Up in Smoke, What Role Should Litigation Play in Funding Canada’s Health Care

Jeff Berryman*

Introduction

Canadians place importance on the provision of universal health care and value their current scheme for the fact that distribution of services is based upon need rather than fault or income. However, to provide this level of service provincial and federal governments, of all political stripes, face a delicate balance of three constraints; cost of health care, cost of other income maintenance schemes such as pensions, and electoral demands for reduced taxes. One product of the interplay of these forces is renewed government interest in enforcing health care cost recovery mechanisms through litigation. In this article I argue such a movement is a retrograde step. Litigation is a good way to make determinations of fault and assign responsibility for wrongdoing. However, such a development is at odds with the organizing principles of our health care. Litigation threatens to undermine those principles by reifying fault as a mechanism for allocating health resources and in effect transferring health funding away from public onto private insurers. In addition, as a source for health funding, litigation incurs significant transaction costs — the cost of litigation — to effect such transfer. Yet, the prospect of litigation funding significant parts of the health care system is becoming increasingly real now that most provinces have enacted class action legislation, or other specifically drafted statutes designed to aid cost recovery actions.

In parts A & B I discuss the triple constraints — funding for health care, pensions and reduced taxes — operating on governments largely as a result of demographic changes in the baby boom generation, and the increased propensity of Canadians to resort to litigation to dispute complex policy issues. In part C, I discuss three ways in which government can pursue health care cost recovery, subrogation, class actions, and specifically enacted legislation. The right of subrogation, a feature of provincial health insurance plans, has always provided an opportunity for cost recovery. Subrogation, a common principle of insurance law, can also be explicated as a part of unjust enrichment. Where modern insurance law practices depreciate the value placed on subrogation, others, approaching from an unjust enrichment law perspective, have argued that it may well provide juridical

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* Jeff Berryman is a Professor in the Faculty of Law, University of Windsor, Windsor, Ontario. The genesis of this article arose from participation at a session titled “You Have Health Problems: Is that your fault?” at the International Bar Association Conference (Auckland, N.Z. 24-29 Oct. 2004). The author is indebted to his colleague, W.A. Bogart, who commented upon an earlier draft of this article.

assistance in advancing a cost recovery claim. Coupling subrogation rights with class action suits offers government huge potential for cost recovery. Canadian provincial class action legislation is conducive to such claims because it readily acknowledges damage claim aggregation and the use of other forms of statistical and epidemiological evidence as part of the litigation process. Finally, specifically enacted legislation, such as that enacted in British Columbia, aimed at recovering damages from the tobacco industry is discussed.

In part D I critique these three methods of cost recovery and the impact that litigation may have on health policy. I argue that through the stealth of litigation and aggressive pursuit of subrogation rights, cherished principles underpinning our health care system may be quietly eroded. While issues raised in litigation such as contributory fault attributable to lifestyle choices made by health victims i.e. smokers, the morbidly obese, etc., should be debated as part of health care policy, it should be done in open public forums, not courtrooms, and by publicly accountable officials, not private lawyers. For provinces, hard pressed for new sources of funding, class actions and suits arising from specifically enacted legislation aimed at overcoming causation and other evidentiary impediments, is seen as a win-win opportunity, promising financial returns with little outlay. Yet, as demonstrated by the United States tobacco settlement, also discussed in part D, these forms of legal suits can have quite troubling results and certainly incur obscene transaction costs. Litigation is not a neutral activity. Before governments advance it as a health cost recovery strategy, its policy ramifications should be debated.

A. The Impending Strain on Health Care

The celebrated Canadian demographer, David Foot, has canvassed how the changing demography of western nations, and in particular the effects of the baby boom and echo boom generations, are shaping polity and social structure. Baby boomers, those born between 1946 and 1964, have benefited from a period of unprecedented economic growth and relative peace. In western nations they have enjoyed access to education, near universal health care, and social safety nets through various schemes providing unemployment insurance, workers compensation, and social welfare. Some sacrifice has been demanded. In the United States and Australia the toll of the Vietnam War, and in Europe the Cold War was largely borne on the backs of the baby boom generation. But this experience also highly politicised them. A wave of democratic socialist governments were elected and introduced advances in human and economic rights. Baby boomers then moved into a phase of acquisitiveness, building and furnishing homes, and rearing children — the echo boom. Now, in unparalleled numbers, the baby boomers face old age and retirement. In Canada the number of citizens aged over 60 is expected to grow from representing 17% of the total population to 28.5% in 2031.3 Most commen-

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4 Romanow Commission, supra note 1. See also Mark W. Rosenberg, “The Effects of Population Ageing...
tators agree that this rise in proportion of aged citizens will make additional demands on health care. Current Canadian figures show that health spending on those aged 65 and over is three times the amount spent on all other younger age groups combined. This can only climb as the proportion of those aged 65 and over increases. Commentators disagree on whether this increase in expenditure will generate a health-funding crisis, or whether it can be managed by making moderate changes in health policy, reallocation within government fiscal envelopes, and general economic growth. Just as with population projections, there is equally great divergence on predicting future health expenditure and economic growth rates. However, extrapolations from the last two decades demonstrate that health expenditure has risen at a faster rate than Canada’s Gross Domestic Product, and thus, absorbs an increasing proportion of provincial and federal government budgets.

In addition to age demography, other particular drivers of health expenditure are the escalating costs and reliance on pharmaceutical drugs, increases in the real wages of health care professionals, greater resort to home care and other health professionals including more sophisticated diagnostic procedures, and real increases in mortality rates.

The other, and more important cost associated with an aging population is the maintenance of social security programs and pensions. The need to fund baby boomers pensions has also generated a great deal of debate. Countries, that run pay-as-you-go schemes, which draw from current taxation to pay present old age security, face a mounting burden as the ratio of working taxpayers falls in comparison to dependent retirees. Movement towards fully funded savings based schemes either public or private that build up national productive savings and investments, would alleviate the anticipated funding problems associated with maintaining present benefits level, and current tax rates to an increasing proportion of the dependent population. This appears to be the path that Canada has opted for in
requiring increasing levels of compulsory contributions to the Canada Pension Plan and changing the investment strategy of the fund. Exacerbating the ability of governments to fund old age security and health care is the accumulated public debt10, which in servicing charges still absorbs 19 cents in every dollar raised by the federal government.

Two influential Canadian economists, Denton & Spencer, argue that increased expenditures associated with an aging population must be viewed in a more dynamic and holistic way. In particular, they argue, that increases in health and social spending will be partially offset by savings in education, employment insurance, and correctional services, and that general growth in the economy has the capacity to generate sufficient revenues to meet expected demands11. Denton & Spencer specifically identify the issue of political will to shift spending priorities, as the major public policy issue to be confronted as a consequence of baby boomer aging12. The current evidence of the public policy debate suggests that the baby boom generation will act more out of self-interest than altruism.

Prior to 1995, consumption in Canada outstripped revenues and savings, leading to growing deficits and debt. In effect, the country mortgaged the future, and if left unattended, would have affected a significant wealth transfer from the youth of tomorrow to the baby boomers of today. In 1995, the federal government reversed the trend line, balanced its budget, and commenced a slow elimination of accumulated debt. The transformation from deficit to surplus budgeting was extremely painful. Government expenditures in transfer payments to provinces, particularly for health care, were cut, as was the federal civil service, and other expectation of receipt of benefits when they retired. To now require that generation to make provision through a pre-funded plan, as well as to maintain benefit levels to current retirees, is to add an additional burden which will not be recovered when they in turn retire. An additional issue involves the investment return on any pre-funded plan. Any rate of return above the rate of growth of the economy is being borne by the generation that is required to pay for it when the contributor retires and seeks return of his or her investment. These are essentially issues of inter-generational transfer. See the critique of the World Bank’s report and later interpretations taken from it in Peter R. Orszag & Joseph E. Stiglitz, “Rethinking Pension Reform: Ten Myths About Social Security Systems” (paper presented at the conference on New Ideas about Old Age Security (September 1999), online: Campaign For Americas Future <http://www.ourfuture.org/docUploads/20010921135334.pdf>.

10 Canada’s public accounts reveal a startling picture over the period covering the birth and growth of the baby boom generation. In 1971 Canada’s federal government had an accumulated debt of $20 billion. By 1995 that debt had climbed to $545 billion and consumed 33 cents in every dollar raised by the government for debt servicing. “Federal Finances,” online: Statistics Canada <http://142.206.72.67/04/04a/04a_008_e.htm>.

11 Frank T. Denton & Byron G. Spencer, “Population Aging and Its Economic Costs: A Survey of the Issues and Evidence” (2000) 19 Supp. 1 Canadian Journal on Aging 1 [Denton & Spencer]. Denton & Spencer point out that the dependency ratio, the portion of the population that does not work compared to the portion that does work, will be similar when the baby boomers retire to that experienced when they were at school. However, it is interesting to note that during that earlier period governments experienced a dramatic increase in deficits and accumulated debt.

12 The Romanow Commission, supra note 1 largely accepts Denton & Spencer’s analysis demonstrated through it citing Rosenberg, supra note 3, who in turn adopts Denton & Spencer manageral response to the costs of providing for an aging population.
government programs eliminated. One interpretation of the federal government initiative at balancing budgets, is to view it as a collective act of social conscience in which those who benefited from the incursion of debt, the retired and baby boomers, accepted a social responsibility to pay down the burden, rather than passing it on to a new generation. Nevertheless, once brought into balance, rather than moving to a rapid elimination of the accumulated debt, the government opted to significantly lower, by an unprecedented amount, personal and corporate income taxes. Deficit financing was not only threatening the economic prospects of future workers, it was also adversely impacting upon the same baby boom generation by limiting their spending power. These policies were not acts of altruism, but of self-interest. Admittedly, Canada is on a trajectory of lowering the accumulated debt, but it will not be eliminated before the majority of baby boomers move from worker to dependency status. Indeed, based upon the present public opinion polls, Canadians wish to see greater public spending on health care and reduced attention to lowering debt, and thereby further delaying debt elimination. It is not a coincidence that health care has catapulted as the dominant public policy concern in both recent provincial and federal elections in Canada. The baby boom generation is using its political clout and influence to ensure comprehensive and accessible publicly funded health care. Again, this could be painted as an act of collective altruism, but it cannot be ignored that the chief recipients of this policy will be the self same baby boomers as they retire, and, on past experience, will increasingly make disproportionate use of these services. The clamouring over protecting universal health care, and in fact extending care into coverage of pharmaceuticals, is in contrast to governmental policy towards post-secondary education. Whereas the baby boom generation enjoyed relatively free tuition, post-secondary students today face large tuition costs, and graduate with what is in affect, a considerable mortgage on their future income stream. This burden, falling on the young, does not resonate to any great extent with an electorate dominated by the old, and is unlikely to be reversed. The self-interest of baby boomers is also reflected in the continued call for lower taxes, ostensibly to raise investment and productivity, despite the fact that Canada enjoys lower tax rates than most OECD countries, although not as low as the United States.

