Conclusion: The Complex Dynamics of Canadian Medicare and the Constitution

Colleen M. Flood and Bryan Thomas

An ongoing challenge in British Columbia, launched by Cambie Surgeries Corporation, aims to lift restrictions on private finance so that Canadians can queue-jump to access care ahead of patients in the public system.[1] The case has major implications, not only for Canadian health care but for our broader understanding of how the *Charter* interacts with universal social programs. The global recognition of human rights in health in the mid-twentieth century was meant to offer protections for the most vulnerable, recognizing that health is not a mere commodity to be distributed by market principles. As a society, our commitment to ensuring fair and equal access to medically necessary care is a gauge of our more fundamental commitment to basic human equality.

As we think about the potential of a *Charter* challenge rolling back laws restricting two-tier care, there are political, societal, and legal factors to weigh, not only by the courts but also by

1 *Cambie Surgeries v British Columbia (Medical Services Commission)*, Docket S090663 (Vancouver) [*Cambie*]. The Supreme Court of Canada has previously found that Quebec's restrictions on parallel private insurance violated the right to life and security of the person, contained in the Quebec *Charter of Human Rights and Freedom*. *Chaoulli v Québec (Attorney General)*, 2005 SCC 35. *Cambie* seeks to expand on this precedent, sector 7 of the Canadian *Charter* to challenge British Columbia's restrictions on extra-billing, parallel private insurance, and dual practice.

policy-makers, patients, and the public. In this concluding chapter, we discuss some of the issues that emerge including: (i) the reality that Canadian governments have not taken sufficient action to quell Canadians' worries about length of wait times, and through this failure have provided the fuel for *Charter* challenges; (ii) the historic struggles to establish Canadian medicare and prevent two-tier care, and the prospects of governments renewing those struggles in the current political climate; (iii) the challenges involved in transposing international evidence on two-tier care to the Canadian context; and (iv) the appropriate role of the courts in adjudicating these complex issues.

The Basis of *Charter* Challenges to Restrictions on Private Finance

Before we discuss the policy implications, it perhaps behoves us to remind the reader of the basics of the *Charter* challenges that could usher in two-tier care in Canada. The *Cambie* claim engages two core *Charter* arguments. The first (and arguably more central) claim is that BC laws restricting privately financed care unjustifiably infringe patients' section 7 right to "life, liberty and security of the person." Here, it is argued that these laws needlessly trap patients in the medicare system's long wait times, denying them the "safety valve," as the *Cambie* claim puts it, of private care. The second argument is that the current regime disadvantages young, elderly, and disabled patients, in violation of the *Charter*'s section 15 right to "equal protection and equal benefit of the law." Current BC law exempts patients covered by workers' compensation from restrictions on two-tier care, allowing them to jump the queue and receive treatment at private clinics, from medicare-enrolled physicians, at premium fees. It is alleged that this regulatory carve-out prioritizes care for younger, non-disabled patients, and disadvantages patients who do not work due to age (too young or too old) and/or disability status.[2] For both

2 This section 15 argument is untested terrain. It is possible that the carve out might be upheld as "reasonably justifiable in a democratic society" under section 1 of the *Charter*, given the costs savings from expediting workers' compensation claims. There is also the question of how the alleged inequality might be remedied: one option is to eliminate the carve out for workers, which amounts to a "levelling down" approach to equality; another option is to create an equivalent carve out for the young, old, and disabled—a hollow remedy, unless these groups

the section 7 and section 15 arguments, even if a court finds that there has been a prima facie infringement of a *Charter* right, the government may defend such infringement pursuant to section 1 of the *Charter*, arguing that any such infringement is "demonstrably justified in a free and democratic society," for example, on the basis that permitting greater privatization of the system will worsen the public health care system, by drawing limited medical manpower from those who need it the most to those with the most resources.

