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THE PUBLIC HEALTH CARE MONOPOLY ON TRIAL

THE LEGAL CHALLENGES AIMING TO CHANGE CANADA'S HEALTH CARE POLICIES

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- In June 2005, the Supreme Court of Canada ruled, as part of its Chaoulli decision, that when the government is unable to provide access to required care within a reasonable timeframe, the prohibition on taking out private health insurance constitutes a violation of patients' rights under Quebec's *Charter of Human Rights and Freedoms*.
- Since it was rendered, this decision has been cited more than 174 times in various cases before Canadian courts. Only two cases, however, have the same goals as Dr. Chaoulli's case at the time, namely an end to the public monopoly in the funding of care regarded as medically required, with one case in Alberta and the other one in British Columbia.
- In December 2011, two Alberta patients who had had to spend tens of thousands of dollars for surgery in the United States initiated legal challenges before the Alberta Court of Queen's Bench with the aim of lifting the prohibition on the province's patients taking out duplicate private insurance.
- In June 2016, one of the most keenly anticipated legal proceedings concerning the public health care monopoly since the Chaoulli case is set to begin before the Supreme Court of British Columbia. The case involves Dr. Brian Day, a former president of the Canadian Medical Association and co-owner of the Cambie Surgery Centre, a private clinic and the largest establishment of its type in British Columbia.
- At the heart of the challenge before the Supreme Court of British Columbia are provisions in the law prohibiting not only duplicate health insurance but also mixed medical practice and the freedom of doctors to determine their own fees.

Chapter 2 – Ten Years after the Chaoulli Decision: How Has the Quebec Health Care System Changed?

- In principle, the legislative changes that followed the Chaoulli decision authorized Quebecers to purchase duplicate private insurance for a limited number of medical and surgical treatments, such as hip and knee replacements and cataract removals. In practice, however, no actual market for this kind of insurance developed, the number of admissible surgeries being too low for new and interesting insurance products for individuals and employers to appear. The maintenance of the prohibition on mixed medical practice also hampered the emergence of such an insurance market.

- The law also authorized public hospitals to sign partnership agreements with private surgery clinics for the transfer of a certain volume of surgeries and treatments. Three agreements of this type signed in recent years led to significantly improved access in the public hospitals concerned.
- The number of specialized medical centres (SMCs) remains relatively small in Quebec's hospital landscape. In March 2015, there were 44 SMCs in Quebec, most of which specialize in plastic and cosmetic surgery. This represents a substantial drop compared to March 2012, when there were 61 of them.
- Wait times for elective surgeries have not improved since 2007-2008. They have gone down slightly for cataract removals (-16%), but have increased for hip (+22%) and knee (+10%) operations.
- Of all the provinces, it is in Quebec that we find the lowest numbers of hip and knee replacements as a proportion of the adult population. These surgery rates are only about half those found in Saskatchewan, which has significantly reduced its wait times since 2010 by increased reliance on private surgery clinics.

- The current capacity to treat patients in the public system is rationed by the government and does not stem from a shortage of caregivers. Since 2005, the number of specialists has even grown three times faster than the Quebec population, an unprecedented increase.
- Many doctors cannot secure the operating time they want and find themselves unable to reduce their waiting lists despite their best efforts. Operating rooms remain significantly underutilized in nearly all of Quebec's administrative regions.

Chapter 3 – Dr. Day's Challenge in British Columbia: Is the Universal Health Care System Really in Danger?

- The difficulty of accessing health care, which keeps worsening in British Columbia, has prompted a group of clinics and patients to go before the courts to contest the legitimacy of the government's monopoly over the provision and financing of health care.
- The four sections of the *Medicare Protection Act* that the plaintiffs are challenging deal with the prohibition on purchasing duplicate private insurance, the prohibition on mixed medical practice, and the prohibition on doctors coming to a mutual arrangement with their patients regarding certain fees. Canada's health care system is an anomaly compared to the systems of the other industrialized countries when it comes to these restrictions.
- If the plaintiffs should win their case, the Canadian system would not thereby come to resemble the American model, but rather the most efficient mixed universal systems in the world, in particular those found in Europe.
- International experience over the past ten years confirms that greater reliance on the private sector, both in terms of funding and in terms of care provision, leads to net improvements when it comes to wait times, without compromising the principle of universality.
- The health economics literature shows that unequal access to care exists to varying degrees in all countries. There is no indication, though, that the presence of a duplicate private insurance market leads to less equitable access to medical services.
- In Canada, a large body of empirical research shows that access to care varies with socio-economic status, despite the prohibition of duplicate private health insurance and other restrictions.

INTRODUCTION

Canadian patients still have very few options when it comes to health care services. The provision of care that is considered medically required remains largely monopolized by the public sector in each province. The role of private health insurance is limited solely to the coverage of services not insured by the public system.

No other industrialized country imposes so many restrictions on its citizens in the field of health care. By observing foreign experiences, it becomes obvious that these restrictions do not give rise to better results in terms of access to care and quality services—quite the contrary. Canada still trails most countries in international rankings when it comes to waiting times for medically required care.[1]

According to certain analysts, Canadians can at least take comfort by telling themselves that they don't have a "two-tiered" health care system. But equal access to care in the current monopolistic system is a myth. A large number of empirical studies show that access to care varies with socioeconomic status in Canada, despite the numerous restrictions.

This is hardly surprising. In the presence of rationed access and waiting lists, it is to be expected that some will use their connections and other stratagems to gain access to the services they need before other people. More and more doctors recognize this. In a poll of Canadian doctors conducted in the spring of 2015, 63% of respondents admitted that wealthier people have easier access to better health care in this country.[2]

Public insurance organizations that are exempt from the *Canada Health Act*, like those covering workplace or road accident victims, are for their part able to call on private health clinics to treat the people they insure in every province. To keep the benefits they pay out from growing too large while the insured await their operations, these organizations consider it crucial that patients be treated and returned to work as quickly as possible. In Quebec, for example, over three quarters of the CSST's spending on medical care and rehabilitation goes to private clinics.

But if the private sector is beneficial for these public organizations, why would it be any different for ordinary citizens? Should Canadians be allowed to purchase, with their own money, private insurance covering spending on medically required care, instead of having to content themselves solely with the public health insurance provided by their government and languish on waiting lists?

A decade ago, the Supreme Court of Canada looked into these questions. In June 2005, in a now-famous ruling, the highest court in the land declared that the prohibition against purchasing private insurance for medical services insured by the public system is a violation of the right to life and security of patients and runs counter to the *Quebec Charter of Human Rights and Freedoms*.

"Canada still trails most countries in international rankings when it comes to waiting times for medically required care."

In the coming months, Canadian courts will once again have to delve into the same questions that were at the heart of the litigation that led to the Chaoulli decision. In one of these cases, which will be heard in British Columbia, the plaintiffs, led by Dr. Brian Day, not only want it to be legal for patients to purchase private insurance covering medically required care; they also want the prohibitions against mixed medical practice and the free determination of doctors' fees to be lifted.

This *Research Paper* examines the legal challenges aiming to change Canada's health care policies. The first chapter provides an overview of the history surrounding the Chaoulli decision rendered ten years ago and the other challenges to the public health care monopoly. The following chapter evaluates patients' access to care in Quebec since the reforms undertaken in the wake of the Chaoulli ruling. Finally, this *Paper* concludes by taking four ideas often heard in the debate on the participation of the private sector in health care and putting them to the test.

1. See among others Canadian Institute for Health Information, *How Canada Compares: Results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*, January 2015.
2. Tristan Bronca, "Why physicians are fed up with Medicare," *Medical Post*, September 29, 2015, pp. 20-21.

CHAPTER 1

A History of the Chaoulli Ruling and Other Challenges to Canada's Health Insurance Laws

In June 2005, the Supreme Court of Canada ruled, as part of its Chaoulli decision, that when the government is unable to provide access to required care within a reasonable timeframe, the prohibition on taking out private health insurance constitutes a violation of patients' rights under Quebec's *Charter of Human Rights and Freedoms*.

The legal saga leading up to this famous ruling stretched over nearly a decade, starting in the mid-1990s. At that time, public trust in the ability of governments to ensure timely access to quality health care was gradually eroding.[3] Waiting times for elective treatments and surgeries, which were growing longer in a context of erratic government funding, led an increasing number of Canadians to seek alternative ways of obtaining the care they needed, including outside the country.[4]

Worsening access, and the complications that can result from this, are illustrated perfectly by the medical history of George Zeliotis, the initial petitioner in the Chaoulli case. The patient's first unhappy experience with the Quebec health care system occurred in 1992, when he had to wait an entire year before undergoing a triple coronary bypass. While convalescing in the hospital, he contracted a throat infection that caused him to lose his senses of taste and touch for a period of one year. In 1995, this retired salesman, then 61 years old, underwent an initial operation to his left hip to stop the pain that had begun two years earlier. Following the operation, however, he found himself with a left leg that was half a centimetre shorter than his right leg. This resulted in back pain so intense that it led to suicidal thoughts.[5]

It was while waiting over a year for an operation to his right hip that Mr. Zeliotis realized that he was not allowed to use his own resources to have the procedure performed sooner in the private sector, either by taking out private insurance or by paying a doctor directly.

The second petitioner in this case was Dr. Jacques Chaoulli, a French-trained doctor who began practising medicine in Quebec in 1986. At that time, Quebec doctors who were just starting their careers had to practice in an outlying region for a three-year period. He returned to Montreal in 1988, but because he had not fulfilled the three-year commitment, he could not obtain the full fee scale from the Quebec health insurance board (Régie de l'assurance maladie du Québec, or RAMQ) for a one-year period. In reaction to this measure, he attempted to set up a practice on Montreal's South Shore, where he offered medical services in patients' homes while continuing to participate in the public plan. The South Shore regional health board did not recognize this practice, however, and Dr. Chaoulli was fined $12,000 in 1996. He then engaged in a long battle aimed at persuading the provincial administrative authorities to provide accreditation for his practice, going so far as to stage a three-week hunger strike to obtain it.

"When the government is unable to provide access to required care within a reasonable timeframe, the prohibition on taking out private health insurance constitutes a violation of patients' rights."

With the failure of his protests, he decided to opt out of the public system and to offer private home services, using an emergency vehicle with a siren and revolving lights. Given that he had left the public system, two clauses in the law stood in the way of his efforts to make his practice profitable: Patients could not get RAMQ to reimburse the amounts paid for health care provided by non-participating doctors, and these doctors could not offer medical services at government-funded hospitals. Dr. Chaoulli then chose to return to the public system, serving as a general practitioner in a walk-in clinic.[6]

Following their many misadventures with the Quebec health care system, Dr. Chaoulli and Mr. Zeliotis joined forces in the fall of 1997 to challenge the constitutionality of Section 15 of the *Health Insurance Act* and Section 11 of the *Hospital Insurance Act*. The argument made by the two petitioners was that limited access to private medical services, the direct result of these sections of

3. Gregory P. Marchildon, *Health Systems in Transition: Canada*, European Observatory on Health Systems and Policies, World Health Organization, 2005, p. 124.
4. Isabelle Paré, "Une médecine pour les riches," *Le Devoir*, November 15, 1997.
5. Aaron Derfel, "The Cost of Health Cuts, Part 2: He Made Surgery Wait Times a National Priority," *The Gazette*, October 22, 2014.
6. Marie-Claude Prémont, "L'affaire *Chaoulli* et le système de santé du Québec : cherchez l'erreur, cherchez la raison," *McGill Law Journal*, Vol. 51, 2006, pp. 167-178.

the law, violates the right to life, liberty, and security of the person guaranteed by the *Canadian Charter of Rights and Freedoms*. Insofar as the public monopoly in the financing of medically required care contributed to the undue lengthening of waiting times for patients, there would ensue a greater risk that an illness or injury could become fatal, thereby undermining the right to life. In a similar vein, the psychological suffering resulting from extended waiting times for treatment, combined with the increased risk that an illness or injury could become permanent, jeopardizes the right to security of the person.

From Quebec Superior Court to the Supreme Court of Canada

This was the petitioners' line of argument as they came before Quebec Superior Court in December 1997. However, their position would be rejected several years later, with the Court ruling that limiting the use of private funding for medically required care was constitutional under the *Canadian Charter of Rights and Freedoms*.

Although the prohibition of private health insurance—and its perverse effects on waiting times—constitutes a potential infringement of the rights guaranteed in the *Charter*, it remains true to the principles of fundamental justice, in the mind of Justice Ginette Piché.[7] In her view, this prohibition would help "guarantee that virtually all existing health care resources in Quebec would be available to the entire Quebec population."

Dr. Chaoulli and Mr. Zeliotis appealed their case in November 2001. They would now argue that restrictions on insurance and on the provision of private health care could be loosened, following the example of certain European countries whose universal health care systems provide better access.[8]

Even so, the three judges of the Quebec Court of Appeal who heard the case—Jacques Delisle, André Forget and André Brossard—again came down against the petitioners. In April 2002, the three judges unanimously rejected the appeal of Dr. Chaoulli and Mr. Zeliotis, upholding Justice Piché's ruling, although for different reasons.

