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Canada's Landmark Chaoulli Decision: A Vital Blueprint for Change in the Canadian Health Care System

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CANADA'S LANDMARK *CHAOULLI* DECISION: A VITAL BLUEPRINT FOR CHANGE IN THE CANADIAN HEALTH CARE SYSTEM

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A recent decision by the Supreme Court of Canada (the Court) may have done more to transform Canada's health care system than three major government health studies and an infusion of $41 billion into the system.[1] On June 9, 2005, in *Chaoulli v. Quebec*, the Court invalidated a Quebec law that prohibited residents from buying private health insurance to pay for services already covered under Canada's public health care system.[2] The decision means that the Quebec government can no longer prevent individuals from obtaining private health insurance or force patients to endure unreasonable waiting times for medical services.[3] The highly anticipated decision is the first to critically examine the constitutionality of Canada's public health care system.[4] It is also the first decision to strike down a health care law shown to result in the suffering and deaths of patients.[5] Although the ruling only applies to the province of Quebec, there are growing concerns that it will dramatically alter the entire Canadian health care system.[6]

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1. CBC News Online, Health Care Introduction (2006), http://www.cbc.ca/news/background/healthcare/index.html.
2. CBC News Online, The Ruling: In Reaction (2006), http://www.cbc.ca/news/background/healthcare/ruling_reaction.html.
3. Jacques Chaoulli, M.D., A Victory for Freedom: The Canadian Supreme Court's Ruling on Private Health Care (June 21, 2005), *in* HERITAGE LECTURES, July 22, 2005, at 3, *available at* http://www.heritage.org/Research/HealthCare/hl892.cfm.
4. RON A. SKOLROOD, *Chaoulli v. Quebec (Attorney General)*: The Supreme Court of Canada Sets the Stage for Fundamental Health Care Reform 1 (2005), *available at* http://www.lawsonlundell.com/resources/ChaoullivQuebec-HealthCareReform.pdf.
5. Chaoulli, *supra* note 3, at 3.
6. *See* Peter J. Carver, *Comment on* Chaoulli v. Quebec, LAW & GOVERNANCE, http://www.longwoods.com/product.php?productid=17191&page=1 (last visited Mar. 15, 2006) ("The Court's judgment in *Chaoulli v. Quebec* may not mean the end of medicare, but it seems likely to be the end of medicare as Canadians have known it").

I. CANADA'S PUBLIC HEALTH CARE SYSTEM

Canada's universal public health care system has been a source of national pride for Canadians since its inception.[7] But it has also been subject to harsh criticism.[8] While some say the system is the best in the world,[9] others argue that it hinders Canadians from accessing the medical services they need and deserve.[10] Called Medicare, the system relies on the principle that access to health care should be based on need rather than on ability to pay.[11] Medicare thus provides universal health coverage for all Canadians regardless of wealth or status.[12]

A. THE ORIGIN OF MEDICARE

Before 1961, only 53 percent of Canadians were insured, and health care costs were the primary cause of bankruptcy in the country.[13] This disturbing trend soon led to a call for a universal system of health care.[14] The federal government began taking a more active role in health care legislation,[15] and Medicare was gradually built province-by-province.[16] Saskatchewan was the first Canadian province to introduce a public health insurance plan for hospital services in 1947.[17] In 1957, the federal government introduced the Hospital Insurance and Diagnostic Services Act, which provided federal cash payments to provinces that covered the costs of hospital services.[18] Under this legislation, the federal government and the provincial governments shared health care costs on a roughly equal basis.[19] Each provincial health plan had to be universally available, portable, and publicly administered to receive federal funding.[20] By the early 1960s, all provinces had public insurance plans with universal coverage for at least in-patient hospital care.[21] In 1966, the federal government expanded coverage to include doctor's services outside hospitals, and by 1972, all provinces universally participated in what is

7. BENEDICT IRVINE, SHANNON FERGUSON & BEN CACKETT, BACKGROUND BRIEFING: THE CANADIAN HEALTH CARE SYSTEM, http://www.civitas.org.uk/pdf/Canada.pdf (last visited Mar. 15, 2006).
8. Chaoulli v. Quebec (Attorney General), [2005] S.C.C. 35 ¶ 2 (Can.).
9. IRVINE, FERGUSON & CACKETT, *supra* note 7.
10. CBC News Online, Public vs. Private Health Care: FAQs, http://www.cbc.ca/news/background/healthcare/public_vs_private.html (last visited Mar. 15, 2006).
11. Canadian Health Coalition, Reaction to the Chaoulli Decision (2005), http://www.healthcoalition.ca/chaoulli-response.pdf.
12. IRVINE, FERGUSON & CACKETT, *supra* note 7.
13. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 171.
14. *Id.* ¶ 56.
15. *Id.*
16. KAO-PING CHUA, CANADIAN HEALTHCARE SYSTEM FACT SHEET, http://www.amsa.org/studytours/CHS_FactSheet.pdf (last visited Mar. 15, 2006).
17. CBC News in Review, Health Care and the Social Fabric (2000), http://www.cbc.ca/newsinreview/Oct2000/HEALTH/FABRIC.HTM.
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.*

now Medicare.[22] Soon, however, rising costs for services and low fees to physicians prompted many physicians to opt out of the public system in order to bill patients directly in the private sector, a practice called extra-billing.[23] By the late 1970s, some Canadians had trouble finding providers that were in the public system, and there were calls to outlaw extra-billing practices.[24]

In 1984, in response to these concerns, the federal government introduced the Canada Health Act (the Act).[25] The purpose of the Act "is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[26] The Act denies federal funding to provinces that allow extra-billing by physicians and forbids private physicians from billing beyond certain amounts.[27] The Act also lists five principles of health care: universality, accessibility, comprehensiveness, public administration, and portability,[28] which "have become the hallmarks of Canadian identity."[29] Universality means that every individual receives health care services on uniform terms and conditions.[30] Accessibility calls for equal access to covered hospital and physician services without any barriers.[31] Comprehensiveness requires all medically necessary services provided by hospitals and physicians to be insured.[32] Public administration means that insurance is administered on a non-profit basis.[33] Portability calls for health coverage that is maintained when a resident moves or travels within Canada or travels outside the country.[34] Each province must abide by all five criteria to receive federal grants.[35]

B. FUNDAMENTALS OF MEDICARE

1. Eligibility and Coverage

Under Medicare, every individual is covered, regardless of income, gender, or race.[36] Covered benefits include all necessary hospital and physician services, which comprise approximately 43 percent of total

22. *Id.*
23. IRVINE, FERGUSON & CACKETT, *supra* note 7.
24. *Id.*
25. CBC News in Review, Health Care and the Social Fabric, *supra* note 17.
26. Canada Health Act, R.S.C., ch. C-6, § 3 (1985).
27. IRVINE, FERGUSON & CACKETT, *supra* note 7.
28. Canada Health Act § 7.
29. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 16.
30. Canada Health Act § 10.
31. *Id.* § 12.
32. *Id.* § 9.
33. *Id.* § 8.
34. *Id.* § 11.
35. CBC News in Review, Health Care and the State (2000), http://www.cbc.ca/newsinreview/Oct2000/HEALTH/STATE.HTM.
36. CHUA, CANADIAN HEALTHCARE SYSTEM FACT SHEET, *supra* note 16.

health care expenditures in Canada.[37] Such services include doctors' visits, hospital care, surgery, and drugs while in the hospital, as well as dental care for children and prescription drugs for welfare recipients and seniors.[38] Furthermore, all Canadians have free choice of what physicians and hospitals they use.[39]

2. *Organization and Financing*

Medicare is a single-payer system where the government is the sole financer of health care.[40] It is financed primarily through provincial income taxes, payroll taxes, and sales taxes, and also through federal grants funded by federal income taxes.[41] But contributions by the federal government continue to decline each year, with federal payments comprising only 20 percent of total health care costs in 2002.[42] In addition, although care is free at the point of use, individuals must pay premiums in certain provinces.[43]

Although the government finances Medicare, it interferes minimally with the actual practice of medicine.[44] This system differs from socialized medicine where a government directly owns hospitals and controls their daily operations, and physicians work directly for the government.[45] Each of the ten Canadian provinces regulates its own health care and has its own public health insurance plan.[46] The overall health care program, however, is national because all provinces are governed by the Act.[47] In addition, there is a mixture of public and private delivery,[48] with roughly 75 percent of health care services in Canada delivered privately.[49] Most Canadian physicians are in private practices, and those who participate in Medicare are reimbursed on a fee-for-service basis by provincial governments.[50] But most provincial governments prohibit these physicians from billing patients directly.[51] Furthermore, although physicians are free to

37. Gregory P. Marchildon, *The Chaoulli Case: Two-Tier Magna Carta?*, Law & Governance 1, http://www.longwoods.com/product.php?productid=17190&page=1 (last visited Mar. 15, 2006).
38. Pierre Lemieux, *Socialized Medicine: The Canadian Experience*, THE FREEMAN, *available at* http://www.theadvocates.org/freeman/8903lemi.html (last visited Mar. 15, 2006).
39. IRVINE, FERGUSON & CACKETT, *supra* note 7.
40. CHUA, CANADIAN HEALTHCARE SYSTEM FACT SHEET, *supra* note 16.
41. *Id.*
42. IRVINE, FERGUSON & CACKETT, *supra* note 7.
43. *Id.*
44. KAO-PING CHUA, SINGLE PAYER 101 (2006), http://www.amsa.org/uhc/SinglePayer101.pdf.
45. *Id.*
46. CBC News in Review, Health Care and the State, *supra* note 35.
47. *Id.*
48. CHUA, CANADIAN HEALTHCARE SYSTEM FACT SHEET, *supra* note 16.
49. CBC News Online, Public vs. Private Health Care: FAQs, *supra* note 10.
50. IRVINE, FERGUSON & CACKETT, *supra* note 7.
51. Colleen M. Flood & Tom Archibald, *The Illegality of Private Health Care in Canada*, CAN. MED. ASS'N J., Mar. 20, 2001, at 826, *available at* http://www.cmaj.ca/cgi/reprint/164/6/825.