Action on Wait Times

Wait times have become a significant problem for the Canadian health care system. In recent years, Canada regularly scores near the bottom of the Commonwealth Fund's rankings of health care systems in eleven high-income countries.[3] Various factors contribute to Canada's poor performance in the latest rankings, including serious problems of affordability and timeliness of care—especially for lower-income Canadians, for whom systemic wait times are compounded by financial barriers owing to significant gaps in medicare coverage (e.g., skipping doctor visits, treatments, tests, and prescriptions due to out-of-pocket costs). Concerns about wait times are galvanizing *Charter* challenges to laws restricting two-tier care on the grounds that if governments cannot provide timely care they must, in a sense, clear the way for Canadians to use their own private resources.

There have been isolated successes in managing wait times across Canadian provinces, but federal and provincial governments have failed to build on these successes and spread the benefits to all areas of the country and all areas of care.[4] For example, Ontario's Cardiac Care Network (the precursor to CorHealth Ontario) has significantly improved access to care, reducing what were perilously

are also offered subsidies to finance private care. The hope for *Cambie* claimants, it seems, is that the courts will not concern themselves with these details, and simply overturn restrictions on two-tier care altogether, leaving government to pick up the pieces. Our hope and expectation is that the courts—which generally approach section 15 claims in health care with skepticism—will give this claim short shrift.

3 E Schneider et al, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care* (New York: Commonwealth Fund, 2017), online: <interactives.commonwealthfund.org/2017/july/mirror-mirror/>.

4 Canada, Advisory Panel on Healthcare Innovation, *Unleashing Innovation: Excellent Healthcare for Canada* (Ottawa: Health Canada, 2015) at 18–19.

long wait times, and improved outcomes for cardiovascular patients.[5] Likewise, the province of Alberta made great strides in one project, streamlining the delivery of knee and hip replacements and creating single-purpose clinics, where care is standardized according to the best available evidence.[6] Yet there has not been an across-the-board effort to reassure all Canadian patients that they will receive care within a reasonable time, regardless of the treatment. In comparison, for example, the United Kingdom implemented a wait time guarantee with a *maximum* of eighteen weeks and definitively tamed their extremely long wait times, particularly for elective surgery.[7]

Canadian efforts to tame the queue have been lukewarm by comparison to the experience in the United Kingdom. Federal funds devoted to this initiative in the 1990s did not achieve the results needed, and, reportedly, new investments for technologies intended to improve access were reportedly used for less pressing purposes, including the purchase of lawn mowers.[8] Governmental inaction in this regard is rooted in part in a deeper problem of Canadian constitutional law and federalism, with the federal government reluctant to enforce conditions on the provinces that are laid out in the *Canada Health Act*, for fear of ruffling provincial feathers.[9] And this reluctance, in turn, may stem from a failure to honour the original pact of medicare, whereby the federal government shares 50 per cent of

5 Robert McMurtry, "Patient-centered healthcare could reduce wait times and improve the Canadian health system" (2015), Evidencenetwork.ca, online: <evidencenetwork.ca/patient-centred-healthcare-could-reduce-wait-times-and-improve-the-canadian-health-system/>.

6 Susan Usher & Cy Frank, "One stop shops for assessment and treatment: Alberta Hip and Knee Replacement Project gets results" Health Innovation Forum, online: <www.healthinnovationforum.org/article/one-stop-shops-for-assessment-and-treatment-alberta-hip-and-knee-replacement-project-gets-results/>.

7 Peter C Smith & Matt Sutton, "United Kingdom" in Luii Siciliani, Michael Borowitz, and Valeri Moran eds, *Waiting Time Policies in the Health Sector: What Works* (Paris: OECD, 2013).

8 Raisa Deber, "Canada" in John Rapoport, Philip Jacobs and Egon Jonsson, eds, *Cost Containment and Efficiency in National Health Systems* (Wiley-Blackwell, 2009) 15 at 18.

