

Private Health Care and the Law Part 2: Lessons for Alberta

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

On September 10, Justice Steeves of the BC Supreme Court released his decision in *Cambie Surgeries Corporation v British Columbia (Attorney General)*. The driving force behind this case was Dr. Brian Day, an orthopedic surgeon who founded a private surgical clinic in Vancouver that engaged in illegal billing practices. When the BC government cracked down on those practices, Day responded by arguing that the combination of long wait times and laws limiting private funding for insured services violated the [Charter](#).

It is important to note that this case only considered private funding for medically necessary hospital and physician services (i.e. those addressed in the *Canada Health Act*, [RSC 1985, c C-6](#)) and not the plethora of other health services for which there is a patchwork of public and private funding, such as drugs and dental care. In a previous [post](#), I examined Justice Steeves' constitutional analysis. Here, I summarize the international evidence on private health care and the implications of this decision for Alberta in light of recent moves to increase private surgical clinics and a [vote](#) at the United Conservative Party's (UCP) Annual General Meeting [supporting](#) privately financed health care.

Introduction

As with other provinces, BC limits private finance for publicly insured services through the *Medicare Protection Act*, [RSBC 1996, c 286](#). Section 45 prohibits insurance for services that are publicly insured, while 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 public plan. In *Cambie*, Justice Steeves found that these limits on private finance violated the right to security of the person, given that some patients waited beyond provincial benchmarks, which may prolong pain and worsen surgical outcomes (at para 1884).

However, even where there is an infringement of the right to security of the person, section 7 of the *Charter* requires a plaintiff to also establish that the violation is not in accordance with the principles of fundamental justice. One such principle is arbitrariness, which Justice Steeves described as the absence of a "rational connection" between the purpose of a law and its effects (at para 2072). He found that the government's purpose was "to preserve and ensure the sustainability of a universal public health care system that ensures access to necessary medical care is based on need and not on an individual's ability to pay" (at para 14). In rejecting the argument that BC's limits on private finance were arbitrary, Justice Steeves engaged in a detailed examination of several health systems, which I address in the next part.

Comparative Health Policy Analysis

People commonly argue that, because other successful health care systems allow private finance for hospital and physician services, Canada ought to follow suit. For example, the plaintiffs in this case argued that “every other OECD country permits or even encourages privately funded healthcare” and “these countries provide healthcare more efficiently and no less equitably than British Columbia” (at para 2148). Arguments for the adoption of private finance very often mistake correlation (i.e. the presence of both private finance and a high performing system) with causation (i.e. that private finance is responsible for that system’s success). These arguments also tend to grossly oversimplify the similarities between the Canadian health care system and that of other countries, thereby encountering what one expert in this case called the dangers of “drive-by” comparisons (at para 2156).

Acknowledging the challenges with comparative health policy analysis, the parties in this case selected jurisdictions that would be most similar to BC without its limits on private finance: the UK, New Zealand, Ireland, and Australia. Quebec was also included, given a Supreme Court of Canada case in which the majority struck down a prohibition on private insurance on the basis of Quebec law (*Chaoulli v Quebec (Attorney General)*, [2005 SCC 35 \(CanLII\)](#)). Because the UK is often touted as having a successful two-tier system that Canada could emulate, Justice Steeves’ description of that system illustrates the problems with reductive arguments, e.g. that features of other health care systems would be feasible in Canada and would improve our health system. In this regard, the plaintiffs argued that “the experience in the United Kingdom demonstrates that private healthcare is ‘perfectly compatible’ with a universal public healthcare system” because the UK “provides high quality and timelier healthcare than British Columbia while also permitting a parallel duplicative private healthcare system” (at para 2172).

In addition to a universal public system (the NHS), about 10% of the UK’s population have private health insurance, mainly for the purpose of avoiding wait times in the public system (at para 2173). One salient distinction between Canada’s system and that of the UK is that the latter’s specialists are “paid by a salary pursuant to employment contracts” (at para 2175). Due to problems with doctors being “enticed away from their responsibilities in the public system”, their contracts regulate how they divide their time between the public and private systems (at para 2176). As with other jurisdictions, the UK struggles to effectively regulate doctors. Justice Steeves found that the risk of doctors prioritizing private patients “would be heightened in British Columbia where physicians work on a fee-for-service basis, they are virtually all self-employed and they determine how much they work, when, and where” and that regulation “may be more challenging than in places where they are employees of public systems” like the UK and New Zealand (at para 2386).

Even if it were possible to import features of the UK’s health care system into Canada, it is unlikely that this would significantly reduce wait times, if at all. Although both countries struggle with wait times, the UK has had recent success in addressing this issue. With respect to the role of private health care in reducing wait times, one of the defendant’s experts stated that “no respectable scholar would attribute the fall in NHS waiting times to any aspect of the private health care insurance market” (at para 2184). Justice Steeves agreed, stating that “I cannot conclude that the introduction of a dual system as in the United Kingdom would somehow

decrease wait times in British Columbia” (at para 2263), citing other factors that led to wait time improvements such as increased spending and wait time targets (at para 2188).

