CHAPTER 4

Chaoulli v Quebec: Cause or Symptom of Quebec Health System Privatization?

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Chaoulli v Quebec

In a much-publicized and contentious decision, the Supreme Court of Canada ruled in 2005 that Quebec's legal prohibition on the purchase of private insurance for publicly insured services contravened the *Quebec Charter of Human Rights and Freedoms, when the public system wait times are too long.*[1] Jacques Chaoulli, an orthopaedic surgeon, had a longstanding, strained relationship with the Quebec health care system. He had opted out of the public health insurance system but was unsuccessful in his attempts to obtain a license for providing privately financed home-delivered medical services and to operate an independent private hospital. In his challenge of Quebec's law banning private insurance, he was supported by George Zeliotis, a user of the health care system who claimed his quality of life had been compromised as a result of having to wait a year for hip-replacement surgery.[2] Notably, Chaoulli and Zeliotis' claims

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1 *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*].

2 *Ibid.*

were not initially joint but they merged their mutual interests after both had unsuccessful attempts with their individual challenges.[3] As discussed in chapter 2, the applicants' challenge relied on both the *Canadian Charter of Rights and Freedoms*[4] and the *Quebec Charter of Human Rights & Freedoms*,[5] but it was only in the latter that the Supreme Court reached a majority conclusion. With respect to the *Canadian Charter*, the court was divided (a 3–3 ruling with one abstention). Therefore, the ruling's influence was largely applicable only in Quebec (although its normative potential as harbinger of future *Charter* challenges was significant).

As others discuss in this volume, the forthcoming challenge in *Cambie*[6] relies on the *Canadian Charter*, and, if successful, will have national implications given the similarities of laws across Canada protective of public medicare. Further, *Cambie* is a much broader challenge than *Chaoulli*, tackling not only the ban on private health insurance, but also provisions related to extra-billing bans, user-fee bans, tariff limits, and dual-practice bans. The implications, therefore, are much broader in terms of potential impact.

In this chapter, we describe the Quebec government's response to *Chaoulli*, explore the extent of privatization of health care in Quebec, and discuss the extent of the evidence showing a relationship between privatization growth and the *Chaoulli* ruling. The introduction of Bill 33 by the Quebec government on the heels of *Chaoulli* raised several concerns about the potential for expansion, and runaway, of the private market,[7] while the then health minister (Philippe Couillard) downplayed its potential impact, pronouncing: "En réponse au jugement rendu par la Cour suprême du Canada, le gouvernement entend agir avec grande prudence et ne permettre qu'une ouverture très limitée à l'assurance privée."[8]

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3 Christopher P Manfredi and Antonia Maioni, "*Chaoulli v Québec*: The Last Line of Defence for Citizens" in *Health Care and the Charter: Legal Mobilization and Policy Change in Canada* (Vancouver: University of British Columbia Press, 2018).

4 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

5 *Charter of Human Rights and Freedoms*, CQLR, 2016, c C-12 [Quebec *Charter*].

6 *Cambie Surgeries v British Columbia (Medical Services Commission)*, (2015) Vancouver S090663 [*Cambie*].

7 Marie-Claude Prémont, "Clearing the Path for Private Health Markets in Post-Chaoulli Quebec" (2008) Health LJ 237.

8 National Assembly of Québec, Committee on Social Affairs, *Consultations Particulières Sur Le Projet de Loi No 33 — Loi Modifiant La Loi Sur Les Services*

In this chapter, we look at the consequences of Bill 33 twelve years after its 2006 implementation. First, we will present the government's response to the *Chaoulli* decision, Bill 33, and demonstrate that the elements of the bill that were of greatest concern—namely, that there would be a surge growth of duplicative private insurance and of private medical clinics—did not manifest as problems. Having said that, Quebec is arguably home to one of the most dynamic private health markets in the country, and thus, as we will discuss, *Chaoulli* may have had an impact outside the scope of Bill 33. In the second section of this chapter, we turn to review some of the critical "hot spots" of privatization in Quebec that could have been exacerbated by *Chaoulli*. We find evidence to show that privatization *was already under way* before this decision, sometimes decades prior. This is true of private diagnostic services, which are reimbursable by private insurance; of physicians opting out of the public system; and of user fees. We then conclude with a contrast of the policy instruments targeted respectively by *Chaoulli* and *Cambie*, and draw hypotheses regarding future responses in Quebec considering the trends observed to this day. Through these examples, we demonstrate that *Chaoulli* was not so much the cause as much as a symptom of rampant privatization of the Quebec system. This would lead us to expect that a decision in favour of *Cambie* would find fertile ground in Quebec.

The Government's Response

One year after the *Chaoulli* ruling, the Quebec government enacted Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*. This legislation did allow for the purchase of private insurance, but only for three procedures (hip, knee, and cataract surgeries). However, it also provided that procedures for which private insurance would be allowed would be determined by regulation, thereby facilitating the subsequent expansion of such. The list of such procedures was indeed subsequently amended in 2008 to include some cosmetic surgeries performed with anaesthesia, and, when provided under general or regional anaesthesia, included some forms of breast, cosmetic, orthopedic, upper

de Santé et Les Services Sociaux et d'autres Dispositions Législatives, 39, No 45 (12 September 2006).

respiratory tract, vascular and lymphatic, digestive, gynecological, nervous system, eye, ear, and cutaneous surgeries, and breast biopsies.[9] While the government's white paper, which preceded the bill and outlined the intended response, proposed clear guidelines for wait times guarantees, no such standard was present in Bill 33, and any designation of "how long would be too long" was ultimately left up to the health minister's discretion.[10] In addition, the bill provided a legal framework for the establishment of (private) specialized medical clinics to perform the above-mentioned surgical procedures, also allowing public hospitals to contract out procedures listed in the regulations to these private clinics when the public system could not meet its wait time objectives. Finally, Bill 33 effectively maintained a seal between public and private practice. First, it maintained the prohibition against public-private dual practice, which prevents physicians from billing both privately and publicly for the same medically necessary acts that are publicly insured. In addition, it included a new provision prohibiting physicians from the public and the private sectors from working under the same roof. In effect, this meant that physicians staffing the private medical clinics had to entirely opt out from receiving any remuneration from the Quebec public insurance plan (RAMQ).

The introduction of Bill 33 was contentious. While the Quebec government asserted that it was a necessary response to a Supreme Court of Canada ruling, commentators claimed that other options were possible. Many indeed argued that the government could (and indeed, should) have invoked the notwithstanding clause (s. 33) of the *Canadian Charter* to maintain the prohibition against private insurance, declaring that it applies despite section 52[11] of the Quebec *Charter*.[12] An in-depth review of stakeholder input during

9 *Regulation Respecting the Specialized Medical Treatments Provided in a Specialized Medical Centre*, CQLR c S-4.2, r 25.

10 "Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality" (2006), online (PDF): *Government of Québec* <https://www.bibliotheque.assnat.qc.ca/DepotNumerique_v2/AffichageFichier.aspx?idf=101908>.

11 Section 52 of the Quebec *Charter* states: "No provision of any Act, even subsequent to the Charter, may derogate from sections 1 to 38, except so far as provided by those sections, unless such Act expressly states that it applies despite the Charter."

12 Jean-Francois Gaudreault-Desbiens & Charles-Maxime Panaccio, "Chaoulli and Québec's Charter of Human Rights and Freedoms," in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate over*

the bill's review process indicates that very little changed between its introduction and final assent, despite vocal reservations from interest groups; for instance, the Confédération des organismes de personnes handicapées du Québec,[13] the Fédérations des infirmières et infirmiers du Québec,[14] and the Confédération des syndicats nationaux[15] all expressed concern during the consultations over the extension of private health care provided for in the bill; the Fédération des médecins omnipraticiens du Québec (FMOQ)[16] and the Fédération des médecins résidents du Québec (FMRQ),[17] while generally agreeing with the government's objectives to reduce wait times, also questioned the necessity of further gains in the private sector. However, despite the concerns raised by stakeholders

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Private Health Insurance in Canada (Toronto: University of Toronto Press, 2005) at 32.

