

Shortfalls of the Canada Health Act:
Overstatements of Financial Benefits and Potential
Pitfalls for the Critically Ill

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I. INTRODUCTION

As portions of the Patient Protection and Affordable Care Act (PPACA) are contested through the United States federal courts¹, there is ongoing discussion about American health reform and how it could have been more ambitious in its scope of coverage and in the level of government involvement. According to an Associated Press poll conducted by Stanford University in late 2010, twice as many Americans think that the PPACA should have done more as think that the government should stay out of healthcare.² In fact, according to a New York Times/CBS poll, seventy-two percent of Americans think that there should be a government administered insurance plan.³

Furthermore, there is still talk of an entirely socialized system in the public discourse.⁴ Those who favor a socialized system sometimes look to Canada's government health insurance system as a model.⁵ One of the

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1. See, e.g., *Florida ex rel. Atty. Gen. v. U.S. Dep't. of Health and Human Servs.*, 648 F.3d 1235, 1328 (11th Cir. 2011).

2. *Poll: U.S. Wants More Health Reform, Not Less*, WWW.CBSNEWS.COM (Oct. 14, 2010, 3:54 PM), <http://www.cbsnews.com/stories/2010/09/25/politics/main6899989.shtml>.

3. Kevin Sack & Marjorie Connelly, *In Poll, Wide Support for Government-Run Health*, N.Y. TIMES 1, 1 (2009), at http://www.nytimes.com/2009/06/21/health/policy/21poll.html?_r=1&ref=us.

4. See, e.g., Atul Gawande, *Getting There From Here: How Should Obama Reform Healthcare?*, THE NEW YORKER, Jan. 26, 2009, at 26-27

5. See *Id.* at 33.

claims made by President Barack Obama is that the U.S. healthcare system, in the way that it prices many consumers out of the healthcare market, causes far too many consumer bankruptcies, and that further reform would alleviate this unfortunate result.⁶ The contention that bankruptcy rates will decrease, however, does not seem to be supported by the facts.

This article will look briefly at the history of the Canadian system of public healthcare and at comparative bankruptcy rates in the U.S. and Canada. I will offer a potential explanation for a portion of insolvencies in Canada by showing the unique role that private actions for reimbursement take in the Canadian system. By looking at an example of the convoluted process of administrative claims for reimbursement, it will become apparent that the Canadian system itself is not without pitfalls and compromises. These pitfalls jeopardize the health and finances of those who are most in need of life-saving health services.

II. THE CANADIAN HEALTH ACT

Canadian universal healthcare was introduced in measures throughout the course of the second half of the twentieth century. The march toward universal coverage started in Saskatchewan with the passage of the first iteration of the Saskatchewan Hospitalization Act in 1946.⁷ From there, Canada moved progressively closer to universal coverage, with prepaid medical service covering more than ninety percent of Alberta residents.⁸ By 1957, the federal government in Canada had passed a program that would cover fifty percent of the cost of any provincial health plan that

6. Invitation to the *Hamilton/Fairfield Democratic Club Healthcare Kickoff Organizing Meeting*, MY.BARACKOBAMA.COM, available at <https://my.barackobama.com/page/event/detail/gpcqvz> (last visited Mar. 4, 2012).

7. Saskatchewan Hospitalization Act, R.S.S. 1978, c. S-23, s.31 (Can.).

8. History, *Alberta Medical Association*, WWW.ALBERTADOCTORS.ORG (last updated: July 25, 2011), <http://www.albertadoctors.org/bcm/ama/ama-website.nsf/0/72D6C5EEBCA2CA9787256E1C0056E7A8?OpenDocument>.

provided universal inpatient and outpatient services, without any additional payments for specific services.⁹