Effects of Privately Financed Health Care

After acknowledging the limits of comparative evidence and thoroughly reviewing the comparator jurisdictions, Justice Steeves identified several interrelated concerns with private finance: longer public wait times, increased costs, inequity, ethical conflicts of interest, and decreased support for the public healthcare system.

Justice Steeves found that it was “very clear that the introduction of duplicative private healthcare would not improve wait times in the public system” (at para 2317), refuting a claim that is often made in favour of privatization. Indeed, he went even further in finding “a strong connection between duplicate private healthcare and increases in wait times in the public system” (at para 2342). In support of this finding, he cited “considerable evidence and literature” demonstrating that when there is private healthcare, “physicians reduce their time and efforts in the public system” (at para 2330). This diversion of physicians to the private system increases wait times in the public system. For example, Justice Steeves referred to a Manitoba study of cataract patients, which showed that they waited longer for care when their doctors worked in both the public and private systems than when they worked solely in the public system (at para 2366). He also cited evidence from a census conducted by the Royal Australasian College of Surgeons that found that 40% of surgeons work only in the private system, and only two specialties (cardiac and pediatric surgeons) worked more in the public system than the private one (at para 2229).

There are similar human resource challenges with other types of health personnel. For example, Cambie paid nurses more and gave them more perks than the public system and “never had difficulty recruiting staff” (at para 2370). Meanwhile, there have been problems with recruitment in BC’s public system, including very serious shortages of operating room nurses (at para 2371). Justice Steeves also commented that the training of health professionals is very costly and time consuming, with the private system receiving a “significant benefit” because it “uses these people but does not pay for their training” (at para 2372).

A second problem with private finance is that it would lead to increased costs, thereby jeopardizing the sustainability of universal public healthcare. According to Justice Steeves, “there is little disagreement that the overall demand for healthcare, public and private, and the overall costs of healthcare, public and private, would increase with the introduction of duplicative private healthcare” (at para 2402). This increased demand is due, for example, to evidence that private health insurance “facilitates overutilization of healthcare, including unnecessary services” (at para 2405). Justice Steeves also found that privatization would drive up costs due to higher administrative expenses (at para 2404) and “significant” regulatory costs (at para 2449). Competition between the public and private systems for the same pool of healthcare professionals would also increase costs (at para 2428).

Justice Steeves also acknowledged a potential loss of federal funding due to private finance. According to the *Canada Health Act*, a province’s transfer payment must be deducted if they

permit extra billing or user charges (ss 18-20). Justice Steeves stated that a “loss of federal funding would clearly result in a weakening of the public healthcare system” (at para 2462).

Another concern relates to inequity, given that “duplicative private healthcare predominantly benefits the wealthy and healthy”, with the private system providing “preferential and timely care” to individuals in those groups (at para 2580). Because of the link between wealth and health (at para 2656), those who can afford to purchase preferential access would generally not be those with the most acute medical needs, thereby exacerbating inequity. In order to avoid large costs, private insurers tend to “exclude persons with the greatest medical needs, those with complex health issues and those with pre-existing conditions” (at para 2579). Some governments regulate against risk selection, but then extensively subsidize the private insurance market in order to ensure its solvency (at para 2594).

Various experts described the equity issues stemming from private finance in other countries. For example, experts from Australia and New Zealand testified that patients sometimes obtain some of their care in the private system (such as diagnostic tests) and then return to the public system for other treatment (such as surgery), which helps them jump ahead in the public queues (at para 2588). There was similar evidence of BC patients paying for private MRIs to accelerate their treatment in the public system (at para 2589). The competition between the public and private systems for healthcare professionals could also adversely affect equity if the government has to reallocate funds to keep up with urgent health needs, which would “have the effect of reducing funding for essential healthcare programs and services that patients in the public system depend on and create a further divide between the private and public systems in the provision of non-acute care” (at para 2638).

Another concern with private healthcare relates to the “real and significant risk” of “perverse incentives and unethical conduct” by doctors (at para 2506). Justice Steeves found “uncontroverted evidence” that “patients are offered and repeatedly encouraged to pay privately for cataract surgery instead of waiting for their surgery in the public system” (at para 2486). Although there are self-regulatory standards limiting self-referral (i.e. referring patients to one’s own private practice), he found ample evidence of doctors violating these standards (at para 2490). Furthermore, the fact that legislative restrictions did not stop some BC physicians from illegally billing underscores how difficult it would be to regulate private healthcare and to enforce those regulations (at para 2506).

The final issue with private finance discussed in *Cambie* was an erosion of political support for the public system and willingness to fund it through taxes. Although the evidence was limited, Justice Steeves found a “rational connection between suppressing and discouraging the emergence of duplicate private healthcare” to ensure “the sustainability of the universal public healthcare system” (at para 2429).

