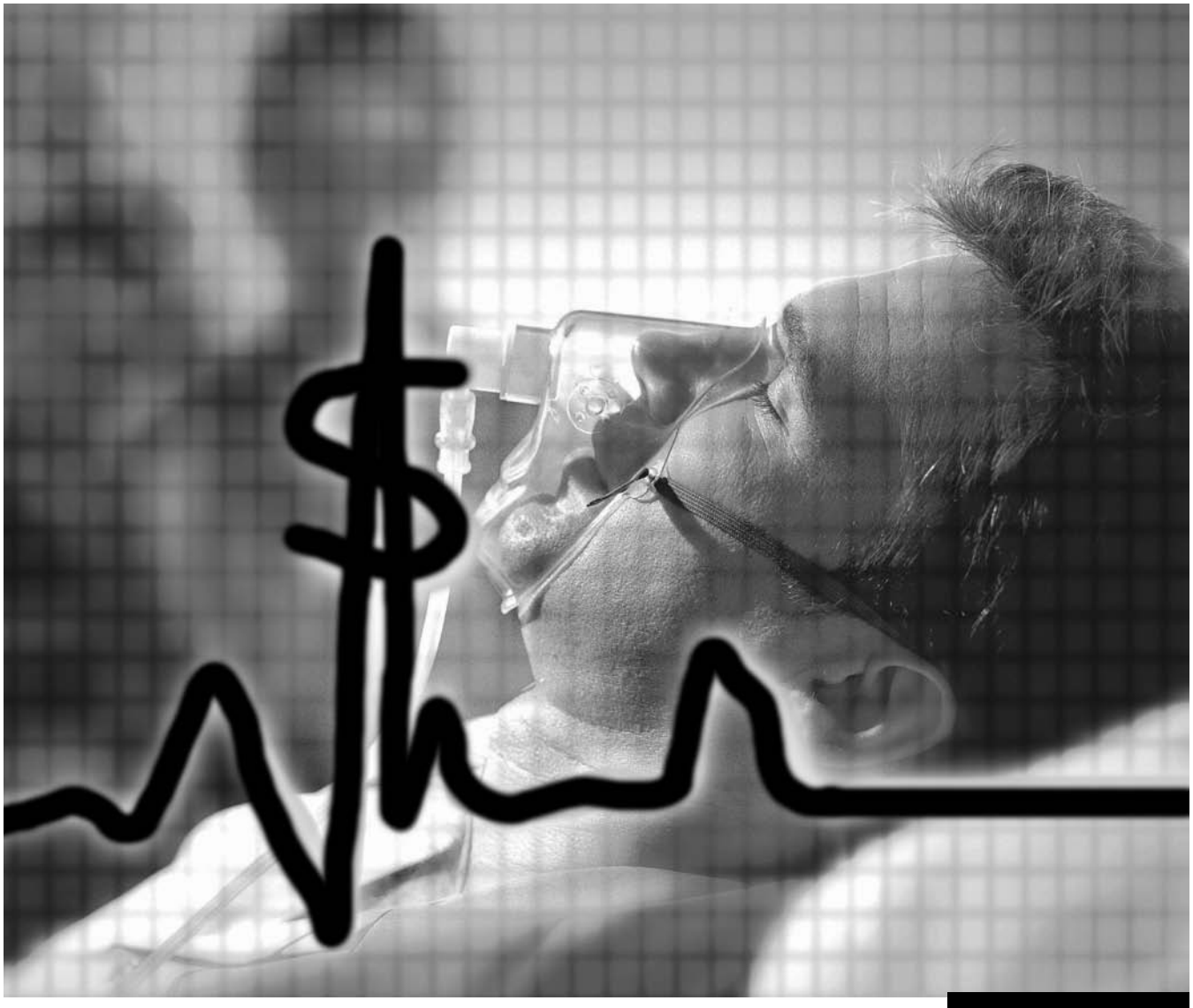
Inside the “Chaoulli” Supreme Court ruling:

What the decision means, the facts on private insurance, and solutions for wait lists



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INSIDE THE CHAOULLI RULING

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Introduction

The privateers' interpretations, dire predictions and worst-case scenarios are flying in the wake of the Supreme Court's ruling in the Chaoulli case. But the heart of the case is clear: the ruling is not a license to privatize – even within the province of Quebec. Instead, the case is a wake-up call for governments to take action to strengthen public health care.

Those pushing health care privatization are using the ruling to argue the floodgates have been opened to for-profit care. CUPE has produced this comprehensive backgrounder to provide facts and arguments countering these claims.

This backgrounder looks first at what the court did – and did not – say, and then looks at what the evidence shows about privatized health care in Europe and elsewhere. It then tackles the myths and realities surrounding wait lists, offering public solutions to shorten wait times. The trade dangers of privatized care – an area not addressed in the court's ruling – is another crucial issue in the wake of Chaoulli. The backgrounder also looks at the true "cost drivers" in the health care system, countering right wing claims that health care workers' wages are making medicare "unsustainable", and closes with actions the federal and provincial governments must take to stop the spread of privatization.

For further background on health care privatization, visit cupe.ca

What the court did (and did not) say

What did the court say?

A slim majority of judges ruled that Quebec's ban on private health insurance for publicly-insured services violated Quebec's *Charter of human rights and freedoms.* The decision, based on selective and at times flimsy evidence, is not a blanket overturning of the ban.