The problems of financing social security and health care, just mentioned, are not unique to Canada. Indeed, the older age demography of Western Europe means that most European countries have a more pressing concern to balance

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13 The Centre for Research and Information on Canada, Press Release, “Canadians’ Priorities: More Money for Health Care, Education; and Improved Federal Provincial Cooperation” (2003), online: The Centre for Research and Information on Canada <http://www.cric.ca/pdf/cric_poll/portraits/portraits_2003/portraits03_priorities_eng.pdf>. When asked where budget surpluses should be allocated, 63% of Canadians favoured expenditure on social programs including health and education, 12% further tax cuts, while only 24% favoured debt reduction.


projected demand with future available resources.\textsuperscript{15} Even modest changes in entitlements and funding have generated a great deal of political protest.\textsuperscript{16} And herein lies the difficulty. The types of structural changes required, whether it be altering entitlements (increasing retirement age, reducing pension levels, or de-listing medically covered services), privatization (both healthcare and pensions have been the subject of such debate), moving from pay-as-you-go to pre-funded (creating individual retirement accounts. Individual health accounts have also been discussed as a means to control spending), or increasing taxation (to reduce debt), do not sit well with an electorate that is self-interested and politically dominant. The likelihood that a single political constituency can be built in the foreseeable future that balances inter-generational interests is remote. Recent studies suggest a correlation between decline in voter turnout and generation effect, unaccounted by any life-cycle phenomenon.\textsuperscript{17} In fact, the decline in post-baby boom voter turnout in elections throughout the Western world discloses a disturbing trend towards political disillusionment, disenchantment, and disenfranchisement.

Unfortunately, economic realities do not wait for political opportunities. The likely result is a state of stasis or modest piecemeal reform. In the case of social security, changes in entitlements, the erosion of benefits that is achieved by inflation, and commensurate change in taxation rates from income creep may be sufficient to prolong current systems. In health care, the impending real increase in demand means that governments must either find new money or match public health service entitlements within the existing fiscal envelope. In Canada, at present, the second alternative is not politically viable.

B. Canada: A Turning to Litigation?

How then does Canada propose to fund its future health care? At present, Canadians enjoy a universally publicly funded health care system. Although health care is a provincial jurisdiction, the federal government provides significant funding as part of a funding transfer scheme known as the Canada Health and Social Transfer (this provides a block grant to the provinces to assist in funding health, social assistance and post-secondary education). Provinces that do not adhere to

\textsuperscript{16} See for example E. Pfanner, “European workers take to the streets to protest planned cuts in pensions”, International Herald Tribune (Paris, France, 10 May 2003) 12.
\textsuperscript{17} See André Blais, Elisabeth Gidengil & Neil Nevitte, “Where does turnout decline come from?” (2004) 43 European Journal of Political Research 221. The authors’ study demonstrates that while life cycle voting patterns normally account for a certain pattern of decline — the young being less likely to vote than the old — the current electoral results reveal a steeper decline between three generations — pre-baby boom, baby boom, and post baby-boom. The young, despite being better educated, pay less attention to politics and do not consider voting as an important civic duty or moral right. See also Jon H. Pammett & Lawrence LeDuc, “Explaining the Turnout Decline in Canadian Federal Elections: A New Survey of Non-voters” (2003), online: Elections Canada <http://www.elections.ca/content.asp?section=loi&document=index&dir=tur&lang=e&textonly=false>.
the tenets of the Canada Health Act\textsuperscript{18} and, in particular, allow extra billing of patients by health providers, face a claw back of equivalent amounts from the bulk funding transfer. Nevertheless, the ratio of federal to provincial funding of health care has fallen, and provincial governments are increasingly becoming frustrated with what they perceive as federal intermeddling in health care delivery.\textsuperscript{19} Left to their own devices a patchwork of coverage would emerge across the country, some provinces de-listing services, others allowing for extra-billing or capitation fees, and others resorting to privatized health care. While the federal government has promised additional funding, its offer is accompanied with strings attached on where the funding is to be spent, and public accountability of the expenditures. In the 2004 provincial budget, the Ontario Liberal Government introduced a dedicated health tax levy to provide additional funding. This initiative was resoundingly criticized as a breach of an election promise not to raise taxes, and, has been identified as a contributing factor, together with statements by the Alberta Premier that his government was considering reforms to health care that may violate the Canada Health Act, to Federal Liberal losses in Ontario in the most recent federal elections, and resulting in loss of majority government status. These incidents attest to the political volatility of the health vote in the electorate.\textsuperscript{20}

In 1982 Canada repatriated its constitution and enacted the\textit{ Canadian Charter of Rights and Freedoms}.\textsuperscript{21} Writing in 1990, the American sociologist, Seymour Lipset, described the adoption of such a Charter as an act of revolutionary proportion and that it would herald the ‘Americanization of Canadian values’.\textsuperscript{22} Judgment is still out on whether such an apocalyptic event has happened,\textsuperscript{23} however, there is little doubt that courts, and litigation, have assumed a much more prominent role in Canada’s social firmament. Nor is resorting to courts the exclusive province of individuals and interest groups. Legislatures are not averse to remitting hot-button political issue for court resolution, and for some obvious

\textsuperscript{18} R.S.C. 1985, c.C-6 [Canada Health Act].
\textsuperscript{19} Romanow Commission,\textit{ supra} note 1. The effective decline in federal funding, and the increase in provincial health care spending, has meant that as a portion of total provincial expenditure the health sector now accounts for 35.4\% of all provincial budgets, whereas in 1978 it accounted for only 28\%.
\textsuperscript{20} It is wrong to construe from these incidents that Canadians, taken as a whole, are opposed to increased taxation to fund social programs. Pollster Michael Adams has recently written on the growing divergence in American and Canadian values. Based on his longitudinal studies he characterises current Canadian values as moving from deference to elites toward greater individuality, but embracing idealism. They are willing to embrace increased taxes to advance national policies that have broad popular appeal, such as health care, although they want political accountability. Michael Adams, Amy Langstaff & David Jamieson,\textit{ Fire and Ice: The United States, Canada and the Myth of Converging Values} (Toronto: Penguin Canada, 2003) [Adams]. I have discussed Adams’s findings in Jeff Berryman, “Canadian Reflections on the Tobacco Wars: Some Unintended Consequences of Mass Tort Litigation” (2004) 53 Int. Comp. Law Q. 579 [Berryman].
\textsuperscript{22} Seymour Martin Lipset,\textit{ Continental Divide: The Values and Institutions of the United States and Canada} (New York: Routledge, 1990).
\textsuperscript{23} See Adams,\textit{ supra} note 20.
reasons.24 Pluralistic societies, such as Canada, which have curbed unchecked majoritarianism still need to find avenues for legitimate decision making in which rights claims can be evaluated. Courts perform such a function as long as they hold the respect of the public. Courts also effectively filter arguments before rendering decisions. In this way the assertion of a claimed legal right that smokers have a right to smoke, which rings through the airwaves of popular media and kitchen table conversations, has no traction in a court of law. Although, arguments that seek to justify curbs on liberty and personal autonomy, because of the health outcomes from second hand smoke, do. Similarly, courts require evidence upon which to make findings to support decision-making, and scrutinize the veracity of such evidence, particularly scientific evidence. Courts are deliberative chambers, not prone to rapid decision-making. Often, procrastination effectively defuses public tension and removes the issue from public attention. Litigation can give the appearance of doing something when alternatives are unpalatable, or can justify not moving forward on a legislative solution. A government, as litigant, can frame and control the issue that is put before a court, thus avoiding other more contentious debates. Litigation can result in negotiated settlement, removing from the public opportunities to participate in what may amount to regulation of an industry, or de facto creation of a tax on consumers. Finally, attacking pariah industries, such as tobacco, asbestos, gun manufacturers, and lead-based paints, through highly publicized litigation can be good for political careers.

It is thus in a milieu of impending need to change funding or entitlements over social programs, a rise in political and public consciousness of legal rights rhetoric, and the role played by litigation and courts to explicate those same proclaimed rights, together with close proximity to the United States, which exercises a pervasive influence on political and social discourse in Canada, that we can discuss the role of litigation as one option to partially address the future funding of Canada’s health care.

C. The Ability to Use Litigation to Recover Health Care Costs

(i) Subrogation and unjust enrichment

There has been a link between health care costs and personal injury litigation for some time in Canadian law. For example, in any personal injury suit, the Ontario Health Insurance Plan (OHIP is part of the provincial Ministry for Health and Long Term Care, which is responsible for all public sector provided health care funding) has a statutory right of subrogation to recover for any services rendered, or which will probably be incurred in the future, to the person injured.25 It is somewhat ironic,

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24 For example, Re Secession of Quebec, [1998] 2 S.C.R. 217 (rights and responsibilities of the federal government should a province vote to secede from Canada). Reference Re Same-Sex Marriage, (2004) 246 D.L.R. (4th) 193 (Reference concerns the ability of the federal government to legislate the licensing of same sex marriages).

25 Health Insurance Act, R.S.O. 1990, c.H.6 [Health Insurance Act]. Similar provisions exist in other provinces. See for example, British Columbia, Hospital Insurance Act, R.S.B.C. 1996, c. 204; Manitoba,
given the insistence of the federal government today in protecting universality of health services based solely on need, that these provisions were inserted at the demand of the then federal government, in return for taking on a responsibility to provide funding in 1957. However, it is important to note the limits in these Acts, and the right of subrogation in general. The right of subrogation is distinct from the injured person entitlement to receive such services under OHIP. Indeed, it would appear that the risk of under compensation for future health expenditures (i.e where the injuries of the claimant are in fact greater than what was calculated at the point of assessment to meet future health care costs), as well as the benefit of surplus compensation ordered by a court, is solely borne by OHIP. Similarly, OHIP’s right of subrogation is subject to any defence that the defendant would have to liability for the claimant’s injury. When Ontario introduced its partial no-fault automobile insurance scheme it eliminated the collateral benefit rule and statutorily abrogated the right of OHIP subrogation. In its place, OHIP negotiated with automobile insurers in Ontario, a formula in which the insurance industry pays an annual percentage of premiums collected to discharge all liabilities to OHIP for any medical and health care services provided, or which will be necessary in the future. This agreement was subsequently legislated into the Insurance Act and appears to have produced significant administrative efficiencies.