13 La Confédération des Organismes de Personnes Handicapées du Québec, "Avis de La Confédération des Organismes de Personnes Handicapées Du Québec (COPHAN) Présenté à La Commission Des Affaires Sociales Sur Le Projet de Loi 33: Loi Modifiant La Loi Sur Les Services de Santé et Les Services Sociaux et d'autres Dispositions Législatives" (October 2006), online (PDF): <http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_2613&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

14 Fédération des infirmières et infirmiers du Québec, "Mémoire: Des Cliniques Publiques Financées Publiquement" (12 September 2006), online (PDF): <www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_6711&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

15 Confédération des syndicats nationaux, "Commentaires de La Confédération Des Syndicats Nationaux Sur Le Projet de Loi No 33: Loi Modifiant La Loi Sur Les Services de Santé et Les Services Sociaux et Autres Dispositions Législatives" (7 September 2006), online (PDF): <www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_2633&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

16 Fédération des médecins omnipraticiens du Québec, "Mémoire de La Fédération Des Médecins Omnipraticiens Du Québec à La Commission Des Affaires Sociales" (13 September 2006), online (PDF): <www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_2691&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

17 Fédération des médecins résidents du Québec, "Mémoire de La FMRQ Déposé Dans Le Cadre Des Travaux de La Commission Des Affaires Sociales" (5 September, 2006), online (PDF): <http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_2693&process=Default&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

during the consultative process, the final bill contained no major amendments.[18] Accordingly, the government appeared to be politically compliant with the goal of private market expansion. Finally, while the bill was introduced as a response to long wait times, it did not include any legislated wait time guarantees.

Consequences of Bill 33

Thirteen years later, what is the legacy of Bill 33 in Quebec? We will examine the three most prominent elements of this legislation; namely, the provisions allowing specialized medical centres (i.e., private medical clinics performing surgical procedures) to contract with the public sector, duplicative private health insurance for specific procedures, and wait times targets. The first two were highly contentious elements that were thought to pave the way for increased privatization of the system, while the third could be a positive development for the public system, helping it to address the problem of wait times that justified the legal challenge in the first instance.

Specialized medical centres and duplicative private health insurance

In 2015, there were thirty-nine specialized medical centres in Quebec.[19] Of these, most centres offer plastic and cosmetic surgeries,[20] with only a minority delivering medically necessary (also publicly insured) services. Contracts between private clinics and public hospitals were similarly extremely rare, from a height of three in 2011 down to one in 2015.[21] In turn, duplicative private health insurance did not develop at all in Quebec with regard to the list of approved

18 "Stages in the consideration of the Bill" (2018), online: *National Assembly of Quebec* <http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-33-37-2.html>.

19 "L'étude des crédits 2015–2016 — Réponses aux questions particulières — Opposition Officielle — Volume 1" (5 May 2015), online (PDF): *Ministère de la Santé et des Services Sociaux* <www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_104227&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.

20 Yanick Labrie, "The Public Health Care Monopoly on Trial: The Legal Challenges Aiming to Change Canada's Health Care Policies" (November 2015), online (PDF): *Montreal Economic Institute* <www.iedm.org/sites/default/files/pub_files/cahier0515_en.pdf>.

21 However, we were not able to document whether this agreement is still in operation.

services. In sum, the impact of Bill 33 per se on private health care in Quebec through two of the most prominent instruments appears to have been quite limited.

Wait times

One of the most prominent issues in the *Chaoulli* decision, and the Bill 33 response, was that of wait times: perhaps the most salient issue at the heart of private versus public health care debates. Prior to 2005, wait list issues were already on the government radar; the 2004 Health Accord, a ten-year framework that identified Federal priorities for provincial and territorial health systems funding provided through the Canada Health Transfer, emphasized the importance of reducing wait times across Canada,[22] including the development of a $5.5 billion Wait Times Reduction Fund.[23] With the principle of asymmetry in Canadian federalism, Quebec was permitted to develop its own wait times reduction strategy under the agreement rather than subscribe to the federal priorities, although it was acknowledged that the priorities were similar.[24] Quebec's initial focus was on improving timely access for tertiary cardiology and radio-oncology.[25] At that time, cataract and joint-replacement surgery were also determined to be priorities, but a system to manage wait lists in these areas was not yet in place.

By December 2005, the Quebec government had committed to assess current wait lists and endeavour to move patients more quickly. Part of the government's response to the *Chaoulli* decision was to guarantee access to these services at a public facility within six months. Notably, this guarantee was not written into the Bill 33 legislation but was enacted as an administrative target. Should the

22 "A 10-Year Plan to Strengthen Health Care" (2004), online (PDF): *Canadian Intergovernmental Conference Secretariat* <www.scics.gc.ca/CMFiles/800042005_e1JXB-342011-6611.pdf>.

23 Sonya Norris, "The Wait Times Issue and the Patient Wait Times Guarantee" in *Current Publications: Health* (Ottawa: Parliament of Canada, October 2009).

24 Health Canada, "Asymetrical Federalism That Respects Quebec's Jurisdiction" (9 May 2006), online: *Government of Canada* <www.canada.ca/en/health-canada/services/health-care-system/health-care-system-delivery/federal-provincial-territorial-collaboration/first-ministers-meeting-year-plan-2004/asymetrical-federalism-respects-quebec-jurisdiction.html>.

25 "Bilan des progrès accomplis à l'égard de l'entente bilatérale intervenue à l'issue de la rencontre fédérale-provinciale-territoriale des premiers ministres sur la santé de septembre 2004" (2005), online (PDF): *Ministère de la santé et services sociaux Québec* <publications.msss.gouv.qc.ca/msss/fichiers/2005/05-720-01F.pdf>.

facility not be able to attain the service within the guaranteed time, it was required to offer the patient another solution by facilitating (and paying for) the procedure in a private facility (a "specialized medical clinic"). Some have argued that this strategy opened the door to increased privatization by explicitly regulating private clinics.[26]

Data allowing a systematic assessment of the impact of this private insurance provision on wait times are scarce. Having said that, there is clear evidence that increasing duplicate private insurance does not alleviate public wait lists.[27] In Quebec, the market for this duplicate health insurance did not develop substantially in the wake of Bill 33, and there has been limited uptake by consumers, likely due to the restricted scope of the products and the parallel efforts to impose wait time guarantees for the same services in the public sector (e.g., cataract, knee, and hip surgeries).[28]

What we can document is that, as of 2017, Quebec's public waits outperformed the Canadian average for the services targeted with the legislation. Eighty-three per cent of hip-replacement surgeries were completed within the benchmark of 182 days (fig. 4.1).[29] Similarly, for knee-replacement surgery, 80 per cent of (public) surgeries achieved the benchmark (fig. 4.2). For cataract surgeries, the benchmark is 112 days; 85 per cent of procedures in Quebec reached this benchmark, surpassed only by Newfoundland and Labrador, with 87 per cent (fig. 4.3).[30]

It is relevant to consider whether Quebec's relatively high performance on these metrics is due to the expansion of the private market for these services. However, we lack data on the performance of private clinics, both in terms of volume and wait times. One of the typical arguments made in favour of allowing two-tier care is

26 Prémont, *supra* note 8.

27 Carolyn DeCoster et al, "Waiting Times for Surgical Procedures," (1999) 37:6 Med Care 187; Stephen Duckett, "Private Care and Public Waiting" (2005) 29:1 Austl Health Rev 87; Carolyn Hughes Tuohy, Colleen M Flood & Mark Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations" (2004) J Health Pol Pol'y & L 359.

28 "No One Wants Quebec's Limited Private Health Insurance," *CBC News* (30 March 2009), online: <http://www.cbc.ca/news/canada/montreal/no-one-wants-quebec-s-limited-private-health-insurance-1.853098>; Marco Laverdière, "Les Suites de l'Arrêt *Chaoulli* et les Engagements Internationaux du Canada en Matière de Protection des Droits Fondamentaux" (2007) 38 RDUS 1.