9 For example, the federal *Canada Health Act* obliges provinces to ensure "reasonable access" to health services. In principle, the federal government could leverage this accessibility principle to hold the provinces to account for long wait times. Of course, the available enforcement mechanism—the withholding of federal transfers—would potentially be politically unpopular, and risk exacerbating wait times.

the costs. As a consequence, provincial governments have an easy scapegoat (federal underfunding) upon which to hang the blame for all problems.[10] Still, given how highly Canadians rank their public health care system, it remains a puzzle why voters are not more demanding of their provincial governments to wrestle down wait times. And, indeed, why provincial governments have not solved this problem in order to win power, particularly since it does not seem (from the successful experiences with reducing wait times in Alberta for hip and knee replacement and for cardiac care in Ontario) that significantly more resources would be required. In other words, the evidence suggests that better management rather than more resources is needed to deal with wait time concerns.

To understand the failure of provinces to act decisively regarding wait times, we need to look not only at the blurred lines of accountability between the federal and provincial governments but also to the history of public medicare and, in particular, the strong role physicians play therein, a history that Greg Marchildon sets out in this volume.[11] In short, tackling the problem of wait times will necessarily require some disruption of the present practices, hierarchies, and power of physicians. Most of us would have experienced a referral from a family doctor, where the reception calls the reception of the selected specialist (hopefully). From this point, one hopes as a patient that the acuity of our situation has an impact on scheduling, but we have no idea. The family doctor refers a patient to one of a handful of specialists that he or she knows, and does not, for example, have any way of knowing if an equally competent specialist has an earlier availability. Instead, the patient must sit in the queue of the anointed specialist even if the system on the whole could meet his or her needs in a far timelier fashion. Lobbying by physicians, nurses, and other health care providers on the topic of health care often refers only to problems of wait times in the most general of ways, and usually does not result in substantive reform proposals but, instead, emphasizes the need not for better management but for more money—always more money. We have many years of experience now to reveal that new monies infused into the health

10 William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield and Colleen M Flood, eds, Canadian Health L & Pol'y (2011) 1 at 31–35.

11 See Marchildon, this volume.

care system—which go to paying higher fees and salaries for doctors, nurses, and other health care professionals—do nothing to galvanize change and improvement. We pay more for doing the same thing.[12]

But will a two-tier system help these problems? An important question in the *Cambie* case is whether there is a sufficient link between long wait times and the laws under challenge (e.g., the BC law requiring doctors to either bill the public system in accordance with a negotiated fee schedule or else opt out, to bill privately).[13] The point of these laws is to reduce the incentives that physicians have to practice in the private sector and, thus, ensure a reasonable supply of physicians to public medicare, as well as ensuring access to care is based on need, not ability to pay.[14] The applicants in *Cambie* claim that *but for these laws* the residents of British Columbia (and indeed Canada) would be able to avoid punishing wait times in the public system, or, at least, that these laws can be lifted without worsening wait times in the public system. A similar claim was accepted by the majority of judges in the *Chaoulli* case that, in 2005, overturned a ban on parallel private health insurance in Quebec, enacted to quell two-tier care.

A closer look at the economics of health care, as Jerry Hurley explained comprehensively in this volume, suggests there is zero evidence that laws limiting private finance in any way exacerbate wait times, at least for the vast majority of Canadians. Take, for example, the patient applicant, Mr. Zeliotis, in the *Chaoulli* case. At sixty-five years of age at the time of the trial, and with pre-existing hip and heart conditions, his "right" to buy private insurance is surely a mirage. Private health insurance coverage, were it offered at all to someone of his age and health status, would be prohibitively expensive, and would likely exclude coverage for pre-existing conditions. Unless regulated, private health insurers will not cover people who are very ill, and once existing subscribers become ill, insurers will do their best to find ways to trim or eliminate coverage. Further, as a result of ill health, many people often find their employment prospects diminished or lost, and those who are sick/without income will

12 *Supra* note 3 at 28.

13 *Medicare Protection Act*, RSBC 1996, c 286, s 17.

14 The preamble to the impugned legislation reads, "the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay." *Ibid*.

find it more and more difficult to pay insurance premiums. Thus, a *Charter* "right" to jump a queue may be viable only for the healthy and wealthy. Moreover, if the laws prohibiting dual practice are overturned, the weight of evidence strongly suggests that physicians will divert their energies and labour increasingly to the private tier, where the patients are likely to be less acute, the rate of pay higher. Although the applicants in *Cambie* strenuously deny such, this would undermine the delivery of care in the public system.

