

The Chaoulli judgment and Quebec's health-care system: Seven proposals in response to the Supreme Court ruling

On June 9, 2005, the Supreme Court of Canada struck down two legislative provisions in Quebec banning contracts with private insurance companies for health-care services covered under the public health-care and hospitalization plan. Four of the seven justices, a majority, concluded that the ban contravenes the Quebec Charter of Individual Rights and Freedoms. Three of the four also arrived at the same conclusion regarding the Canadian Charter of Rights and Freedoms. The other three justices (the dissenting minority) wanted to rule that banning private insurance contravenes neither the Quebec nor the Canadian Charter.

The application before the Court claimed that waiting times in the public system, given Quebec's ban on private insurance, put the applicant's right to life and safety at risk. The two applicants, Chaoulli and Zeliotis, were asking that, in the context of long waiting lists, the ban on private insurance be lifted for non-participating physicians. This is what the majority of four out of seven judges accorded.

The Court's decision received a mixed welcome, ranging from enthusiasm to fear. Some hope to use the ruling to reinforce the public health-care system. Some see it as an opportunity to open the way to a larger, even major, role for private health-care resources in Quebec and Canada.

In these early stages, it is important to distinguish what the ruling says from what some would like it to say. It is also important to distinguish the Supreme Court's conclusions from their eventual political impact.

The decision invalidates the two sections banning any insurance contracts for services covered by the public system (hospitalization and health-care insurance). Despite all appearances, this does not mean that the opposite is true, i.e. that all insurance contracts for services covered by the public system will be allowed. This is because of the existence of other **valid and central** legislative provisions, such as those linked to the category of non-participating physicians (*Health Insurance Act*, L.R.Q. Ch. A-29, Art 1 e, 26, 28, 30). There is a basic legal principle that provisions must be interpreted in the light of other provisions.

As for services supplied by physicians, the June 9 decision covers only the services of non-participating physicians, wherever they might practice in Quebec. The above-mentioned articles, which were not called into question by the Supreme Court, state that a physician participating in the public plan cannot receive private payments, whether from the patient directly or from the patient's insurer. Therefore, private insurance cannot apply to these services, even if there is no ban on private insurance. This is a major distinction and we must underline it. The majority justices put forward the mechanism of the complete separation of medical practice – the clear line drawn between participating and non-participating physicians – to support their ruling that banning private insurance is not essential. A close reading of the legal documents clearly shows that Chaoulli and Zeliotis's

application only targets non-participating physicians. And this is exactly – and **only** – what the Supreme Court majority granted them.

The judgement of Justice Deschamps of the Supreme Court, which strikes down the private insurance ban and which was supported by three other justices, is based on the central principle of mutually exclusive categories of participating and non-participating physicians. *A contrario*, we must conclude that, in the absence of the separation of medical practice financed by public or private funds, the Supreme Court majority would not have invalidated the provisions in question. The one is conditional on the other.

In January 2006, Quebec's National Assembly will hold a parliamentary commission to study proposals to be considered in response to the ruling. An inter-ministerial committee is working on preparing these proposals for legislative amendments. This committee's mandate is broad. It includes "a study of the impact [...] of the establishment of a private insurance scheme for hospital and health-care services; an attentive and complete analysis of the various modes of organizing health care that allow more or less co-habitation of public and private funding [...] as well as proposals for measures enabling the preservation of the integrity of the Quebec public system" (Affidavit of deputy minister Iglesias, MSSS, June 27, 2005). Others suggest a health-care funding scheme like the one set up by Quebec's General Drug Insurance Plan (See Santé Inc., September 2005, pp. 28-31).

In brief, speculation is rampant. The Supreme Court ruling (although it wasn't unanimous and bears on one particular aspect of the system's problems) could be used as a pretext to radically amend the legislative structure of health-care and hospitalization plans, even though such action is clearly not a necessary response to the Supreme Court's conclusion, or could even be contrary to it.

The road ahead could be dangerous. That is why we think it is urgent to put our cards on the table and make concrete proposals aimed essentially at first taking stock of the problem of unacceptable waiting times that forms the basis of the Supreme Court's ruling, then at preserving the integrity of a viable public health-care system capable of innovating and facing the challenges of accessibility.

