WHAT THE *CHAOULLI* DECISION SAID ABOUT HEALTH CARE RHETORIC VS. HEALTH CARE REALITY

Stanley Hartt

Was the Supreme Court's decision last June against Quebec's ban on private insurance for medically necessary services another landmark on the way to an American-style system or a wake-up call to government providers? Stanley Hartt writes that the decision was, among other things, a reality check: "We permit our politicians to studiously under-fund while pompously defending the five principles of the *Canada Health Act*," writes Hartt, "provided they repeat often and loudly enough that "Canada will never have a two-tier health care system." With waiting times for public health care undermining the standard of care, Hartt says, we already have a two-tier system: "the lucky and the unlucky!"

Le jugement de la Cour suprême de juin dernier invalidant l'interdiction par le Québec de toute assurance privée pour des services médicaux nous a-t-il rapproché d'un système à l'américaine ou a-t-il plutôt servi d'avertissement aux fournisseurs gouvernementaux ? Selon l'ancien sous-ministre fédéral des Finances Stanley Hart, il aura surtout rappelé certaines réalités : « Nous laissons nos politiciens défendre pompeusement les cinq principes de la Loi canadienne sur la santé tout en les laissant lui consacrer des fonds insuffisants, écrit-il, à condition qu'ils répètent aussi souvent et vigoureusement que possible que le Canada n'aura jamais de système à deux vitesses. » Mais avec des délais d'attente qui contreviennent de fait aux normes en matière de soins, nous avons déjà un système à deux vitesses, « l'un chanceux, l'autre pas ».

Ever since the recent decision of the Supreme Court of Canada in *Jacques Chaoulli et al v. The Attorney General of Quebec et al.* struck down Quebec's ban on private medical insurance, a veritable industry has emerged. Scholars, analysts and commentators are collectively wringing their hands over how such a thing could have happened. This is judicial activism gone mad, they argue. Imagine using the Charter to do away with a national icon, the single payer health insurance system, which everyone knows works best! The truth is that the use of the Charter to fight the nefarious consequences of a much-beloved program is no more inappropriate than the battle for equality rights. The mere fact that medicare has become associated with our very identity as Canadians does not justify the state arrogating to itself the monopoly provider role and then not providing timely care. Canadians quite properly take comfort in the fact that the underlying principles of publicly funded health insurance are designed to ensure that none of us impoverishes our family with the costs of a serious, prolonged, unexpected or final illness. But we have erected that laudable objective into a mantra that borders on the unreasonable, demanding that no one toy with the paradigm, even to improve it. Indeed, purporting to "improve" medicare has joined the list of ideas that are greeted with droll derision, like "trickle-down economics."

Our precious medicare system has become a sort of opiate of the people. We want so much to believe the services will be there for us when we need them, regardless of ability to pay, that we fail to see around us the evidence that, in many unfortunate cases, patients suffer and die because wait times are too long. Our beliefs intrude on the facts and obscure our vision. We don't want to see the hundreds and hundreds of cases where patients spend weeks on gurneys in hospital corridors because no beds are available, and harried resident physicians spend mere seconds with a needy person before being forced to race off to the next urgency. We permit our politicians to studiously under-fund while pompously defending the five

principles of the *Canada Health Act*, provided they repeat often and loudly enough that "Canada will never have a two-tier health care system." The partisans of the status quo attribute all sorts of false intentions to the Supreme Court majority: the Court was not discarding the equity principle that underlies our system of rationing scarce medical and financial resources; it was not asserting a constitutional right to private insurance; and it was not ignoring evidence that the scholars, analysts and commentators trot out in public affairs journals. The Court was simply demanding that the governments of Canada translate rhetoric into practice. The justices comprising the majority in the Supreme Court looked at and listened to all manner of information and evidence that went beyond the individual situations of Dr. Chaoulli and Mr. Zeliotis. The majority considered statistical information about waiting times in Canada and the impact of parallel public and private health care and insurance systems in a wide variety of countries. It drew a constitutional bright line in the sand to guide governments toward a reasonable test of what obligations the Charter imposes on them as monopoly providers of medical services.

None of the sky-is-falling scenarios concerning the consequences that might be in store for the public plan, advanced in hyperbolic earnestness by the respondents' lawyers, justifies the haphazard selection of particular individuals to contribute their bodies for suffering. The social policy dogma that the very existence of the public plan, or at least its quality, would be irreparably damaged if parallel health care services were to be allowed or encouraged, was found by the majority to be insupportable in the face of domestic and international evidence. Canadian provinces are forced by budgetary constraints to restrict the supply of medical services by limiting admissions to medical schools, by capping the fees billed by physicians, by inducing early retirement for doctors and nurses, and by refusing to adopt a rational plan to evaluate the credentials of qualified practitioners from other countries, among many other ways. The argument that private insurance would siphon resources away from the public system, leaving inferior service for those unable to pay for private insurance or private care, is only tenable if there is a fixed supply of medical services, which is patently false except in the very short run.

