Chaoulli Five Years On: All Bark and No Bite?

A Paper Presented at the 2010 Annual Meeting of the Canadian Political Science Association
Concordia University, Montreal, Quebec

Please Note: This is a draft copy, comments are welcome. Contact the author before citing as revisions will likely be made before final publication.

DRAFT

Daniel Cohn, Ph.D.,
Associate Professor
School of Public Policy & Administration
York University
4700 Keele Street
Toronto, Ontario
M3J 1P3

Tel. 416.736.2100 ext. 77276
Email dcohn@yorku.ca
Web www.yorku.ca/dcohn

© The Author

Abstract:

In June 2005 the Supreme Court handed down a complex and non-unanimous decision in the case *Chaoulli v. Quebec*. The ruling held that prohibitions on the sale of private health insurance for services that are already provincially insured are unlawful, but only under certain circumstances. Further adding to the complexity of the ruling is that it was so worded as to apply only to the Province of Quebec. The *Chaoulli* ruling generated a virtual avalanche of media stories and a significant volume of scholarly publications. Such activity is characteristic of a public policy-network and its associated policy-community that have been severely disrupted. This paper identifies the element of the ruling which caused this disruption and goes on to ask why this disruption failed to produce a suitable policy window for reforming Canadian health policy along lines favoured by free-market advocates. Specifically, Canada's system of provincial universal public health insurance plans remains largely as it was before the ruling and no meaningful market for parallel private insurance has emerged. Only a handful of niche products have entered the field. Significantly, Canada's major insurers have shown little interest in offering such coverage. This paper argues that the reason for this reticence is simply that there is no business case for the major insurers to offer such a product. Even if the courts were to further widen the conditions under which rival private insurance for provincially insured services could be sold and were to lift other restrictions as well, a profitable private alternative to provincial health insurance would still be very difficult to create. As far as health care policy-making is concerned, *Chaoulli* has proven to be a decision which is primarily bark and very little bite. The paper concludes by asking what lessons the Canadian health policy community can draw from the *Chaoulli* decision with regard to how future issues are assessed and debated.

DRAFT

1. Introduction:

In June 2005 the Supreme Court handed down a complex and non-unanimous decision in the case *Chaoulli v. Quebec* (Supreme Court of Canada 2005). The ruling held that prohibitions on the sale of private health insurance for services that are already provincially insured are unlawful, but only under certain circumstances. Further adding to the complexity of the ruling is that it was so worded as to apply only to the Province of Quebec. The ruling generated a virtual avalanche of media stories and a significant volume of scholarly publications. One edited volume included 27 contributions grouped under eight headings (Flood, Roach, and Sossin 2005). There was also a selection of articles in Canada's leading medical journal (Hadorn 2005, 271-273; Lewis 2005, 275-277; Schumacher 2005, 277-278; Smith 2005, 273-274; Quesnel-Vallee et al. 2006, 1051-1052; Flood and Sullivan 2005, 142-143), a series in *The Health Law Journal* (cf Premont 2007, 43-86; Jackman 2007, 87-141) and the Osgoode Hall Law Journal (Flood 2006, 273-310; Manfredi and Maioni 2006, 249-271; Gilmour 2006, 327-347; Jackman 2006, 349-375). The ruling was the topic of one of the premier events held annually by the leading think-tank for Canada's economic and governmental elites, the C.D. Howe Institute (Monahan 2006). There were also several further individual academic articles (cf Paradia and Robert 2009, 72-75; Baterman 2006, 38-64; Premont 2008, 237-264), think-tank pieces (cf McIntosh 2006; Rachlis 2005; Chaoulli 2006; Maioni and Manfredi 2005, 52-56), reviews of the ruling and its implication in the business trade publications (cf Vu 2006, 1-14; Hobel 2006, 18; Harding and Picard 2005, 77-79) and of course news stories, editorials and op-eds in the mainstream media. Many of these popular pieces were written by authors engaged in the academic debate or featured interviews with them (cf Aaron 2005, A.1; Fischer 2005, A.4; Flood 2005, A.17; Roach, Flood and Sossin 2005, A.23; Manfredi 2005, A.25; Maioni 2005, F.05; Marmor 2005, A.26; Monahan 2005, A.27; Shortt 2005, A.15) .

This sort of coverage is symbolic of an event that is disruptive in a public policy process. For many years scholars have argued that public policy in democracies is made in subsystems. Following Howlett and Ramesh (2003, 150-157) these will be called policy-networks. Here below the level of general observation, issues are debated in detail between participants who are familiar with each other and their respective views and vantage points. These participants tend to be heavily "invested" in the work of the policy-network and have substantial interests at stake in the deliberations of the network. Informing and supporting their debates is an ideational structure and other less interested participants who share these ideas or an understanding of the controversies if the ideas themselves are contested. This wider group is described as a policy-community. Howlett and Ramesh (2003, 150-157) categorize policy-networks according to the idea sets that are relevant to their debates and the number of actors and the power relationships between them. As will be discussed below, in recent decades the Canadian health policy-network has become among the most closed of such systems in that the policy community it is a part of has a dominant set of ideas, and because the network itself has few actors dominated by the state. In a well-established policy-network of this type there are disagreements but also a general consensus as to what the issues needing attention are and the appropriate set of theoretical tools for analyzing issues and evaluating options. There is also a resistance to changing these ideational structures and

DRAFT

possibly to admitting new members into the deliberations of the network. A disruptive event throws a policy-network and its wider community into disarray and creates room for new entrants and divergent views. Such disruptions can also be a factor that contributes to opening a policy-window. This is a time when perceptions as to what is a pressing problem, public opinion, interests of policy-actors and environmental factors align so that policy-making or policy change can occur (Kingdon 1995).

The next section of the paper will look at the Canadian health policy-network and the ideas that inform its deliberations and the behaviour of the policy-community that supports its work. Afterwards attention shifts to the *Chaoulli* decision so as to identify why it created such a large disruption. Section four focuses on why the disruption did not generate a policy-making window suitable to change policy in the manner favoured by free-market advocates. Specifically, we need to ask why five years after *Chaoulli*, Canada's system of provincial single-payer, universal public health insurance plans have survived largely intact. This paper argues that there were several reasons why a policy-making window failed to open, these include a less than clear endorsement from public opinion that change was needed, institutional barriers in Canada's federal system of government that tend to slow and moderate major policy changes and most importantly, a lack of interest (at least for the present) among Canada's health and life insurers in seeing the present system change. Even if the *Chaoulli* decision were to be further expanded so as to apply to all of Canada (rather than just Quebec) and broadened (so as to allow for either a completely comprehensive alternative to public insurance or coverage for most elective, non-urgent care, rather than just supplements for procedures where Canadians face unreasonable wait-times), this paper argues insurers would still be hesitant to create a market as a genuine competitor for provincial plans would not likely be a very profitable product to offer, nor would such insurance save provincial governments much money, decreasing the odds that they will ever encourage such a move. Evidence to support this analysis is drawn from news accounts, publicly available documents and statistics as well as a small set of interviews with public-policy participants. It should be noted that this project is a work in progress. Not all the interviews that the author hopes to conduct have been completed and further ones are scheduled.

