

Travelling for Healthcare from Canada: An Overview of Out-of-Country Care Funded by Provincial/Territorial Health Insurance Plans

Vivien Runnels and Corinne Packer

INTRODUCTION

Many countries have seen fit to make healthcare arrangements for their citizens when, for a variety of reasons, domestic healthcare is unable to provide the medical treatments or interventions required. In some cases, these arrangements are made within country, but outside the patient's province or territory. Many cross-border patients are treated in hospitals located close to provincial borders. For example, residents of the Mamawetan Churchill River region in the province of Saskatchewan receive services at Flin Flon Hospital in the neighbouring province of Manitoba (CIHI, 2010). In other cases, patients are sent out of country for the medical care they need. Sometimes patients explore medical care out of country and afterwards seek reimbursement of costs (Xuereb, 2011). In Canada, which is a federation of provinces and territories where the majority of healthcare is publicly insured, all provinces and territories currently have provisions in their health insurance plans to facilitate and cover the cost of both out-of-province/territory and out-of-country care (OOCC). These provisions offer the possibility of alternative or additional healthcare options outside the home province.

As Canadians look to have their health needs met in a timely fashion, we have seen evidence of increasing pressure from physicians, patients and healthcare advocates to provide funding for cross-border care, whether it is for out-of-province care, or for OOCC.¹ The media is

increasingly dotted with reports of patients seeking medical treatment abroad on their own initiative and at their own cost (i.e., as medical tourists). But so, too, are there increasing reports of individuals hoping for facilitation and payment of their health services abroad through public health insurance plans. Evidence of this growing trend can be found in the number of requests and appeals made directly to ministries of health that organize OOCC, to the quasi-judicial appeal boards which hear the appeals of patients whose cases have not been approved or resolved to their satisfaction, and in the number of cases that have been investigated by provincial ombudsmen or reviewed by the courts.² In the case of cross-provincial border care, there is some publicly available documentation and a compilation of data by the Canadian Institute of Health Information recording the transfers of funds and the costs of services (CIHI, 2010). However, data with regards to funded OOCC are not currently available publicly.

In this chapter, we examine OOCC funded by Canadian provincial/territorial health insurance plans. For the purpose of this review, we have defined OOCC as care funded by provincial/territorial health insurance plans where patients physically travel or are transported to a location in another country for the purpose of medical treatment. We consider some challenges to the current system of OOCC which include: increasing knowledge of, and demand for, OOCC; associated increases in costs to meet demand; challenges associated with the application of legislation and guidelines; and, the role of the media, particularly the Internet. We also suggest some potential research questions on OOCC and provide reasons for taking a broader look at the health equity and economies of scale trade. We suggest some general implications of cross-border and OOCC for a country which has a publicly-funded healthcare system.

TRAVELLING FOR HEALTHCARE

Travelling for care deviates from 'close to home' care one would traditionally expect from healthcare systems. For urban populations in particular, 'close to home' care means ready access, time savings, and minimal disruption to personal lives. In rural and northern areas of Canada, healthcare (such as for childbirth), is not always close to home, and travel can be onerous as well as socially and personally disruptive (PHAC, 2009). However, the value of 'close to home' whilst becoming increasingly realizable in rural and remote areas (NorthWest LHIN, 2009), differs from well-entrenched images of patients accessing care in doctors' offices, clinics, and hospitals. Telemedicine, where care 'travels' to the patients through information technologies, has become a preferred option in some cases to expensive, long distance travel. In Canada, telemedicine has improved access to healthcare, reduced patient waiting times, and allowed patients to save money (NorthWest LHIN, 2009).³ However, despite these changes, and in contrast to 'close to home' care, cross-border care requires (often long distance) travel away from home, the travelling always being done by the patient.

Not all patients are able, or keen, to travel for healthcare. Additionally, travelling with a medical condition has disadvantages that include increased patient stress, and, for some countries, reductions in hospital revenues. It also raises a number of associated legal and ethical concerns (Boyd, McGrath, & Maa, 2011). Some evidence infers that for some treatments the further residents live from healthcare facilities, the less likely they are to access post-operative care. In fact, doctors' selections of certain types of healthcare may even be impacted by their assessment of distance to facilities or care for patients (Athas, Adams-Cameron, Hunt, Amir-Fazli, & Key, 2000). If medical care can be matched domestically, people and their governments

would prefer to receive and deliver treatments close to home (Boyd, McGrath, & Maa, 2011; Atwater, 2008). However, costs of treatment and timeliness of care also come into play.