Our primary objective in this effort is not to start a discussion on all aspects of funding and organizing health care (where we do in fact think improvements are necessary or should be pursued), but rather to focus our proposals directly on waiting times.

Goals

In the face of falsely alarmist speeches, we must first remember that Quebec's public health-care system has more strengths than weaknesses, as reflected in the general health of the population. In Quebec, citizens may legally claim free access to medically required health services (with a few exceptions noted below), meaning this right comes with citizenship and does not depend on a person's socio-economic situation. This basic legal right to health care is not at all at issue in the Supreme Court of Canada's ruling. In order to maintain access to health care and services as a basic human right not dependant on an

individual's socio-economic status, we must demand that the following two goals be adopted and upheld through the seven interrelated proposals listed below.

Goal 1: Ensure universal access to high-quality public health care and health services.

Goal 2: Reduce waiting times at all levels.

Each of the seven following proposals aims to meet these goals.

1. **Ensure free and public coverage for all medically necessary services, whether or not they are offered in a hospital. Notably, this means re-instating medically necessary services that have been excluded from public insurance coverage – in particular, diagnostic tests.**
2. **Eliminate budget restrictions in the health-care system that unnecessarily limit the use of otherwise available human and material resources.**
3. **Continue the process of lifting ceilings on physicians' incomes, in order to increase their availability so as to better respond to the needs of the population.**
4. **Maintain the category of non-participating physicians and the principle that physicians must choose to be exclusively inside or outside the public plan.**
5. **Prohibit non-participating physicians from charging higher fees for the same services provided by participating physicians.**
6. **Reserve equipment in public facilities for the exclusive use of participating physicians.**
7. **Ensure public and transparent analysis of waiting lists, and take active measures to provide physicians, patients, health institutions and case managers with information and referral services.**

We will briefly explain each proposal, with context and proposed recommendations.

Proposal 1

Ensure free and public coverage for all medically necessary services, whether or not they are offered in a hospital. Notably, this means re-instating medically necessary services that have been excluded from public insurance coverage – in particular, diagnostic tests.

In a public health-care plan, it is essential to cover all medically required services. According to the Supreme Court, these services must be delivered within a reasonable period of time. So, we must ask ourselves, “where are unacceptable delays occurring right now?” Furthermore, we must recognize that no system can (or should) completely

eliminate all wait times, or else the system would grow unmanageably large and prohibitively expensive.

From the passing of the *Health Insurance Act*, the Quebec government adopted, through regulations or orders-in-council, a list of services that would not be covered, for example examinations or services unrelated to healing or prevention of illness, and cosmetic surgery. Since the 1980s, exclusions to public coverage based on the place they are delivered increased, to the point where certain tests are now only covered when they are carried out in a hospital setting, for example ultrasound, tomography (scanning), Magnetic Resonance Imaging (MRI), and others.

At the same time, public policy (funding, subsidies, tax laws) promoted the acquisition of these diagnostic devices in clinics outside the hospital setting. When a patient's health requires tests that are not covered outside the hospital setting, the attending physician often has no other option than to give the patient the difficult choice of waiting weeks before undergoing the test in the hospital or paying out of pocket for quicker access through a clinic. This problem varies greatly from region to region, depending on the availability of public resources, thus creating inequities between regions and even between some Montreal neighbourhoods.

These situations sometimes create ethical problems where a physician with financial interests in a private clinic is placed in a conflict of interest. This passive privatization of health-care services is unacceptable. Public health policies should not put patients in situations where they must pay for services required for their health.

The public policy to fund the purchase of devices by private clinics (especially through tax policies) should be in line with the objective of covering medically required services. Thus, the public plan must pay for medically required services, whether they are provided in a hospital environment or not.

Proposal 2

Eliminate budget restrictions in the health-care system that unnecessarily limit the use of otherwise available human and material resources.

Unreasonable wait times for some services have become the Achilles heel of the Quebec public health-care system and are the targets of the Supreme Court ruling. It is therefore necessary and important to respond to this by trying to identify the systemic causes, which are also garnering media and public attention.

