Chaoulli Ten Years On: Still about Nothing?

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Abstract

Five years ago this author presented the paper Chaoulli Five Years On: All Bark and No Bite? The paper argued that five years after the Supreme Court of Canada's *Chaoulli v. Quebec* ruling, there was still no noticeable impact on Canada's system of provincial single-payer universal health insurance plans. The paper argued that this was because the large life and health insurance firms had little if any interest in competing with publicly funded health insurance in Canada and because politicians saw little to gain by going down that road. Ten years on, even as the opponents of the present health insurance regime try to use *Chaoulli v. Quebec* to force changes in the laws of other provinces, this is still, for the most part, the case. Unlike the legendary comedy program Sienfeld, *Chaoulli v. Quebec* is not totally about nothing. However, so far, it has proven to be about as close to being about nothing as any ruling of the Supreme Court is likely to get.

Daniel Cohn, Ph.D.
Associate Professor
The School of Public Policy & Administration
York University
4700 Keele Street
Toronto, ON
M3J 1P3, Canada

tel: 1-416-736-2100 ext. 77276
email: dcohn@yorku.ca
www: www.yorku.ca/dcohn

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Introduction:

In June 2005 the Supreme Court handed down a complex and non-unanimous decision in the case *Chaoulli v. Quebec*. The ruling held that Quebec's prohibition on the sale of private health insurance for services that are already provincially insured was unconstitutional, but only under certain circumstances. Further adding to the complexity of the ruling is that it was reasoned in a way so as to only apply to Quebec in the first instance. The ruling generated a virtual avalanche of media stories and a significant volume of scholarly publications. One edited volume included 27 contributions grouped under eight headings (Flood, Roach, and Sossin 2005). There was also a selection of articles in Canada's leading medical journal (Hadorn 2005; Lewis 2005; Schumacher 2005; Smith 2005; Quesnel-Vallee et al. 2005; Flood and Sullivan 2005), a series in *The Health Law Journal* (Premont 2007; Jackman 2007) and *The Osgoode Hall Law Journal* (Flood 2006; Manfredi and Maioni 2006; Gilmour 2006; Jackman 2006). The ruling was even the topic of one of the premier events held annually by Canada's leading think-tank for economic and governmental elites, the C.D. Howe Institute (Monahan 2006). There were also several further individual academic articles (Paradia and Robert 2009; Baterman 2006; Premont 2008), think-tank pieces (McIntosh 2006; Rachlis 2005; Chaoulli 2006; Maioni and Manfredi 2005), reviews of the ruling and its implication in the business trade publications (Vu 2006; Hobel 2006; Harding and Picard 2005) and of course news stories, editorials and op-eds in the mainstream media. Many of these popular pieces were written by authors engaged in the academic debate or featured interviews with them (Aaron 2005; Fischer 2005; Flood 2005; Roach, Flood and Sossin 2005;Maioni 2005; Monahan 2005; Shortt 2005) .

This sort of coverage is symbolic of an event that is disruptive in a public policy process. For many years scholars have argued that public policy in democracies is made in subsystems known as policy-networks. Here below the level of general observation issues are debated in detail between participants who are familiar with each other and their respective views and vantage points. These participants tend to be heavily "invested" in the work of the policy-network and have substantial interests at stake in the deliberations of the network. Informing and supporting their debates is an ideational structure and other less interested participants who share these ideas or an understanding of the controversies if the ideas themselves are contested. Howlett, Ramesh and Perl (2009) categorize policy-networks based on the idea sets that are relevant to their debates and the number of actors and the power relationships between them. In recent decades the Canadian health policy-network has become what Howlett et al. would describe as a closed system. This is because the policy community that the network is a part of has a dominant set of idea and the network itself has only a few actors dominated by the state. In a well-established policy-network of this type there are disagreements but also a general consensus as to what the issues needing attention are and the appropriate set of theoretical tools for analyzing issues and evaluating options. There is also resistance to both changing these ideational structures and to admitting new members into the deliberations of the network. A disruptive event throws a policy-network and its wider community into disarray and creates room for new entrants and divergent views and might be a factor that contributes to opening a policy-window. This is a time when interests, public opinion and events align so that policy-making or policy change can

occur (Kingdon 1995). Therefore, as we mark the tenth anniversary of the *Chaoulli v. Quebec*, it is worth asking what has changed in the way Canadian health care is financed as a result of the policy window that was opened when the Supreme Court's ruling disrupted this network? In an early paper delivered to this conference on the fifth anniversary of the ruling, it was argued that nothing much had changed and that nothing much would change because Canada's major health and life insurance companies had no material interest in change, nor did provincial governments (Cohn 2005).

Among the means that have be proposed for evaluating change in public policy, one of the most widely used has been the three category typology of policy change proposed by Hall (1993). Change can be said to occur at three orders of magnitude.

- First order change (routine adjustments in existing policies)
- Second order change (change in the policies used to achieve existing goals)
- Third order change (paradigmatic change, change in the goals of policy and the ideas underpinning them).

