

# Law & Governance

*Legal Focus on Healthcare and Insurance*

Policies, programs, practices & opinions for the providers, administrators & insurers of healthcare services

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## *Health Services Research after Chaoulli v. Quebec (Attorney General):* New Inspiration, New Challenges

Neil Seeman & Adalsteinn D. Brown

### A "Wake-Up Call" to Government.

**M**any observers have interpreted the Supreme Court of Canada's ruling in *Chaoulli v. Quebec (Attorney General)* as a critical "wake-up call," inspiring provincial and federal governments to measure and report on wait times for publicly insured services and to establish evidence-based benchmarks for acceptable waits (Noseworthy 2005; Flood and Sullivan 2005; Shumacher 2005; Hadorn 2005). Although the Supreme Court has delayed implementation of its ruling (retroactive to June 9) for 12 months, the decision has served as a springboard for intense public debate over the measurement of wait times.

In a Pollara survey following the ruling, 63% of Canadians said they would be willing to pay out-of-pocket to have faster access to medical services for themselves or their family (Pollara 2005). An Ipsos-Reid survey found 70% of Canadians in agreement with the proposition that they should be able to buy medical services from a

private healthcare provider if they so wish (Ipsos-ReidA 2005). A second Ipsos-Reid poll released in August by the Canadian Medical Association found that 81% of physicians were of the opinion that the ruling will reduce waiting lists "by increasing the supply of services" (Ipsos-ReidB 2005). These polling results suggest a sense of exasperation on the part of a majority of Canadians who believe their governments have not reduced wait times to acceptable levels (Toronto Star 2005). Some feel there can be no such thing as an "acceptable wait" for an essential medical service and nothing less than immediate access should be available for those Canadians willing and able to pay for it (Esmail 2005).

In response to public agitation over wait times, politicians have identified the reporting and benchmarking of medically acceptable waits as objectives of the highest priority. Federal Minister of Health Ujjal Dosanjh has recently called long wait lists for key medical procedures the "symbol of our problems" with Medicare (Hilborn 2005).

Many wait-times measurement and benchmarking initiatives have been completed, and several others are under development. Provincial programs to report wait times for different procedures are underway in Ontario, British Columbia, Alberta, Nova Scotia, Manitoba and Saskatchewan. In April, the Wait Times Alliance published its interim report prescribing maximum wait times for MRIs and cardiac care, hip and knee replacements, cancer care and cataract repairs. In June, the Canadian Orthopedics Association issued benchmarks for key orthopedic surgeries. The Health Council of Canada has pledged to announce benchmarks for medically acceptable waits by December 2005, and a new federal advisor on wait times, Dr. Brian Postl, was appointed in July. The Western Canada Wait List Project (WCWL) continues to produce maximum acceptable waiting times for a range of procedures, and several research organizations – notably, the Institute for Clinical Evaluative Sciences, the Cardiac Care Network and the Saskatchewan Surgical Care Network – have led the way in reporting wait times for key surgical procedures at a provincial level.

#### **Wait Times and Health Systems Research Take on New Legal Significance**

As a result of Chaoulli, wait-times research of this kind and health policy research generally in Canada will now take on heightened legal significance. The Court has signaled that future litigants may rely on established benchmarks, targets and care guarantees to establish the appropriateness of legal claims that allege unacceptable waits. More broadly, comparative health-systems research will now provide an evidentiary basis upon which judges may make their determination of the constitutionality of provincial insurance plans. For example, judges will be asked to consider empirical evidence presented by litigants regarding the effects of different approaches to the financing of healthcare generally, or of specific areas – notably, physician services and hospital services – on timely access, quality, equity, overall costs and distributive burden. To be sure, judges' use of scientific and social science introduced at trial is not new; however, judicial reliance on evidence from the relatively new fields of benchmarking, performance measurement and health-systems scholarship raises ethical implications and other process challenges for wait-times research and related policy planning.

#### **The Justices' Reliance on Health Systems Research**

Despite their areas of disagreement, the three judgments in the Chaoulli decision concur on one essential point: Reliable wait-times and health-systems research must play a major role in determining the consistency of provincial insurance schemes with the rights to life and liberty found in section 7 of the Canadian Charter of Rights and Freedoms.

