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Modernizing the Canada Health Act

Colleen M. Flood
University of Ottawa

Bryan Thomas
Ottawa Centre for Health Law

Colleen M. Flood* and Bryan Thomas**

Modernizing the *Canada Health Act*

The Canada Health Act (CHA) *was adopted in 1984, to shore up a health-care system conceptualized in the 1960s. Under the* CHA, *universal coverage is limited to "medically necessary" hospital and physician services, to the exclusion of vital goods and services such as outpatient pharmaceuticals, dental care, long-term care, and many mental health services. Inequities resulting from these gaps in public coverage are partly to blame for pushing Canada's health system to the bottom of recent international rankings. But there is more to modernizing Canada's health care system, we argue, than filling these gaps in universal coverage. Every major health system review undertaken in Canada over the past decade has ended with a call for greater* accountability, *and rightly so: accountability is arguably the sine qua non of high-performing health systems. Whereas many countries have established open and rigorous processes for evaluating health goods and services, targeting public spending on those that deliver the biggest bang for buck, Canada's governance mechanism for defining the medicare basket is passive, opaque and only tenuously evidence-driven. A move to expand medicare's scope of coverage must be accompanied by improvements in this type of accountability.*

La Loi canadienne sur la santé (LCS) a été adoptée en 1984 pour consolider un système de soins de santé mis en place dans les années 1960. Sous le régime de la LCS, la couverture universelle est limitée aux soins hospitaliers et médicaux « médicalement nécessaires ,» à l'exclusion des produits et des services tels que les produits pharmaceutiques ambulatoires, les soins dentaires, les soins de longue durée et de nombreux services en santé mentale. Les inégalités résultant de ces lacunes dans la couverture publique sont en partie à blâmer pour le classement en queue de peloton du système de santé canadien par rapport à d'autres pays. Les auteurs soutiennent que la modernisation du système de soins de santé du Canada exige beaucoup plus que de combler ces lacunes dans la couverture universelle. C'est à juste titre que chaque examen approfondi du système de santé entrepris au Canada au cours de la dernière décennie s'est conclu par un appel à une plus grande obligation de reddition de comptes : cette obligation est sans doute l'élément essentiel des systèmes de santé les plus efficaces. Alors que de nombreux pays ont mis en place un processus ouvert et rigoureux pour évaluer les produits et les services de santé, ciblant les dépenses publiques sur les produits et les services les plus rentables pour les sommes dépensées, le mécanisme de gouvernance du Canada pour définir le « panier de soins » est passif, opaque et n'a que des liens ténus avec les preuves. Une décision d'élargir la couverture de l'assurance-maladie doit s'accompagner d'améliorations de ce type d'obligation de reddition de comptes.

* Colleen M. Flood is a Professor in the University of Ottawa and a University Research Chair in Health Law & Policy.

** Bryan Thomas is a Research Associate with the Ottawa Centre for Health Law, Policy & Ethics.

Introduction

As we write about the future—in our case the future of the *Canada Health Act*[1]—we have to reflect a little on the past. We have written extensively[2] about constitutional challenges to Canadian medicare—particularly *Chaoulli v. Quebec* and its progeny.[3] These challenges have drawn the courts into a perennial debate in Canadian health policy concerning whether patients have a "right" to purchase care privately, bypassing wait times in the public system. But as we look to the future, we must look up from immediate threats. While this rights-focused debate has taken centre stage over the past decade, a more insidious threat to universality has worked in the shadows: the steady erosion of medicare's promise, as Canadians' actual health care needs migrate away from areas protected under the *CHA*. In this article, we thus look forward—and do our best to sketch a broad vision for modernizing the *CHA* to address this problem.