We know that health-care resources are limited and that they must be very carefully managed. The concept of a "waiting list" is in itself complex, and the dissenting justices brought up the inconsistencies and unscientific method of measuring wait times. There is certainly important work to be done in this respect. As for the lack of human resources, this was brought about by various measures, including quotas for admittance to certain professions, as well as by encouraging physicians and other experienced health

professionals to take early retirement, part of the wave of political decisions in the zero-deficit era. This situation is being corrected by increasing the number of students in university programs. The delay in procuring certain diagnostic devices in the public sector is also at issue. Once again, a process of catch-up has begun.

Let us take for granted that we are targeting waiting times that an expert committee would judge to be clearly unreasonable. Among the reasons for lower productivity of available human and material resources in the public health-care system, we can identify two key issues.

One is inadequacy of hospital budgets allocated according to the number of beds, not according to the seriousness of the illnesses being treated or the incidence of health problems in the population served by the hospital. These hospitals have the facilities and staff necessary to do more interventions, but do not function at full capacity because their budgets do not allow it.

This method of allocating budgets by health facility and the type of limits should be questioned within a process that would involve health authorities and the institutions.

Proposal 3

Continue the process of lifting ceilings on physicians' incomes, in order to increase their availability so as to better respond to the needs of the population.

A second cause of unreasonable waiting times occurs when the physician is prepared to work longer hours to respond to the needs of her patients, but does not do so because she has reached her quarterly or bi-yearly billing limit, with the ensuing impact on access to care.¹

The suppressed services are not superfluous, abusive, or otherwise not medically required. Abusive or superfluous medical practice is subject to separate controls under the Régie de l'assurance médicale du Québec (RAMQ – Quebec medicare), professional corporations, and the facilities' Councils of physicians, dentists, and pharmacists.

The money recovered from general practitioners by the RAMQ in 2003-2004 amounted to \$2,086,000 (Rénald Dutil, *Le médecin au Québec*, May 2005), but we do not know how many patients were refused services because of these limits.

We propose that this type of limit on remuneration be gradually lifted within a transparent process that involves the health authorities and the physicians' federations.

¹ Explanatory note added by CUPE National: In Quebec, physicians are allowed to bill up to a certain level at the full fee schedule; for services above that level, they are reimbursed at a lower rate.

Proposal 4

Maintain the category of non-participating physicians and the principle that physicians must choose to be exclusively inside or outside the public plan.

It is untrue, as some have said since June 9, 2005, that the Supreme Court has opened the door to private insurance contracts for all hospital and health-care services covered by the public plan. For services supplied by physicians in a hospital or elsewhere, only those services supplied by a non-participating physician can be covered by private insurance. In the face of this opening to private insurance contracts by the Supreme Court, it is even more critical to maintain the category of non-participating physician, part of the *Health Insurance Act* (L.R.Q., c. A-29, Art. 1 e), 26, 28, 30).

The Supreme Court only accepted to lift the ban on insurance because the Quebec legal system provides for the clearly drawn line of medical practice between participating and non-participating physicians. Lifting this statute would contravene the Supreme Court's ruling. All Canadian provinces have similar rules, which are expressed slightly differently from one province to another. This rule is inherent in the health-care systems of Canadian provinces and is aimed at reducing the possibility of subsidizing a parallel health-care system through public funding.

A mixed medical practice (public and private funding) could accelerate the trend toward, overall, a greater proportion of physician time spent in private practice, versus time spent working in the public system. This could encourage physicians to refer patients to their private practice, which is a commonly stated problem of mixed practice. This loss of human resources seems to be especially risky when we consider the current conditions of medical practice in those sectors where access is already severely compromised.

It seems more rational to us and more in line with the Supreme Court's ruling to directly correct these problems rather than to promote a hybrid system that would further dilute resources.

Proposal 5

Prohibit non-participating physicians from charging higher fees for the same services provided by participating physicians.