opt out of Medicare at any time,[52] those who do will not receive government funding and are forbidden to bill more than what they would make under Medicare.[53] This makes opting out of Medicare risky for physicians and keeps the system strong.[54]

3. *Health Insurance*

Although Medicare covers basic medical services, several health care costs are not covered.[55] These expenses include costs for prescription drugs, dental care, vision care, long-term-care facilities, and assistive equipment.[56] In 2004, of the $130 billion dollars that Canada spent on health care, $40 billion was spent on such services.[57] Canadians must pay these costs themselves or obtain a private insurance plan to cover them.[58]

Canada is the only nation other than Cuba and North Korea to prohibit private health insurance for services already provided by the public system.[59] By comparison, most countries with compulsory government insurance, such as the United Kingdom, still allow individuals to purchase private insurance if they elect to do so.[60] Six of the nine Canadian provinces use this measure,[61] which ultimately limits the market for opted-out physicians because only patients who can afford to pay out-of-pocket can use their services.[62]

C. A Need for Change

Critics of Medicare complain "that everything is free but nothing is accessible."[63] Although 80 percent of Canadians claim to be satisfied with their health care access, there are serious problems in the system.[64] Years ago, when the federal government provided approximately one-third of the money spent on health care, lengthy wait times for treatment were not an issue.[65] But in the early 1990s, when the federal government drastically reduced the amount of money given to provinces for health care, complaints about health care access intensified.[66] Today, Canadians endure increasingly longer wait times to see specialists, undergo elective surgery, and obtain diagnostic tests.[67] Others face huge bills for prescrip-

52. *Id.*
53. IRVINE, FERGUSON & CACKETT, *supra* note 7.
54. *Id.*
55. CBC News in Review, Health Care and the State, *supra* note 35.
56. *Id.*
57. CBC News Online, Public vs. Private Health Care: FAQs, *supra* note 10.
58. CBC News in Review, Health Care and the State, *supra* note 35.
59. OpinionJournal.com, Unsocialized Medicine (June 13, 2005), http://www.opinionjournal.com/editorial/feature.html?id=110006813.
60. Lemieux, *supra* note 38.
61. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 77.
62. Flood & Archibald, *supra* note 51, at 828.
63. IRVINE, FERGUSON & CACKETT, *supra* note 7.
64. CBC News Online, Health Care Introduction, *supra* note 1.
65. *Id.*
66. *Id.*
67. *Id.*

tion drugs,[68] and there are fewer doctors, nurses, hospital beds, and hospital equipment than are needed.[69] There is also barely enough money to fund hospitals,[70] with 70 percent of Canadian hospitals operating at a deficit in 2003.[71] These troubles prompted major political candidates in Canada's 2004 national election to finally concede that Medicare is failing[72] and led Prince Edward Island Premier Patt Binns to warn that Canada's "system is not sustainable, the principles of the Canada Health Act are at risk, and health care as we know it will not survive the end of the decade."[73] It finally became clear that too much emphasis had been placed on sustaining the current system rather than on improving it.[74]

At the heart of Medicare reform is a variety of data on waiting times for treatment, as well as three major health studies and a First Ministers Conference.[75]

1. Waiting List Statistics

A waiting list is a list that patients enroll in once they choose to undergo an elective procedure.[76] In Canada, waiting lists do not exist for emergency procedures.[77] In 2003, Statistics Canada found that the median waiting time for Canadians was 4.3 weeks for surgeries, 4.0 weeks to see a specialist, and 3.0 weeks for diagnostic tests.[78] In a 2004 survey, the Fraser Institute found that Canadian patients requiring surgery faced a total average waiting time of 17.7 weeks, from the initial visit to the family doctor through to surgery.[79] The survey also found that the median waiting time for treatment was 8.4 weeks to see a specialist and 9.4 weeks between seeing a specialist and receiving treatment.[80] Overall, 85 percent

68. *Id.*
69. CBC News in Review, Principles, Ideals, and Practicalities (2000), http://www.cbc.ca/newsinreview/Oct2000/HEALTH/IDEALS.HTM.
70. D. Martin Low, Q.C., Lydia Wakulowsky & Geoff Moysa, *Failing on the Fundamentals: The Chaoulli Decision*, LAW & GOVERNANCE 3 (2005), http://www.longwoods.com/product.php?productid=17188&page=1.
71. THE COMMONWEALTH FUND, CANADIAN HOSPITALS AND THE HEALTH CARE SYSTEM: VIEWS OF HOSPITAL EXECUTIVES 2 (2004), http://www.cmwf.org/usr_doc/data_canada_743.pdf.
72. Robert J. Cihak, *The Truth About Canada's Ailing Health-Care System*, THE SEATTLE TIMES, July 13, 2004, *available at* http://seattletimes.nwsource.com/html/opinion/2001977834_cihak13.html.
73. Conrad F. Meier, *Canadian Health Care System Nears Collapse*, HEALTH CARE NEWS, May 1, 2004, *available at* http://www.heartland.org/Article.cfm?artId=14789.
74. Low, Wakulowsky & Moysa, *supra* note 70, at 4.
75. *See, e.g.*, CLAUDIA SANMARTIN ET AL., *Waiting for Medical Services in Canada: Lots of Heat, but Little Light*, CAN. MED. ASS'N J., May 2, 2000, *available at* http://www.cmaj.ca/cgi/content/full/162/9/1305 (evaluating the variability of wait time statistics in Canada); CBC News Online, Studied to Death? (2005), http://www.cbc.ca/news/background/healthcare/studiedtodeath.html (discussing the major Canadian health reports and conferences).
76. KAO-PING CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, http://www.amsa.org/studytours/WaitingTimes_primer.pdf (last visited Mar. 15, 2006).
77. *Id.*
78. *Id.*
79. IRVINE, FERGUSON & CACKETT, *supra* note 7.
80. CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, *supra* note 76.

of median waiting times exceeded clinically reasonable delays.[81] Comparatively, while Americans wait approximately three days for a cranial MRI scan, Canadians wait an average of five months.[82] Studies indicate that it can take six months to have a cataract removed in Canada, and heart surgeons report patients dying while waiting for surgery.[83] For example, a doctor in 1999 described how 192 patients waiting to receive coronary artery bypass surgery died or became too sick to have the surgery before making it to the front of the line.[84] Waiting times would arguably be even longer if Canadians were unable to obtain services in the United States.[85]

Due to a wide variation in quality statistics,[86] the extent and nature of the waiting list problem in Canada is not definitive.[87] The shortage of accurate data is caused by differences in wait time measurements, disparities in reporting methods, variation in how waiting lists are developed and managed, and a lack of government standards on whether and when a patient is placed on a waiting list.[88] In addition, waiting times vary widely by specialty, procedure, province, and region.[89] Overall, while it is clear that waiting lists are a problem for certain elective procedures in Canada, it is not apparent how bad the crisis really is.[90]

2. *The Mazankowski Report*

In August 2000, Alberta Premier Ralph Klein asked Don Mazankowski for recommendations on how to control increasing health care costs.[91] On January 8, 2002, the Mazankowski Report was released and called for increased private funding where insured services would no longer be provided solely by Medicare.[92] Among the forty-four recommendations, the report proposed more limited coverage of Medicare, new sources of revenue, province-wide health care standards, and a requirement that physicians work a percentage of the time in the public system.[93] In addition, the report suggested reduced waiting times with guaranteed access to certain procedures within ninety days of diagnosis.[94] In response to the report, the government of Alberta is waiting to see what actions the federal

81. IRVINE, FERGUSON & CACKETT, *supra* note 7.
82. *Id.*
83. Lemieux, *supra* note 38.
84. Cihak, *supra* note 72.
85. OpinionJournal.com, *supra* note 59.
86. CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, *supra* note 76.
87. TIMOTHY CAULFIELD, *Chaoulli v. Quebec (Attorney General)*: The Supreme Court of Canada Deals a Blow to Publicly Funded Health Care (2005), *available at* http://www.law.uh.edu/healthlaw/perspectives/September2005/(TC)ChaoulliComment.pdf.
88. SANMARTIN ET AL., *supra* note 75, at 1306.
89. CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, *supra* note 76.
90. *Id.*
91. CBC News Online, Studied to Death?, *supra* note 75.
92. *Id.*
93. *Id.*
94. *Id.*

government takes before making significant changes.[95]

3. *The Kirby Report*

The Standing Senate Committee on Social Affairs, Science, and Technology studied the Canadian health care system for two years.[96] The final report, named the Kirby Report after Senator Michael Kirby, was released on October 25, 2002.[97] A key component of the report was a tax that would raise $5 billion a year to expand hospitals, buy new equipment, and recruit doctors and nurses.[98] In addition, the report called for a Care Guarantee to establish maximum waiting times for each medical procedure.[99] Under this system, if patients waited longer than the guaranteed time, provincial governments would be required to provide those services through other means,[100] such as by paying for out-of-province or out-of-country treatment.[101] While the report encouraged the preservation of Medicare, Senator Kirby warned that if the recommendations were not adopted, a very convincing case could be made that private health insurance is necessary.[102] He suggested that "a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled countries to achieve broader coverage for all their citizens."[103] As of yet, the key recommendations of the Kirby Report have not been adopted at the federal level.[104]