The *CHA* was adopted in 1984 to shore up a health care system conceptualized in the 1960s. Under the *CHA*, universal coverage is limited to "medically necessary" hospital and physician services, to the exclusion of vital goods and services such as outpatient pharmaceuticals, dental

1. RSC 1985, c C-6 [*CHA*].
2. See e.g. Colleen M Flood, "*Chaoulli*: Political Undertows and Judicial Riptides" (2008) (Special Edition) Health LJ 211; Colleen M Flood & Amanda Haugan, "Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care" (2010) 5:3 Health Economics, Policy & L 319; Colleen M Flood & Bryan Thomas, "Blurring of the Public/Private Divide: The Canadian Chapter" (2010) 17:3 Eur J Health L 257.
3. *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*]; Writ of Summons filed by Dr. Brian Day and three other private surgical companies (2009), online: <bchealthcoalition.ca/what-you-can-do/save-medicare/court-documents>.

care, long-term care, and many mental health services.[4] As Canada's population ages and copes with growing levels of chronic disease, these excluded categories of care represent a growing percentage of overall health spending—a dynamic often termed "passive privatization." It is the inequities resulting from these gaps in public coverage, in part, that push Canada's health system to the bottom of recent international rankings, as alarming numbers of low-income Canadians reply "yes" when asked, for example, whether they "[d]id not get a recommended test, treatment, or follow-up because of cost in the past year."[5] (The country's restrictions on privately financed care—while the subject of endless hand-wringing by courts and commentators here at home— are seldom even mentioned in these international comparisons.)

There is more to modernizing the *CHA* than simply expanding the scope of coverage. Every major health system review undertaken in Canada over the past decade has ended with a clarion call for greater accountability,[6] and rightly so: accountability is arguably the *sine qua non* of high performing health systems.[7] Health systems operate more fairly and efficiently when rationing decisions are made through a transparent, evidence-based process.

On the accountability score too, the *CHA* is decades behind the time. In theory, provinces are held accountable to *CHA*'s vision of universal health care through financial incentives: the federal government is authorized to withhold a portion of health transfers from provinces that violate *CHA* principles by, for example, allowing extra-billing for "medically necessary" services, or failing to provide comprehensive coverage for same. Yet as health spending has grown as a percentage of provincial spending over the years—driven in part by cuts to federal health transfers in the 1990s—federal governments have persuaded themselves that it is politically unfeasible to impose these financial penalties. Thus, for example, when Quebec recently passed legislation that, among other

4. Colleen M Flood & Bryan Thomas, "Fragmented Law & Fragmented Lives: Canada's Mental Health Care System" in Jennifer Chandler & Colleen M Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016).

5. Karen Davis et al, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally* (June 2014) at 24, online: The Commonwealth Fund <www.commonwealthfund.org>.

6. Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health LJ 1 at 29.

7. Colleen M Flood, "One Big Idea: Accountability" in Julio Fenk & Steven Hoffman, eds, "*To Save Humanity:" What Matters Most for a Healthy Future* (Oxford: Oxford University Press, 2015) 119; Colleen M Flood & Sujit Choudhry, "Strengthening the Foundations: Securing the Modernity of the Canada Health Act" in Thomas A McIntosh, Pierre-Gerlier Forest & Gregory P Marchildon, eds, *The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004) 346.

things, will normalize and regulate user fees—seemingly a clear-cut violation of the *CHA*—the federal government was conspicuous in its silence.[8] "The *Canada Health Act* is a dead letter," as leading columnist Andrew Coyne put it back in 2010.[9]

More to the point, the *CHA*'s framework of accountability, such as it is, would be outdated and inadequate even if it *were* scrupulously enforced. Whereas many countries have established open and rigorous processes for evaluating health goods and services, targeting public spending on those that deliver the biggest bang for the buck, Canada's governance mechanism for defining the medicare basket is passive, opaque and only tenuously evidence-driven.[10] In our view, a move to expand medicare's scope of coverage must be accompanied by improvements in this type of accountability. Before delving into this more deeply, it is worth retracing the historical developments that shaped the current *CHA* and created this predicament.

I. *History of the CHA and why it shows its age*

As a legislative expression of the country's durable and defining values, the *CHA* is perhaps second only to the *Canadian Charter of Rights and Freedoms*. Calls to "modernize" the hallowed *CHA* therefore invite a degree of cognitive dissonance: while it is appropriate to celebrate and defend the *CHA*'s core values of universality, accessibility and so on, one must at the same time acknowledge that the *CHA* entrenches policy choices that were compromises at the outset, and have impeded medicare's ability to evolve alongside Canadians' changing health care needs ever since.