Subrogation is most commonly applied in the context of indemnity insurance, although it is also a principle of common law, now justified as part of the law preventing unjust enrichment. In the context of health care the statutory subroga-
tion provisions mirror the insurance context, the aim being to prevent the victim of a wrongful act or omission from being over-compensated by way of double recovery, and for the cost of wrongdoing to be placed upon the wrongdoer’s shoulders. Many have questioned the need for subrogation in the insurance field to achieve the desired result of minimizing over-compensation. A far more effective and administratively workable way is simply to reduce the claimant tort damages by any amounts received from collateral sources, as now practiced in Ontario automobile insurance. In addition, subrogation usually engages two insurers, the wrongdoers normally carrying liability insurance, and is simply a way of transferring loss, but burdening the transaction with cumbersome litigation and expense. Rendall has also observed that the subrogation provisions in provincial health care plans appear conceptually schizophrenic in light of the long march toward publicly funded universal health care that has sought to displace private sector providers, and, which seeks to provide for all, regardless of fault.

The desire to minimize double recovery is perfectly consistent with the compensation principle, and thus a tort victim should not be able to receive benefit of a government provided health scheme and then also recover compensation from the tortfeasor for an expenditure he has not had to bear. But, the alternative way of eliminating the problem is simply to make a deduction from the damage claim that the victim brings. As recently explored in the Supreme Court of Canada, the weight of academic literature concludes that this is a far more efficient way to deal with the problem of double recovery, than incurring the additional litigation costs of adjusting a loss through subrogation rights. The Supreme Court also suggested that the rule of deductibility is becoming increasingly entrenched in judicial decisions.

An argument made in favour of subrogation, as in tort law generally, is that it ensures the full costs of the wrongdoer’s activity is internalized by the wrongdoer, and thereby effective deterrence is achieved. In the remaining area of personal


34 Brown & Menezes, supra note 32. Also accepted by a majority of the Supreme Court of Canada in Somersall v. Friedman, [2002] 3 S.C.R. 109 [Somersall].

35 B. (M.) v. British Columbia (2003), 230 D.L.R. (4th) 567 (SCC) [B. (M.)]. The court was asked to review the deductibility of social assistance payments as part of an award for loss of earnings. The court held such payments should be deducted. See also Ratych v. Bloomer, [1990] 1 S.C.R. 940 [Ratych].

36 B. (M.), ibid. See also the discussion of collateral benefits in Ken Cooper-Stephenson, Personal Injury Damages in Canada, 2nd ed. (Scarborough: Carswell, 1996) [Cooper-Stephenson]. The major recognized exception to a deductibility rule is where the claimant has provided his or her own private insurance. The Supreme Court of Canada has held that the individual prudence of a claimant to make provision for an accident through their own insurance should not inure for the benefit of the tortfeasor in reducing the damages recoverable (Cunningham v. Wheeler, [1994] 1 S.C.R. 359).
injury where civil litigation plays a role (workers compensation and no-fault automobile insurance absorb most claims based upon accidental injury) there is already incentive for the plaintiff to sue for wrongdoing to ensure recovery for income replacement, property damage, and health care costs not covered by any publicly funded health insurance. The fact that health care is immediately provided the victim and funded by a public entity does not weaken this incentive to sue. If subrogation is then exercised to recover health expenditures the full cost will be shifted to the wrongdoer. However, the deterrent role of tort law is much over rated, it being appreciably undermined by the widespread availability of liability insurance to wrongdoers. While insurers adjust premiums to reflect wrongdoer risk assessment, wrongdoers are usually pooled for assessment purposes rather than individually determined. In addition, the tendency in insurance is towards first party insurance to maximize efficiencies, and, as a consequence, insurers will negotiate private agreements (knock for knock) among themselves to limit rights of subrogation. The ultimate expression of these negotiations is that practiced by the automobile insurance industry in Ontario (see above) and in comprehensive workers compensation schemes.37

Dagan & White have recently argued that common law (legal or equitable) subrogation could be utilized to mount a legal claim by governments against injurious industries, and in particular, how claims to recover health care expenditures against gun and tobacco industries in the United States could be analysed within this conceptual framework.38 Dagan & White commence their analysis by locating common law subrogation within the law of unjust enrichment. Where the government pays for medical services caused by an injurious industry it is enriching that industry by relieving it of a liability it would normally have to bear. Such a payment would not be considered an unjust enrichment if it were made by a volunteer acting officiously. For Dagan and White, the unsolicited conferral of the benefit is made unjust where it is a collective good that should be advanced, but where there is a high risk that a potential defendant will avoid providing the benefit and free-load on the provision of others. They suggest that the conferral of unsolicited benefits often arises where the payer (subrogee) and the defendant tortfeasor have interests that are locked in together. They give as one example, the right of one member to a class action suit, who has paid the lawyer fee, to recover from other members of the suit. Against this must be considered the justifiable concerns of the defendant to raise objections as to whether payment by the payer constitutes a real benefit to the defendant. If the defendant does not put the same value on the payment made for him by the payer’s actions, then, arguably, he has not benefited to the same extent (in restitution this is the concern over subjective devaluation and incontrovertible benefit, particularly of non-cash benefits). The other concern is the fact that payment is being forced upon the defendant against his will (in restitution this raises the concept of free acceptance).

Applying this criteria to the State tobacco settlements in the United States\(^{39}\) Dagan & White suggest that there is some degree of lock in between the tobacco industry and state governments. Unfortunately, much of the settlement in the US tobacco action involved compensation for prospective expenditures incurred up to 2025; allowed for discretionary expenditure by the states on other smoking preventive measures; and compensated at a level that seemed well above what the states would actually incur under the medical aid scheme given the nature of privatized medicine in the US, and the funding of health care by private insurers who still retain their own rights to sue.\(^{40}\) The settlement operates to prevent and ameliorate the harms of tobacco rather than to compensate directly for the costs incurred by the state to provide medical services. Dagan & White describe the lock in as tenuous but still argue that it fits into a subrogation analysis. Drawing from insurance law, they suggest that the volunteer rule — that voluntarily paying another’s debt does not operate to create an unjust enrichment — has rarely operated as a bar to a subrogation claim brought by an insurer who has paid out on a colourable insurance claim. The rule has not operated in such circumstances owing to the public policy that encourages insurers to err on the side of caution when rejecting claims. By analogy, where government is considering policy to advance public health and safety, it should not have to weigh in the balance whether it is jeopardizing its claims against those who are responsible by making voluntarily payments.\(^{41}\) If sufficient lock in can be demonstrated, such that the government is not considered a volunteer, then attention turns to potential defences by the tobacco industry. The issue of potential subjective devaluation is handled by the fact that the government claim as subrogee is derivative of the person injured, and is thus subject to all the defences of assumption of risk, causation, and time limitations. Similarly, because unjust enrichment is concerned with reversing enrichment — corrective rather than distributive justice — the government action is confined to the actual expenditures it has made — the detriment suffered — and which alleviate the tobacco industry liability to individual claimants.

\(^{39}\)Dagan & White, \textit{ibid.} provide a concise summary of the State tobacco settlement in the United States. In essence, in 1997 several states commenced law suits to recover state funded medical costs associated with the provision of medical care to those who suffered from tobacco products. After numerous negotiations involving both state and federal government entities these negotiations collapsed. In 1998, 50 states entered into a new settlement agreement with the tobacco industry. Under this comprehensive agreement the tobacco industry is obligated to pay $240 billion through to the year 2025 to compensate for medical expenditures. The comprehensive agreement also makes provision for restrictions on tobacco advertising and marketing, reduction of tobacco by minors, and restrictions on tobacco lobbying. In return, the tobacco industry gained protection against state and municipal government suits for tobacco related actions as well as indirect protection of the tobacco market from new competitors who would also become subject to the settlement’s terms and incur a significant tax on their product.

\(^{40}\)Dagan & White, \textit{ibid.} suggest that the tobacco industry was motivated to agree to this settlement to ward off impending bankruptcy proceedings that would have resulted if the state suits had proceeded. The settlement confers indirect protection on the industry from new competitors, while at the same time allowing the tobacco industry to shift the cost of the settlement through to consumers in increased tobacco prices, rather than shareholders. In settling the dispute the tobacco industry also gains an ally in lobbying for federal intervention to enact a limiting liability bill. State governments will also become dependent upon the revenues from this source.

\(^{41}\)Dagan & White, \textit{ibid.}
Dagan & White’s analysis is an elegant argument on how restitution can be used to legally conceptualize a government claim for recompense of medical services. The law of unjust enrichment in Anglo-Canadian jurisprudence provides a similar analytical framework. It asks three questions; has there been a benefit to the defendant? Has it been at the expense of the plaintiff? Is there an absence of juridical reason to explain the transfer to the defendant (or the presence of an unjust factor requiring the enrichment to be reversed)? The discharge of a tortious legal liability to pay for medical care as part of a personal injury suit is of benefit to the tortfeasor, and if paid for by a government department, a corresponding detriment has been incurred. The absence of any juristic reason (the payment of the medical care was not as a result of a contract, a gift, or act of a volunteer acting officiously) and the presence of an unjust factor (compulsion) complete the requirements of the unjust enrichment claim; i.e. in Ontario, as with other provinces in Canada, the public insurer is statutorily required to fund health care costs incurred by an eligible insured.

The unjust enrichment claim may not be as simple as presented here. If the provision of health care in Ontario follows an insurance model, then the unjust enrichment action follows closely the insurance right to subrogation. Under that right the insured is entitled to have his or her claim against the wrongdoer fully satisfied before the insurer is entitled to recover for what it has paid out under the insurance policy. To the extent that the insured has not received full satisfaction the insurer has no claim or right to subrogation. However, at least three courts in Canada have asserted that the respective provincial health plans, although called insurance, are not in fact, insurance schemes.