CANADA'S PUBLICLY FUNDED CROSS-BORDER CARE

Legislative context

Canada is a federated country with ten provinces and three territories. The Canadian healthcare system is guided by the Canada Health Act of 1984. This Act sets out the principles of the Canadian health care system, and outlines the terms of agreement of the federal government with the provincial and territorial governments with regard to transfers of funding for the payment of healthcare. Healthcare is delivered and administered for the most part by the provinces. The federal government has certain responsibilities with regard to the provision of healthcare, but these are largely limited. The provinces are not required to provide services that are not listed in the Canada Health Act. An important feature of the Canadian healthcare system as a whole is that it is publicly-funded, and has a single payer (a province or territory). In 2011, of the approximately CAN\$200.5 billion estimated to be spent on healthcare, around 70% of this is expected to come from the public sector: 65.3% was expected to come from provincial/territorial governments (this figure includes federal transfer payments⁴), 3.5% for federal government direct health care services, 0.4% from municipal governments⁵ and 1.3% from social security funds (CIHI, 2011).⁶ The Canada Health Act builds on five main principles: public administration; comprehensiveness; universality; portability; and, accessibility. The principle of accessibility (Section 12.1) is fundamental to publicly-funded cross-border care in that provincial healthcare insurance plans are obligated to provide for insured health services on

uniform terms and conditions such that insured persons have reasonable access to healthcare, and provide payment for all insured health services.

Provisions and processes for OOCC

In keeping with the requirements of the Canada Health Act, all of Canada's provincial and territorial healthcare plans provide for reimbursement of costs for health services obtained by a patient out of country in emergency situations, but only at the rates that the provinces have established for in-province care, and on a time-limited basis. Plans typically provide coverage for emergency medical treatment of Canadians for up to three months if they find themselves outside of their province. A patient on vacation or on business outside of Canada who requires emergency treatment may therefore only receive what amounts to partial reimbursement of the total costs, depending on healthcare costs in the destination country. The provinces and territories therefore encourage all travelers to take out additional personal health insurance.⁷ In these cases, travel by an individual is voluntary and not undertaken for health purposes, but healthcare plans acknowledge that Canadians may become sick or injured whilst outside the country and that the potential patient is not abandoned on leaving the country, nor denied ongoing care on return. But, this form of insurance coverage, which is limited to money transfers (usually directly to the patient), contrasts with another form of coverage, which is the focus of this chapter. In this different form of OOCC, patients are *sent* abroad by provincial/territorial healthcare plans for specialized healthcare services or treatments which are pre-approved, pre-arranged and paid for by provincial (or territorial) ministries of health.

Depending on the patient's specific situation and the province/territory, some or all of the costs of OOCC will be covered under provincial/territorial health insurance plans, determined by

a process designed to ascertain that the patient meets the conditions for OOCC. These criteria for eligibility are generally similar in all provinces and territories, and are as follows:

- the treatment or care must be medically required;
- the medical or hospital service must be demonstrated to be unavailable in the province/territory and/or elsewhere in Canada; that is, “if all Canadian medical resources have been exhausted”(Manitoba Health, 2011a);
- the delay in the provision of medical care available in the province/territory or elsewhere in Canada must be considered to be immediately life threatening or may result in medically significant irreversible tissue damage;
- the treatment must fall under insured medical, oral surgeries and/or hospital services; and,
- the applicant must be a resident of the province/territory (BCMSP, 2011).

The interpretation of these eligibility criteria is somewhat problematic. For example, what is meant by ‘medically required?’ What is understood by ‘delay?’ Flood, for example, has identified “the determination of what constitutes a sufficiently serious delay to merit seeking out-of-country healthcare services” as a major quandary for out-of-country health services. (Flood, 2004:3)

Some variations or additions to these general conditions occur. For example, Prince Edward Island (PEI) which is a small province, permits patients to apply for care if only one specialist practices in the province, although prior approval to go out-of-country must still be obtained from the Medical Director (Health PEI, 2011). Understandably, small provinces may find it hard to justify certain investments in health human resources or laboratories because of their small population base, whilst the same investments are deemed financially reasonable in the more

populated provinces. Additionally, some provinces will cover some costs that are not covered by others. For example, Manitoba makes it known that it is “only one of a few provinces in Canada that offers assistance to help cover transportation costs” that are related to receiving medical care outside the province (Manitoba Health, 2011b). Transportation and accommodation costs (outside of a hospital) are typically not covered by provincial/territorial health insurance plans.

In order to receive medical care out of country through provincial/territorial insurance plans, specific procedures need to be followed in order to determine eligibility. In the case of the Ontario OOCC Prior Approval Program, a family physician (general practitioner) must take the first steps towards determining need with the patient. The family physician initiates the request for approval, and is required to refer a patient to a specialist physician or an assessment centre within Ontario for assessment. Only after the specialist physician has seen the patient and judged that the care needed cannot be obtained within the province does the specialist write an application for funding for out-of-country health services to the provincial health authority. The referring physician and a specialist must both complete and sign the application form, along with the patient or his/her representative who has power of attorney. The form must be accompanied by relevant documentation, such as clinical reports and lab test results (Ontario Ministry of Health and Long Term Care, 2011a; Ontario Ministry of Health and Long Term Care, 2011b).