The first two orders of change are symptomatic of stable networks and involve no change in the ideational framework known as a "policy paradigm" that structures the debates of the network. Third order change indicates the emergence of a new policy paradigm and re-arrangements in the makeup, and/or balance of power within the network.

This paper will use Hall's typology to evaluate the change that *Chaoulli v. Quebec* has created in the financing of Canadian health care. It will be shown that for the most part, any change that has happened has been first order in nature. In answering the question why? It is suggested that the explanation given five years ago still holds true. More substantial change is not in the interest of the major insurance companies and politicians who lead provincial governments.

Lack of Paradigmatic (Third Order) Change:

Given the nature of this audience, it is not necessary to spell out in detail either the history of how Canada arrived at a system of provincially run plans to finance medically necessary physician care and diagnostic services, nor the loose federal frame-work that enables Ottawa to transfer significant financial resources to the provinces so as to help pay for this care. It is enough to say that over the years the conditions set by Ottawa have gradually become more general and less detailed (Cohn 1996). When looked at comparatively, Canada has one of the most decentralized health systems of any federation (Banting and Corbett 2002). However, even though the detailed rules have been reduced there has been a similarly gradual tightening of basic features and the development of a pan-Canadian understanding of citizenship rights within health care so that some would argue that the field has been gradually "defederated" (Graefe and Bourns 2009). *The Canada Health Act* of 1984, played an important role in this process. This act consolidated many of the conditions that governed federal conditional grants to the provinces for health care. These principles are:

- Public Administration: Each province must establish a publicly administered not for profit health insurance plan.

- Comprehensiveness: All medically necessary hospital, physician and diagnostic services (whether in hospital or outside of one) must be fully insured.
- Universality: All permanent residents of a province must be eligible for coverage
- Portability: Coverage must be good across Canada so that if a person travels they will still be covered, or so if they move their coverage will stay in effect until they are deemed to be a permanent resident of their new province
- Accessibility: All services must be reasonably accessible to all residents of the province. Under this heading *The Canada Health Act* extended the long standing ban on charges at point of service for any medically necessary hospital and diagnostic services to physician services as well.

Alongside of these principles *the Act* also prescribes penalties if provinces violated the ban on extra-billing. The Federal Minister of Health is empowered to reduce a province's federal grants by the total amount of extra-billing it allows. In short *The Canada Health Act* defines medically necessary services as a right of citizenship that all Canadians ought to enjoy in a fully equal manner without charge at point of care. These five conditions and the principles they represent have achieved strong public support. Even while acknowledging things are not perfect and that sometimes the health care system falls seriously short of expectations, Canadians still support the model outlined in *The Canada Health Act* and the values it represents (Mendelsohn 2002). Public support for *The Canada Health Act* is so strong, that in the past, opponents of the system have recognized it to be unassailable and have backed away from recommendations that would directly violate it (Kirby and LeBreton 2002; Mazankowski 2002). What is not defined as a right of citizenship is that residents of each province should receive the same care. In fact, the various reforms enacted in the late 1970s were intended to allow the provinces to make different choices as to what to insure so as to allow for experimentation as to the best and most efficient care. Consequently, a further principle in this paradigm is that as provinces enjoy constitutional paramouncy in the health care policy area -- for the most part -- each province gets to determine what is, and is not medically necessary, and therefore eligible for full public financing.

Chaoulli v. Quebec, has not changed this and there has been no weakening in public support for universality (Marchildon 2014, 378). With the ruling the Supreme Court of Canada has made it known that *The Charter of Rights and Freedoms* applies to provincial decision-making. If a province deems something to be medically necessary and cannot provide it at public expense, in a timely manner, the ruling endorses the idea that the province should not prevent others from paying for it. In short, *Chaoulli V. Quebec* has not changed the paradigm, it is one of those things that structures the meaning of the already existing term "for the most part".

So far, attempts to use the decision as a legal lever to force change in spite of the consensus in favour of the existing paradigm have failed. This is the case whether the change sought has been to move to the right and end universality, or to the left, re-defining universality so as to expand the community of people covered and the services paid for publicly. A search of the *Quicklaw* database revealed 174 records in which the case *Chaoulli v. Quebec* was cited. 15 of these cases could reasonably be said to be about the financing and delivery of health care (see appendix for a listing of the cases). Only two of the cases involved the same aim as Chaoulli, an overturning of a provincial ban on third party payment for provincially insured medical services. In *Allen v. Alberta* the applicant lost. Meanwhile *Schooff v. Medical Service Commission [BC]*, is still

ongoing. This case was commenced in 2009 and may finally come to trial in the fall of 2015. Therefore not much more can be said about it. It is worth briefly considering the trial judge's reasons for ruling against the applicant in *Allen v. Alberta* as they illustrate how difficult it will likely be to replicate Chaoulli's victory. Justice Jeffrey was willing to consider that *Chaoulli v. Quebec* had application outside of Quebec and that it might be possible to bring a challenge using Section 7. of *The Charter* (even though Chaoulli's own victory hinged on the slightly different wording of Quebec's own rights declaration which supplements *The Charter*). However, the judge was not willing to accept that just because a ban on third party payments was found to cause delay in Quebec in 2005 that a similar legislative provision did so in Alberta subsequently. The judge demanded proof that Alberta's ban on third party payment causes delays in the present time. That it *might* cause an increase in waiting times was not good enough.