All of this runs counter to the animating spirit of the *Charter*, with its commitment to ensuring that all Canadians have a "right to the equal protection and equal benefit of the law."[15] The Supreme Court of Canada long ago recognized the importance of interpreting the *Charter* in a manner that preserves protections for those less advantaged, with Chief Justice Dickson famously writing that "the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons."[16] Comparative evidence, particularly from Australia as Fiona McDonald and Stephen Duckett discussed in this volume, suggests that in the absence of significant governmental subsidies and regulations (e.g., mandatory purchase if above a certain income level), private health insurance will only serve a small percentage of the population—the wealthy and the healthy.

History of Medicare and the Power of Physicians

If courts overturn laws protecting public medicare they will do so in the context of a difficult and complex history of government-physician relations in Canada. Public medicare, particularly insurance covering physician services, was a hard-won battle, as physician associations railed against the prospect of being conscripted into public service. The legacy of the physician strike in Saskatchewan in 1962 resulted in a particular Canadian accommodation where physicians are still largely autonomous fee-for-service practitioners. In the light of this history, it is perhaps not surprising that the *Charter* challenges to laws restrictive of two-tier care have been spearheaded by

15 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 15.

16 *R v Edwards Books and Art Ltd.* [1986] 2 SCR 713, 35 DLR (4th) 1 at para 141.

physicians themselves—first Dr. Chaoulli, in 2002, and now Dr. Day, the main physician behind the *Cambie* challenge.

The applicants in the *Cambie* case are seeking to persuade the court that they need not deeply consider the policy consequences of a decision to overturn laws protecting public medicare. Their argument will be that, having proclaimed laws limiting two-tier care as unconstitutional, it will then fall to government to respond with a new set of laws, and the court should not worry exactly what those laws or policies may be, provided they are constitutionally compliant,[17] what is known in constitutional parlance as "dialogue theory."[18] On its face, this sounds feasible—that when courts overturn laws governments respond by bringing forth new laws that are constitutionally compliant to achieve their objective. Yet our history reveals not only the very special nature of public medicare relative to all other social programs but also the Sisyphean political work involved in establishing and maintaining public medicare. It is just as likely that if a court tears down laws protective of public medicare, many provincial governments would welcome this outcome given that, as we write, seven of thirteen provinces and territories are led by centre-right governments. Provinces may welcome two-tier care as a way to relieve political pressure on them to improve public medicare and give doctors even more of what they want; namely, more autonomy and more ways of earning extra income. Given the history of medicare, it is naive to assume that governments will respond to a loss in *Cambie* by taking bold steps to tackle wait times while redoubling their commitment to the principle of access according to need.

Complexity and Comparative Evidence

Comparative evidence on how other countries address wait times and restrict two-tier care will be important to the adjudication of *Charter* challenges to laws protecting public medicare. Canadian courts are interested in this kind of evidence to understand to what extent Canada's restrictions on two-tier care are reasonable and proportionate. In other words, it will be easier for a Canadian

17 *Cambie* (Plantiffs' Final Argument) at paras 2324–2326.

18 Peter W Hogg & Allison A Bushell, "The *Charter* Dialogue between Courts and Legislatures (Or Perhaps the *Charter of Rights* Isn't Such a Bad Thing After All" (1997) 35 Osgoode Hall LJ 75; Kent Roach, *The Supreme Court on Trial: Judicial Activism or Democratic Dialogue* (Toronto: Irwin Law, 2001).

government to justify restrictions on a two-tier system if other countries have similar laws. For example, Canada's broad restrictions on the advertising and promotion of tobacco products were struck down by the Supreme Court in 1997, in part because they were deemed to be more restrictive than measures taken in other countries.[19] As comparator countries became more restrictive of tobacco advertising, the Supreme Court revisited the issue and upheld wide-ranging restrictions in 2007.[20]