4. *The Romanow Report*

Roy Romanow was appointed in April 2001 to head the Commission on the Future of Health Care in Canada (the Commission).[105] The Commission's task was to make recommendations on how to preserve Medicare in Canada.[106] The Romanow Report was released eighteen months later and contained forty-seven recommendations.[107] Among the key proposals was an increase in federal contributions, stable funding where the governments provide at least a minimum amount of money each year, greater governmental accountability to show how the money is being

95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.*
99. Antonia Maioni & Christopher Manfredi, *When the Charter Trumps Health Care-A Collision of Canadian Icons*, POLICY OPTIONS DOSSIER, Sept. 2005, at 54, *available at* http://www.irpp.org/po/archive/sep05/maioni.pdf.
100. *Id.*
101. CBC News Online, Waiting for Access (2004), http://www.cbc.ca/news/background/healthcare/waiting.html.
102. CBC News Online, Studied to Death?, *supra* note 75.
103. Low, Wakulowsky & Moysa, *supra* note 70, at 4.
104. CBC News Online, Studied to Death?, *supra* note 75.
105. *Id.*
106. *Id.*
107. *Id.*

spent, and the implementation of national drug and home care plans.[108] The Commission observed that "[l]ong waiting times are the main, and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public health care system."[109] The report suggested that provincial governments take immediate action to manage wait lists by standardizing criteria and providing clear information to patients.[110] But the report also insisted that Canadian governments maintain equality of access to all citizens and preserve the integrity of Medicare by limiting the private sector.[111] In the Commission's view, while a private health insurance option might improve waiting times for the few who could afford it, it would make the situation worse for Medicare patients because necessary resources would be diverted to the private sector.[112]

5. *The First Ministers Conference*

In September 2004, in response to the growing concerns about health care and waiting times surrounding the Romanow Report, Prime Minister Martin convened a First Ministers Conference.[113] In a "10-Year Plan to Strengthen Health Care,"[114] the ministers agreed to develop a National Wait Times Strategy for the areas of cancer care, cardiac treatment, diagnostic tests, joint replacements, and cataract surgeries.[115] A set of national wait time benchmarks were to be set by December 31, 2005, and all provinces agreed to meet the benchmarks by December 31, 2007.[116] In addition, the ministers agreed on a $41 billion infusion into Medicare over ten years.[117] While helpful, the additional financing will not necessarily solve the problems in Canada's system.[118] As Canadian Medical Association President Dr. Albert Schumacher remarked, "the increase has 'just kept us from bleeding to death.'"[119]

D. THE HEALTH POLICY DEBATE

The debate over a single-tier system like Medicare versus a two-tiered system where a private and public sector coexist has gained momentum in

108. *Id.*
109. CBC News Online, Waiting for Access, *supra* note 101.
110. *Id.*
111. CBC News Online, Studied to Death?, *supra* note 75.
112. CAULFIELD, *supra* note 87.
113. CBC News Online, Health Care Introduction, *supra* note 1.
114. SUSAN MUNROE, MEDICAL ALLIANCE URGES SPEED IN REDUCING HEALTH CARE WAIT TIMES, http://canadaonline.about.com/od/healthcarecanada/a/waittimes.htm?terms=can+wait (last visited Mar. 15, 2006).
115. CBC News Online, Health Care Introduction, *supra* note 1.
116. WAIT TIME ALLIANCE FOR TIMELY ACCESS TO HEALTH CARE, FINAL REPORT: IT'S ABOUT TIME! 11 (2005), *available at* http://www.eyesite.ca/english/press/WTA/wait-times_e.pdf.
117. CBC News Online, Health Care Introduction, *supra* note 1.
118. Low, Wakulowsky & Moysa, *supra* note 70, at 3-4.
119. *Id.*

Canada in recent years.[120] This debate is an ongoing search for the best use of resources to provide Canadians with timely access to care.[121]

1. *The Case for Medicare*

Proponents of Medicare believe that health is a human right.[122] They argue that access should be based on need alone[123] and that it is immoral for some individuals to use money to purchase better health care than others.[124] In their view, it is better that everyone receive less as long as it is equal.[125] A majority of Canadians subscribe to this view, as evidenced by the fact that, in Quebec, 62 percent of the population want doctor's visits to be free, and 82 percent think people should pay nothing for hospital care.[126]

Supporters of Medicare refer to evidence that countries with two-tiered hospital systems have longer waiting lists in the public system than countries with a single-payer system.[127] For example, a 1997 study found that patients waited almost three times longer for cataract surgery if their physicians worked in both the public and private sectors.[128] England and New Zealand, both with two-tiered hospital systems, have longer waiting times in the public system than countries with single-payer systems.[129] Proponents of a single-tier system argue that profit motive in a two-tiered system will attract doctors and resources away from the public system, leaving those who cannot afford private insurance with inferior care and longer wait times.[130] Additionally, doctors practicing in both systems have financial incentive to boost their private practices by keeping public waiting lists long,[131] and private facilities have a tendency to pick healthier and younger patients, leaving the more expensive patients to the public system.[132]

Those who support Medicare argue that the long waiting lists are not the result of a fundamental flaw in the system but are instead caused by

120. THE COLLEGE OF FAMILY PHYSICIANS OF CANADA, ISSUES NOTE: PRIVATE-PUBLIC HEALTH CARE DEBATE IN CANADA 2, http://www.cfpc.ca/local/files/Communications/Health%20Policy/Private_public_debate19Aug05.pdf (last visited Mar. 15, 2006).
121. *Id.*
122. Canadian Health Coalition, Chaoulli v. Quebec Action Alert 1 (2005), http://www.healthcoalition.ca/chaoulli-action2.pdfActionAlert.
123. Marchildon, *supra* note 37, at 2.
124. Lemieux, *supra* note 38.
125. *Id.*
126. *Id.*
127. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS 9 (2005), *available at* http://cupe.ca/updir/rev_CONSOLIDATED.pdf.
128. *Id.*
129. *Id.* at 12.
130. Low, Wakulowsky & Moysa, *supra* note 70, at 4.
131. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 8.
132. *Id.*

large reductions in federal health care funding.[133] They insist that the problems can be fixed by increasing funding, not by establishing a two-tiered health system.[134] They recommend increased capital investment in physical plants, equipment, and human resources[135] and note that Britain's public wait times were decreased by increasing public funding and medical staff.[136]

Proponents of Medicare also claim that private facilities deliver a lower standard of care[137] and undermine the education of health care practitioners.[138] There is evidence to suggest that private nursing homes are more frequently cited for deficiencies in quality and that private hospitals have higher death rates.[139] Additionally, because public hospitals are used to train health professionals, the private sector potentially harms training practices by drawing experienced staff away from the public system.[140]

Supporters of Medicare also insist that single-payer systems dramatically reduce administrative costs, freeing up more money to be used for health care services.[141] As evidence that administration costs increase with privatization, they note that administrative costs in the United States are over 31 percent of total health care spending compared to only 16.7 percent in Canada.[142] Canada is heralded as "one of the most efficient [countries] in terms of the ratio of productivity to administrative costs in the world."[143]

Supporters of Medicare refer to the current system in the United States, the largest and most expensive two-tiered health system in the world, as an example of what happens when a parallel system exists.[144] Health care in the United States is more expensive and commercial than in any other country.[145] Roughly 14 percent of the population, 40 million

133. CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, *supra* note 76.
134. *Id.*
135. PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, STATEMENT ON THE CANADIAN SUPREME COURT DECISION ON PRIVATE INSURANCE 1, http://www.healthcoalition.ca/chapnhp.pdf (last visited Mar. 15, 2006).
136. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 12.
137. *Id.* at 10.
138. *Id.* at 11.
139. *Id.* at 10.
140. *Id.* at 11.
141. CHUA, SINGLE PAYER 101, *supra* note 44.
142. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 9.
143. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 252.
144. ONTARIO HEALTH COALITION, URGENT UPDATE: THE SUPREME COURT RULING ON PRIVATE HEALTH CARE 3, http://www.healthcoalition.ca/chaohc.pdf (last visited Mar. 15, 2006).
145. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 10.

people, are uninsured,[146] and many of the uninsured are minorities.[147] Unpaid medical bills in the United States cause 200,000 bankruptcies a year.[148] In 2004, more than 50 percent of all personal bankruptcies were due to health care expenses,[149] and at least 18,000 Americans die each year because of inadequate health coverage.[150] Additionally, although the United States spends a significantly higher percentage of its GDP on health care than Canada, overall coverage is much less in the United States, and health outcomes are worse.[151] To avoid a system like the United States, many Canadians remain committed to keeping Medicare strong.[152]

2. *The Case for a Two-Tiered System*

Critics of Medicare believe that Canada's restrictions on private health care are causing problems with access, choice, and quality in health care services.[153] They argue that Canada, out of all countries with universal access, spends most on health care while ranking among the lowest in access to physicians, quality of medical equipment, and overall health outcomes.[154] Opponents view the long waiting lists as a fundamental flaw in Medicare and claim that waiting lists would be shortened under a two-tiered system.[155] They also insist that individuals who can afford private health insurance and services should be permitted to purchase them to avoid unreasonable delays.[156] In a 2005 survey, 49 percent of Canadians supported a private insurance option, and a majority of Canadians believed that permitting private insurance would improve waiting times, overall access, and quality of care.[157]