29 Canadian Institute for Health Information, "Wait Times" (2017), online: <http://waittimes.cihi.ca/>.

30 *Ibid.*

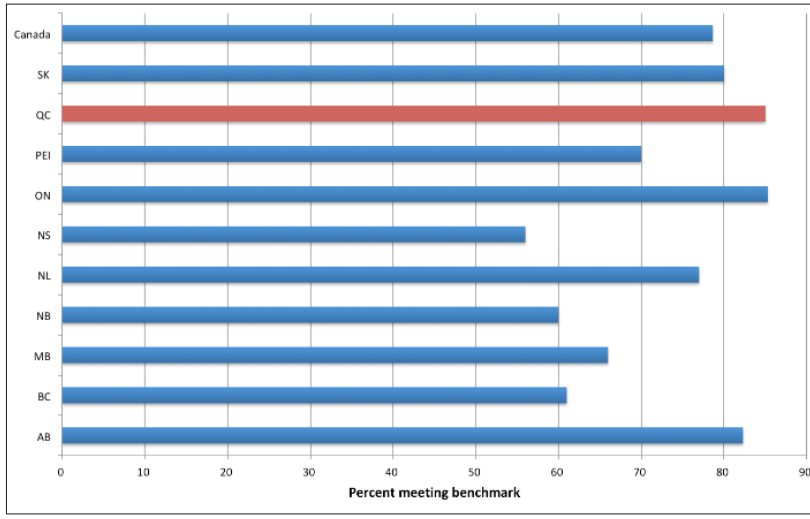

Figure 4.1 Hip-replacement surgeries: Percentage of surgeries meeting benchmark for waiting times in 2016, by province.
Source: Canadian Institute for Health Information, "Benchmarks for treatment and wait time trending across Canada" (2019), online: <http://waittimes.cihi.ca/>.

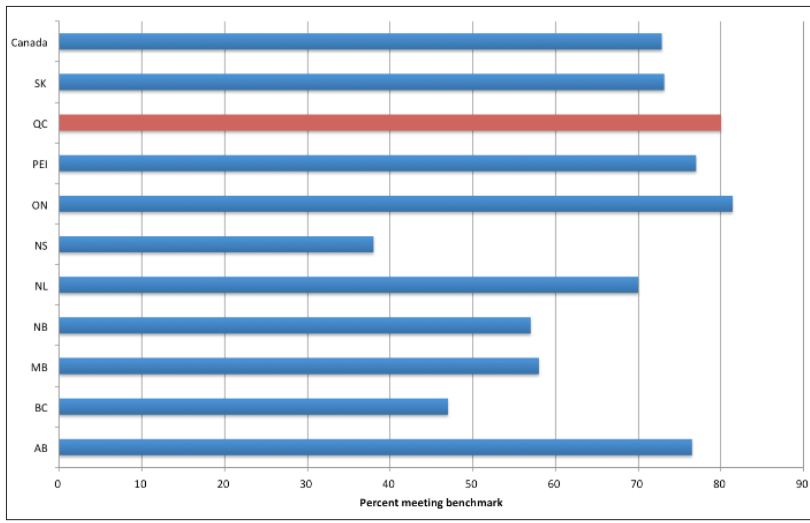

Figure 4.2 Knee-replacement surgeries: Percentage of surgeries meeting benchmark for waiting times in 2016, by province.
Source: Canadian Institute for Health Information, "Benchmarks for treatment and wait time trending across Canada" (2019), online: <http://waittimes.cihi.ca/>.

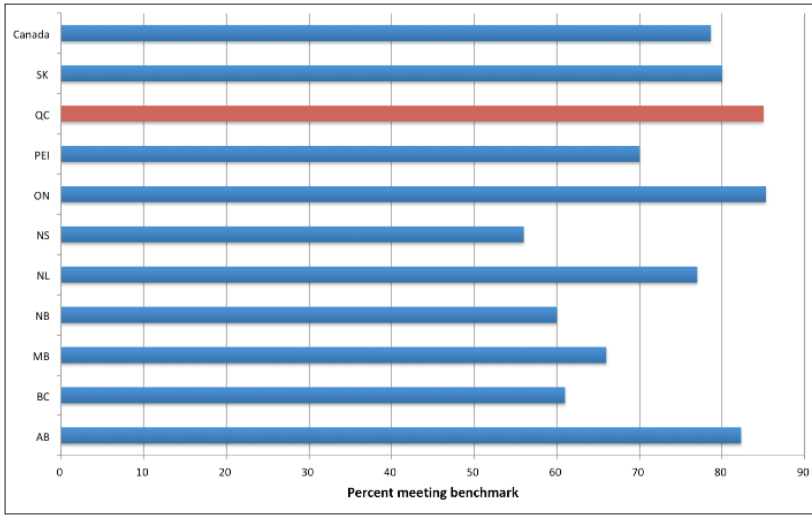

Figure 4.3. Cataract surgeries: Percentage of surgeries meeting benchmark for waiting times in 2016, by province.
Source: Canadian Institute for Health Information, "Benchmarks for treatment and wait time trending across Canada" (2019), online: <http://waittimes.cihi.ca/>.

that an expansion of private services will reduce pressure on the public system, thereby allowing the public system to perform better. But international data demonstrate that parallel private systems rarely lead to improved public-sector performance,[31] and, in fact, a Canadian natural experiment showed that public-private dual practice increased wait times in the public sector.[32] Furthermore, we do not have comparable time-series data dating back sufficiently before the implementation of Bill 33 to allow a clear analysis of the trend in wait times—and the potential causal impact of the bill. Finally, the provisions in Bill 33 put pressure on the public system to attain wait time standards or else assume the administrative and cost burden of accommodating patients in a parallel sector. This alone could explain a potential improvement in performance. Finally, in addition to revoking the prohibition on private insurance, Bill 33 also mandated centralized wait list mechanisms for specialized services within each hospital centre and required increased monitoring of the amount of time patients were spending on wait lists. In our view, it is highly

31 Duckett, *supra* note 28; Tuohy, *supra* note 28.
32 DeCoster, *supra* note 28.

likely that these provisions did far more to improve wait times than the few specialized medical centres operating in Quebec.

Hot Spots of Health Care Privatization in Quebec

Diagnostic Imaging

With regard to the privatization debate and the growth of private services, one area in which Quebec has been widely publicized has been in the growth of private diagnostic-imaging clinics.[33] According to Canadian Institute for Health Information (CIHI) statistics on select medical-imaging equipment in Canada (fig. 4.4), there has been a steady growth in the availability of MRI and CT scanners in free-standing facilities in Quebec over the past twenty years.[34] Based on the data collected in the CIHI survey, free-standing facilities reported private health insurance, out-of-pocket payments, and other private insurance as their primary source of operating revenue.[35] While some have argued that the *Chaoulli* decision acted as a catalyst for the introduction of duplicative private health insurance and the growth of private health markets,[36] we demonstrate in this section that the provision of private insurance for services such as diagnostic imaging in Quebec *precedes Chaoulli*, and is rooted in legislative and regulatory amendments throughout the 1980s and 1990s.

In December 1981, the Quebec government passed Bill 27, *An Act to amend various legislation in the field of health and social services*.[37] Among other changes, the bill allowed the government greater authority in publicly delisting certain medical services, notably on the basis of location. Previously, governments could only determine the *type* of services that could be included or excluded from the

33 Wendy Glauser, "Private Clinics Continue Explosive Growth" (2011) 183:8 CMAJ 437.

34 Canadian Institute for Health Information, "Medical Imaging in Canada, 2007," (Ottawa: Canadian Institute for Health Information, 2008), online: <https://secure.cihi.ca/free_products/MIT_2007_e.pdf>; Canadian Institute for Health Information, "Medical Imaging in Canada, 2012" (2013), online (PDF): <https://www.cihi.ca/en/mit_summary_2012_en.pdf>.

35 Gilles Fortin, Jennifer Zelmer & Kira Leeb, "More Scans, More Scanners" (2005) 8 Healthcare Q 28.

36 Prémont, *supra* note 8.

37 *An Act to Amend Various Legislation in the Field of Health and Social Services*, SQ 1981, c 22.