With this kind of approach to constitutional interpretation—where it is a very difficult challenge for a government to justify a *Charter* infringement unless other countries have similar laws—Canada's restrictions on two-tier care are certainly in jeopardy. If one takes a superficial look at Canada's approach to regulating public medicare, it is easy enough to tell a story of Canada as a relative outlier in vigorously suppressing a two-tier system. But this kind of legal reasoning is blind to the particular history, structure, and dynamics of the Canadian health care system. For example, England permits two-tier health care (some 10 per cent of the population have private health insurance and can "jump the queue") and has succeeded in taming wait times (at least until recently). But the fact of two-tier was not *the reason* why wait times were reduced in England: two-tier care has always been a feature of the English system and likely contributed to the problem of long wait times in the first place,[21] and they subsequently had to be tackled with a systematic approach of targets, incentives, and other means *within the public health care system*.[22] Moreover, a key difference between England and Canada is that in England physicians are primarily paid on a salary basis. This means that government has greater managerial oversight over physicians, and can negotiate contractual terms that control work hours, impose systemic fixes for wait times, and so on. By contrast, Canadian physicians enjoy far greater professional autonomy, operating as independent contractors who (mostly) bill government on a fee-for-service basis. In the absence of any restrictions on parallel private practice, Canadian physicians will freely migrate their time

19 *RJRMacDonald Inc. v Canada (Attorney General)*, [1995] 3 S.C.R. 199.

20 *Canada (Attorney General) v* JTI-Macdonald Corp., [2007] 2 S.C.R. 610.

21 John Yates, "Lies, Damn Lies and Waiting Lists" (1991) 303 BMJ Clinical Research 802.

22 Carol Propper et al, "Did 'Targets and Terror Reduce Waiting Times in England for Hospital Care" (2008) 8 J Economic Analysis & Pol'y 1.

across the public and private tiers, with financial incentive to cater first and foremost to lucrative private-pay patients.

Perhaps, as in France and Australia, it could be possible to entice some physicians to prioritize the poor or those in high need (e.g., by paying doctors extra benefits such as pensions and such, or restricting the right to work in a parallel private tier to more senior physicians); but it would be incredibly speculative, on the part of Canadian courts, to presuppose that this could come to pass across Canadian provinces. And there is of course the cost to the public purse of paying doctors even more and/or shoring up private insurance to preserve some semblance of equitable access according to medical need. All of this would surely undercut any notion that courts are not wading full square into the world of complex public-policy trade-offs, with significant public resource implications.

Appropriate Role of the Courts

To this point, we have emphasized the importance of applying nuanced historical and comparative analysis to decision making around restrictions on two-tier care. This leads us to a further concern, namely, whether and to what extent *courts* are the appropriate venue for these complex deliberations.

Many have worried that the courts are not well-positioned to adjudicate matters—such as the design of health systems—that involve multifaceted trade-off of scarce resources across the needs of an entire population.[23] The courts' core institutional competence, the argument goes, lies in sorting through past interactions between a plaintiff and a defendant—not in grappling with a half-century of medicare's evolution in a comparative international context.[24] Hopefully, this volume will have impressed upon readers the myriad complexities associated with two-tier care that have not been acknowledged, let alone adequately addressed, in decisions like *Chaoulli*—for example, the fiscal and regulatory challenges that have

23 Kent Roach, "Polycentricity and Queue Jumping in Public Law Remedies: A Two-Track Response" (2016) 66 UTLJ 3 at 5.

24 Christopher P Manfredi & Antonia Maioni, "Judicializing Health Policy: Unexpected Lessons and an Inconvenient Truth" in James B. Kelly & Christopher P Manfredi, eds, *Contested Constitutionalism* (Vancouver: University of British Columbia Press, 2009) c. 7 at 137.

arisen in Ireland and Australia as they propped up two-tier care while attempting to avoid glaring inequities in access.

An added wrinkle here is that courts are to some degree *aware* of their own institutional limitations and keen to avoid the appearance of overreach when adjudicating *Charter* challenges to major social programs. In practice, this has meant that courts are especially reluctant to recognize *positive* interpretations of section 7 right to life and security of the person—that is, interpretations that would oblige government to make meaningful, systemic improvements to medicare. With rulings such as *Chaoulli*, recognizing only a *negative* right to be free from unnecessary state interference when purchasing health care privately, the court hopes to avoid dirtying its hands with the messy business of fixing wait times within medicare.