> Dr. Allen is asking the court to accept his theory that the Prohibition creates or exacerbates wait times thereby preventing access to health care. His application requires evidence proving his theory but offers none. The added time Dr. Allen would have to have waited for his surgery in Alberta may have been no different in the absence of the Prohibition. That competing theory has just as much support on this record…
>
> Dr. Allen has not demonstrated, on a balance of probabilities, a sufficient causal connection. He has not shown that the Prohibition deprived him of life, liberty or security of his person. His application fails at the first step in the section 7 analysis (Allen v. Alberta paras 53-55).[1]

The other 13 cases found in Quicklaw all sought to expand the definition of universality so as to force the provinces, and in two cases the federal government, to pay for care they did not wish to pay for or include people under universal coverage whom are presently not considered to be members of the community of eligibility. Only two of these 13 cases succeeded, *C [by his Litigation guardians] v. Ontario Health Insurance Plan (General Manager)*and *Canadian Doctors for Refugee Care v. Canada.* However, it needs to be noted that the court found that the agency involved in the first case had used an unreasonable decision-making process. It was for this reason that the court ruled in favour of two of the three applicants involved, not the arguments presented by the applicants from *Chaoulli v. Quebec*. The second case was a challenge to the present federal government's policy of refusing to pay for the medical care costs of some refugee claimants resident in Canada. Again, although Chaoulli v. Quebec was cited, the main reasons used by the court to justify the ruling were found elsewhere. In this case, a conclusion was reached that the federal government's policy toward some refugee claimants was

[1] It should also be noted that Ries (2011) cites two additional cases similar to *Chaoulli v. Quebec* which have been filed that were not found by the search strategy and which might be germane. *Murray v. Alberta* involves a resident of Alberta who is seeking to bring a similar action to that of Chaoulli as a class-action law suit. Meanwhile in Ontario two residents who felt they had to leave the province to get necessary care have challenged the constitutionality of Ontario's Health Insurance Plan (*McCreith and Holmes v. Ontario*).The first case was not found by the search as, so far, no matters have come to court other than the application to be treated as a class. During such a motion no consideration is given to the substance of the case. Meanwhile the Ontario case has not even gotten to the point where motions and actions which would be taken note of by law reports have occur. Even by the standards of Canadian law, these two cases seem so slow moving that it leads one to wonder if the applicants seriously intend to go through with their actions.

"cruel and unusual" treatment and thereby a violation of Section 12 of *The Charter of Rights and Freedoms* (*Canadian Doctors for Refugee Care v. Canada*, para 1080).

An indicator of the strength of the policy paradigm is found in the fact that all of these cases were defended, even those brought against Alberta and British Columbia, provinces regularly held out as having the most rightward leaning governments in the country. In Alberta plans to break out of the policy paradigm and pursue a so called "Third Way" between the present Canadian system and the US model faltered and then were permanently discarded in 2006 when Ralph Klein was forced out of the Premier's office by his own party (Gregoire 2006; Sibbald 2006, 1829-1830). At approximately the same time the BC Liberal government of Gordon Campbell also appears to have lost interest in paradigmatic change in the area of health care. In spite of a lot of talk and a global tour to look at alternative systems, when the dean of BC political reporters wrote Campbell's political obituary in 2010, health care was not even mentioned (Palmer 2009 and 2010). Christy Clark, his successor as BC Liberal leader and premier, has not raised the matter and her government is continuing a vigorous defense of the *Schooff* case. A further indicator of the resilience of the policy paradigm is found in how Quebec itself responded to *Chaoulli v. Quebec*. Rather than using the ruling as an excuse to abandon the paradigm it complied with the ruling in such a way as to make the results almost moot. Rather than abolishing the ban on duplicative private insurance for provincially insured services in total, it instead only allowed private insurance for three forms of surgery (cataract surgery, hip and knee replacements), areas where wait-times were found to be unacceptably long and in those areas alone. However, it also has to be noted that some close observers of Quebec health politics see *Bill 33* (the law which implemented these changes) as a sort of Trojan Horse. On the surface all it does is minimally meet the requirements to comply with the court decision. However, some of its provisions also facilitate the increased private ownership of clinics and hospitals. At some point, it is argued, these facilities could form the foundation for a two-tier system for medically necessary care (Premont 2008). This will be taken up further in the next section of the paper.