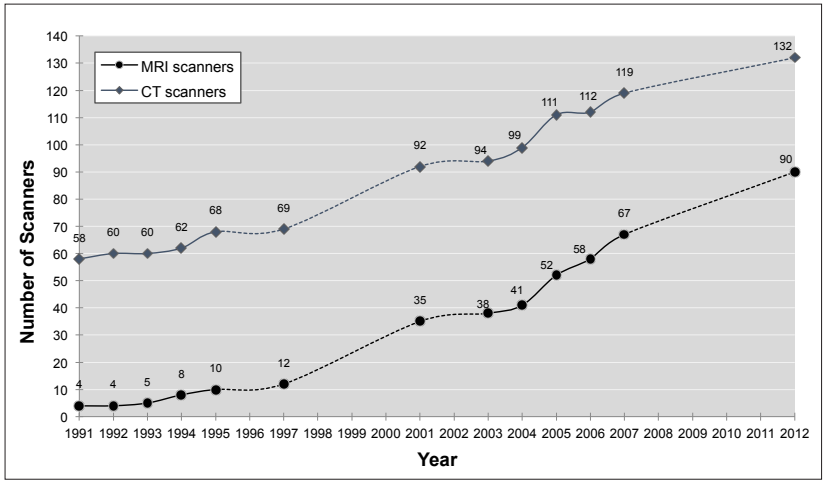

Figure 4.4. Number of MRI and CT scanners in free-standing facilities, Quebec, 1991–2012.

Source: Canadian Institute for Health Information, "Medical Imaging in Canada 2007" (2007), online (PDF): <https://secure.cihi.ca/free_products/MIT_2007_e.pdf>.

public basket, and how often they could be delivered.[38] These reforms were applied in 1982 to delist mammograms, thermography, and ultrasonography from public coverage when services were delivered *outside of a hospital*. CT scans and MRIs were subsequently delisted in 1988 and 1989, respectively. The delisting of diagnostic tests in out-of-hospital settings took place in a period of economic strain brought on by a national recession, from 1981 to 1982, and cutbacks in federal transfers for health following the replacement of the Canada Assistance Plan by the Established Programs Financing in 1977.[39] Given the economic context in which the changes were brought about, and the explicit goal of Bill 27 to "rationalize the provision of health … and social services by health establishments," it seems that cost containment was the primary goal of the reform by effectively throttling back the supply of diagnostic services.[40]

It is important to note that this experience was not unique to Quebec. A review by Vandna Bhatia of the policy shifts in the

38 Amélie Quesnel-Vallée, "Delisting Medical Imaging in Private Settings from Public Coverage in Québec" (2013) 1:1 Health Reform Observer 1.

39 *Ibid.*

40 *Ibid* at 2.

funding and delivery of health care in Canada argued that the 1980s and 1990s signified a shift in debates on medicare to defining "core" services based on what was "prudently reasonable" for governments.[41] She argues that it was policy shifts such as these that laid the legal foundation for a duplicative private health system to deliver for-profit imaging services outside of the public system. Quebec has largely maintained the ban on duplicate private health insurance for services under the public basket (except for select procedures as prescribed in Bill 33 and later changes to the regulation). However, it is important to note that by delisting diagnostic-imaging services such as CT and MRI by location, the purchase of private health insurance for these services was no longer duplicative but, rather, supplementary. Therefore, the prohibition on duplicative private health insurance (and other tenets of the *Canada Health Act*[42] such as extra-billing, user fees, and dual practice) arguably did not now apply to these diagnostic services delivered in out-of-hospital settings in Quebec.[43]

Emergence of a private health insurance market?

Despite this permissive legal provision, Quebec has not evidenced an explosive growth of private markets at the expense of public diagnostic-imaging services. Undoubtedly, there has been a marked growth in MRI and CT scanners in free-standing facilities since the early 1990s (fig. 4.4). However, in comparing the proportion of private MRI and CT scanners relative to public scanners (fig. 4.5), we see that it has remained relatively stable over the last decade. Thus, the number of private machines appears to be increasing at the same pace as public scanners over this period. Although the data are incomplete (there were no data collected between 2008 and 2011), we do not suspect substantial deviations from this trend. With regard to the emergence of a private health insurance market for diagnostic-imaging services in Quebec, the data are limited, though there is

41 Vandna Bhatia, "Social Rights, Civil Rights, and Health Reform in Canada" (2010) 23:1 *Governance* 37.

42 *Canada Health Act*, RSC 1985, c C-6.

43 Colleen M Flood & Bryan Thomas, "Blurring of the Public/Private Divide: The Canadian Chapter" (2010) 17:3 Eur J Health L 257.

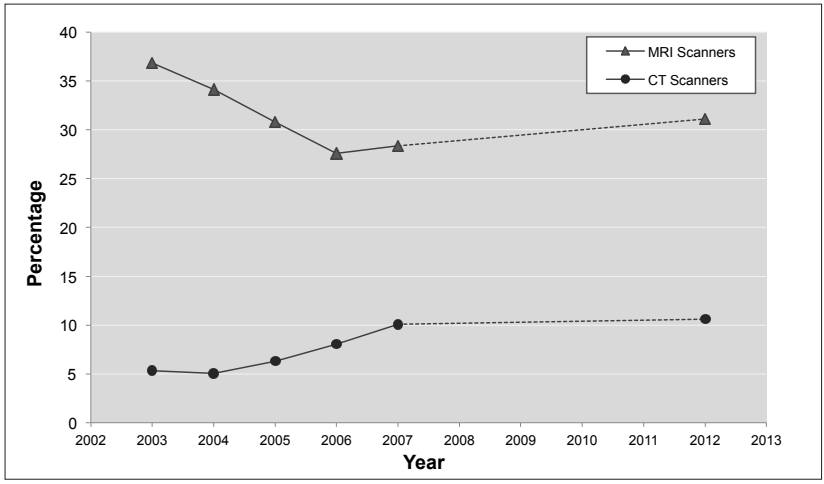

Figure 4.5. Proportion of MRI and CT scanners in free-standing facilities, 2003–2012.
Source: Canadian Institute for Health Information, "Medical Imaging in Canada 2007" (2007), online (PDF): <https://secure.cihi.ca/free_products/MIT_2007_e.pdf>.

evidence of the existence of both individual and group markets for private insurance for imaging services.[44]

Post-Chaoulli: Relisting of services?

Delisting has not been a unidirectional process in Quebec, as some relisting has or may be about to occur. First, at the end of the 1990s, dangerously long wait lists for breast-cancer screening in public hospitals led the government to relist mammograms performed out of hospital; however, this relisting was not extended to all private clinics, and only applied to governmentally approved designated screening centres (centres de dépistage désignés).[45]

More recently, in December 2016, the health minister announced that ultrasound services carried out in private radiol-

44 SunLife Financial, "Plan Comparison," online: <https://www.sunlife.ca/slfas/Health/Personal+health+insurance/ PHI/Plan+comparison?vgnLocale=en_CA>; Quebec Blue Cross, "Compare Our Plans," online: <https://qc.bluecross.ca/health-insurance/health-insurance-101/compare-our-plans>.

45 Minh-Nguyet Nguyen et al, "Quebec Breast Cancer Screening Program: A Study of the Perceptions of Physicians in Laval, Que," (2009) 55:6 Can Fam Physician 614.

ogy clinics would be covered under the public plan.[46] However, it is noteworthy that the public coverage extends only to ultrasounds performed or evaluated by radiologists,[47] while ultrasounds performed by another provider (i.e., a technician in radiology) are not publicly covered and may still be eligible for reimbursement under a private insurance plan. Similarly, as of 26 January 2017, optical tomography services (excluding retinal imaging) provided by ophthalmologists within private clinics are also covered under the Quebec public health care plan.[48] The Ministry of Health and Social Services (Ministère de la Santé et des Services sociaux) reported that it will extend coverage to include CT scans and MRIs in the future, although these services currently remain delisted outside of hospital settings.[49]

However, the announcement and implementation of these changes were met with considerable resistance from specialists in Quebec, notably the Fédération des médecins spécialistes du Québec (FMSQ) and the Association des radiologistes du Québec (ARQ). These specialist organizations claimed that private clinics would lack the human resources and financial capacity to immediately meet the demand for services by the public.[50] Several media reports have documented claims of appointment cancellations by private clinics, seemingly due to the lingering uncertainty of how much specialists in these settings will be reimbursed.[51]

This negative response from physicians suggests that the relisting did not arise from their leadership but rather from the Quebec government, and under conditions that they do not deem favourable. Furthermore, much as the relisting of mammograms in 1998 occurred

46 "Ultrasounds in Private Clinics Now Covered Under Medicare," *Montreal Gazette* (29 December 2016), online: <http://montrealgazette.com/news/local-news/ultrasounds-in-private-clinics-now-covered-under-medicare>.