The judges were clear that the ban only violates Quebec's *Charter* when there are lengthy waiting times for treatment in the public system. The judges attempted to clarify the dividing line as "circumstances where the government is failing to deliver health care in a reasonable manner" – though the judges did not define what was a reasonable or unreasonable wait time beyond vague references to "quality and timeliness".[1]

The case was appealed to the Supreme Court by a doctor well-known for his support of privatized health care, Dr. Jacques Chaoulli[2], and his patient, who had encountered a year-long wait for hip surgery, George Zeliotis. They essentially argued that patients facing lengthy waiting lists should have the right to buy private insurance that would pay for privately-delivered medical services.

The majority on the court made this decision by interpreting the protections in Quebec's *Charter* (which are broader than protections in the Canadian *Charter*). In doing so, the majority overturned two lower court rulings that upheld the ban on private health insurance.

Further demonstrating that this case is clearly limited to situations where there are long waiting lists, the majority held that "[g]overnments have promised on numerous occasions to find a solution to the problem of waiting lists…it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens."[3]

Disturbingly, the majority rejected arguments that a ban on private care was necessary to protect the public health care system. They did so in the face of persuasive and compelling evidence supporting the Quebec government's argument, presented both at trial and by interveners at the Supreme Court. As an interesting aside, both the Quebec and federal government's arguments before the Supreme Court are comprehensive overviews of how private care can undermine public health care – advice they do not necessarily always follow in practice.[4]

The majority tacitly acknowledged accessing private insurance won't shorten wait times, saying it "does not necessarily provide a complete response to the complex problem of waiting lists."[5] They also summarize Chaoulli and Zeliotis' arguments in a way that highlights the underlying political agenda: "The appellants do not seek an order that the government spend more money on health care, nor do they seek an order that waiting times for treatment under the public health care system be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services."[6]

The court's ruling struck down the sections of Quebec's *Health Insurance Act* and *Hospital Insurance Act* that outlaw private insurance. The judgment was issued on June 9, 2005. Two months later, the court issued a "stay", suspending the judgment's effect for a year.

Was it a unanimous ruling?

No. It was a deeply divided court that split 4-3. The four justices in the majority on the Quebec *Charter* issue didn't even agree on all of their findings. The three judges who disagreed with the majority ruling wrote a strongly-worded, evidence-based dissent which forms part of the judgment. There were two vacancies on the court at the time of the hearing.

The arguments got heated – the majority ruling accuses the dissenters of having an "emotional reaction" to the case.[7]

However, the majority judges also rely on dramatic language that could evoke emotional responses, quoting evidence that a patient with coronary disease is "'sitting on a bomb' and can die at any moment."[8] They also base their ruling on "unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care"[9] – without any supporting evidence that allowing private insurance would reduce the number of deaths.

Justice Marie Deschamps wrote for the majority on the Quebec *Charter*, but declined to make a decision under the Canadian *Charter*, leaving that issue tied 3-3. She scorned the dissenters' analysis of the evidence surrounding the dangers of private care as "characteriz[ing] the debate as pitting rich against poor"[10]. However, a few paragraphs later, she herself argues that a ban 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."[11] The other majority judges raise a similar argument.[12] However, as the dissenters point out, those who seek and qualify for private insurance will be the wealthier members of society.[13]

What did the dissenting judges say?

They argued that Quebec's ban on private insurance was a reasonable measure, accepting the evidence that allowing private insurance would fuel the growth of for-profit care, which in turn would undermine the public system.

Their blistering response made several other key points. Long waiting lists cannot be resolved as a matter of constitutional law, they stressed.[14] They also said the majority did not clearly define a way forward, and that the arguments behind the case were seriously flawed. They also pointed out the weaknesses in the reasoning underpinning the majority judges' ruling, questioning their use of evidence and bluntly stating that the evidence before the court did not prove private insurance was the appropriate solution[15].

The judges were clear that the case presented an issue the courts can't properly handle. They argued that public vs. private health care "has been the subject of protracted debate across Canada through several provincial and federal elections. We are unable to agree with our four colleagues…that such a debate can or should be resolved as a matter of law by judges."[16]

They further argue that courts are not "well placed to perform the required surgery" to solve problems with public health care[17], and that "the debate is about social values. It is not about constitutional law"[18]. The appropriate forum to resolve a concern about wait times is in the arena of politics, they argue.[19] Citing a 2003 Supreme Court ruling, the justices point out that "Members of Parliament are elected to make these sorts of decisions and have access to a broader range of information, more points of view, and a more flexible investigative process than courts do."[20]

The three dissenting judges point to the majority's vague use of "reasonable" to describe health services. They rhetorically ask, "How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard."[21]

It is worth quoting the dissenters' assessment of Chaoulli and Zeliotis' main argument, which they describe as "based largely on generalizations about the public system drawn from fragmentary experience, an overly optimistic view of the benefits offered by private health insurance, and oversimplified view of the adverse affects on the public health system of permitting private sector health services to flourish and an overly interventionist view of the role the courts should play in trying to supply a "fix" to the failings, real or perceived, of major social programs."[22]

They rightly pointed out that the evidence around waiting lists is "subject to contradictory evidence and conflicting claims", referencing both the Romanow and Kirby reports.[23]

Finally, the dissenters cautioned against the Charter being used to "'roll back' the benefits of a legislative scheme that helps the poorer members of society."[24]

Who does the ruling affect?