Opponents also argue that Medicare is unreasonably expensive.[158] For example, in Quebec, public health expenditures amount to 29 percent of the entire budget.[159] It costs $1,200 per year in taxes for each Quebec citizen to access Medicare, which is more expensive than most private

146. *Id.*
147. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 175.
148. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 10.
149. Roy Romanow, *Now's the Time to Stand Up for Medicare*, LAW & GOVERNANCE (2005), http://www.longwoods.com/product.php?productid=17187&page=1.
150. PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, *supra* note 135, at 2.
151. Romanow, *supra* note 149.
152. *See, e.g.*, Canadian Health Coalition, Chaoulli v. Quebec Action Alert, *supra* note 122, at 1 ("The way you avoid all of the problems of a two-tier system, which we see in the United States . . . is to make sure your public health-care system is very, very strong. . . .Health care should not be based on your pocketbook, it should be based on need").
153. Flood & Archibald, *supra* note 51, at 825.
154. Cihak, *supra* note 72.
155. CHUA, WAITING LISTS IN CANADA: REALITY OR HYPE?, *supra* note 76.
156. CBC News Online, Public vs. Private Health Care: FAQs, *supra* note 10.
157. IRVINE, FERGUSON & CACKETT, *supra* note 7.
158. Lemieux, *supra* note 38.
159. *Id.*

health insurance plans.[160] As health costs continue to rise, government expenditures cannot keep up.[161] As a result, hospital equipment is often outdated, and the number of hospital beds continues to decline.[162] Governments also must put caps on professional fees, prompting physicians to spend less time with their patients and take more time off.[163]

In addition, critics of Medicare note that since the system primarily covers hospital and physician care, fewer health costs each year are covered by Medicare, leaving Canadians to pay more of the costs themselves.[164] Covered services now comprise less than half of total health care expenditure in Canada, with care now being more focused on prescription drugs and community care not covered by Medicare.[165] Spending on prescription drugs is rising faster than anything in Canada's health budget and is now the second most important component of health care spending in the country,[166] with the amount Canadians spend on prescription drugs rising between 7 and 8 percent each year.[167]

II. THE LANDMARK CASE: *CHAOULLI V. QUEBEC*

The Quebec government, like several other Canadian provinces, prohibited citizens from obtaining private health insurance for services already covered under Medicare.[168] Significant delays in treatment in Quebec's public system were a problem, and patients were forced to wait long periods of time to receive certain medical services.[169] But because of the restrictions on private health insurance, these patients could not bypass the delays by seeking treatment privately.[170] They were required to wait for treatment in the public system because it was their only option.[171]

A. CASE BACKGROUND

The controversy in *Chaoulli v. Quebec* was not whether citizens have a constitutional right to private health insurance[172] or whether a single-

160. *Id.*
161. *Id.*
162. *Id.*
163. *Id.*
164. IRVINE, FERGUSON & CACKETT, *supra* note 7.
165. *Id.*
166. CBC News Online, Price of Care (2004), http://www.cbc.ca/news/background/healthcare/priceofcare.html.
167. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 19.
168. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 1.
169. JAY MAKARENKO, THE CHARTER & PUBLIC HEALTH CARE IN CANADA, http://www.mapleleafweb.com/features/medicare/charter-heath-care/index.html (last visited Mar. 15, 2006).
170. *Id.*
171. *Id.*
172. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 14.

tiered system is preferable to a two-tiered system.[173] Nor was the issue whether governments can implement universal health care programs, as all parties to the litigation agreed that only the government can provide "the social safety net consisting of universal and accessible health care."[174] Instead, with the concern of long wait times growing nationwide, the case was ultimately about the overall condition of Medicare and whether governments may prohibit access to private health care when many patients are forced to wait for treatment in the public system.[175]

1. The Parties

In 1994, 61-year-old appellant George Zeliotis began having hip problems.[176] He had a left hip operation in 1995 but had to wait nearly a year before he could have surgery on his right hip.[177] During his wait, Mr. Zeliotis looked into having his surgery performed at a private medical facility to receive treatment more quickly, and he also inquired about purchasing private health insurance to cover the costs of the surgery.[178] But he soon discovered that obtaining surgery at a private facility and purchasing private health insurance were both prohibited by Quebec laws.[179] His only other option was paying out-of-pocket for surgery in the United States, which was beyond his financial means.[180] Out of options, Mr. Zeliotis pleaded his case to administrators, politicians, and the media, but to no avail.[181]

Appellant Jacques Chaoulli was a Quebec physician who made various attempts to set up a private, home-based practice for doctors making house calls.[182] But the regional board refused to recognize his practice in 1996, even after intense lobbying and a hunger strike to draw attention to the situation.[183] Dr. Chaoulli then decided to opt out of Medicare but soon discovered that few patients were willing to pay for medical services without insurance, and opted-out physicians were barred from treating patients in publicly funded hospitals.[184] Although Dr. Chaoulli was not Mr. Zeliotis' physician while he was waiting for surgery, the two parties joined forces as plaintiffs in 1997 for their legal challenge against the government of Quebec.[185]

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173. *Id.* ¶ 108.
174. *Id.* ¶ 2.
175. MAKARENKO, *supra* note 169.
176. Maioni & Manfredi, *supra* note 99, at 53.
177. *Id.*
178. MAKARENKO, *supra* note 169.
179. *Id.*
180. Low, Wakulowsky & Moysa, *supra* note 70, at 1.
181. Maioni & Manfredi, *supra* note 99, at 53.
182. *Id.*
183. *Id.*
184. *Id.*
185. *Id.*

2. *The Challenged Provisions*

When the case began in 1997, the two main pieces of legislation governing health care in Quebec were the Hospital Insurance Act (HOIA) and the Health Insurance Act (HEIA).[186] The general purpose of the statutes was to promote high quality health care for all citizens regardless of income,[187] and they provided that the government was responsible for funding and providing these health care services.[188] Mr. Zeliotis and Dr. Chaoulli challenged two provisions in the acts that placed restrictions on private health insurance and services in Quebec.[189]

The HOIA established access to hospital services and regulated hospitals in Quebec.[190] The purpose of the HOIA was to ensure free hospital care to residents upon uniform terms and conditions.[191] Mr. Zeliotis and Dr. Chaoulli challenged section 11 of the HOIA, which stated that "[n]o one shall make or renew, or make a payment under a contract under which a resident is to be provided with . . . any hospital service that is one of the insured services."[192] This provision prohibited private insurance only for basic medical services already covered by Medicare.[193] Even under the act, patients were free to purchase private insurance for all other health services.[194]

The HEIA regulated health care insurance in Quebec[195] and ensured access to necessary medical services for all Quebec residents.[196] Mr. Zeliotis and Dr. Chaoulli challenged section 15 of the HEIA, which stated that "[n]o person shall make . . . a contract of insurance under which an insured service is furnished."[197] Like the HOIA, this provision prohibited private insurance for services covered by Medicare.[198] It also prohibited opted-out physicians from billing more than what they would receive under Medicare.[199]

3. *The Constitutional Guidelines*

Although the Quebec legislature is responsible for deciding what health care system is best for residents, this decision is subject to constitutional limitations.[200] Courts review the constitutionality of laws passed by the government of Quebec against both the Canadian Charter of

186. MAKARENKO, *supra* note 169.
187. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 49.
188. *Id.* ¶ 52.
189. MAKARENKO, *supra* note 169.
190. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 19.
191. *Id.* ¶ 52.
192. *Id.* ¶ 3.
193. MAKARENKO, *supra* note 169.
194. *Id.*
195. *Id.*
196. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 19.
197. *Id.* ¶ 3.
198. *Id.*
199. *Id.* ¶ 52.
200. *Id.* ¶ 107.

Rights and Freedoms (the Canadian Charter) and the Quebec Charter of Human Rights and Freedoms (the Quebec Charter).[201] The Canadian Charter is part of the Canadian Constitution and applies to all governments and people in Canada.[202] Meanwhile, the Quebec Charter was passed by Quebec's National Assembly and only applies to the province of Quebec.[203]

a. The Canadian Charter

During the 1990s, it became increasingly common for courts to use the Canadian Charter in decisions regarding health care policy.[204] Section 7 of the Canadian Charter reads, "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[205] Thus, there is a two-step analysis under section 7 where the claimant has a dual burden of proof.[206] First, a claimant must prove that there was a violation of the right to life, liberty, or security of the person.[207] Second, the claimant must prove that the violation was not in accordance with the principles of fundamental justice.[208] In general, principles of fundamental justice are traditional rules that Canadian society is built upon.[209] They are principles that can be precisely identified and that are generally accepted among reasonable people.[210] Courts have previously recognized the respect for human dignity, the right to be presumed innocent until proven guilty, the right to a fair and impartial trial, and fair punishment as examples of principles of fundamental justice.[211] Generally, to be in accordance with principles of fundamental justice, a government must not act arbitrarily or without good cause.[212] Legislation is arbitrary where it lacks a factual connection to the objective underlying the legislation.[213]

If a claimant can prove deprivation of rights under section 7, the government then has the burden of proof to show that the violation is justified under section 1 of the Canadian Charter.[214] Section 1 reads, "[t]he Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law

201. *Id.* ¶ 26.
202. MAKARENKO, *supra* note 169.
203. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 25.
204. Maioni & Manfredi, *supra* note 99, at 52.
205. Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11, §7 (U.K.).
206. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 29.
207. *Id.*
208. *Id.*
209. MAKARENKO, *supra* note 169.
210. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 127.
211. MAKARENKO, *supra* note 169.
212. *Id.*
213. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 134.
214. *Id.* ¶ 29.