2. Canada's Health Policy-Network at the Time of the *Chaoulli* Decision

In the mid 20th century Canada's health policy-network was dominated by organizations representing physicians. However, the introduction of public funding as the main source of money to finance the sector has led to a gradual shift whereby the medical associations have had to cede this dominant position to the public servants representing governments. This transition was not always consensual and resulted in several attempts at resistance. However, by the end of the 1980s, governments had firmly established their control over the policy-network (Boase 1996, 287-310). As noted above, in a well established policy-network there is more than a constant cast of players with an interest in the issue, there is also a common understanding of the causes of policy problems, how to identify them, what acceptable solutions look like, and the core values that ought to animate action. In the Canadian health policy-network this ideational framework rests on at least three structures:

DRAFT

- The nature of Canadian federalism
- The basic principles regarding how medically necessary care ought to be organized and funded which are contained in *The Canada Health Act*
- The organizational structure of health care as a service.

The Constitution Act of 1867 and the judicial interpretations that have given a living meaning to this document divide responsibilities for health care between the federal and provincial governments. Most matters in terms of funding, organizing and delivering care for most Canadians, as well as the licensing of facilities and health professionals fall within the powers of the individual provinces (and by convention the territorial governments to the extent they are capable). Ottawa's responsibilities are more in the areas of support, such as the regulation of therapeutic products (drugs and medical devices), radioactive and nuclear safety, and the protection of Canada from major health threats. As well, the federal government has created a further role for itself in the field of health care by offering grants to provinces for the support of their health care systems on condition that they follow the rules that Parliament sets regarding health policy. Federalism is generally seen as having had the effect of slowing policy change in Canada as reforms in most major policy areas require a federal-provincial consensus to proceed. Health policy has exhibited this trait. Over the years the conditions set by Ottawa gradually grew more general and less detailed (Cohn 1996). When looked at comparatively, Canada has one of the most decentralized health systems of any federation (Banting and Corbett 2002, 1-38). However, even though the detailed rules have been reduced there has been a similarly gradual tightening of basic features and the development of a pan Canadian understanding of citizenship rights within health care so that some would argue that the field has been gradually "defederated" (Graefe and Bourns 2009, 187-209). *The Canada Health Act* of 1984 (Parliament of Canada 2010), played an important role in this process. This act consolidated many of the conditions that governed federal conditional grants to the provinces for health care. These principles are:

- Public Administration: Each province must establish a publicly administered not for profit health insurance plan.
- Comprehensiveness: All medically necessary hospital, physician and diagnostic services (whether in hospital or outside of one) must be fully insured.
- Universality: All permanent residents of a province must be eligible for coverage
- Portability: Coverage must be good across Canada so that if a person travels they will still be covered, or so if they move their coverage will stay in effect until they are deemed to be a permanent resident of their new province
- Accessibility: All services must be reasonably accessible to all residents of the province. Under this heading *The Canada Health Act* extended the long standing ban on charges at point of service for any medially necessary hospital and diagnostic services to physician services as well.

DRAFT

Along side of these principles this act also prescribed penalties if provinces violated the ban on extra-billing. The Federal Minister of Health was empowered to reduce a province's federal grants by the total amount of extra-billing it allowed. In short *The Canada Health Act* defines medically necessary services as a right of citizenship that all Canadians ought to enjoy in a fully equal manner. These five conditions and the principles they represent have achieved strong public support. Even while acknowledging things are not perfect and that sometimes the health care system falls seriously short of expectations, Canadians still support the model outlined in *The Canada Health Act* and the values it represents (Mendelsohn 2002, viii). Public support for *The Canada Health Act* is so strong that, in the past, opponents of the system have recognized it to be unassailable and have backed away from recommendations that would directly violate it (cf Kirby and LeBreton 2002; Mazankowski 2002).

Finally, we have to take into account the organizational structure of health care as a service. As noted above, during the decades from 1960 through to the 1980s, the medical community and state actors were engaged in a long-term struggle for control of the Canadian health policy-network with the state ultimately coming out on top (Boase 1996, 287-310). However, this description fails to acknowledge the federal provincial divide discussed above. While both federal and provincial state actors might agree that they, not the doctors ought to be in charge, they have at times had strong disagreements and some provincial governments have even sought to either repudiate or at least work around *The Canada Health Act*. This divide has perhaps given the medical community additional leverage it might not have had in a unitary state and allowed physicians to avoid being further displaced in the health policy-network. Specifically, physicians have managed to come to a reasonably stable relationship with the various provincial governments regarding the organizational structure of health care as a service. The medical community enjoys the professional autonomy to organize and carry out their work as they see fit, within the financial and planning framework determined by their provincial government (Tuohy 1999, 204-205). As we will see, the *Chaoulli* decision created such a large disruption as it appeared to present a serious challenge to the values underpinning the Canada Health Act and the historic bargain struck between physicians and governments at the start of the medicare era, while promising to ignite a round of tensions between Ottawa and the provinces with governments that had historically been antagonistic towards *The Canada Health Act*, but whom had recently been reconciled to leadership from Ottawa by the 2004 10 year health accord and agreement by Ottawa to avoid unilaterally enforcing the provisions of *The Canada Health Act* (Government of Canada 2004).

DRAFT

3. The *Chaoulli* Decision:

In reading the *Chaoulli* decision one has to keep in mind that rulings can be read in different ways. At a minimum three such distinct approaches to reading the rulings of the Supreme Court seem relevant here. First there is what we can perhaps call the technical legal ruling. This is the ruling itself where someone has either appealed a decision from a lower court or the government of Canada or a province has itself referred a law to the court for an evaluation of its constitutionality. Second there is the political interpretation

of the ruling, where actors seek to employ the text for purposes beyond the narrow technical decision (Morton and Knopff 2000, 159; Russell 2005, 5-19). Finally there is the academic reading of the ruling which often focuses on what the ruling might mean as policy and legal experts seek to extrapolate from the ruling to determine the impact for public policy and future cases (Manfredi and Maioni 2006, 249-271), some of which might be on topics quite remote from the subject of the decision being discussed (cf Sossin 2005, 161-183; Stewart).

Beginning narrowly, we can start by analyzing specifically what the *Chaoulli* ruling (Supreme Court of Canada 2005) stated. Jacques Chaoulli, a physician in the province of Quebec and a patient, George Zeliotis, challenged the provisions of two provincial statutes that had the effect of prohibiting private health insurance from covering services insured by Quebec's provincial health plan. Chaoulli was concerned because he believed this ban prohibited him from engaging in a business he wished to engage in (providing home based health services that the provincial plan refused to cover). Zeliotis was concerned as he believed he had been compelled to wait unfairly long for care under Quebec's provincial plan and should be able to purchase additional private insurance if he or any other patient wished to avoid such waits. Quebec argued that the provisions were necessary to preserve the integrity of the publicly funded health care system in Quebec. If private insurance were allowed, this would cause the supply of services within the provincially funded system to erode and make equal access to care an unobtainable goal. Publicly funded health care is a public policy that provides substantial benefits to Quebeckers, and that therefore, even if the ban violated the rights of the appellants it was a reasonable limit on their rights. To quote from Justice Deschamps' decision for the majority:

> In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state (Supreme Court of Canada 2005, para.4) .