Justice Delisle saw the right to enter into a private insurance contract as an economic right that is not fundamental to human life, meaning there was no violation of Section 7 of the *Canadian Charter*, since it does not cover this type of right. Justice Forget, although judging that the right claimed by the petitioners could not be purely economic, nevertheless arrived at the same conclusion as Justice Piché of Quebec Superior Court, namely that the prohibition on taking out duplicate private insurance did not violate the principle of fundamental justice and therefore was not contrary to the rights guaranteed by the *Charter*. Meanwhile, Justice Brossard found that it was not necessary to consider either the economic nature of the right or the principle of fundamental justice since it had not been demonstrated, in his view, that the prohibition on entering into a private health insurance contract would jeopardize the basic right to life and security.[9]

"Following their many misadventures with the Quebec health care system, Dr. Chaoulli and Mr. Zeliotis joined forces in the fall of 1997."

The petitioners chose to appeal this ruling, and the Supreme Court of Canada agreed in May 2003 to hear the appeal. When arguments began to be heard before the seven judges the following year, the scope of the challenge had grown substantially. Numerous participants wanted their voices heard in connection with this increasingly well-publicized saga. Among them were as many groups denouncing the hegemony of the government monopoly in the health care system as organizations defending the status quo and rejecting private medicine in Canada.[10]

The Supreme Court finally rendered its verdict on June 9, 2005. In a split decision, four of the seven judges came down in favour of petitioners Chaoulli and Zeliotis, overturning the previous rulings issued by the courts of first and second instance. The highest court in the land therefore ruled that the prohibition on private health insurance violates patients' right to life and security and runs counter to the Quebec *Charter of Human Rights and Freedoms*.

7. See Christopher Manfredi and Antonia Maioni, "L'arrêt *Chaoulli* et la judiciarisation des politiques de santé," in François Béland *et al.* (eds.), *Le privé en santé : Les discours et les faits,* Les Presses de l'Université de Montréal, 2008, pp. 264-280.
8. *Idem*, p. 268.
9. Quebec Court of Appeal, *Chaoulli v. Québec (Attorney General)*, 2002.
10. Christopher Manfredi and Antonia Maioni, *op. cit.*, footnote 7, pp. 270-271.

This ruling of the Court thus invalidated two provisions in Quebec's health care laws, namely Section 11 of the *Hospital Insurance Act* and Section 15 of the *Health Insurance Act*.

The central element in the trial was the length of waiting lists and its consequences, since this symbolized the failure of the public health care monopoly and called into question the morality of prohibiting private medicine, insofar as patients who see their health and quality of life deteriorate under the current system have no available alternative.[11]

In the opinion of Chief Justice Beverley McLachlin and Justice John C. Major, "[t]he 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."[12]

Their ruling also stated that "[t]he evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care."[13]

As for Justice Marie Deschamps, who decided the case, she relied on a comparison of Quebec's health care system with those of comparable OECD countries to show that allowing patients to take out private insurance does not jeopardize the sustainability of the public health care system. Her line of argument was also based on observations from three Canadian provinces—Nova Scotia, Saskatchewan, and Newfoundland and Labrador—that at the time already allowed the use of private insurance for care insured by the public sector, without thereby contravening the principles set out in the *Canada Health Act*.

In the opinion of Justice Deschamps, "[t]he prohibition on private insurance creates an obstacle that is practically insurmountable for people with average incomes. Only the very wealthy can reasonably afford to pay for entirely private services. Assuming that a permit were issued, the operation of an institution that is not under agreement is the exception in Quebec."[14] In her view, the prohibition of private health insurance for care covered by the public system cannot be justified under the Quebec *Charter*.[15]

Reactions to the Chaoulli Ruling

The ruling initially drew substantial media attention, and reactions were highly polarized. On the one hand, it was demonized by anyone who saw private sector participation in the field of health care as a threat to the principle of universal access to care.[16] For these critics, allowing doctors outside the public system the chance to be paid by private insurance represented the beginning of a "two-tier" health care system in which the wealthy would have the possibility of being treated more quickly in the private sector and the less fortunate would still be stuck with long waiting times in the public sector.[17]

"The central element in the trial was the length of waiting lists, since this symbolized the failure of the public health care monopoly and called into question the morality of prohibiting private medicine."

On the other hand, the ruling was well received by experts who were of the view that a greater role for the private sector would help cut waiting times and improve access to care. Among others, this was the case of former Quebec Health Minister Claude Castonguay, perceived as the founding father of Quebec's public health insurance plan, and of Michel Clair, a former Parti Québécois minister and chair of the Clair Commission set up in the early 2000s to study the province's provision of health and social services.[18]

A majority of the Quebec medical community also came down in favour of the ruling. A survey conducted in the weeks following the Chaoulli judgment indicated that

11. Supreme Court of Canada, *Chaoulli v. Québec (Attorney General)*, 2005.
12. *Ibid.*, paragraph 106, p. 844.
13. *Ibid.*, paragraph 140, p. 854.
14. *Ibid.*, paragraph 55, p. 825.
15. The dissenting judges—Louis LeBel, Ian Finnie, and Morris Fish—argued that it was not within the jurisdiction of a court of justice to rule on the dispute raised by the Chaoulli case, which falls rather into the political domain.
16. Marie-Claude Prémont, "Régime public universel de santé au Québec : L'urgence d'agir à la suite du jugement de la Cour Suprême," *Le Devoir*, June 16, 2005.
17. Colleen M. Flood, Kent Roach and Lorne Sossin, *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada*, University of Toronto Press, 2005; Marie-Claude Prémont, "Clearing the Path for Private Health Markets in Post-Chaoulli Quebec," *Health Law Journal*, Vol. 16, 2008, p. 251.
18. Denis Lessard, "Le père de l'assurance maladie approuve," *La Presse*, June 10, 2005; Michel Clair, "Il faut se ressaisir : Le jugement de la Cour suprême doit donner une nouvelle impulsion à notre système de santé," *La Presse*, June 11, 2005.

seven out of 10 doctors and future doctors held the view that a ruling of this type would cut waiting times and improve clinical services without interfering with universality of access in the public health care system.[19]

Others, including Patrick J. Monahan, the Dean of Osgoode Hall Law School at Toronto's York University, found that the ruling even added an important missing piece to the principles incorporated in the *Canada Health Act*, namely accountability to patients:

> Far from heralding the destruction of Canada's publicly funded health care 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*—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 judgement, "access to a waiting list is not access to healthcare."[20]

The Chaoulli Ruling Inspires Other Cases

There is no doubt that the Chaoulli ruling was one of the most significant in Canadian legal history. Since it was rendered in June 2005, it has been cited more than 174 times in various cases before Canadian courts. Among these are some 15 cases bearing directly or indirectly on the issues of financing and provision of health care.[21] Only two cases, however, have the same goals as Dr. Chaoulli's case at the time, namely an end to the public monopoly in the funding of care regarded as medically required, with one case in Alberta and the other one in British Columbia.

In December 2011, two Alberta patients who had had to spend tens of thousands of dollars for surgery in the United States initiated legal challenges before the Alberta Court of Queen's Bench with the aim of lifting the prohibition on the province's patients taking out duplicate private insurance.[22]

Darcy Allen, a dentist in Okotoks, had to give up his practice in 2009 because of chronic backaches and unbearable pain resulting from a hockey accident two years earlier. Rather than wait more than two years in Alberta's public system—his appointment having been set for September 2011—he had to resign himself to paying $77,000 from his personal savings to get the required surgery in Montana.[23]

As for the other originating plaintiff in this case, Richard Cross, a Calgary businessman, he had to endure four years of intense back pain before finally deciding to spend $24,000 to have an operation in Arizona in May 2010.[24]

"It is easy to see how, by depriving surgery centres of much of their workforce and potential clientele, provisions in British Columbia's health insurance laws prevent the emergence of a true private alternative for patients."

The plaintiffs lost in the Court of Queen's Bench in April 2014. Then in September 2015, the Alberta Court of Appeal rejected arguments from Darcy Allen's lawyers, citing a lack of evidence showing that the public monopoly in the financing of medically required care violated his rights.

Justice Slatter's ruling was harshly criticized by jurists who had closely followed the hearing as reflecting his personal views more than legal precedents.[25] Like the Chaoulli case, this challenge seems likely to end up before the Supreme Court of Canada in the near future.

The other case involves Dr. Brian Day, a former president of the Canadian Medical Association and co-owner of the Cambie Surgery Centre, a private clinic and the

19. Matthew Sylvain, "Quebec Medical Community Open to Change Following Chaoulli Case," *Medical Post*, August 9, 2005, p. 9.
20. Patrick J. Mohanan, *Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the "Sixth Principle" of the Canada Health Act*, C.D. Howe Institute Benefactors Lecture, November 29, 2006, p. 5.
21. Daniel Cohn, *Chaoulli Ten Years On: Still about Nothing?* Document presented at the annual conference of the Canadian Political Science Association, Ottawa, June 2015, p. 3.
22. John V. Carpay on behalf of Richard Cross, *Originating Application*, Court of Queen's Bench of Alberta, December 20, 2011; John V. Carpay on behalf of Darcy Allen, Court of Queen's Bench of Alberta, December 16, 2011.
23. The Canadian Press, "Appeal court tosses out constitutionality challenge over health care," *Winnipeg Free Press*, September 9, 2015.
24. Bill Graveland, "Alberta Ban on Private Health Insurance Challenged in Calgary Court," *Maclean's*, October 17, 2013. It should be noted that Richard Cross decided to withdraw his challenge following a preliminary hearing before the judge. See John V. Carpay and I. Christine Enns on behalf of Darcy Allen, *Factum – Appeal from the Judgement of the Honourable Mr. Justice P.R. Jeffrey*, Court of Appeal of Alberta, March 31, 2014, 24.
25. See among others Jennifer Koshan, "Is there a right to private health care in Alberta? A 'constitutional vivisection'," University of Calgary, Faculty of Law blog, September 23, 2015.

largest establishment of its type in British Columbia. To the extent that the public system fails to provide access to care within a reasonable time, as evidenced by long waiting lists, Dr. Day argues that patients should be allowed to use their own resources to have themselves treated in the private sector, as is the case in all other countries.[26]

At the heart of the challenge he brought before the Supreme Court of British Columbia together with a group of private clinics in January 2009 were provisions in the law prohibiting not only duplicate health insurance but also mixed medical practice and the freedom of doctors to determine their own fees.[27]

Indeed, British Columbia's *Medicare Protection Act* forbids patients from using private insurance to pay for care already covered by the public system, which is to say care that is deemed medically necessary. Nor are doctors allowed to practice in the public sector and the private sector simultaneously, and therefore from receiving payment from both of these sources at the same time. Doctors participating in the public system cannot demand fees higher than those set by the government. Doctors who choose to leave the public system must bill their patients directly and may not receive funding from the public plan.

A private clinic seeking to offer surgical treatments is therefore caught in an impasse. First, since very few people can afford to pay for this type of procedure directly from their own pockets, the clinic can rely on only a limited clientele. Indeed, many of these clinics are only profitable insofar as they treat patients sent by the Workers' Compensation Board, which provides insurance to injured workers.[28] In addition, the financial risk faced by doctors who fully opt out of the public system is so great that very few of them choose this path.

It is easy to see how, by depriving surgery centres of much of their workforce and potential clientele, provisions in British Columbia's health insurance laws, just like Quebec's, prevent the emergence of a true private alternative for patients.

The plaintiffs' lawyers in this case will argue that these restrictions, unique in the industrialized world, run counter to the human rights and freedoms guaranteed by the *Canadian Charter*.

Six patients joined the case starting in 2012. In November 2015, however, only four remained: Chris Chiavatti, Krystiana Corrado, Mandy Martens and Walid Khalfallah. The others had died while awaiting the hearing. One of the remaining four, Walid Khalfallah, a teenager with a particularly severe form of scoliosis, is now paraplegic, having been unable to obtain the required surgery in a timely fashion. After waiting two and a half years in the Canadian public health care system, he resigned himself to undergoing his operation in Washington State.[29]

"The Supreme Court of Canada will once again be called upon to rule on the constitutionality of certain sections of the law preventing the development of private medicine in Canada."

In June 2016, one of the most keenly anticipated legal proceedings concerning the public health care monopoly since the Chaoulli case is set to begin before the Supreme Court of British Columbia. Whatever the outcome, many analysts believe that the Supreme Court of Canada will once again be called upon to rule on the constitutionality of certain sections of the law preventing the development of private medicine in Canada.

26. Steve Bosch, "Dr. Brian Day, co-owner of the Cambie clinic, said Canada is the only country in the world where patients are prevented from using their own money to 'look after their own bodies with their own resources'," *Edmonton Journal*, January 13, 2015.
27. Lauren Vogel, "Medicare on Trial," *Canadian Medical Association Journal*, Vol. 186, No. 12, September 2014.
28. Injured workers and other patient groups (RCMP employees, soldiers in the Canadian Armed Forces, individuals in federal detention centres, members of First Nations) are not subject to the *Canada Health Act*. This explains why the Workers' Compensation Board can send the people it insures for treatment in private clinics without violating the law. See Jeremiah Hurley *et al.*, "Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers," *Healthcare Papers*, Vol. 8, No. 3, 2008, p. 11.
29. Don Plant, "Paralyzed teen face of fight for private health care," *Kelowna Daily Courier*, February 26, 2015.

CHAPTER 2

Ten Years after the Chaoulli Decision: How Has the Quebec Health Care System Changed?