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43 On benefit and detriment, Canadian law has taken a fairly simplistic approach where the benefit constitutes the payment of a monetary amount. See Peter v. Beblow, [1993] 1 S.C.R. 980; Garland, ibid.

44 See Maddaugh & McCamus, supra note 33. Provincial legislatures may have altered this priority. In both Ontario and Alberta the legislation purports to give a direct statutory right to the crown to bring such an action against a wrongdoer, although it is still dependent upon the ability of the crown establishing that the insured had a right to recover against the wrongdoer. See s. 36.1(1) of the Health Insurance Act, supra note 25; s. 62 of the Hospitals Act, supra note 25.

45 Ledingham v. Ontario Hospital Services Commission, [1975] 1 S.C.R. 332, specifically holding that the claim of the Hospital Service Commission (the forerunner to OHIP) did not rank pari passu with the injured party’s claim but was subservient until the victim’s claim was fully satisfied. See also Somersall, supra note 34.

46 In Alberta see Kucyk v. Commercial Union Assurance co. of Canada (1991), 84 D.L.R. (4th) 745 (Alta. C.A.) [Kucyk] wherein the court characterized the scheme as conferring an entitlement upon Albertan residents to hospital services for which they are not being indemnified by the plan. Rights to recover by the Province against wrongdoers are according to the wording of the statute and not by virtue of general principles of subrogation. In Ontario see Spath v. Anglo Canada General Insurance (1994), 17 O.R. (3d) 507, appeal dismissed (1996), 28 O.R. (3d) 256 (C.A.) [Spath] determining that OHIP did not constitute
If the right to subrogation under general principles of insurance is not available, then the unjust enrichment action that allows for recovery where a claimant has compulsorily discharged another liability is an alternative conceptual pigeonhole. But, here again, there are potential impediments. The unjust enrichment action exists where the claimant has been subject to a common liability with the defendant to the third party, and for which the defendant is primarily liable. In suits to recover health expenditures, the government has discharged its own statutory liability to meet the health care costs of its residents, while the liability of the wrongdoer is tortious. The claims are not coextensive. In fact, in the absence of the statutory right of subrogation, any payment made by the province to cover health expenditures would not constitute an unjust enrichment. The injured victim would not have a claim for such damages because, in effect, they have not incurred a loss. As a consequence, a tortfeasor would incur no liability for that part of the claim and has thus not had any liability discharged by the third party, i.e. the government. Further, it is not clear who bears the primary liability for such medical costs incurred. It would seem incorrect to assert that the victim of wrongdoing is primarily required to look to the wrongdoer to recover health care costs, ahead of its entitlement under the government run scheme. In fact, the victim’s statutory entitlement to claim health care may itself constitute a juristic reason justifying the transfer such that it is not unjust. Any restitution claim would not be subject to the claim of the victim being fully satisfied before being recovered, as with a claim

47 I have chosen to keep the law of subrogation as a distinct classification from the compulsory discharge of another’s liability, and other recognized categories of restitution. If subrogation is merely a remedy, as now asserted in England (Banque Financière de la Cité v. Parc (Battersea) Ltd., [1998] 1 All E.R. 737 (HL)) then it is possibly incorrect to keep this distinction, although subrogation is such an ingrained feature of insurance law. If the underlying basis justifying subrogation is the prevention of unjust enrichment, its intersection with other categories of recognized unjust enrichment will need to be worked out. See Peter Birks, Unjust Enrichment (Oxford: Oxford University Press, 2003). The following text in this article identifies some of the problems when what appears to be subrogation is analysed as a claim based on the compulsory discharge of another’s liability.

48 See Maddaugh & McCamus, supra note 33; Goff & Jones, supra note 43; Virgo, supra note 33; Fridman, supra note 33.

49 The restitution claim is built upon the rules established in Moule v. Garrett (1872), L.R. 7 Ex. 101, in which the claimant must show; (1), claimant must have been under legal compulsion when the benefit was conferred; (2), claimant must show that the payment to the third party discharged a legal liability of the defendant; (3), that the claimant and the defendant were subject to a common liability to the third party and for which the defendant was primarily liable to pay; and (4), the claimant has not acted officiously. Both Maddaugh & McCamus, supra note 33 and Goff & Jones, supra note 33 are very critical of this restrictive interpretation. Both argue that the claim should not be dependent upon establishing a common liability.

50 Garland, supra, note 42.
based on subrogation based on insurance principles. The right to unjust enrichment sits with other legal claims against the wrongdoer where it can be established.

Another interesting ramification of the provincial health schemes is that the legislation generally confers a right to recover for prospective health care costs. The legislation speaks of claims to recover “the cost incurred for past insured services and the cost that will probably be incurred for future insured services”.\(^{51}\) The legislation also confers an independent procedural right to recover against the wrongdoer, but still derivative of the injured party, and subject to assessment issues concerning contributory negligence, causation, and limitations by the injured party.\(^{52}\) No unjust enrichment claim would support such action because at the time it is brought there has been no detriment incurred by the government insurer of prospective costs.

The Ontario court in *Spath v. Anglo Canada General Insurance* suggested that the analogy between the provision of health care in Ontario and insurance, breaks down when we consider how the medical scheme has been designed. Every person resident in Ontario is eligible to be covered by the plan, which is funded directly from tax revenues and not through risk assessed premiums. Although physicians are treated as independent businesses and bill OHIP directly, their fee schedule is negotiated collectively and they are not permitted to bill above the rate set by the Ministry in those negotiations. Ontario residents receive a health identification card to be presented when requesting medical services, but they do not enter or receive any written contract with OHIP. The other provinces adopt similar approaches to Ontario. It is a misnomer to call these insurance schemes, and rights of subrogation as being contractual rather than statutory. In fact, courts appear to have accepted the argument that a right of subrogation is of little value and often amounts to a windfall to the insurer,\(^{53}\) and that; at most, the preferred approach to provincial health care schemes is that they should be viewed as first party insurance alone with abridged rights of subrogation.\(^{54}\)

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\(^{51}\) For example, see Ontario *Health Insurance Act*, supra note 25, ss. 30(1) and s. 36.1. Alberta *Hospitals Act*, supra note 25, s. 62.

\(^{52}\) Mason (Litigation Guardian of) v. Ontario (Minister of Community & Social Services) (1998), 39 O.R. (3d) 225 (CA).

\(^{53}\) See Somersall, supra note 34 at para. 71, wherein Iacobucci J., for a majority of the Supreme Court of Canada, accepted Brown & Menezes assertion by citing the following passage “most observers consider the cost-saving rationale of subrogation to be insignificant at best and that, in fact, a successful recovery in a subrogation claim is really a windfall for an insurer”. And later in the judgment, describing the value of the right of subrogation as ‘near-negligible’.

\(^{54}\) See *Kucyk*, supra note 46, per Kerans J., for the Alberta Court of Appeal, observing that cost recovery through extension of a right of subrogation was inconsistent with the principle behind the health care scheme: “After all, the idea underlying the scheme might be what some call the principle of universality: hospital care in this age imposes too great a burden for an individual, and the care for all should be shared by all. Were that so, it might be contradictory to the principle of the scheme that all means of potential recompense available to the individual should also be available to the Minister” (at 747). *Wipfli*, supra note 46. And, *Ontario (Ministry of Health and Long-Term Care) v. Georgiou* (2002), 61 O.R. (3d) 285 (C.A.) giving a liberal interpretation of the prohibition on subrogation under the *Insurance Act* provisions creating Ontario’s no-fault automobile insurance scheme, which prevented the Ministry of Health, which...
The direction of courts towards minimizing subrogation rights runs counter to the apparent direction of the Ontario Ministry of Health and Long Term Care (OMHLTC) itself. The Ministry subrogation unit currently handles approximately 12,000 files, most self-reporting by plaintiffs’ lawyers, and collects net on average $14 million annually.\(^5\) These claims arise from the following types of injuries: slip and falls; boating, air and rail accidents; product liability or manufacturing defects; medical malpractice or professional negligence; dog bites; municipal liability; assaults; some motor vehicle accidents; and class actions.\(^6\) In comparison to the assessment in lieu of subrogation claims ($80 million per annum in 1996) negotiated with the insurance industry for automobile claims, the amount recovered is small, and represents less than 0.05% of Ontario total health budget ($25.5 billion). Yet, there is a clear desire to increase cost recovery, as evident by Cabinet approval in 1999 to increase staff of the subrogation unit.\(^7\) Renewed vigour in collection can have some interesting repercussions. For example, subrogated claims in the area of medical malpractice account for approximately 20% of the net amount recovered ($2.35 million in 2002/3). The greater success in this area has the flow on effect of driving up physicians medical malpractice insurance, which, in Canada, is primarily organized through a physician owned collective, the Canadian Medical Protective Association (CMPA). In Ontario, the rise in medical malpractice insurance fees drove the Ontario Medical Association (OMA) and the CMPA to negotiate a separate reimbursement fee, in addition to the usual physician service reimbursement schedule. The circularity of this arrangement has not gone unnoticed. Thus, we have the Ministry paying the patient health care costs, for which the patient must bring a subrogated claim in any suit brought against the physician, and for which the ministry is paying by recompense of physician third party liability insurance premiums to the CMPA. Both the CMPA and the Canadian Medical Association have repeatedly called for the elimination of subrogation rights by the Ministry in medical malpractice suits, claiming that it would reduce CMPA medical malpractice claims and settlements by 5%.\(^8\)

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\(^5\) Facts and figures supplied by the Subrogation Unit of the Ministry of Health and Long Term Care, and kept on file with the author.  
\(^7\) Staff numbers increased from 14 to 21. Facts and figures supplied by the Subrogation Unit of the Ministry of Health and Long Term Care, and kept on file with the author.  

operates OHIP, from exercising its statutory right of subrogation under the Health Insurance Act. Although see Stein v. Sandwich West (Township) (1995), 77 O.A.C. 40 [Stein] noting the subrogation provisions of the Health Insurance Act; Mason, supra note 52 comparing the Health Insurance Act to insurance.
It is clearly possible for provincial health plans to seek recovery under existing legislative subrogation provisions, and to use those provisions to target particularly insidious wrongdoers — tobacco, asbestos, fast food — whose products arguably wreak havoc on health care. Whether Provincial ministries should pursue this strategy will be discussed later. However, it is in the area of product and manufacturer liability, coupled with the adoption of class action proceedings, that Ontario’s Ministry of Health and Long Term Care appears to have placed under close scrutiny.59

(ii) Class actions

Class actions, although a feature of Quebec law for over twenty-five years,60 have only recently been adopted in most of the other common law provinces.61 Ontario legislation, representative of the others in most respects, attempts to build upon developments in the United States, but also, to overcome perceived problems. One such problem is the aggregation of damages as a common issue, and one often likely to be broached in mass tort claims where recovery of health care expenditures will form a significant part of the damages claim.