A majority of the justices of the Supreme Court hearing the case agreed that this was unfair and struck down the offending provisions. However, they did not strike down all provincial barriers to private health insurance and they did not create a pan-Canadian rule. Their ruling only applies to Quebec as the majority only ruled that the appellants' rights under a statute of the Quebec National Assembly, *The Quebec Charter*, not *The Canadian Charter of Rights and Freedoms*, had been violated. In doing so the author of the majority decision, Justice Deschamps, drew a distinction between the wording of Section 7 of *The Canadian Charter of Rights and Freedoms* (right to life, liberty and security of the person) and the comparable, but not identical Section 1 of *The Quebec Charter*. In doing so, she argued that the Quebec National Assembly had decided to grant Quebeckers a broader protection from the state than that which is constitutionally required under *The Canadian Charter of Rights and Freedoms*. Specifically, Deschamps drew attention to the fact that Section 7 of *The Canadian Charter of Rights and Freedoms* permits the state to violate ones right to life, liberty and security of the person if such a violation is "in accordance with the principles of fundamental justice". However, no such ability to balance the rights of an individual and

society is contained in Section 1 of the Quebec Charter. It was this broader protection that allowed her to formulate an argument as to why the appeal ought to succeed (Supreme Court of Canada 2005, para. 26-36).

The justices decided this because they found that the existing system forced Zeliotis to wait unfairly long for care and because the absolute ban on private insurance was deemed to be too extreme a measure to fulfill the government of Quebec's objective of preserving the public health insurance system (it was not a reasonable limit on the rights of Zeliotis and Chaoulli). Given that Quebec's own law does not permit the state to do harm to a resident, even if the harm is the result of a policy needed to ensure fundamental justice, Quebec would have to find another way to protect the public health system from having its resources bled away. In short, the majority of the judges accepted that some patients wait unfairly long in Quebec and rejected the notion that a ban on private insurance that competes with provincial plans is allowable to preserve the public system in Quebec. While preserving the public system is a worthy goal, the majority felt there were other measures, less damaging to Zeliotis's and Chaoulli's rights, that could have been used. The important point here is that if there were not unfairly long waiting times (waiting times that endangered the life and health of patients) then there would have been no basis to find in favour of the appellants, even under *The Quebec Charter*. Here it is worth quoting directly from the ruling:

> Governments have promised on numerous occasions to find a solution to the problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens…
>
> The relief sought by the appellants does not necessarily provide a complete response to the complex problem of waiting lists. However, it was not up to the appellants to find a way to remedy a problem that has persisted for a number of years and for which the solution must come from the state itself. Their only burden was to prove that their right to life and to personal inviolability had been infringed. They have succeeded in proving this. The Attorney General of Quebec, on the other hand, has not proved that the impugned measure, the prohibition on private insurance, was justified under s. 9.1 of the *Quebec Charter*. Given that this finding is sufficient to dispose of the appeal, it is not necessary to answer the other constitutional questions. (Supreme Court of Canada 2005, para. 96-101).

Similar to *The Canadian Charter of Rights and Freedoms*, *The* Quebec Charter has a section which explains the limits of the rights it guarantees, or the justification for violating them. The test for determining if a violation of an individual's rights is justified is similar to the test used for *Canadian Charter* cases and first developed in *R v. Oakes* (Supreme Court of Canada 1986). In this case Deschamps decided that while preserving the publicly funded health system was a pressing public need, the violation was not justified as it exceeded the minimum impairment of rights needed to achieve this end. To this end Justice Deschamps cited both experience inside and outside of Canada to rule that the public goal of protecting the integrity of a publicly funded health care

system does not require a ban on private insurance (Supreme Court of Canada 2005, para. 84).

Some legal analysts have long argued that one should not be surprised by decisions such as the one rendered in *Chaoulli*. According to their narrative, Canada is a liberal capitalist society. In such a society law exists primarily to protect economic power. Therefore, one should not be surprised when a court rules that people who are unsatisfied with a public service ought to have the right to spend their own money on something else, even if this private consumption jeopardizes the supply of the service in the public plan. In short inequalities produced by wealth are generally not the concern of the courts in a country such as Canada (Petter 2005, 116-138). Nevertheless, for the policy-network of actors engaged in debates regarding health care policy, it was a major shock with the potential to destabilize their environment. To understand why, we will first have to explore how the *Chaoulli* ruling was read into politics and into implications for public-policy.

As Manfredi and Maioni (2006, 249-271) have observed, rights challenges are, at their root, political activities. The aim is to use the law so as to change the basic ground rules under which policy-making is conducted, strengthening the position of those who wish to see a change in public policy. This was especially the case for the organizations and individuals that “intervened” in case on the side of Chaoulli and Zeliotis, sending attorneys to make arguments to the court even though they were not directly involved. Others intervened in the case so as to prevent this. We can see these interveners as those who are seeking to either loosen the bonds holding together a policy-network or to preserve it. *The Chaoulli* case attracted a very large cast of interveners, including the Federal Government, other provinces, medical associations and labour unions, advocates for the poor, supporters of universal public health insurance, members of the Senate of Canada and private-for-profit health facilities (Supreme Court of Canada 2005). It should be noted that one organization that was noticeable by its absence was the Canadian Life and Health Insurance Association. The different interveners often had very different reasons for being on the side that they were on, showing that law, like politics can indeed make strange bedfellows. For example, an interviewee familiar with the litigation of the case argued that some of the interveners on the side of overturning Quebec’s laws actually wanted to do so in order to strengthen the public health care system. In this interpretation, the case was not so much about the right to contract for private insurance but to give the health policy-network a necessary shake up, by empowering patients and making it clear that the *Charter of Rights and Freedoms* prevails over all areas of Canadian public policy including health care. If either a policy, or non-decision, had the effect of endangering life and health (such as the refusal to either redesign the health system or better fund it so as to reduce waiting times) then there ought to be some recourse. The health policy-network should not remain isolated from accountability. Writing about the case, Monahan (who acted in *Chaoulli* for the interveners from the Canadian Senate) has made a similar argument. In his view, this case has caused a new sixth general principle to be added to the five enumerated in *The Canada Health Act*. This new principle is accountability to patients (Monahan 2006). Meanwhile his co-counsel, Stanley Hartt, reasons that if unreasonably long waiting times for care were not politically unacceptable before *Chaoulli*, making them legally indefensible for a universal publicly funded health system will certainly do the trick:

DRAFT

> It may well be moot whether the majority's reasoning is equally applicable in other provinces, because it is highly unlikely that the issue of timely availability of medical services will come before the courts again. Given the finding of the majority that people are dying on waiting lists, it would be politically impossible for any government to ask the courts to give it the right to continue this state of affairs. The only possible argument for an elected Attorney General to make in the future would be that wait times have been fixed and are no longer a problem, or that people are not in fact suffering and/or dying in the province (Hartt 2005, 511).

However, in the same essay, Hartt also, perhaps un-knowingly, also suggests why such a sensible situation would be potentially so disruptive to the Canadian health policy-network.

> After *Chaoulli*… waiting times for medically necessary services (whether diagnosis or treatment) can not surpass the maximum time periods deemed, as to each condition, disease or symptom respectively, medically advisable by professional medical opinion generally, as the same may evolve from time to time. There is no ability to pay test, no deference to the right of the State to determine the allocation of its limited financial resources, no standard of the greatest good for the greatest number. Social policy engineering has given way as it should have, to individual rights. If the state chooses to be the exclusive provider of medically necessary health care services,.. then, if if it fails to deliver timely access, it cannot prevent citizens from obtaining access from other sources (Hartt 2005, 512-513).