National medicare was established incrementally, following the lead of Tommy Douglas's CCF government in Saskatchewan, whose *Saskatchewan Hospitalization Act, 1946* established that all hospital and diagnostic services would be provided free of charge to residents of the province.[11] Inspired by the success of this program, the federal government passed legislation in 1957—the *Hospital Insurance and Diagnostic Services Act*—which offered 50/50 cost-sharing to all provincial governments that

8. Ryan Meili & Danielle Martin, "Federal politicians should be denouncing Quebec's new move on health-care fees," Editorial, *Montreal Gazette* (13 October 2015), online: <www.montrealgazette.com>.

9. Andrew Coyne, "It's Like Putting a Puzzle Together," *Maclean's* (9 April 2010), online: <www.macleans.ca>.

10. Colleen M Flood, Carolyn Tuohy & Mark Stabile, "What Is In and Out of Medicare? Who Decides?" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 15.

11. SS 1946, c 82.

followed Saskatchewan's model and provided hospital and diagnostic services to all residents on "uniform terms and conditions."[12]

Its coffers flush with this new financial support from Ottawa, Saskatchewan's CCF government next enacted legislation in 1961 that would provide universal coverage for physician services *outside* of hospital. This met strong opposition from organized medicine, as physicians feared losing professional autonomy and economic bargaining power as medicine came under increased government control.[13] A doctors' strike in Saskatchewan was resolved only through assurances that doctors would remain independent professionals, billing government on a fee-for-service basis, while government's role would be limiting to paying the bills.[14] This design feature cast a long shadow over the future of medicare,[15] and may be partly to blame for the ongoing lack of systems-level accountability, as described below. The federal government, again following Saskatchewan's lead, rolled out the *Medical Care Act*[16] in 1966, requiring that provinces receiving federal funding provide universal coverage for hospital *and* physician services.[17]

Problems of accessibility surfaced in the 1970s, as physicians engaged in extra-billing (i.e., charging patients a discretionary sum on top of fees paid by provincial plans).[18] The federal government responded in 1984 by adopting the *CHA*. The latter specifically prohibits user charges and extra-billing, and, in addition, requires that provincial insurance plans comply with five broad principles: comprehensiveness, accessibility, universality, public administration, and portability. As under the prior *Medicare Act*, provincial compliance with the *CHA* is achieved using a carrot-and-stick approach, with federal government offering the provinces various financial supports for health care on the condition that they enact laws and regulations prohibiting extra-billing and user charges, and comply with the five principles. This approach has largely worked, as provinces across the country have enacted a range of legislative measures to meet the conditions imposed by the *CHA*.[19]

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12. SC 1957, c 28.
13. Gregory P Marchildon, *The Evolution of Medicare in Canada* (Report on Behalf of the Attorney General of British Columbia, 2013) at 9-13.
14. *Ibid* at 9.
15. Carolyn Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford University Press, 1999) at chapter 7.
16. SC 1966-67, c 64.
17. Marchildon, *supra* note 13 at 25-27.
18. *Ibid* at 27-28.
19. Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 CMAJ 825.

From the writings of medicare's principal architects, it appears that protections for medically necessary hospital and physician services were meant only as the foundation of a more comprehensive public system. For example, Justice Emmett Hall writes in the 1964 *Royal Commission on Health Services Report* that, "prescribed drugs should be introduced as a benefit," as "an early objective of the Canadian Parliament."[20] In a sense, then, deference to the *CHA* has contributed to calcifying the system at a point where its incremental expansion stalled in the 1960s—reflecting the state of medicine at the time, which centered around hospital and physician services.