It was not until 1985 that uniform healthcare in Canada was effectively guaranteed to all residents with the passing of the Canada Health Act.¹⁰ In the modern bill, the federal government of Canada provides payment to the provincial governments for their healthcare programs provided that they meet five criteria.¹¹ The first such criterion is public administration: that is, that it be operated publicly, not-for-profit, and with direct governmental oversight.¹² The next criterion, comprehensiveness, requires that the provinces provide coverage for all “insured health services. . .” provided by physicians, dentists, and other qualified providers.¹³¹⁴ The third criterion, universality, requires that all “insured persons” in the province be covered by the province’s medical plan.¹⁵ “Insured persons” are defined as those residents of the province who have resided there for at least three months and are neither a member of the Canadian Forces, nor a member of the Royal Canadian Mounted Police, nor a person serving a term of imprisonment.¹⁶ The fourth criterion, portability, is met in part if the plan provides for services in other provinces and outside of Canada on a substantially similar basis to the services provided in the province.¹⁷ Portability, as it relates to coverage outside of Canada, will be a focus of the

9. J. Gilbert Turner, *The Hospital Insurance and Diagnostic Services Act: Its Impact on Hospital Administration*, 78 CAN. MED. ASS’N, J. 768, 768 (1958), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1829926/?page=1>.

10. Canada Health Act, R.S.C. 1985, c. C-6 (Can.), available at <http://laws-lois.justice.gc.ca/PDF/C-6.pdf>.

11. *Id.* s. 4, 7.

12. *Id.* s. 7, 8.

13. *Id.* s. 9.

14. See, e.g., Ont. Ministry of Health and Long-Term Care, *Schedule of Benefits for Physician Services under the Health Insurance Act*, [WWW.HEALTH.GOV.ON.CA](http://www.health.gov.on.ca), http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html (last visited Mar. 24, 2012) (providing a list of insured services in Ontario).

15. R.S.C. 1985, c. C-6, s. 10.

16. *Id.* s. 2.

17. *Id.* s. 11.

second half of this paper. The fifth and final criterion, accessibility, is met in part if the plan “does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons.”¹⁸

Ostensibly, the Canadian system for federal payment of provincial healthcare coverage outlined in the preceding paragraph provides coverage to all Canadian citizens in a manner that guarantees relative uniformity. While this proposition seems to be basically true, fundamental financial implications are often overlooked in the discussion of this system’s efficacy.

One need not look any further than relative rates of bankruptcy to see how the implications of Canada’s healthcare system are misinterpreted. The total number of consumer bankruptcies in Canada in 2007 was 79,796 out of a government-estimated population of 32,929,700.^{19 2021} In contrast, the number of consumer bankruptcies in the U.S. in 2006 was 617,660 out of a government-estimated population of 299,398,484.^{22 23} This puts the rate of consumer bankruptcies in Canada at 242 for every 100,000 of

18. *Id.* s. 12(a).

19. Office of the Superintendent of Bankruptcy Canada, *Annual Statistical Report for the 2007 Calendar Year – Tables 1 to 5*, OSB.IC.GC.CA (last modified: Jan. 1, 2012), <http://www.ic.gc.ca/eic/site/bsf-osb.nsf/eng/br01779.html#table2>.

20. Statistics Canada, *Population by Year, by Province and Territory*, WWW.STATCAN.GC.CA (last modified: Sep. 28, 2011), <http://www40.statcan.gc.ca/101/cst01/demo02a-eng.htm>.

21. Note that I have chosen to compare 2007 Canadian bankruptcy statistics to 2006 U.S. bankruptcy statistics. The reason for this comparison is that in 2007, the U.S. experienced a dramatic increase in consumer bankruptcies of approximately 35%, whereas Canada experienced a relatively minor increase in bankruptcies in 2008 of approximately 12% prior to which they had been relatively constant. I chose to compare the two most recent years for which there was little presumed statistical noise due to the global economic crisis.

22. U.S. Federal Courts, *Bankruptcy Cases Commenced, Terminated, and Pending during the Twelve Month Periods Ended Dec. 31, 2006 and 2007*, WWW.USCOURTS.GOV, http://www.uscourts.gov/uscourts/Statistics/BankruptcyStatistics/BankruptcyFilings/2007/1207_f.pdf.