For now, nobody. After issuing the judgment, the government of Quebec requested an 18-month delay in the ruling's implementation. In early August 2005, the court granted a 12-month suspension of the ruling's effect.[25] Quebec has a year, from June 9, 2005, to improve the situation that led to the original court case. There have been many developments since the original case was launched in 1997, including increased federal transfers and numerous federal and provincial initiatives to improve many aspects of public health care, including work on waiting lists. This means the door is still wide open for Quebec to maintain its ban on private insurance and defend a single-tier, public health system. However, recent statements by both the province's premier and health minister call into question their commitment to public health care, signaling the need for renewed pressure on this front.

Does the ruling affect other provinces?

No. Even if the ruling had taken effect immediately, its impact was limited to the province of Quebec – and within the province, was contained to one aspect of the province's health care system. The court was split on whether Quebec's private insurance ban violated the Canadian *Charter of Rights and Freedoms* – which has a much narrower scope than the Quebec charter. The court split 3-3, with Justice Deschamps voicing no opinion on whether the Canadian *Charter* was violated.

Does this affect the Canada Health Act?

No. The CHA remains fully in effect. Chaoulli and Zeliotis did not challenge the constitutionality of the CHA in their case. None of the judges questioned the validity of the CHA. The dissenting judgment makes mention of "the commitment in principle in this country to health care based on need, not wealth or status, as set out in the Canada Health Act," and references the Act's principles in several places. (emphasis in the original)[26]

The legal tools for provinces to maintain single-tier public health care remain in effect. Even Justice Deschamps, one of the justices who ruled in favour of Chaoulli, said, "In this regard, when my colleagues ask whether Quebec has the power under the Constitution to discourage the establishment of a parallel health-care insurance plan, I can only agree with them that it does."[27]

What evidence did the majority rely on?

A very narrow and selective body of research. Justice Deschamps dismissed a wealth of evidence presented at trial – and reiterated in presentations before the court

– saying she was "of the opinion" that the well-documented impacts of private care were "highly unlikely in the Quebec context."[28]

Amazingly, given the wealth of research, reports and studies before them, the majority cast themselves as "confronted with competing but unproven 'common sense' arguments, amounting to little more than assertions of belief. We are in the realm of theory."[29] One health policy analyst has described the majority's analysis of health care research as "facile at best".[30] The dissenting judges emphasize that the expert witnesses offered "a good deal more" than just common sense.[31]

The majority judges relied mainly on the interim report of the Kirby committee – even though the report's findings differed from the final report. They paraphrase the Kirby report as finding that "far from undermining public health care, private contributions and insurance improve the breadth and quality of health care for all citizens."[32] However, as the dissenting judges point out, the final report of the Kirby committee draws conclusions that do not endorse two-tier care.[33] They quote the Kirby report conclusion that "allowing a private parallel system…will make the public waiting lines worse."[34]

The majority judges accepted the arguments of Dr. Edwin Coffey that private insurance wouldn't harm medicare, even though the trial judge concluded that "Dr. Coffey stood alone in both his expert evaluation and the conclusions he reached."[35] Coffey is a senior fellow at the right-wing Montreal Economic Institute, as is Chaoulli.

The majority also cited Dr. Eric Lenczner as an authority, even though both the trial judge and Zeliotis' lawyer agreed he was not qualified as an expert. Lenczner is an orthopaedic surgeon who operates at a private clinic in a wealthy Montreal neighbourhood.[36] His testimony was "largely anecdotal and of little general application", and included a story about a golfer whose wait for surgery meant he lost access to his golf membership for a season.[37]

The dissenting judges questioned the majority's use of evidence, saying "bits of evidence must be put in context." In their criticism, they argue it is "particularly dangerous to venture selectively into aspects of foreign health care systems with which we, as Canadians, have little familiarity."[38] In their dissent, the judges draw on a broad and diverse body of research and testimony to make their points.

Finally, the dissenters pointed to a more appropriate solution for lengthy wait lists. The Quebec government has a built-in "safety valve" that allows residents to get care outside the province when delays in the public system create problems. Patients who feel they aren't getting fast enough treatment can challenge the administration of this safety valve in court, the judges argue. This case-by-case approach is a more reasonable approach than Chaoulli and Zeliotis' full frontal attack on the entire public system, they conclude.[39]

Who is behind this case?

American conservatives call Dr. Jacques Chaoulli a "superstar", and he is equally at home with right-wing thinkers in Canada who favour privatization. Shortly after the

court issued its ruling, Chaoulli met with a who's who of American right-wingers who want to keep public health care out of their country.[40] Chaoulli has waged a lengthy fight to deliver privatized health care, including running a private house call business in Quebec.

In bringing the challenge about private insurance, Chaoulli had one clear goal, as the dissenting judges noted: "[p]rivate insurance is a condition precedent to, and aims at promoting, a flourishing parallel private health care sector. For Dr. Chaoulli in particular, that is the whole point of this proceeding."[41] The dissenters also quote from the trial judgment, which found Chaoulli's motives to be "questionable".[42]

Dr. Chaoulli's patient, George Zeliotis, is equally problematic. The dissenters supported the trial judge's finding that "Mr. Zeliotis has not demonstrated that systemic waiting lists were the cause of his delayed treatment."[43] In fact, the judges point out, the trial presented ample evidence that "the delays Mr. Zeliotis experience…were caused not by excessive waiting lists but by a number of other factors including his pre-existing depression and his indecision and unfounded medical complaints…Mr. Zeliotis sought a second opinion, which he was entitled to do, and this further delayed his surgery. More importantly, his physician believed that Mr. Zeliotis was not an 'ideal candidate' for the surgery because he had suffered a heart attack and undergone bypass surgery earlier that year."[44]

Assessing the international evidence

What is the international evidence on private health insurance?