In conclusion, perhaps no greater evidence can be found as to how robust the paradigm is and how broad the consensus surrounding it is, than the behavior of Stephen Harper's Conservative government in Ottawa. During a sabbatical from party-politics, Harper was leader of the right-of-centre National Citizens' Coalition. In that role, he had been one of the signatories of the famous "fire wall" letter. In the letter, a group of notable Albertans urged Premier Klein to openly defy federal laws that limited Alberta's ability to follow the New Right agenda that they shared with the Premier. Among the actions they urged was that Alberta ignore the provisions of the *Canada Health Act* which prohibited private financing of care (Harper et al. 2001). Elected Prime Minister roughly six months after the *Chaoulli v. Quebe*c ruling, it was widely expected Harper would use the decision to undermine the existing policy paradigm. In fact he did nothing of the sort. Instead he spoke out against Alberta's third-way proposals, warning that his government would do what it had to do to ensure that all provinces complied with the *Canada Health Act* (McFarlane 2006; Heard and Cohn 2009). Since winning a majority in 2011, Harper has not been the most supportive Prime Minister the policy-paradigm has ever had, but he has also made no moves to challenge or weaken the paradigm either.

Lack of Second Order Change (Change in Policy), but maybe First Order Change (Routine Adjustments in Existing Policies):

It also appears that *Chaoulli v. Quebec*, has not resulted in second order changes in the area of how Canadian health care is financed and delivered. This does not mean that there have not been changes in the policy used to finance and deliver Canadian health care. What is meant is that the changes which have occurred did not involve the introduction of new policy but only the routine adjustment of existing ones. Even then, the changes that have occurred are the result of processes that began before the ruling in 2005. What is fair to say is that the ruling gave some actors a renewed sense of urgency. In particular, this might be the case with so called "alternative financing and service delivery" arrangements such as the use of public-private partnerships (P3s) to build and maintain health infrastructure.

The interest among provincial governments in using P3s to build health infrastructure goes back to the 1990s and picked up steam at the start of the millennium as provinces scrambled to both redress a lack of investment in infrastructure and also their desire to reshape and restructure their health institutions (such as by redressing the imbalance found to exist in terms of urgent care and long term care beds). Whether this was wise or not is open to question. However, it cannot be denied that derivatives of the P3 model have been used with increasing frequency across Canada (and in other countries as well) when health infrastructure is constructed (Cohn 2004; 2006; 2008a; 2008b; Whiteside 2009; 2011; Cruz and Marques 2013). If it did nothing else, the *Chaoulli v. Quebec* ruling focused minds on the issues of waiting-times (Fenn 2006; McIntosh 2006). To the degree this question was tied to a lack of facilities, as opposed to finding better procedures for structuring care, the ruling undoubtedly gave a boost to facility construction and the model that tends to lead to shorter construction times is the P3 approach.[2] As already noted above, Premont (2006) observes that the legislation written by Quebec so as to bring its health insurance scheme into line with the Supreme Court's ruling, included language to help facilitate private ownership and financing of hospitals. Yet, as noted above, the shift to using P3s and other forms of privately owned facilities to deliver publicly funded care was already well underway. If *Chaoulli v. Quebec* had a role it was to add one more argument, the need for urgency, not to create a shift in policy. In other words, the change was of first order magnitude, not second order.

A second policy instrument that should be discussed here is one that is often neglected, administrative discretion. To some extent or another, doctors and those who finance their activities and those of private clinics in every province have developed tactics to skirt the various laws and regulations provinces have created to ensure universal access to medically necessary care at no cost to the patient. As Taylor (1978) told us, in Saskatchewan the original physician insurance plan included the right of doctors to "opt-out" and extra-bill," (charge patients privately and at a rate higher than the provincial plan allowed, with the patient seeking reimbursement up to the provincial rate) as a symbolic protection of professional autonomy. Other provinces adopted this too and it was tolerated as long as only a small minority of

[2] It must be stressed that the dominant view in health policy research is that – for the most part -- Canada has enough capacity in terms of personnel and facilities. The wait-time issue is one that is created and must be solved by better developing and implementing better procedures for managing and delivering care, and most critically, by focusing more resources on maintaining health (cf Lewis 2005).

physicians made use of the freedom. When the number of physicians who were extra-billing grew in response to provincial restraint in the late 1970s and 1980s, the loophole was closed via the *Canada Health Act* in 1984 (Tuohy 1988; Cohn 1996; Heard and Cohn 2009). Post-*Canada Health Act*, the provinces adopted a variety of strategies to prevent extra billing. Most significantly, the provincial plans generally prohibit so called "double dipping". If a physician agrees to accept money from their provincial insurance scheme, they cannot offer otherwise insured services to insured members of the public at a higher cost. Ontario and Manitoba went further and have made it impractical to even opt out (McIntosh 2006: 6-7). After doing this, the provinces have been consistently confronted with schemes that bend and sometimes break the rules. As with other regulatory regimes, not all violations are necessarily pursued and prosecuted. There is, in short, administrative discretion at work as to when and where to enforce laws. Did *Chaoulli v. Quebec* lead to a permanent change in the degree of leeway provinces have granted to those playing at the margins of the system or simply to the continuation of the already existing discretion in pursuing violators? Some have argued it has led to more leeway, especially in Quebec (Contandriopolus, cited by Flood 2010). However, it also needs to be remembered that the existing use of discretion has been quite substantial at times. So substantial that at the turn of the millennium, the Auditor General of Canada (2002: Chapter 3) felt the need to speak out and urge the federal government to improve its monitoring of provincial compliance with the *Canada Health Act*. Therefore, perhaps the best that can be said is that, as with the shift to P3s, *Chaoulli v. Quebec* has provided one more argument in favour of the already existing use of discretion in the enforcement of provincial laws, not a new reliance on it. Once again the change that occurred was first order in nature. The next section of the paper looks at why third and second order change failed to emerge. The answer given is that neither the most powerful private actors with interests at stake (the major insurance companies) nor provincial governments have any material interest in changing the policy paradigm or policies used to enact it.