United States jurisprudence conveys antipathy toward mass tort claims involving personal injury and damage aggregation as being capable of resolution through class actions. Indeed, the US Supreme Court has reiterated the Advisory Committee notes to US Federal Court Rule 23 Class Actions,62 that mass tort claims will not “ordinarily be appropriate” for class treatment, because the issues of damage assessment, liability, and applicable defences are more likely to be dependent upon individual circumstances, such that any common issues are not likely to satisfy the ‘predominance requirement’. (I.e. under Rule 23(b)(3) “questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy”.)63

59 The Ontario Ministry Subrogation Unit reports (March 2004) that they have recovered in 6 class actions and have 25 provincial and 5 national class action suits under watch. Facts and figures supplied by the Subrogation Unit of the Ministry of Health and Long Term Care, and kept on file with the author.
60 For a description of Quebec’s class action law see Christine Carron, “25 Years of Class Actions in Quebec: Time to Take Stock?” (2004) 1 The Canadian Class Action Review 141.
63 Amchem Products Inc. v. Windsor, 521 U.S. 591 (1997). The US Supreme Court affirmed the lower court’s decision not to allow approval of a class action settlement only of all asbestos claimants because it failed to provide adequate representation to all affected by the class designation (i.e. the settlement did not adequately balance the claims of asbestos victims who were exhibiting medical harms against those who had been exposed but were currently not exhibiting any symptoms of harm.), and, that what common issues of the defined class were apparent, were not sufficiently predominant over the interest of having individual assessments. See also Ortiz v. Fibreboard Corp., 527 U.S. 815 (1999).
Nevertheless, this *de jure* impediment to mass tort class action claims engaging damage aggregation must be contrasted with the evidence of its *de facto* occurrence. Erichson\(^{64}\) and Hensler\(^{65}\) have catalogued the informal aggregation that happens in spite of the US Supreme Court rulings. The economies of scale are just too great to forfeit for claims that would otherwise be non-viable as individual actions.\(^{66}\) Claimants prefer to partake in a settlement that may impose uniform levels of compensation based on a restricted range of variables, rather than preserve the chance for recovery in costly individual litigation.

In contrast to the United States, Ontario, and other provinces that modelled their legislation after Ontario, have explicitly recognized aggregation of damage claims. Ontario *Class Proceedings Act* allows for a class action to be part of a bifurcated litigation model in which substantive issues concerning liability and applicable defences can be heard as part of the common issues of a class action, even if damage quantification can only proceed on an individual basis.\(^{67}\) The *Class Proceedings Act, 1992* also specifically provides for aggregation of monetary relief where the totality of the defendant liability can be determined without resorting to claims proof by individual class members. If this is attainable, judgment can then be granted and the defendant largely disappears from the litigation. The *Class Proceedings Act, 1992* then goes on to provide for distribution of the judgment by allowing a variety of court approved means, including, averaging or proportional distribution grids etc, simplified and expedited claims processing, and the use of sampling and other statistical evidence to determine individual awards. Finally, the Supreme Court of Canada has recognized that under the appropriate circumstances damage quantification itself can constitute a common issue for class certification and resolution.\(^{68}\)

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\(^{66}\)David Rosenberg, “Mass Tort Class Actions: What Defendants Have and Plaintiffs Don’t” (2000), 37 Harv. J. on Legis. 393, explaining the economies of scale that flow from mass tort class actions and why aggregation should be formally allowed.

\(^{67}\)Class Proceedings Act, 1992, supra note 61. Section 6 provides that a court shall not refuse certification purely on the grounds that “the relief claimed includes a claim for damages that would require individual assessment after determination of the common issues.” See also the Ontario Law Reform Commission Report on class actions discussion, on which the legislation was modelled. Ontario, Ontario Law Reform Commission *Report on Class Actions*, vol. II (Toronto: Ministry of the Attorney General, 1982) at 531. This approach is consistent with the belief that the Canadian threshold standards concerning class action certification are lower than comparable US standards. See S. Gordon McKee, “Why the Development of Mass Torts in Canada is Important to Corporate America” (2004) 71 Defense Counsel Journal 32.

\(^{68}\)Rumley v. British Columbia, [2001] 3 S.C.R. 184, holding that punitive damages constituted a common issue where the claimants were alleging systemic negligence against a defendant who operated residential schools in which the class claimants had been abused.
It is still early days for Canada and class action proceedings in mass tort situations; however, a number have been before Canadian courts resulting in both granting and denying certification. In *Caputo v. Imperial Tobacco Ltd.*, certification was denied respecting an action brought against tobacco manufacturers for injuries caused by the use of cigarettes. Justice Winkler denied certification on the basis that the plaintiff had failed to establish a sufficiently defined class sharing substantial common issues, such that neither liability could be determined as a common issue, nor aggregated damages because assessment would be dependent upon individual factors. In contrast, the same court in *Wilson v. Servier Canada Inc.*, **71** allowed certification of a product liability claim relating to the injurious effects of the diet drug Ponderal. The court recognized the bifurcated approach adopted under the legislation and identified an appropriate class of claimants whose claims would benefit from having common issues surrounding liability resolved by class proceeding, even if damage claims would require individual assessment.

The prospect of certification, and the explicit recognition of aggregate damages, increases the likelihood that mass tort actions in Canada will result in class action settlements. This has emerged as a rather murky area in American jurisprudence, where the traditional adversarial process gives way to collaboration between plaintiffs and defendants lawyers in presenting a united front to the court for approval. Often, lawyer self-interest is advanced over class and sub-classes of plaintiffs, or where one represented class is played off against a putative un-represented class who will nevertheless be bound by the settlement, and may even have their claim extinguished. **72** The Ontario legislation seeks to ameliorate some of these excesses by requiring court approval to any settlement **73** as well as separate approval to a solicitor’s fees. **74** Court approval to settlement is determined on the grounds of what is fair and reasonable **75** and can only be granted of a certified class action.

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69 See the cases grouped in Micheal A. Eizenga, *et al.*, *Class Actions Law and Practice*, looseleaf (Toronto: Butterworths, 1999) at §2.21 and 2.22.


72 See John C. Coffee, “Class Wars: The dilemma of the Mass Tort Class Action” (1995) 95 Colum. L. Rev. 1343. Coffee notes that a distinction exists between small claimant class actions — those which apart from the class action process would be non-viable — and where defendants will strenuously resist certification, and, large claimant class actions — typically engaging personal injury cases, and where defendants will actually encourage class action suit and settlement so as to control liabilities and stave off bankruptcy. In particular, the settlement class action presents a golden opportunity to limit or extinguish future claimants — those who were exposed to the injurious activity but have yet to show injury. Coffee also notes the phenomenon of ‘reverse auction’ in which the defendant of a potential large claimant class action forces plaintiff lawyers, representing a number of claimants, into a bidding war to determine who it will settle with, and so structure the terms of settlement for all potential and future claimants. See also Howard M. Erichson, “Mass Tort Litigation and Inquisitorial Justice” (1999) 87 Georgetown L. J. 1983 describing the role of courts asked to approve settlement class actions as engaged in inquisitorial rather than adversarial processes.


74 Ibid s. 32.

75 The criteria used to determine ‘fair and reasonableness’ is that suggested by Herbert Newberg.
Thus, in situations where the parties have settled prior to certification (in the US called a settlement only class action) and seek approval of the settlement, a Canadian court must also satisfy itself that certification would prima facie be available. An apparent lacuna in the law is that while a putative claimant has a right to receive notice and to opt out of the class following certification (s. 9), once a settlement is approved, the putative claimant will be bound by the terms of settlement (s. 29(3)). This means that the putative claimant in a situation where settlement approval and certification is heard at the same time, is dependent upon the Court insisting on the preservation of opting out provisions in the terms of the settlement, or in requiring (allowing) the parties to amend the class definition in the certification so as to exempt the non-notified party from the terms of the settlement.

The rights of the Ministry of Health and Long Term Care to recover health care expenditures in a class action suit mirrors that available in any civil suit in exercise of rights of subrogation. However, the number of claimants involved and the monetary amounts at stake obviously attract bureaucratic attention. For the Ministry, the ability to assess past and future health care costs of particular groups in society (whether defined by age, ethnicity, gender, medical history, occupation) is a matter of daily epidemiological research. Under the Class Proceedings Act, 1992 this evidence is readily accepted to determine distribution of an award. Where, either through settlement or judgment, the court has approved a global or capped award, or has approved a formula system in which claimants are entitled to prove their individual claims, it will be both possible and practicable for the Ministry to argue its subrogated entitlement. This award would not need to be dependent upon individual claimants establishing their prior entitlement. Any issues relating to causation or contributory negligence, which may adversely impact upon individual assessments, and which would then diminish any amount that the Ministry could recover on a derivative subrogated claim basis, will already be built


76 A further refinement is the all-or-nothing settlement only class action in which the defendant adds a term to the settlement agreement that preserves its right to dispute class certification should the court not approve the settlement. Canadian courts have endorsed such negotiations to encourage efficient disposition of potential class proceedings. See Coleman v. Bayer Inc. (2004), 47 C.P.C. (5th) 346 (Ont. Sup. Ct.) [Coleman].


78 This was the option taken in Coleman.

79 Section 23(1) states: For the purposes of determining issues relating to the amount or distribution of a monetary award under this Act, the court may admit as evidence statistical information that would not otherwise be admissible as evidence, including information derived from sampling, if the information was compiled in accordance with principles that are generally accepted by experts in the field of statistics (supra note 61).
into the epidemiological evidence used to support the Ministry claim for a fixed part or percentage of a global or formula award. Thus, just as in the asbestos class action proceedings in the United States, the individual claimant’s smoking habits frequently occurred as a variable on any compensation grid in reduction of the claimant’s claim, so can these contributory risk factors be built into any statistical basis of recovery for health expenditures across a large number of claimants. An added advantage to recovery pursuant to class action suits for the Ministry is the possibility of recovering medical monitoring and diagnostic costs for asymptomatic claimants. In Wilson, Cumming J. suggested that such costs could be recovered where the claimant could show the basic elements of a tort claim in which the injury was the need for medical screening. In fact the Ontario Health Ministry pursuant to its statutory subrogation rights was asserting this claim.