23. U.S. Census Bureau, *Table 1: Annual Estimates of the Population for the United States, Regions, and States and for Puerto Rico: April 1, 2000 to July 1, 2006*, CENSUS.GOV, http://www.census.gov/popest/data/historical/2000s/vintage_2006/index.html.

population, versus 206 out of every 100,000 of population in the U.S. Unfortunately, due to both a limited amount of reliable historical data regarding bankruptcy rates and the gradual nature of Canada's introduction of universal coverage, an analysis of Canadian bankruptcy rates pre- and post-their enactment of universal health coverage is not feasible. A study published in *The American Journal of Medicine*, however, seems to buck the conventional wisdom on the relationship between increasing healthcare coverage and a subsequent decrease in the bankruptcy rate, finding that consumer bankruptcy rates in Massachusetts were not greatly affected by the enactment of universal healthcare there in 2006.²⁴ The relative rates of bankruptcy in the U.S. and Canada, coupled with the analysis of bankruptcy data in Massachusetts calls into question the notion that should universal health care be enacted, we would see a different bankruptcy picture.

Of course, the conclusion outlined above appears to be perplexing. It seems a reasonable assumption that in a system with universal government-provided coverage where there are no other obvious anomalies, the rate of bankruptcy would be lower than in a more market-based system where many individuals are priced out of the insurance market entirely. However, when you look at just a small sampling of private administrative actions for health care reimbursement in Canada, a problem becomes clear. Although the general populace seems to be in relatively good health in Canada, with a 2009 average life expectancy of eighty-one years compared to seventy-eight years in the U.S.,²⁵ those who become exceptionally ill, requiring treatment outside of Canada, appear to be at a unique financial disadvantage. In part, these instances of financial catastrophe are the result of the limits of the

24. David U. Himmelstein et al., *Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?*, 124 AM. J. MED. 224, 224 (2011).

25. The World Bank, *Life Expectancy at Birth, Total (Years)*, WWW.WORLDBANK.ORG, <http://data.worldbank.org/indicator/SP.DYN.LE00.IN>.

portability requirement of the Canada Health Act.²⁶ Particularly, the portability requirement for medical care sought outside of Canada is explicitly set up to respect provincial legislation requiring pre-approval for such care.²⁷ I will examine the problematic administration of the portability requirement through a few decisions of the Health Services Appeal and Review Board of Canada's most populous province, Ontario.

III. CASE STUDIES

The case of *S.A. v. The General Manager, Ontario Health Insurance Plan*, is a clear demonstration of the potential personal financial and health dangers of the way Ontario's portability requirement is administered for those with serious medical conditions who require treatment outside of Canada.²⁸ Ms. A, a colorectal cancer patient at the Juravinski Cancer Centre in Ontario (Juravinski), was advised by her Canadian oncologist (Dr. Major) in October 2005 that her cancer had metastasized and that she should start treatment with Erbitux (cetuximab).²⁹ Dr. Major recommended that Ms. A receive infusions of Erbitux in the U.S., because although Erbitux could have been purchased in Ontario, Juravinski would not pay for her infusions.³⁰ Under Ontario's healthcare regulation, outpatient visits solely for the administration of "drugs, vaccines, sera or biological products" would not be covered by the Ontario Health Insurance Plan (OHIP).³¹

Ms. A filed an application with OHIP for pre-approval of payment for

26. Canada Health Act, R.S.C. 1985, c. C-6, s. 11 (Can).

27. *Id.*

28. *S.A. v. Ontario (Health Insurance Plan)*, 2006 CanLII 79506 (ON HSARB) (Can. Ont.), available at <http://www.canlii.org/eliisa/highlight.do?text=denial&language=en&searchTitle=Ontario++Health+Services+Appeal+And+Review+Board&path=/en/on/onhsarb/doc/2006/2006canlii79506/2006canlii79506.html>.

29. *Id.* at 3.

