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THE CONTINUING LEGAL EDUCATION COMMITTEE OF THE CANADIAN BAR ASSOCIATION
IN PARTNERSHIP WITH THE ONTARIO BAR ASSOCIATION

CRITICAL ISSUES IN HEALTH LAW:
A NATIONAL SUMMIT

"Private" Health Care in Ontario – Current Status and Future Outlook

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May 2007

"Private" Health Care in Ontario – Current Status and Future Outlook

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The term "Private Health Care" is really a misnomer insofar as it represents a prohibited activity in Ontario. Presently, there is no prohibition against private health care and it openly exists in Ontario in various forms. What the "fuss' is about is private "medically necessary" health care, which represents the payment for insured services outside of the Ontario Health Insurance Plan (OHIP) from patient to provider. This paper will look at a few examples of private health care in Ontario to demonstrate what is presently allowed within the current legislative scheme and to explore where things are likely to head in the future.

For the Provincial Government, the prohibition against private "medically necessary" health care is a double-edge sword. On the one hand, they have created legislation to carve out a list of uninsured (not medically necessary) services that they do not want to pay for. However, on the other hand, they want to ensure that this list is strictly enforced so that the tables are not turned and health care providers use the "grey area" as a means to bill for services outside of OHIP. In certain situations, health care providers will characterize the services they provide as being outside of OHIP, so that they can freely bill the patients at market (non-OHIP) rates. Moreover, there is clearly a substantial group of Ontario citizens willing to accept these characterizations and to spend their own after tax dollars to receive medical services.

Before looking at private health care examples in Ontario, it would be instructive to first understand how, and why, both the federal and provincial policy and legislation is structured as it is, with regard to health care funding in Canada and in Ontario.

How Federal Legislation Dictates Provincial Policy & Legislation

Although under the Constitution the primary responsibility for health care in Canada is under the jurisdiction of the provinces, the federal government has been able to "wrestle" some of these constitutional powers away from the provinces. This has been accomplished by relying on underlying federal powers (i.e. *Peace, Order and Good Government*)[1] and by setting up financial incentives for the provinces to follow the federal government's health care policy (i.e. Transfer Payments to the Provinces).

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[1] *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

The history of medicare in Canada began in the early 1970's with federal policy which had as its stated objectives: ***universality***, so that Medicare would be available to all Canadian residents; ***portability***, ability to obtain medical treatment across all provinces; ***comprehensive coverage***, coverage for all necessary medical services and ***administration*** of the health care system on a non-profit basis.

In order to have the provinces "sign on" to this federal mandate, the federal government became the "financier" of health care in Canada. This initially was accomplished by "per capita" transfer payments to the provinces. These transfer payments, however, were frozen in the early 1980's.

In 1984, the Federal government enacted the *Canada Health Act*,[2] which set conditions and criteria for the provinces to follow if they wished to qualify for federal funding for health care. The primary objective of this legislation is stated in Section 3 of the *Canada Health Act*:

> *It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers*[3]

Realizing that the *Canada Health Act* alone would not be sufficient to maintain the public healthcare system across all provinces, the federal government began to withhold "cash contributions" to the provinces, unless the province's provincial health insurance legislation followed the federal mandate. In section 7 of the *Canada Health Act*, the criteria which a province must satisfy before being eligible to receive a full "cash contribution" from the federal government with regard to "payment for health services" is stated and is summarized as follows:

- **Public administration** – Provincial health insurance plan must operate on a non-profit basis
- **Comprehensiveness** – A provincial health insurance plan must ensure that all insured services are provided by health care providers
- **Universality** – A provincial health insurance plan must ensure that 100% of all insured persons in a province are entitled to coverage (i.e. everyone)
- **Portability** – A provincial health insurance plan must ensure that individuals are allowed to access their coverage out-of-province, across Canada, with no penalties
- **Accessibility** – A provincial health insurance plan must ensure that insured health services are provided on uniform terms and conditions and must provide compensation for health care providers[4]

Further, the *Canada Health Act* contains key provisions which are foremost in dictating how the provinces across Canada must establish and set up their respective health insurance plans.

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[2] *Canada Health Act*, R.S.C. 1985, c. C-6.
[3] *Ibid* at section 3.
[4] *Supra* note 2 at section 7.