Implications for Alberta

Like other provinces, Alberta limits private finance in healthcare. As with one provision challenged in *Cambie*, Alberta prohibits doctors from billing the government for providing services and charging patients additional fees on top of that (*Alberta Health Care Insurance Act*,

[RSA 2000, c A-20, s 9 \(AHCIA\)](#)). Alberta also prohibits private insurance for services covered under the public plan (*AHCIA*, s 26). Although *Cambie* will likely be [appealed](#), it supports the argument that limits on private finance are constitutional. However, provinces are not compelled to employ such limits. In fact, there is little stopping a province from establishing a parallel private system for medically necessary hospital and physician services, apart from the threat of the federal government withholding transfer payments under the *Canada Health Act*.

At the UCP's Annual General Meeting on October 17, members voted in favour of a policy that would support private finance in health care. Specifically, the policy refers to patients choosing whether to use the public or the private system, the latter of which they would pay for either out-of-pocket or through private insurance. Although not all meeting resolutions become law, they do help to inform the party's platform development. If this policy does become law, the large body of evidence cited in *Cambie* and elsewhere indicates that this would adversely affect the public system.

Apart from the possibility of moving forward on private finance, Alberta has already taken steps towards significantly increasing the number of publicly funded surgeries that are completed in private facilities. As I have argued [elsewhere](#), evidence links private delivery with increased costs, reduced quality of care, and inequity. Although the focus in *Cambie* was on private finance, some of the same arguments apply to private delivery. For example, depending on the contracts negotiated with the government or the ability to treat a greater number of patients in private facilities, the promise of higher earnings may pull doctors away from public hospitals. Because those with complex medical needs are often unsuitable for treatment in private facilities, they may have to wait longer for care in public hospitals while those who are healthier receive care sooner.

Because the jurisdictions studied in *Cambie* employ private delivery, their experiences are relevant for Alberta, particularly that of Quebec. Following the Supreme Court's decision in *Chaoulli*, publicly funded procedures were increasingly contracted out to private facilities. However, these facilities also provide privately funded services by doctors who have opted out of the public system. As with Quebec, Alberta physicians can opt out of the public system entirely and charge patients for healthcare services (*AHCIA*, ss 8-9). While anecdotal reports suggest that only one or two Albertan physicians have done so, the number is much higher in Quebec. Although there was a correlation between the expansion of private surgical facilities and a significant increase in the number of opted out physicians in Quebec (at para 2251), no study has established a clear causal link between the two (at para 2253). It is possible, however, that Alberta's expansion of private delivery could increase the number of physicians who opt out of the public system entirely.

Expert witnesses in *Cambie* highlighted several additional regulatory concerns with private facilities. For example, one noted a problematic queue jumping practice where patients pay to see an opted-out general practitioner, who refers them to an opted-in surgeon (at para 2244). The Quebec government responded to this preferential access for private patients by prohibiting the co-mingling of opted-in and opted-out doctors in the same facilities. However, these rules have been circumvented, for example by referring doctors and surgeons splitting into separate corporate entities within the same building and continuing to refer to one another (at para 2245).

One expert also testified about the rise in extra billing and user charges in Quebec (at para 2248). Based on the experience of BC and Quebec, with some doctors flouting regulatory requirements, the growth in private surgical delivery in Alberta may well prompt similar behaviour. Quebec has also struggled with public funds being used to cross-subsidize private services within these facilities (at para 2248). Alberta has not said if or how it plans to address these issues as it expands private surgical clinics. Quebec responded by requiring clinics to provide all pre and post-operative, rehabilitation and home care services, instead of pushing these costs onto the public system (at para 2249).

Conclusion

Alberta has shown its receptiveness to private healthcare, first with the significant expansion of private surgical delivery and now with the UCP passing a resolution to increase private finance. Justice Steeves' thoughtful and detailed analysis of comparator jurisdictions reveals several important concerns with privatization, including increased wait times, increased costs, inequity, ethical issues for physicians, and eroded support for the public system. His analysis also underscores the problem with arguments that Canada could or should adopt the policies of other countries, which also struggle with maintaining robust and equitable public health care systems. On the basis of these concerns and the lack of evidence in support of private finance, the government ought to reject the proposal from the UCP's Annual General Meeting.

While the government may ultimately reject private finance, it is highly unlikely to reverse course on expanding private delivery. However, it should pay close attention to the experience of Quebec, which points to the need for increased regulation before proceeding with implementation. Specifically, Justice Steeves concluded that "where even a very limited form of duplicative private healthcare is allowed, it is necessary to implement extensive regulations of that private market" and the government must account for the fact that "enforcement of those regulations can be very challenging" (at para 2440). In other words, it seems that relying on personal responsibility alone will not be enough to prevent the erosion of the public system.

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