as can be demonstrably justified in a free and democratic society."[215] In order for a law to be justified under section 1, the government must show that the goal of the law is pressing and substantial and also that the law is reasonable in that: (1) there is a rational connection between the law and the legislative objective; (2) the law impairs the guaranteed right only minimally; and (3) the effect of the law is proportionate to its objective.[216]

b. The Quebec Charter

The sweeping purpose of the Quebec Charter is to guarantee respect for human beings.[217] Under section 1 of the Quebec Charter, all human beings are guaranteed the "right to life, and to personal security, inviolability and freedom."[218] Under this provision, there is no reference to principles of fundamental justice as in the Canadian Charter.[219] Thus, there is not a dual burden of proof on the claimant as there is under section 7 of the Canadian Charter.[220] Under section 1 of the Quebec Charter, a claimant must only prove a violation of one of the enumerated rights.[221] Therefore, the Quebec Charter has a scope that is potentially broader than the Canadian Charter.[222]

Even if a section 1 right has been violated, the government can still show that the violation is justified under section 9.1 of the Quebec Charter.[223] Section 9.1 is similar to section 1 of the Canadian Charter.[224] It reads, "[i]n exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Quebec."[225] The test to be applied under section 9.1 of the Quebec Charter is similar to the test under section 1 of the Canadian Charter;[226] that is, in order for legislation to be justified, it must be neither irrational nor arbitrary, and the means chosen must be proportionate to the intended result.[227]

4. The Claims

The appellants in *Chaoulli* contended that the Quebec government's prohibition on private insurance deprived patients of expedient access to health care by forcing them to wait for treatment in the public system.[228]

215. Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11, §1 (U.K.).
216. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 48.
217. *Id.* ¶ 25.
218. Quebec Charter of Human Rights and Freedoms, R.S.Q., ch. C-12, § 1 (2004).
219. SKOLROOD, *supra* note 4, at 6.
220. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 30.
221. *Id.*
222. *Id.*
223. *Id.* ¶ 47.
224. SKOLROOD, *supra* note 4, at 6.
225. Quebec Charter of Human Rights and Freedoms §9.1.
226. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 47.
227. *Id.*
228. *Id.* ¶ 2.

They claimed these waiting lists violated the rights to life and to personal security, inviolability, and freedom under section 1 of the Quebec Charter and section 7 of the Canadian Charter and were therefore unconstitutional.[229] In their view, delays in treatment resulted in a higher chance that a patient's illness could become fatal, and this risk of death was a violation of the patient's right to life.[230] They also argued that delays in treatment caused patients to experience great psychological suffering, which infringed on the security of a person to be free from physical, mental, or psychological harm.[231] Lastly, according to the appellants, the Quebec government's limitation on private health insurance was arbitrary and therefore not in accordance with the principles of fundamental justice.[232]

The government of Quebec argued that a parallel private system would divert resources away from the public sector and consequently harm the quality of public care.[233] It claimed that the prohibition did not violate the principles of fundamental justice because the protection of Medicare was an important government objective that could only be achieved by limiting access to private health care.[234]

5. Previous Litigation

a. Superior Court of Quebec

Mr. Zeliotis and Dr. Chaoulli brought the first action in the Superior Court of Quebec in 1997,[235] and the ruling was delivered in 2000.[236] Justice Piche found that the Canadian Charter section 7 rights of life, liberty, and security of the person included the right to adequate health care[237] but also noted that there was no right to determine the source of that care.[238] She recognized that waiting lists were long[239] and agreed that these lists constituted a violation of an individual's right to receive adequate health care.[240] But she found that limitations on private insurance, while impeding some individual rights, were legitimate means of protecting the combined rights of the rest of Canadian citizens.[241] Justice Piche observed that the evidence did not conclusively prove that a private health care system would solve the waiting list problems.[242] She found that the purpose of "the prohibition was to ensure equality in Quebec's

229. *Id.* ¶ 5.
230. MAKARENKO, *supra* note 169.
231. *Id.*
232. *Id.*
233. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 135.
234. MAKARENKO, *supra* note 169.
235. *Id.*
236. Low, Wakulowsky & Moysa, *supra* note 70, at 1.
237. MAKARENKO, *supra* note 169.
238. Maioni & Manfredi, *supra* note 99, at 53.
239. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 7.
240. MAKARENKO, *supra* note 169.
241. Maioni & Manfredi, *supra* note 99, at 53.
242. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 7.

public health care system by discouraging the development of a parallel private health care system."[243] In her view, the establishment of a private system would threaten the integrity of Medicare, and a limitation on access to private care was necessary to protect the current system.[244] She therefore found the prohibition to be in accordance with the principles of fundamental justice and constitutional under the Canadian Charter.[245]

b. Quebec Court of Appeal

Mr. Zeliotis and Dr. Chaoulli next appealed to the Quebec Court of Appeal, but it upheld the Superior Court decision and dismissed the appeal in 2002.[246] Unlike the Superior Court, the Court of Appeal found that section 7 of the Canadian Charter was not relevant to the case because the right to health care is an economic right and not fundamental to an individual's life.[247] It observed that wait lists did not pose "a real, imminent or foreseeable deprivation" of rights.[248] It also upheld the Superior Court's conclusion that even if there had been a violation of section 7 rights, the violation would have been constitutional because the limitations were necessary to restrict the development of a parallel private system.[249]

B. THE COURT'S DECISION

Following the decision by the Court of Appeal, Mr. Zeliotis and Dr. Chaoulli appealed to the Court[250] for a one-day hearing on June 8, 2004.[251] By the time the appeal was granted in May 2003, additional parties had joined the lawsuit.[252] Organizations and businesses with a direct economic stake in the decision sided with the appellants.[253] Five other provinces, Ontario, Manitoba, British Columbia, New Brunswick, and Saskatchewan, as well as high-profile interest groups, sided with the government of Quebec.[254] The central issue on appeal was "whether the prohibition [wa]s justified by the need to preserve the integrity of the public system."[255] In a surprising decision, the Court overturned the decisions of the two lower courts.[256] The decision was highly divided, with four of the seven justices siding with the appellants and the other three

243. Low, Wakulowsky & Moysa, *supra* note 70, at 1.
244. MAKARENKO, *supra* note 169.
245. *Id.*
246. Low, Wakulowsky & Moysa, *supra* note 70, at 1.
247. *Id.*
248. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 11.
249. MAKARENKO, *supra* note 169.
250. *Id.*
251. JOHN J. MORRIS ET AL., CANADA: THE IMPACT OF THE SUPREME COURT OF CANADA'S DECISION IN CHAOULLI V. QUEBEC (ATTORNEY GENERAL) (2005), http://www.mondaq.com/i_article.asp_Q_articleid_E_34952.
252. Maioni & Manfredi, *supra* note 99, at 54.
253. *Id.*
254. *Id.*
255. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 14.
256. MAKARENKO, *supra* note 169.

justices dissenting.[257] The Court found that Quebec's ban on private health insurance for services already covered under Medicare violated the Quebec Charter and was therefore unconstitutional.[258] Despite the varying opinions, there was one common idea shared by every justice hearing the case.[259] They all agreed that rights are violated when suffering patients are required to endure long delays while waiting for medical treatment.[260] This suffering encompasses not only death and physical harm but also mental stress and anguish as well.[261]

1. The Majority Opinion

In her majority opinion, Justice Deschamps found the prohibition to be unconstitutional under section 1 of the Quebec Charter.[262] She observed that waiting lists caused delays in treatment and that these delays increased a patient's risks of mortality, pain, suffering, and irreparable injury.[263] She concluded that these risks violated the rights to life and personal inviolability under section 1 of the Quebec Charter.[264]

Justice Deschamps then concluded that the violation of section 1 rights was not justified under section 9.1 of the Quebec Charter.[265] Although she agreed that the purpose of the ban was legitimate and that the prohibition was rationally related to its objective, she found that it more than minimally impaired individuals and was therefore unconstitutional.[266] First, she found that the government of Quebec failed to meet its burden of proof under section 9.1 because there was insufficient evidence to show that a parallel private health care system would harm Medicare.[267] Second, after reviewing health care plans in other Canadian provinces and western democracies, she observed that there were a variety of other measures available to protect the integrity of Medicare aside from a ban on private insurance.[268] Lastly, she disagreed that the court should defer to the legislature on matters of social policy.[269] She commented that "[t]he courts have a duty to rise above political debate. They leave it to the legislatures to develop social policy. But when such social policies infringe rights that are protected by the charters, the courts cannot shy away from considering them."[270]

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257. MORRIS ET AL., *supra* note 251.
258. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 2.
259. Low, Wakulowsky & Moysa, *supra* note 70, at 1.
260. *Id.*
261. *Id.*
262. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 15.
263. MAKARENKO, *supra* note 169.
264. *Id.*
265. *Id.*
266. SKOLROOD, *supra* note 4, at 6.
267. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 68.
268. SKOLROOD, *supra* note 4, at 7.
269. *Id.*
270. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 89.