Section 18, reproduced below, states that in order for a province to receive their full cash contribution from the federal government, the provincial legislation must contain a **ban on extra billing**:

> *In order that a province may qualify for a full cash contribution ... no payments may be permitted by the province... under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners.*[5]

In addition, Section 19 contains a prohibition against user charges. As reproduced below, if a province allows user charges under their provincial health care insurance plan, they may not qualify for their full cash contribution:

> *In order that a province may qualify for a full cash contribution ... user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.*[6]

Finally, the key components of the *Canada Health Act,* with respect to ensuring compliance of the accompanying provincial health insurance legislation, are contained in Sections 20 and 21, which set out that **there will be a deduction from the Federal transfer of payment to the province if the province allows extra billing and/or user fees to occur**. The provision on extra-billing is set out below:

> *Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province ... charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.*[7]

The purpose of explaining the above "history of public healthcare in Canada" is to ensure the "driving force" behind the Ontario government's ban on billing insured services outside of OHIP, extra billing and queue jumping is understood. Essentially, it is driven by the Province's desire to remain onside with the federal government and to thereby ensure that the flow of federal money for provincial healthcare continues. As a result of this federal legislation, the provincial legislation has been modelled to ensure compliance with the federal objectives.

Ontario Policy/Legislation Re Public Health Care

The legislation in Ontario which governs public policy in the health care system is primarily the *Commitment to the Future of Medicare Act, 2004* ("*CFMA*")[8]. The preamble[9] to this legislation

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[5] *Supra* note 2 at section 18.
[6] *Supra* note 2 at section 19.
[7] *Supra* note 2 at sections 20(1).
[8] *Commitment to the Future of Medicare Act,* 2004, S.O. 2004, c. 5.

clearly demonstrates that it is the **intent** of the Ontario government to echo the policies contained within the federal *Canada Health Act.*

The provincial government's purpose in passing the *CFMA* was to strengthen the existing prohibition of **"two tiered"** medicine by closing what they perceived to be legislative loopholes allowing queue-jumping and extra billing.

In this regard, section 10(3)(a) of the *CFMA* provides that physicians must not accept payment for insured services to insured persons other than from OHIP:

> *A physician or designated practitioner shall not accept payment or benefit for an insured service rendered to an insured person except from the Plan, including a payment made in accordance with an agreement made under subsection 2 (2) of the Health Insurance Act;*[10]

In addition, section 10(1) explicitly states that there is a ban on extra-billing:

> *A physician or designated practitioner shall not charge more or accept payment or other benefit for more than the amount payable under the Plan for rendering an insured service to an insured person.*[11]

Essentially, the above two provisions operate to prohibit a physician from performing medically necessary procedures and charging for insured services provided to insured persons outside of OHIP, or charging or accepting payment for more than the amount payable by OHIP for the same service.

Furthermore, section 10(5) provides that no person, other than a person set out in section 10(3) (i.e. a physician or other designated practitioner), may charge for an insured service provided to an insured person:

> *No person or entity may charge or accept payment or other benefit for an insured service rendered to an insured person,*
>
> *(a) except as permitted under this section; or*
>
> *(b) unless permitted to do so by the regulations in the prescribed circumstances and on the prescribed conditions.*[12]

Section 19 of the *CFMA* makes it an offence to contravene the above prohibitions and sets out the penalties for a breach thereof. An individual would be liable to a fine of not more than

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[9] CFMA Preamble (excerpt) Continue to support the prohibition of two-tier medicine, extra billing and user fees in accordance with the *Canada Health Act and* believe in a consumer-centred health system that ensures access is based on assessed need, not on an individual's ability to pay;

[10] *Supra* note 8 at section 10(3)(a).

[11] *Supra* note 8 at section 10(1).

[12] *Supra* note 8 at section 10(5).

$10,000 and a corporation would be liable to a fine not exceeding $25,000.[13] In addition, an Order to pay compensation or restitution could be made.[14]

In addition to monetary penalties, a physician would be vulnerable to the government moving by injunctive relief, designed to close his/her office, if it continued to be in flagrant violation of the existing legislative framework.