Information must be provided on the case and explanations given as to why OOCC is needed. The Ministry of Health reviews the application, and must approve it before treatment is obtained abroad, otherwise costs will not be reimbursed. In other words, not only must eligibility be established, but a patient must be pre-approved for OOCC by the provincial ministry of health if the costs of the healthcare are to be borne by the province. This process adds to the waiting time as the patient waits to be seen by a specialist who may refer the patient to yet another

specialist within the province who is either able to offer the treatment or surgery or will recommend OOCC.

Health services and treatments which have been approved by out-of-country prior approval programs in different provinces and territories have included cancer treatment, diagnostic testing, high-risk bariatric surgery, residential treatment (such as for psychiatric disorders, eating disorders or substance abuse), neurosurgery, spinal surgery, and pregnancy complications.

APPEALING THE DECISIONS OF HEALTH MINISTRIES

Many applications for OOCC are not approved because they do not meet the requirements of the legislation as interpreted by the provincial/territorial ministries of health. Patients have options to appeal their ministry's non-approval decisions. In Ontario, patients may appeal directly to the Ministry as well as to the province's Health Services Appeal and Review Board (HSARB), which is an independent quasi-judicial tribunal. Board members of this tribunal who serve on a part-time basis are appointed by the Lieutenant Governor-in-Council and include healthcare providers, lawyers, social workers, and business people. Appeal proceedings are public, and members of the public can have access to information on these unless the Board orders otherwise. The decisions of the Board are posted to the Canadian Legal Information Institute (CanLII).⁸

Undergoing an appeal can be difficult and painful for patients seeking treatment (Priest, 2009). The urgent nature of some cases may mean that any delay in subsequent approval of treatments can adversely impact patients' opportunities for treatment; for example, they may no

longer be eligible for clinical trials, or infections may prevent them from travelling or being accepted for care in some locations. For example, Valerie Niles, who successfully appealed for funding, was subsequently rendered ineligible for OCCC because of a complication that developed after the appeal was granted. Susan Caiger-Watson was also denied care and successfully appealed the decision but, like Valerie Niles, was also affected by a complication (Priest, 2009).

Outside of appeals to ministries of health and associated review boards and the courts, a number of provinces have independent officers (ombudsmen) who investigate the public's complaints about government services.⁹ The role of the ombudsman extends in part to determining fairness and equity, with regards to access to healthcare. In Ontario, for instance, the Ombudsman investigated a case where a patient (Suzanne Aucoin) complained about not being approved for treatment. The Ombudsman found in favour of Ms. Aucoin, stating that she had been wrongfully denied approval for OCCC (Marin, 2007). This case prompted an external review of the program by the MOHLTC and Ms. Aucoin was able to receive OCCC coverage (Lindberg & Risk, 2007). In 2009, a number of complaints received by the Ombudsman in Alberta prompted him to embark on an investigation into out of country health services. The Ombudsman found that appeals to the Out-of-country Health Services Appeal Panel of Alberta were administratively unfair, prompting a number of recommendations (Button, 2009).

OCCC AND WAITING LISTS

Some appeals for reimbursement for OCCC have been brought on the basis of lengthy waiting lists leaving patients with no choice but to personally take steps and acquire healthcare

outside of Canada. However, OOCC was not designed specifically as a response to relieve a healthcare system's waiting lists, but to be responsive to an individual's healthcare needs in keeping with the legislation. According to most provincial and territorial health insurance plans, eligibility for OOCC is determined on the basis of a high level of urgency, particularly when a person is affected by a condition identified as 'immediately life threatening or [that] may result in medically significant irreversible tissue damage.' However, in certain cases, OOCC has been used as a technique to manage waiting lists. In 1991, for example, the Ministry of Health in British Columbia authorized coronary artery bypass surgeries in Seattle, Washington hospitals to relieve waiting lists (Katz, Migala, Welch, 1991; Katz, Cardiff et al, 2010). Other examples of groups of patients being sent out of Canada because of waiting lists have included breast cancer patients (Dayes et al, 2006).

Provincial ministries of health and other parts of the healthcare system, including hospital departments, have taken steps in many cases to reduce patient time spent on waiting lists and to reduce the size of waiting lists by prioritizing urgent and non-urgent issues, increasing infrastructure and generally introducing efficiencies such as centralized booking.¹⁰ However, the questions remain as to how long must a patient wait, and how long is too long (Fogarty, 2008)?