In short, if Hartt's interpretation is correct, provincial governments have lost the right to plan health care. This right now solely resides with the medical community. Their only option is to pay whatever bill they are sent or allow for at least the possibility of a privately funded parallel system. This would be a dramatic change to the bargain at the core of Canadian health policy. Physicians are free to practice medicine as they see fit within the financial framework determined by state actors (Tuohy 1999, 204-205). It would completely reverse the history of the last fifty years which have seen state actors achieve dominance over medicine within the Canadian health policy-network (Boase 1996, 287-310)

Meanwhile, others who intervened in the case to oppose the appellants did so because they appreciated that, to quote Manfredi and Maioni such cases can take on "a separate political life" (2006, 249-271). As one interviewee noted, these actors intervened out of concern that the case would be read as a justification for right-of-centre governments to do what they would prefer to do and introduce a complete system of parallel, privately funded care (popularly known as a "two-tier" system). And in fact, this is how the decision was read on the political right (National Post 2005, A.20). That is also certainly the spin appellant Chaoulli put on the case, here writing for the American Cato Institute.

DRAFT

> The ruling in *Chaoulli v. Quebec* has expanded the right of Canadians to obtain private medical care and opened the door to a parallel, private health care system. Canada's Supreme Court has thus validated freedom of contract as an important component of patients' rights. The ruling also provides a basis for challenging other government activities in health care (Chaoulli 2006, 1)

Perhaps demonstrating the fears of the organizations that intervened opposite the appellants, after the *Chaoulli* decision, British Columbia's and Alberta's centre-right governments gave serious consideration to abandoning universal publicly funded health insurance for other models involving private competition. However, Ralph Klein's "Third Way" and Gordon Campbell's "Conversation on Health," ultimately amounted to little. This was in part because the public appeared to be willing to punish governments that unnecessarily tampered with the status quo (Sibbald 2006, 1829-1830; Palmer 2009, A.3). Although the courts might have decided that the Canadian icon of Charter Rights trumped the equally iconic *Canada Health Act* (Maioni and Manfredi 2005, 52-56), the public was less clear in their judgments, as were many opinion formers in the media (Quesnel-Vallee et al. 2006, 1051-1052). Meanwhile in Quebec, before the government even released its formal response to the decision, the health minister began talking approvingly of European systems that allow parallel private health insurance, arguing they held lessons Quebec ought to consider (Manfredi and Maioni 2006, 249-271). Eventually, Quebec went further than some experts believed that the province had to go in order to comply with the *Chaoulli* ruling. "The political fallout of *Chaoulli* in Quebec shows that the focus of public interest has been shifted and drastically redefined in order to make public regulation more friendly and supportive of private healthcare markets" (Premont 2008, 237-264). Not only did the province modify its ban on private health insurance to allow it where there has been a history of undue waits, the province also introduced measures to facilitate the creation of private surgical clinics and a private health market by allowing hospitals to form partnerships with opted out clinics, and finally in 2009, by eliminating its ban on doctors practicing simultaneously in the public and private systems (Premont 2008, 237-264; Picard 2009, L1). Still, as in the case of Alberta and British Columbia, federalism has likely served to restrain the government from going beyond allowing insurance for services that have historically experienced undue waits. Perhaps surprisingly to some, the newly minted Conservative government of Stephen Harper came out squarely in support of the terms of *the Canada Health Act* and warned both Quebec and the other provinces that any response they make to Chaoulli ought to be in keeping with the terms of the *Act*. The Prime Minister himself even personally intervened in Alberta's debate over the third way, cautioning Alberta's government not to go down its intended policy path towards two-teir health care (McFarlane 2006, A.15). In essence, *Chaoulli* gave the opponents of universal publicly funded health care an apparently principled argument to confront the widely popular vision of health care as a right equally accessible to all regardless of ability to pay, that is symbolized by *The Canada Health Act* and which is at the core of the ideational framework for the health policy-community and the policy-network of interested actors embedded in this community. Many long time opponents of the status quo, opponents who had previously had to back down in the face of public concern that they might violate *The Canada Health Act*, were empowered to take another kick at the can. At least

DRAFT

temporarily it drew into question what Howlett and Ramesh would call "the dominant idea set" and threatened to replace it with a more fluid plurality of acceptable ideas, thus transforming the policy-community from a well ordered one into a more fractious environment (Howlett and Ramesh 2003, 154).

In judging the politics of the *Chaoulli* ruling, we can perhaps conclude by noting that there is plenty there for those who wish to tear down medicare and also for those that wish to preserve and even improve Canada's system of provincial single payer universal health insurance schemes. While critics of the system can claim a meaningful moral victory with *Chaoulli* and are attempting to use it to undermine the present system (Rachlis 2005), those that want to preserve the system have perhaps found a new argument to motivate political decision makers to take the tough decisions, and to spend the needed funds to make the system work (Fenn 2006, 527-547).

This has essentially been the reading given to *Chaoulli* by the academic researchers closely affiliated with the health care public policy-network and some political leaders (McIntosh 2006; Rachlis 2005; Sibbald 2006, 567). It was only because there were unfairly long waitlists that the court ruled against Quebec. Therefore, if the wait-list issue is tackled, then the *Chaoulli* ruling loses its salience. As McIntosh observes (2006), meaningful actions to address the waitlist issue began a year before the *Chaoulli* ruling in 2004 with the ten year federal-provincial accord on health. As part of the accord, provinces were taking steps to quantify waits, and tackle the bottlenecks, information gaps and funding shortfalls that produced the worst ones. Such work is slow, grinding and hard to notice up close. It is only over time, as they add up that the changes they produce can be observed. This is also in keeping with the federal nature of decision making in Canadian health care and the dominant role professionals still play in the delivery system, if not decision-making regarding finances (Banting and Corbett 2002, 1-38; Tuohy 1999). While physicians have continued to be embraced as vital partners in this work and there has undoubtedly been a new openness to dealing with the issue in partnerships with health providers, rather than imposing economic analysis on them, state actors have not been willing to cede the dominant role within the policy-network to medical actors, nor have they given up on health planning (Fenn 2006, 527-547). Further buttressing this view has been the responses that Ontario, British Columbia and Alberta have made to plaintiffs seeking similar rulings to *Chaoulli* in other parts of Canada. Even though British Columbia and Alberta had toyed with abandoning universal public health insurance for medically necessary services, like Ontario they ultimately chose to mount defenses rather than give in.[1] Clearly these provinces are confident that the Quebec ruling does not apply and that politically, either the waitlist issue identified by Hartt does not matter, or that they can make the argument that they have made sufficient progress towards solving it. One interviewee for this project observed that at the end of the day, it might be the resolution of these cases (especially the one involving Ontario where 33 percent of Canadians reside) that determines the ultimate impact *Chaoulli* has. If the three provinces noted above prevail, then *Chaoulli* will lose much of its relevance. By identifying the issue as wait-times, not a deeper philosophical or constitutional principle, and by rejecting the claim that the medical community itself can

[1] These cases are: Canadian Independent Medical Clinics Association v. British Columbia; William Murray v. Alberta; and Flora v. Ontario Health Insurance Plan

DRAFT

identify what is and is not a reasonable wait, the health policy-network has been able to reassert its control and maintain its coherence at least in the short-term.

This hesitancy to declare the efforts of the actors involved in the health policy-network totally successful is based in two sources. First the copycat lawsuits are still out there. Second, one of the policy experts interviewed for this piece provided grounds for skepticism. This long-term observer and participant in the Canada's health policy-network has concluded that *Chaoulli* case, or no *Chaoulli* case, little has changed in the way decision-makers approach the issue of health care as a public policy problem. In this interviewee's view, there is simply no political will anywhere in Canada to meaningfully tackle health reform so as to enhance quality, cut wait times and improve sustainability for the long-term. In this interviewee's view, future crises are inevitable. In fact they might already be here. A recent story in *The Canadian Medical Association Journal* highlighted the pressure that the recession is placing on Ontario's health budget and the implications this will have for the provision of hospital care (Eggerston 2010, 157-158).