Private Health Care Examples in Ontario

Against the backdrop of the legislative scheme prohibiting extra billing, it is interesting to look at examples of private health care centres presently operating in Ontario. In particular, ***how they do business*** and ***what legislation they work around*** are key areas of interest. In addition, realistic opportunities for the growth of "private" (or more accurately, non-hospital delivered services) health care in Ontario, based on the present legislative scheme will be discussed.

1. Private MRI Centres:

The demand for high end diagnostic services has been coupled with the development of a lengthy wait for such services via the customary means (physician referral to a hospital based facility). As a result, some organizations have seen this as a business opportunity and have established facilities to provide these types of services **outside** of the regular OHIP route. Such a company is "Medcentra" which states on its website:

> *Booking your clients into Ontario's only MRI facility exclusively dedicated to non-OHIP, third party services.*[15]

As the website explains, it offers MRI services for patients under one of four circumstances:

a. Automobile Insurance Claims;
b. Worker's Compensation claims (WSIB);[16]
c. Third party services; and
d. Non-residents.

The one common element of all of the above is that they are not, by definition, insured services and as a result, do not fall under the OHIP billing umbrella. Further, when a service does not fall under the OHIP umbrella, it can be billed to the patient (or their representative) at market rates without offending any legislation.

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[13] *Supra* note 8 at section 19.
[14] *Supra* note 8 at section 19(5).
[15] www.medcentra.com
[16] WSIB represents the Worker's Safety Insurance Board under the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16, Sch. A.

a. Automobile Insurance Claims

Any assessment or examination arising from a motor vehicle accident is specifically excluded as an insured service and therefore, can be provided and billed outside of OHIP.[17] Therefore, any MRI ordered by a patient's auto insurance company or by lawyers representing the accident victim can be arranged for and paid by the insurance company directly to MedCentra without any consideration of OHIP billing limitations (i.e. amount, etc.) or queue jumping. Regarding the "medical necessity" of this service, arguably, a MRI ordered subsequent to a motor vehicle accident is medically required. However, based on this legislative exclusion, this service is not "deemed" to be medically necessary, by way of its definition as being excluded from insured services.

For an automobile insurance company or lawyer of the accident victim, a MRI can be a very useful diagnostic aid in determining the injuries sustained by their insured. This of course factors into the entitlement an insured would have to Accident Benefits under the legislative scheme.[18] Therefore, speeding up the process by obtaining a MRI sooner, rather than later, could prove to be a significant cost saving for an insurance company.

b. Worker's Compensation Claims

Section 11.2(2) of the *Health Insurance Act* [19] explicitly states that services provided to a person under the *Workplace Safety Insurance Act, 1997*[20] are not considered to be insured services. Further, section 33(2) of the *Workplace Safety Insurance Act, 1997* clearly states that it is duty of the Workplace Safety and Insurance Board (the "Board") to pay for a worker's health care services.[21] Therefore, based on the above, the services provided at MedCentra pursuant to a claim under the *Workplace Safety Insurance Act* would be deemed to be **uninsured** and can be provided at a rate deemed appropriate, and which of course, the Board is willing to pay. The discretion as to what constitutes an appropriate fee is set out in Section 33(3) of the *Workplace Safety Insurance Act, 1997*,[22] which gives the Board the power to establish fee schedules for health care as it considers appropriate.

For the Board, the benefit of having MedCentra provide these services would be that workers on disability would be able to obtain necessary MRI scans much sooner than they would be able to at other facilities or hospitals. For the Board, the sooner that workers could return to better health, the less entitlement they would have to disability benefits and therefore, the Board could realize an overall financial saving.

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[17] Ontario Regulation 552 at section 24(1)8.2 under the *Health Insurance Act,* R.S.O. 1990, c. H.6.
[18] Statutory Accidents Benefits Schedule, O. Reg. 776/93 under the *Insurance Act,* R.S.O. 1990, c. I.8.
[19] *Health Insurance Act,* R.S.O. 1990, c. H.6, section 11.2(2).
[20] *Workplace Safety and Insurance Act, 1997,* S.O. 1997, c. 16, Sch. A.
[21] *Ibid.* Section 33(2).
[22] *Supra* note 20 at section 33(3).

c. Third Party Services

Section 24(1) of Regulation 552 under the *Health Insurance Act* [23] carves out a list of services which when rendered by physicians or practitioners are not insured services, in that they are for reasons other than medical necessity. Therefore, if a service is on this list, it is not seen to be an insured service and as a result, the prohibition against extra-billing and billing outside of OHIP would not apply. This list includes such things as cosmetic services, experimental treatment, telephone advice, and other items.