Further, the issue of wait times has become a matter for judicial review, in which plaintiffs seek accountability for healthcare, including timely access to care, through the Canadian Charter of Rights and Freedoms (with the exception of Quebec which applies its own Charter of Rights and Freedoms).¹¹¹² The 2005 Supreme Court of Canada's landmark Chaoulli decision¹³ has opened the door for lawsuits on the basis that a "lack of timely care may nevertheless infringe a patient's right to life and security for the person" (Georgas & Shap, 2006, 14). While the reasons for bringing forth challenges at this level of the judiciary are

understandable, it is not ideal. As Jackman (citing Sheldrick) notes, “leveraging access through the courts is costly and time consuming” (Jackman, 2010). According to Jackman, “there is judicial reluctance to seriously engage with rationing of publicly funded health care services – the reasons why or the ways in which decisions are made – as a *Charter* issue”(Jackman, 2010 p.4).¹⁴ ¹⁵ From the perspective of an ill individual who needs treatment without delay, pursuing access through the courts is not an attractive option to obtain care either. Regardless of court activity and Charter challenges, media reports continue to suggest that any wait times for treatment are a driver of patients’ applications for OOCC, whether or not wait times meet benchmarks for medically acceptable wait times for treatment. Advertisements for medical centres or treatments may prey on this uncertainty and fear, and easy-to-access hospitals and clinics on the US/Canada border also prove attractive to anxious patients (Health Council of Canada, 2011).¹⁶

CROSS-BORDER CARE AS A LENS ON GAPS IN THE CURRENT HEALTH CARE SYSTEM

Demand for particular types of cross-border care can act as a lens on the current health care system. For example, in Ontario, bariatric surgery is a comparatively recent specialty that is becoming more widely available to patients. However, morbid obesity was becoming a significant health problem prior to 2009, when the Ontario MOHLTC made a commitment towards developing a Bariatric Registry and Bariatric Centres of Excellence. According to the Bariatric Registry project website¹⁷ these Centres will reportedly increase capacity by over 750%, although no actual numbers are listed alongside these percentages. While waiting for the

Centres to be created, bariatric surgery still remains listed as an out-of-country service, and preferred providers in the US are indicated.¹⁸ But, Ontario's response to the high demand for bariatric surgery may be a demonstration that trends in requests for OOC are used as an indicator of needed treatment or surgery in Canada, as well as a practical response to an increasing demand that could be justified through economies of scale. Analysis of the reasons why approval requests for OOC are made may indeed provide useful information for system planners and administrators of increasing trends in illness and/or growing demands to address health problems, keeping in mind that they may also be a reflection or result of policy decisions not to provide certain treatments in-country.

There are a number of issues with regards to ethics and the law that regulate access to new treatments in Canada (Somerville, 1999). However, the rapid availability of new information through the Internet and its associated technologies, have complicated these discussions. Groups of patients and their supporters who acquire knowledge of promising new technologies and surgeries that are being utilized outside of Canada may apply pressure to ministries of health and regulatory bodies such as Health Canada to offer these procedures in Canada or, at a minimum, to open up access to these technologies through OOC programs. For example, in 2010, Dr. Paolo Zamboni's 'discovery' of CCSVI in patients with MS and its treatment through endovascular surgery, along with positive preliminary results of a study indicating a decrease in MS patients' symptoms, led to the procedure being encouragingly dubbed 'liberation therapy.' This led to a movement of Canadian MS patients to countries such as the US and India that offer the surgery, which has not been approved and thus remains unavailable in Canada (CTV.ca News Staff, 2009; Centre of Excellence for CCSVI Testing, 2011). In this example, knowledge of new treatments through the media and Internet has led

patients and their families to form their own ideas of what they think they need to address their health issues. Public knowledge of enrollments in clinical trials, and participation in experimental treatments available outside the country, accompanied by anecdotal reports of improvements, has arguably influenced if not accelerated discussions of the science of such treatments, and has influenced decisions to fund research in these areas.¹⁹

From a different perspective, as a source of health care information the OOCC Prior Approval Program provides something other than filling a gap in health care services. According to the Ontario MOHLTC, physicians and patients often do not have information about services available in Ontario. Applications for Prior Approval Program are thus often resolved with information from the Ministry of the location within Ontario of the healthcare service sought.²⁰ The OOCC Program thus oddly fills a gap in critical information on healthcare services available within the province, which preferably should be accessible by other, less time-consuming means.

