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Private Health Care and the Law Part 1: Litigation Challenging Limits to Private Care

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Case Commented On: *Cambie Surgeries Corporation v British Columbia (Attorney General)*, [2020 BCSC 1310 \(CanLII\)](#)

On September 10, Justice Steeves released his decision in *Cambie Surgeries Corporation v British Columbia (Attorney General)*, which addresses the constitutionality of BC’s limits on private health care. The plaintiffs argued that if the government could not provide timely care, it could not prevent patients from accessing private care (at para 27), while the government argued that limits on privatization are necessary to protect the public system and ensure equitable access. This blog post summarizes the 880-page ruling, with a focus on section 7 of the *Charter*. It omits other issues, including a brief analysis of section 15 of the *Charter* (at paras 2804-2874) and a discussion of the impartiality and independence of expert witnesses (at paras 1064-1152). For readers who are unfamiliar with constitutional law, [this](#) document briefly outlines the approach courts take in adjudicating *Charter* claims. A second blog post will discuss the relevance of this case in Alberta.

Background

The driving force behind this case is Dr. Brian Day, an orthopedic surgeon who founded a private surgical clinic called Cambie Surgeries. The other plaintiffs include patients and a clinic that conducts assessments and consultations, arranges diagnostic testing, and provides patients with access to Cambie. After turning a blind eye for [many years](#), the BC government [cracked down](#) on Cambie’s illegal billing practices, which resulted in this constitutional challenge to BC’s limits on private health care. Justice Steeves characterized this claim as seeking to “legitimize the manner in which the corporate plaintiffs have been operating for over the past 20 years, i.e., allowing enrolled physicians to provide private pay surgical services at private clinics and charging patients beyond the [publicly insured] rates for those services” (at para 2014).

The claim focused on three sections of the *Medicare Protection Act*, [RSBC 1996, c 286](#), which are similar to those contained in other provincial health insurance laws. Section 45 prohibits insurance for services that are publicly insured (referred to as duplicate private insurance). Sections 17 and 18(3) prevent health facilities and physicians (other than those who have elected not to participate in the public insurance plan) from charging fees and billing at rates that exceed the fee schedule in the public plan. Although these provisions do not prohibit private health care, they have the effect of “detering potential competition” between the public system and a private system (at para 2028).

To succeed with a claim under section 7 of the *Charter*, a plaintiff must establish an infringement of his or her rights to life, liberty, or security of the person. The plaintiff must also show that the deprivation of those rights does not accord with the principles of fundamental justice, which require that laws not be arbitrary, overbroad, or grossly disproportionate. The government then has an opportunity to justify the infringement under section 1 of the *Charter* by establishing that it has a pressing and substantial objective, the impugned law is rationally connected to that objective, the government could not have achieved that objective in a manner less impairing of rights, and there is proportionality between the law's benefits and its burdens.

This case takes place against the backdrop of *Chaoulli v Quebec (Attorney General)*, [2005 SCC 35 \(CanLII\)](#), in which the Court struck down Quebec's prohibition on duplicate private insurance. Justice Deschamps resolved the case using Quebec law, with the remaining justices disagreeing on whether this provision violated the *Charter*. While all six remaining justices agreed that the prohibition on private insurance engaged the rights to life and security of the person, they were evenly split on whether it offended the principle that laws must not be arbitrary.

Right to Life and Security of the Person

Justice Steeves found that “when the province assumes a monopoly power over the provision of medical services it is under a constitutional duty to ensure that the service is provided in a timely fashion” (at para 1330). In *Chaoulli*, the justices disagreed about what constituted a constitutionally compliant wait time and the suitability of the courts to make such determinations (at paras 105, 162). However, since *Chaoulli* was decided in 2005, wait time standards have evolved, and Justice Steeves relied on what he described as “comprehensive and sophisticated diagnostic prioritization mechanism in the form of British Columbia's prioritization codes and corresponding wait time benchmarks” (at para 1332).

With regard to the level of harm required to engage section 7, Justice Steeves adopted the language of “clinically significant” from *Chaoulli* (at para 1713). Given that patients often view waiting for care as undesirable, assessing waits from their subjective perspective is a relevant consideration but is not sufficient to resolve the issue (at para 1714). Because “wait lists are an unavoidable and necessary feature of rationing healthcare services” (at para 1727), no public or private health care system “could function solely on the basis of patient demand” (at para 1726). Instead, provincial benchmarks represent “a useful proxy for the threshold to be used for deciding whether waiting for medical care is clinically significant” (at para 1736). Justice Steeves viewed these benchmarks as “generalized and objective evidence that some patients are at greater risk of deterioration of their underlying condition and reduced surgical outcomes” (at para 1737).

In contrast to *Chaoulli*, Justice Steeves did not find a violation of the right to life. He noted that the elective surgeries at issue were not, by definition, intended to treat life-threatening conditions (at para 1748). In addition, patients whose conditions become life-threatening are no longer suitable for treatment at private clinics (at para 1761). Justice Steeves also accepted evidence that “when patients face risk to life or limb they are provided with timely and high quality care” (at para 1752).