Similarly, section 24(1)8.2 of Regulation 552 creates an exclusion for third party (uninsured) services by setting out that a service is a third party service if it is for the production or completion of a document, or the transmission of information to any person other than the insured person, **provided that the service relates to any of the following**:

i. admission to or continued attendance in a school, community college, university or other educational institution or program,

ii. admission to or continued attendance in a recreational or athletic club, association or program or a camp,

iii. an application for, or the continuation of, insurance,

iv. an application for, or the continuation of, a licence,

v. entering or maintaining a contract,

vi. an entitlement to benefits, including insurance benefits or benefits under a pension plan,

vii. obtaining or continuing employment,[24]

viii. an absence from or return to work,

ix. legal proceedings.[25]

Therefore, even a medically necessary service could, by way of the above, be considered to be an uninsured service if it is provided under the above context. As a result, the above list provides numerous opportunities for Med Centra to "justify" that an otherwise medically necessary service is in fact a third party service.

In order to document the non-insured nature of the service, MedCentra has potential clients complete an Application form which sets out their applicable third party circumstances and who the third party is. Once this is accomplished, MedCentra has the legal justification for billing this service outside of OHIP to a third party who will pay MedCentra directly on behalf of the patient. Regarding the legitimacy of this arrangement, this of course would depend on the nature of the

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[23] *Supra* note 17 at section 24(1).

[24] This is the provision routinely utilized by "Executive Medical Clinics" where payment is made for these services by the Executive's employer.

[25] *Supra* note 17 at section 24(1)8.2.

third party arrangement or whether the third party arrangement was specifically created to subvert the usual OHIP process and provide faster access to an MRI.

These third party "loopholes" were not intended by government to create opportunities to convert otherwise medically necessary insured services into uninsured services. While not aware of any situation where these "loopholes" have been challenged by the Minister of Health and Long-Term Care, the risk of such a Ministry challenge does exist, especially if the popularity of the service grows.

d. Non-Residents

Uninsured services include services provided to an un-insured person.[26] Only "insured persons" are entitled to receive "insured services". If, however, an uninsured person (i.e. a non-resident) receives what would otherwise be considered an insured service, this service would not be classified as an insured service and would not be paid for by OHIP. Therefore, medically necessary services could be provided to uninsured persons (non-Ontario patients and Americans) without offending the *Health Insurance Act*. Further, as the prohibition against billing outside of OHIP or extra billing, as set out in the *CFMA*,[27] only pertains to the provision of "insured services" to "insured persons", therefore, any services provided to **uninsured persons** can be freely performed and billed at market rates. Therefore, any patient from a province other than Ontario or from the U.S. can have a MRI performed at MedCentra without offending provincial legislation.

Summary – Private MRI Centres:

Overall, MedCentra serves as an example of a private organization offering health care services outside of the government sponsored OHIP system. As noted above, this can only be accomplished under specific circumstances. Notable is the fact that MedCentra is affiliated with a major hospital in Toronto (St. Michael's Hospital) and on its face, purports to not overtly challenge any existing government regulations. While MedCentra only offers MRI services, it is conceivable that other otherwise medically necessary services (i.e. surgery) could be offered along the same basis.

2. Executive Medical Clinics (Medcan)

Aside from acute care services, there is a demand in Ontario for routine preventive medical care, in light of the shortage of family physicians. In Ontario, the government has openly acknowledged this shortage and the long wait time for appointments that often results. So have the patients and their physicians. The result has been the establishment of clinics which offer "Executive Medical Services" based on the offering of ***preventative health care*** which by

[26] *Supra* note 19 at sections 11(1) and 11.2.
[27] *Supra* note 11.

definition, cannot, *prima facie*, be "medically necessary". By focusing on preventive health services, these clinics are not providing insured services and as a result, can bill directly to patients at market rates without offending any legislation. Frequently, the fees charged for a package including an assessment can be in the range of a few thousand dollars.