Indeed, this concern with avoiding overreach was a point of underlying consensus in the otherwise pointed argumentation between the minority and the majority in *Chaoulli.* Far from advocating a bold defense of positive rights within medicare, the minority emphasized that even the protection of negative rights would strain the courts' competence. The minority was at pains to highlight all of the questions that were unanswered—and perhaps unanswerable in principle—in the majority's interpretation of section 7:

> What, then, are constitutionally required "reasonable health services"? What is treatment "within a reasonable time"? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard. The public cannot know, nor can judges or governments know, how much health care is "reasonable" enough to satisfy s 7 of the *Canadian Charter of Rights and Freedoms.* … It is to be hoped that we will know it when we see it.[25]

As other legal scholars have observed, this tacit judicial preference for recognizing negative rights and denying positive rights is pernicious. It risks creating a "two-tier constitution," where the courts are available to assist those who have the financial means to help themselves (e.g., by purchasing private insurance), but closed off people who

25 *Chaoulli* supra note 1 at para 163.

have no choice but to depend on government services.[26] True, there are isolated moments where the courts have expressed openness, in theory, to the possibility that section 7 confers a positive right to, for example, minimal levels of social assistance.[27] But these glimmers of hope are offset by rulings such as *Canadian Doctors for Refugee Care v Canada*,[28] where, in upholding refugees' right to health care, the federal court relied on section 12 protection against cruel and unusual punishment to avoid recognizing positive rights under section 7. And it seems Canadian jurisprudence on this point has verged away from rationality when it leads to the conclusion that governmental failure to fund, for example, life-saving health care for refugee amounts to cruel and unusual punishment under s 12 but cannot trigger a s 7 claim to either life or security of the person.

In the final analysis, this antipathy toward recognizing positive rights in health care may have less to do with the difficulty of finding "manageable constitutional standards," and more to do with brute concerns about fiscal responsibility. Health care is already the largest line item on provincial budgets, and courts may worry that the enforcement of a positive right to reasonable wait times will be an added strain on public funds. As Chief Justice McLachlin and Justice Major begin their concurrence in *Chaoulli*, they express relief that the claimants "do not seek an order that the government spend more money on health care, nor do they seek an order that waiting times for treatment under the public health care scheme be reduced."[29] What gets overlooked here is that recognizing negative rights, and opening the door to two-tier care, may *also* have serious implications for the public purse. We see this in Quebec, where, in its scramble to limit the spread of two-tier care from *Chaoulli*, the government responded with commitments to tackle wait times by, among other things, contracting with private clinics to address overflows. Looking internationally, we see countries like Australia, Ireland, and France

26 Lorne Sossin, "Towards a Two-Tier Constitution: The Poverty of Health Rights" found in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 161 at 171.

27 See *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84, [2002] 4 SCR 429 at paras 78 and 83.

28 *Canadian Doctors for Refugee Care v. Canada (Attorney general)*, 2014 FC 651.

29 *Chaoulli*, supra note 1 at para 103.

devising elaborate Rube Goldberg contraptions of regulations and tax subsidies to sustain two-tier systems.

It is reasonable to ask whether the courts should be involved at all in the redesign of health systems; some esteemed constitutional scholars have pointed to *Chaoulli* as a paradigmatic example where the court should have deferred to government.[30] Having said that, if courts *are* to involve themselves in these complex issues, they must at the very least show an equal willingness to defend the right to timely treatment of patients who seek treatment *within* medicare. As Norman Daniels, a leading thinker on justice within health systems, explains in an oft-quoted passage:

> Rights are not moral fruits that spring from bare earth, fully ripened, without cultivation. Rather, we may claim a right to health or health care only if it can be harvested from an acceptable general theory of distributive justice or from a more particular theory of justice for health and health care.[31]

Anyone claiming that unreasonable wait times are a violation of one's human rights owes us an explanation of how that right will be meaningfully protected for each and every Canadian.