Likewise, the *CHA*'s lax approach to systems-level accountability is a vestige of the past, partly reflecting political compromises reached early on. From medicare's embryonic stage in Saskatchewan, Canadian physicians have used the threat of strikes to fiercely guard their professional autonomy—securing a uniquely hands-off governance arrangement in which they operate as self-regulated, independent contractors, billing government on a fee-for-service basis, and are largely entrusted to define the medicare basket through their individual and collective judgments about the volume and mix of care provided (more on this below).[21] This can be contrasted, for example, with England's National Health Service (NHS), where physicians work under contract, are paid by way of a salary and are currently beholden to job plans in the public sector that include quality standards, outcome and efficiency measures, and clinical standards.[22]

II. *How do we decide what services are publicly funded?*

It is safe to say that no policymaker conceptualizing a health system in 2016 would settle upon the *CHA*'s model. Canadians—particularly those at the lower end of the income spectrum—are suffering major health incidents, and in some cases losing their lives due to arbitrary gaps in coverage. For example, a recent study found that roughly 5,000 deaths and up to 2,700 heart attacks could have been prevented among younger and middle-aged diabetes patients in Ontario, over the six-year period studied,

20. Emmett M Hall, *Royal Commission on Health Services Report* (Ottawa: Queen's Printer, 1964) at 39-40. For more discussion, see Steven G Morgan & Jamie R Daw, "Canadian Pharmacare: Looking Back, Looking Forward" (2012) 8:1 Healthcare Policy 14 at 16; Katherine Boothe, "How the Pace of Change Affects the Scope of Reform: Pharmaceutical Insurance in Canada, Australia, and the United Kingdom" (2012) 37:5 J Health Pol, Pol'y & L 779.

21. Tuohy, *supra* note 15 at chapter 7; Flood, Tuohy & Stabile, *supra* note 10.

22. English National Health Service, *Terms and Conditions—Consultants (England) 2003* (London, National Health Service, 2007).

if the province had a universal drug plan.[23] The lack of universal drug coverage appears also to have a general effect on access to care, as lower income Canadians avoid or delay seeking care for fear of incurring costly prescriptions.[24] Beyond these glaring concerns about equitable access, the *CHA*'s gaps in coverage result in overall higher costs. For example, Canadian physicians are remunerated on a fee-for-service basis and have no incentive to consider the financial implications of the drugs they prescribe. Under a more comprehensive scheme, incentives could be put in place to internalize these costs for physicians, for example, by requiring physicians to operate within "prescribing budgets."[25]

When it is not issuing categorical exclusions, the *CHA* is surprisingly open-ended in defining the medicare basket. Section 2 of the *CHA* notionally limits medicare dollars to "medically necessary" hospital services and "medically required" physician services. But there is no rigour in the application of these limitations—as Nuala Kenny puts it, "medical necessity is what doctors decide needs to be done or what doctors actually do."[26] The main stricture here is that physicians require a fee code when billing medicare for a specific service, and the menu of fee codes is renegotiated annually between provincial medical associations and provincial health insurers. This is not a rigorous process in which the comparative evidence is adduced for given therapies, and hard choices are made about which should be added or delisted. Instead, the list has tended to expand year after year, as new treatments are added while old treatments remain on the list.[27]

The point is not that the current *CHA* forbids this type of accountability; it simply does not do enough to achieve it on an ongoing basis. Over the years, there have been isolated attempts at systematically examining the basket of "medically necessary care" and delisting unnecessary services. In the early 1990s, for example, Ontario considered deinsuring a range of services, including costly cosmetic and reproductive procedures, as well as routine annual physicals. Physicians groups were actually in favour of

23. Gillian Booth et al, "Universal Drug Coverage and Socioeconomic Disparities in Major Diabetes Outcomes" (2012) 35:11 Diabetes Care 2257.

24. Mark Stabile, "Private Insurance Subsidies And Public Care Markets: Evidence From Canada" (2001) 34:4 Can J Economics 921; Sarah Allin & Jeremiah Hurley, "Inequality in Publically Funded Physician Care: What is the Role of Private Prescription Drug Insurance" (2009) 18:10 Health Economics 1218.

25. Elias Mossialos, Tom Walley & Caroline Rudisill, "Provider incentives and prescribing behavior in Europe" (2005) 5:1 Expert Rev Pharmacoecon Outcomes Res 81.

26. Nuala P Kenny, *What Good is Health Care? Reflections on the Canadian Experience* (Ottawa: Canadian Hospital Association Press, 2002) at 62.

