for example, insisting that in exchange for federal transfers, the provinces truly meet the criterion of accessibility under the CHA. Section 12(1) of the CHA requires that provinces ensure "reasonable access" and on a basis that does not "impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise" such reasonable access. Surely it is past time that this criterion was rendered meaningful by the federal government insisting upon reasonable wait times in exchange for federal investments.

Conclusion

It is long past time that the federal and provincial governments took steps to address the problem of wait times, which have severely undermined public confidence in medicare, softening them up for the false prophets claiming privatization will make things better. Moreover, we know from experience that the key to improving wait times is better management and not a huge investment of resources. Examples include Ontario's Cardiac Care Network that significantly improved access to care by centralizing the triage of cardiac patients, reducing what were perilously long wait times and improving outcomes, and Alberta's evidence-based approach to knee and hip replacements under the leadership of the late Dr. Cy Frank, creating single-purpose clinics where care is standardized according to the best available evidence, which dramatically improved wait times for orthopedic patients without requiring a significant investment of resources (McMurtry 2015; Usher and Frank 2008). The problem of wait times can be solved for all Canadians with political will, but to achieve this, Canadians must demand more of their politicians when it comes to healthcare. As Canadians we have been too content to rest upon the fact that we outperform the US healthcare system. We need to do much better than that and insist upon high-performing healthcare systems from coast-to-coast with timely access to the care we need.

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