In terms of pragmatics, the notion that positive rights are a *bridge too far* for the courts cannot be sustained. In *Chaoulli*, the majority entrusted the hard work of operationalizing negative rights to government, granting a one year "suspended declaration of invalidity," during which the Quebec government could enact law and policy reforms to address the issue. There is nothing stopping the courts from employing a similar dialogic mechanism to operationalize positive rights to timely care *within* medicare. From its very inception in international law, the right to health has never been conceived of as a trump on the use of public finances. International law has always expressly understood that governments are accountable

30 See, e.g., Sujit Choudhry, "Worse than *Lochner*?" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 75.

31 Norman Daniels, *Just Health: Meeting health needs fairly* (New York: Cambridge University Press, 2008) at 315.

for the "progressive realization" of these rights, achieving maximal compliance *within* current resource constraints.[32]

In the comparative literature on health rights, a common concern is that the recognition of a positive right to health care will open the floodgates to endless litigation, as patients turn to the courts in an effort to jump queues or secure funding for drugs left off of public formularies. And it is true that this concern has manifested itself in countries such as Colombia[33] and Brazil,[34] threatening the sustainability of public health care systems and skewing the allocation of health care resources toward high-cost drugs sought by wealthier patients, who have the means to litigate. There is no reason whatsoever to suppose that a recognition of positive rights would send Canada down a similar path and indeed recognition of a positive result to health within a Constitution may result in much more incremental attempts by the court to spur governmental action and accountability. Canadian courts could be a force for systems-level accountability—holding governments accountable for establishing fair and efficient *processes* for wait time management and coverage decisions—without opening the floodgates to endless individual claims.[35] Moreover, as we have seen with initiatives in Ontario with cardiac care and in Alberta with hips, knees, and joints, for the courts to insist that governments tackle wait times need not have significant public-resource implications. In doing so, the courts would be insisting on governmental accountability for that which is promised under the *Canada Health Act*, and the various provincial statutes passed in accordance, to ensure *access* to care on the basis of need, not ability to pay, and, further, to hold the federal government accountable for the various commitments they have made in international law to uphold the right to health.

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32 UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the highest attainable standard of health*, 22nd Sess, UN Doc E/C.12/2000/4 (2000).

33 Everaldo Lamprea, "Colombia's Right-to Health Litigation in a Context of Health Care Reform" in Colleen M Flood & Aeyal Gross, eds, *The Right to Health at the Public/Private Divide* (New York: Cambridge University Press, 2014)

34 Mariana M Prado, "Provision of Health Care Services and the Right to Health in Brazil: The Long, Winding and Uncertain Road to Equality" in Flood & Gross, eds, *ibid.*

35 Colleen M Flood & Aeyal Gross, "Contexts for the Promise and Peril of the Right to Health" in Flood & Gross, *ibid.*

Concluding Words

Debate over two-tier care is said to be something of a national pastime for Canadians, stretching back long before the courts entered the fray. Interest in the topic is understandable, as most Canadians have some direct experience with wait times, and talk of "solving" the problem through two-tier care excites ideological passions in a way that careful study of comparative evidence does not. Even as this debate continues, Canadians remain ultimately content and protective of medicare: merely to *have* a universal health care system is an ongoing source of pride, it seems, for a country whose primary point of comparison is the United States. The trouble is that these two predilections—fixation on debates over two-tier care and a degree of complacency borne of measuring our system against the low bar of the US health care system—prevents Canadians from demanding of their governments real solutions to the problem of wait times. And as time passes, Canadians may come to accept the creeping advance of privatization and grow complacent about the importance of maintaining high-performing universal health care.

For better or worse, the courts are now a primary locus for debate over the future of two-tier care. It is often thought that intractable political debates can be resolved by handing the issue over to the courts, to be adjudicated by reference to generally accepted *Charter* principles. This approach has worked, arguably, in settling debate over issues like same-sex marriage, medical aid-in-dying, and medical cannabis.[36] Unfortunately, it seems quite unlikely that the judicialization of the two-tier-care debate will bring anything comparable by way of lasting resolution. There are so many moving parts within a health care system, and such a wealth of comparative evidence to be studied and transposed to the Canadian context, that judicial interventions are bound to raise more questions than they resolve.