Thanks but No Thanks, Government and Insurance Company Reponses to Chaoulli v. Quebec:

Perhaps demonstrating the fears of the organizations that intervened opposite the appellants, after the *Chaoulli v. Quebec* decision, the right-of-centre governments of both British Columbia and Alberta gave serious consideration to abandoning universal publicly funded health insurance for other models involving private competition. However, Ralph Klein's "Third Way" and Gordon Campbell's "Conversation on Health," ultimately amounted to nothing. First, the public appeared to be willing to punish governments that unnecessarily tampered with the status quo (Sibbald 2006; Palmer 2009). Although the Campbell and Klein governments had an instinctive desire to promote private sector alternatives as a way to save money, they could not hide the fact that even their own handpicked international consultants believed that introducing private financing would lead to increased provincial costs, not lower ones (Aon Consultants 2006). Even economists who believed private financing might have a valuable role in other respects, warned Canadian governments that although private financing might lower the costs of health care to governments (by shifting the burden on to others) it would nevertheless increase the costs to society overall (Conference Board of Canada 2006, 24). Seeing neither votes nor material

savings for their budgets in a renewed drive to private financing for health care, both provinces backed away from making paradigmatic or even second order changes.

Having said that, it is also true that there are many cases in history where strong interest group pressure has led governments to do things they might not have otherwise done. In the case of moving towards greater private financing of health care, the interests with most at stake are the large insurance companies. Perhaps surprisingly to some, they did not jump on *Chaoulli v. Quebec* and use it as a lever to force open the Canadian market for medical insurance. The Canadian Life and Health Insurance Association did not even intervene in the case. In fact, *Chaoulli v. Quebec* has likely proven to be as big a challenge to the big private insurers as it has been for provincial governments.[3]

Private health insurers presently play an important and profitable part in the Canadian health care system. The majority of Canadian families have some form of private insurance which supplements the coverage they receive from their public provincial plan. Hence such coverage is often called "extended health insurance" or "supplemental coverage". While medically necessary hospital, diagnostic and physician services are governed by the terms of *the Canada Health Act* and almost totally paid for by public insurance plans, there is a mix of effort for everything else including, dental care, non-medical vision care (optometry), prescriptions, health products such as mobility aids, long-term and home care, as well as mental health. Low income families, seniors and those with chronic conditions are eligible for public help (including both direct funding and tax credits, others have no coverage at all (Marshall 2003; Evans 2004; Canada Customs and Revenue Agency 2003; Cohn 1996). Expenditures by private insurers on behalf of clients comprise roughly 12 percent of total health spending in Canada. The vast majority of Canadians who enjoy this private supplemental or "extended" health and dental insurance do so as a result of employer paid benefits. Consequently, it should not be a surprise that a person's standing in the job market goes a long way to determining if them and their family will have this private coverage on top of the basic provincial insurance (Marshall 2003; Hurley and Guindon 2008).

It is instructive to note here that it took the Canadian Life and Health Insurance Association almost four years to frame a coherent answer as to how governments ought to respond to *Chaoulli v. Quebec* (Canadian Life and Health Insurance Association 2009). The document begins by stating right up front that the best role for private health insurance in Canada is to stick to its current mandate, supporting and supplementing public insurance schemes. The document claims that the Association's members do not want to replace the public plans. It then cautiously

[3] So far as the author is aware, none of the major insurance companies are seeking to capitalize in a significant way on the *Chaoulli v. Quebec* decision. The only companies moving into the market are very small niche operators and some, such as Viator Priority Care are more properly characterized as medical tourism scheme as they offer to pay the cost of taking Canadians who are waiting for treatment to the US for treatment by an un-named health care network. Another plan that has gained prominence, OneWorld Medicare's Medical Access Insurance utilizes a network of private surgical clinics available in BC and Alberta, but skirts medicare laws by moving patients across provincial lines (elective care out of province is argued to be non-medically necessary by the operators). Neither is directly sponsored by a major insurance company. Instead they are being offered by independent brokers who then pass off the underwriting to larger companies.

advances the argument that the present division of responsibilities is not ideal. As noted above, medically necessary hospital, diagnostic and physician services are almost exclusively public covered (so called *Canada Health Act* services). Meanwhile, there is a mix of effort on everything else such as prescription drugs, dentistry, long-term and home care. Government covers low income families, the elderly and others with chronic illness to some extent, while others rely on private insurance or must pay on their own. The report asks whether it might be wise to allow private insurance for a wider range of elective care and then re-invest the savings in extending public coverage for *Non-Canada Health Act* services presently uncovered. In short, it is asking provinces to reconsider how they determine what is and is not medically necessary (and thereby open to private insurance). This would be a second order change (introducing new policies), not a third order (paradigmatic change). The report is hardly the work of a group eager to supplant the public system.