An example of an Executive Medical Clinic is the Medcan clinic, which on its website advertises preventive health services:

> *We focus on identifying health risks before signs and symptoms occur. Using the best available testing, we screen for risk of cancer, heart disease, diabetes, and an array of other illnesses.* [28]

The backbone of the service provided by Medcan is the Comprehensive Health Assessment, which is described as a complete assessment of a client's current state of health, in order to manage their future heath needs. The assessment includes a series of sophisticated diagnostic tests and includes an extensive review of a client's medical history, lifestyle and a detailed follow-up report.[29] The areas in which these types of clinics get into "trouble" is when they also offer insured services (medically necessary care) through OHIP from the same physicians to the same patients. When this occurs, this raises questions of whether or not the clients of the clinic are receiving preferential access for insured services that they would not otherwise receive, had they not been a client of the clinic. Regarding Medcan, they also offer a "Wellness Plan" which includes access to one of the team of medical professionals by telephone 24/7.

Generally, the basis for offering preventative or Executive medicine outside of OHIP without offending any existing legislation is due to the fact that such services do not meet the definition of insured services under the *Health Insurance Act*.[30] The *Health Insurance Act* defines insured services as being prescribed (i.e. in the OHIP Schedule of Benefits) medically necessary services rendered by a physician. Executive medical screenings, which can be defined as comprehensive assessments for wellness or preventative health planning do not meet the "medical necessity" requirement, as they are by definition, preventative. Therefore, they do not qualify for OHIP reimbursement. As a result, they can be provided and billed to individuals at market rates without offending any legislation.

Other <u>not</u> medically necessary services provided in the context of a Wellness Clinic may include such services as:

- Services provided by non-physician personnel such as nurses, psychologists, etc.;
- Screening or diagnostic testing that is <u>not</u> medically necessary;
- Facilitating opinions from or consultations with non-Canadian medical personnel;
- Alternative medical therapies;

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[28] www.medcan.com
[29] www.medcan.com.
[30] *Supra* note 19 at section 11.2.

- 24/7 telephone advice and assistance; and

- Services currently de-listed as Insured Services under the OHIP Schedule of Benefits, including such things as dermatological treatments and procedures - such as removal of moles, warts, laser treatments for removal of scarring and birth marks.

3. Private Surgical Centres

The type of surgery provided in a private surgical centre is either insured (medically necessary) and/or uninsured surgery (i.e. cosmetic surgery). Providing uninsured surgical services does not offend any existing legislation as the legislation is not intended to, nor does it want to, curtail this type of activity. Therefore, a plastic surgeon, for example, is free to set up a surgical practice and offer uninsured surgical services directly to patients and have patients pay fees directly to the surgeon or centre.[31]

Regarding insured surgical services, this is altogether a different situation for a number of reasons. Foremost is that as an insured service, it must be billed within the existing OHIP fee guide and therefore, no extra-billing may occur and be passed on to the patient. In this way, a patient cannot be charged an additional fee for a surgery in addition to what OHIP pays.

Regarding professional fees, the OHIP fee guide sets out that a physician can charge professional fees to the maximum amount payable by OHIP for an insured service. However, even with this "cap" on professional fees, surgeons may be willing to accept this capped professional fee in return for being able to "control" their own surgical centre, schedule procedures as they like and most importantly, recoup operating costs (i.e. tray fees).

As stated above, a private surgical centre would not be permitted, by law, to bill in excess of the OHIP Schedule of Benefits ("extra billing") for any medically necessary services provided to insured persons. Not only does this apply to the actual professional fee, it also applies to other fees associated with the insured service. In the preamble to the OHIP Schedule of Benefits[32], under the heading of ***Constituent and Common Elements of Insured Services***, the prohibition against billing the patients for "extras" is stated as follows:

> *Patients cannot be charged for the premises, equipment, supplies and personnel for services... rendered outside of a hospital or independent health facility if the premises, equipment, supplies and personnel, support, assist or provide a necessary adjunct to an insured service ...as charging a patient would be contrary to the Independent Health Facilities Act.*

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[31] The only requirement for the surgeon is that he/she maintains the standard of professional practice in performing these surgeries and that no more than three individuals are kept overnight, so as not to offend section 4 of the *Private Hospital Act*, R.S.O. 1990, c. P.24.

[32] Schedule of Benefits for Physician Services under the *Health Insurance Act*, effective April 1, 2007.