How has the wait time situation in the public health care system evolved in Quebec since the Chaoulli decision? Have the reforms adopted in the wake of the judgment led to improved access to health care services for patients over the past ten years?

Very Timid Reforms

The Court's decision hinted at several major changes in public policies regarding health care services in Quebec. The government's response, however, was very timid. After a reprieve granted by the Court, the government finally adopted a bill in December 2006 in order to comply with the ruling.[30] Three reforms followed from this.

1) Duplicate private insurance

In principle, the legislative change authorized Quebecers to purchase duplicate private insurance for a limited number of medical and surgical treatments, such as hip and knee replacements and cataract removals.

In practice, however, no actual market for this kind of insurance developed, the number of admissible surgeries being too low for new and interesting insurance products for individuals and employers to appear. The maintenance of the prohibition on mixed medical practice also hampered the emergence of such an insurance market. It is to be expected that as long as doctors will have to completely disaffiliate themselves from the public system in order to provide services in the private sector, there will be few private services to insure.

2) Specialized medical centres

The new legal provisions aimed to provide a tighter regulatory framework for private surgery clinics—newly referred to as specialized medical centres (SMCs).

SMCs are for-profit facilities, independent of hospitals, in which the law initially allowed the provision of hip, knee, and cataract surgeries. Since then, nearly fifty specialized medical treatments have been added to the list, the vast majority being cosmetic and eye surgeries.[31]

Doctors operating an SMC must be either exclusively participating in Quebec's public health insurance plan, or exclusively non-participating.[32] The former are therefore reimbursed by the government, while the services offered by the latter must be paid for directly out of the pockets of patients.

The law also authorized public hospitals to sign partnership agreements with clinics for the transfer of a certain volume of surgeries and treatments (which remained covered by the public system).

The number of such centres remains relatively small in Quebec's hospital landscape. In March 2015, there were 44 SMCs in Quebec, basically small in size, most of which specialize in plastic and cosmetic surgery.[33] This represents a substantial drop compared to March 2012, when there were 61 of them.[34]

"As long as doctors will have to completely disaffiliate themselves from the public system in order to provide services in the private sector, there will be few private services to insure."

Only a minority of SMCs provide medically required health care services, and they do so almost exclusively in the context of partnership agreements signed with public hospitals. The burdensome regulatory framework and the lack of autonomy of hospital administrators in the negotiation of these agreements, however, are such that there are very few of them. Yet three agreements of this type signed in recent years led to significantly improved access in the public hospitals concerned.[35]

The partnership between Sacré-Cœur Hospital and the Rockland MD private surgery centre in Montreal is a perfect example. From 2008 to 2015, over 12,275 day sur-

30. Government of Quebec, *An Act to amend the Act respecting health services and social services and other legislative provisions*, 2006.
31. Government of Quebec, *Regulation respecting the specialized medical treatments provided in a specialized medical centre*, 2008.
32. Article 333.3 of the *Act Respecting Health Services and Social Services*, which prohibits physicians participating in the public plan and non-participating physicians from working together in the same specialized medical centre was challenged before the courts in recent years. Judge Courville of the Superior Court of Quebec ruled in favour of the strict maintenance of the article of law. See Jessica Nadeau, "Santé : La cour maintient le mur entre le public et le privé," *Le Devoir*, June 26, 2015.
33. Quebec Department of Health and Social Services, *L'étude des crédits 2015-2016—Réponses aux questions particulières, Opposition officielle*, Volume 1, Committee on Health and Social Services, 2015, pp. 268-290.
34. Quebec Department of Health and Social Services, *L'étude des crédits 2012-2013—Réponses aux questions particulières, volet santé*, Volume 2, Committee on Health and Social Services, 2012, pp. 40-43.
35. See among others Ronald Denis, "Moins d'attente, plus d'opérations," *La Presse*, June 6, 2011; Mathieu Courchesne, "Cité-de-la-santé : six mois d'attente pour être opéré," *Le Journal de Montréal*, February 16, 2013; Françoise Le Guen, "L'Institut de l'œil des Laurentides est là pour rester," *Le Courrier*, June 11, 2014.

Table 2-1

Average wait times for different types of surgery, Sacré-Cœur Hospital and all Quebec hospitals, as of August 22, 2015

	ALL QUEBEC HOSPITALS	SACRÉ-CŒUR HOSPITAL
Hip surgery	**15 weeks**	**7 weeks**
Knee surgery	**17 weeks**	**8 weeks**
Cataract surgery	**7 weeks**	**5 weeks**
Day surgery	**9 weeks**	**7 weeks**
Surgery with hospitalization	**6 weeks**	**6 weeks**

Source: Quebec Department of Health and Social Services, SIMASS databases, Chirurgies : Listes d'attente des chirurgies dans les hôpitaux du Québec, August 2015.

geries were carried out thanks to the agreement linking these two facilities.[36] This initiative led to considerable reductions in the number of patients waiting for an operation, to the hospital's operating rooms being freed up, and to an average of 400 additional more-complex operations being performed there each year. Breast cancer patients saw their average wait times for an intervention go from over six months to under two weeks.[37] As shown in Table 2-1, waiting times for surgeries at Sacré-Cœur Hospital are now far lower on average than in Quebec hospitals taken as a whole.

Despite these results, after months of hemming and hawing,[38] the Department of Health and Social Services finally decided in September 2015 to put an end to the agreement, even though, a year earlier, its own data had once again confirmed that the same operation is less expensive to carry out at the Rockland MD clinic than at Sacré-Cœur Hospital.[39]

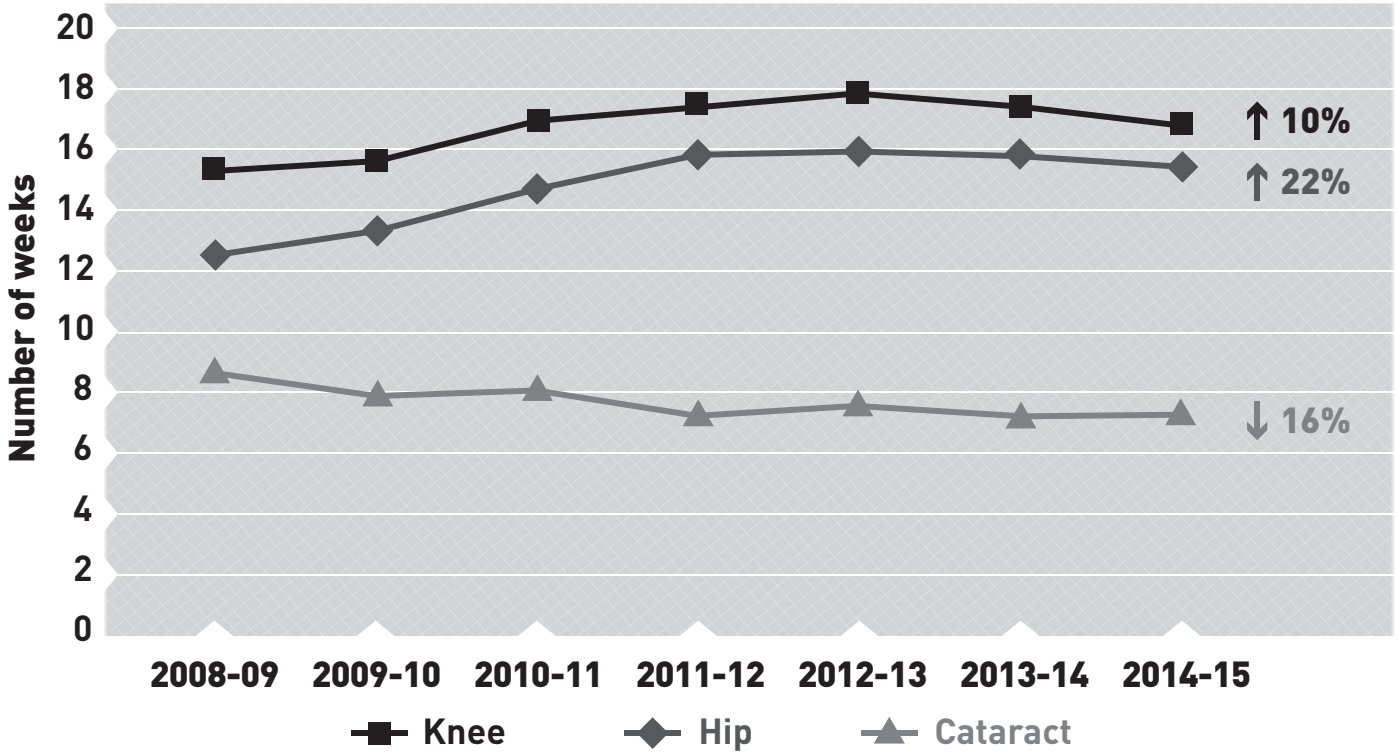
> **"Only a minority of SMCs provide medically required health care services, and they do so almost exclusively in the context of partnership agreements signed with public hospitals."**

Consequently, as of October 31, 2015, there remained just one partnership agreement, the one linking the Cité-de-la-Santé Hospital and the Clinique Chirurgicale de Laval. From 2010-2011 to 2014-2015, over 18,000 surgeries were performed in this clinic thanks to this agreement.[40] While this may seem like a lot, it represents a tiny fraction of all the elective surgeries performed in Quebec's health care system, which totalled nearly 2.3 million operations during this period.[41]

36. Héloïse Archambault, "La CAQ scandalise par la fin de l'entente," *Le Journal de Montréal*, 16 septembre 2015.
37. Ronald Denis, *op. cit.*, footnote 35.
38. See the following articles: Tommy Chouinard, "Philippe Couillard défend le privé en santé," *La Presse*, March 13, 2014; Gabrielle Duchaine and Ariane Lacoursière, "Interventions d'un jour : Québec abandonne deux ententes avec le privé," *La Presse*, June 11, 2014; Marco Bélair-Cirano, "Barrette est disposé à faire appel à la clinique privée Rockland MD," *Le Devoir*, July 4, 2014; Philippe Teisceira-Lessard, "PPP avec la clinique Rockland MD : Barrette met fin à l'expérience," *La Presse*, August 26, 2014; Amélie Daoust-Boisvert, "Rockland MD : L'entente pourrait être maintenue," *Le Devoir*, August 27, 2014; Héloïse Archambault, "Rockland MD : Fin de l'entente qui permettait les chirurgies au privé," *Le Journal de Montréal*, September 16, 2015.
39. Gabrielle Duchaine, « Chirurgies : pas plus cher au privé, selon une étude », *La Presse*, 25 avril 2015.
40. Héloïse Archambault, "Encore une entente pour envoyer des patients au privé," *Le Journal de Montréal*, June 23, 2015.
41. Quebec Department of Health and Social Services, "Number of demands for elective surgery performed, by category of surgery," May 2015. Data obtained through a demand for access to information, May 2015.

Figure 2-1

Average wait times in Quebec for hip, knee and cataract surgeries, 2008-2009 to 2014-2015



Source: Quebec Department of Health and Social Services, "Number of demands for elective surgery performed, by category of surgery," May 2015. Data obtained through a request for access to information.
Note: These are average wait times between consultation with a specialist and surgical procedure. Since the database was set up in June 2007, the data are available only starting in 2007-2008, and are considered reliable only as of 2009-2010.

3) A mechanism for managing wait times

A new information system to track the evolution of wait times for elective surgery was created and came into effect in June 2007. The purpose of this mechanism for managing access, which was put in place in each hospital, was to better coordinate resources and information among the different clinical departments.

The government also set the maximum wait time for treatment at six months for hip, knee, and cataract surgery. If 90% of cases are treated within this timeframe, the target is considered to have been reached. Contrary to popular belief, this is not a legal right of patients, but simply administrative targets for hospitals.

Past the wait time targets of six months, the patient can be offered the option of being transferred to another hospital in the province. Although no case of its kind has been reported publicly, it would nonetheless be possible for a patient, with the agreement of the Department of Health and Social Services and after a wait time deemed to be unreasonable, to potentially be treated in a private clinic or even outside Quebec. The costs of the procedure would then be covered by the government itself.