In order to fully grasp the situation, one must move beyond politics and consider the economic factors. From this perspective the challenges facing companies that wish to create a parallel for-profit insurance plan in Canada are substantial. Ironically enough, the BC Health Coalition hit the answer squarely on its head when they wrote that private health insurance which operates parallel to public plans run by the provinces would represent a product "that most of us can't afford." Unless a large pool of clients can afford a product, it is difficult for insurers to offer. This is because the basic principle that makes insurance work, the pooling of risks, does not apply. To understand why it is so hard to find clients, we have to appreciate:

- The principle sources of funding for private insurance are third party private payers, primarily employers.
- The difference between the Canadian and American context, specifically, the existence of a "public option" in Canada.
- The different structure of wealth in Canada

Although private insurers are paying for treatments and therapeutic products need by individuals and families, their real clients are the employers who foot much of the bill. For the most part, these employers were not interested in adding to the costs of their benefits plans in 2005 and that commitment to holding the line on benefit costs only solidified as the global recession of 2007-2009 commenced. Consequently, the reporting on *Chaoulli v. Quebec* in the human resources trade publications was focused on strategies businesses could employ to ensure their existing obligations did not expand to encompass the sort of coverage now allowed in Quebec (Vu 2006; Harding and Picard 2005; Gonzalez 2007; Gonzalez 2005; Boisvert 2006). Given the economic situation we now face as the slow recovery out of the recession continues six years later, it is hard to see how this refusal to expand benefits would have changed much.

If employers are not keen to fund the private insurance of the type now allowed in Quebec as a result of *Chaoulli v. Quebec* and potentially elsewhere in Canada, let alone a complete US style parallel private insurance scheme, what potential is there for a market to emerge among individual purchasers? To some extent the answer to this question depends on the degree to which these purchases are publicly subsidized. In one study economists predicted that if the province of Alberta replicates the public subsidies offered to Australians then perhaps 28% of

residents would enroll in private schemes (Emery and Gerrits 2005, 111-146). However, as the Alberta and BC experience showed, it would be politically impossible for any provincial government to not only introduce a two-tier system, but then offer public subsidies to those who join the upper tier. Another important point made by Emery and Gerrits (2005, 111-146) is that when public insurance was introduced in Australia, take-up rates for private insurance dropped dramatically. This is precisely the fear that US health insurance companies had during the recent debates on health reform in that country. Studies by reputable analysts showed that if a "public option" were part of the reform package, nearly 70 percent of those presently holding private insurance would switch to the public option or be switched into it by their employers. The cost and efficiency advantages of the public scheme, which would be assumed to use its purchasing clout to negotiate better deals than any other insurer could get, would make private plans uncompetitive. (Sheils 2009). Summing up the likely impact that a public health insurance option would have, *The Wall Street Journal* titled its editorial on the topic "The End of Private Health Insurance" (2009, A.14). It was the one reform America's health insurance could not accept and they lobbied furiously to get it removed from the plan (Britt 2010).

Not only does a parallel insurance system represent a bad business model in general, but in Canada it would likely be even more challenging. Assuming no serious deterioration in the nature of the publicly funded system, take up rates for any form of parallel private insurance are likely to be lower in Canada than in the United States because of the difference in income distributions. The following table illustrates this, showing average pre and post-tax incomes in Canada and the United States divided into quintiles.

Table 1. Average Income for Quintiles, 2011, Canada and the United States[4]

$1 Cdn = $1 US Rounded to nearest hundred	Canada		United States	
	Average Market Income	Average Post-Tax & Transfer Income	Average Market Income	Average Post-Tax & Transfer Income
Q1	6,800	15,100	7,900	31,600
Q2	24,300	33,400	31,100	Data not Available
Q3	47,200	51,200	55,400	58,000
Q4	80,200	75,900	89,600	Data not Available
Q5	170,100	139,400	240,800	188,300

As can be seen, Americans in 2011 enjoyed significantly higher average incomes than did Canadians at similar points in the income distribution. The disparity is especially stark when we look at Q5. Canadians at the top of our income distribution enjoy much lower incomes than Americans whether we are talking about the incomes earned in the market or whether we are talking about after government transfers and taxes have been factored in. The net result is that when faced with the option of a private alternative to a free public service, fewer families are likely to have the needed available income to accept the offer.

