AN AMERICAN IN CANADA — MAKING SENSE OF THE SUPREME COURT DECISION ON HEALTH CARE

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POLICY DOSSIER OPTIONS

Canadians hardly needed reminding that the Supreme Court's June 9 decision to strike down the Quebec prohibition on private health insurance for publicly insured services was a landmark judgment. The reactions were many, fulsome, and all over the policy map. Americans, however, hardly heard of the controversy, hardly surprising given the imbalance between northward and southward flows of news.

For critics of Canada's Medicare, the narrow 4-3 decision was judicial confirmation of the program's overall failure to provide timely and proper access to care. For Medicare's supporters, the decision represented a threat to its core values, especially the principle that access to care should not vary with one's willingness and ability to pay for private health insurance coverage.

For external observers such as me, (a US academic teaching in Canada), the decision was remarkable for two key reasons. It illustrates vigorous judicial intervention in a political and policy field usually reserved to legislatures. And, at the same time, the court's majority relied on extraordinarily odd reasoning to justify is position that access to care was so unsatisfactory in Quebec that the ban on private insurance for publicly covered services violated Quebec's charter of rights. Neither "theory [n]or common sense" provided the majority's justification. Rather, they claimed, "evidence" about how other industrial democracies organize their financing of medical care provided their "empirical" grounds. Whether the court has any special competence in evaluating the performance of health systems is a serious, deeper question that warrants (and has received) attention.

For decades, Canada's form of governmentally financed health insurance has been unusual in its ban on supplementary coverage. For leaders like Alberta's Ralph Klein, who have long argued for more private financing and provision of medical care, the Supreme Court's decision

prompted his immediate approval. "Any change that gives Canadians more choice in accessing health care," he stated on June 9, was worthy. The president of the Canadian Medical Association, Dr. Albert J. Schumacher, described the Court's ruling as "historical," one that "could substantially change the very foundations of Medicare as we know it." For those like former Saskatchewan premier Roy Romanow who have long celebrated Medicare, the decision is a call to action. After all, the court did not hold that the ban was unconstitutional itself. Instead, it argued that the "prohibition on obtaining private health insurance is not constitutional where the public system fails to deliver reasonable services."

The very narrowness of the decision's grounds is crucial to making sense of the immediate response to the decision: the fear Medicare defenders felt, the delight critics expressed, and the policy implications imagined. There was little doubt that private health insurance would be soon for sale in Quebec. But it seemed just as certain that in other provinces, the decision would prompt governmental attention to waiting list problems on the scale of Quebec's in recent years. In that respect, the decision to my mind warranted less celebration from privatizers and justified less fear from defenders of Medicare. Understood symbolically, it was easy to understand why the ideological stakes initially seemed so high on both sides.

How the Supreme Court made use of evidence from other systems of publicly financed medical care is both complicated, flawed and ironic. The experience of other countries with supplementary insurance, the majority contended, "refutes the government's theory that a prohibition on private health insurance is connected to maintaining quality public health care." The court went on to state that "it does not appear that private participation leads to the eventual demise of public health care."

Both of these factual claims are true. Every western European country with universal or near-universal health insurance does permit private financing of care. Nor has any of those countries experienced the "demise" of its public financing in the past decades. But what strikes the outside policy analyst is the peculiarity — indeed perversity — of the reasoning the court used. Why would anyone sensibly defend the Canadian ban on supplementary coverage because, otherwise, public programs debase quality or suffer demise?

The real justification of the ban on supplementary health insurance is egalitarian and prudential. Parallel financing, ample research has shown, increases overall costs. Moreover, the experience of private supplementary insurance in Europe is that parallel financing persistently raises questions of fairness. They are a never-ending source of complaint, as illustrated by the controversies over pay beds in British NHS hospitals, private insurance coverage of co-payments in France, and the exiting from the public insurance "pool" of those in Germany's top 10 percent of income earners. Those features are known to the scholars of health care but they were not what the judges noted. The findings suggest prudent lessons from other countries, not stories of policy collapse from supplementary coverage. Evaluating Canada's ban involves matters of judgment about what is fair and less costly, not what is simply possible to do.