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Appellants Jacques Chaoulli and his patient, George Zeliotis – who contended that he had waited too long for his hip surgery – challenged the constitutionality of Quebec’s prohibition on private insurance for services that fall within the public plan. To evaluate this claim, Justice Bastarache, Chief Justice Beverley McLachlin and Justice John Major noted that lawyers for the government of Quebec did not “present economic studies or rely on the experience of other countries” (Chaoulli: para. 136). They castigated the experts in health administration and policy called upon by the government for basing their opinions on “common sense” rather than empiricism. The Justices also rebuked experts for the appellants for “their own conflicting ‘common sense’ argument for the proposition that prohibiting private health insurance is neither necessary nor related to maintaining high quality in the public healthcare system” (Chaoulli: para. 137).

“ Chaoulli presents new pressures for researchers, policymakers and expert advisory panels involved in establishing wait-times benchmarks. Perceived challenges in meeting absolute benchmarks and the diverse range of factors behind wait times may lead all parties toward preferring benchmarks that set a maximum waiting time for a proportion of the population. ”

Confronted with “competing but unproven ‘common sense’ arguments ... amounting to little more than assertions of belief,” the three Justices relied on health-systems research offered by the appellants at trial (Chaoulli: para. 138). The results of this research indicated to them that other Western democracies have long offered private insurance alongside state-funded insurance for core medical services without clear evidence that this arrangement had undermined the quality of publicly insured care. Pointing to the report of Senator Kirby (Senate of Canada 2002), the Justices noted that, despite the availability of private insurance in the United Kingdom, only 11.5 per cent of the population had purchased it. Accordingly, they concluded that “the public system has not suffered as a result of the existence of private alternatives” (Chaoulli: para. 146).

Madame Justice Marie Deschamps, in a separate judgment that also found on behalf of the appellants, concluded that, in light of numerous government commissions and reports, there was “ample evidence” upon which to determine the public policy impact of prohibiting private insurance. However, since the Canada Health Act does not “provide benchmarks for the length of waiting times that might be regarded as consistent with the principles it lays down, and in particular with the principle of real accessibility” (Chaoulli: para. 16), Justice Deschamps based much of her assessment of the reasonableness of the Quebec private insurance prohibition on scholarship (Tuohy et al. 2004) describing mechanisms in OECD countries that, in her view, protect public plans from abuse. Examples included Australian prohibitions on preventing private insurers from charging greater premiums for higher risk individuals, and, in the United Kingdom, caps on the amount of money that physicians working full time in public hospitals may bill in the private sector to supplement income earned in the public sector.

The dissenting judgment of Justices Binnie, LeBel and Fish expressed the most frustration of all with the lack of reliable evidence documenting the extent of the wait-times problem in Canada. Unlike the other opinions, the dissenting judgment saw this as a “major evidentiary difficulty for the appellants” (Chaoulli: para. 217).

Since the onus of proving a government violation of the Charter falls on the plaintiffs, the Justices denied the appeal on the ground that the Court did not possess the legal capacity to decide whether Quebec enjoyed the constitutional authority to discourage a private-tier health sector by prohibiting the purchase and sale of private health insurance. Nor could the Justices rely on prior decisions, notably *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, which found that the government was not required to fund a specialized high-cost treatment for autistic children. Describing the Supreme Court’s decision in *Auton*, Justices Binnie, LeBel and Fish noted:

*“It did not on that occasion address in constitutional terms the scope and nature of ‘reasonable’ health services. Courts will now have to make that determination. What, then, are constitutionally required ‘reasonable health services’? What is treatment ‘within a reasonable time’? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard.”*

(Chaoulli, para. 163; Emphasis added)

For Justices Binnie, LeBel and Fish, the lack of established benchmarks called for judicial restraint and a refusal to allow the appeal. For the remaining Justices, it led to reliance on evidence from the health-economics and comparative health-systems literature upon which they could assess the “common sense” of the expert testimony introduced by the litigants. The clear implication in all three decisions is that clinically accepted benchmarks, had they been in existence and in evidence, would have been strongly determinative of terms such as “reasonable health services,” “medically necessary services,” and “treatment within a reasonable time.”

“Expert advisors who participate will now be cognizant of the legal ramifications of the panel’s conclusions. This may decrease their willingness to participate, making researchers’ efforts to recruit experts more difficult. This situation might necessitate the greater involvement of patients in benchmarking exercises, which in turn would require considerable efforts on the part of researchers to educate patient participants on the nature of the benchmarking process.”