[4] According to the data available on the Bank of Canada website, the average exchange rate for the Canadian – US Dollar pair in 2011 was approximately even. Hence no adjustment is required.

How expensive it is to buy health insurance as an individual? The Henry J. Kaiser Family Foundation's, "Health Insurance Market Place Calculator" (2015) can provide some idea as to the costs facing American families who lack employer provided coverage. According to the calculator, a family of four (both parents age 35, non-smokers) with a family pre-tax income of $50,000 per year would pay an estimated premium of $3,340 per year (6.7% of the family's pre-tax income). The true market cost for this insurance would have be $9,625. However, this family would also be eligible for a $6,285 subsidy from the federal government. It should also be noted that this calculation is based on selecting a mid-level "silver" plan that comes with substantial user fees. The maximum annual total for user-fees this family would be liable for under a silver-level plan in 2015 is $10,400 (or up to 1/5th of the family's income used in this example). If a better quality gold or platinum plan were selected premium costs would rise as the available subsidy is the same regardless of what level plan is selected.[5]

Given the above discussion, it is difficult to see where the market would be for private health insurance that competes with Canada's provincial public programs. Employers don't want to pay and few individual families are likely to purchase it unless it is heavily subsidized by the state. Offering such subsidies would be an unrealistic proposition as this would undercut the supposed policy purpose of allowing such insurance, to reduce public expenditures. Even *Chaoulli v. Quebec's* applicability were extended beyond Quebec and the *Canada Health Act* amended to allow private insurance to expand, it is hard to see private health insurance that offers parallel coverage to provincial plans growing beyond a small niche offering. The presence of such a niche product might be philosophically displeasing for the defenders of Canadian medicare, but it likely will not jeopardize the system. Given these facts, it is also easier to understand why insures did not seize on *Chaoulli v. Quebec* and use it as a battering ram against the existing policy-network, and why the Campbell and Klein governments eventually walked away from their plans to introduce two-tier health care.

5. Conclusion: *Chaoulli v. Quebec*, Still about Nothing?

This paper presented the *Chaoulli v. Quebec* decision as a disruptive event for the Canadian health policy-network. Using Hall's typology of policy change (1993), it was then argued that in fact, the decision has had little impact on Canadian health care policy. There has been neither third order change (change in the paradigm) nor second order change (change in policies and instruments) that can be attributed to the decision. The best that can be said is that the decision might have encouraged first order change (ordinary routine change in existing policies and instruments). To explain why this was the case the paper argued that although a disruptive event can open a policy-window, this does not mean decision-makers will automatically climb through, nor does it mean that powerful interest groups will encourage them to do so. There was no major change to Canadian health policy because neither politicians nor the major insurance companies

[5] While this illustration is useful to highlight how expensive a private insurance model can be to both the individual and the government that has to subsidize it, it should not be used to make direct comparisons to Canada. This is because plans conforming to the Patient Protection and Affordable Care Act also include some things not necessarily public funded at zero cost to the patient by Canada's provinces such as pharmaceutical drugs, rehabilitation care and mental health services. These costs in Canada fall into the category of so-called "extended" or "supplemental" insurance which provinces fund for some patients and families suffering some conditions and which many families have private insurance to cover some of the costs for.

had could benefit from embracing the change on offer. It is incorrect to say *Chaoulli v. Quebec* is like Sienfeld, a show about nothing. However, it is as close to being about nothing as any Supreme Court decision can get.

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Appendix: Cases involving the financing and delivery of health care that cite Chaoulli v. Quebec

	Case	Main Issue	Reason to bring up Chaoulli
1	Bartley et al. v. Her Majesty the Queen in Right of Ontario [Indexed as: Bartley v. Ontario], 84 O.R. (3d) 71	Challenge to Ontario practice of billing negligent drivers for cost of Fire Dept. attendance at crash site on highways -- Dismissed	Delays in obtaining medical treatment can trigger S.7 Claims Chaoulli found not applicable to this case.
2	Wynberg et al. v. Her Majesty the Queen in Right of Ontario; Deskin et al. v. Her Majesty the Queen in Right of Ontario [Indexed as: Wynberg v. Ontario], 82 O.R. (3d) 561	Right of autistic children over age of six to receive same intensive treatment at public expense as those under six. -- Dismissed	Right to security includes mental health and treatments related to development. However, Chaoulli does not establish a positive duty on provinces to pay for medically necessary care.
3	Flora v. General Manager, Ontario Health Insurance Plan [Indexed as: Flora v. Ontario Health Insurance Plan (General Manager)], 83 O.R. (3d) 721	Demand Ontario pay for liver transplant done outside province after patient denied treatment as a result of medical evaluation -- Patient appealed decision to HSARB, rejected and then courts – Dismissed. Appeal to higher court also dismissed	Chaoulli does not establish a positive duty on provinces to pay for medically necessary care.
4	C.C.-W. (by his Litigation Guardian, M.W.) v. The General Manager, Ontario Health Insurance Plan J.F.-T. v. The General Manager, Ontario Health Insurance Plan The Estate of Mailloux, Deceased v. The General Manager, Ontario Health Insurance Plan [Indexed as: C.-W. (C.) v. Ontario Health Insurance Plan (General Manager)], 95 O.R. (3d) 48	Plaintiffs were denied reimbursement for care outside of province as did not seek prior written approval of GM of OHIP. HSARB confirmed denial as found no power in legislation for GM to grant retroactive approval. Court ruled GM could give retroactive approval IF care sought in an emergency where seeking approval would be unreasonable delay (referred two of three cases back to HSARB for reconsideration)	Chaoulli, government action prohibiting behavior amounted to Section 7. Violation. Court sided with 2 of 3 plaintiffs but not due to Chaoulli. Ruled HSARB decision that GM cannot give retroactive approval was an unreasonable decision.
5	The Person in Charge of the Centre for Addiction	Accused found mentally unfit to stand trial and a treatment order	Chaoulli issue: When forensic psychiatric facilities triage