As well as being described as a “generous program that serves a diversity of needs and provides a range of health care services to Ontarians seeking access to treatment outside the province” (Lindberg & Risk, 2007), implying that the Ontario MOHLTC may be doing more than is strictly required by the law, OOCC has also been described as a ‘safety valve.’²¹ Although ‘safety valve’ and its purposes are not defined by the MOHLTC, it suggests that OOCC can be used to address those gaps that surface for individual cases, but also for identifying and resolving health system problems more broadly. Indeed, this has been recognized outside of Canada by critics of Canada’s single payer health system (Priest, 2009).²² However, in providing a ‘safety valve,’ OOCC may divert attention from the provision of access to new treatments in Canada, and the building of new capacity to deliver these treatments, new

treatments that may not be available neither in the patient's home province, nor in Canada as a whole.

QUESTIONS OF COST, HEALTH EQUITY AND A NEED FOR FURTHER RESEARCH

To this point, we have focused on the content and processes associated with OOCC, but additional questions regarding the costs of care need to be posed. Does the Canadian healthcare system provide the conditions for treating Canadians in the most cost-effective way? Or, conversely, does cross-border care lead to a distortion of the allocation of healthcare resources? Is out-of-country/cross border care a cost *driver* or a cost *saver* for the Canadian health system? The costs of administering and providing care in the US, which is the primary location for Canadian OOCC, is more expensive than in Canada (Woolhandler et al, 2011). However, OOCC is not currently viewed as a major cost driver for Canada's public healthcare system. According to the Canadian Institute for Health Information (CIHI), the "biggest cost increases in the system are spending on new drugs, medical technology, medical imaging, costly interventions and community services" (2010). None of these 'cost drivers' or 'cost escalators' specifically includes spending on cross-border care, which is sufficiently small that it is included in the 'other' category of health expenditures (Conference Board of Canada, 2004). However, a report by the Canadian Health Services and Research Foundation (CHSRF) noted that "a substantial proportion of observed healthcare expenditure growth remains unmeasured" and information on cost drivers, referring to factors that drive healthcare expenditures, is limited (Constant et al, 2011). New technologies that are not available in Canada, for example, may lead to increased use

of OOCC and increased costs. The CHSRF report, however, does not discuss any up- or down-sides of the use of hospital arrangements out of country.

Does medical travel, even when it is paid for by public plans, genuinely offer positive opportunities and overall benefits for health systems in either or both sending and receiving countries? We suggest there are ways to approach this question, but until the research is conducted, answers are merely speculative. One way relates to an economic evaluation of OOCC. When rare surgeries can be organized with skilled surgeons and the necessary equipment outside of Canada, does it make economic sense to develop rarely used capacity to perform the same surgeries at a high cost in Canada?²³ In a recent media report, the Ontario Minister of Health, Deb Matthews, addressed this point, noting that for rare cases and for cases in which Canadian doctors are ‘not competent,’ OOCC provides an answer for the treatment of rare and uncommon diseases or surgery. It can also facilitate diagnostic tests and rare or unusual pharmaceutical treatments that are not available in Canada (Light, Lexchin, 2005).²⁴ Canada’s comparatively small provincial and territorial populations and subsequent limitations on provincially covered services and pharmaceuticals means it is more cost-effective to occasionally send citizens to New York State to obtain rare surgical care or the drug *Avastin* (Marin, 2009). Other routes for out-of-country treatment include enrolment in experimental surgeries or other forms of clinical trials.

BEYOND THE MOVEMENT OF PATIENTS: CONCLUSIONS

To understand the direct and indirect effects of publicly funded cross-border healthcare requires further research and understanding of the challenges to the current system of OOCC.

These include an increasing public knowledge and demand for new technologies and procedures, and the associated costs of meeting such a demand; the role of the media, appeal processes and legal challenges associated with the application of the legislation and guidelines, and other related laws and policies; and the familiarity of patients, their doctors and consultant specialists with cross-border provisions and agreements. Although travel by patients in the physical sense for some procedures may become a thing of the past, as long as the Canadian healthcare system plays catch-up with new technologies or procedures, or new technologies are so new that Canadians can only access them through clinical trials or experimental treatments elsewhere, and as long as waiting lists for certain procedures remain extensive, OOCC will likely still be needed as a ‘safety valve’. Canadians, who have a publicly funded healthcare system, will continue to need certain types of care, and will likely demand and expect more of their healthcare system in the face of new technologies. They will also continue to test the extent of the state’s responsibility for the public provision of healthcare. As a consequence, OOCC programs will likely be tested to their budgetary and conceptual limits.

¹ See, for example, a public petition entitled “Patient battling OHIP over surgery” retrieved December 1, 2012 from <http://humanrights4u.com/Hajinian>.

² See, for example Ontario Superior Court of Justice. Divisional Court. Lederman, Swinton and Baltman JJ. Court File No.: 367/07, 599/06 and 620/07. Date 20090112. Retrieved December 1, 2012 from http://www.hsarb.on.ca/english/docs/legal/CCW_JFT.pdf.