27. Flood, Tuohy & Stabile, *supra* note 10 at 62.

delisting some specialist services, because once deemed not medically necessary, they are allowed freer rein to provide them in the more lucrative private market.[28]

Because the *CHA* operates at the interface of the federal government and the provinces, it does not provide any accountability mechanism that can be exercised by *patients* vis-à-vis decisions about what falls within the medicare basket.[29] There have of course been a variety of *Charter* challenges, alleging that health care funding decisions by government violate the section 15 equality guarantee and/or the section 7 guarantee of security of the person.[30] Overall, the courts have been highly deferential to the legislature on this front,[31] explaining in *Auton v. British Columbia* that "the legislature is under no obligation to create a particular benefit,"[32] and that "[t]he legislative scheme…namely the *CHA*…does not have as its purpose the meeting of all medical needs."[33] As Choudhry explains, "[t]he clear message from the Court was that the Court did not wish judges to be drawn into adjudicating upon the design of medicare on a case-by-case basis, a task for which they are poorly qualified."[34] Elsewhere, we have asked whether the courts have options for assisting plaintiffs here, short of adjudicating particular therapies on a case-by-case basis.[35] One option, which joins up with our recommendations below, is that the courts might prod government to at least establish a transparent and reasonable process for making these determinations.

All of this yields results that are perverse from the standpoint of achieving optimal results from a financially strained public health system. While patients with diabetes die for lack of drug coverage, provincial insurers will, as a matter of course, pay for therapies that are comparatively unimportant (e.g. bunion removal), so long as they are delivered by a physician. And indeed, the predominant payment model—

28. Tuohy, *supra* note 15 at 219.

29. But see Sujit Choudhry, "The Enforcement of the *Canada Health Act*" (1996) 41:2 McGill LJ 461.

30. *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624, [1997] SCJ No 86; *Auton (Guardian as litem of) v British Columbia (Attorney General)*, 2004 SCC 78, [2004] SCJ No 71 [*Auton*].

31. Colleen M Flood & YY Brandon Chen, "Charter of Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2010) 19:3 Annals Health L 479.

32. *Auton, supra* note 30 at para 41.

33. *Ibid* at para 43.

34. 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 at 93.

35. Bryan Thomas & Colleen M Flood, "Putting Health to Rights: A Canadian View on Global Trends in Litigation Health Care Rights" (2015) 1:1 Can J Comparative & Contemporary L 49.

fee-for-service—encourages over-delivery of physician services. One oft-cited study estimates that between 30 to 40 percent of total health care utilization in Canada is unnecessary, attributable to "physician-induced demand."[36]

III. *How should we make decisions on what to fund?*

The challenge, then, is to at once open up the basket of public coverage to encompass the true range of "medically necessary" health goods and services, while at the same time targeting coverage at those goods and services that are most beneficial and cost effective. This will inherently require flexibility in our legal and governance design, as the contents of the medicare basket must evolve with technological advancements and Canadians' changing medical needs.

This may sound like a recipe for ever-increasing expenditures and mean that public health care is unsustainable over the long term. Thus, an equally important component, to be combined with flexibility, is the ability to deinsure treatments that are relatively unimportant. We are not Pollyannaish about how difficult this will be to implement: merely because a given therapy is *relatively* unimportant, this does not mean it is unimportant altogether. Decisions to delist—or to fund only in special circumstances—will be resisted by some groups because they value either the service itself or the income earned from delivering the service. However, there are examples where this principle has been implemented effectively, such as Pharmac in New Zealand, which is tasked with providing universal drug insurance for all citizens within the strictures of a limited budget and must therefore make hard choices, at times in the face of formidable public protest and political interference.[37]

What is clear from the literature and experience of different systems in defining what should be the range of insured benefits is that there is no right answer for all systems.[38] What is fair and just for any particular health-care system will be a function of its resources, the needs of its

36. Gregory L Stoddart et al, *Why Not User Charges? The Real Issues* (Toronto: Premier's Council on Health, Well-being and Social Justice, 1993).

37. Jacqueline Cumming, Nicholas Mays & Jacob Daubé, "How New Zealand has contained expenditure on drugs" (2010) 340:7758 Brit Med J 1224.