4. Where are the insurance companies?

This paper argues that there were several reasons why a policy-making window failed to open, these include:

- a less than clear endorsement from public opinion that change was needed
- institutional barriers in Canada's federal system of government that tend to slow and moderate major policy changes,
- and most importantly a lack of interest (at least for the present) among Canada's health and life insurers in seeing the present system change.

It is to this final point that the paper now turns. As noted above, the Canadian Life and Health Insurance Association (the trade association for the industry) did not intervene in the case. In this section we will look at their response to *Chaoulli* and make the argument that their luke warm greeting for the *Chaoulli* decision helps further explain the resilience that the policy-network demonstrated in the face of the shock presented by *Chaoulli*. The response of the private insurers, as well as the fact that their preferred policy (allowing private insurance for most elective treatments) was unlikely to save money for provincial governments were also important factor in explaining the collapse of the Klein "Third Way" in Alberta and British Columbia's similar consideration of the introduction of a parallel private insurance system. While *Chaoulli* destabilized the system and opened space for new entrants into the policy-network, the actors with the largest interests and the most resources (the major life and health insurers) have so far declined to take up the offer, allowing the existing actors in the policy-network to re-solidify their position.

The working assumption among many supporters of Canada's system of provincially run single-payer universal health insurance plans is that the private health insurance industry is eager to capitalize on any weakness in the system. That if allowed, they would happily jump into the market and compete with provincial plans. For example, writing on the court challenge that a number of BC based private clinics have made to the constitutionality of the BC medical services plan, The BC Health Coalition writes: "This

lawsuit is driven by private, for-profit clinic owners who want private health insurance companies' to have access to Canadian health care and to open B.C. to unequal, two-tier US-style private health insurance that most of us can't afford" (BC Health Coalition 2010). If that were the case, why have the giant Canadian life and health insurers been so hesitant to capitalize on *Chaoulli*? In fact, *Chaoulli* has proven to be as big a challenge to the private insurers as it has been to the public plans.[2]

Private health insurers presently play a small but important part in the Canadian health care system. The majority of Canadian families have some form of private insurance which supplements the coverage they receive from their public provincial plan. Hence such coverage is often called "extended health insurance" or "supplemental coverage". While medically necessary hospital, diagnostic and physician services are governed by the terms of *the Canada Health Act* and almost totally paid for by public insurance plans, there is a mix of effort for everything else including, dental care, non-medical vision care (optometry), prescriptions, long-term and home care, as well as mental health. Low income families, seniors and those with chronic conditions are eligible for public help (including both direct funding and tax credits), others use private insurance and still others have no coverage at all (Marshall 2003, 5-12; Evans 2004, 139-196; Customs and Agency 2003, 1-19; Cohn 1996). Expenditures by private insurers on behalf of clients comprise roughly 12 percent of total health spending in Canada. The vast majority of Canadians who enjoy this private supplemental or "extended" health and dental insurance do so as a result of employer paid benefits. Consequently, it also should not be a surprise that one's stature in the job market goes a long way to determining if you and your family will have this private coverage on top of the basic provincial insurance (Marshall 2003, 5-12; Hurley and Guindon 2008).

It is instructive to note here that it took the interest organization representing the industry almost four years to frame a coherent answer as to how governments ought to respond to the need for reform given the new conditions created by the *Chaoulli* ruling

---

[2] So far as the author is aware there are presently two insurance schemes seeking to offer coverage to Canadians as a result of *Chaoulli*. However, other similarly small players likely exist. One of the products discussed here, Viator Priority Care is more properly characterized as a medical tourism scheme as it offers to pay the cost of taking Canadians who are waiting for treatment to the US for treatment by an un-named health care network. The other plan, OneWorld Medicare's Medical Access Insurance also inpart utilizes the network of private surgical clinics available in BC and Alberta. Neither is directly sponsored by a major insurance company. Instead they are being offered as a niche product indirectly by independent brokers who then pass off the underwriting to companies, RSA Group and Industrial Alliance respectively. Both plans have limits on available life-time coverage, some restrictions on insurance for pre-existing conditions and are made available via employer group purchase. Consequently, a person who is seriously ill with a chronic illness could well exhaust the coverage they offer (Smolkin 2007). It should also be noted that not all underwriters offer similar peace of mind to clients. Industrial Alliance is a large and growing player in the Canadian life and health market with a strong record of dealing fairly with clients. An example was the firm's decision to fully compensate investors who lost out in the ABCP fiasco when Canadian money markets froze up in 2007 (Anonymous 2007). This decision was made at the very start of the crisis and long before the industry-wide settlement was reached. Unfortunately, however, the best that can be said about RSA Group (formerly Royal Sun Alliance) is that they obey the law. When the Group's UK parent decided to cease operations in the United States, several major clients complained that the capital being left in the new successor company was inadequate to pay outstanding claims. In ruling on the arrangements, the regulators called on to evaluate the plan made the following observation: "the actions of Royal UK, though legal, are unfortunate and not the actions of fair businesspeople" (Greenwald 2007, 1)

DRAFT

(Canadian Life and Health Insurance Association 2009). The document begins by stating right up front that the best role for private health insurance in Canada is to stick to its current mandate, supporting and supplementing public insurance schemes, not replacing them. It then cautiously advances the argument that the present division of responsibilities is not ideal. As noted above, medically necessary hospital, diagnostic and physician services are almost exclusively public covered (so called *Canada Health Act* services). Meanwhile, there is a mix of effort on everything else such as prescription drugs, dentistry, long-term and home care. Government covers low income families, the elderly and others with chronic illness to some extent, while others rely on private insurance or must pay on their own. The report asks whether it might be wise to allow private insurance for a wider range of elective care and re-invest the savings in extending public coverage for *Non-Canada Health Act* services. As we will see below, it is doubtful that this would actually save any money, especially if the federal government objects and fails to amend the *Canada Health Act*. In that situation, federal penalties would wipe out the savings. Further, as we will see, take up rates for private insurance will be low unless it is subsidized or made compulsory. Nevertheless, this report is hardly the work of a group eager to supplant the public system. At best they want a larger share of the pie, not a new recipe.

One expert interviewed for this project suggested that this hesitance is a result of the fluid nature of the situation. Until the copycat challenge to Ontario's health insurance plan is resolved, the big players are unsure as to whether there will be a large enough potential pool of enrollees to create a market. However, in order to fully grasp the situation, one must move beyond politics and consider the economic factors. From this perspective the challenges facing companies that wish to create a parallel for-profit insurance plan in Canada are substantial. Ironically enough, the BC Health Coalition hit the answer squarely on its head when they wrote that private health insurance which operates parallel to public plans run by the provinces would represent a product "that most of us can't afford." Unless a large pool of clients can afford a product, it is difficult for insurers to offer. This is because the basic principle that makes insurance work, the pooling of risks, does not apply. To understand why it is so hard to find clients, we have to appreciate:

- The principle sources of funding for private insurance are third party private payers, primarily employers.
- The difference between the Canadian and American context, specifically, the existence of a "public option" in Canada.
- The different structure of incomes in Canada

Although private insurers are paying for treatments and therapeutic products needed by individuals and families, their real clients are the employers who foot much of the bill. For the most part, these employers were not interested in adding to the costs of their benefits plans in 2005. Consequently, the reporting on Chaoulli in the human resources trade publications was focused on strategies businesses could employ to ensure their existing obligations did not expand to encompass the sort of coverage now allowed in Quebec (Vu 2006, 1-14; Harding and Picard 2005, 77-79; Gonzalez 2007, 77-78;

DRAFT

Gonzalez 2005, 4-36; Boisvert 2006, 20). Given the economic situation we now face in 2010 it is hard to see how this refusal to expand benefits would have changed much.