47 Gouvernement du Québec, (2016) GOQ II, 50.

48 "Quebec to Foot the Bill for Ultrasounds in Private Clinics," *CBC News* (6 July 2016), online: <https://www.cbc.ca/news/canada/montreal/quebec-health-care-ultrasounds-covered-2016-1.3667513>.

49 *Ibid.*

50 "Ultrasounds in Private Clinics Now Covered Under Medicare," *Montreal Gazette* (29 December 2016), online: <https://montrealgazette.com/news/local-news/ultrasounds-in-private-clinics-now-covered-under-medicare>.

51 Catherine Solyom, "Private Clinics Turning Away Patients for Ultrasounds," *Montreal Gazette* (10 January 2017), online: <http://montrealgazette.com/news/private-clinics-turning-away-patients-for-ultrasounds>.

in reaction to a crisis, this latest wave of relisting by the Quebec government is plausibly occurring in reaction to (or anticipation of) increasing pressure from the federal government to cut down on user fees and threats of clawbacks of the Canada Health Transfer.[52] More generally, this physician resistance to relisting services illustrates that past private health-sector expansion could set off an institutional path dependency, which risks impeding future broadening of public programs.[53] Under this framework, not only physicians but also patients who are able to access and afford private services may be resistant to these changes, making privatization all the more challenging to overturn.[54]

Physicians Withdrawing From the Public System

Physicians in Quebec can choose between three statuses vis-à-vis the public insurance one-payer system: participating, non-participating, and opted out. Most physicians in Quebec are *participating* in the public system, whereby they agree to bill the government directly for medically insured services rendered, and are remunerated at the tariffs set by the province. These physicians must also abide by the regulation that they cannot directly bill patients for services deemed "medically necessary" (i.e., publicly covered under the law). Few physicians elect to be *non-participating* in the public system, as this status entails that they bill patients directly, but at the tariffs that are set out by the province. Patients receiving medically necessary services from these physicians bear the onus of subsequently applying to the ministry for full reimbursement of costs. Finally, a small but growing proportion of physicians have *opted out* of the public system altogether, beyond the scope of the provincial *Act respecting health and social services*. As such, they bill patients directly for all services rendered and at rates set at their discretion, usually higher than the tariffs set out by the province. These physicians are not allowed to bill the public system for any

52 Benjamin Shingler & Jonathan Montpetit, "Ottawa Threatens to Cut Quebec's Health Payments over User Fees," *CBC News* (19 September 2016), online: <http://www.cbc.ca/news/canada/montreal/quebec-gaetan-barrette-user-fees-philpott-1.3768799>.

53 Bhatia, *supra* note 42.

54 Daniel Béland & Jacob S Hacker, "Ideas, Private Institutions and American Welfare State 'Exceptionalism': The Case of Health and Old-Age Insurance, 1915–1965" (2004) 13:1 Int J Soc Welfare 42.

service rendered, and they cannot practice in the same location as participating physicians. However, while physicians are not permitted to practice in both the public and private systems at the same time, moving between is relatively easy: the opt-out requests take effect thirty days after submission of the required form to the RAMQ, and opting back into the system only requires eight days.[55] Patients who receive services from these physicians must pay at the point of service and are not eligible for any reimbursement from either public or private insurance.

The RAMQ publishes a list of prevalent non-participating and opted-out physicians, updated monthly. These lists provide the physician name, name of the clinic if applicable, health region, specialty, and the start date of this status. Using these data, we reconstructed annual flows of physicians opting out from the system who were still opted out as of December 2017. It is important to note that these data are likely an underestimate, as we are not able to reconstruct a full history of movement in and out of the public system. Given the ease of movement between the participating and opted-out statuses noted above, there may have been past spikes in opting out that have since abated as physicians reassumed participating status, and the current state of RAMQ data does not render this movement.

Bill 33 could have influenced the number of physicians opting out through its provision allowing for the establishment of specialized medical centres (private surgical clinics), which were then permitted under the *Act respecting health and social services*[56] to provide services otherwise publicly insured on a private-purchase basis (with another provision allowing for private health insurance reimbursement for these particular services), and, most notably, to be contracted by public hospitals to provide these services. Given the nature of these services, we would expect to see an impact on specialists but not family physicians. To examine the association of Bill 33 on opting-out behaviour, we present in figures 4.6 and 4.7 the number of family physicians and specialists who have opted out.

Looking at the year 2006 in figures 4.6–4.8, we see that the number of physicians opting out (and were still opted out as of

55 *Regulation Respecting the Application of the Health Insurance Act*, CQLR c A-29, r 5, s 29; Héloïse Archambault, "Des spécialistes font le va-et-vient entre les deux systèmes" *Journal de Montréal* (8 February 2017), online: <http://www.journaldemontreal.com/2017/02/08/des-specialistes-font-le-va-et-vient-entre-les-deux-systemes>.

56 *Act respecting health services and social services*, CQLR c S-4.2.

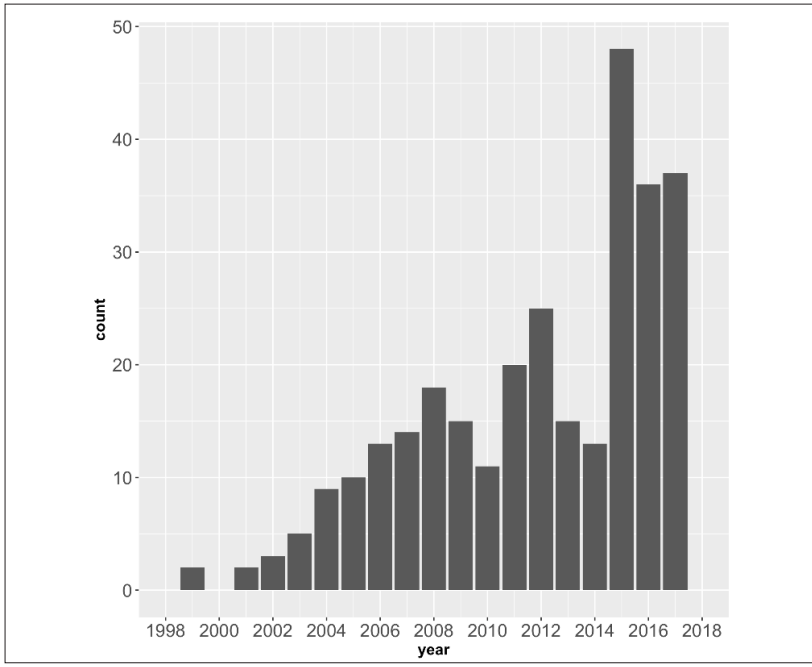

Figure 4.6. Number of family physicians opted out of the public insurance system as of December 2017, by year of exit.
Source: Régie de l'Assurance Maladie Québec, "Number of Family Physicians Opted Out of the Public Insurance System as of December 2017" (December 2017), online (PDF): <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>.