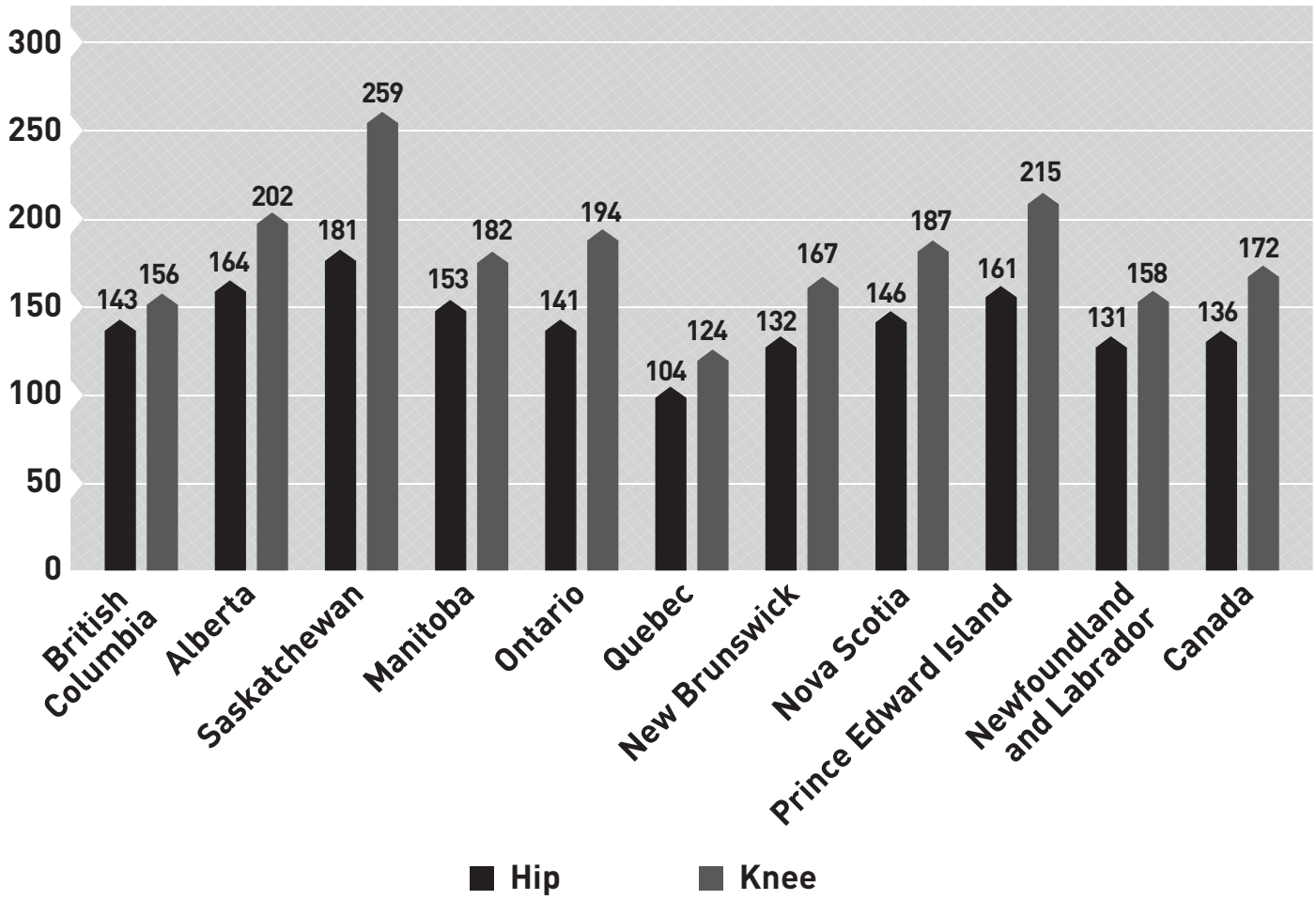
Still Waiting

The database that was created now allows us to observe that on average, wait times for elective surgeries have not improved in Quebec since 2007-2008.[42] They have gone down slightly for cataract removals (-16%), but have increased for hip (+22%) and knee (+10%) operations. Over the past year, average wait times were over 15 weeks for hip surgery and nearly 17 weeks for knee

42. According to the Expert Panel for Patient-Based Funding, average wait times for several surgical specialties decreased from 2008-2009 to 2011-2012. The data obtained from the Quebec Department of Health and Social Services did not allow us to confirm these results. See Expert Panel for Patient-Based Funding, *Better Access to Surgery: An Expanded Activity-Based Funding Program*, Technical Paper 1, February 2014, p. 13.

Figure 2-2

Rates of hip and knee replacements, per 100,000 adults aged 20 and over, Canada and Canadian provinces, 2012-2013



Source: Health and Welfare Commissioner, *La performance du système de santé et de services sociaux québécois 2015 : Résultats et analyses*, September 2015, p. 41.

surgery, not including the prior wait time for an appointment with the general practitioner and the specialist[43] (see Figure 2-1).

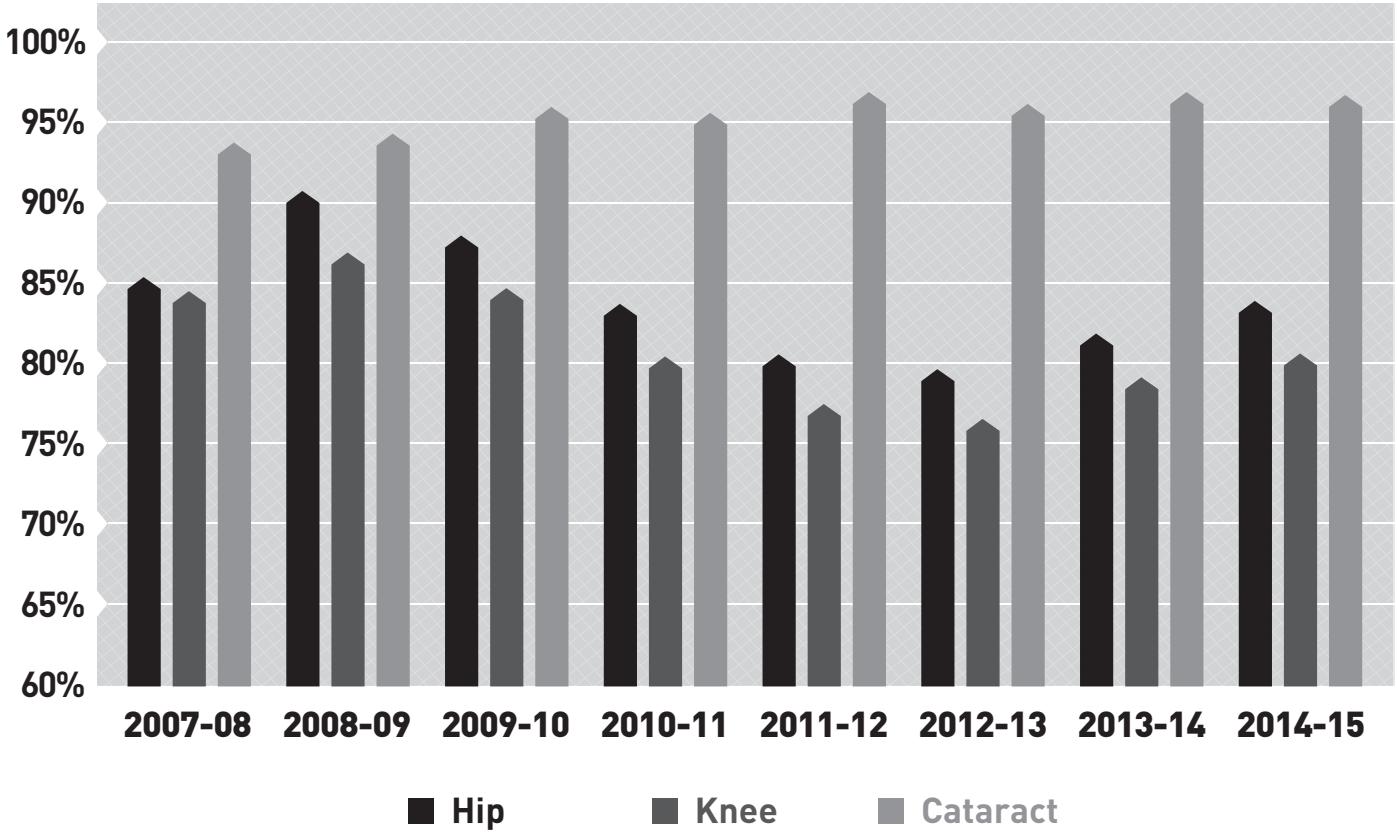
It is true, as certain experts have pointed out,[44] that the number of elective surgeries performed has increased since the early 2000s, in conjunction with the aging of the population. However, this trend did not accelerate starting in 2007—quite the contrary.[45] Moreover, of all the Canadian provinces, it is in Quebec that we find the lowest numbers of hip and knee replacements as a proportion of the adult population[46] (see Figure 2-2). These surgery rates are only about half those found in Saskatchewan, which has significantly reduced its wait times since 2010 by increased reliance on private surgery clinics.[47]

As for the maximum wait time targets set at six months by the government, they have still not been met for many patients. As can be seen in Figure 2-3, nearly one patient in five must still wait over six months for a hip or knee operation. We can also see that the situation is worse than in 2008-2009.

43. Quebec Department of Health and Social Services, Accès aux chirurgies par agence et pour l'ensemble du Québec – Réalisées, 2015.
44. Expert Panel for Patient-Based Funding, *op. cit.*, footnote 42, p. 11.
45. Yanick Labrie, "Annexe technique au Point sur l'arrêt Chaoulli et les réformes en santé," Montreal Economic Institute, June 2015.
46. Health and Welfare Commissioner, *La performance du système de santé et de services sociaux québécois 2015 : Résultats et analyses*, September 2015, p. 41.
47. Saskatchewan Surgical Initiative, "Big Gains in Access, Safety and Quality: Year 4 Report," May 2014.

Figure 2-3

Percentage of patients who are operated on within the maximum prescribed wait time (6 months) in Quebec, for hip, knee, and cataract surgeries, 2007-2008 to 2014-2015



Sources: Department of Health and Social Services, Data obtained through a request for access to information (2009-2010 to 2014-2015); Écosanté database (2007-2008 and 2008-2009).

Unsurprisingly, these wait times for surgery have significant impacts for patients in many respects.[48] In a vast study, researchers affiliated with the faculty of medicine at Laval University recently looked into the consequences of long wait times for surgery on patient health and quality of life. Their results showed that patients who had to wait the longest before their knee replacements suffered more pain and had more functional limitations than the others six months after surgery.[49]

> **"Average wait times were over 15 weeks for hip surgery and nearly 17 weeks for knee surgery, not including the prior wait time for an appointment with the general practitioner and the specialist."**

Did the Chaoulli Decision Open the Door More Widely to the Private Sector?

Certain supporters of the maintenance of the public health care monopoly deplore the Chaoulli decision's opening of the door to a greater reliance on the private sector,[50] which is to say, to entrepreneurship and patient freedom of choice. As proof, they claim among other

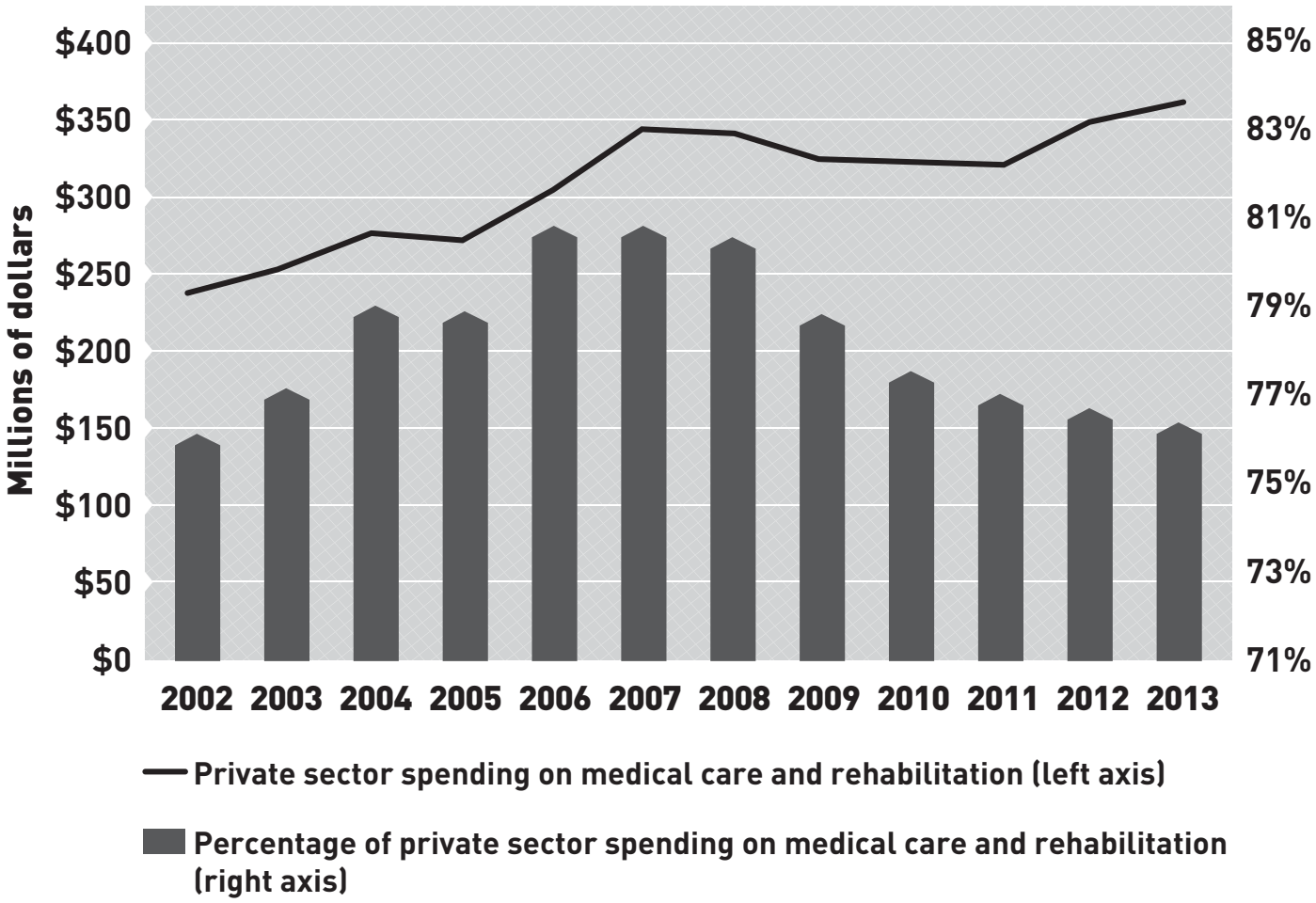
48. Ariane Lacoursière, "En attente d'une opération, elle risque de perdre l'usage de ses jambes," *La Presse*, June 27, 2014.