38. Lawrence Jacobs, Theodore Marmor & Jonathan Oberlander, "The Oregon Health Plan and the Political Paradox of Rationing" (1999) 24:1 J Health Pol Poly' & L 161; Jacqueline Cumming, "Core Services and priority-setting: the New Zealand experience" (1994) 29:1 Health Policy 41; Government Committee on Choices in Health Care, 1992, *Choices in Health Care* (Chair: AJ Dunning) (Netherlands); Segev Shani et al, "Setting priorities for the adoption of health technologies on a national level—the Israeli experience" (2000) 54:3 Health Policy 169; Michael Drummond & Corinna Sorenson, "Nasty or Nice? A Perspective on the Use of Health Technology Assessment in the United Kingdom" (2009) 12 Value in Health S8.

people, and changing medical innovation and technologies. Further, what is fair and just for a health-care system at one point in time will not be so in the future because the various factors—needs, resources, and technologies to meet those needs—are constantly changing. Consequently, the best we can do from a public policy perspective is make sure we have robust and fair *processes* to determine what is publicly-insured at any particular time. In our view, this basic principle of fairness is what should be enshrined in the *CHA*. With appropriate enforcement this will ensure a better future for Canadian medicare and the people that it serves.

There is an interesting congruence between health policy experts, legal scholars, and moral philosophers around this emphasis on accountability. Philosophers Daniels and Sabin have made the case that citizens in pluralistic societies will never reach moral agreement on principles for resolving rationing problems; thus, they claim, our aspirations for justice in health care should aim at achieving fair *processes* for rationing. What does a fair process look like, from the standpoint of a philosopher? Daniels and Sabin set out four basic conditions for a fair process. First, the Publicity Condition requires that rationales be publicly accessible, in part because this enables a sort of "case law" effect whereby decisions are made on a principled and consistent basis. Second, the Reasonableness Condition requires that the reasons for coverage rest on a reasonable construal of how society should achieve value for money in health care. Third, their Relevance Condition requires that decisions account for pertinent facts, and assign no weight to irrelevant facts—e.g., the fact that a given treatment benefits a vocal and politically mobilized segment of the population is irrelevant in deciding whether to provide coverage. Fourth, the Appeals Condition requires that patients have an opportunity to challenge rationing decisions, ensuring an ongoing and iterative form of accountability where past decisions can be challenged in the light of advancing medical knowledge, unique clinical circumstances, and so on.[39] To lawyers, the conditions laid out by Daniels and Sabin may seem elementary—we expect our courts to abide by these conditions as a matter of natural justice. Within our health- care system, though, it is not at all uncommon for patients to be confronted by what appear to be arbitrary rationing decisions, with no apparent avenue for clarification or appeal.

39. Norman Daniels & James E Sabin, "Limits to healthcare: Fair procedures, democratic deliberation, and the legitimacy problem for insurers" (1997) 26:4 Philos Public Aff 303.

IV. *Reform of the* CHA

What then is required to reform the *CHA*? We have made the case that the *CHA* needs to be modernized: to be expanded to include a broader range of services beyond those supplied by physicians and in hospitals. However, much of the present case for changing the *CHA* is made not for expanding its protective reach, but to privatize what it presently protects. Thus, before we begin this section, it is important to mention how a campaign to modernize the *CHA* could be co-opted to a regressive end and to think through how to avoid this outcome.

There are multiple false arguments put forward for the privatization of hospital and physician services that are currently publicly insured under the *CHA*. Most rest on the multiple failings of the present Canadian system—blaming the woes of inefficiency, long wait times, lack of breadth of coverage, relatively high overall spending and so forth *on the very fact of public financing*. If only, the privatization merchants argue, there was a greater role for more private finance (and in particular, so that individuals with greater wealth could use a bit of extra money to jump queues) our problems would be cured.[40] To be sure, in recent years, it has been easy to paint Canada as a relatively poor performer in international rankings, adding fuel to the fire that change is required.[41] But blaming the "public" part of the Canadian system for problems of, for example, wait times misdiagnoses the problem. All of this argumentation for more privatization flies in the face of health services research evidence showing that public finance is not the cause of problems of inefficiency and over-spending;[42] indeed, it is more often the *solution* to these kinds of issues. Unregulated private finance, for example, as we see in the US, raises both prices and overall expenditure without any commensurate increase in performance or improved health outcomes. Systems with much higher overall rates of public finance, such as England, tend to perform well both on equity and efficiency grounds.