Absolutely nothing can be more contrary to the principles of fundamental justice than the purely arbitrary and random manner in which actual patients are selected to be the ones whose care is delayed beyond reasonable and medically advisable waiting times. Canada does have a two tier medical care system: the lucky and the unlucky! The catch-22 of a monopoly medical care provider that does not provide timely access to care is an untenable interference by the state with a citizen's rights to life and security of the person guaranteed by section 7 of the Charter. However legitimate the goal of preserving the integrity — financial and structural — of the public health care and insurance plans, this objective must be weighed against the individual patient's right to fight for his or her life. Patients cannot be treated as conscripts, selected arbitrarily and randomly to die or suffer for the greater interest of the state. So the majority of the Court was not the activist bench that its detractors imagine. Far from creating an antithetical, private regime at the expense of the single-payer monopoly, the majority saw themselves as using a Charter remedy to remove an obstacle imposed by the state, but which the state could not justify in the face of evidence of the different private and public schemes successfully co-existing in most OECD countries.

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Some of the handwringers find solace that the judgment, as the Court chose to construct it, only applies in Quebec. This is because three judges found that waiting times extending beyond what is medically reasonable violated the Charter, three others found that they did not, and one determined that these waiting times violated the Quebec Charter but expressed no opinion on section 7 of the Canadian Charter, which is worded somewhat differently than the equivalent provisions of the Quebec Charter. The differences between the charters do not justify a conclusion that waiting times in another province that led to death, suffering, or deterioration of health would be tolerated. The real reason for the elegant choice to organize the decision in the way the judges did was political. A judgment that was more intrusive, imposed by values external to Quebec, would give rise to stronger pressures to invoke the notwithstanding clause of section 33. The same motivation lay behind the Court's decision to grant Quebec a stay of 12 months from June 9, 2005, the date of the judgment. The Court, having accepted the fact that people die on waiting lists in some serious cases, could

appear to be sanctioning a continuation of this state of affairs for another 12 months. Quebec did not request a stay at the hearing; it was requested by the 10 members of the Senate of Canada who intervened and fully argued before the Court without a peep from the attorney general of Quebec.

Again, the explanation seems to lie in the politics of the situation, not subtle juridical distinctions. It may well be moot whether the majority's decision is equally applicable in other provinces because, given the finding of the majority that people are dying on waiting lists, it would be politically impossible for any government to ask the courts to give it the right to uphold the status quo. The only possible argument for an elected attorney general to make in the future would be that wait times have been fixed and are no longer a problem, or that people are not in fact suffering and/or dying in the province.

Before *Chaoulli*, the well-intentioned state could attempt to keep the total cost of delivering medical services to Canadians low by virtue of the insurance principle (the larger the insured group, the lower the cost of insuring each member of the group, the universal group being, by definition, the largest). Budgets could be cut, then partially restored with great flourish (as in the recent Health Accord with the provinces, which held out the prospect of an additional $41 billion over 10 years), but the decision was always political, based on what could be done given the competing claims on government revenues and the need for politicians to keep many other constituencies and lobbies happy.

With *Chaoulli*, governments are subject to what is known in Quebec law as an "obligation of result." Waiting times for medically necessary services cannot surpass the maximum time periods deemed — for each condition, disease or symptom — medically advisable by professional medical opinion generally, as the same may evolve from time to time. There is no ability-to-pay test, no deference to the right of the state to determine the allocation of its limited financial resources, no standard of the greatest good for the greatest number. Social policy engineering has given way, as it should have, to individual rights. If the state chooses to be the exclusive provider of medically necessary health care services, (and no one disputes that the state has the right, but not the obligation, to organize the health care system in this manner), then, if it fails to deliver timely access, it cannot prevent citizens from obtaining access from other sources. The minority, in order to demonstrate how non-judicial the issues raised in *Chaoulli* are (in their eyes), asks questions about the standards to be set for timely care and who is to set them. The minority provides no answer to those individuals who, much as they may agree with the objectives of Quebec's health care legislation, believe they have a justiciable right to object when the parsimony of the state, and its impotence in trying to live up to its overblown pontificating, result in people suffering, deteriorating and dying because of the unavailability of meaningful (i.e., timely) access to health care.

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Jacques Chaoulli, the winner in the landmark Supreme Court decision overturning Quebec's ban on private health insurance. Stanley Hartt writes that the decision was a reality check.