There are also, in a sense, moving parts *within the legal system* which may preclude any durable judicial resolution of the debate over two-tier care. Judges have differing ideological perspectives, which can subtly influence their framing of questions and subsequent analysis; this framing effect may pass unnoticed in the whirlwind of

36 *Reference re Same-Sex Marriage*, [2004] 3 S.C.R. 698.

facts and law stirred up in these sprawling, complex constitutional challenges. We already see variations in judicial framing in the handful of cases that have been adjudicated by provincial courts under the *Chaoulli* precedent. One key variable here is the framing of the plaintiffs' evidentiary burden in establishing a rights infringement. There appear to be two framings in circulation—one individualistic, and the other solidaristic. Under the individualistic framing, the plaintiff must merely demonstrate that their individual section 7 rights have been infringed by restriction on two-tier care. This generous framing has found its way into the case law in interlocutory decisions of the *Cambie* trial, as Justice Winteringham of the BC Supreme Court reasoned that Cambie Surgeries' claim had prima facie merit:

> I am satisfied that the evidence establishes a number of physicians will not perform private-pay medically necessary health services should the MPA Amendments be brought into force. As such, prospective private health care patients will be precluded from accessing health services in a manner that may alleviate their wait time. Furthermore, there is a sufficient causal connection between denying access to private-pay medically necessary health services and ongoing or greater physical and/or psychological harm that the delay may cause.[37]

Under the *solidaristic* framing, plaintiffs face the more onerous burden of establishing that restrictions on two-tier care have contributed to unreasonable wait times for *all* similarly situated patients. We see this framing applied in *Allen v Alberta*,[38] as plaintiff Darcy Allen attempts a cut-and-paste application of *Chaoulli* to overturn Alberta's prohibition on parallel private insurance. Allen's claim was rejected as the court insisted on robust evidence of the causal connection between the prohibition on parallel private insurance and public-system wait times:

> Dr. Allen avoided a deprivation to the security of his person, but I have nothing on the record to show that the deprivation he

37 *Cambie Surgeries Corp. v British Columbia* 2018 BCSC 2084.

38 *Allen v Alberta*, 2014 ABQB 184 (CanLII). The ruling was later upheld in *Allen v Alberta*, 2015 ABCA 277, albeit with some hesitation as to whether the trial court had "set too high an evidentiary burden on the appellant." *Ibid* at para 25.

> faced in Alberta … was a result of the Prohibition. A vast array of alternate possibilities come to mind for the added wait times in Alberta that may have nothing to do with the Prohibition: under-funding, mis-management, shortage of qualified practitioners, disproportionate incidence of this particular condition at the relevant times, unexpected population increases or merely differences in population concentrations and distributions, to name a few.

Needless to say, the choice of framing will play a major role in the outcome of these challenges: it is tautological that restrictions on two-tier care lead to longer wait times for would-be queue-jumpers, showing that those restrictions contribute to increased wait times *overall* which is vastly more challenging. It is not obvious which of these two framings should predominate. For present purposes, we simply mean to highlight that judicial resolution of the two-tier care debate is likely to remain elusive because even the *framing of questions* admits of enormous ambiguity.

Is two-tier care the future? If there is a thread of optimism running through this volume, it is that Canada has a wide array of options at its disposal to address wait times while maintaining the equity and universality of its public health care system. In our opinion, the highest imperative is that medicare make good—on a systems level—on the *Canada Health Act*'s principle of accessibility. The courts can play a meaningful role in this. If long wait times for essential care are a violation of human rights, then courts should defend that right whether a patient seeks care privately or within the public system. Upholding positive rights in this way need not involve the courts in micromanaging medicare wait times. Significant gains could be made if the courts simply ordered government to establish a fair and efficient *process* for managing wait times system-wide—leaving it to government to design and implement wait time management systems on the basis of robust and readily available evidence, both from within Canada and from international experience.

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