Therefore, any fees charged pertaining to any use of premises, equipment, supplies or personnel that assists or provides a **necessary adjunct** to an insured service, cannot be charged to the patient in addition to the fees set out in the OHIP Schedule of Benefits. This prohibition would not apply to surgical services performed on uninsured persons or if the services are deemed to be third party services.

As a result of the above, the quandary for any prospective private surgical centre is how to obtain funding for operating costs without offending the existing legislation. The short answer is that presently this can only be accomplished by dealing directly with the government and obtaining a license under another piece of legislation in Ontario, that being the *Independent Health Facilities Act.*[33]

a. Shouldice Hospital

Shouldice Hospital is a licensed Private Hospital under the *Private Hospitals Act.*[34] A Private Hospital is a class of hospital separate from a Public Hospital[35] and is defined as:

> *a house in which four or more patients are or may be admitted for treatment, other than, an independent health facility within the meaning of the* Independent Health Facilities Act *or a hospital within the meaning of the* Public Hospitals Act...[36]

Shouldice Hospital has 5 operating rooms and performs a specialized type of procedure, surgical hernia repair. It allows patients to contact the centre directly and schedule their own surgeries without a referral. It performs 7,000 hernia operations per year and claims to have a complication and infection rate of less than 0.5 %.[37]

Regarding funding for the operating costs, as a Private Hospital, Shouldice receives government funding by way of a global budget for these costs. Therefore, the Ministry of Health underwrites the costs paid by Shouldice to perform the surgeries in much the same way that it funds surgical services provided in a hospital. The professional fees payable to the surgeon are paid in the customary way as set out in the OHIP fee guide. Therefore, in this way, Shouldice is completely within the legislation scheme.

While this legislation seems available to all, it is not. The *Act* indicates that only those licenses which were in existence on the 29th of October, 1973 will be continued in Ontario.[38] Therefore, only private hospitals that currently exist (i.e. Shouldice) are renewed annually after appropriate peer review and accreditation on the basis of "grandfathered" provisions in the act. Based on

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[33] *Independent Health Facilities Act,* R.S.O. 1990, c. I.3.
[34] *Private Hospitals Act,* R.S.O. 1990, c. P.24.
[35] *Public Hospitals Act,* R.S.O. 1990, c. P.40.
[36] *Supra* note 34 at section 1.
[37] www.shouldice.com
[38] *Supra* note 34 at section 3(1).

the current climate, it is very unlikely that any "new" private hospitals will be permitted in the foreseeable future.

b. Don Mills Surgical Unit (Centre)

The Don Mills Surgical Unit (DMSU) is another example of a Private Hospital operating within the existing legislation in Ontario grandfathered into the current legislative scheme. DMSU however, differs from Shouldice in that it provides both insured and uninsured services under one roof.

The insured or medically necessary services offered include cataract surgery and orthopedic procedures (i.e. knee arthroscopy). For these services, DMSU receives a global budget to offset the costs of the operating expenses (i.e. tray fees).[39]

With regard to uninsured services, such things as cosmetic surgery and unfunded prostate procedures are performed and billed directly to patients. As these procedures are excluded from the definition of insured services under the *Health Insurance Act*,[40] they do not offend any existing legislation and can be billed to patients directly.

c. Cosmetic Surgical Practices

Cosmetic surgery practices are another example of "private health care" in Ontario and clearly demonstrate that the legislative provisions designed to prevent extra-billing and queue jumping are not intended to stand in the way of surgical centres offering uninsured (i.e. cosmetic) surgical services. There is no legislation directly standing in the way of a plastic surgeon looking to set up a private surgical centre.[41]

Summary re Private Surgical Practices

The above examples illustrate that not only do private surgical centres exist, but they operate with the full acquiescence of the government. However, both Shouldice and DMSU are exceptional examples which are fortunate to have been in existence prior to the current legislative scheme. As a result of their standing, they have been able to secure government funding to operate their centre and therefore, have not had to "push the boundaries" of what is allowed or what is not allowed.

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[39] www.dmsu.com

[40] *Supra* note 17 at section 24(1).

[41] Aside from legislation such as the *Private Hospitals Act* which set out criteria for keeping patients overnight. As well, other regulations regarding professional standards would apply as well.