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40. See e.g. Nadeem Esmail & Bacchus Barua, "The private sector plays a role in other universal health systems. Why not here?," Editorial, *The National Post* (25 November 2015), online: <news.nationalpost.com>; Jeffrey Simpson, "It wouldn't kill us to look at Australian health care," Editorial, *The Globe and Mail* (24 November 2010), online: <www.theglobeandmail.com>; Brian Day, "30 years of health-care dysfunction," Editorial, *The National Post* (1 April 2014), online: <news.nationalpost.com>.

41. Davis et al, *supra* note 5 at 24.

42. Carolyn Hughes Tuohy, Colleen M Flood & Mark Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations" (2004) 29 J Health Pol Pol'y & L 359; Stephen J Duckett, "Private care and public waiting" (2005) 29 Aust Health Rev 87; Sara A Kreindler, "Policy strategies to reduce waits for elective care: a synthesis of international evidence" (2010) 95 Brit Med J 7.

The repeated arguments made for further *private finance* as salvation for Canadian medicare are in part due to ideology against redistribution and in part due to interest groups who seek further avenues to game the system and secure higher rents. For example, some Canadian physicians, not content to be among the highest paid in the world,[43] want, in addition to the public moneys they are paid, to be able to charge patients additional private fees ("extra-billing"). Somewhat extraordinarily, this advocacy has been able to be transformed into a constitutional claim by employing the *Charter of Rights and Freedoms*. The constitutional argument is, of course, not framed in the desire of physicians to make more money, but as a claim that the fundamental integrity of patients is challenged by limits in public medicare, resulting in wait times that may cause suffering. The appeal of private finance as a safety-valve, allowing those with means to buy their way past public restrictions, has received some traction in the courts, indeed at the highest level in the 2003 Supreme Court case of *Chaoulli*.[44] But, as mentioned earlier, the overwhelming research evidence shows the regressive and inefficient effects of increased private finance in a system. The public part of the Canadian system is being blamed (with some success) both in the media and in the courts for the problems of the system, rather than the blame being laid where it rightly lies, namely with the large role for unregulated private finance.

But as progressives wage the battle to maintain one-tier medicare—fighting off court challenges and increased media attacks—they risk not fighting a larger and more important war. A focus on protecting the present one-tier system of finance for hospital and physician services means that the drive to expand public medicare to other areas—that today are as much if not more important—constantly falter. For example, arguments in favour of including prescription drugs in the *CHA* falter on the same old shoals of yesteryear, namely that by some mysterious set of forces overall costs for drugs have to be reduced before they are included in universal medicare. The newest Minister of Health, Jane Philpott, has suggested that "before we take on responsibility for even considering an expansion of what will be publicly funded we need

43. Mark Stabile, "Paying doctors and wait times: How does Canada compare?," Editorial, *The Toronto Star* (2 May 2012), online: <www.thestar.com>.

44. See litigation launched by Dr. Brian Day challenging BC laws preventing extra-billing: Writ of Summons filed by Dr. Brian Day and three other private surgical companies (2009), online: <www.bchealthcoalition.ca/what-you-can-do/save-medicare/court-documents>.

to drive down drug costs."[45] Again, the international research evidence is very clear—publicly financed systems are not only more equitable but generally more efficient, as they are able to achieve lower prices. Thus, in order to get prices down and reduce costs, governments must press out boldly and expand coverage to include a broad range of services. As a consequence, they will have better price control over a broader range of services that are of higher value to Canadians. This will also result in a fairer and more effective system, enabling priorities for funding health services to go to the highest value. They will be able to secure more for less, and maximize public welfare.