It may be that the problem of the Chaoulli case for Medicare defenders was the argumentation the government's lawyers' offered, not the merits of the case for banning supplementary coverage. To the extent the government justified their defense by threats of Medicare's demise or its loss of quality, they made a serious mistake. There was and is no reason to believe that parallel systems cannot maintain decent quality or survive in recognizable form. The UK has had queue jumping through private insurance since 1948, but the NHS remains primarily a place where care is free at the point of service and the over whelming proportion of the population relies on it for care. That the British government is today tying to "purchase" care from private suppliers from Europe and the United States is itself worthy of attention. The official justification of that policy is the attempt to reduce the capacity of the privately insured to gain unfair advantage. More access on NHS medical grounds will, according to this view, *reduce* the ability of the wealthier to "jump the queue."

The central policy point to make about parallel health insurance is rather simple. Such systems are likely to be more expensive overall, are certain to be less fair, and will not by themselves do very much at all about the length of waiting lists. After all, if Dr. Chaoulli serves a privately financed patient at time. The can not at the same time treat a publicly financed one. This point, so obvious to the outsider prompted less immediate attention than one would have expect-

ed. Put differently, one cannot coherently claim to be green and white all over at the same time.

The irony is that a controversial, flawed and limited court decision might may well prompt some very desirable results. Those would be remedial legislative action in some jurisdictions (to avoid the decision's implications) and, more generally, greater intellectual clarity about why restricting private coverage expressed firm and important Canadian beliefs about how access to care ought to be shared out. If that were to occur, the Supreme Court's decision would be a landmark one in a quite different sense.

In the days following the decision, there was a deluge of commentary among critics, defenders, and explicators of the court's decision. Those commentaries prompted further attention to two questions: One, why introducing private funding and delivery might not reduce waiting lines (and times)? And, two: precisely what was wrong with the court's interpretation of the comparative "evidence" on which they relied?

The answer to the first question is that, in the short run, the supply of caregivers is largely fixed. That means private financing will redistribute attention to some over others, not increase the availability of care itself. The court, as Francois Beland has noted, did not take on the question of how less waiting time for patients like Zeliotis would fail to increase the waiting time of others. The majority decided that the burden of proof was not on the plaintiffs to show that private insurance "cures" the waiting list problem. And, as Beland puts it, the court "completely avoid[ed] examining the possibility that introducing private insurance would lengthen waiting lists in the public sector."

What was wrong with the majority's treatment of comparative evidence would require an additional essay. As it happens, I provided testimony to the trial court about what comparative health policy evidence there was on this topic. So, let me simply repeat what I wrote in conclusion, which directly contradicts the majority's claims and was cited by the dissenters. "Doubts about the plaintiff's assumptions are not only based on theoretical problems with the argument that an "exit of anyone from public insurance waiting lists must improve the chances to get care for Canadians left on those lists....There is considerable empirical evidence for such skepticism. Real world demonstrations...[demonstrate] what might well occur in Canada....In France, for example, there is continuous dispute about the role of cost sharing by patients in restraining demand for services in a fair and effective way. The result there [has been] less reduction of medical care used (whether justified or not) but the substitution of one source of payment for another. This multiplication of sources of finance weakens rather than strengthens the capacity of a society to decide democratically what health care its citizens should be entitled to and how scarcity should be apportioned."

The court's majority posed the wrong questions when dealing with comparative evidence and thus was unable to reject the twin arguments that parallel systems increase costs and allocate access to care unfairly, if that means using ability and willingness to pay as a criterion of access. What is even more puzzling is that the court's majority was willing to reject the decisions and grounds of two Quebec courts in a major case that but for one vote would have gone the other way. One ought to be concerned with this kind of judicial expansion.

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