³ Bryan Meadows, for example, reports that “the use of telemedicine in the North West LHIN (a health authority in Northern Ontario) resulted in more than \$9 million in avoided travel costs, and more than 23 million kilometres in avoided patient travel.” This information can be found in the article, “Investments help keep health care close to home” from The Chronicle Journal,

March 12, 2011. This article was retrieved December 1, 2012 from

<http://www.chroniclejournal.com/content/news/local/2011/03/12/investments-help-keep-health-care-close-home>.

⁴ It is noted that national health expenditures are reported based on which jurisdiction holds responsibility for payment, not on the source of the funds, with the exception of designated health transfers to municipal governments which are included in the provincial government sector. See Canadian Institute for Health Information, 2011.

⁵ The municipal government sector expenditure includes healthcare spending by municipal governments for institutional services; public health; capital construction and equipment; and dental services provided by municipalities in the provinces of Nova Scotia, Manitoba and British Columbia (CIHI, 2011, p. 77 and p.95).

⁶ Social security funds include the healthcare spending by workers' compensation boards, and other funds such as the premiums paid by the subscribers of the Quebec Drug Insurance Fund (CIHI, 2011, p. 77).

⁷ It should be noted that the purchase of private insurance does not guarantee that the payment of costs are covered. See, for example the article, "Retired couple billed \$50,000 despite travel insurance" from CBC news on November 16, 2011. This article can be found at <http://ca.news.yahoo.com/retired-couple-billed-50-000-despite-travel-insurance-133857063.html>.

⁸ For example, see <http://www.canlii.com/en/index.php>.

⁹ See for example, the Ontario Ombudsman at <http://www.ombudsman.on.ca/Home.aspx>. Accessed September 12, 2011.

¹⁰ See for example, Kielar et al. 2010.

¹¹ See for example, *Cilinger c. Quebec (P.G.)* [2004] and *R. v. Morgentaler* (1988) Both cited in Jackman, M. (2010).

¹² Reference to the Canadian Charter of Rights and Freedoms Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c.11 [Charter].

¹³ *Chaouilli v. Quebec (Attorney General)* [2005] SCC 35 [“Chaouilli”].

¹⁴ Jackman also noted that the Ontario Court of Appeal upheld the trial court’s conclusion that lack of OHIP funding for all out-of-country medical treatments did not violate section 7 of the *Charter*.

¹⁵ Outside of Canada, plaintiffs may pursue reimbursements through other laws, for example, in Europe, any resident (in Malta) is entitled to receive medical treatment in any EU member state at the expense of the Maltese Government (Xuerab, 2011).

¹⁶ For example, through an organization called VIP Docs Inc., which has a Burlington, Ontario address, a Canadian patient can book an MRI or CAT scan at the Buffalo General Hospital, as well as advertising cross-border Canadian referrals to U.S. physicians for scans, assessments, surgery and treatments. The articles were accessed December 1, 2012 at <http://www.buffalo-mri-cat-scans.com/> and <http://www.vipdocs.com/request.htm>.

¹⁷ See website <http://www.bariatricregistry.ca/>.

¹⁸ For the Ministry of Health and Long Term Care website, see here http://www.health.gov.on.ca/english/providers/program/ohip/outofcountry/us_preferred_providers/bariatric_services.html.

¹⁹ See for example Health Canada (2011) Statement by Minister Aglukkaq on CCSVI and MS. June 29, 2011 Ottawa, Ontario Accessed from http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2011/2011_87-eng.php on December 1, 2012; Multiple Sclerosis Society of Canada (2010)

stated that over \$2.4 million committed to support seven operating grants to explore the relationship of CCSVI to MS. Information found at http://mssociety.ca/en/releases/nr_20100611.htm.

²⁰ Information obtained through personal communication.

²¹ *Ibid.*

²² See, for example, Goodman, J.C.; Herrick, Devon M. Twenty Myths about Single-Payer Health Insurance - International Evidence on the Effects of National Health Insurance in Countries around the World. Dallas: National Center for Policy Analysis. In this book, it is stated that “Canada uses the US as a safety valve for its overtaxed healthcare system, with provincial governments and patients spending a combined total of more than \$1 billion a year on U.S. medical care.” Information was accessed December 1, 2012 from <http://www.debate-central.org/topics/2002/book2.pdf>.

²³ This report was prompted by the case of ‘Rose’ from Markham, Ontario whose surgery to remove Tarlov cysts was performed in November 2010 by Frank Feigenbaum, a Kansas City US surgeon who had performed ‘hundreds’ of such surgeries. In addition, see March 21, 2011 article by Lisa Priest, “Ontario looks to change the rules for those with rare conditions” from the Globe and Mail. This article was accessed at <http://m.theglobeandmail.com/news/national/ontario/ontario-looks-to-change-the-rules-for-those-with-rare-conditions/article1939555/?service=mobile>.