December 2017) did not radically increase after the bill was passed. Instead, the onset of the trend appears to predate this decision. Figure 4.6 indeed suggests that among family physicians, the data show a generally linear, gradual progression since 2001. According to the Collège des médecins du Québec, there were 9,976 family physicians actively practicing in the province at the end of 2017, of whom our data show 296 are opted-out physicians (3 per cent). As shown in figure 4.7, among specialists, there are much fewer opted-out physicians, with a non-discernable pattern over the period, aside from a remarkable peak in 2017. Data disaggregated by specialty in figures 4.9 and 4.10 which indicate that the bulk of the 2001–2015 opt-out physicians were among plastic surgeons and dermatologists, ostensibly for the elective cosmetic-procedures market. Similar to family physicians, though, the cumulative trend shown in figure 4.8 indicates a gradual, linear progression (with the exception of 2017, skewing

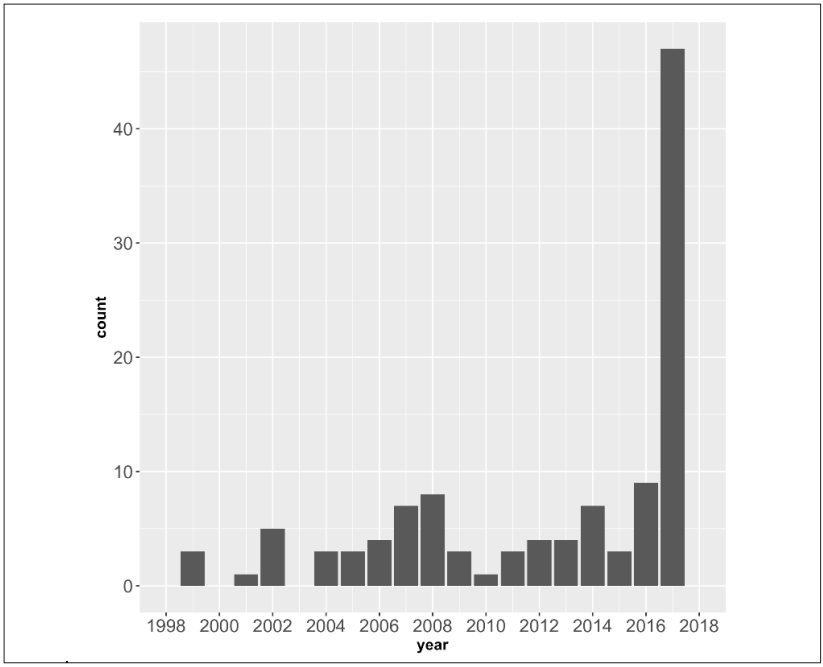

Figure 4.7. Number of medical specialists opted out of the public insurance system as of December 2017, by year of exit.
Source: Régie de l'Assurance Maladie Québec, "Number of Medical Specialists Opted Out of the Public Insurance System as of December 2017" (December 2017), online (PDF): <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>.

the data upward). There are currently 13,650 specialists practicing in Quebec, of whom 117 are opted-out physicians (0.86 per cent).

Figure 4.6 shows a 2015 peak among family physicians, which can likely be attributed to the passing of a highly contentious bill that imposed practice quotas (Bill 20), on the heels of a massive reform of the governance of the primary-care system.[57] In turn, the 2017 peak among specialists is likely associated with protests over the formal prohibition of user fees that was implemented by the Quebec government in early 2017. Indeed, the data disaggregated by specialty, shown in figures 4.9 and 4.10, indicates that the bulk of the opt outs

57 Bill 10, *An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*, 1st Sess, 41st Leg, Quebec, 2014; Amélie Quesnel-Vallée & Renée Carter, "Improving Accessibility to Services and Increasing Efficiency Through Merger and Centralization in Québec" (2018) 6:1 Health Reform Observer 1.

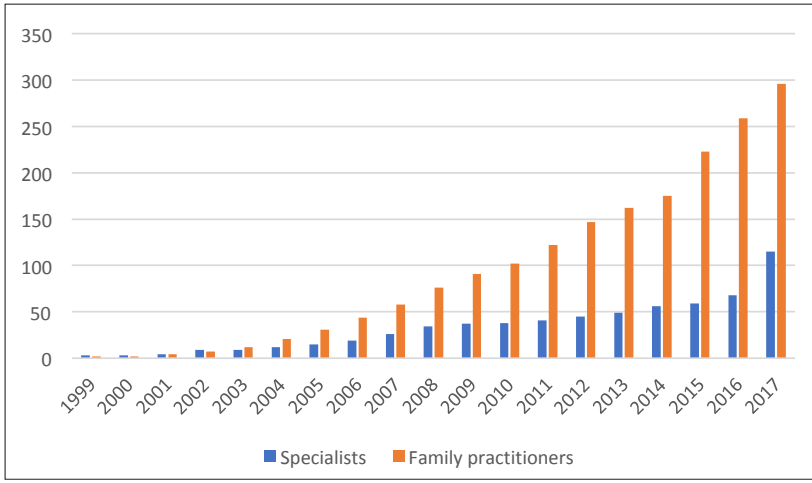

Figure 4.8. Cumulative totals of physicians opting out of the Quebec public health care system as of 7 December 2017, by year of exit.
Source: Régie de l'Assurance Maladie Québec, "Cumulative totals of physicians opting out of the Quebec public healthcare system" (December 2017), online (PDF): <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>.

occurred among gastroenterologists, urologists, radiologists, and ophthalmologists, who were highly affected by this decision. The Quebec government's decision to reign in user charges followed acrimonious exchanges with the federal government on the prevalence of user fees in Quebec, in contravention of *Canada Health Act* requirements. One of the important sources of user fees came from participating specialists working outside hospitals—that is, in private clinics—who collected fees from the RAMQ for publicly insured services, while also charging users a fee to (arguably) cover the practice overhead. With the prohibition of user fees, some specialists have deemed this business model not viable, and have opted out of the system to charge patients for the entirety of the service.

In sum, based on this indicator of physician status in the program, it does not appear that the *Chaoulli* decision had a lasting effect on physicians opting out of the program. Instead, the steady growth of family physicians opting out began in 2001, and has continued relatively unabated since then. In contrast, recent peaks suggest both family and specialist physicians are opting out in protest over governmental actions they disagree with. However, we are not entirely able to rule out that there may have been a larger group of

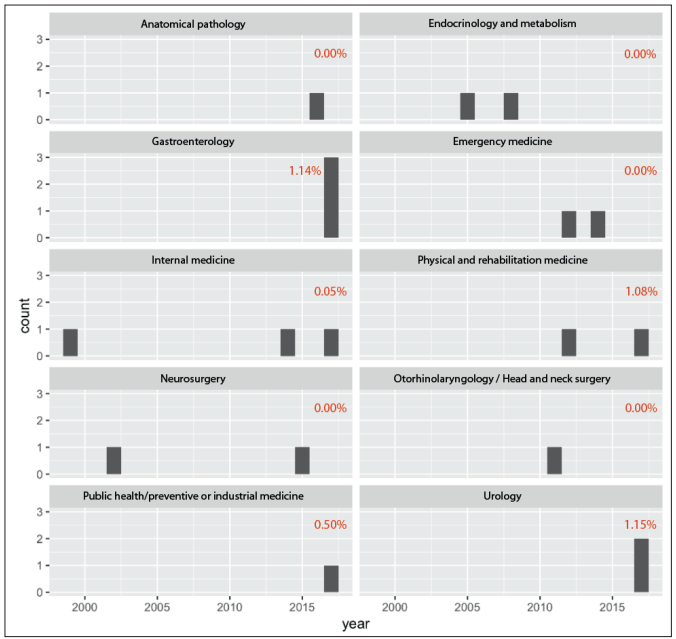

Figure 4.9. Number of Specialists withdrawing per year.
Note: Percentages in red refer to the percentage of the practicing specialist population in that year.
Source: Régie de l'Assurance Maladie Québec, "Number of Medical Specialists Opting Out of RAMQ by Year" (December 2017), online (PDF): <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>.

