

Canada Health Act needs bite

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We could wait six weeks for magnetic resonance imaging (MRI) here in Ottawa, or we could cross the river to Gatineau, Quebec, shell out \$745 and get one tomorrow. But we'd be crossing more than a river. We'd be traversing one of the tenets of the Canada Health Act: accessibility. Some can afford to pay \$745; others cannot. And that is the point.

Canadians have agreed that publicly funded health care is in our collective best interest. In exchange for a federal health transfer expected to total \$37.1 billion in 2017/18, the provinces must adhere to the five tenets of the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. This includes a ban on private insurance for medically necessary services, extra billing and user fees.

But what happens when governments allow the public system to deteriorate such that it violates human rights? This was the argument behind the successful 2005 *Chaoulli v. Quebec* challenge.¹ The court ruled that a one-year wait for a hip replacement violated provincial human rights law, and that Quebec would have to either shorten wait times or allow the procedure to be done privately. It chose the latter.

Potential human rights violations are also being debated in the *Cambie Surgeries Corporation* case now before the British Columbia Supreme Court. The court will decide whether the ban on private insurance violates the Canadian Charter of Rights and Freedoms. That decision could have far-reaching consequences on the Canada Health Act and for Canadians who cannot pay or do not have private insurance. But being unable to get the medical treatments Canadians need in the publicly delivered system also has consequences.

We now have a proliferation of private clinics. There's no recent national tally, but in 2008, the Ontario Health Coalition estimated that 90 private clinics were openly violating the prohibition on double billing.² The Canada Health Act stipulates that the amount overbilled will be deducted from federal contributions for health. In 2014/15, British Columbia was docked \$241 637³ — about half the amount extra billed by the Cambie Surgery Centre in one month, according to a 2012 audit.³ BC is the only province trying to enforce the Act, but there are violations in Ontario and elsewhere. Saskatchewan recently began offering MRIs for a fee because of long wait times.³

The problem is that the Canada Health Act has no bite. It will come as no surprise that those doing the extra billing don't report their violations. And provinces only voluntarily report violations to Health Canada. No one has to do anything, so most do nothing.

Health care delivery is not automatically bad because it is private and good because it is public. It is good when it ensures

universality and equity of access to quality care, and bad when it fails to deliver. Some proponents of expanding private health care in Canada may cite this principle, but the burden of proof falls on them to show that private health care would be better than the status quo. A 2010 synthesis of international evidence from western Europe (including the United Kingdom), North America and Australasia, found that private health insurance had no impact on public wait times.⁴ Further, the private clinics were associated with lower quality and higher costs.⁴

The courts have a role in ensuring that the Charter is upheld in how our health care system is legislated to run, but that's not the same as letting the courts *decide* whether we have private health care. If legislation is struck down under the Charter, it's up to governments to enact new, Charter-compliant legislation. Having government fix the public system is a far more obvious solution than throwing it away for two-tiered health care that has dubious prospects for protecting the right of *all* Canadians to access health care. The new Canada Health Accord between our federal and provincial governments must ensure that the universality and equity of our present system are upheld.

The idea of allowing a parallel private health care system to emerge alongside our present system raises grave concerns, but that doesn't mean we're happy with the status quo. Wait lists must be slashed. We need to spend smarter and be innovative, which must also be part of the Canada Health Accord deliberations. Universality should be at the top of the list. But it's also the time for Federal Minister of Health Dr. Jane Philpott to strengthen the Canada Health Act and punish violations by levying fines equitably and thoroughly to safeguard our health care system. Reportedly, she conveyed just that message to Quebec recently,⁵ which may have prompted that province's decision to abolish extra billing. That's a step in the right direction.

References

1. *Chaoulli v. Quebec* (Attorney General) 2005 1 SCR 791, 2005 SCC 35. Available: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2237/index.do> (accessed 2016 Sept. 21).
2. Glauser W. Private clinics continue explosive growth. *CMAJ* 2011;183:E437-8.
3. Meili R. It's time Ottawa enforces the Canada Health Act. Montreal: Institute for Research on Public Policy; 2016. Available: <http://policyoptions.irpp.org/2016/04/04/its-time-ottawa-enforces-the-canada-health-act/> (accessed 2016 Sept. 21).
4. Kreindler SA. Policy strategies to reduce waits for elective care: a synthesis of international evidence. *Br Med Bull* 2010;95:7-32.
5. The murky waters of Quebec extra-billing. *Globe and Mail* 2016:A10.

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