Many countries have a mixed public-private health care system, each with complex features and different regulatory frameworks. The majority judgment of the Supreme Court relied on evidence that mistakenly portrays Canada's private health insurance limits as unique among developed countries. The public-private distinction in health systems is commonly blurred, and while few countries explicitly ban private insurance for hospital and physician services, many arrive at the same end by different means.[45] Countries with social justice and equity goals spend considerable energy restricting the private insurance industry because it tends to increase costs and discriminate against already marginalized groups in society.

Private insurance entails "perverse incentives" to increase costs and undermine equality of access. In the UK, Australia and New Zealand, specialists are employed on a salaried basis in the public sector and a fee-for-service basis in the private sector. They have a financial incentive to maintain long waiting lists in their public practice to generate demand for private-pay services.[46]

Private insurance requires extensive regulation to counteract its ill effects. Dutch regulation of its substantial private insurance system is complex and far-reaching. Individuals cannot seek quicker care in the private sector. Providers are

paid the same whether they work in the private or public sector. Treatment is provided in exclusively non-profit hospitals. Successive attempts by Dutch coalition governments to modify the tight regulatory framework while maintaining equal access safeguards have proven extremely difficult.[47]

In Australia, legislation prevents private insurers from avoiding risk by refusing to cover patients with pre-existing conditions or complex needs. The UK introduced measures to reserve time from specialists for work in the public sector. Sweden, Luxembourg, Greece and Italy prohibit doctors from practicing in both sectors at once.[48]

Patients recognize private insurance as a rip-off. Private health insurance became so unpopular in Australia that the federal government had to buttress the sector with massive corporate subsidies and penalties for citizens who refused to sign up. The government funds 30 per cent rebates for affluent Australians who purchase private coverage, coupled with a one per cent penalty tax on medium and high-earners who fail to take out a policy. In 2000, the government upped the ante by allowing a premium surcharge on customers who did not join before a July 1 deadline.[49]

Private insurance restrictions are one of a number of policy options to protect public health care. Federal and provincial regulation in Canada has somewhat contained the growth of the for-profit health care industry, though several provinces are now more vigorously pushing privatization. Rather than prohibit private insurance, some provinces prohibit physicians from working both in the public sector and in the private sector.[50] Without being able to piggyback on the public system, private markets have limited room for expansion.

What is the international evidence on health care privatization?[51]

Private funding and for-profit delivery lengthen waiting lists. Countries with parallel private hospital systems have larger waiting lists and longer waiting times in the public system than countries with a single-payer system.[52] The same holds true when public and private systems co-exist within a country. A 1997 study by researchers from the University of Manitoba found that patients waited almost three times longer for cataract surgery if their doctors worked in both the public and private sectors.[53] Private health care exacerbates waiting list problems because:

- It attracts doctors and other health care providers, already in short supply, away from the public system.
- Doctors practicing in both systems have an incentive to boost their private practice by keeping waits long on the public side.
- Private clinics and hospitals tend to "cherry pick" patients who are healthier and younger. They cater to the "easier" non-emergency cases, leaving the more costly ones to the public system.[54]

For more research on the impact of privatization on waiting lists, see the section: *Real solutions for shorter wait lists.*

Administration costs increase with privatization. In Britain, market-style reforms introduced by the Conservative government and continued by New Labour increased managerial and administrative staff levels across the NHS. Between 1997 and 2002, the number of senior managers increased by 59 per cent, compared with a 27 per cent increase in the NHS workforce.[55] Numbers of administrative and clerical staff rose by 18 per cent in the decade to 1991, while admin costs rose from 6 per cent of NHS spending to 11 per cent over the same period.[56]

Administration costs in the United States are over 31 per cent of health care spending compared to 16.7 per cent in Canada. Canada's Medicare program has overhead of 1.3 per cent; the overhead among private insurers is high world-wide: 13.2 per cent in Canada, 15.8 per cent in Australia, 20.4 per cent in Germany, and 11.7 per cent in the U.S. Underwriting and marketing account for two-thirds of the additional overhead costs.[57]

Public funding subsidizes corporate profits and executives' income. Between 1995 and 2003, labour costs dropped from 57 per cent to 46 per cent of NHS spending

while the amount spent on goods and services from the private sector increased from 40 per cent to 52 per cent of spending.[58] US Health Maintenance Organizations' profits of $11.4 billion for 2004 were up 11 per cent over the year before. The previous year, HMO profits registered an 86 per cent gain.[59] The top executives running private plans averaged a salary of more than $15 million in 2002, not counting stock options.[60]

Competition brings more transaction costs. Contracting for services requires formulating precise specifications and standards, administering the contract, and monitoring compliance. The more purchasers are fragmented, the weaker is their bargaining power. In the United States, competition means duplicate claims-processing facilities and providers having to deal with multiple insurance products – all with different eligibility rules and approval requirements, billing and co-payment procedures, and referral networks.[61] A meticulous meta-analysis by P.J. Devereaux and colleagues found that payments for care in for-profit hospitals were 19 per cent higher than in not-for-profit hospitals.[62] Fragmentation also precludes global budgets for providers, one of the factors behind Canada's minimal overhead costs.