Noting the various evidentiary issues (e.g. determining whether pain or psychological harm is attributable to the underlying condition or the wait), Justice Steeves found that taken as a whole, evidence from the patient plaintiffs, generalized wait time information, and expert evidence demonstrated that some patients waited past the provincial benchmarks (at para 1884). These waits engaged the right to security of the person, given that “waiting beyond this benchmark may cause prolonging of pain and suffering and deterioration of their underlying condition which also increases the risk of reduced surgical outcomes” (at para 1884).

Various factors unrelated to capacity in the public system can cause waits (e.g. patient preferences, physician referral practices, and wait list management strategies, at paras 1640, 1891). Furthermore, even without the impugned laws, some patients would be unable to obtain treatment in private clinics due to the complexity of their medical conditions (at para 1891). Instead, only harms that have a “sufficient causal connection” with the impugned laws violate security of the person (at para 1887). The causal link in this case is complex because the law does not directly prohibit private care, but merely discourages “the emergence of a parallel private healthcare system by setting restrictions on both the financing and supply of private healthcare” (at para 1900). This can be contrasted with cases like *R v Morgentaler*, [1988 CanLII 90 \(SCC\)](#), [1988] 1 SCR 30, in which the law directly interfered with one’s ability to obtain health care services. Accordingly, the plaintiffs had to “show that the impugned provisions have the effect of rendering private surgical care unavailable” and that this was not the result of other factors (at para 1905).

Citing *Chaoulli*, Justice Steeves found a link between security of the person and the prohibition on private insurance, given that the law “effectively prevents most...beneficiaries from obtaining insurance to cover the cost of private care which they otherwise cannot afford to pay for out of pocket” (at para 1909). He also accepted the plaintiffs’ argument that laws preventing doctors from charging more than the rate paid under the public plan make it “uneconomical to provide private surgical services” (at para 1930) because they render doctors unable to “recoup the significant operating costs associated with running a private surgical facility” (at para 1929). Justice Steeves found a causal link between the three impugned provisions and security of the person, given that they limit the supply of “timely private surgical care” and deny patients “access to such services that would otherwise be available” (at para 1930).

Principles of Fundamental Justice

This case addressed three principles of fundamental justice: arbitrariness, overbreadth, and gross disproportionality. Justice Steeves described the legislative purpose, which is relevant to all three principles of fundamental justice, as preserving the universal public health care system and ensuring that access to medically necessary care is determined by needs rather than ability to pay (at para 1972). Justice Steeves found that the impugned provisions had three interrelated effects: to make a parallel private market for insured services economically non-viable (at para 2042), to suppress and discourage a private market that would compete with the public system (at para 2043), and to create barriers for beneficiaries to access private services (at para 2043).

In *Carter v Canada (Attorney General)*, [2015 SCC 5 \(CanLII\)](#), the Court described arbitrariness as a “situation where there is no rational connection between the object of the law and the limit it imposes on life, liberty or security of the person” (quoted at para 2068). The *Chaoulli* decision attracted significant [criticism](#), with the majority’s level of scrutiny arguably well exceeding an assessment of whether the law was arbitrary. According to the majority, “many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada” (at para 140). This quotation suggests that the majority may have substituted their preferred method of achieving the legislative objective for the means selected by the government, rather than asking whether the law met the relatively low threshold of being rationally connected to its objective. Justice Steeves appeared to distance himself from this approach in stating that although other policy approaches may be more “sufficiently connected” to the objective, this has “no bearing” on the section 7 analysis and policy alternatives are more appropriately considered under section 1 (at para 1539).

The *Chaoulli* decision exhibited a rudimentary appreciation of health care systems and the importability of health policies from one political, social, economic, and legal context to another. In contrast, Justice Steeves took a methodical approach to his discussion of the health care systems of comparator jurisdictions, their differences with BC’s health care system, and the evidence on privatization from these countries, including an evaluation of the methodological strengths and weaknesses of that evidence. Citing this comparative evidence, Justice Steeves concluded that the plaintiffs had failed to “demonstrate that there is no connection or no rational connection” between the purposes of the legislation and its effects (at para 2272).

In fact, he found “that there is evidence here that supports the defendant’s position that the introduction of private healthcare would detrimentally affect the public system” (at para 2272). Specifically, he cited evidence suggesting that duplicate private health care would create or exacerbate inequity (at para 2663), increase demand for services and overall costs (at para 2664), reduce capacity in the public system due to the diversion of human resources (at para 2664), and incentivize doctors to prioritize private patients (at para 2665). There was less conclusive evidence suggesting that private health care may erode support for the public system (at para 2666). Given these concerns, the impugned laws were not arbitrary.