If employers are not keen to fund the private insurance of the type now allowed in Quebec as a result of *Chaoulli* and potentially elsewhere in Canada, let alone coverage for all elective care (the preferred option of the CLHIA) or a complete US style parallel private insurance scheme, what potential is there for a market to emerge among individual purchasers? To some extent the answer to this question depends on the degree to which these purchases are publicly subsidized. In one study economists predicted that if the province of Alberta replicates the subsidized private insurance program in Australia, perhaps 28% of residents would enroll in private schemes (Emery and Gerrits 2005, 111-146). However, what the authors neglect to mention is that the political climate in Australia is different from Canada. The notion of a government offering subsidies to people who buy private insurance is less controversial there than it likely would be here. *Chaoulli*, if it is extended across Canada, would be of no help. That ruling only says private insurance should be allowed, it does not compel provinces to subsidize it and use it as a form of regressive income transfer. The need to subsidize private parallel insurance would very graphically give the lie to the claim provinces would save money by introducing such schemes alongside of public ones. In fact, when Alberta asked consultants to estimate the savings that would be achieved by allowing parallel private insurance for non-emergency "elective" services (the sort of role for private insurance that the Canadian Life and Health Insurance Association envisions is at least plausible), the grim news came back that there was no evidence that any savings would be achieved. The consultants argued any minor efficiency gains from competition and savings in terms of delivery costs would be wiped out by the anticipated federal penalties. Parroting much of the conventional wisdom that informs debates in the Canadian health policy community, the consultants reported that the best hope for making health care sustainable was to make the present system more efficient, being vigilant regarding cost controls, and working harder to keep Albertans healthy (Aon Consultants 2006, 7.1-17).

An important point made by Emery and Gerrits (2005, 111-146) is that when public insurance was introduced in Australia, take-up rates for private insurance dropped dramatically. This is precisely the fear that US health insurance companies had during the recent debates on health reform in that country. Studies by reputable analysts showed that if a "public option" had been part of the reform package, nearly 70 percent of those presently holding private insurance would have switched to the public option or been switched into it by their employers. The cost and efficiency advantages of the public scheme, which would have used its purchasing clout to negotiate better deals than any other insurer could get, would have made private plans uncompetitive (Sheils 2009). Meanwhile if it failed to use this advantage to lower costs, then there would have been no policy rational for the "public option". Perhaps over dramatic, but *The Wall Street Journal* nevertheless decided to title its editorial on the topic: "The End of Private Health Insurance" (The Wall Street Journal 2009, A.14).

Assuming no serious deterioration in the nature of the publicly funded system, take-up rates for parallel private insurance are likely to be lower in Canada than in the United States because of the difference in income distributions between the two countries. This is likely to be the case whether the parallel private insurance introduced is a full program,

DRAFT

a limited one for elective care (which the Canadian Life and Health Insurance Association feels is plausible) or the sort *Chaoulli* allows (for procedures where significant waiting times exist). Once again, as the BC Health Coalition noted, the reason for this is simply because we cannot afford it. The following table illustrates this, showing the average pre and post tax incomes by quintile in Canada and the United States expressed in US dollars.

Table 1. Average Income for Quintiles, 2007, Canada and the United States in $US

2007 data	Canada		United States	
C$ = .93 US$ Rounded to nearest hundred	Pre-tax average income	Post-tax average Income	Pre-tax average income	Post-tax average income
Q1	3,600	12,900	10,500	10,500
Q2	21,000	28,600	27,700	27,400
Q3	42,200	43,700	46,200	45,200
Q4	69,500	63,900	72,500	70,000
Q5	147,000	117,800	158,400	150,900

(sources: (Statistics Canada 2009; United States Bureau of Labor Statistics 2009; Bank of Canada Financial Markets Department 2009))

As can be seen when we look at the average incomes for Q4 and Q5, Americans at the upper end enjoy significantly higher incomes than do Canadians at a similar point in our income distribution. The disparity is especially stark when we look at the average after-tax incomes in Q5. Here Americans enjoy an average advantage of $33,100 (or roughly 28% above the Canadian average for the same quintile). Canadians at the top of our income distribution enjoy lower incomes than Americans and the tax system takes a much larger bite. The net result is that when faced with the option of a private alternative to a free public service, fewer families are likely to have the needed available income to accept the offer.

Consequently, it is difficult to see where the market would be for parallel private health insurance that competes with provincial public programs. Employers don't want to pay for it and few individual families are likely to purchase it unless it is heavily subsidized by the state. Offering such subsidies would be an unrealistic proposition as this would undercut the supposed policy purpose of allowing such insurance, to reduce public expenditures. Even if the legal environment were clarified and *the Canada Health Act* is amended to allow private insurance to expand both geographically and in terms of the services it can ensure (beyond those for which wait times for care are unreasonable to include all elective care), it is hard to see private health insurance that offers parallel coverage to provincial plans growing beyond a small niche offering. The presence of such a niche product might be philosophically displeasing for the defenders of Canadian medicare, but it likely will not jeopardize the system. Given these facts, it is also easier to understand why insurers did not seize on *Chaoulli* and use it as a battering ram against the existing policy-network. It is also easier to understand why the Campbell and Klein governments eventually walked away from their plans to introduce two-tier health care. Not only were the plans unpopular, they would have produced empty rights given that the

DRAFT

major life and health insurers likely would have proven unwilling to offer products for the markets that these governments were intent on creating and even if products emerged, there would have been no meaningful savings for the public purse.

5. Conclusion: *Chaoulli*, All bark and no bite?

This paper presented the *Chaoulli* decision as a disruptive event for the Canadian health policy-network. After identifying the salient structural and ideational elements of the policy-network and its surrounding community, the paper proceeded to identify why the *Chaoulli* ruling had the potential to disrupt this network and its community. The paper then went on to explore reasons why, in spite of this disruption, a policy window suitable for introducing parallel private health insurance failed to emerge. Here a number of factors were explored including public opinion, the nature of Canadian federalism and the economic barriers to creating an effective private health insurance scheme opposite a well functioning public option. To emphasize this last point, the actor with the greatest interest in forcing open a policy window so as to realign the policy-network, Canada's life and health insurers, did not show deep interest in pursuing the opportunity and the proposals they did make did not address the needs of the state actors who dominate the policy-network.