Private financing of health care infrastructure increases costs and undermines quality. Public-private partnerships in the UK and Australia, as in Canada, are fraught with problems of poor quality, inappropriate design, and dangerously inadequate standards of cleaning and other support services.[63] In the United Kingdom, the high costs of the first wave of Private Finance Initiative hospital schemes resulted in a 30 per cent reduction in beds and a 25 per cent reduction in budgets for clinical staff.[64]

For-profit facilities deliver a lower standard of care. Investor-owned nursing homes are more frequently cited for quality deficiencies and provide less nursing care,[65] and investor-owned hospices provide less care to the dying,[66] than non-profit facilities. For-profit hospitals and dialysis clinics have higher death rates.[67]

For-profit health care entrenches inequalities in health status and access to care. The Australian government's cuts to the public sector and incentives for private health care have led to severe inequalities for rural and Aboriginal citizens.[68] In the United States, where health care is more expensive and more heavily commercial than anywhere else in the world, 14 per cent of the population, 40 million people, have no health insurance.[69] Eighty per cent of the uninsured are workers.[70] The poorest Medicare beneficiaries spend half their income on medical costs, and unpaid medical bills cause 200,000 bankruptcies a year.[71] Visible minority Americans are at least twice as likely to be uninsured as whites.[72]

Recent research on Sweden shows that equity and social solidarity are being eroded by user fees, public sector rationing and other market-driven health care reforms. Following the expansion of patient fees, people with lower-income, who have higher rates of chronic illness and disability, were found to delay or forego care more often than those who

were financially better off. This was especially true for immigrants.[73]

For-profit health care undermines education of health care practitioners. Public hospitals are almost exclusively the training ground for medical, nursing and allied health professional students. By drawing experienced staff from the public system, the private sector is subsidized by the publicly funded education system and exacerbates training and health human resource problems.

Privatization is often imposed against the better judgment of local providers. In the UK, the Department of Health forced the Primary Care Trusts in Oxfordshire to establish a controversial private sector treatment centre for cataract treatment, despite the doctors' concerns that it would undermine the financial viability of Oxford's existing public eye hospital.[74] By the end of 2005, primary care providers will be obliged to offer patients at least one private hospital among referral choices. Irrespective of what doctors recommend or patients choose, ministers want at least 10 per cent of NHS elective operations carried out by the private sector in 2006, rising to 15 per cent by 2008.[75] This policy has been strongly criticized by the British Medical Association. London NHS managers working for Health Secretary John Reid studied the plans and found they are unaffordable and will undermine the viability of public NHS facilities.[76]

Real solutions for shorter wait lists

Will private health care ease wait list pressures?

No - quite the opposite. Evidence from Canada and other developed countries tells us that private payment and provision actually lengthen wait lists.

England and New Zealand, which have parallel private hospital systems, have larger waiting lists and longer waiting times in the public system than countries with a single-payer system.[77] Studies that have compared wait lists within countries have found similar inequalities; the more for-profit health care in a given region, the longer the waits for patients in the public system.[78] When public wait times dropped in Britain, it was because of increased public funding and numbers of front-line staff.[79]

In Sweden, which allowed the growth of private hospitals and "internal markets", waiting lists have grown again to the levels of the early 1990s.[80] The number of patients on cataract waiting lists almost doubled between 1992 and 2000.[81] When the Stockholm Capio hospital and other for-profit hospitals failed to achieve cost savings or productivity increases, the government legislated in 2001 to prevent municipalities from privatizing more hospitals.[82] More recent legislation bans any new private hospitals from treating state-insured patients, to end the practice of private patients buying their way past hospital waiting lists.[83]

The Australian government heavily subsidizes private health insurance, yet public wait times are similar to Canada's.[84] An evaluation of Australia's parallel private system by Jeremiah Hurley and his colleagues found that the government's subsidies for private insurance cost $1.5 billion a year.[85] Investing this money in public hospitals would alone resolve between one-half and two-thirds of all private demand.[86] In 1998, the government withdrew its ban on "queue-jumping" by private patients in public hospitals, and there is evidence that the higher revenue earned from private patients is affording them preferential treatment.[87]

In New Zealand, market-style reforms implemented in the 1990s led to higher costs and longer waiting lists. The government instituted internal markets and invited competition between public and private hospitals. The results? Prices at private hospitals were generally higher than at public hospitals, administration costs increased 40 per cent over two years, and hospital waiting lists rose, some by as much as 50 per cent.[88] The new government elected in 1999 changed course, reversing a number of commercial-oriented reforms.

Canadian experiments with private health care have similarly failed to improve waiting lists. A 1997 study by Carolyn DeCoster and her colleagues at the University of Manitoba found that patients waited longer for cataract surgery if their

doctors worked in both the public and private sectors. Those patients waited up to 26 weeks, while patients whose doctors worked only in public hospitals received treatment within 10 weeks. People from high-income neighbourhoods received the faster treatment. Women waited about three weeks longer for surgery than men.[89]

Consumers' Association of Alberta researcher Wendy Armstrong found similar results for cataract surgery patients in Alberta. In Calgary, where all cataract surgeries were performed in private clinics, patients waited an average of 16 to 24 weeks. In Edmonton, where 80 per cent of cataract surgeries were done in public hospitals, waiting lists were five to seven weeks long.[90]

Why do private insurance and private delivery not solve wait time problems?

Health care providers are lured away from the public system.[91] The hours spent by physicians, nurses, technicians and other providers in private facilities are hours taken away from the public sector. There is already a shortage of these practitioners, and it takes many years to train more.

