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Private Health Care and the Law Part 3: Not the Anticipated Conclusion but Still Not a Loss for Public Health Care

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Decision commented on: *Cambie Surgeries Corporation, et al v Attorney General of British Columbia, et al*, 2023 CanLII 26745

On April 6, 2023, the Supreme Court of Canada (SCC) dismissed an application for leave to appeal the decision of the BC Court of Appeal in *Cambie Surgeries Corporation, et al v Attorney General of British Columbia, et al*, 2023 CanLII 26745. Previous blog posts by one of the authors of this post describe the trial decision in detail (see here and here). Many expected that the SCC would hear this case, given the importance of the issues at stake, the strongly-worded concerns with the public health care system expressed by Justice Lauri Ann Fenlon at the BC Court of Appeal (*Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2022 BCCA 245 (CanLII)), and the fact that the SCC's 2005 decision in *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 (CanLII), left the constitutionality of limits on private finance in health care unresolved. To many, this decision represents a missed opportunity for the SCC to provide clarity on this defining yet widely-debated feature of our health care system.

Long wait times due to human resource challenges and COVID-related surgical backlogs have fueled the ongoing debate about two-tier health care in Canada. Some argue that Canada needs to embrace two-tier health care so that individuals can have access to paid health care services in a parallel private system. On the other hand, many argue that two-tier health care results in health professionals leaving the public system to work in private facilities and exacerbates health inequities. Policy-makers also have a range of views on the role that private finance ought to play in Canada's public health care system. For example, some provincial premiers are receptive to private finance, as exemplified by Saskatchewan Premier Scott Moe's endorsement of private diagnostic clinics and Alberta Premier Danielle Smith's support for health spending accounts. In contrast, the federal government has oscillated away from its historically lax enforcement of the *Canada Health Act*, RSC 1985, c C-6 (*CHA*) and recently withheld substantial transfer funds from a number of provinces for permitting private pay diagnostics and other services. They have indicated that they have plans to do the same for virtual primary care services where patients pay out-of-pocket.

Background

Dr. Brian Day, who co-founded Cambie Surgeries Corporation, has been the driving force behind this 14-year litigation. According to the province of BC, Dr. Day's clinic engaged in illegal billing in contravention of both the *CHA* and BC's *Medicare Protection Act*, RSBC 1996, c 286, (*MPA*). When the province moved to enforce their legislation, Dr. Day responded by challenging the

constitutionality of provisions in the *MPA* limiting private finance. Specifically, he argued that the combination of long wait times in the public system and laws limiting access to private care violated the rights to life, liberty, and security of the person in a manner that was not in accordance with the principles of fundamental justice, in contravention of section 7 of the *Charter*.

Provinces operationalize the *CHA* and limit private payment for medically necessary hospital and physician services through a variety of mechanisms, such as prohibiting private insurance for publicly insured services, creating financial disincentives for doctors to treat patients privately, and banning extra-billing. Extra-billing occurs when a physician bills the government for an insured service and charges the patient an out-of-pocket fee on top of that. The *CHA* requires the federal government to claw back from its transfer payments any amount that a province has permitted in extra-billing on a dollar-for-dollar basis. In BC, federal transfer payments were reduced by $15.9 million in 2018, $16.2 million in 2019, and $16.8 million in 2020 due to private clinics such as Cambie engaging in extra-billing, some of which was later reimbursed when the province entered into a plan with the federal government to address these charges.

Although the *MPA* prohibits extra-billing, it does not prohibit physicians from providing private health care services so long as those services are not covered within the public plan or the physician has opted out of the public plan. Physicians are simply restrained from billing both the public system and privately for the same service.

At trial, after engaging in a thorough cross-jurisdictional comparison of the impact of private finance in health care, Justice John Steeves concluded that while it was possible for the combination of long wait times and limits on private finance to violate the right to security of the person under section 7 of the *Charter*, this violation was in accordance with the principles of fundamental justice (*Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2020 BCSC 1310). This finding was due to a variety of policy concerns with private finance, which centered around equitable access to care and the impact that private health services may have on the public system. For example, Justice Steeves concluded that "there is a rationally based risk that the introduction of duplicative private healthcare in British Columbia would have a direct negative impact on equitable access to necessary medical services", including "equity in access, equity in utilization, equity in finance and equity in health and socioeconomic outcomes" (at para 2656). He went on to state that a parallel private system "would create a two-tier healthcare system where preferential treatment can be purchased either directly or through private insurance", which "would discriminate against the poor and the ill" and "exacerbate existing health inequities" (at para 2656).

On appeal, Chief Justice Robert Bauman and Justice David Harris determined that the purpose of providing health care based on need, and not ability to pay, was based on the fundamental principal of fairness, and the provisions in the *MPA* that limited private finance were designed to facilitate access to medically necessary health services for all. Health care services that are distributed based on ability to pay may frustrate that objective and, in turn, engage an entirely different cohort's section 7 rights (2022 BCCA 245 at paras 354-5).