4. Private Health Care – Future Outlook

As demonstrated in the above examples, the key to any successful private health care venture that wishes to provide insured (medically necessary) services is to obtain a source of funding for operating costs. Presently, this cannot be recouped directly from patients and must be paid by the government, except under certain circumstances.[42] In this way the government effectively regulates who can operate a private health care (i.e. surgical) centre. While any physician can offer insured services to an insured person, receiving payment for operating expenses can only come from the government at the present time.[43]

The present political climate in Ontario clearly signals a deep seated commitment on the part of the current government to continue to enforce the existing legislative regime. Therefore, any expansion to two-tiered care (for-profit private "medically necessary" health care) does not seem to be on the horizon. What is on the horizon, however, is a shift to **not-for profit** private health care clinics, which receive provincial funding to provide their services. An example of this is the Kensington Eye Institute, which was established in 2006 as the third largest cataract facility in Canada. The Kensington Eye Institute provides eye care in the heart of downtown Toronto and is structured as a not-for-profit corporation licensed under the Ministry of Health and Long Term Care as an Independent Health Facility (IHF). The corporate leadership of the Institute is a volunteer Board of Directors.[44] With regard to funding, through its Foundation (Kensington Foundation), Kensinton has raised all necessary capital funds. For operating costs, the government has pledged to provide the necessary operating funds, estimated to be $ 5 million annually.[45]

The Kensington Eye Institute serves as an example of the current government's **Transformation Agenda**, which sets out numerous goals, among which include the shifting of services from acute care hospitals into the community.[46] Therefore, it is in this manner that the existing government seems willing to allow (and fund) private medically necessary insured services. This "breakthrough" comes with a price, that being to operate as a not for profit entity.

The approach used by the Kensington Eye Institute could be used for various other types of medically necessary services plagued by long wait times and accessibility problems, such as cancer care, orthopedic surgery and dialysis to name a few. The key, however, for any prospective individual or organization is that any proposed centre be structured as not for profit.

5. Private Health Care – Testing the Limits

If a physician wishes to establish a for-profit private health care centre and provide insured (medically necessary) services to insured persons, they may wish to test the government's

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[42] 3rd party, WSIB, auto insurance claims and for uninsured persons.
[43] Not including 3rd party, WSIB, auto insurance claims and for services for uninsured persons.
[44] www.tkei.org.
[45] Ministry of Health and Long-Term Care Press Release on Kensington Eye Institute, January 9, 2006.
[46] Ministry of Health and Long-Term Care, Minister George Smitherman's Speaker Notes on Transformation Agenda, September 2004.

resolve on the crest of the *Chaoulli* [47] decision. In 2005, the Supreme Court of Canada released its decision in *Chaoulli* and this has resulted in much debate and consternation at both the federal and provincial levels. It is important to understand the impact of the *Chaoulli* decision on our current healthcare environment, since it does leave a very significant door open to expand the delivery of private medical services in Ontario.

While the *Chaoulli* decision was based upon a ban on private health insurance, as contained in the Quebec *Health Insurance Act,*[48] the principles discussed in that decision can be applied to the public/private health care debate in other provinces (i.e. Ontario). The appellants in *Chaoulli*, Dr. Jacques Chaoulli (Quebec physician) and George Zeliotis (a patient with numerous health problems), contested the validity of the prohibition on private health insurance that was present in the Quebec Health Insurance legislation. They argued that this prohibition deprived patients of timely access to health care services free from the waiting times inherent in the public system and therefore, violated their rights under Section 1 of the *Quebec Charter of Human Rights and Freedoms* [49] (protection of one's right to life and personal inviolability) and Section 7 of the *Canadian Charter of Rights and Freedoms* (protection of one's right to life, liberty and security of the person).

The majority of the Supreme Court of Canada held that the Quebec legislation, which banned private insurance, was a violation of the patient's *Charter* rights and a violation of the *Quebec Charter* rights and was not a limit demonstrably justified in a free and democratic society. In reaching this decision, the Supreme Court balanced an individual's right to timely health care vs. the overall public policy and objective of maintaining and sustaining a provincial public health care system. The Court held that where the lack of timely health care can result in death, one's Section 7 right to the protection of "life" is engaged. Further, if the lack of access to timely health care could result in serious psychological and/or physical suffering, this would also trigger one's Section 7 right to protection and security of the person. In addition, the Court held that there was a *prima facie* violation which was not justified as a reasonable limit in a democratic society.