49. François Desmeules *et al.*, "The Impacts of Pre-surgery Wait for Total Knee Replacement on Pain, Function and Health-Related Quality of Life Six Months after Surgery," *Journal of Evaluation in Clinical Practice*, Vol. 18, No. 1, 2012, pp. 111-120

50. See Mathieu Perreault, "Le Québec est la province qui fait le plus de place au privé," *La Presse*, April 23, 2010; Astrid Brousselle Damien Contandriopoulos *et al.*, "Why Trudeau must save medicare in Quebec," *Toronto Star*, November 5, 2015.

Figure 2-4

Spending on medical care and rehabilitation by the CSST in private clinics (absolute amount and as a percentage of total spending), 2002 to 2013



Source: Commission de la santé et de la sécurité du travail, *Rapport annuel de gestion* (the years 2005 to 2013); Régie de l'assurance maladie du Québec, Base de données ORIS, Tableau SM.30 : Nombre de médecins, nombre de services médicaux et coût de ces services selon le type de service et la catégorie de médecins, CSST, 2002-2013; Author's calculations.

things that the number of doctors not participating in the system has been growing since the reforms that followed the judgment.[51]

Yet indicators show that Quebec's health care system is not experiencing more privatization—quite the contrary. As we have seen, the number of specialized medical centres (SMCs) has been falling for several years. Moreover, the portion of total spending on medical care and rehabilitation by Quebec's Workers' Compensation Board, the CSST, which is the number 1 buyer of health services in Quebec's private clinics,[52] has fallen steadily since 2007 in the province (see Figure 2-4). Indeed, although 76% of the CSST's spending on medical care and rehabilitation goes to private clinics, this portion peaked at 81% in 2006.

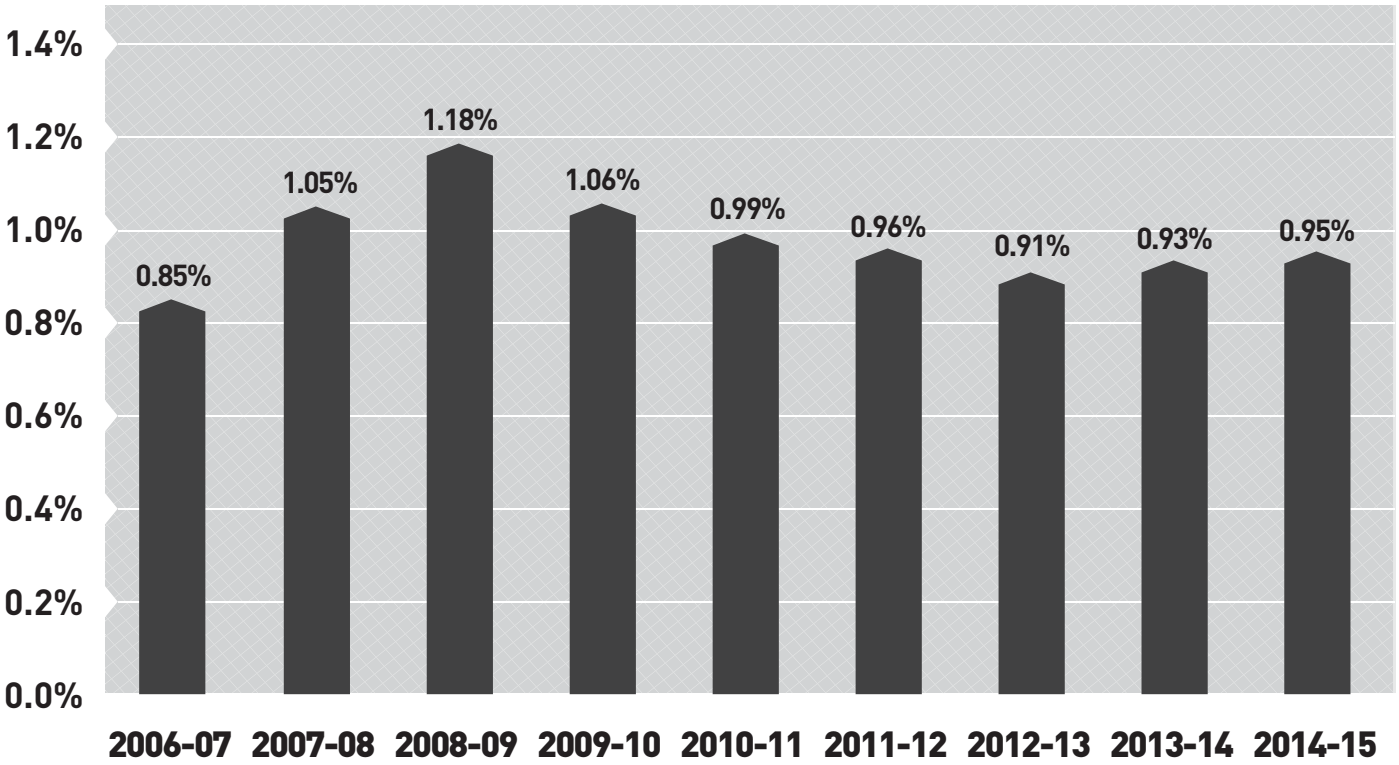
> **"Nearly one patient in five must still wait over six months for a hip or knee operation."**

Even though the data do show that a growing number of family doctors are choosing to no longer participate in the public system, this is not the case for medical specialists. The most recent data indicate that a little over

51. Jessica Nadeau, "Les médecins migrent vers le privé," *Le Devoir*, July 7, 2015.
52. Jacinthe Tremblay, "La CSST, acheteur no 1 de soins privés au Québec," *Le Devoir*, November 12, 2008.

Figure 2-5

Number of specialists not participating in the public insurance plan (RAMQ) as a percentage of the total number of specialists in Quebec, 2006-2007 to 2014-2015



Sources: Quebec Department of Health and Social Services, *L'étude des crédits 2011-2012 : Régie de l'assurance maladie du Québec—Réponses aux questions générales et particulières*, Committee on Health and Social Services, 2011, p. 135; Quebec Department of Health and Social Services, *L'étude des crédits 2014-2015 : Régie de l'assurance maladie du Québec—Réponses aux questions générales et particulières*, Committee on Health and Social Services, 2014, p. 134; Quebec Department of Health and Social Services, *L'étude des crédits 2015-2016 : Régie de l'assurance maladie du Québec—Réponses aux questions particulières*, Committee on Health and Social Services, June 2015, p. 147; Canadian Institute for Health Information, Supply, Distribution and Migration of Canadian Physicians, 2007-2014.

2% of general practitioners and a little under 1% of specialists are no longer remunerated by RAMQ.[53] In fact, as Figure 2-5 illustrates, the number of specialists who are non-participants in the public plan, as a proportion of the total number of specialists, has remained at the same level year in and year out since 2006-2007.

It must be noted that the difficulty of accessing frontline care leads numerous patients to pay out of pocket for the services of a family doctor. Nearly one in four Quebecers still has no family doctor.[54] Wait times for an appointment are relatively long in Quebec, and are not getting any shorter.

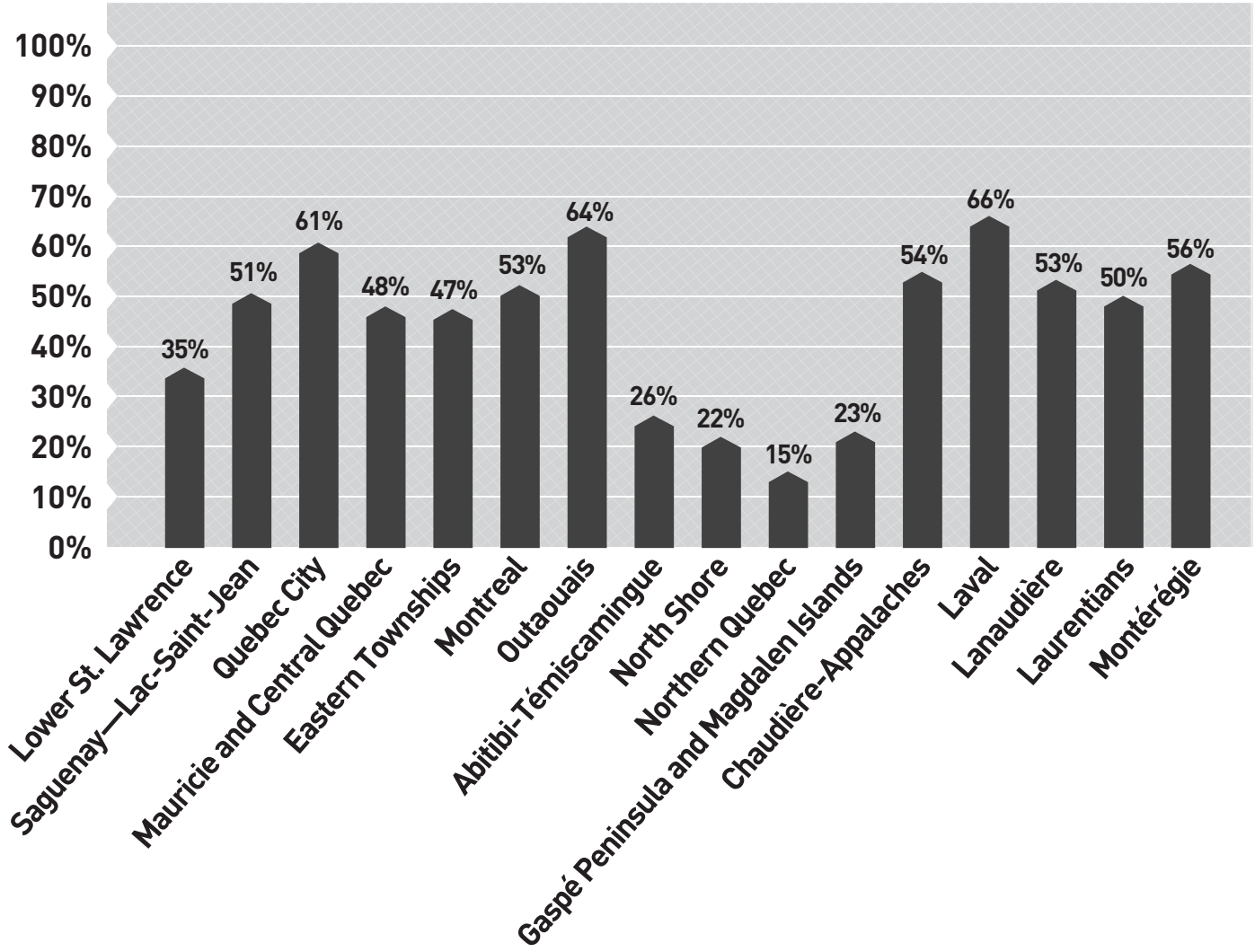
It is also important to understand that the services of family medicine are less expensive than the majority of those provided by specialists, like elective surgeries. For example, a hip replacement costs around $16,000 in a private clinic, compared to between $100 and $300 for a consultation with an unaffiliated general practitioner.[55] Since the clientele for the treatments offered by specialists is more limited, taking costs into account, it is not

"The current capacity to treat patients in the public system is rationed by the government and does not stem from a shortage of caregivers."

53. See the sources for Figure 2-5; Héloïse Archambault, "Plus de 200 médecins de famille ont quitté le régime public," *Le Journal de Montréal*, April 29, 2014, p. 3.
54. Statistics Canada, CANSIM Table 105-3024: Population reporting a regular family physician, household population aged 15 and over, Canada, provinces and territories, 2013.
55. Isabelle Ducas, "La santé a-t-elle un prix?" *La Presse*, January 21, 2013.

Figure 2-6

Rate of utilization of operating rooms by administrative region in Quebec, 2012



Source: Health and Welfare Commissioner, Atlas CSBE régional – Résultats de performance, 2012.

surprising to find that few specialists have so far chosen to stop participating in the public plan, contrary to general practitioners.

"The government chose to interpret the Supreme Court's judgment narrowly, and the timid reforms adopted have not led to improved access to hip, knee, and cataract surgeries."

It is alleged by certain analysts that the legislation prohibiting mixed medical practice is necessary in order to keep doctors, of which there are not an overabundance, from leaving the public sector for the private sector. The result of this, according to these critics, would be a worsening of wait times and of the quality of services for patients who are dependent on the public system.[56]

Yet such an argument ignores two important points. First of all, the current capacity to treat patients in the public system is rationed by the government and does not

56. Colleen Fuller, *Cambie Corp. Goes to Court: The Legal Assault on Universal Health Care*, Canadian Centre for Policy Alternatives, April 2015, p. 9.

stem from a shortage of caregivers (who are among the most numerous of all Canadian provinces). The number of doctors in the health care system has never been so high.[57] Since 2005, the number of specialists has even grown three times faster than the Quebec population, an unprecedented increase.[58]

The main cause of the wait times therefore stems from a poor allocation of medical resources within the system. Indeed, the workload of Quebec doctors is actually limited by quotas and rules designed to contain costs.[59] Many doctors therefore cannot secure the operating time they want and find themselves unable to reduce their waiting lists despite their best efforts. As can be seen in Figure 2-6, operating rooms remain significantly underutilized in nearly all of Quebec's administrative regions.