Because Justice Deschamps found the prohibition to be unconstitutional under the Quebec Charter, she declined to assess the issue under the Canadian Charter.[271] The three justices in the concurring opinion also found the prohibition to be unconstitutional under the Quebec Charter, so the decision only impacts the province of Quebec, rather than all of Canada.[272]

2. *The Concurring Opinion*

In their concurring opinion, Justices McLachlin, Major, and Bastarache agreed with Justice Deschamps that Quebec's limitation on private health insurance violated section 1 of the Quebec Charter.[273] But they concluded that the prohibition also violated the rights of life and security of the person under section 7 of the Canadian Charter.[274] The justices emphasized that the Canadian Charter does not include a constitutional right to health care.[275] But they found that the prohibition created "a virtual monopoly for the public health scheme" that resulted in impermissible delays in treatment.[276] They observed that the problem of waiting lists was significant and severe[277] and noted that, "[a]ccess to a waiting list is not access to health care. . . . [T]here is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care."[278] The justices found that delays in treatment resulting from these waiting lists caused significant anxiety and depression in patients[279] and that such physical and psychological suffering violated the right to security of the person under section 7.[280] In cases where the patient was at risk of dying, they found that delays in treatment also violated the section 7 right to life.[281]

The justices then concluded that the insurance prohibition was contrary to the principles of fundamental justice because it was arbitrary.[282] They were not persuaded that allowing private health care insurance would have a detrimental impact on Medicare.[283] In fact, the justices emphasized that the existence of a parallel private system would serve to strengthen Medicare rather than undermine it.[284] Because they could find no evidence that the prohibition of private insurance was necessary to maintain the integrity of Medicare, they found the prohibition to be

271. *Id.* ¶ 15.
272. MAKARENKO, *supra* note 169.
273. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 102.
274. *Id.*
275. *Id.* ¶ 104.
276. *Id.* ¶ 106.
277. SKOLROOD, *supra* note 4, at 2.
278. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 123.
279. *Id.* ¶ 117.
280. MAKARENKO, *supra* note 169.
281. *Id.*
282. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 128.
283. MORRIS ET AL., *supra* note 251.
284. SKOLROOD, *supra* note 4, at 3.

arbitrary and in direct violation of section 7 of the Canadian Charter.[285]

Finally, the three justices evaluated the prohibition under section 1 of the Canadian Charter, where they concluded that it was not justified.[286] They agreed that the maintenance of a strong public system was a legitimate goal.[287] But in assessing proportionality, they found that the prohibition failed to meet two requirements of the three-prong test.[288] First, they found no rational connection between the prohibition of private insurance and the goal of protecting Medicare.[289] Second, they concluded that the ban impaired the rights of individuals more than minimally.[290] Because the prohibition could not ultimately be justified under section 1, the justices concluded that it must be struck down as unconstitutional.[291]

3. *The Dissenting Opinion*

Justices Binnie, LeBel, and Fish dissented and concluded that the prohibition did not violate either the Canadian Charter or the Quebec Charter.[292] The justices agreed that, in some circumstances, a ban on private insurance could violate the rights to life and security of the person under the Canadian Charter because it could put patients at risk of suffering and death.[293] But in their view, the issue should not be resolved by constitutional law.[294] They emphasized that the implementation of a two-tier health care system would be contrary to the policy adopted by both the Quebec legislature and the federal government, and would be an extreme, unwarranted shift in Canadian health policy.[295] The justices emphasized that it is not the role of courts to settle the health care debate and that the determination of private versus public health care is a social policy issue that should be resolved by legislatures rather than by judges.[296] They noted that legislatures "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."[297]

Furthermore, the justices concluded that the prohibition was in accordance with the principles of fundamental justice because it was not arbitrary.[298] They determined that the goal of the Quebec legislature was to promote high quality health care for as many people as possible, regardless of status or wealth.[299] In their view, the prohibition on private insur-

285. *Id.*
286. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 154.
287. *Id.* ¶ 155.
288. SKOLROOD, *supra* note 4, at 3.
289. *Id.*
290. *Id.*
291. *Id.*
292. MAKARENKO, *supra* note 169.
293. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 191.
294. *Id.*
295. *Id.* ¶ 176.
296. Low, Wakulowsky & Moysa, *supra* note 70, at 2.
297. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 176.
298. MAKARENKO, *supra* note 169.
299. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 236.

ance was rationally related to and consistent with that objective.[300] They found that expansion of the private sector would ultimately harm Medicare[301] and concluded that prohibiting private health insurance would deter such expansion, thereby protecting the integrity of Medicare.[302] Ultimately, according to the justices, because the prohibition was in accordance with the principles of fundamental justice, it was constitutional under the Canadian Charter.[303] The justices used similar reasoning to declare the laws constitutional under the Quebec Charter as well.[304]

C. THE EVIDENCE FACTOR

The difference in the conclusions reached by the majority and dissenting justices hinged primarily on interpretation and use of evidence.[305] The majority justices discounted a large portion of the expert testimony accepted by the trial court, choosing instead to study health systems of other Canadian provinces and western democracies.[306] Meanwhile, the dissenting justices deferred to the trial court's interpretation of the evidence and government health reports.[307]

1. Expert Testimony and Reports

Justices McLachlin, Major, and Bastarache accepted some expert testimony from the trial court regarding the seriousness of the waiting list problem.[308] They noted that patients with coronary disease are "sitting on a bomb" and can therefore die while on waiting lists.[309] They also noted that 95 percent of Canadians waiting for knee replacement surgery must wait up to two years and that such delays subject the patients to great pain and increased risk of irreparable injury.[310] The majority justices also relied on an interim Kirby Report that concluded that a parallel private system does not negatively impact a public health care system.[311] The interim Kirby report noted "that far from undermining public health care, private contributions and insurance improve the breadth and quality of health care for all citizens."[312] On the other hand, the justices rejected evidence from the Romanow Report, noting that it was "a matter of some

300. *Id.* ¶ 239.
301. *Id.* ¶ 242.
302. MAKARENKO, *supra* note 169.
303. *Id.*
304. *Id.*
305. SKOLROOD, *supra* note 4, at 2.
306. *See* CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 6.
307. *See id.*
308. *See Chaoulli v. Quebec*, [2005] S.C.C. ¶¶ 112, 114.
309. *Id.* ¶ 112.
310. *Id.* ¶ 114.
311. Canadian Health Coalition, Backgrounder: Chaoulli v. Quebec (Attorney General) 1 (2005), http://www.healthcoalition.ca/scc-chc.pdf.
312. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 147.

debate . . . [that] cannot be determinative of this litigation."[313]

The majority justices also reviewed the trial court expert testimony arguing both in favor of and against the prohibition.[314] The government's experts in health administration and policy claimed that removing the prohibition would harm the quality of Medicare by making private health services more accessible.[315] But the justices observed that the experts did not have knowledge in waiting times for treatment, and they did not base their opinions on actual economic studies or experiences of other countries.[316] The appellants' experts claimed that prohibiting private health insurance was not necessary to protect the public system.[317] They emphasized that a private insurance option would reduce the burden on Medicare by making alternative medical care more accessible, thereby improving health care for everyone.[318] Every justice in the majority rejected the expert testimony for both sides on grounds that the opinions were based solely on "'common sense' arguments, amounting to little more than assertions of belief."[319]

Meanwhile, the dissenting justices relied on evidence accepted by the trial judge that a private system would divert resources away from the public system, deal only with low risk patients, and lessen government support, ultimately resulting in decreased funding for Medicare.[320] They pointed to evidence that patients who use physicians working in both the public and private sectors wait longer than patients who use physicians working solely in the public sector.[321] They also relied on expert testimony that parallel private heath insurance would increase overall health care costs.[322] The dissenting justices referred to the final Kirby Report, which, unlike the interim report relied on by the majority, concluded that "allowing a private parallel system will . . . make the public waiting lines worse."[323] They observed that the Romanow Report also recommended continuation of a single-tier system.[324]

The dissenting justices also found that the lack of accurate data on waiting times for treatment made it impossible to determine exactly how serious the waiting list problem really was[325] and noted that waiting times alone do not prove that a health care system is failing.[326] The justices observed that waiting lists are a necessary and implicit form of rationing in the health care system because the potential market for health services

313. *Id.* ¶ 151.
314. *Id.* ¶ 63.
315. *Id.* ¶ 136.
316. *Id.*
317. *Id.* ¶ 137.
318. *Id.*
319. *Id.* ¶ 138.
320. SKOLROOD, *supra* note 4, at 5.
321. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 244.
322. *Id.* ¶ 255.
323. *Id.* ¶ 243.
324. *Id.* ¶ 230.
325. *Id.* ¶ 217.
326. *Id.* ¶ 219.

is limitless.[327] By this view, waiting lists "are the inevitable result of a public system that can consequently offer universal access to health services within the limits of sustainable public spending,"[328] and any alternatives to this are financially infeasible.[329] The justices commented that rationing in Canada's system occurs based on medical need rather than on income and therefore the patients who are in most need of care generally receive it first.[330] Any exceptions to this, they noted, should be addressed on a case-by-case basis.[331]

2. *Other Canadian Provinces*

Justice Deschamps relied on mechanisms used by other Canadian provinces to limit private sector expansion.[332] While three of the provinces, Alberta, British Columbia, and Prince Edward Island, only prohibit private health insurance, the other six provinces successfully use other measures as well.[333] Ontario, Nova Scotia, and Manitoba prohibit opted-out physicians from billing more than what they would receive under Medicare, thereby eliminating the financial incentive for physicians to opt out.[334] Of these three provinces, Nova Scotia does not prohibit private health insurance.[335] Ontario and Manitoba prohibit private insurance, but they refund amounts paid by patients to opted-out physicians.[336] Saskatchewan, New Brunswick, and Newfoundland are completely open to the private sector, and residents are free to purchase private health insurance.[337] New Brunswick permits physicians to set their own fees, while Saskatchewan allows only opted-out physicians to set their own fees.[338] Newfoundland reimburses patients for fees paid to opted-out physicians, up to the amount covered by Medicare.[339] Ultimately, because there was no evidence that the public health care systems in these provinces were disadvantaged, the majority concluded that prohibiting private health insurance was not the only effective way to discourage expansion of the private sector.[340] Even the dissenting justices acknowledged that other mechanisms were available to provinces aside from a ban on private insurance.[341]

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327. *Id.* ¶ 221.
328. *Id.*
329. *Id.*
330. *Id.* ¶ 223.
331. *Id.*
332. *Id.* ¶ 69.
333. *Id.* ¶ 72.
334. *Id.* ¶ 71.
335. *Id.*
336. *Id.*
337. *Id.* ¶ 73.
338. *Id.*
339. *Id.*
340. *Id.* ¶ 74.
341. *Id.* ¶ 174.