30. *Id.*

31. See Health Insurance Act, R.R.O. 1990, Reg. 552 /8(1)(5)(iv) (Can.), available at http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_ev002.htm#BK5.

out of country care in the U.S at the “private infusion clinic” of Dr. Isosceles Garbes (Dr. Garbes) in West Seneca, New York.³² Her application was denied.³³ The reasons for denial were (1) that Erbitux treatment was still considered experimental and (2) that Erbitux treatment was available in Ontario, although not as a covered service under OHIP.³⁴ It is important to note that Erbitux was approved to treat advanced colorectal cancer in the U.S. in early 2004, nearly two years prior to Ms. A’s application for payment.³⁵

Ms. A began treatment at Dr. Garbes’ clinic at a cost of U.S. \$14,000 out-of-pocket per month, at the same time commencing her appeal of the OHIP decision to deny coverage.³⁶ After a little over a month, she was allowed to receive Erbitux at Juravinski under a Canadian federal Special Access Programme at a cost to her of U.S. \$8,000 a month.³⁷ After three months of care at Juravinski under the Special Access Programme, she filed another application with OHIP for pre-approval of out of country care, this time for treatment at the Roswell Park Cancer Center in Buffalo, New York.³⁸ Her application was approved, and she received Erbitux treatment at the Roswell Park Cancer Center completely covered by OHIP.³⁹ At this point, she had incurred around U.S. \$30,000 in out-of-pocket costs for the administration of life-saving Erbitux treatment.⁴⁰

The appellate panel affirmed OHIP’s denial of coverage for Ms. A’s

32. S.A., CanLII 79506 (ON HSARB) at 3.

33. *Id.*

34. *Id.*

35. F.D.A. News Release, FDA Approves Erbitux for Colorectal Cancer (Feb. 12, 2004), available at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2004/ucm108244.htm>.

36. S.A., CanLII 79506 (ON HSARB) at 3.

37. *Id.*

38. *Id.*

39. *Id.*

40. *See id.*

Erbix treatment at Dr. Garbes' private clinic.⁴¹ The regulation governing medical services outside Canada require that the services be performed at a hospital or health facility as defined by statute and that the services be generally accepted in Ontario and either be not available in Ontario or requiring travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.⁴² Interestingly, however, the appellate panel's denial of coverage for Ms. A's treatment was on the grounds that Dr. Garbes' office did not satisfy the statutory definition of "health facility."⁴³ The definition required that the facility be licensed, and, although Dr. Garbes was a fully licensed physician, his private clinic was not separately licensed.⁴⁴ The fact that Dr. Garbes' office's licensure was at issue in the case was not disclosed to Ms. A until after she had accumulated over \$14,000 in medical bills there.⁴⁵ The appellate panel, however, did not view OHIP's failure to disclose the true reason for denial of payment as relevant and consequently, affirmed OHIP's decision to deny coverage of Ms. A's treatment at Dr. Garbes' offices.⁴⁶

Additionally, with little fanfare, the appellate board denied coverage for the more than \$20,000 in Erbix treatment provided to Ms. A at Juravinski under the Special Access Programme.⁴⁷ The grounds for this denial were that Section 8(1)(5)(iv) of Regulation 552 of Ontario prohibits payment for medical visits that are solely for the administration of "drugs, vaccines, sera or biological products."⁴⁸ It is not at all clear in the record, how, given this regulation, Canada's healthcare system might cover such care outside of the

41. *Id.* at 8.

42. *Id.* at 4.

43. *Id.* at 7

44. *Id.*

45. *See id.* at 6.

46. *Id.* at 7.

47. *Id.* at 8.

48. *Id.*

inpatient hospital context.

The purpose of the aforementioned appellate tribunal decision is not to provide a reader with anything approaching a comprehensive view of Ontario's problems with the portability requirement. Rather, the account above is intended to illuminate something that distinguishes the Canadian from the U.S. system. Specifically, it is the dangerous effect of coverage decisions being administrative decisions that are in many ways akin to those that the Internal Revenue Service in the United States makes on a daily basis.⁴⁹ In this decision, the Ontario Health Services Appeal and Review Board denied coverage for care that Ms. A received in Canada under a Special Access Programme, all while Ms. A was receiving identical care covered by OHIP outside of Canada at a Buffalo, NY cancer center all at a higher cost to OHIP.⁵⁰ Any attempts to reconcile the Board's decision to deny reimbursement for past care with the fact of Ms. A's continued coverage for the same medical services out of country defies logic.