Since doctors earn more in the private sector[92], they have an incentive to maintain lengthy wait lists in their public practice in order to nudge patients towards their private practice.[93]

Private clinics and hospitals tend to "cherry pick" patients who are healthier and younger, and cater to non-emergency care.[94] For-profit facilities also tend to provide a lower standard of care.[95] Expensive cases and complications are left to the public sector, increasing demand on the public system.

As the more privileged patients – those better equipped to advocate for prompt care and adequate funding – abandon the public system, providers and governments have less incentive to resolve wait list problems.

What are the solutions to long wait lists?

Better management and targeted resources are needed to tackle health care bottlenecks.

Invest health care dollars in public delivery. The federal government's Wait Times Reduction Fund and transfer payments for health care must be exclusively directed to non-profit service delivery. Likewise, provincial funding must be directed to public facilities, not private clinics.

Centralize and coordinate information on wait lists. This includes coming up with standard definitions and measurements. Currently, depending on who is keeping track, the wait list clock starts ticking at different points: when the patient is referred by their GP, gets accepted by a specialist, is booked by the hospital, or at some other marker. The Fraser Institute has the least reliable indicator: physicians' opinions on how long they <u>think</u> their patients have to wait.[96]

Keep lists current and valid. Lists are often unreliable, containing patients who already had the procedure, no longer need it, or have died. Decisions about who gets what surgery often do not follow clinical practice guidelines.[97] Studies in Britain and other countries have shown that between 20 and 30 per cent of patients are inappropriately placed on wait lists.[98] Removing people who should not be on a list reduces last minute cancellations and allows managers to better plan.

Coordinate management of wait lists. Most lists are kept by individual doctors, and patients are not regularly moved onto the shortest list. Progress is being made through projects like the Cardiac Care Network of Ontario, the Saskatchewan Surgical Care Network, and the Western Canada Waitlist Project.[99] Improving data and agreeing on benchmarks is, however, only the first step. Referring patients to shorter lists and integrating care is necessary to reduce the underlying bottlenecks.

Centralize booking, expand case management, and improve teamwork. Michael Rachlis recommends shared care arrangements, where family doctors consult with specialists to reduce unnecessary referrals.[100] Rachlis also points to the success of case managers – hospital staff who specialize in coordinating patient care, for example finding available providers, arranging patient transfers within the region or out-of-province, and facilitating access to other services.[101]

Consolidate the different steps in diagnosis and treatment. The Sault Ste. Marie, ON, breast health centre reduced the wait time from mammogram to breast-cancer diagnosis by 83 per cent by integrating the diagnostic procedures - mammogram, ultrasound and biopsy.[102]

Invest in public sector infrastructure and staffing to clear backlogs. In some treatment areas, inadequate equipment and facilities are impeding delivery. Across the health care system, shortages of health care providers and over-taxed education systems are slowing progress. Extending the use of existing operating rooms and other infrastructure, as well as building and staffing new surgery clinics in the public sector, will help address shortfalls.

Coordinate care to deal with underlying mismatches of capacity and demand. Michael Rachlis argues that additional resources can help providers catch up to demand, but we need to better manage the flow of patients through the system for a lasting solution. Consolidating lists and procedures and coordinating care are necessary to make a profound dent in lists, as are democratic and transparent methods to allocate operating room time.[103]

Use health care providers to their full potential, and achieve multidisciplinary collaboration. Using nurses – RNs, practical nurses, and psychiatric nurses – as well as paramedical professionals and other practitioners to their full scope of practice will help meet demand. Faster progress is also needed towards multidisciplinary teamwork.

Expand services and improve coordination in continuing care. Having community supports in place will ease pressure on emergency wards and hospital beds. A British Columbia study on home care by Marcus Hollander found that, on average, health care costs to government for home care clients were half to three quarters of costs for clients in residential care.[104] Inadequate funding for home care and residential long-term care has increased the burden on hospitals and exacerbated waiting list problems.

Commit energy and resources to primary care reform. While family practice teams and alternatives to fee-for-service have made some headway in recent years, the pace of change has been slow. Community health centres, despite their proven success, have not been expanded by most provinces. Investment in prevention of illness and management of chronic health conditions, multidisciplinary team practice, and community public health programs would improve health outcomes and reduce reliance on the acute care system.

Trade dangers of privatization

What are the trade implications of the Chaoulli decision?

The potential trade implications of the Chaoulli decision are enormous. While the ruling itself is clearly limited to Quebec, key provisions in two international trade agreements could expand the scope of the judgement to the rest of the country if private insurance is allowed to expand in Quebec. In this way, Canada's obligations under international trade agreements bring added danger to any privatization or commercialization of public health care.

The North American Free Trade Agreement (NAFTA) and the World Trade Organization's General Agreement on Trade in Services (GATS) both contain powerful provisions on investment and services that promote and cement privatization.

The most serious trade threat comes from NAFTA.[105] Public policies and services have already faced challenges under sweeping investment provisions that allow corporations to sue foreign governments if they think a government measure (regulation, law or policy) lessens their profits. Public services such as health care are mostly protected from these investment rules – as long as the services remain public.[106]

Adding to the risk, Canada "listed" – put on the negotiating table – private health insurance under the financial services rules of the GATS in 1994[107], giving US and European private insurers new rights and powers and making future expansion of publicly-insured services much more difficult.