	and Mental Health et al. v. Her Majesty the Queen et al. [Indexed as: Centre for Addiction and Mental Health v. Ontario], 111 O.R. (3d) 19	issued. Judge told a bed at an appropriate institution would not be available for 6 days. Judge ordered accused not be taken to jail but to institution and back to court each day until admission possible. Hospital authorities appealed – Appeal allowed	patients undergoing court ordered admission they do not automatically violate the S.7 rights of patients.
6	Toussaint v. Canada (Attorney General), [2011] 4 F.C.R. 367	Application for judicial review of federal government refusal to pay costs of medical care for person resident in Canada without status who has applied for permanent residence -- Dismissed	Court notes Chaoulli decision does not provide a free-standing right to government paid health care and in any event is only applicable vis-à-vis Quebec government.
7	Gray v. Ontario, [2006] O.J. No. 266	Appeal of decision by Ontario to close several homes for mentally challenged residents. -- Dismissed	Charter does not provide a free-standing right to health care.
8	Sagharian (Litigation guardian of) v. Ontario (Minister of Education), [2008] O.J. No. 2009	Appeal of dismissal of claim for damages on behalf of children with autism denied intensive treatment -- Dismissed	Chaoulli issues around "delay" not engaged as Ontario has the right to triage
9	Graham v. Ontario Health Insurance Plan (General Manager of), [2014] O.J. No. 1185	Appeal of claim for reimbursement for treatment received out of province for a treatment not covered in Ontario was denied and HSRB confirmed denial – Dismissed	Court found Chaoulli not relevant Chaoulli does not create positive right to care.
10	Jane Doe 1 v. Manitoba, [2005] M.J. No. 335	Successful appeal by Crown of summary decision in favour of plaintiff who challenged constitutionality of province's funding regime for therapeutic abortions -- Trial ordered	Chaoulli among other cases demonstrates complexity of S.7 issues involved and was released since lower court judgement
11	Canadian Doctors for Refugee Care v. Canada (Attorney General), [2014] F.C.J. No. 679	case challenging federal government decision not to fund health care for persons awaiting determination of refugee status who originated or travelled through designated countries – application granted as regulation	Chaoulli relied upon to determine if group has right to standing; in the case and SCC caution that courts should take in evaluating foreign health care systems and policy choices; obligation of courts to

		amounted to cruel and unusual treatment	not avoid complex matters; standard for determining if S.7. engaged
12	Waap v. Alberta, [2008] A.J. No. 1014	Patient suing for damages from physicians – allegedly negligent-- and provincial insurance plan after undergoing cancer treatment abroad –Dismissed, behavior did not meet standard of negligence and no grounds to include province in suit	In Chaoulli standard for portability is portability between provinces not internationally
13	Allen v. Alberta, [2014] A.J. No. 345	Patient claimed inability to buy private insurance caused delay in treatment in AB and to avoid went to US for care. Sought declaration that prohibition on private health insurance in Alberta unconstitutional. Dismissed – No evidence surgery in AB would have happened sooner if prohibition did not exist	Case directly engages same issues as Chaoulli
14	Schooff v. Medical Services Commission, [2009] B.C.J. No. 2309 also Cambie Surgeries Corp. v. British Columbia (Medical Services Commission), [2010] B.C.J. No. 1766	Main issue: Allegation sections of Medicare Protection Act that prohibit private payment for provincially insured services are unconstitutional – trial ordered. Second case was successful appeal against an injunction issued as part of the main case which would have allowed the BC Medical Services Commission to audit the clinic's records prior to a decision in the main case.	Case directly engages same issues as Chaoulli
15	Mendoza (Guardian ad litem of) v. Community Living British Columbia, [2009] B.C.J. No. 1370	Application to require province to pay for all services in a mentally disabled patients treatment plan -- Dismissed	Chaoulli concurring judgement by CJ and Major J. that Chaoulli does not create a positive right to publicly funded health care