Even in cases where the appellate panel eventually ordered OHIP to reimburse patients for out-of-country medical care, the process is not without its own particular hardships, both financial and otherwise. One example of this is the case of *D.L. v. The General Manager, The Ontario Health Insurance Plan*.⁵¹ In this appeal, Mr. L was contesting a denial of coverage to seek orthopedic surgery at a facility in Lake Worth, Florida for

49. The mechanism for opposing out of country coverage in Ontario works similarly to the Internal Revenue Code's anti-injunction provisions. That is, the party seeking coverage for out of country care must formally be denied coverage. Then, after being denied coverage and paying out of pocket for service, the patient must then initiate litigation to recover money already expended. This is analogous to the U.S. taxpayer first having to pay a tax and then suing to seek reimbursement only after the government makes a determination as to the applicability of the tax. *See* 26 U.S.C. § 7421(a) (2006).

50. *S.A.*, CanLII 79506 (ON HSARB) at 3.

51. *D.L. v. Ontario (Health Insurance Plan)* 2006 CanLII 79436 (ON HSARB) (Can. Ont.), available at <http://www.canlii.org/eliisa/highlight.do?text=denial&language=en&searchTitle=Ontario+-+Health+Services+Appeal+And+Review+Board&path=/en/on/onhsarb/doc/2006/2006canlii79436/2006canlii79436.html>.

a severe injury to his left shoulder.⁵² After visiting his primary care physician, Mr. L waited three months to see a specialist, who was ultimately unable to perform the necessary surgery.⁵³ Mr. L waited an additional three months to see another specialist, who then advised him that it would be approximately one and a half to two years before he could perform the surgery.⁵⁴ Because of extreme pain that was preventing him from performing his job, Mr. L sought and received surgery almost immediately in the U.S.⁵⁵ Payment for this surgery was initially denied by OHIP on the grounds that the treatment was available in Ontario, although approximately two years later the Appeal and Review Board reversed and ordered OHIP to reimburse Mr. L.⁵⁶ It is easy to see how a system that often necessitates long drawn out procedures for reimbursement of medical care can lead to substantial financial burden, even when it is functioning properly.

Despite constitutional challenges to the PPACA pending,⁵⁷ it is still salient to examine how we might adapt our healthcare system in a way that optimally responds to complex health conditions and does not put personal healthcare and financial needs at odds with one another. It seems clear that a Canadian style single payer system as it exists is a less than ideal solution. Specifically, Americans have reason to fret over a system such as Canada's that allows provinces to be making highly technocratic decisions about what healthcare does and does not get paid for. The cases highlighted elucidate why we probably should not strive to a future where the payment of substantial healthcare bills depend on strict definitions of phrases such as

52. *Id.* at 2.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 5.

57. *See supra* p. 1 and note 1.

“health facility.”⁵⁸

IV. CONCLUSION

Although the piecemeal system of American healthcare is far from perfect, with respect to the most critically ill, Canada’s system presents a bleak alternative. Claims during the U.S. healthcare debate that a socialized system will lead to death panels are of course ill founded and overstated.⁵⁹ Nevertheless, Canada’s system presents a legitimate fear that when the government finances healthcare, it is often ill equipped to make coverage decisions and pay for the treatment of serious and life-threatening maladies when more immediate care is needed than the system can normally provide. Where a patient is unable to finance their own treatment, this reality may leave patients with few good options. In a system that in some cases requires its sickest to finance their own care, it is not hard to see how bankruptcy and the foregoing of available, but costly, out-of-pocket remedies might pose a significant threat.

58. See *S.A.*, CanLII 79506 (ON HSARB) *supra* note 28 at 7.

59. Jim Rutenberg & Jackie Calmes, *False ‘Death Panel’ Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 14, 2009, available at <http://www.nytimes.com/2009/08/14/health/policy/14panel.html?pagewanted=print>.