The GATS also contains related provisions concerning market access and national treatment, which could also be triggered by private insurance breaking into public health care.[108] Quite simply, trade deals and medicare do not mix. Rather, "they rest on principles that are, at root, incompatible."[109]

Despite these realities, the Supreme Court decision did not consider the trade dangers of for-profit care. As trade analyst Scott Sinclair has noted, the ruling is a "Trojan Horse" for giant health care and health insurance corporations that want to gain access to and profit from Canada's "market".[110]

How could corporations use trade deals to gain access to Canadian health care?

If private health insurance companies are allowed to cover publicly-insured procedures in Quebec, it provides an entry point to pry open services in the rest of the country, even if courts in other provinces have not ruled it is unconstitutional to ban private insurance.

Allowing private insurance to expand to cover publicly-insured services would

throw Canada's provincial health insurance plans into competition with private suppliers, creating the opportunity for a potential trade challenge[111]. Responding to challenges about including private health insurance in the GATS in 1994, federal officials argued the existing public health insurance system was not affected, since the GATS excludes governmental services that are supplied..."neither on a commercial basis ... nor in competition with one or more service suppliers."[112] The Chaoulli ruling, if implemented, would eliminate that defence.

Private insurance for services not listed on public plans poses a further problem, especially as governments delist more services and fail to approve new ones. Governments already face many roadblocks to expanding insured services publicly – or bringing privatized services back under public insurance at a later date. Increased market access for private insurance corporations as a result of Chaoulli would further complicate what is already murky terrain.[113]

The GATS rules and NAFTA's tough "expropriation" provisions would work in tandem to accelerate the growth of private insurance markets and to make dislodging foreign insurers from the health sector next to impossible.

Provincial policies, guided by the Canada Health Act, deliberately discourage the growth of private insurance markets by, for example, setting fee caps, restricting direct and extra-billing, preventing public subsidy of private practice and ensuring publicly insured health services are paid for by a provincially-run public authority.[114]

If private insurance is permitted to expand into what is currently forbidden territory, such public policies will be viewed as illegal trade barriers. In covered sectors such as health insurance, the GATS guarantees foreign service providers the right to enter the market and fully access the same government subsidies and other advantages given to domestic service providers.

But aren't there protections built into these deals?

Just as Canada's public health care system has been built around the public monopoly over health insurance, the limited protections for health care that Canada negotiated in the NAFTA and the GATS are based on the existing separation between private and public health insurance "markets." As Scott Sinclair notes, "It is the public, not-for-profit nature of Canadian health care that minimizes the risk of trade treaty challenges. If that foundation is shifted, our health care system's protection…crumbles."[115]

Trade rules would vastly expand their reach because the narrow protections granted under GATS and NAFTA do not permit governments to provide services that compete with private suppliers. The Supreme Court ruling could destroy this basic separation, if private insurers, including foreign companies, are allowed to cover the full range of health services in

Quebec. This would neuter the exemptions negotiated for Canadian health care.[116]

If Quebec's ban on private health insurance for publicly insured services is eroded or abolished, Canada's trade treaty commitments will make it very difficult to curb the growth of two-tier medicine or to reverse course and restore a universal, public health insurance system. In particular, NAFTA's investor-to-state provisions "risk making experiments with for-profit health care essentially irreversible".[117]

The role of drugs in rising health costs

What are the true cost pressures in the Canadian health care system?

In the wake of the recent Supreme Court ruling on private health insurance, pro-privatization Doctor Jacques Chaoulli and his supporters have claimed the "monopoly" character of medicare is inefficient and that health care workers are to blame for rising costs. In fact, frontline workers' incomes have remained stable or eroded, depending on the province. The biggest driver of rising health care costs, and one that we can rein in without compromising quality, is pharmaceuticals.

Canadian Institute for Health Information data on hospital spending shows that support services fell from 22.1 per cent of hospital spending in 1993/1994 to 16.9 per cent in 1999/2000. Hospital spending as a whole has fallen over the past 30 years in relation to total health spending. During the 1990s, hospitals' share of total health spending declined 7.7 per cent. Canadian spending on hospitals totalled $34.4 billion in 2002.[118]

In contrast, drug spending has steadily increased. Prescription drug costs rose 62.3 per cent between 1994 and 2004.[119] Adjusted for inflation, the amount that we spend on drugs is going up at between 7 and 8 per cent each year – three times the rate of inflation.[120]

Drugs now rank second after hospitals in terms of share of total health care spending, having overtaken spending on physicians in 1997. The share of total spending going to drugs rose from 9.5 per cent in 1985 to 16.2 per cent in 2002. Spending was expected to hit $21.8 billion, or 16.7 per cent of total health care spending in 2004.[121]

The rapid rise in drug costs is primarily due to the ongoing substitution of newer, more expensive drugs in place of older, less expensive products. The newer drugs, in the majority of cases, have no added benefit. Assessments of new drugs from Canada, France and the USA show that at best one quarter of new drugs offer some additional clinical benefit and likely as few as three per cent are major therapeutic advances.[122]

The multiplicity and fragmentation of Canadian drug plans impedes better management of drug benefits, including decisions on what drugs get funded and the ability to negotiate lower prices. Australia manages to buy drugs at a cost 10 per cent below Canada's by having a single national buyer, and New Zealand achieved 50 per cent savings using coordinated bargaining methods.[123] The move to bulk purchasing in some provinces is a step forward, but a national pharmacare program would achieve far greater savings and would improve the quality of prescribing.[124]

Other factors behind high drug costs include: pharmaceutical companies' influence on research, education and clinical practice[125], aggressive advertising,[126] and patent protections enjoyed by brand-name pharmaceutical companies.[127]

Taking action

The Chaoulli Supreme Court decision is not a licence to privatize Canada's health care system. But pro-privatization interests are trying to stretch the ruling's narrow meaning for their own political purposes. Canadians must press provincial and federal politicians to address the real problems behind waiting lists.