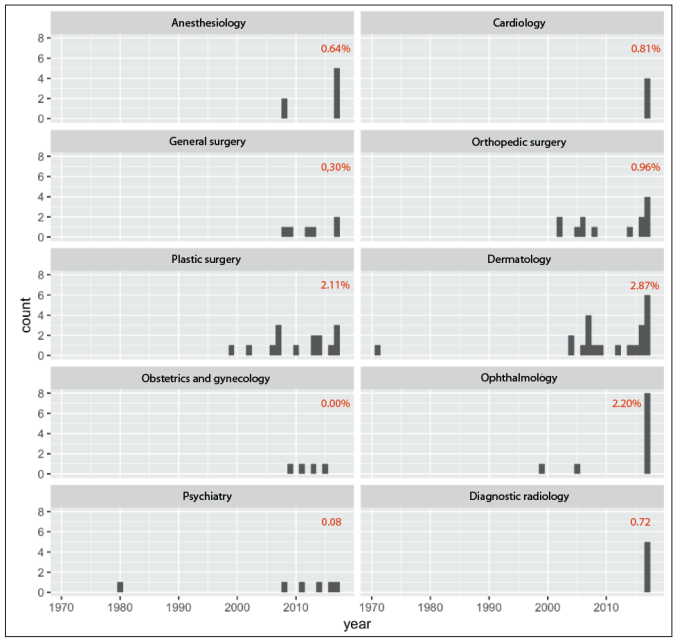

Figure 4.10. Number of specialists withdrawing per year.
Note: Percentages in red refer to the percentage of the practicing specialist population in that year.
Source: Régie de l'Assurance Maladie Québec, "Number of Medical Specialists Opting Out of RAMQ by Year" (7 December 2017), online (PDF): <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengages.pdf>.

physicians who have opted out in 2005–2006 and would have subsequently rejoined the public system. Indeed, while physicians are not permitted to practice in both the public and private systems at the same time, moving between is relatively easy. Furthermore, the other counterfactual that we lack is what would have happened had the government not passed Bill 33, or passed a more lenient law. Given the movements we currently observe, it is plausible that the opting out of specialists might have begun several years ago. Meanwhile, looking into the future, whether those who have recently opted out in protest will remain out of the system for extended periods of time remains to be seen.

User Fees

User fees have been prevalent in Quebec for some time, despite being prohibited in the *Canada Health Act* for "medically necessary" hospital services and "medically required" physician services.[58] In fact, they were written into agreements between the government and physician unions at the outset of the medicare program in Quebec in 1970 but were meant to be restricted to a few outpatient procedures, charged to patients only exceptionally, and only if they involved small amounts of money.[59] In practice, the Quebec ombudsman has found that the number of procedures increased over the years, that the practice was widespread, and that amounts charged could reach several hundreds of dollars per procedure.[60] For instance, clinics have often charged an amount to patients to cover costs of eye drops, IUD insertion, and instruments and medication for colonoscopies,[61] as well as to cover general overhead costs, including rent, equipment, and staffing. The shift toward treating more patients as outpatients that began in the 1990s saw medical practice performing increasingly advanced services outside of hospitals. User fees generally increased in step with this trend.

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58 *Canada Health Act, supra* note 43.

59 Le Protecteur du citoyen, "Avis Sur Les Frais Accessoires En Matière de Santé et de Services Sociaux" (1 October 2015), online (PDF): <https://protecteurducitoyen.qc.ca/sites/default/files/pdf/2015-10-01_avis-frais-accessoires.pdf>.

60 *Ibid*.

61 Loreen Pindera & Benjamin Shingler, "What Can You Be Billed for? A Guide to Québec's Ban on Medical User Fees," *CBC News* (26 January 2017), online: <www.cbc.ca/news/canada/montreal/gaetan-barrette-user-fees-abolition-1.3951648>.

Bill 33 may have sent a signal of governmental leniency toward the imposition of user charges in out-of-hospital settings and, indeed, in 2011, following a series of investigative journalism reports uncovering significant infractions in the use of user fees, the RAMQ established an investigative team. Nine investigation reports have been published on the RAMQ website, six of which represent unique investigations after 2011.[62]

Four of the six reports pertained to health "plans" in which prospective patients were required to pay annual membership fees to access a clinic's physicians (some of whom were participating in

62 Régie de l'assurance maladie du Québec, "Enquêtes de la Régie de l'assurance maladie du Québec sur des coopératives de santé" (28 September 2011), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-coop-fr.pdf> [Régie de l'assurance maladie du Québec, "Coopératives de Santé"]; Régie de l'assurance maladie du Québec, "Enquête de la Régie de l'assurance maladie du Québec sur le centre de chirurgie et de médecine Rockland inc." (16 February 2012), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-rockland-fr.pdf> [Régie de l'assurance maladie du Québec, "Chirurgie et de médecine Rockland inc."]; Régie de l'assurance maladie du Québec, "Enquête de la Régie de l'assurance maladie du Québec sur la Clinique Globale Santé Express de Blainville" (22 March 2012), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-clinique-blainville-fr.pdf> [Régie de l'assurance maladie du Québec, "Clinique Globale Santé Express de Blainville"]; Régie de l'assurance maladie du Québec, "Enquête de la Régie de l'assurance maladie du Québec sur la Clinique chirurgicale de Laval," (22 March 2012), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-clinique-laval-fr.pdf> [Régie de l'assurance maladie du Québec, "Clinique chirurgicale de Laval"]; Régie de l'assurance maladie du Québec, "Enquête de la Régie de l'assurance maladie du Québec sur la clinique médicale Plexo Médiclub" (17 January 2013), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-clinique-medicale-plexo-mediclub-jan-2013-fr.pdf> [Régie de l'assurance maladie du Québec, "Plexo Médiclub"]; Régie de l'assurance maladie du Québec, "Enquête de la Régie de l'assurance maladie du Québec sur le Service de concierge pédiatrique Medisys 123" (28 February 2013), online (PDF): *Régie de l'assurance maladie du Québec* <http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/fr/rapports/rappenq-medisys-faits-saillants-fev-2013-fr.pdf> [Régie de l'assurance maladie du Québec, "Pédiatrique Medisys 123"].

the RAMQ).[63] These were found to be not in accordance with the law in a few respects—they typically required payment in advance of service provision, payment or membership was required before access to a physician would be granted, and, in some cases, the fees were considered accessory costs (i.e., costs related to covered services for which the professional is billing the government, which are prohibited under the *Canada Health Act*). One of those reports found that a clinic had sufficiently changed its business plan following a change in ownership such that the law was no longer contravened.[64] One report assessed fees charged to insured persons for insured services and found that some practices were not in accordance with the law.[65] Finally, the last report uncovered a situation that appears to still be in practice to this day.[66] This pertains to the use of the third-party payer provision in contravention of the law. The *Health Insurance Act*[67] contains a provision allowing for third-party payment for insured health services, which permits, notably, the province's workplace compensation board, athletics organizations, or employers, for instance, to pay privately for services for their members. The rationale was that it is more cost effective to ensure the promptest return to work possible for wage earners unable to work because of an accident or a disabling condition than to have them wait for public services while on a disability pension. The physicians performing the insured services may be participating in the public system, but in these cases their services are paid directly by the organization and not reimbursed by RAMQ. However, this provision does not allow for patients to pay for services, whether directly or indirectly, through a third party. Yet, the RAMQ investigation in 2012 found that the Clinique chirurgicale de Laval had allowed patients to pay for an insured service indirectly through a third party, and the clinic

63 Régie de l'assurance maladie du Québec, "Coopératives de Santé," *supra* note 63; Régie de l'assurance maladie du Québec, "Clinique Globale Santé Express de Blainville," *supra* note 63; Régie de l'assurance maladie du Québec, "Plexo Médiclub," *supra* note 63; Régie de l'assurance maladie du Québec, "Pédiatrique Medisys 123," *supra* note 63.