In terms of reform of the *CHA* we would make the following recommendations:

a. The *CHA* be expanded to include a broad range of kinds of health care, including prescription drugs, diagnostics, mental health (psychology), home care and dental care. The *CHA* should be amended to require that the Minister appoint an expert taskforce every five years to report on the general areas of care/service delivery and whether broad categories of care/services should continue to be included or excluded.

b. The CHA be amended to illuminate the present definition of "medical necessity," which is presently undefined. Reform must be respectful of differing provincial needs and resources but will require provinces to meet basic principles of fairness by implementing an arm's length, evidence-based process to determine on a rolling basis what services and goods are publicly insured. To be clear, this does not have to be a hard-and-fast list. It likely will be that the evidence supports funding of certain services for certain treatment profiles and not for others: thus conditional listing is likely to be the norm. The *CHA* should be amended to require each province put in place a *process*, which follows Norman Daniels's accountability for reasonableness framework and general principles of procedural fairness from administrative law.[46] The *CHA* should require (1) there be an arm's length body tasked with prioritizing services, (2) there should be opportunities for individuals to make the case for funding particular treatments, (3) reasons should be provided (and thus the basis for choices to fund or not fund will be transparent), (4) and there should be the possibility of appeal.

45. Allison Vuchnich, "Medical journal urges health minister to use science and evidence to guide public policy," *Global News* (7 December 2015), online: <www.globalnews.ca>.

46. Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2008).

c. The *CHA* should be changed to acknowledge that not all services of any value will be funded, but that citizens should expect that a broad range of important services will be publicly-funded and that these determinations will be made on the basis of a fair and open process.

d. The *CHA* should bind the federal government to put in place a process to monitor what services are publicly funded across different provinces and to make this information available to Canadians on a central website, so that differences between provinces can be monitored over time.

One issue that remains to be resolved is the role for extra-billing and user charges. As explained, bans on extra-billing and user charges for hospital and physician services were brought into place as part of the *CHA* in 1984 in response to growing accessibility through the 1970s as physicians charged patients add-on fees for publicly-insured services. There is no evidence that this problem would not re-emerge if the bans were lifted in the present day. Some countries—notably England—allow a small two-tier system on top of the public system. But one can't assume that because something works in one country it will necessarily work the same way in another. Extra-billing is largely a non-issue in England because, as explained, their specialists and surgeons are employed and paid on a salary basis on contract in public hospitals, ensuring that the vast proportion of physician work manpower serves the public system and with no ability to "extra-bill." In sharp contrast to England and many other countries, Canadian physicians continue to be paid predominantly on a fee-for-service basis. Allowing extra-billing would sanction the vast majority of Canadian physicians to charge whatever they wished to the vast majority of Canadian patients. Given this present state of affairs, it is rational for the *Canada Health Act* to maintain the bans on extra-billing and user charges for "medically necessary" physician services.

Aside from physician services, there may be arguments for some small levels of user charges levied on some services in some circumstances. For example, wealthier individuals could be required to pay a larger proportion of the cost of a service through a user charge. However, having full coverage for the entire population ensures a level of political commitment to the concept of public health insurance and for this reason alone it likely is a good idea to cover all members of a community on a first dollar basis. We would recommend that a modernized *CHA* require universal, first-dollar coverage for all "medically necessary" goods and services; however, provinces should be permitted to levy user charges for services on wealthier members of society provided they evaluate the

impact of user charges on access and equity and that this evaluation is made publicly available every year. In the absence of such an evaluation/ report the levying of user charges should be considered in breach of the *CHA*.

Conclusion

We need a system that is constantly evaluating what services merit public funding (1) relative to the changing needs of Canadians, (2) according to changing technologies, and (3) according to changing spaces and places of care (e.g. out of hospitals and into community settings). A modern health care system is not one that prioritizes hospital services or physician services *simply because they are delivered in hospitals or by physicians*. Instead, a modern system will rationally evaluate the evidence and impact of a broad range of services that can advance human health and decide which of these services should be insured for the community *at that time*. Our prescriptions for reform will improve overall governance and result in a Canadian health-care system that is better able to stand the test of time by continually evolving to ensure a fair and efficient health-care system. There are many political forces pushing the Canadian system to further and greater levels of private finance. Consequently, our look here to the future of the *Canada Health Act* may not be what actually happens in the coming decades, but it is what needs to happen to ensure a just and fair system for Canadians.