In reaching its decision, the Court held that it did not believe that prohibiting private insurance is the only way for a province to protect the integrity of its public health plan. Speaking on behalf of the Majority of the Court, Justice Deschamps indicated that:

> *Even if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity. In fact, because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved.* [50]

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[47] *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791 (S.C.C.).
[48] *Health insurance act*, R.S.Q. c. A-29.
[49] *Charter of Human Rights and Freedoms*, R.S.Q. c. C-12.
[50] *Supra* note 47 at para. 74.

The interaction between the legislation, which prohibited private health insurance and the access to private health services, was succinctly stated by Chief Justice McLachlin and Justice Major also speaking on behalf of the Majority of the Court:

> *The Canada Health Act, the Health Insurance Act, and the Hospital Insurance Act do not expressly prohibit private health services. However, they limit access to private health services by removing the ability to contract for private health care insurance to cover the same services covered by public insurance. The result is a virtual monopoly for the public health scheme. The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person. Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so.*[51]

The above paragraphs, taken from the *Chaoulli* decision, emphasize the Supreme Court of Canada's "view" on provincial government monopoly over the current public health care system.

Charter Challenge in Ontario

The groundwork for a *Charter* challenge in Ontario based on *Chaoulli* could exist if a physician is willing to bill patients directly (and in excess of the fee guide) for insured medically necessary services and if a patient requiring such a service is willing to pay for such a service. In addition, such a patient would have to meet the following criteria:

1. The patient has suffered a serious injury affecting their enjoyment and quality of life;
2. The wait time for this procedure (i.e. surgery) is documented to be lengthy (i.e. 1 year or more);
3. The patient is committed to using their own personal funds to pay for the service rather than suffer in pain.

In order for the finding in *Chaoulli* to be extended, so that similarly the ban on billing outside of OHIP and extra billing could also be found to be a violation of one's *Charter* rights, one would have to prove the same elements as those proven in *Chaoulli*. Whether or not any party could challenge and prove these elements would of course depend on the specific factual circumstances. Overall, however, given the serious waiting list crisis in Ontario for certain types of surgery, a persuasive *Charter* argument could probably be put forth.

If a Charter challenge was brought in Ontario on the above basis, the key, however, to whether or not a *Charter* challenge would prevail would depend on whether or not the government would

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[51] *Supra* note 47 at para. 106.

be able to establish (by way of s. 1 of the *Charter*) that the "means" they have chosen (i.e. a prohibition on private health care) is proportional to the infringement of one's right to life, liberty and security of the person.

In order for the government to demonstrate that the prohibitions under the legislation[52] could be saved by Section 1 of the *Charter*, they would have to demonstrate that with regard to the legislation it has as its objective a **pressing and substantial objective**, namely, preservation of the public health care system; there is a **rational connection** between the extra billing ban and the objective of the legislation; the ban on extra billing **minimally impairs** one's *Charter* rights; and **proportionality** exists between the ban on extra billing and the objective of the legislation.[53]

In this case, it is likely that the "minimal impairment" part of the "test" would be the key element for the government in defending the challenged provision. Therefore, the government would most likely have to demonstrate that the measure they have chosen (i.e. ban on extra billing) has **minimally impaired** one's *Charter* rights as minimally as possible. In doing this, the government would have to prove that lesser restrictive measures could not have been utilized in place of this provision. This would necessitate the government demonstrating that there were no other means by which they could have met the objective of preserving the public health plan, rather than resorting to an across the board ban on extra billing.

Therefore, based on *Chaoulli*, in Ontario, as long as waiting lists for many surgical procedures remain lengthy and prevent a patient from receiving timely care, *Chaoulli* may prevent the government from meeting the test for minimal impairment. As a result, for the willing physician and patient, a challenge could be made. The downside of course is that this would require knowingly breaking the law (for the physician and the patient) and would result in a lengthy legal process. It is most likely this reason which has resulted in no such case to date. As a result, it is more likely that private (medically necessary) health care will only proceed along the government's terms.

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[52] *Supra* notes 10, 11 and 12.
[53] *R. v. Oakes*, [1986] S.C.J. No. 7 (S.C.C.).