Before wrapping up, a difficult question needs to be asked. Did *Chaoulli* have to be as disruptive as it was? All of the information presented here regarding the political and economic problems facing the creation of a parallel private health insurance system were well known at the time. While no evidence is offered to support this opinion, it appears to this author that the policy community surrounding health care policy-making in Canada has become un-necessarily distrustful of the state actors who are at the core of the policy-network which they cluster around. Here the author must confess that, on occasion, he too has made this mistake. While individuals who occupy high political office at the federal level and in the provincial capitals may prefer to abolish Canada's system of universal public health insurance plans and replace it with a more mixed model incorporating private insurance, this paper has shown they are not so blinded by their ideology to pursue a plan that would harm their own governments. When the facts, in terms of political consequences and economic outcomes were put on the table, both British Columbia and Alberta altered course. Even Prime Minister Harper, who as head of the National Citizen's Coalition had urged Alberta to violate *the Canada Health Act* and unilaterally introduce a parallel private health insurance system, changed his mind once in power (McFarlane 2006, A.15; Harper et al. 2001, 16-17). Abolishing *the Canada Health Act* or altering it to allow provinces to do what they may with financing and insurance would effectively turn Ottawa from a central actor in the health policy-network into a marginal one. Given how much Canadians care about the issue, no leader can risk being placed at the mercy of others on such a topic and Harper seems to understand this, just as Mulroney did before him. Preserving *the Canada Health Act* preserves the power of the Canadian Prime Minister and his or her government relative to the provinces. In short, the actors who populate the Canadian health policy-community (especially the academics) have a vision of politics and policy-making that seems to neglect the power of institutions and which preferences the ability of actors to make

DRAFT

history, rather than be influenced by it. Given the prominence that institutional and historical materialist forms of analysis have in Canadian academia, this is a somewhat surprising conclusion. The wisdom of McIntosh's advice is perhaps more clear now than ever. He titled his short essay on *Chaoulli*: "Don't Panic" (2006). It might be beneficial if we apply that insight when the inevitable next potentially disruptive event emerges.

References

Aaron, D. 2005. Shot in arm for private hospitals: *The Gazette*, Jun 11, 2005.

Anonymous. 2007. Canadian insurer hopes buyback eases liquidity concerns. *Best Wire*, 22 August 2007, 2007.

Aon Consultants. 2006. Economic analysis. In *Health benefits design options for Alberta Health and Wellness.*, 7-1-7-17. Edmonton, AB: Aon Consulting.

Bank of Canada Financial Markets Department. 2009. *Year average of exchange rates*. Ottawa: Bank of Canada.

Banting, Keith G., and Stan Corbett. 2002. Health policy and federalism: An introduction. In *Health policy and federalism: A comparative perspective on multi-level governance.*, eds. Keith G. Banting, Stan Corbett, 1-38McGill-Queen's University Press.

Baterman, Thomas M. J. 2006. Legal modesty and political boldness: The Supreme Court of Canada's decision in Chaoulli v. Quebec. *Review of Constitutional Studies* 11, (1) (July 2006): 38-64.

BC Health Coalition. 2010. *Round one victory! courts allow BC health coalition to participate in private clinics lawsuit. audit of private, for-profit cambie clinic to proceed* . Vancouver: BC Health Coaltion.

Boase, Joan, Price. 1996. Institutions, institutionalized networks and policy choices: Health policy in the US and Canada. *Governance* 9, (3): 287-310.

Boisvert, Michele. 2006. A door a jar. *Benefits Canada* 30, (6) (June 2006): 20.

Canadian Life and Health Insurance Association. 2009. *CLHIA report on health care policy: Towards a sustainable, accessible, quality, public health care system*. Toronto: Canadian Life and Health Insurance Association.

Chaoulli, Jacques. 2006. *Policy analysis: A seismic shift: How Canada's supreme court sparked a patients' rights revolution.* Washington, DC: Cato Institute, 568.

DRAFT

Cohn, Daniel. 1996. The Canadian health and social transfer: Transferring resources or moral authority between levels of government? In *Canada: The state of the federation 1996.*, eds. Patrick C. Fafard, Douglas M. Brown, Queen's University Institute of Intergovernmental Relations.

Canada Customs and Revenue Agency. 2003. *Medical expense and disability tax credits and attendant care expense deduction.*

Eggerston, Laura. 2010. Ontario hospitals say service, staff or program cuts may be inevitable. *Canadian Medical Association Journal* 182, (3) (23 February 2010): 157-8.

Emery, J. C. Herbert, and Kevin Gerrits. 2005. The demand for private health insurance in Alberta in the presence of a public alternative. In *Health services restructuring in Canada: New evidence and new directions.*, eds. Charles M. Beach, Richard P. Chaykowski, Sam Shortt, France St-Hilaire and Arthur Sweetman, 111-146. Kingston, ON: John Deutsch Institute for the Study of Economic Policy.

Evans, Robert G. 2004. Financing health care: Options, consequences, and objectives. In *The fiscal sustainability of health care in Canada: The Romanow papers volume 1.*, eds. Gregory P. Marchildon, Tom McIntosh and Pierre-Gerlier Forest, 139-196University of Toronto Press.

Fenn, W. Michael. 2006. Reinvigorating publicly funded medicare in Ontario: New public policy and public administration techniques. *Canadian Public Administration* 49, (4): 527-47.

Fischer, Doug. 2005. Walking the line over private health care: *The Ottawa Citizen*, Dec 8, 2005.

Flood, Colleen M. 2006. *Chaoulli's* legacy for the future of Canadian health care policy. *Osgoode Hall Law Journal* 44, : 273-310.

Flood, Colleen, M., Kent Roach, and Lorne Sossin, eds. 2005. *Access to care, access to justice: The legal debate over private health insurance in Canada*. University of Toronto Press: Toronto.

Flood, Colleen, M, and Terrence Sullivan. 2005. Supreme disagreement: The highest court affirms an empty right. *Canadian Medical Association Journal* 173, (2) (19 July 2005): 142-3.

Flood, Colleen. 2005. Will private health insurance deliver? Colleen Flood says examples elsewhere show Canadians won't really benefit. *Toronto Star*, Jul 3, 2005.

Gilmour, Joan M. 2006. Fallout from *Chaoulli*: Is it time to find cover? *Osgoode Hall Law Journal* 44, : 327-47.

Gonzalez, Gloria. 2007. Quebec private health care law won't change most benefit plans. *Business Insurance* 41, (18) (30 April 2007): 77-8.

———. 2005. Canadian high court rejects ban on private health coverage. *Business Insurance* 39, (25) (20 June 2005): 4-36.

Government of Canada. 2004. *Communiqué: A 10-year plan to strengthen health care, september 16, 2004*. Ottawa: Government of Canada.

Graefe, Peter, and Andrew Bourns. 2009. The gradual defederalization of Canadian health policy. *Publius* 39, (1) (Winter): 187-209.

Greenwald, Judy. 2007. RSA runoff sale OK'd with some restrictions; DaimlerChrysler appeals decision by Delaware regulator. *Business Insurance*, 26 February 2007, 2007.

Hadorn, David. 2005. The *Chaoulli* challenge: Getting a grip on waiting lists. *Canadian Medical Association Journal* 173, (3) (2 August 2005): 271-3.

Harding, Wade, and Francois Picard. 2005. An open door. *Benefits Canada* 29, (12) (December 2005): 77-9.

Harper, Stephen, Tom Flanagan, Ted Morton, Ranier Knopff, A. Crooks, and K. Bosessenkool. 2001. The Alberta agenda [an open letter to the Hon. Ralph Klein, Premier of Alberta]. *Policy Options.* April 2001.

Hartt, Stanley. 2005. Arbitrariness, randomness and the principles of fundamental justice. In *Access to care, access to justice: The legal debate over private health insurance in Canada.*, eds. Colleen M. Flood, Kent Roach and Lorne Sossin, 505-520. Toronto: University of Toronto Press.

Hobel, John. 2006. Let's argue about health care. *Canadian HR Reporter* 19, (11) (5 June 2006): 18.

Howlett, Michael, and M. Ramesh. 2003. *Studying public policy: Policy cycles and policy subsystems*. 2nd edition ed. Toronto: Oxford University Press.