In what may be described as a reluctant concurrence, Justice Fenlon expressed significant concerns with wait times in Canada's public health care system, disagreeing with the majority on one key point. She found that the objectives of the legislative limits on private finance were grossly

disproportionate to their goal of seeking "to preserve a public health care system that is intentionally under-designed in order to achieve fiscal sustainability" (at para 390). Furthermore, "eliminating the availability of timely private care comes at too high a cost to the life and security of those individuals who cannot access timely care in the public system, but who would be able to access private care" (at para 392). Although she recognized the "legal dissonance in finding that a law that does not accord with the principles of fundamental justice is nonetheless constitutional" (at para 417), Justice Fenlon found the violation of section 7 could be justified as a reasonable limit under section 1 of the *Charter*. She found that protecting the most vulnerable in society, who would be the most heavily burdened by any negative impact on the public health care system, was a sufficient justification for the "prolonged suffering, irremediable physical harm, and even increased risk to life" that resulted from BC's limits on privately financed health care (at para 417).

Despite this division at the Court of Appeal, Dr. Day was unsuccessful in persuading the SCC to hear his appeal.

Prior Jurisprudence

In 2005, the SCC considered private finance for publicly insured services in *Chaoulli v Quebec (Attorney General)*. Justice Marie Deschamps found that Quebec's prohibition on private insurance for publicly insured services violated the province's *Charter of Human Rights and Freedoms*, but declined to opine on whether the provision violated the Canadian *Charter*. The remaining six justices were evenly split on whether the ban on duplicate private insurance violated section 7 of the *Charter*. The debate centered around whether Quebec's law was arbitrary and, more broadly, the institutional competence of the Court to consider complex public policy issues like private health care.

While three of the justices found that the law was arbitrary due in large part to the presence of private finance in other health care systems internationally, the other three found that there was sufficient expert evidence pointing to concerns with private finance, such as a parallel private system competing with the public system for resources. With respect to the appropriate role of the courts in this debate, according to Chief Justice Beverley McLachlin and Justices John Major and Michel Bastarache, "[t]he fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance when citizens challenge it" (at para 107). In contrast, Justices Ian Binnie, Louis LeBel and Morris Fish stated that, "[t]he resolution of such a complex fact-laden policy debate does not fit easily within the institutional competence or procedures of courts of law" and questioned whether "the courts are well placed to perform the required surgery" on our health care system (at para 164).

The SCC's decision was widely criticized by both proponents of public health care and its detractors due, for example, to the justices' cavalier international health system comparisons, the rigorous definition of arbitrariness applied by some of the justices, and the Court's failure to understand the nuances of the Canadian health care system. It is possible that the scathing critiques of *Chaoulli* and the politically fraught issues at play in *Cambie* impacted the Court's decision not to hear the appeal in the latter case.

Conclusion: Public Healthcare Post-Cambie

The *Cambie* case is part of a broader ongoing debate around the appropriate role of private finance in the future of Canada's health care system. For example, there are contentious debates about the equity and cost concerns associated with the publicly funded but privately delivered surgical services that a number of provinces have embraced. Many also argue that certain models of virtual care and medical concierge clinics that co-mingle insured and uninsured services either violate or skirt the rules limiting private payment for medically necessary services. Patients are also increasingly taking advantage of regulatory loopholes that allow them to receive faster access to health services such as elective surgeries by paying privately for those services in other provinces.

The decision in *Cambie* does little to directly limit these expanding forms of privatization, as it is ultimately up to the provinces and the federal government to choose to enforce existing legal limits on private finance. Although the *Cambie* decision allows for BC to continue to enforce its limits on private finance, thereby protecting its federal transfer payments, it does not compel the government to do so. While the finding that BC's limits on private finance are constitutional may prompt some provinces to ramp up enforcement of their analogous laws, other provinces have expressed concern about conditions attached to federal transfer payments in areas of provincial jurisdiction. Some provinces have permitted private finance, even if it means jeopardizing federal transfer payments (see e.g. here and here).

Cambie was celebrated as a victory by many advocates of Canada's public health care system. While it did preserve the single payer foundation of our system (at least in BC), it should not be seen as an endorsement of the current state of health care in Canada. Instead, the significant challenges with access to care faced by many Canadians, which were acknowledged both at trial and appeal, suggest that policy-makers need to continue to work to improve the system. The fact that elective surgery wait times can be sufficiently long to engage constitutional rights should be of concern to policy-makers and Canadians. For now, given the constitutionality of legal limits on private finance, the BC government has the opportunity to address these concerns within the context of the public system, rather than being compelled to open up the health care system to private finance and the concerns that it raises with equity.

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