(iii) Specifically enacted legislation

In contrast to the derivative nature of the subrogated claim, is specifically enacted legislation, as adopted, first in British Columbia, and then in Newfoundland and Labrador, to deal with health costs associated with tobacco consumption. Both Provinces have enacted legislation modelled after Florida and Vermont that significantly changes traditional common law rules with respect to causation, damage assessment and enterprise liability. Following its enactment the tobacco industry mounted a successful constitutional challenge to the legislation. Rather than appealing the decision, the British Columbia legislature corrected and re-enacted the statute, now titled the Tobacco Damages and Health Care Costs Recovery Act.

The legislation is designed to overcome three perceived impediments to suits against the tobacco industry to recover health expenditures. One, while it can be said of a general population that tobacco causes a series of injuries including cancer, cardiovascular and bronchial diseases, because tobacco injuries have a long latency period, it is difficult to link any particular individual injury to tobacco as a single causative element of the harm. A variety of factors may have contributed to the

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80 See Issacharoff, supra note 65, discussing the reliability of variables in asbestos claims.
81 The other factor that Cumming J. suggested needed to be proved, was that the claimant had ingested the drug Ponderal in sufficient quantities such that it was the proximate cause justifying increased monitoring (Wilson, supra note 71).
85 Tobacco Manufacturers Liability for Medical Expenditures, V.S.A. Tit. 33.
87 S.B.C. 2000, c.30 [TDHCCRA].
individual injuries. Two, again because tobacco related injuries have a long latency period and an individual pattern of smoking is unlikely to be confined to a single manufacturer’s product, it is difficult to make a conclusive link between any individual claimant and a single named defendant. Three, tobacco companies operate in a global environment and often establish shell companies to operate in a single jurisdiction. Any judgment gained in a provincial court may prove illusory if it simply leads to the bankruptcy of a shell company.

In answer to the first impediment the legislation provides for a new statutory action — a tobacco related wrong — in which the government must prove on a balance of convenience standard that; (a) the defendant breached a common law, equitable or statutory duty or obligation owed to persons exposed to tobacco; (b), that the type of exposure can cause or contribute to disease; and (c), during all or part of the period in which the breach occurred the defendant product was offered for sale in British Columbia. The government has its own exclusive action not dependent upon any rights of subrogation. The government action is further assisted by allowing for health recovery costs to be made on an aggregate basis in which the government does not have to provide details of expenditures made touching any particular individual but is allowed to advance a claim based on a statistically meaningful sample. The Act also provides that both the government claim and any class action proceeding, may rely upon epidemiological, sociological and other studies to establish causation and quantify damages.

The second impediment is met with the statutory adoption of a market share theory of liability. The TDHCCRA provides a formula based on the quantity and length of time that a manufacturer has been supplying the British Columbian market to determine its market share. Finally, to meet the third impediment, the Act has an exhaustive definition of a manufacturer constituting a form of enterprise liability provision, and which pierces the corporate veil. In the initial TDHCCRA, the enterprise provisions were held to be unconstitutional as amounting to an extra-territorial claim beyond provincial jurisdiction. Following re-enactment the tobacco industry again raised a constitutional challenge to the legislation, which was successful at the trial level on substantially the same grounds i.e. extra-territorial effect of the legislation making the pith and substance of the legislation beyond

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89 Supra, note 87, s.3(1).
90 Ibid. s. 2(1). With respect to a meaningful sample, the act envisages that the defendant will be given access to health records of the sample to allow expert testimony without the need for individual victims to be compellable or identified.
91 Ibid. s.5.
92 Ibid. s.1(2) definition section under “manufacturer”, s. 3(3)(b). An individual claimant or class action suit may also access the market share doctrine to recover damages, s.7(2) & (3).
93 JTI-Macdonald, supra note 86. The court determined that because the legislation purported to create a tort out of conduct that may have occurred outside provincial boundaries and that the enterprise liability implicated both domestic and foreign corporations, the pith and substance of the legislation was outside provincial jurisdiction. See Elizabeth Edinger, “The Tobacco Damages and Health Care Costs Recovery Act: JTI-Macdonald Corp. v. British Columbia (Attorney General)” (2001) 35 Canadian Business L. J. 95, for a discussion of the constitutional issues.
provincial jurisdiction.\footnote{British Columbia v. Imperial Tobacco Canada Ltd. (2003), 227 D.L.R. (4th) 323 (B.C.S.C.).} On appeal, the trial court was reversed and the constitutionality of the legislation upheld.\footnote{British Columbia v. Imperial Tobacco Canada Ltd. (2004), 239 D.L.R. (4th) 412 (B.C.C.A.).} The changed wording in the statute clarifying that the government cause of action, namely a tobacco related wrong arose only in relation to a breach of duty owed to a person in British Columbia, to recover health care costs incurred in British Columbia as a result of exposure to tobacco products in British Columbia, and was thus clearly within the pith and substance of provincial jurisdiction.

The British Columbian government has since announced that it intends to pursue its suit against the tobacco industry under the legislation.\footnote{See Susan Brice, Minister of State for Mental Health and Addiction Services, Press release, “Why BC is Taking Tobacco Manufacturers to Court” (14 June 2004).} This does not necessarily mean that the government action is plain sailing. The Court of Appeal simply ruled on constitutional validity, and not application, the latter requiring an evidential record. The crown still needs to prove a breach of common law, equitable or statutory duty, most likely, knowingly providing a defective product, failure to warn, deceit, and misrepresentation. And, that exposure (in essence smoking under the definition section of the \textit{TDHCCRA}) to the type of tobacco product can cause or contribute to disease. At this point two presumptions assist the crown. One, the population exposed (read smoking) to the product would not have been exposed but for the wrong, and, two, the exposure caused the risk of disease in a portion of the population as shown by the epidemiological evidence. It is then up to the defendant to provide evidence to rebut the presumptions, and show on a balance of probabilities that the wrong did not cause or contribute to the exposure (i.e. that insured persons would have smoked regardless of the wrong), or, that exposure (smoking) did not cause the disease or increased risk of disease. However, in rebutting the presumption, the defendant will not have access to individual records of insured persons who have receive health benefits. The defendant will be able to challenge the sampling evidence of the crown, and may provide its own sampling research in which it may have secured waivers of confidentiality by any participants in the survey. Obviously, the defendant survey would have to have statistical credibility. Nor does the legislation preclude a defendant from raising assumption of risk and contributory negligence as defences,\footnote{The British Columbian legislation is less heavy handed than the Floridian statute it was modelled on, and which abrogated these defences entirely (\textit{Medicaid Third-Party Liability Act}, supra note 84). The Florida statute was upheld in a constitutional challenge (See \textit{Agency for Health Care Administration v. Associated Industries} 678 So. 2d 1239 (Fla S.C. 1996) cert. denied 117 S. Ct. 1245 (1997)), although the subsequent comprehensive state tobacco settlement resulted in any subsequent action being dropped. See discussed in Tiffany S. Griggs, “Medicaid Reimbursement From Tobacco Manufacturers: Is the States' Legal Position Equitable?” (1998) 69 U. Colo. L. Rev. 799.} although it makes it problematic to prove in a statistical way what has traditionally be thought of as very idiosyncratic decisions by smokers. It also shifts a significant cost to defendants to defend, although this cost is one the tobacco industry can readily shoulder, if a defence is to be based on survey and sampling data rather than individual cross-examination
of victims of tobacco. In *JTI-Macdonald*, Rowles J.A. also flagged some evidential issues for the crown concerning problems associated with migrants to and from British Columbia, and for which the crown would have problems bringing within the terms of the statute. This signals the likelihood that the Province will have to create numerous sub-classes of citizens for which it is seeking recovery in varying amounts depending upon length of residency, and when and where the sub-class commenced smoking.

Within the three legal methods discussed above there is clearly the opportunity for governments to pursue recovery of health expenditures. Explicit legislation currently targets tobacco, although the focus could readily be applied to other insidious manufacturers. The legislation has the merits of public discussion before enactment. In contrast, the long held right of subrogation, now coupled to class actions, has not been debated with respect to its impact on health care policy. Through stealth of litigation, health policy may be irrevocably changed.

**D. Litigation and Health Care Policy**

Underlying any understanding of the role that litigation and tort law has, if any, in funding health care, is an appreciation of the organizing principles that support each respective regime. Litigation is an effective way to meticulously find and scrutinize facts; determine issues of rights, responsibilities, and duties, and attribute fault or wrongdoing. Litigation also serves a useful function in quantifying losses and harm. Tort law, explained on corrective justice grounds, requires findings of wrongdoing arising from a breach of duty owed between litigants. Tort law, explained on distributive justice grounds, seeks to fairly apportion the benefit and burdens of risky behaviour between litigants, i.e. it punishes with liability those who fail to identify and take account of risks that injure others, and which could reasonably have been avoided.98

In contrast, the provision of primary health care throughout Canada is organized along distributive justice lines writ large. Its services are funded from progressive tax revenues gathered from the community at large and supplied to those in medical need. However, because it is organized as a comprehensive no-fault scheme it does not require adjudicative mechanisms to determine risk, fault, duty, or responsibility; issues which are irrelevant to establishing medical need or entitlement. The real risk of the litigation strategy to funding health care is that its slow encroachment threatens the underlying organizing principle of current health policy, namely universal no-fault.99 Of course it would be foolish to argue

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99 See Romanow Commission, *supra* note 1. Chapter headed “Message to Canadians” describing the essential values of Canada’s national health care system, including “equity, fairness and solidarity”, and as a “right of citizenship”. Later decrying those advocating more radical solutions including user fees, medical service accounts, de-listing of services, greater privatization, and a parallel private system as being unable to show proof that Canada’s system would be cheaper or improved from there adoption.
that Canada’s primary health care system is stringently no-fault. Daily, decisions are made on who does and does not get service, often coloured by attributions of fault or negative life style considerations; for example, liver transplants refused to alcoholics, those affected by drug addiction, and those HIV positive. And, it may well be that the light of litigation should be shone on some of these practices. However, the reason for doing so is to improve equity and fairness in decision-making, and not to attribute fault or recover contributory medical costs.