### **New Considerations in Health Services Research**

In its interim report, the Wait Times Alliance suggested an acceptable wait of nine months – within three months for consultation, within six months for surgery – for non-urgent cases of hip surgery. According to a recent WCWL study, physicians deemed a wait of 26 weeks to be reasonable for people with mild hip or knee pain (WCWL 2005). Had they relied on these benchmarks, the appellants’ submissions might have been stronger. Other benchmarks in development may promote longer acceptable wait times for this type of surgery. If future data were to demonstrate that provinces are in fact meeting their benchmarks, putative claims challenging the legality of different provincial delivery models would be less likely to succeed. Therefore, researchers and governments should be on notice that the publication of wait-times targets and benchmarks may be used by gov-

ernments (to defend) and by aggrieved patient plaintiffs (to impugn) the legality of the various provincial health systems.

The new legal significance of benchmarks for wait times presents positive and negative implications for health-services research. On a positive note, the Prime Minister stated that the Chaoulli decision recognizes “the absolute necessity of cutting waiting times, of establishing benchmarks so that people will see that they can have complete confidence in their healthcare system” (Schmitz 2005). According to an Ipsos-Reid poll (2005A) cited earlier, 60% of Canadians feel the ruling will have the ultimate impact of forcing governments to invest resources to reduce wait times. The decision may also inspire provinces that have not done so already to add wait-times benchmarks to their health-system reform plans. Benchmarks will vary by province, but linking benchmarks to provincial delivery systems will introduce a higher minimum standard of care.

### **Legal Implications to the Research Process**

Chaoulli presents new pressures for researchers, policy-makers and expert advisory panels involved in establishing wait-times benchmarks. Perceived challenges in meeting absolute benchmarks and the diverse range of factors behind wait times, notably patients’ own actions in delaying treatment or changing providers while on the wait list, may lead all parties toward preferring benchmarks that set a maximum waiting time for a proportion of the population – i.e., a stipulation that 95% of the population receive care within 90 days. This looser type of benchmark would reduce an individual claimant’s likelihood of success but might increase the chances of success for a class action, of the type now underway by a class of breast cancer survivors in Quebec (*Cilinger c. Centre hospitalier de Chicoutimi*) who have been waiting for radiation therapy at 12 hospitals following breast cancer surgery beyond eight weeks. (The Quebec Supreme Court has recently refused to allow the suit to name the Quebec government as a co-defendant). If a class of patient plaintiffs could establish that it did not receive care within a medically appropriate wait time under this looser type of benchmark, the implication would be that the province or hospitals were not meeting their legal obligations.

After Chaoulli, the selection of expert panelists to set benchmarks will also present a challenge. Expert advisors who participate will now be cognizant of the legal ramifications of the panel’s conclusions. This

may decrease their willingness to participate, making researchers' efforts to recruit experts more difficult. This situation might necessitate the greater involvement of patients in benchmarking exercises, which in turn would require considerable efforts on the part of researchers to educate patient participants on the nature of the benchmarking process. Participants may also be more tentative in their conclusions, knowing that future courts will be paying attention. At the same time, providers may be perceived as advocating more stringent benchmarks as a way of legally guaranteeing their patients the possibility of access, whether it is medically required in a case or not. By contrast, government may be perceived as having an interest in setting relaxed benchmarks because of its desires to meet the competing public demands for timely care and an affordable and sustainable healthcare system.

One approach to mediating such varied interests is to design nomination processes for expert advisors that ask them to declare any real or potential competing interests, including any paid or unpaid affiliations with government or medical associations. This approach favours transparency in potential conflicts. Alternately, as the question of who sits on such panels increases in importance, the paramount goal may be a balance of competing interests across panels.

As a practical consequence of these process challenges, researchers may require new funding to conduct benchmarking research. Should the prevalence of potential conflicts present undue hurdles to the assembly of expert panels, researchers may be compelled to base their conclusions on evidence of lesser reliability, such as systematic literature reviews culled from benchmarking exercises in other countries.

Diverse sets of provincial benchmarks will inevitably differ, varying in their rigour. As with any expert clinical evidence, it will take time for benchmarks to become generally accepted among healthcare practitioners. Over time, benchmarks will coalesce into accepted ranges of performance on which judges may rely when adjudicating legal claims alleging unsatisfactory waits for publicly insured services. If it promotes the emergence of generally accepted benchmarks for which governments remain accountable, the Chaoulli ruling will therefore have improved the quality and equity of medical care throughout Canada. It will also have served the interests of justice, which requires reliable evidence against which to test the validity of competing legal claims. **L&G**

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