3. Other Western Democracies

The majority justices also relied heavily on the public health care systems of other western democracies that allow access to private health insurance.[342] In their view, this evidence was the best indicator of whether a prohibition on private insurance was necessary to protect the quality of Medicare.[343] They relied primarily on the health care systems of Australia, the United Kingdom, Sweden, and Germany.[344] Australia's public system is financed in the same manner as Quebec's system, yet private and public sectors coexist in Australia, and private health insurance is available.[345] The Australian government balances the parallel sectors by allowing taxpayers to deduct 30 percent of the cost of private insurance.[346] The United Kingdom does not prohibit private health insurance nor limit a physician's ability to opt out of the public system.[347] But physicians are limited in the amounts they can bill in the private sector.[348] Notably, only 8 percent of hospital beds in the United Kingdom are private, and only 11.5 percent of Britons had obtained private insurance in 1998.[349] Sweden does not prohibit private health insurance nor refund private health care costs, yet private insurance accounts for only 2 percent of total health care spending, and there are only nine private hospitals.[350] Meanwhile, Sweden's universal public system has wider coverage than Canada's system.[351] In Germany, although private health insurance is available, 88 percent of the population remains in the public system.[352]

Ultimately, the majority justices concluded that the experiences of these countries proved that a private insurance alternative would not harm or destroy Medicare in Quebec.[353] They observed that these countries can deliver "medical services that are superior to and more affordable than the services that are presently available in Canada" while still allowing for a private sector.[354] Because the mechanisms used in these countries successfully discourage doctors, patients, and services from moving to the private sector,[355] the justices found that a prohibition of private insurance was not necessary to protect the integrity of Medicare.[356]

In contrast, the dissenting justices suggested that the experiences of

342. *Id.* ¶ 139.
343. *Id.* ¶ 150.
344. *See id.* ¶¶ 79-81, 142-46.
345. *Id.* ¶ 79.
346. *Id.*
347. *Id.* ¶ 80.
348. *Id.*
349. *Id.*
350. *Id.* ¶ 81.
351. *Id.* ¶ 142.
352. *Id.* ¶ 145.
353. *Id.* ¶ 148.
354. *Id.* ¶ 140.
355. Carver, *supra* note 6.
356. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 152.

other countries were not determinative.[357] They noted that it was dangerous to explore the unfamiliar health care systems of other countries because each system is unique,[358] and no single international model exists.[359] They also observed that the evidence of these countries showed that an increase in private funding will lead to a decrease in public funding.[360]

III. THE FUTURE OF MEDICARE IN CANADA

Following the *Chaoulli* ruling, the Quebec and federal governments asked for an eighteen month suspension of the decision.[361] The governments claimed they needed time to analyze the impact of the decision in light of the Act and also to devise measures to respond to the ruling.[362] Two months after issuing the judgment, the Court granted a one-year suspension, retroactive to June 9, 2005, which means there will be no change in Quebec law until June 9, 2006.[363]

A. THE REAL IMPACT OF THE DECISION

The decision in its narrow sense means that the two challenged provisions in the HEIA and HOIA are invalidated, at least as of June 9, 2006, when the suspension ends.[364] But the ruling promises to have a much more profound impact, one that "will undoubtedly shape the public/private health care debate throughout Canada, both in terms of how other provincial governments structure their medical plans and potentially as a basis for further legal challenges."[365] The potential effects of the decision are being rabidly debated.[366] Some believe the decision opens the floodgates to private care[367] and signals the end of Medicare in Canada.[368] Others argue that a two-tiered system will not result as long as Medicare is strengthened.[369] Admittedly, the impact of the decision is difficult to predict and highly speculative.[370] But upon close inspection, it seems most likely that the decision will serve as a catalyst to finally force Cana-

357. *Id.* ¶ 150.
358. *Id.* ¶ 229.
359. *Id.* ¶ 228.
360. *Id.* ¶ 248.
361. CBC News Online, Health Care Introduction, *supra* note 1.
362. Maioni & Manfredi, *supra* note 99, at 55.
363. CBC News Online, Health Care Introduction, *supra* note 1.
364. SKOLROOD, *supra* note 4, at 8.
365. *Id.*
366. *See, e.g.*, CBC News Online, The ruling: In reaction, *supra* note 2 (describing the various reactions to the decision).
367. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 1.
368. *See* CBC News Online, The ruling: In reaction, *supra* note 2 ("This is the end of medicare as we know it").
369. *See id.* ("We're not going to have a two-tier health-care system in this country. What we want to do is to strengthen the public health-care system").
370. MORRIS ET AL., *supra* note 251.

dian governments to address the problem of scarce medical resources and long waiting times.[371]

1. *Future Litigation*

Traditionally, courts have given rather restricted health care rights to Canadians under the Canadian Charter.[372] But the majority in *Chaoulli* recognized the right of Canadians to have reasonable access to health care.[373] All seven justices recognized that undue delay in obtaining health care may violate the rights of life and security of the person under the Canadian Charter in certain circumstances.[374] This means that citizens can now make claims against governments when they face delays in treatments, and governments must act to ensure reasonable access.[375] Because of this, an increase in similar lawsuits in other provinces is likely.[376]

While future litigation involving access to health care is expected, it is unclear how the Court will rule in such cases because it was so highly divided in the *Chaoulli* decision.[377] Only three justices found that there is a right to timely health care access under section 7 of the Canadian Charter,[378] which leaves open the question of whether the Canadian Charter can be used successfully in future litigation involving similar prohibitions.[379] In addition, the composition of the Court has changed since the decision was handed down.[380] Two recent appointees to the Court, Justices Abella and Charron, did not participate in the *Chaoulli* decision, so future cases involving this issue may give rise to a different outcome.[381] A further complication is that the split between the majority and dissenting opinions revolved around very different interpretations of the evidence.[382] Unless a new major health study provides better insight into waiting times and medical care standards, other governments and courts will likely encounter the same difficulties in evaluating the data.[383]

Furthermore, because the majority gave no guidance as to what constitutes reasonable care, this standard will have to be developed in future litigation.[384] As the dissenting justices noted, "What, then, are constitutionally required 'reasonable health services'? . . . The majority does not tell us. The majority lays down no manageable constitutional stan-

371. Low, Wakulowsky & Moysa, *supra* note 70, at 2.
372. MAKARENKO, *supra* note 169.
373. *Id.*
374. SKOLROOD, *supra* note 4, at 8.
375. MAKARENKO, *supra* note 169.
376. Low, Wakulowsky & Moysa, *supra* note 70, at 3.
377. MAKARENKO, *supra* note 169.
378. *Id.*
379. SKOLROOD, *supra* note 4, at 9.
380. Low, Wakulowsky & Moysa, *supra* note 70, at 3.
381. *Id.*
382. SKOLROOD, *supra* note 4, at 8.
383. *Id.*
384. *Id.*

dard."[385] The lack of an applicable standard leaves the door open to future challenges based on any wait time whatsoever.[386] It is also unclear from the decision whether other problems, such as a patient's inability to pay for certain medical services, will qualify as a violation of the right to reasonable health care access, so future litigation to assess these questions is likely.[387]

2. *The Role of Courts*

The *Chaoulli* decision also has potential impact on the role that Canadian courts will play in determining health care policy in the future.[388] The case suggests that Canadian courts now have a strengthened role in health care issues.[389] Traditionally, courts have not interfered in government health care decisions, instead allowing legislatures to determine Canadians' access to medical treatment.[390] But now that a right to timely access to health care has been established, the role of courts is significantly broader in that courts will now be responsible for determining exactly what constitutes timely access.[391] Patients who claim that their rights of access are violated will be able to resort to the courts for help, and the courts will be able to force the government to change its policies accordingly.[392]

3. *Medicare*

Many people have interpreted the *Chaoulli* decision as opening the door to private health care across Canada.[393] Proponents of Medicare fear the decision will make room for a two-tier health care system as exists in the United States.[394] As the dissenting justices noted, "[p]rivate insurance is a condition precedent to, and aims at promoting, a flourishing parallel private health care sector."[395] But this is unlikely to be the case.[396] Because *Chaoulli* was ultimately decided under the Quebec Charter and not the Canadian Charter, the ruling itself is limited only to the province of Quebec.[397] Other Canadian provinces are not directly

385. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 163.
386. Colleen M. Flood & Terrence Sullivan, *Supreme Disagreement: The Highest Court Affirms an Empty Right*, CAN. MED. ASS'N. J., July 19, 2005, at 1, *available at* http://www.cmaj.ca/cgi/rapidpdf/cmaj.050759v1.
387. MAKARENKO, *supra* note 169.
388. *Id.*
389. *Id.*
390. *Id.*
391. *Id.*
392. *Id.*
393. *Id.*
394. Marchildon, *supra* note 37, at 1.
395. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 181.
396. *See* MAKARENKO, *supra* note 169.
397. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 5.