"Wait times have not improved significantly since the Chaoulli decision, despite the growing number of doctors and the massive injection of funds in the public system."

Second of all, it would be possible to require that doctors put in a minimum number of hours of work in the public system (equivalent to a full-time job), as is the case in most OECD countries, while leaving them free to work in the private sector a few hours a week. According to a study carried out in 2009, Quebec is depriving itself of an additional supply of labour equivalent to 790 full-time specialists, just on weekdays, by prohibiting mixed medical practice.[60]

Taking a Page from Europe's Mixed Systems

In the end, the wait time situation in Quebec has changed little since the Chaoulli decision. The government chose to interpret the Supreme Court's judgment narrowly, and the timid reforms adopted have not led to significantly improved access to hip, knee, and cataract surgeries. Patients waiting for treatment have very few options outside the public system.

Ten years later, Judge McLachlin's statement is as relevant as ever. As of March 31, 2015, nearly 20,000 Quebecers had been waiting for surgery for more than six months in the public health care system.[61] As we saw, wait times have not improved significantly since the Chaoulli decision, despite the growing number of doctors and the massive injection of funds in the public system (+56%).[62]

57. In 2014, there were 239 doctors per 100,000 residents in Quebec and 224 doctors per 100,000 in Canada as a whole. See Canadian Institute for Health Information, Supply, Distribution and Migration of Canadian Physicians 2014, September 29, 2015.

58. The number of specialists grew from 8,054 in 2005 to 10,000 in 2014, an increase of 24.1%. The Quebec population, for its part, grew by 8.4% from 2005 to 2014. Canadian Institute for Health Information, *Supply, Distribution and Migration of Canadian Physicians 2005*, September 30, 2006, p. 47; Institut de la statistique du Québec, Population du Québec, 1971-2015.

59. The same is true of nurses in Quebec, over half of whom work part-time. See Régys Caron, "Plus de 50 % des infirmières travaillent à temps partiel," *Le Journal de Montréal*, October 12, 2015; Julie Frappier, "The Availability of Nurses for Mixed Practice," Economic Note, Montreal Economic Institute, June 2008.

60. Marcel Boyer and Julie Frappier, "Medical Specialists in Quebec: How to Unlock the Reserve Supply," Economic Note, Montreal Economic Institute, April 2009.

61. Department of Health and Social Services, Accès aux chirurgies par agence et pour l'ensemble du Québec – En attente, 2015.

62. Public sector health care spending jumped by 55.6% from 2005 to 2014, in current dollars. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2014*, October 2014, p. 162.

CHAPTER 3

Dr. Day's Challenge in British Columbia: Is the Universal Health Care System Really in Danger?

Ten years after the Chaoulli decision, a new challenge to the laws governing health insurance is set to begin in Canada, this time before the Supreme Court of British Columbia.[63] The difficulty of accessing health care, which keeps worsening in that province, has prompted a group of clinics and patients to go before the courts to contest the legitimacy of the government's monopoly over the provision and financing of health care.

British Columbia is among the provinces in Canada where waiting times for elective surgeries are the longest.[64] Just 67% of patients waiting for hip surgery and 57% of those waiting for knee surgery went under the knife within the wait time benchmark of 182 days. The situation for patients waiting for cataract surgery is hardly better, with 70% of them (compared to 80% in Canada as a whole) operated within 112 days or less, the established benchmark[65] (see Figure 3-1).

The situation is not improving, either.[66] Whereas the number of surgeries carried out has been growing almost everywhere in Canada since 2009, this is not the case in British Columbia. The province compares poorly in terms of numbers of hip and knee surgeries per 100,000 inhabitants, according to the latest figures compiled. Since 2009, British Columbia has registered the worst change in the number of hip (0.7%) and knee (-6.2%) surgeries of all provinces in proportion to population, and by a wide margin.[67]

The plaintiffs in this case, to which Dr. Brian Day is associated, maintain that these prolonged waiting times in the public health care system lead to unjustified patient suffering and harm. They are asking the Supreme Court to rule on the constitutionality of laws forbidding mixed medical practice, duplicate private health insurance, and the freedom of doctors in the private sector to set their fees. The plaintiffs intend to argue that these prohibitions violate the *Canadian Charter of Rights and Freedoms*.

Considering how attached Canadians are to their health care system, it is not surprising that these legal proceedings are worrisome to many. Some even go so far as to claim that they represent the biggest current threat to the public health care system in Canada.[68] Is this true? Do the arguments put forward by those who wish to maintain the government's monopoly over the financing of medically required care stand up under scrutiny? This chapter examines four notions commonly expressed in this debate and tests them against the facts.

"British Columbia is among the provinces in Canada where waiting times for elective surgeries are the longest."

Myth 1: Canada's Health Care System Would Become "Americanized"

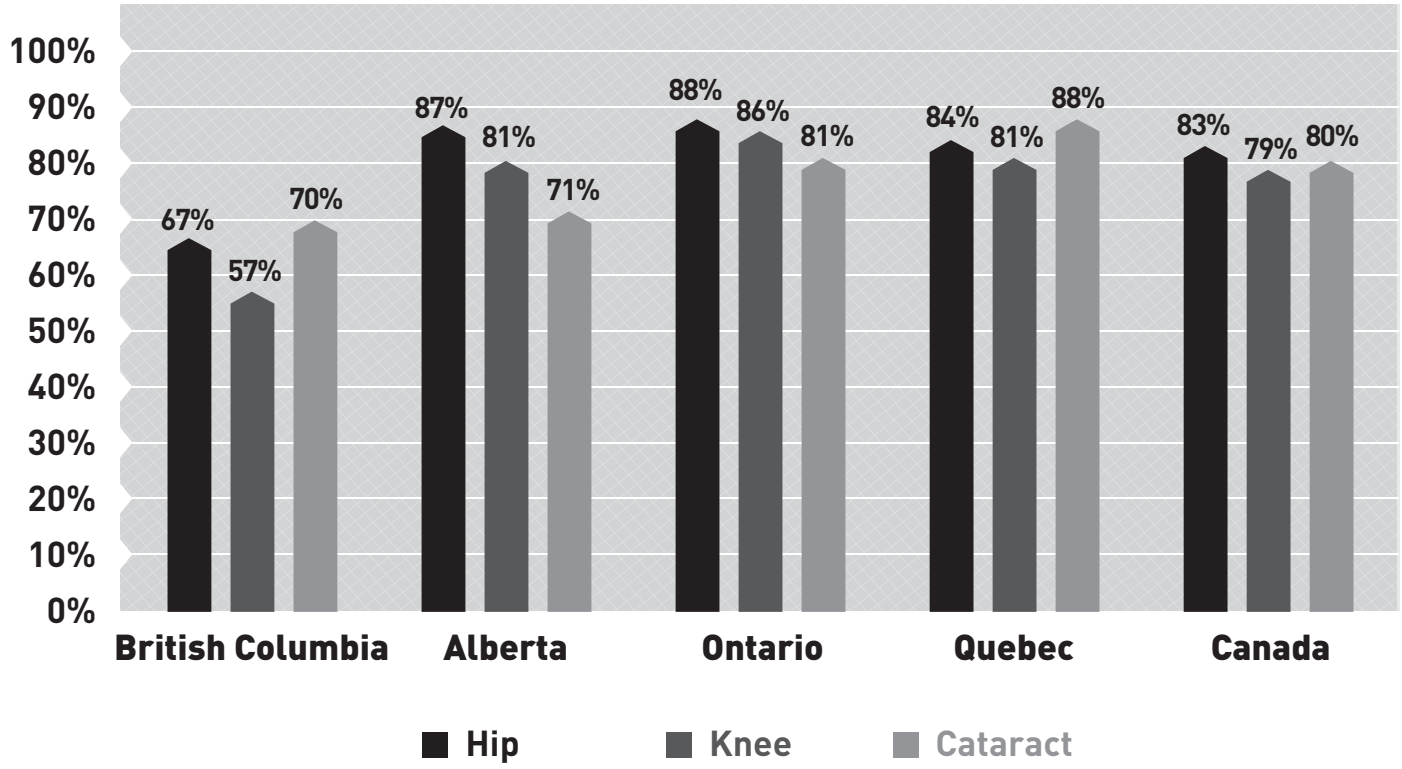
Many commentators fear that the upcoming trial in British Columbia could spell the collapse of Canada's universal health care system if the plaintiffs should win the case they have brought before the courts.[69] Indeed, it is common to hear certain analysts raise the spectre of the so-called "Americanization" of our health care system, following which certain Canadian patients would be excluded from the health insurance coverage they currently have.[70]

In fact, nothing could be further from the truth. The four sections of the *Medicare Protection Act* that the plaintiffs are challenging deal with the prohibition on purchasing duplicate private insurance, the prohibition on mixed medical practice, and the prohibition on doctors coming to a mutual arrangement with their patients regarding certain fees.

63. The legal challenge, already postponed several times, is in principle set to begin June 6, 2016. Keith Fraser, "Vancouver MD's challenge to private health care laws gets June trial," *The Province*, October 5, 2015.
64. Tara Carman, "B.C. surgery waits among Canada's worst," *Vancouver Sun*, April 14, 2015; Hong Chen, Qu Qian and Anming Zhang, "Would Allowing Privately Funded Health Care Reduce Public Waiting Time? Theory and Empirical Evidence from Canadian Joint Replacement Surgery Data," *Production and Operations Management*, Vol. 24, No. 4, April 2015, p. 613.
65. Canadian Institute for Health Information, Benchmarks for treatment and wait time trending across Canada, 2014.
66. Bacchus Barua and Frazier Fathers, *Waiting Your Turn: Wait Times for Health Care in Canada, 2014 Report*, Fraser Institute, November 2014, pp. 15-21.
67. These rates are standardized by age. Canadian Institute for Health Information, *Hip and Knee Replacements in Canada: Canadian Joint Replacement Registry 2015 Annual Report*, September 2015, pp. 22 and 40.
68. Theresa Boyle, "B.C. Supreme Court case 'biggest threat to medicare in this generation'," *Toronto Star*, April 25, 2014.
69. *Idem*.
70. Colleen Fuller, *op. cit.*, footnote 56, pp. 30-32. Certain authors go even further and imply that Canadians could be, like certain American citizens, pushed into bankruptcy by their inability to pay their health care bills. See among others Inge de Becker, "Doctor's prognosis: American-style health care a nightmare," *The Chronicle Herald*, August 26, 2014.

Figure 3-1

Percentage of patients operated on within wait time benchmarks, 2014



Note: The wait time benchmarks are 182 days for hip or knee surgery, and 112 days for cataract surgery.
Source: Canadian Institute for Health Information, Benchmarks for treatment and wait time trending across Canada, 2014.

Canada's provincial health care system is an anomaly compared to the systems of the other industrialized countries when it comes to these restrictions. Canada is an exception in limiting the role of private health insurance solely to the coverage of services that are not insured by the public plan, in the majority of provinces.[71] Indeed, duplicate private insurance is available in numerous OECD countries, including Australia, Denmark, Finland, Greece, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden, and the United Kingdom.

> **"Canada is an exception in limiting the role of private health insurance solely to the coverage of services that are not insured by the public plan, in the majority of provinces."**

Duplicate insurance is legal in other countries as well, like Belgium, France, and Germany, but remains insignificant simply because there are no waiting lists to speak of.

Canada is also alone in prohibiting its doctors from practicing in both the public sector and the private sector.[72] Only New Brunswick, Newfoundland and Labrador, and Prince Edward Island authorize mixed practice, even though does not seem widespread.[73] In practically all OECD countries, mixed practice is allowed, although it is generally regulated. It is a way to increase the capacity of the health care system in terms of labour. In Australia, Denmark, England, and Norway, studies have shown that doctors with mixed practices increase the

71. See among others A. Detsky and C. D. Naylor, "Canada's Health Care System – Reform Delayed," *New England Journal of Medicine*, Vol. 349, No. 8, pp. 804-810.

72. Ariadna García-Prado and Paula González, "Whom Do Physicians Work For? An Analysis of Dual Practice in the Health Sector," *Journal of Health Politics, Policy and Law*, Vol. 36, No. 2, 2011, pp. 265-294.

73. Gerard W. Boychuk, *The Regulation of Private Health Funding and Insurance in Alberta Under the Canada Health Act: A Comparative Cross-Provincial Perspective*, SPS Research Papers, Vol. 1, No. 1, December 2008, pp. 16-17.

overall numbers of hours devoted to treating patients, without reducing the services they provide within the public system.[74]

Whereas 99% of hospitals in Canada are public, in all other countries, private medical facilities play a prominent role in the provision of hospital services.[75] On average, in OECD countries, 27% of hospitals are private and for-profit, 22% are private and non-profit, and 51% are public.[76] Over one third of hospitals are private and for-profit in Germany (42%), France (39%), and Australia (36%). These hospitals find ways of organizing their work that entail efficiency gains, reduce costs, and shorten wait times.[77]

Therefore, if the plaintiffs should win their case, chances are good that private hospitals would appear on the Canadian landscape. But contrary to some claims, the Canadian system would not thereby come to resemble the American model, but rather the most efficient mixed universal systems in the world, notably found in Europe.