REFERENCES

- Athas, W. F., Adams-Cameron, M., Hunt, W. C., Amir-Fazli, A., & Key, C. R. (2000). Travel distance to radiation therapy and receipt of radiotherapy following breast-conserving surgery. *Journal of the National Cancer Institute, 92*, 269-271.
- Atwater, A. (2008, May 29). Some US hospitals try to draw foreigners with flat-rate care. *The Wichita Eagle*, p. 1C.
- Boyd, J. B., McGrath, M. H., & Maa, J. (2011). Emerging trends in the outsourcing of medical and surgical care. *Archives of Surgery, 146*, 107-112.
- British Columbia Medical Services Commission. (2011, January 19). *Out of province and out of country medical care guidelines*. Retrieved December 1, 2012 from http://www.health.gov.bc.ca/msp/infoben/ooc_funding_guidelines.pdf.
- Button, G. (2009, May). *Prescription for Fairness*. [Special Report: Out of Country Health Services]. Edmonton: Alberta Ombudsman.
- Canadian Institute for Health Information. (2010). *Have health card, will travel: Out-of-province/-territory patients*. [Health System Performance Analysis in Brief]. Retrieved December 1, 2012 from http://secure.cihi.ca/cihiweb/products/out_of_province_aib_201003_e.pdf.
- Canadian Institute for Health Information. (2011). National health expenditure trends, 1975 to 2011. Retrieved December 1, 2012 from http://secure.cihi.ca/cihiweb/products/nhex_trends_report_2011_en.pdf.
- Centre of Excellence for CCSVI Testing and Liberation Treatment in India. (2011). [Website]. Accessed December 1, 2012 at <http://liberationtreatmentindia.com/>.

- Conference Board of Canada. (2004). *Understanding health care cost drivers and escalators*. Ottawa: The Conference Board of Canada.
- Constant, A., Petersen, S., Mallory, C. D., & Major, J. (2011). *Research synthesis on cost drivers in the health sector and proposed policy options: CHSRF series of reports On cost drivers and health system efficiency: Paper 1*[Canadian Health Services Research Foundation]. Retrieved December 1, 2012 from http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/CHSRF_Synthesis_on_Cost_Drivers_ENG-FINAL.sflb.ashx.
- CTV.ca News Staff. (2009, November 21). The liberation treatment: A whole new approach to MS. *CTV.ca*. Retrieved December 1, 2012 from http://www.ctv.ca/CTVNews/WFive/20091120/W5_liberation_091121.
- Dayes, I. S., Whelan, T. J., Julian, J. A., Kuettel, M. R., Regmi, D., Okawara, G. S., et al. (2006). Cross-border referral for early breast cancer: An analysis of radiation fractionation patterns. *Current Oncology*, *13*(4), 124-129.
- Flood, C. M., Tuohy, C., & Stabile, M. (2004, March 3). *What is in and out of medicare? Who decides?* [IRPP Working Paper Series no. 2004-06]. Montreal: Institute For Research on Public Policy.
- Fogarty, C., & Cronin, P. (2008). Waiting for healthcare: A concept analysis. *Journal of Advanced Nursing*, *61*(4), 463-471.
- Georgas, W.P., & Shap, L. (2006). Medical services for Ontarians outside of Canada. *Law and Governance*, *10*(2), 12-16.
- Goodman, J. C., & Herrick, D. M. (2002). *Twenty myths about single-payer health insurance: International evidence on the effects of national health insurance in countries around the*

- world* [National Center for Policy Analysis]. Retrieved December 1, 2012 from <http://www.coalitionoftheobvious.com/Singlepayer.pdf>.
- Health Council of Canada. (2011, May). *Progress report 2011: Health care renewal in Canada*. Toronto: Health Council of Canada.
- Health PEI. (2011). *Hospital and medical services insurance on Prince Edward Island: Benefits, eligibility, out-of-province coverage* [Montague: Health PEI]. Retrieved December 1, 2012 from http://www.gov.pe.ca/photos/original/hpei_hms_ins.pdf.
- Jackman, M. (2010). Charter review as a health care accountability mechanism in Canada. *Health Law Journal*, 18, 1-30
- Katz, S.J., Mizgala, H.F., & Welch, H.G. (1991). British Columbia Sends Patients to Seattle for Coronary Artery Surgery. *JAMA*, 266(8), 1108-1111.
- Katz, S.J., Cardiff, K., Pascali, M., Barer, M.L., & Evans, R.G. (2002). Phantoms In The Snow: Canadians' Use Of Health Care Services In The United States. *Health Affairs*, 21(3), 19-31.
- Light, D.W., & Lexchin, J. (2005). Foreign Free Riders and the High Price of US Medicines. *BMJ*, 331(7522), 958-960.
- Lindberg, M.C., & Risk, J. (2007). *External Review of the Ontario Health Insurance Plan's Out-of-Country Program*. Toronto: Ministry of Health & Long-Term Care.
- Mackinnon, B. J. (2003, October 21). Some cancer patients being sent away for treatment. *The Saint John Telegraph*.
- Manitoba Health. (2011a). *Out-of-province medical referrals*. Manitoba Health. Retrieved December 1, 2012 from <http://www.gov.mb.ca/health/mhsip/oop.html>.