The test for overbreadth asks “whether a law that otherwise has a rational connection between its purpose and effects, is nonetheless problematic because it goes too far by capturing some persons or activities that bear no relation to the law’s purpose” (at para 2675). The plaintiffs argued that “other countries show that a duplicative private healthcare system can coexist with a viable and sustainable public system” (at para 2679). Justice Steeves rejected this as “recasting” their arbitrariness argument (at para 2679) and in found that on the contrary, the experience of other jurisdictions “demonstrates that it is a rational policy response to restrict or even suppress a duplicative private healthcare system in order to protect the public system from the harms of private care” (at para 2680).

The plaintiffs also argued that the impugned provisions captured activities that were not problematic, such as physicians who have maximized the available operating time in public hospitals and who wish to provide private care, which they claimed does not drain human

resources from the public system (at para 2681). Justice Steeves found that excess capacity in the public system is exaggerated and that being in the operating room full-time would take doctors away from other essential activities such as consultations, follow-up care, teaching, and administration (at para 2703). Furthermore, he noted that the plaintiffs' argument only addressed human resource issues and neglected to consider the other negative effects of privatization such as increased demand for health services, increased costs, and inequity (at para 2707).

In *Canada (Attorney General) v Bedford*, [2013 SCC 72 \(CanLII\)](#), the Court stated that gross disproportionality arises when a law's effects "are so grossly disproportionate to its purposes that they cannot rationally be supported", which only applies "in extreme cases where the seriousness of the deprivation is totally out of sync with the objective" (quoted at para 2724). Justice Steeves rejected the plaintiff's contention that the impugned laws deprive patients of the ability to "save their own lives, or avoid serious physical and psychological harm, by accessing timely private care" (at para 2753). He acknowledged that the effect of wait times "should not be taken lightly" (at para 2765) and that waiting for care can be "extremely difficult to manage" (at para 2772). However, there was no evidence that patients die waiting for care (at para 2755). Instead, patients receive timely care when life or limb is threatened (at para 2756) and they advance on wait lists if their conditions deteriorate (at para 2773). Furthermore, private clinics do not address life-threatening situations given that they do not provide emergency services or treat complex cases (at para 2756).

Justice Steeves also concluded that without the impugned laws, the problems the plaintiff attributed to waiting (e.g. "severe and prolonged suffering") would worsen in the public system and "those with pre-existing conditions, co-morbidities or insufficient funds" may have to wait longer than they currently wait for care (at para 2775). Those with the most urgent medical needs would be "highly unlikely to benefit from a duplicative private system" (at para 2776) and instead would be "dependent on a public system struggling with reduced capacity due to competition with a parallel private over the same pool of healthcare professionals" (at para 2777).

Section 1 Analysis

Had the plaintiffs succeeded with their section 7 arguments, Justice Steeves would have upheld the law under section 1 of the *Charter*. He found that "preserving and ensuring the sustainability of the universal public healthcare system" and ensuring necessary medical care "is funded and delivered based on need and not the ability to pay" were pressing and substantial objectives (at para 2902). There was a rational connection between these objectives and laws "suppressing and discouraging the emergence of a duplicative private healthcare system" that would compete with the public system for human resources (at para 2904), increase demand for health services and resulting costs (at para 2904), increase wait times in the public system (at para 2904), and create incentives for health professionals to prioritize private patients over public ones (at para 2905).

With respect to minimal impairment, Justice Steeves found that without the current laws, the government would have to enact a substantial regulatory system to mitigate threats to the public system (at para 2914). Other countries have struggled with enacting and enforcing effective regulations, such as rules ensuring that physicians spend adequate time treating public patients.

In this regard, Justice Steeves cited evidence that “physicians, especially specialists providing elective surgical services, are not meeting their obligations in the public system before working in the private system” (at para 2917). In addition, such regulations would not address other concerns with privatization like inequity (at para 2918). BC’s legislative history indicates that less restrictive rules were ineffective at ensuring equitable access to care (at para 2921).

In assessing the proportionality between the law’s salutary and deleterious effects, Justice Steeves acknowledged that some patients have unreasonably long waits and a subset of those patients experience adverse consequences such as deterioration and reduced post-operative outcomes (at para 2925). However, other patients do not experience these issues and patients who deteriorate while waiting will advance on wait lists (at para 2926). On the other hand, Justice Steeves concluded that the benefits of the law were “substantial” and the provisions “essential” to preserving the universal public health care system and ensuring equitable access (at para 2928). Furthermore, the government required “reasonable room to manoeuvre” in an area with competing claims and resource demands (at para 2933).

Conclusion

Although proponents of public health care celebrated the BC government’s victory, an [appeal](#) is already planned and many speculate that this case is destined for the Supreme Court of Canada. The trial judge’s methodical and cautious approach to the evidence will help to insulate his decision from a successful appeal. Although this case may represent a blow to privately financed health care services, many provinces have privatization initiatives underway that target the delivery system rather than the financing of health services. In the second part of this blog post, I address privatization in Alberta and apply the comparative health policy evidence from this case to Alberta’s policies.

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