Myth 2: Access to Care in the Public System Would Decline

Certain analysts maintain that the easing of restrictions with regard to private medicine, as the plaintiffs in the Day case are calling for, would only benefit a small number of very wealthy people, and would lead to longer wait times for all other patients, who depend on the public sector.[78]

Yet international experiences over the past ten years confirm that the presence of a private health care system parallel to the public system is not incompatible with health care services that are accessible to all. Insofar as those who are covered by duplicate insurance policies use the private system while continuing to contribute to the financing of the public system through their taxes, more resources can be devoted to each patient who uses the public system. Therefore, access to care for all patients in the public system is improved.

"On average, in OECD countries, 27% of hospitals are private and for-profit, 22% are private and non-profit, and 51% are public."

Countries like England and Denmark, which have increased their reliance on the private sector since the turn of the new millennium, both in terms of funding and in terms of care provision, have experienced clear improvements when it comes to wait times.[79] These countries offer relevant lessons for Canada, since they have universal health care systems that most resemble the Canadian system.[80] Among other things, they had long been gripped with waiting list problems in the 1990s before initiating reforms designed to liberalize their systems.[81]

In Denmark, the percentage of the population holding insurance that covers treatment in private clinics and hospitals grew from less than 5% in 2003 to over 40% in 2014.[82] Researchers have recently shown that duplicate private insurance coverage was associated with a 10% average reduction of public hospital usage. This means that the budget for health care increased, and that overall access to health care services, all other things being equal, improved for all patients, whether or not they had private insurance.[83] Wait times for elective surgery fell from an average of 90 days in 2001 to 49 days in 2014,

74. Karen Bloor *et al.*, "Variation in Activity Rates of Consultant Surgeons and the Influence of Reward Structures in the English NHS," *Journal of Health Services Research and Policy*, Vol. 9, No. 2, 2004, p. 82; Terence Chai Chang, Catherine M. Joyce and Anthony Scott, "An Empirical Analysis of Public and Private Medical Practice in Australia," *Health Policy*, Vol. 111, No. 1, 2013, pp. 43-51; Karolina Socha and Michael Bech, "Dual Practitioners Are as Engaged in Their Primary Job as Their Senior Colleagues," *Danish Medical Journal*, Vol. 59, No. 2, 2012; Karl-Arne Johannessen and Terje P. Hagen "Physicians' Engagement in Dual Practices and the Effects on Labor Supply in Public Hospitals: Results from a Register-Based Study," *BMC Health Services Research*, Vol. 14, No. 299, 2014.

75. Contrary to certain statements, hospitals in Canada (including those in British Columbia) are publicly owned, which both Statistics Canada and the OECD recognize. See Statistics Canada, *Guide to the Public Sector in Canada*, Catalogue No. 12-589-X, September 2008, p. 68; OECD, Statistical Database, Health Care Resources, Hospitals, 2012.

76. Grégoire de Lagasnerie *et al.*, *Paiement des hôpitaux et dégressivité tarifaire dans les pays de l'OCDE*, OECD, March 2015, p. 28.

77. See among others Oliver Tiemann and Jonas Schreyögg, "Changes in Hospital Efficiency after Privatization," *Health Care Management Science*, Vol. 15, No. 4, 2012, pp. 310-326; Neelam Sekhri, Richard Feachem and Angela Ni, "Public-Private Integrated Partnerships Demonstrate the Potential to Improve Health Care Access, Quality, and Efficiency," *Health Affairs*, Vol. 30, No. 8, 2011, pp. 1502-1503; William B. Weekes, Marie Jardin and Alain Praponaris, "Characteristics and Patterns of Elective Admissions to For-Profit and Not-for-Profit Hospitals in France in 2009 and 2010," *Social Science and Medicine*, Vol. 133, 2015, pp. 53-58; Paul H. Jensen, Elizabeth Webster and Juilia Witt, "Hospital Type and Patient Outcomes: An Empirical Examination Using AMI Readmission and Mortality Records," *Health Economics*, Vol. 18, 2009, pp. 1440-1460.

78. These analysts present data that is generally from over ten years ago. See among others Colleen Fuller, *op. cit.*, footnote 56; Alex Peden, "Backgrounder: Court Challenges to One-tier Medicare," *EvidenceNetwork.ca*, October 15, 2014; Vanessa Brcic, "Evidence Is In: Privately Funded Health Care Doesn't Reduce Wait Times," *Policy Note,* Canadian Centre for Policy Alternatives, June 14, 2015.

79. Luigi Siciliani, Valerie Moran and Michael Borowitz, "Measuring and Comparing Health Care Waiting Times in OECD Countries," *Health Policy*, Vol. 118, No. 3, December 2014, pp. 292-303.

80. Health economists refer to these single-payer systems funded through taxation as Beveridgian systems, in contrast with Bismarckian systems, which allow room for multiple insurers and are financed through social contributions (Switzerland, Netherlands, Belgium, Germany, and France, for example).

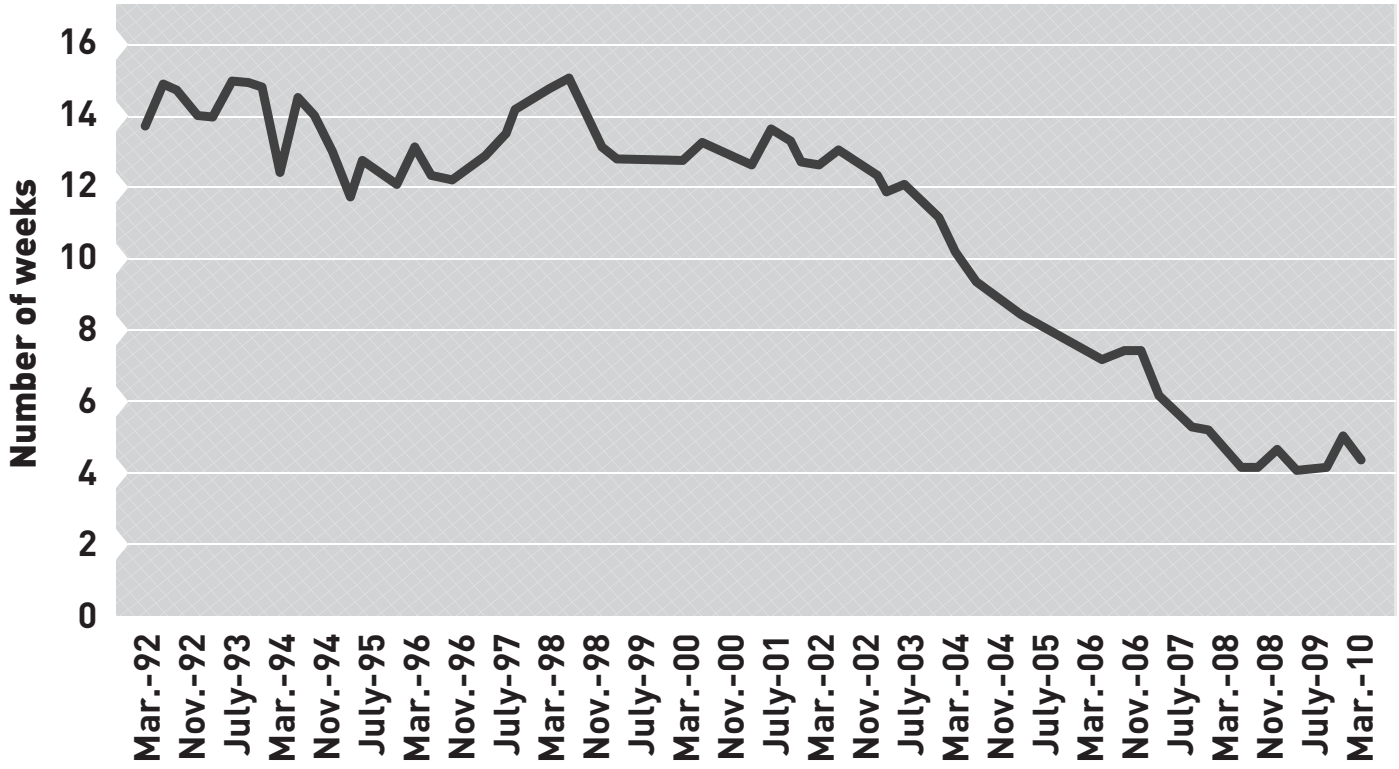
81. Lars Thorup Larsen and Deborah Stone, "Governing Health Care Through Free Choice: Neoliberal Reforms in Denmark and the United States," *Journal of Health Politics, Policy and Law*, Vol. 40, No. 5, October 2015, p. 945; Christian Rioux, "La Grande-Bretagne, royaume des files d'attente," *Le Devoir*, May 2, 2000.

82. Forsikiring & Pension, *Sundhedsforikring Antal forsikede, praemier og erstatninger*, Statistics Denmark, *Table BEF5: Population – 1 January, by sex, age, and country of birth*.

83. Rikke Søgaard, Morten Saaby Pedersen and Michael Bech, "To What Extent Does Employer-Paid Health Insurance Reduce the Use of Public Hospitals?" *Health Policy*, Vol. 113, November 2013, p. 65.

Figure 3-2

Evolution of median wait times for elective surgery in England, 1992 to 2010



Source: Department of Health of England, Inpatient and Outpatient Waiting Times Statistics, Historical Time-Series, 1988-2010.

a drop of nearly 50%.[84] According to a recent study, Denmark had the second shortest wait times among 16 countries evaluated, with median delays half as long as Canada's.[85]

In England, starting in 2002, a series of reforms were adopted based on freedom of choice and competition between medical facilities in both the public and the private sectors.[86] The increase in the number of private surgery centres, which went from 10 to 161 in the space of a few years,[87] did not lead to reductions in the volume of operations carried out in public hospitals, but rather added extra resources to the system as a whole. This contributed to a significant reduction in waiting times in public hospitals.[88] Wait times for elective surgeries fell by over 66% between 2002 and 2010 (see Figure 3-2).[89] British researchers recently evaluated the gains for patients (in terms of quality of life) associated with the elimination of waiting lists for hip and knee surgeries over the past decade at 635 million pounds sterling per year.[90]

"Countries like England and Denmark, which have increased their reliance on the private sector since the turn of the new millennium, have experienced clear improvements when it comes to wait times."

84. Sundheds– og Ældreministeriet, *Status på sundhedsområdet*, [Denmark Health Department, State of Health Care], September 2015, p. 11.
85. Luigi Siciliani, Valérie Moran and Michael Borowitz, "Measuring and Comparing Health Care Waiting Times in OECD Countries," *Health Policy*, Vol. 118, No. 3, December 2014, pp. 292-303.
86. See among others Martin Gaynor, Rodrigo Morena-Serra and Carol Propper, "Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy*, Vol. 5, No. 4, 2013, pp. 134-166.
87. Elaine Kelly and Gemma Tetlow, *Choosing the Place of Care: The Effect of Patient Choice on Treatment Location in England, 2003-2011*, The Nuffield Trust/ Institute for Fiscal Studies, November 2012, p. 3.
88. Elaine Kelly and George Stoye, "New Joints: Private Providers and Rising Demand in the English National Health Service," Working Paper W15/22, Institute for Fiscal Studies, August 2015, p. 4.
89. Department of Health of England, Inpatient and Outpatient Waiting Times Statistics, Historical Time-Series, 1988-2010.
90. Silviya Nikolova, Mark Harrison and Matt Sutton, "The Impact of Waiting Time on Health Gains from Surgery: Evidence from a National Patient-Reported Outcome Dataset," *Health Economics* (forthcoming).

Myth 3: Quality of Care in the Public System Would Deteriorate

In the debate surrounding Dr. Day's case, another argument of supporters of the public monopoly holds that the existence of a private alternative would necessarily lead to the deterioration of the public health care system. In other words, what the private sector would gain, the public sector would lose.[91]

This notion is also contrary to the observed facts. Public spending per capita is actually higher in most countries with a parallel private sector than it is in Canada. In addition, public health care spending has continued to climb in countries where a parallel private sector developed in recent years, places like Australia, Denmark, New Zealand, and the United Kingdom, to name just a few.

"Public spending per capita is higher in most countries with a parallel private sector than it is in Canada."

In England, the goal of the reforms based on the increased participation of private providers and patient freedom of choice was not only to reduce wait times in the health care system, but also to improve the efficiency of the provision of non-urgent care by separating routine treatments from urgent and more complex care. A committee of experts made up of members of the Royal College of Surgeons of England was set up in 2010 to investigate the results of these reforms. Their analysis showed that these private treatment centres, far from selecting only the less complex cases, instead raised the bar in terms of efficiency and quality of care.[92] Improved access therefore did not come at the expense of the quality of care patients received—quite the contrary.

A similar phenomenon exists in Italy, another country whose universal health care system is often cited as an example for the success of its market reforms in recent decades.[93] A recent study shows that there is a significant positive correlation between quality of care in each of the regions and levels of private spending per capita. This result calls into question the notion that higher private spending contributes to undermining the quality of care in the public system. And as the Italian researchers specify, "This result […] undermines the simplistic notion that higher levels of private spending are a direct consequence of poor quality in the public sector."[94]

Denmark provides another persuasive example, since it is the OECD country that devotes the most public resources to health care as a proportion of the size of its economy.[95] It is also the country that relies on the most extensive welfare state, with public spending accounting for nearly 60% of its GDP.[96] And yet, this did not stop it from expanding the role of the private sector in the funding and provision of hospital care over the past decade. The number of private clinics and hospitals went from 59 in 2002 to 249 in 2010.[97] As we saw above, the number of Danes with private insurance allowing them to be treated in these facilities is around nine times higher today than in 2003.