What should provincial governments do in the wake of the Chaoulli decision?

Quebec must use the 12-month suspension granted by the Court to reinforce public insurance and delivery and to shorten waiting lists.

All provinces and territories must:

- halt the spread of private insurance and private for-profit delivery, including private clinics;
- strengthen the regulatory measures that protect public health care, including prohibiting providers from working in both the public and private systems and prohibiting opted-out physicians from charging more privately than they could get from the public sector;
- invest in public continuing care and pharmacare programs to expand and strengthen Medicare;
- speed up progress on primary care reform, including multidisciplinary practice, alternatives to fee-for-service, health promotion, and chronic care programs;
- enable health care providers to use their full range of knowledge and skills and to work collaboratively;
- reinvest in public health care and stop delisting services;
- fix wait list problems with targeted resources and better management;
- report all information pertaining to private clinics and other for-profit health providers to the federal Minister of Health. This includes the number of such facilities, the amount of money spent at them as well as the number of services performed at them.
- adhere to the principles of the Canada Health Act, and direct all federal funds to non-profit health care providers.

What should the federal government do in the wake of Chaoulli?

Health Minister Ujjal Dosanjh must be pressured to address the real problems behind waiting lists. He must properly monitor and enforce the Canada Health Act. This includes taking action against private, for-profit clinics that are undermining the public system and banning public private partnerships (P3s) in health care.

The Minister himself says private clinics hurt the system. He recently told a Vancouver radio station that "when you have a lot of [private clinics] you will have all of the energy and all of the assets and all of the personnel drained from the public system, and the public system would be far worse than it is today."

Dosanjh stated for-profit, private clinics are “absolutely not a panacea” for long wait times, and he admitted they are “not any more efficient or less expensive” than public health services.

It’s good to see that Dosanjh is aware that private clinics hurt the public system. That awareness must translate into action:

- The federal government must attach strings to its health care cash. Federal funds transferred to the provinces must be earmarked exclusively for public delivery of health care services. This will improve public health care while reducing waiting lists and limiting exposure to trade challenges.

- Dramatically improved monitoring, enforcement and reporting on the Canada Health Act are further accountability measures that will benefit public health care. The federal government’s current track record on these fronts is one of inaction.

- As part of stringent CHA enforcement, the federal government must withhold funding to provinces that are violating CHA principles by letting for-profit clinics and other private operators expand.

- The federal government must also look to the future and expand public health care. A key improvement would be the establishment and funding of a national home care program, with funding tied to public delivery and Canada Health Act principles.

- Another much-needed innovation, one that would address the fastest-growing costs in health care, is a national pharmacare program with a national, evidence-based formulary, reference-based pricing, bulk purchasing, and accelerated access to non-patented drugs.

- Finally, the federal government must act in future rounds of trade negotiations to remove health care services, including insurance, administration, cleaning and other support services, from international trade deals.

[1] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 158

[2] See "A Doctor-Lawyer-Gadfly v. Canada's Medical System", *New York Times*, (2005, May 21) p. 4 and "In Blow to Canada's Health System, Quebec Law is Voided", *New York Times*, (2005, June 10) p. 3.

[3] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 96

[4] Factum of Attorney General of Canada and Factum of Attorney General of Quebec (2004).

[5] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 100

[6] Ibid, at para 103.

[7] Ibid, at para 16.

[8] Ibid, at para 112.

[9] Ibid, at para 123.

[10] Ibid, at para 16.

[11] Ibid, at para 55.

[12] Ibid, at paras 111, 137.

[13] Ibid, at para 274.

[14] Ibid, at para 191.

[15] Ibid, at para 251.

[16] Ibid, at para 161. See also para 276, where the judges note: "Shifting the design of the health system to the courts is not a wise choice."

[17] Ibid, at para 164.

[18] Ibid, at para 166.

[19] Ibid, at para 166.

[20] Ibid, at para 176.

[21] Ibid, at para 163. See also para 209.

[22] Ibid, at para 169.

[23] Ibid, at para 217.

[24] Ibid, at para 274.

[25] Chaoulli v. Quebec (Attorney General), ruling on motion made Aug. 4, 2005.

[26] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 230

[27] Ibid, at para 14.

[28] Ibid, at para 66.

[29] Ibid, at para 138.

[30] Lewis, Steven. Medicare's fate: Are we fiddlers or firefighters, written for the *Winnipeg Free Press*. Retrieved August 11, 2005, from http://www.longwoods.com/product.php?productid=17186&page=1

[31] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 213

[32] Ibid, at para 147.

[33] Ibid, at paras 226, 230.

[34] Ibid, at para 243. They further bolster this finding by citing the conclusions of the Romanow report, the Turcotte report and the expert witnesses who testified at the original trial.

[35] Ibid, at para 215. See also Para 252, where Coffey again is singled out as the lone supporter of a two-tier system.

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[37] Chaoulli v. Quebec (Attorney General), [2005] S.C.J. No. 33 at para 225

[38] Ibid, at para 229-230.

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