Aggressive pursuit of subrogation rights by provincial health ministries carries both policy and practical risks to current health policy. The schizophrenic quality of such a claim was mentioned earlier. Provincial pursuit of subrogation rights perpetuates the myth that health care is a pure insurance scheme. Any applicable defences the third party can allege against the insured limit the extent of recovery under the right. Following the insurance analogy forward, a person injured from self inflicted wounds, or while in the course of committing a crime, should not receive coverage. It is not too hard to envisage the insurer (i.e. Provincial government) writing its insurance policy to exclude certain liabilities (i.e. in effect de-list covered medical services, a practice already occurring to some extent in Canada) based on life style choices i.e. whether the person is a smoker or obese. For an insured, this would require that he or she secure alternative insurance to cover these risks of no or under insurance, but now from the private sector, and most likely, based on premiums that build in some form of individual risk assessment. Of course, many would be unable to secure such insurance, as happens in the United States. The irony of such a movement is that if a provincial government became nothing more than an insurer, it would itself, negotiate the equivalent of knock for knock agreements with private insurers and contractually limit subrogation rights.

There are numerous arguments given in support of tort law, although the most common are to effect compensation and deterrence. The study by Dewees, Duff & Trebilcock, confirms that tort law is a poor and inadequate model to achieve compensation, and has largely been abandoned by most Western nations with respect to automotive and workplace injuries. Deterrence advocates argue that tort law shifts the cost of wrongdoing onto the tortfeasor so that the full cost of activities, which are not criminally prohibited, are internalized. In this way the market costs of an activity can reflect the true risks associated with its use and production. Put into operation, deterrence may be either too little, because not all

100 See the discussion in P. Mailly, “Fine Wine and Ideal Theory” Windsor Yearbook of Access to Justice [forthcoming in 2005].
101 This form of insurance is already common in Canada as part of employment related contracts providing drug, dental, and other extended health care services.
102 In the area of medical mal-practice, where the Ontario Ministry is both the first party insurer and in effect third party liability carrier for physicians it is being urged to eliminate subrogation rights. See discussion above at text accompanying notes 57-58.
tort victims sue, or too much, if tort victims are able to shift their own contributory wrongs to the tortfeasor, or receive damages in excess of compensation (i.e. punitive and aggravated damages). A difficulty with deterrence theory justification for tort law is the misalignment of the tort action and the behavioural modification that it seeks to encourage, with the actual harm caused to the tort victim. For example, in the area of tobacco suits, the tort more often alleged is a failure to warn, or deceit and misrepresentation. The behavioural modification the tort aims to accomplish is to ensure tobacco manufacturers properly inform consumers about the risks associated with tobacco products, and liability will be reduced where the tortfeasor can show the victim’s informed consent or voluntary assumption of risk. From society’s point of view, there is no social utility in tobacco consumption whatsoever, and the desired behavioural modification is tobacco cessation rather than product information correction. Recovery of health care expenditures, pursuant to a right of subrogation in such action, only partially achieves society’s objective, and in fact makes the argument why tobacco consumers should be made to share in the cost of health care services, so that they are encouraged to internalize the cost of their own destructive behaviour. The disproportionate demand that tobacco consumers make on health services is an issue that warrants debate, but policy makers, not through the stealth of litigation, should undertake it openly in public. 104

A right of subrogation, if underpinned by the law of unjust enrichment, illuminates other concerns. The unjust enrichment claim is based upon the compulsory discharge of a present legal liability of the defendant. Absent the statutory right of subrogation accorded government health ministries, the weight of judicial opinion treats health expenditure as a form of state funded benefit, the effect of which reduces the legal claim of the claimant against the tortfeasor. In this sense, the legal claim is reduced by the amount of the benefit because the claimant has not experienced that as a loss. 105 The presence of a statutory subrogation right, whether it is exercised or not, 106 changes the picture; it constitutes the payment of health services by the government scheme an unjust enrichment of the tortfeasor. The statutory right to subrogation is an indication that the payment by the govern-

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104 It is easy to pick on the tobacco industry because one can safely assert that there is no social utility in having tobacco available. The only claim, and I would suggest it is a marginal claim given the effects of second hand smoking on other individuals, is that it appeals to liberal sentiments about individual autonomy and freedom of choice. The misalignment of tort action and consequent harm becomes much more difficult when we contemplate suits against the fast food industry. Again, the tort action is most likely designed to encourage proper product information associated with excessive consumption of dietary fats. The harm is an increase in obesity and a slew of associated health problems. The desired behavioural modification is to accept a healthy balanced diet. This time there is social utility in fast food as a food source. How does the recovery of health care costs pursuant to subrogation in an action where the main defence will likely be assumption of risk, contributory negligence, and informed consent, advance the behavioural modification of encouraging a healthy balanced diet?

105 See Ratych, supra note 35; Cooper-Stephenson, supra note 36.

106 See Stein, supra note 54, where OHIP waived its right to subrogation, and the claimant was still entitled to bring full recovery of its losses against the defendant.
ment was neither gratuitous nor officiously granted, but one made under compulsion of law. Although, it seems anomalous that the presence of such a minor provision in the *Health Insurance Act* can have such a significant impact on the construction of the legislation, which seems, so overwhelming to be, a social benefit scheme for all regardless of fault.

Is it accurate in Canada to portray the tortfeasor as one who has been enriched by the apparent discharge of their legal liability to bear costs for health care? Primary health care organized on a no-fault basis, and which mirrors first party insurance, draws funding through progressive taxes on all sectors of the economy. In fact, in Ontario a specific employer health tax is imposed, now matched by a new individual health tax premium. These taxes mean that the benefit conferred by discharging a legal liability of a manufacturer is, in a *de facto* sense, a paid for benefit, resulting in the conclusion that there is a juristic reason explaining the transfer and thus does not constitute an unjust enrichment. It is for these reason, and others, that Cooper-Stephenson concludes: “The socialized health care system does not blend well with the tort compensation system, and the integration of the two systems creates assessment problems of a unique character within the award for costs of care.”

The combining of subrogation rights together with class action proceedings raises special concerns beyond the fact that the amounts recoverable have the potential to dramatically increase. The State tobacco settlements in the United States raise sufficiently disturbing questions about process and result to question why Canadian jurisdictions should follow and legitimate such activities as a means to secure additional health funding.

The tobacco settlement is problematic in a number of respects. First, the promised payment of $240 billion through to the year 2025 bear little correlation with the actual anticipated medical care expenses. Dagan & White have suggested that actual costs attributable to the tobacco industries wrongdoing would amount

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107 *Employer Health Tax Act*, R.S.O. 1990, c. E.11. The act provides generous exemptions, an employers first $400,000 of payroll being exempt from paying the tax. The tax is in addition to employer levies to cover workplace injuries under the *Workplace Safety and Insurance Act*, *supra* note 37.

108 The reintroduction of an individual health premium on all taxpayers ironically may strengthen the argument that health care is purely an insurance scheme in Ontario. In effect, it may bring the provision of health care more within the ‘insurance exception’ (*see supra* note 36) to the collateral benefit rule and thus favour non-deductibility in any claim.


110 For an outline of these settlements see *above* note 39. The State actions were not class actions themselves, but were based on either a claimed legal right to recover health care expenses based on a breach of duty — either statutory or tortious — owed to the state, or pursuant to a subrogation right to all Medicaid recipients.

to $30-35 billion. Viscusi has argued that in fact the cost of tobacco smoking is a net wash to the States once one accounts for the shortened life span of smokers, and the commensurate impact on lower pension and social security payments that result. When tax revenues from tobacco are taken into account, the States experience a net benefit from tobacco smokers. Comparable Canadian figures reveal a similar picture. Canadian health care costs directly attributable to smoking have been put at $2.5 billion, and increase in long term care at $1.5 billion. The cost of tobacco on the economy only begins to grossly exceed the revenues from tobacco taxes when losses in productivity experienced from the premature death, and workplace absenteeism of smokers, is taken into account.

Figures of this magnitude are not the stuff of routine litigation before courts. The huge tobacco settlement in the US led to an unusually structured settlement. In effect, the award constituted a litigated tax on tobacco. The tobacco settlement structured payments based on future cigarette consumption in which the States compensation would diminish as demand dropped, or if new tobacco entrants forced competition for market share. In addition, to protect existing market share, the settlement made provision for voluntary adoption of a model statute which would impose a tax on both participating and non-participating tobacco companies to fund the settlement. Any new tobacco entrant was thus bound to fund the settlement, even though it could hardly be held responsible for the wrong for which it settled. The effect of these provisions is to make the respective States willing accomplices to market collusion so that the significant income stream from the settlement is preserved. In addition, the settlement results in the industry being able to meet its obligations by increasing product price alone without the need for either the company or its shareholders absorbing the loss. The argument that cost of wrongdoing is internalized and that deterrence is imposed, assuming its validity, collapses with this type of settlement. Armed with these settlements some States

112 Dagan & White, supra note 38 draw their conclusion from the study of Willard G. Manning et al., The Cost of Poor Health Habits (Cambridge: Harvard University Press, 1991) which found that tobacco smokers added $6,000 per person (in 1991) lifetime medical costs. States through Medicaid bear only a portion of these costs put at $557 per person. Taking this figure and multiplying it by the number of smokers in the US comes to $30-35 billion.

113 Viscusi, supra note 112, Tobacco: Regulation and Taxation through Litigation 22.

114 Viscusi, ibid, stresses that one must look at the overall lifecycle costs associated to smoking. Smokers who die at a younger age do not absorb the medical expenses normally associated with the elderly, when medical expenses in the last five years of life typically consume equivalent amounts as that spent on the entire preceding part of a person’s life.