Hurley, Jeremiah, and G. Emmaneul Guindon. 2008. *CHEPA working paper series, paper 08-04, private health insurance in Canada*. Hamilton, ON: Centre for Health Economics and Policy Analysis.

Jackman, Martha. 2007. Health care and equity: Is there a cure? *Health Law Journal* 15: 87-141.

———. 2006. The last line of defence for [which?] citizens: Accountability, equality, and the right to health in *Chaoulli*. *Osgoode Hall Law Journal* 44, : 349-75.

DRAFT

Kent Roach,Colleen Flood and Lorne Sossin. 2005. A way forward for medicare. *Toronto Star*, Sep 16, 2005.

Kingdon, John W. 1995. *Agendas, alternatives, and public policies, second edition*. New York: Harper Collins.

Kirby, Michael, and Marjorie LeBreton, et al. 2002. *The health of Canadians: The federal role, final report on the state of the health care system in Canada*. Ottawa: Senate of Canada: The Standing Committe on Social Affairs, Science and Technology.

Lewis, Steven. 2005. Physicians, it's in your court now. *Canadian Medical Association Journal* 173, (3) (2 August 2005): 275-7.

Maioni, Antonia, and Christopher Manfredi. 2005. When the Charter trumps health care: A collision of Canadian icons. *Policy Options.* September 2005.

Maioni, Antonia. 2005. Canada should beware Europe's health-care model. *Toronto Star*, Dec 24, 2005.

Manfredi, Christopher P., and Antonia Maioni. 2006. The last line of defence for citizens': Litigating private health insurance in *Chaoulli v. Quebec*. *Osgoode Hall Law Journal* 44: 249-71.

Manfredi, Antonia Maioni and Christopher. 2005. A blow to champions of medicare. *Toronto Star*, Jun 10, 2005.

Marmor, Ted. 2005. Medicare views. *The Globe and Mail*, Dec 7, 2005.

Marshall, Katherine. 2003. Benefits on the job. *Perspectives on Labour and Income* 4, (May): 5-12.

Mazankowski, Donald. 2002. *A framework for reform: Report of the premier's advisory council on health*. Edmonton: Alberta Health and Wellness.

McFarlane, Lawrie. 2006. PM deals coup de grace to 'third-way' health care. *Victoria Times-Colonist* April 27th, : A.15.

McIntosh, Tom. 2006. *Don't panic: The hitchhicker's guide to Chaoulli, wait times, and the politics of private insurance.* Ottawa: Canadian Policy Research Networks, .

Mendelsohn, Matthew. 2002. *Canadians' thoughts on their health care system: Preserving the Canadian model through innovation.* Commission on the Future of Health Care in Canada.

DRAFT

Monahan, Patrick J. 2006. *Chaoulli v. Quebec and the future of Canadian healthcare: Patient accountability as the 'sixth principle' of the Canada Health Act*. Toronto: C.D. Howe Institute.

Monahan, Patrick J. 2005. Wait times key to saving medicare. *Toronto Star*, Nov 17, 2005.

Morton, F. L., and Rainer Knopff. 2000. *The charter revolution and the court party*. Peterborough, ON: Broadview.

National Post. 2005. Destroying medicare's myths. *National Post*, 10 June 2005, 2005.

Palmer, Vaughan. 2009. Liberals tackle health care with their new best friends, the nurses. *Vancouver Sun*, 19 March 2009, 2009.

Paradia, Gilles, and Lionel Robert. 2009. Research illuminating public policy debates: Private sector roles in Quebec healthcare. *Healthcare Policy / Politiques De Sante* 4, (3): 72-5.

Parliament of Canada. 2010. Canada Health Act: 1984 C6 S1. *Consolidated Statutes of Canada*.

Petter, Andrew. 2005. Wealthcare: The politics of the charter re-visted. In *Access to care, access to justice: The legal debate over private health insurance in Canada.*, 116-138. Toronto: University of Toronto Press.

Picard, Andre. 2009. Private health care slips under radar. *Globe and Mail* 16 July, (16 July 2009): L1.

Premont, Marie-Claude. 2008. Clearing the path for private health markets in *post-Chaoulli* Quebec. *Health Law Journal* Special Edition: 237-64.

———. 2007. Wait-time guarantees for health services: An analysis of Quebec's reaction to *the Chaoulli* Supreme Court decision. *Health Law Journal* 15: 43-86.

Quesnel-Vallee, Amelie, Melanie Bourque, Cara Fedick, and Antonia Maioni. 2006. In the aftermath of *Chaoulli v. Quebec*: Whose opinion prevailed. *Canadian Medical Association Journal* 175, (9) (24 October 2006): 1051-2.

Rachlis, Michael, M. 2005. *Public solutions to health care wait lists*. Ottawa: Canadian Centre for Policy Alternatives.

Russell, Peter, H. 2005. *Chaoulli*: The political versus the legal life of a judicial decision. In *Access to care, access to justice: The legal debate over private health insurance in canada.*, eds. Colleen Flood M., Kent Roach and Lorne Sossin, 5-19. Toronto: University of Toronto Press.

DRAFT

Schumacher, Albert. 2005. Doctors put patients first in health care debate. *Canadian Medical Association Journal* 173, (3) (2 August 2005): 277-8.

Sheils, John. 2009. *The impact of the house health reform legislation on coverage and provider incomes: Testimony before the energy and commerce committee, US House of Representatives [given on june 25]*. Washington, DC: Lewin Group.

Shortt, Sam. 2005. Ruling won't improve health care. *The Ottawa Citizen*, Jun 15, 2005.

Sibbald, Barbara. 2006. Alberta health reforms shelved, again. *Canadian Medical Association Journal* 174, (13) (20 June 2006): 1829-30.

———. 2006. Clement: Set wait-times or the courts will. *Canadian Medical Association Journal* 175, (6): 567.

Smith, Richard. 2005. The private sector in the English NHS: From pariah to saviour in under a decade. *Canadian Medical Association Journal* 173, (3) (2 August 2005): 273-4.

Smolkin, Sheryl. 2007. Jumping he queue: New insurance products pay for private health care. *Employee Benefit News Canada* 1 February, .

Sossin, Lorne. 2005. Towards a two-tier constitution? The poverty of health rights. In *Access to care, access to justice: The legal debate over private health insurance in canada.*, eds. Colleen M. Flood, Kent Roach and Lorne Sossin, 161-183. Toronto: University of Toronto Press.

Statistics Canada. 2009. *Cansim data base: Table 202-0701*. Ottawa: Statistics Canada.

Stewart, Hamish. Implications of *Chaoulli* for fact finding in constitutional cases. In *Access to care, access to justice: The legal debate over private health insurance in Canada.*, eds. Colleen M. Flood, Kent Roach and Lorne Sossin. Toronto: University of Toronto Press.

Supreme Court of Canada. 2005. *Chaoulli v. Quebec* (attorney general). *SCC* 35, .

———. 1986. *R. V. Oakes. 1. S.C.R.* 103 .

The Wall Street Journal. 2009. The end of private health insurance. *The Wall Street Journal* 13 April, (13 April 2009): A.14.

Tuohy, Carolyn. 1999. *Accidental logics: The dynamics of change in the health care arena in the United States, Britain and* Canada., Oxford University Press.

United States Bureau of Labor Statistics. 2009. *Consumer expenditure survey CEXS table 1. quintiles of income*. Washington, DC: United States Bureau of Labour Statistics.

DRAFT

Vu, Uyen. 2006. No rush to private health insurance. *Canadian HR Reporter* 19, (8) (24 April 2006): 1-14.

DRAFT