So, how much health care is enough? Enough to ensure that the presumed beneficiaries of the plan suffer and die from their illnesses and not from the unavailability of access to the services purportedly provided by the system. How many MRIs does the Constitution require? Enough to ensure that the diagnostic information MRIs were invented to provide is available to each patient's physician while there is still time to do something about it. Otherwise, the objectives of the legislation are frustrated, and amount to nothing more than speechmaking, and the state loses its right to preserve the monopoly status of its public plan for failure to fund it to a minimal constitutional standard.

In their landmark report entitled *The Health of Canadians — The Federal Role*, the Standing Senate Committee on Social Affairs, Science and Technology developed and explained a concept they called the Health Care guarantee. The Guarantee, summarized in the most simple terms, calls upon governments to make the principle of accessibility in the *Canada Health Act* a fact by ensuring that access is timely. If governments wish to retain the monopoly provider role they have carved out for themselves, for all the good social policy reasons the Supreme Court minority recount, they cannot have it both ways. Each individual must have an explicit promise from his or her provincial plan that medically necessary health services will be delivered in a medically timely manner. The test of what is medically timely (and therefore "reasonable") would be based on the best insights and knowledge that medical science has at its disposal at any given time. It would not be up to the courts to come up with such outer limits for diagnosis or treatment, but to the medical professions themselves.

Even if there is a potential range of responses that competent professionals would offer in a given situation, identifying the consensus standard of practice is not a new concept in law. It arises regularly in professional negligence and malpractice cases. Once the standards were set, governments would have to put their money where their mouths are. In planning the treatment options for patients in facilities within the province, authorities would have to bear the guarantee in mind. If they could not schedule a place and time for care delivery within the vicinity of the patient's residence, they would have to begin planning for alternatives elsewhere within the province, or, if they really dropped the ball due to some confluence of circumstances, outside the province or even outside the country.

The only problem is that we might not be able to afford the guarantee. The revenues and borrowing capacity of Canada, its provinces and territories, might not be sufficient to fund medical and hospital services to the level required. In that case, far from deferring to political decision-making mechanisms as to "how much health care is enough," Canadians should demand that their politicians stand down, blushing as they go, from the undeliverable promises they have been making to us for a generation.

The hoped-for result would be the opposite of the most-feared consequence — budget-busting trips to far-off lands for what might have been available at home in a few more months. The prospect of losing big would motivate the decision-makers not to go there in the first place. Care would in fact be made available to the patient, who would otherwise be forced to travel. Neither the patient nor the patient's family particularly want to go abroad at a time of great stress caused by the vicissitudes of serious illness. Nor does the government want to incur the financial penalty, and so it would behave rationally and pre-empt the big, unaffordable expense of avoidable medical travel by better case and treatment planning. The beauty of the Health Care Guarantee is that it provides a self-regulating remedy to the constitutional dilemma of timely care and section 7. If all patients who benefited from the guarantee were in fact receiving their diagnosis and treatment within the time parameters established from time to time using the best medical advice possible, they would, by definition, be receiving timely care and reasonable access in the constitutional sense. This measure would not avoid all future litigation over medical care, but it would establish a bright line where clear standards benefited everyone, rich and poor alike.

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As if to demonstrate that the theory of establishing a consensus on medically acceptable wait times can be translated into practice, *The Globe and Mail* reported on April 4, 2005, that Canada's doctors, acting through an organization known as the Wait Time Alliance of Canada, had issued the first in a series of standards for a variety of medical conditions: routine hip and knee replacements should be done within nine months (three months for consultation and a further six months for surgery); routine cataract surgery, four months; radiation therapy for cancer patients, ten working days; non-urgent heart by-pass surgery, under six months; CT scans, MRIs and nuclear medicine diagnostic imaging, within seven days.

Canada's health care system is, of course, not a disaster zone. Every day major and minor miracles are performed by skilled, hard-working and dedicated providers. Even as we, as a society, grind down their earning power, these well-trained and highly motivated professionals provide a wonderful product. But the legal issue is whether, at the margins, those individuals the system fails (and there are large numbers of those), who wait for treatment in anxiety and fear and who, sometimes (and "sometimes" is too often) deteriorate when they could have been cured, suffer when their pain could have been alleviated or die when they might have lived, have a constitutional right to complain.

The Supreme Court of Canada has answered "yes" and instead of grousing about it, Canada should get on with fixing its system. The decision about what kind of system — public, private or mixed — we will use to provide plan beneficiaries with the care they need is still up to Canadians, but governments need to look honestly at the resources available to them, and the competing claims on those resources, and come up with a realistic plan for what is in fact achievable. Wishing *Chaoulli* away won't work.

Stanley Hartt was on the legal team representing 10 members of the Senate of Canada who intervened in the case of Chaoulli v. A.G. Quebec. *This article is a precis of a paper Hartt delivered at a University of Toronto law conference in September on "Access to Care, Access to Justice."*