64 Régie de l'assurance maladie du Québec, "Clinique Globale Santé Express de Blainville," *supra* note 63.

65 Régie de l'assurance maladie du Québec, "Chirurgie et de Médecine Rockland Inc," *supra* note 63.

66 Régie de l'assurance maladie du Québec, "Clinique chirurgicale de Laval," *supra* note 63.

67 *Health Insurance Act*, CQLR c A-29.

had to reimburse the patients.[68] Despite this precedent, reports suggest other clinics have recommended this provision as a loophole to encourage patients to pay indirectly for services as recently as 2017.[69]

Following public discontent about the widely varying nature of these user charges, in November 2015, Bill 20 was passed,[70] which, among other things, included an amendment to regulate user fees. However, as mentioned earlier, the *Canada Health Act* explicitly prohibits the charging of user fees for medically insured services. In September 2016, the federal government thus sent Quebec a letter threatening to clawback transfer payments if user fees were not banned, and, in response, on 26 January 2017, user fees were legally banned in Quebec.[71] This regulation was reinforced through a law to increase the powers of RAMQ to recover fees deemed to be user fees or extra-billing from the physicians who charged them, which had been passed in the National Assembly seven weeks earlier.[72]

A community group has been maintaining a registry of complaints about user charges.[73] The conclusions from their 2017 report suggest that while user charges have decreased since implementation of the regulation, administrative fees—which are allowed—have increased. The implication is that clinics may have shifted invoicing from one category to another to offset the lost revenue.[74]

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68 Régie de l'assurance maladie du Québec, "Clinique chirurgicale de Laval," *supra* note 63.

69 Salimah Shivji, "Quebec Doctors Use Loophole to Sidestep New Law Banning Extra Fees," *CBC News* (24 January 2017), online: <http://www.cbc.ca/news/canada/montreal/rockland-md-loophole-user-fees-1.3950216>.

70 *Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*, CQLR 2015, c A-2.2.

71 *Règlement abolissant les frais accessoires liés à la dispensation des services assurés et régissant les frais de transport des échantillons biologiques*, CQLR c A-29, r 7.1.

72 "Projet de loi no 92: Loi visant à accroître les pouvoirs de la Régie de l'assurance maladie du Québec, à encadrer les pratiques commerciales en matière de médicaments ainsi qu'à protéger l'accès aux services d'interruption volontaire de grossesse (titre modifié)" (2016), online: *Assemblée nationale du Québec* <www.assnat.qc.ca/fr/travaux-parlementaires/projets-loi/projet-loi-92-41-1.html>.

73 Clinique Communautaire de Pointe-Saint-Charles, "Registre de Surveillance Des Frais Accessoires: Analyse Préliminaire Des Données Quantitatives" (November 2017), online (PDF): <https://ccpsc.qc.ca/sites/ccpsc.qc.ca/files/donn%C3%A9espreliminaires%20R.surveillance.pdf>.

74 Amélie Daoust-Boisvert, "Près de 300 remboursements de frais accessoires en santé depuis un an," *Le Devoir* (12 February 2018), online: <https://www.ledevoir.com/societe/sante/519932/frais-accessoires-un-an-et-des-rembourse-

Anticipated Response to *Cambie v British Columbia*

In the preceding two sections, we have shown that the Quebec government's response to *Chaoulli*, Bill 33, did not in and of itself directly contribute to further privatization of the health system, at least insofar as its two principal policy instruments of (private) specialized medical clinics and a very limited role for duplicative private health insurance are concerned. However, it is still true that Quebec is now home to a dynamic private health market, and to better understand this phenomenon we examined three "hot spots" of this market, namely private diagnostic imaging and insurance for these services, physicians opting out of the system, and user fees. Taken together, these hot spots are indicative of underlying trends that predated the *Chaoulli* decision—trends which have not abated since then; far from it.

So why did the *Chaoulli* decision have so little impact, and what might we gather from this experience for Quebec looking toward a future where *Cambie* is successful in liberalizing some or all of the laws under challenge?

Policy Instruments at Stake

Flood and Archibald[75] provided a framework for understanding the legal hurdles against the development of a private market in provincial health systems. In table 4.1, we present the policy instruments they outlined in the article, for British Columbia, Quebec pre- and post-Bill 33, and as to whether they were or are targeted by the *Chaoulli* or *Cambie* case, respectively. We highlight in red the instruments acting as a barrier against privatization, and in green those that are more permissive (or in the absence of which we could expect greater development of private health care). Beyond the fact that *Cambie* is directed at the *Canadian Charter*, which would increase its jurisdictional reach relative to *Chaoulli*, a clear picture emerges

ments>; Catherine Crépeau, "Les frais administratifs remplacent les frais accessoires," *Protégez-Vous* (5 April 2018), online: <www.protegez-vous.ca/nouvelles/sante-et-alimentation/les-frais-administratifs-remplacent-les-frais-accessoires>; "Quebec Doctors Still Charging Administrative Fees, Watchdog Group Says," *CBC News* (21 January 2018), online: <www.cbc.ca/news/canada/montreal/quebec-doctor-fees-pointe-st-charles-1.4497324>.

75 Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 CMAJ 825.

from this table to the effect that the *Cambie* decision would have far more profound implications by targeting essentially the whole range of policy instruments at hand.

Table 4.1. Provincial regulation of privately financed hospital and physician services

Red indicates the instruments acting as a barrier against privatization, and green those that are more permissive.

Policy issue	BC	QC, pre-Bill 33	QC, post-Bill 33	Targeted by *Chaoulli*	Targeted by *Cambie*
Opting out of public insurance plan					
Can physicians opt out of the public plan?	Y	Y	Y		
Can opted-in physicians bill patients directly?	N	N	N		
Extra-billing measures					
Direct prohibition: Is there an explicit ban on extra-billing for opted-in physicians?	Y	Y	Y		X
Can opted-out physicians bill any amount?	Y	Y	Y		
Status disincentive: Is public-sector coverage denied for patients receiving insured services from opted-out physicians?	Y	Y	Y		?
Private insurance for publicly insured services					
Are contracts of private insurance for publicly insured services prohibited?	Y	Y	N*	X	X
Can private insurance pay for all or part of opted-out physician's fees?	N	N	Y*	X	X
* Restricted to services listed in the regulation.					

Source: Adapted from Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 CMAJ 825.

Fertile Ground in Quebec

Beyond the hot spots presented above, other elements of the Quebec health system suggest that liberalization of the legislation limiting the purview of the private sector could be met with support from

the business sector, as well as from certain segments of the physician population.

The first potential zone of support comes from the business sector. In Quebec, physician incorporation played out at two levels: at the level of the individual physician, in which case the primary benefit of incorporation is a reduction in personal taxes; and at the level of the medical clinic, which allows for broader ownership beyond physicians. A review of the Supreme Court decision in the *Chaoulli* case, and its potential impact on privatization of health care in Quebec, points out that the provisions in Bill 33 allow for greater involvement of investors (up to 50 per cent of shares of a specialized medical centre can be owned or managed by investors) than a subsequent regulation on physician incorporation, which requires that "all voting shares of a medical practice [be] the property of a physician and all managing directors [must be] physicians as well."[76] The review goes on to warn: "The incorporation of physicians and the development of investor-owned health facilities introduce major pressures for the commercialization and transformation of medical practice."[77]

The second potential seed for private growth in Quebec that we see has to do with a small but vocal minority of physicians who would welcome greater liberalization of their practice conditions with regard to the ban on public-private practice. In recent years, the FMSQ—the specialist-physicians' union—launched a legal challenge arguing that the provisions from Bill 33 that prevented participating and non-participating physicians from practicing together in specialized medical clinics infringed on the right to freedom of association guaranteed by both the Quebec and Canadian charters. The Quebec Superior Court ruled in 2015 that this right was not infringed, a decision that was subsequently upheld by the Quebec Court of Appeal in 2017.[78]

Along with the hot spots, these two areas offer fertile grounds for a liberalization of the legislation preventing the development of private health care in Quebec. As we have shown, the policy instruments that were modified following *Chaoulli*[79] resulted in relatively

76 Prémont, *supra* note 8.

77 *Ibid* at 247.

78 *Fédération des médecins spécialistes du Québec v Bolduc*, 2017 QCCA 860.

79 *Chaoulli*, *supra* note 2.

benign changes, and the hot spots that we pointed to had roots that predated this decision, which persist to this day. This is what leads us to argue that *Chaoulli* was more a symptom than a cause of the private expansion in Quebec, and why we would expect that commercial interests are poised to act promptly and decisively following any decision in favour of *Cambie*.

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