- Manitoba Health. (2011b). *Out-of-province transportation subsidy program for approved out-of-province medical referrals*. Manitoba Health. Accessed December 1, 2012 at <http://www.gov.mb.ca/health/mhsip/travel.html>.
- Marin, A. (2007). *Annual report 2006-2007* [Ombudsman Report]. Retrieved December 1, 2012 from <http://www.ombudsman.on.ca/Ombudsman/files/c4/c4ab902d-6d8b-4c5e-bb22-6ccda8f4e7ae.pdf>.
- Marin, A. (2009, September). *A vast injustice: Investigation into the Ministry of Health and Long-Term Care's decision-making concerning the funding of avastin for colorectal cancer patients*. Toronto: Ombudsman Ontario.
- Meadows, B. (2011, March 12). Investments help keep health care close to home. *The Chronicle Journal*. Retrieved December 1, 2012 from <http://www.chroniclejournal.com/content/news/local/2011/03/12/investments-help-keep-health-care-close-home>.
- Multiple Sclerosis Society of Canada (2010). Over \$2.4 million committed to support seven operating grants to explore the relationship of CCSVI to multiple sclerosis. [News release]. *Multiple Sclerosis Society of Canada*. Retrieved December 1, 2012 from http://mssociety.ca/en/releases/nr_20100611.htm.
- NorthWest Local Health Integration Network. (2009, November). *Environmental scan: A supporting document to the Integrated Health Services Plan 2010-2013*. Retrieved December 1, 2012 from http://www.northwestlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/00%20Environmental%20Scan%20-%20June%202010.pdf.

- Ontario Ministry of Health and Long Term Care. (2011a). *OHIP: OHIP out of country services*. [Public Information – Ministry Programs]. Retrieved December 1, 2012 from <http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry/travellers.aspx>.
- Ontario Ministry of Health and Long Term Care. (2011b). *OHIP: OHIP out of country services, prior approval* [Public Information – Ministry Programs]. Retrieved May 11, 2012 from http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry/prior_approval.aspx
- Public Health Agency of Canada. (2009). *What mothers say: The Canadian maternity experiences survey* [Public Health Agency of Canada]. Retrieved December 1, 2012 from <http://www.phac-aspc.gc.ca/rhs-ssg/pdf/survey-eng.pdf>.
- Priest, L. (2009, January 2). *OHIP Delays Robbed Cancer Victim of Chance to Live*. *The Globe and Mail*. Retrieved December 1, 2012 from <http://www.theglobeandmail.com/news/national/article964750.ece>.
- Priest, L. (2011a, March 21). *Ontario looks to change the rules for those with rare conditions*. *The Globe and Mail*. Retrieved December 1, 2012 from <http://m.theglobeandmail.com/news/national/ontario/ontario-looks-to-change-the-rules-for-those-with-rare-conditions/article1939555/?service=mobile>.
- Priest, L. (2011b, May 25). *Unwanted patient battling OHIP over surgery*. *The Globe and Mail*. Retrieved December 1, 2012 from <http://www.theglobeandmail.com/news/national/unwanted-patient-battling-ohip-over-surgery/article2035204/>.
- Seelye, K. (2009, November 7). *Looking abroad for health savings*. *New York Times*. Retrieved December 1, 2012 from <http://prescriptions.blogs.nytimes.com/2009/11/07/looking-abroad-for-health-savings-2/>.

Sheldrick, B. M. (2003). Judicial review and the allocation of health care resources in Canada and the United Kingdom. *Journal of Comparative Policy Analysis*, 5, 149-166.

Somerville, M. A. (1999). The ethics and law of access to new cancer treatments. *Current Oncology*, 6(3), 161-174.

Woolhandler, S., Campbell, T., & Himmelstein, D. U. (2003). Costs of health care administration in the United States and Canada. *New England Journal of Medicine*, 349(8), 768-775.

Xuereb, M. (2011, June 28). Ruling opens door wider to free treatment abroad – ‘Far-reaching’ implications for health service. *The Times of Malta*. Retrieved December 1, 2012 from <http://www.timesofmalta.com/articles/view/20110628/local/Ruling-opens-door-wider-to-free-treatment-abroad.372745>.