At the very beginning of the health-care plan, Quebec implemented two main measures to direct maximum resources to the public plan and minimize the use of public funds to subsidize private health care: establishing the category of non-participating physicians (which we are asking to be maintained in point #4) and the ban on private insurance (which was just struck down). This type of measure enables us to reduce the risk of cross-subsidization of the private medical industry through public funding. Since the second measure has just fallen for non-participating physicians, we propose implementing a complementary measure to protect the public system, one that is already in use in Ontario,

Manitoba, and Nova Scotia, by regulating the fees that non-participating physicians can charge.

We propose that legislation limit financial compensation paid to non-participating physicians by the patient or his insurer to the same level as the fees negotiated and approved for a practice within the public sector.

Proposal 6

Reserve equipment in public facilities for the exclusive use of participating physicians.

Physicians choosing to work within a privately funded system and companies choosing to operate in this market must take responsibility for their choice, especially with respect to the investment required. The public sector should not subsidize private clinics' infrastructure or equipment. These amounts can be considerable, especially for some specializations. Similarly, equipment funded by public money must be reserved for the exclusive use of patients covered by the public plan, in order to reduce the risk of indirect public subsidies to private services. It is inadmissible for patients covered by a private plan to have better access to public equipment.

Proposal 7

Ensure public and transparent analysis of waiting lists, and take active measures to provide physicians, patients, health institutions and case managers with information and referral services.

In his recent *Report on developments since the Federal-Provincial Agreement in 2004* (MSSS, 2005), Quebec's health minister announced "steps to clarify the content of waiting lists" and "a plan to prioritize patients whose waiting list (only for certain procedures) is longer than recognized times." This step presupposes that there will be consensus on the definition of acceptable wait times for diagnosis or for a necessary treatment or service. It also presupposes that tools and criteria will be developed to "prioritize" patients on the same waiting list. These problems are already being studied in Canada (see the work of the *Western Canada Waiting List Project*) and elsewhere. We can expect the acceptable time to vary according to the point of view of the analysis and the values of the physicians, patients, decision-makers, economists, and other experts. Any process to establish such barometers must be transparent and conclusions must be subject to periodic reviews.

The fuzziness surrounding questions of accessibility maintains a feeling of general insecurity and gives rise to the worst kind of speculation. We need an integrated system to supervise and analyze the impact of waiting lists on the health, activities and quality of care of Quebecers.

Such a system would allow us to implement more judicious use of our resources and set up concrete projects to respond to the problems of accessibility. Information should be publicly available and aimed at patients, physicians, institutions, and managers.

Furthermore, while respecting the patient's right to choose, new Health and Social Services Centres or Regional Agents could be responsible for informing everyone about availability and, on request, for referring patients to those places where services are available.

Conclusion

In conclusion, we must recognize that the Chaoulli ruling summons us to better understand the problem of accessibility in our public health-care system and to act rationally and in a concerted fashion to solve the problems we have underlined. The Supreme Court ruling in no way imposes the false loophole of developing a parallel private health-care system. In fact, it is based on the opposite idea. Nothing justifies radical change to the legal system of the public health-care and hospitalization plan.

If recourse to a completely private health-care plan or co-habitation of public and private funding can, at first glance, reassure some people, these systems would quickly reveal their faults. In addition, "the arrival of services funded by the private sector runs the risk of compromising the efforts by the ministry and the entire health-care and social services network to encourage a greater integration of services, since many players could be working on the margins of the public system" (Affidavit of deputy minister Iglesias, of MSSS, June 27, 2005, paragraph 15, p. 4).

The health-care system has been one of the most debated social issues in Quebec over the past 40 years. There is not a Quebecer who does not have an opinion on the subject and who is not concerned about its future. The Quebec system has never hesitated to propose innovative and daring solutions to remain up to date.

In response to the Chaoulli ruling, we put forward these proposals to ensure the viability of a public health-care system that will be better prepared to adapt to challenges through better tools to supervise and analyze problems of accessibility. These problems certainly mean large, targeted, medium and long-term investment. Any funding must result in concrete projects involving many players. The Quebec government must act carefully with respect to its health-care plan and clearly side with its citizens. The right to health care in Quebec is a citizen's right, and it must stay that way.

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