impacted, and the Act remains fully in effect.[398] While there will likely be a short burst of private clinic expansion in Quebec, this will not have a dramatic impact on the public system because private clinics have existed for years.[399] But some initial shortages in public practices are possible.[400]

A crucial aspect of the majority's decision is that it found that access to health care was reduced by two factors: public waiting lists and limited access to private treatment.[401] Because the Court could not remedy the waiting list crisis, the only action it could take was to allow greater access to private health care.[402] The Court did not state that the Quebec government must increase access to private care unconditionally.[403] It only stated that greater access must be allowed if patients do not receive suitable treatment within the public system.[404] The majority justices noted that a "prohibition on obtaining private health insurance, while it might be constitutional in circumstances where health care services are reasonable as to both quality and timeliness, is not constitutional where the public system fails to deliver reasonable services."[405] This indicates that bans on private health insurance could possibly withstand a constitutional challenge if Medicare is implemented in a way that avoids long wait lists.[406] Therefore, if governments can reduce waiting times and ensure that patients receive treatment in a timely manner, then they may be able to limit access to private insurance.[407] But if waiting lists continue to be a problem, patients should be allowed to receive faster care through the private system if they choose to do so.[408]

Even if Quebec removes the prohibition against private insurance, it can legally replace it with other forms of regulated access to minimize the impact of the decision.[409] Justice Deschamps noted that "Quebec has the power under the Constitution to discourage the establishment of a parallel health care system."[410] As shown by the evidence in *Chaoulli,* there is a variety of constitutional legal tools available for provinces to maintain a single-tier public health system.[411] Quebec arguably does not need a prohibition on private insurance to minimize the private sector because it already has several constitutional mechanisms at its disposal to serve the same purpose.[412] Ultimately, if Quebec can legally prevent a flourishing

398. *Id.*
399. Steven Lewis, *Medicare's Fate: Are we Fiddlers or Firefighters?*, LAW & GOVERNANCE (2005), http://www.longwoods.com/product.php?productid=17186&page=1.
400. *Id.*
401. MAKARENKO, *supra* note 169.
402. *Id.*
403. *Id.*
404. *Id.*
405. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 158.
406. MORRIS ET AL., *supra* note 251.
407. MAKARENKO, *supra* note 169.
408. *Id.*
409. Maioni & Manfredi, *supra* note 99, at 56.
410. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 14.
411. *Id.* ¶ 74.
412. Carver, *supra* note 6.

private sector, then the right to purchase private insurance is altogether meaningless.[413]

B. A Call for Government Action

In the end, the *Chaoulli* ruling "is not a license to privatize," even in Quebec.[414] Instead, the case represents a wake-up call for Canadian governments to strengthen Medicare.[415] The *Chaoulli* decision makes it clear that the issue of medical access and waiting lists can no longer be ignored by governments.[416] As the majority noted in their opinion, "[g]overnments have promised on numerous occasions to find a solution to the problem of waiting lists. . . . [I]t seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defen[s]e for citizens."[417] In this respect, the decision is a blessing in disguise for Canadians, regardless of what form of health care system they support.[418] While some may disagree that courts are responsible for resolving health policy issues, the Court's involvement in *Chaoulli* was a necessary result of Canadian governments' failure to address the recurring problems in Medicare.[419]

The government of Quebec, along with all other provincial governments, should use the grace period until June 2006 to improve health care access by dealing with the problem of waiting lists.[420] Governments must act quickly to ensure that patients have timely access to quality medical services.[421] Although several developments have been made since *Chaoulli* first began in 1997, including increased federal spending and a plan to improve waiting lists, there is more that can be done.[422] The ruling should encourage governments to speed up their schedules and reduce waiting lists sooner than originally planned.[423] As agreed upon at the First Ministers Conference, the Wait Time Alliance released its final report on benchmark waiting times in August 2005, two months after the *Chaoulli* decision was announced.[424] In response to the decision, the re-

413. Flood & Sullivan, *supra* note 386, at 2.
414. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 21.
415. *Id.* at 1.
416. Morris et al., *supra* note 251.
417. *Chaoulli v. Quebec*, [2005] S.C.C. ¶ 96.
418. Lewis, supra note 399.
419. Skolrood, *supra* note 4, at 9.
420. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 21.
421. Morris et al., *supra* note 251.
422. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 5.
423. *A Strange but Useful Decision*, Community Action, June 20, 2005, *available at* http://www.highbeam.com/doc/1G1-133810225.html.
424. *See* Wait Time Alliance for Timely Access to Health Care, *supra* note 116.

port recommends that provincial governments hurry to meet the new benchmark times by March 31, 2006, twenty-one months ahead of the original schedule.[425] Governments should strive to meet these benchmark waiting times to ensure timely access.[426] Governments should also consider additional health care funding to improve the waiting list situation.[427] The Wait Time Alliance final report suggests that an additional $3 billion over five years is necessary to reduce waiting times.[428] The report emphasizes that this money should be used to add more doctors and nurses to the system and to reimburse patients for out-of-country or out-of-province medical services.[429] The Wait Time Alliance report also recommends a 4-M Toolbox of Strategies to mitigate, measure, monitor, and manage wait times.[430] Using the report as a guide, provincial governments should implement a system of wait list management to ensure that lists are kept current and that waiting patients are followed up regularly.[431] Additionally, governments can pursue incentive strategies such as withholding payments to hospitals that do not have adequate wait time management systems in place.[432]

Furthermore, provincial governments should use this opportunity to strengthen and expand Medicare.[433] For example, they can invest more money in public health care delivery[434] and increase the number of health care workers.[435] They can establish a national home care plan to reduce the pressure on hospitals for resources.[436] They can also implement a national pharmacare plan for prescription drugs to increase the coverage of Medicare.[437] Finally, they can increase efficiency by operating public emergency rooms at full capacity and creating public surgery clinics.[438]

In addition to improving the quality and breadth of Medicare, governments can also employ various legal measures to halt the growth of pri-

425. *Id.* at 5.

426. Health Coalition, Backgrounder: Chaoulli v. Quebec (Attorney General), *supra* note 311, at 3.

427. MUNROE, *supra* note 114.

428. *Id.*

429. *Id.*

430. WAIT TIME ALLIANCE FOR TIMELY ACCESS TO HEALTH CARE, *supra* note 116, at 4-5.

431. Lewis, supra note 399.

432. *Id.*

433. CANADIAN UNION OF PUBLIC EMPLOYEES, THE CHAOULLI SUPREME COURT OF CANADA DECISION 3 (2005), *available at* http://www.cupe.ca/updir/Chaouilli_Backgrounder_rev.pdf.

434. CANADIAN UNION OF PUBLIC EMPLOYEES, INSIDE THE "CHAOULLI" SUPREME COURT RULING: WHAT THE DECISION MEANS, THE FACTS ON PRIVATE INSURANCE, AND SOLUTIONS FOR WAIT LISTS, *supra* note 127, at 13.

435. CANADIAN UNION OF PUBLIC EMPLOYEES, THE CHAOULLI SUPREME COURT OF CANADA DECISION, *supra* note 433, at 3.

436. *Id.*

437. *Id.*

438. *Id.*

vate insurance and delivery.[439] For example, they can refuse to subsidize private care and personnel.[440] They can prohibit physicians from practicing in both the public and the private sectors[441] and prohibit opted-out physicians from billing more privately than they would make under Medicare.[442] Governments can reward medical students who sign contracts to practice exclusively in the public sector.[443] Governments can also strictly adhere to the principles of the Act by withholding funding to provinces that violate the Act by allowing privatization to expand.[444]

C. A Blueprint for Change

Inevitably, the *Chaoulli* decision will spur public debate on Medicare and general health policy in Canada for years to come.[445] It dares Canadians to finally reevaluate their beloved health care system[446] and promises to be an impetus of much-needed change in Canadian Medicare.[447] In the end, the *Chaoulli* decision is an ultimatum for Canadian governments to either strengthen and improve Medicare or permit the development of a private system.[448] If Canadian governments are committed to preserving Medicare, as they say they are, then they must take action.[449] If they do not, courts will continue to intervene in cases where Medicare fails to deliver reasonable and timely services, and private health care will continue to expand.[450] Whichever road Canadian governments take in the future, Medicare in Canada likely will never be the same again.[451] As Ray Romanow himself noted, "[t]he blueprint for change is there - it's just waiting to be put into practice."[452]

439. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 21.
440. Lewis, supra note 399.
441. Chaoulli v. Quebec Action Alert, *supra* note 122, at 1.
442. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 21.
443. Lewis, supra note 399.
444. Canadian Union of Public Employees, Inside the "Chaoulli" Supreme Court Ruling: What the Decision Means, the Facts on Private Insurance, and Solutions for Wait Lists, *supra* note 127, at 22.
445. *See* Low, Wakulowsky & Moysa, *supra* note 70, at 3.
446. *See id* ("What can be said with certainty about the Chaoulli decision is that it challenges Canadians to radically rethink their health care system, and with it, a piece . . . of their national identity").
447. *See* CBC News Online, The Ruling: In Reaction, *supra* note 2 ("This is a great victory for all Canadians. It will be a new start for health care in the country").
448. Morris et al., *supra* note 251.
449. *See* Skolrood, *supra* note 4, at 9.
450. *Id.*
451. *See* Carver, *supra* note 6.
452. Romanow, *supra* note 149.