This greater reliance on the private sector has not provoked the carnage so dreaded by those who support the maintenance of Canada's government health care monopoly. As specified by a Danish researcher who has studied the question in depth:

> It is not a frontal attack on the existing public sector provision, but rather the slow introduction of a competing system, where private alternatives are offered alongside the universal public health care system. […] Since these new [private alternatives] do not directly undermine existing institutions, they have not initially provoked much counter mobilisation. […] The rise in [private health insurance] has not corroded the support for the traditional public service model in Denmark.[98]

Myth 4: Equity of Access to Care Would Be Threatened

The goal of providing services to all citizens, regardless of income, is shared by all OECD countries with universal health care systems. The health economics literature nonetheless shows that unequal access to care exists to varying degrees in all of these countries. There is no

91. Mark Stabile, "Why a two-tiered system won't solve our health care woes," *The Globe and Mail*, March 27, 2014.
92. J. Chard, M. Kuczawski, N. Black and J. Van der Meulen, "Outcomes of Elective Surgery Undertaken in Independent Sector Treatment Centres and NHS Providers in England: Audit of Patient Outcomes in Surgery," *The BMJ*, Vol. 343, 2011.
93. See among others Margherita Stancati, "Competitive Care," *Wall Street Journal*, April 13, 2010.
94. Mario Del Vecchio, Lorenzo Fenech and Anna Prenestini, "Private Health Care Expenditure and Quality in Beveridge Systems: Cross-Regional Differences in the Italian NHS," *Health Policy*, Vol. 119, No. 3, May 2015, pp. 356-366.
95. Hélène Barroy *et al.*, *Sustainable Universal Coverage in France: A Perpetual Challenge*, World Bank, Discussion Paper No. 91323, June 2014, p. 11.
96. OECD, *Government at a Glance 2013*, November 2013, p. 75.
97. Sundhedsstyrelsen, *Aktivitet pa private sygehuse 2006-2010*, Dokumentation af Det Specialiserede Sundhedsvæsen, 2011, p. 5.
98. Jeppe Dørup Olesen, "Policymaking without Policy Choice: The Rise of Private Health Insurance in Denmark," *Journal of Public Policy*, Vol. 29, No. 3, 2009, p. 282.

indication, though, that the presence of a duplicate private insurance market leads to less equitable access to medical services.

In a recent analysis of 19 countries, for example, OECD researchers found that Denmark and the United Kingdom—where duplicate insurance covers 41% and 16% of the population, respectively—are the two most egalitarian countries in terms of access to health care. In fact, among the countries studied, Denmark is the only one where the likelihood of visiting a doctor is higher among low-income people (lowest quintile) than among high-income people (highest quintile). In the United Kingdom, low-income people are more likely to visit a doctor than those with higher incomes once variations in patients' needs are taken into account.[99]

"Denmark and the United Kingdom—where duplicate insurance covers 41% and 16% of the population, respectively—are the two most egalitarian countries in terms of access to health care."

It is also interesting to note that the reforms that have made more room for competition and entrepreneurship in England and Denmark over the past decade have not led to less equitable access to care—quite the contrary.[100] Patients from underprivileged backgrounds in England have instead seen their wait times for a great many surgical treatments fall faster than other patients over the course of the 2000s.[101]

On the other hand, a large body of empirical research shows that access to care varies with socio-economic status in Canada, despite the prohibition of duplicate private health insurance and other restrictions.[102] These studies find that it is the poorest Canadians who have the least access to health care, particularly when it comes to their first contact with the health care system. According to one of these studies, 30% of the poorest Quebecers (versus 16% of the richest) reported having unmet health care needs, primarily due to long wait times or the impossibility of seeing a doctor when they need to.[103]

The available data also show that richer Canadians generally enjoy privileged access to the public health care system, thanks to their connections and to other factors that allow them to skip the queue.[104] Given the existence of rationed access and waiting lists, it is to be expected that some will use more or less legitimate means to obtain access to required services before other people.

Moreover, according to researchers from the University of Waterloo and from Canada's Finance Department who investigated the evolution of health care usage over a 25-year period, from 1978 to 2003, access to care is less and less equitable in Canada. They mention that "[p]rior to the introduction of the [*Canada Health Act*], Canadian utilization studies indicate that equity principals were intact."[105]

Also, international data have shown that duplicate private insurance makes the financing of health care systems more progressive.[106] Researchers recently sought to confirm this thesis once again using data from Italy. They concluded that while wealthier individuals were more likely to purchase duplicate health insurance, they opted out of the public sector, thereby freeing up more resources to treat the patients in that system, starting with those with the lowest incomes.[107]

Conclusion

A lot of ink has already been spilled regarding the case that will soon be before the Supreme Court of British Columbia.

99. Marion Devaux and Michael de Looper, *Income-Related Inequalities in Health Service Utilisation in 19 OECD Countries, 2008-2009*, OECD Health Working Papers No. 58, 2012.
100. For England, see Richard Cookson, Mauro Laudicella and Paolo Li Donni, "Does Hospital Competition Harm Equity? Evidence from the English National Health Service," *Journal of Health Economics*, Vol. 32, No. 2, 2013, pp. 410-422.
101. Zachary N. Cooper *et al.*, "Equity, Waiting Times, and NHS Reforms: Retrospective Study," *The BMJ*, Vol. 339, September 3, 2009.
102. See for example W. McIsaac, V. Goel and D. Naylor, "Socio-Economic Status and Visits to Physicians by Adults in Ontario, Canada," *Journal of Health Services Research and Policy*, Vol. 2, No. 2, 1997, pp. 94-102; G. A. Hawker *et al.*, "The Effect of Education and Income on Need and Willingness to Undergo Total Joint Arthroplasty," *Arthritis & Rheumatism*, Vol. 46, No. 12, 2002, pp. 3331-3339; Louise Pilote *et al.*, "Universal Health Insurance Coverage Does Not Eliminate Inequities in Access to Cardiac Procedures after Acute Myocardial Infarction," *American Heart Journal*, Vol. 146, No. 6, 2003, pp. 1030-1037; David A. Alter *et al.*, "Socioeconomic Status, Service Patterns, and Perceptions of Care among Survivors of Acute Myocardial Infarction in Canada," *Journal of the American Medical Association Journal*, Vol. 291, No. 9, 2004, pp. 1100-1107; Kimberlyn M. McGrail, "Income-Related Inequities: Cross-Sectional Analyses of the Use of Medicare Services in British Columbia in 1992 and 2002," *Open Medicine*, Vol. 2, No. 4, 2008, pp. e3-e10.
103. Jean-Frédéric Lévesque *et al.*, "Emerging Organisational Models of Primary Healthcare and Unmet Needs for Care: Insights from a Population-Based Survey in Quebec Province," *BMC Family Practice*, Vol. 13, No. 66, 2012.
104. D. A. Alter, A. S. Basinski and C. D. Naylor, "A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario," *Annals of Internal Medicine*, Vol. 129, No. 7, 1998, pp. 567-572.
105. J. L. Curtis and W. L. MacMinn, "Health Care Utilization in Canada: Twenty-Five Years of Evidence," *Canadian Public Policy*, Vol. 34, No. 1, 2008, p. 67.
106. Adam Wagstaff and Eddy Van Doorsaler, "Equity in Health Care Finance and Delivery," *Handbook of Health Economics*, Vol. 1, Part B, 2000, p. 1826.
107. Daniele Fabbri and Chiara Montfardini, "Opt Out or Top Up? Voluntary Health Care Insurance and the Public vs. Private Substitution," *Oxford Bulletin of Economics and Statistics* (forthcoming).

Table 3-1

Comparison of the health care systems of England, Denmark, and British Columbia in terms of the role of the private sector in the provision and funding of care

	ENGLAND	DENMARK	BRITISH COLUMBIA
Duplicate private insurance	Yes. 16% of the population (2012)	Yes. 41% of the population in 2014 (5% in 2003)	Not authorized
Mixed public-private medical practice	Yes. 39% of doctors ("consultants") in 2012	Yes. 15% of medical specialists (2008)	Not authorized
Private hospitals and surgery clinics	The number of private centres (ISTC) went from 10 in 2006 to 161 in 2011, contributing to reducing wait times in the system	The number went from 59 in 2002 to 249 in 2010, a 322% increase	Around 1% of surgeries in the public health care system were entrusted to private centres in 2013-2014
Policy of patient freedom of choice	Yes	Yes, if patients wait more than 30 days	No
Evolution of wait times for elective surgeries	Median wait times reduced by over 60% from 2002 to 2010	Average wait times reduced by 46% from 2001 to 2014	No notable improvements in wait times over the past decade

Sources: Forsikiring & Pension, *Sundhedsforikring Antal forsikede, praemier og erstatninger*; Statistics Denmark, Table BEF5: Population – 1 January, by sex, age, and country of birth; Elaine Kelly and Gemma Tetlow, *Choosing the Place of Care: The Effect of Patient Choice on Treatment Location in England*, 2003-2011, The Nuffield Trust/Institute for Fiscal Studies, November 2012, p. 3; Yanick Labrie, *For a Universal and Efficient Health Care System: Six Reform Proposals*, Research Paper, Montreal Economic Institute, March 2014, Tables 2 and 3; Pamela Fayerman, "Allowing complex surgeries at private B.C. clinics could take up to 24 months," *Vancouver Sun*, June 10, 2015.

A victory for the plaintiffs in these proceedings could give rise to significant changes in the province's health care system, bringing it more in line with the European systems that are among the best in the world. Several experiences in Europe, including those in England and Denmark (see Table 3-1), show that it is possible to improve access to health care by encouraging entrepreneurship and giving patients greater freedom of choice, all without undermining the principles of equity and universality that the Canadian population holds dear.

CONCLUSION

Ten years have gone by since the famous Supreme Court of Canada decision in the Chaoulli case. On June 9, 2005, after almost a decade before the courts contesting the legitimacy of the government's health care monopoly, Jacques Chaoulli and George Zeliotis finally won their battle.

The highest court in the land had just ruled that when the government is unable to offer timely access to required care, the prohibition against purchasing private health insurance constitutes a violation of the rights of patients. "Access to a waiting list is not access to health care," declared Chief Justice Beverley McLachlin in her verdict.

The Court's decision hinted at several major changes in public policies regarding health care services in Quebec. Unfortunately, nothing has really changed since then. First, by limiting the number of admissible surgeries, the government ensured that no private insurance market could emerge. Maintaining the prohibition on mixed medical practice did not help, either. Obviously, as long as doctors will be obliged to disengage completely from the public system in order to offer services in the private sector, there will be few private services to insure.

"Whatever the outcome of the judicial challenges, it's a safe bet that governments will have to loosen the public monopoly's grip on the funding and provision of medically required care."

The government also set the maximum wait time for treatment at six months for hip, knee, and cataract surgery. Contrary to popular belief, this is not a legal right that patients have, but simply administrative targets for hospitals. These have approximately zero incentive effect: Nearly one in five patients still waits more than six months for a hip or knee operation, and the situation is worse than in 2007.

Finally, a new information system was set up to track the evolution of wait times for various medical and surgical procedures. This database allows us to observe that wait times for elective surgeries have not seen any notable improvements in Quebec since 2008. While they have fallen slightly for cataract removals, they have risen for hip and knee operations. In the past year, the average wait times were more than 15 weeks for hip surgery, and nearly 17 weeks for knee surgery, not including the prior delays in obtaining appointments first with a general practitioner and then with a specialist.

Taking inspiration from the Chaoulli case, other similar cases have been heard, or will soon be heard, before the courts in other provinces. The fact is that the public system in each of the provinces struggles to respond adequately to the needs of the population within a reasonable timeframe. Canada is at the bottom of the class in international rankings when it comes to timely access to medically required care.

The options outside of the public system being limited, more and more Canadians are opting for medical tourism. An estimated 52,000 Canadians chose to pay out of pocket for health care services outside the country in 2014.[108] Indeed, Canada is among the industrialized countries where people spend the most on medical tourism. These expenses keep rising, having jumped by over 70% during the first decade of the new millennium.[109]

Given the aging of the population, it is to be expected that more and more Canadians will need surgical interventions, such as hip and knee replacements and cataract removals, for which waiting times in the public system keep getting longer.

Whatever the outcome of the judicial challenges, it's a safe bet that governments will have to loosen the public monopoly's grip on the funding and provision of medically required care in order to meet these growing needs. They would be advised to take a page from Europe's mixed universal systems, which are far more accessible.

108. Bacchus Barua and Feixue Ren, "Leaving Canada for Medical Care, 2015," *Fraser Research Bulletin*, Fraser Institute, March 2015.
109. Chung-Ping A. Loh, "Trends and Structural Shifts in Health Tourism: Evidence from Seasonal Time-Series Data on Health-Related Travel Spending by Canada During 1970-2000," *Social Science & Medicine*, Vol. 132, 2015, pp. 173-180.

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