117 The percentage of the settlement borne by tobacco users is put at 90% (Michael DeBow, “The State Tobacco Litigation and the Separation of Powers in State Governments: Repairing the Damage” (2000) 31 Seton Hall L. Rev. 563).
have now entered into bond sales securitizing the tobacco settlement, literally cashing in the income stream to meet present budgetary constraints.\textsuperscript{118}

A second problem with the tobacco settlement is the transaction costs expended to generate the settlement. Private lawyers representing the States, often on a contingency fee basis, negotiated the settlement. In Florida, Mississippi and Texas, the fee to around two-dozen plaintiff lawyers amounted to $8.2 billion, approximately 25\% of the settlement. Other States have settled in the multi-million dollar range, while in California a court has recently upheld an initial arbitration award of $1.3 billion.\textsuperscript{119} The argument in favour of contingency fees as widening access to justice to those with inadequate means to fund litigation is lost when the claimant is government. These obscene fees have lead some legislatures to statutorily deny the right of government to enter into contingency fees arrangements with outside lawyers.\textsuperscript{120}

A third problem with the tobacco settlement is the complete lack of public scrutiny of the process and the eventual settlement. The settlement is seen as a simple act of government settling a private dispute, a matter of daily routine. No other consumer tax could be imposed outside the watchful eye of legislature or the public. The tobacco settlement has fuelled a debate that the United States is increasingly becoming a nation regulated through litigation.\textsuperscript{121} And, that American tort law is, as Atiyah asserted, under the control of a sort of pro-plaintiff party which seems to see its function as performing the redistributive exercises performed by legislatures in other democratic systems.\textsuperscript{122} The growing movement to sue gun manufacturers, paint manufacturers, alcohol, gaming, and fatty food producers\textsuperscript{123}

\textsuperscript{118} See the discussion document, “Securitization: An Option for State Tobacco Settlement Funds” (8 September 1999), online: National Governors Association <http://www.nga.org/center/divisions/1.1188.C_ISSUE_BRIEF%5ED_607.00.html>, Alaska, Alabama, South Dakota and South Carolina have all entered into securitization schemes.

\textsuperscript{119} Many of the initial contingency fee agreements provided a 25\% fee. These were later reopened after public dissatisfaction at the amounts involved. An arbitration process was set in place to determine the fees. See Daniel J. Capri \textit{et al.}, “The Tobacco Litigation and Attorneys’ Fees” (1999) 67 Fordham L. Rev. 2827; Little, supra note 117. In California a court has now upheld an arbitrators original ruling of $1.3 billion to a 56-lawyer consortium. California’s settlement was worth $25 billion. In New York, whose share of the settlement was also $25 billion, legal fees of $625 million were paid. See Tom Perrotta, “$1.3 Billion Fee Upheld in California Tobacco Case” New York Law Journal (19 May 2004), online: Law.com <http://www.law.com/jsp/article.jsp?id=1084824763775>.

\textsuperscript{120} See DeBow, supra note 118.

\textsuperscript{121} Viscusi, supra note 112. For a comprehensive thesis about the transformative role of litigation in society see W.A. Bogart, \textit{Consequences: The Impact of Law and its Complexity} (Toronto: University of Toronto Press, 2002).


confirms the worst suspicions of sceptics, that in the United States, what Robert Reich, President Clinton Secretary of Labour claimed, that: the era of big government may be over, but the era of regulation through litigation has just begun is truly upon us. In this new world lawyers see themselves as a de facto fourth branch of government.

One cannot automatically extrapolate from the United States equivalent developments in Canada, although it would be foolish to believe that Provincial Attorney Generals are oblivious to the money obtained by their State counterparts in tobacco litigation. Because Canada has not developed its product liability law to accommodate strict liability, significant impediments will arise. Without specific legislation a direct legal action between health care provider and insidious industry is unsettled legal terrain. A subrogation claim is certainly viable. Any doubt over the nature of the legal claim may be offset by ease in class certification. And, in any case, it was the fear of civil suit, including the prospect of specifically enacted legislation, as in Florida, together with a variety of ex cura developments, which brought the tobacco industry into a private settlement. If settlement achieves results in tobacco, there is good reason to believe that Canadian governments will be as equally sagacious to target other injurious industries. But a claim based on aggregating subrogation rights will require detailed evidence on the cost of medical services provided and promised for the future. Costing medical services is difficult. Ontario’s Minister of Health recently admitted that his ministry faces huge problems in just understanding the complexity of the health scheme, and finding out such simple issues as how many medical procedures of a certain type are performed annually. If compensation were recovered in any litigation, the ministry would be obliged under the legislation to furnish those services. The process of quantifying damages could result in privileging one form of medical patient, i.e. victim of tobacco, as against others. The ministry would have an incentive to build as much of the costs of health services into the damages claimed so as to maximize its return on the litigation investment. In time, depending on changing health protocols, the services promised, and which must be furnished to meet the statutory requirement, may be quite different to those then publicly funded under a strained health system. Similarly, a patient for whom damages under subrogation have been awarded, may, if the concept of tort and fault become further integrated into health funding, find that the services provided are

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124 Robert B. Reich “Regulation is out, Litigation is in” USA Today (11 Feb 1999), online: The American Prospect <http://www.prospect.org/webfeatures/1999/02/reich-r-02-11.html>.

125 Coined by Walter Olson author of The Rule of Lawyers: How the New Litigation Elite Threatens America’s Rule of Law (2003) in his article, “The Florida Jurors: Anything but Typical” The Wall Street Journal (July 12, 1999) A29. As Olson states, this new de facto branch of government is one defined by the fact that it: …pays a whole lot better than the other three, isn’t subject to the disclosure rules and blind trusts we expect of presidents, senators and chief justices, does its unaccountable work behind the doors of settlement rooms from which the public is excluded, and, best of all, doesn’t have to face those pesky distractions known as ‘elections’.

126 I have explored some of these legal impediments in an earlier article. See Berryman, supra note 20.

diminished on the basis of their own moral failings in contributing to their own health problems. Or, be confined to medical service that can be funded from their damages account itself being quantified in advance of need, and from poor information on the escalating cost of medical services. The possibility of securitizing any award and realising its current cash value today, coupled with a statutory guarantee to provide the promised service in the future, would be tantamount to further shifting health care costs to a later generation.

Contingency fees in Canada of the magnitude of billions of dollars may currently appear fanciful. Yet, the Government of Newfoundland and Labrador has entered into a contingency fee arrangement with a US firm to pursue tobacco litigation to recover health care costs.128 There is a view that such arrangements are win-win, because the government has the chance to receive a dividend from the award without having to bear any of the costs. Of course, a settlement that simply shifts the cost onto consumers, as in the US, simply means that a potentially large transaction costs has been assumed to increase current sin taxes on tobacco.129

Specific legislation aimed at a particular form of harm, and designed to recover health costs, at least has the advantage that it is the product of public scrutiny before a legislature. Yet, even here there is evidence of a misalignment between public goals and what is legally attainable under the legislation. The British Columbian tobacco legislation that supports litigation is aimed at ameliorating procedural barriers to enable claims based on established tort actions such as deceit, misrepresentation and failure to warn. In the legislature, Andrew Petter, then cabinet minister and now Dean of Law (University of Victoria, BC), identified the legislative intent as addressing the: “extraordinary, unique difficulties in bringing evidence forward and demonstrating that in fact the damages that have been alleged have been caused. What this legislation will allow the government to do is ensure that a court can reach a fair determination based upon evidence.”130 M. Farnworth, the minister responsible for the bill’s passage, was more blunt. In the second reading debate he asserted: “We believe that the tobacco industry targets children in marketing. We believe the industry manufactures a product that kills people. We believe the industry should be held accountable for the costs of treating tobacco-related illnesses.”131 And later in the debate: “our government remains firm in its resolve to seek compensation for tobacco-related health care

129 A recent settlement of the Ponderal class action drug case (Wilson, supra note 71) demonstrates the returns for claimant counsel. The settlement is for $40 million, of which the government health ministry will receive $1 million in full settlement of all health expenditures, plus a chance to participate in any excesses after all class members’ claims have been processed. Class counsel will receive $4 million fees and will make a request for court approval for an additional $10 million to be paid from the settlement fund. Terms of settlement available, online: Rochon Genova LLP <http://www.rochongenova.com/docs/RG%20Final%20Settlement%20Agreement.pdf>
130 British Columbia, Legislative Assembly, Hansard, 6 (7 June 2000) at 16318 (Hon. A. Petter)
131 British Columbia, Legislative Assembly, Hansard, 6 (7 June 2000) at 16314 (Hon. M. Farnworth).
costs, to expose the misconduct of the tobacco industry and to deter future misconduct.132 These are noble goals, but the text of the legislation seems at odds with their realisation. If cost recovery of future health expenditures and correct information on the damages of smoking by young people is the intent, as declared by the minister, then the legislation seems a particularly obscure way to achieve it. This legislation is far removed from the form of direct controls on advertising, and the imposition of taxes to increase the cost of tobacco, both strategies that have a proven track record of behavioural modification.133

Conclusion

Jeffrey Simpson, the Globe & Mail political columnist, constantly reminds Canadians of the insatiable appetite of primary health care for government funds, largely as a result of an ageing population, and that throwing more money at it can only offer band-aid solutions for an ailing system.134 The Romanow Commission identified core values of Canada’s health system around the principles of equity, fairness and solidarity. No single model will provide a solution to fit all provinces, and they should be left to experiment, consistent with their own political values and aspirations. Many see hope in finding efficiencies in delivery of services, including publicly funded private clinics, and productivity gains by purchasing deliverables between competing entities rather than simply providing base funding to expensive hospitals and long term care facilities. Aggressive pursuit of a litigation strategy, either through subrogation claims, class actions, or specific legislation, aimed at cost recovery is a retrograde step. It is retrograde because it does nothing to address health reform; yet, its adoption threatens to distort the core values of Canada health care system. The path of health reform has been toward no-fault, where attribution of blame for injury serves little or no purpose. Litigation re-establishes fault as an allocation mechanism possibly privileging some, but more likely denying others, by legitimating and equating health funding to individual choice rather than medical need. It may be appropriate that public debate take place on whether smokers, the obese, alcoholics, and others whose life style choices increase health risks should receive equal availability to medical services, but this debate should take place openly, and not under the cover of litigation initiated at the behest of government.

Class actions and specific legislation aimed at shoring up governments cost recovery strategy makes litigation that much more likely to happen. Governments can only salivate at the prospect of reaping an unbudgeted fiscal dividend, even if

132 Ibid. at 16314.
134 This has been a continual theme of Jeffrey Simpson. See Jeffrey Simpson “Rearranging the health deck chairs” Globe & Mail (14 September 2004) A21; Jeffrey Simpson “This health-care sausage won’t serve up reform” Globe & Mail (17 September 2004) A17.
it is the product of a private law suit incurring large transaction costs for the services of a new legal elite marshalling around mass tort liability suits. Specific legislation, and the ensuing litigation, focuses upon redressing past wrongs, rather than providing a meaningful compass toward desirable behavioural modification.