CHAPTER 2

Chaoulli to *Cambie*: Charter Challenges to the Regulation of Private Care

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Unlike the *Universal Declaration of Human Rights*,[1] the *International Covenant on Economic, Social and Cultural Rights*,[2] and many other twentieth-century constitutions,[3] the *Canadian Charter of Rights and Freedoms*[4] does not contain an explicit right to health or to health care services. Instead, section 7 of the *Charter* guarantees everyone in Canada "the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Section 15 of the *Charter* promises every individual "the equal protection and equal benefit of the law without discrimination."[5] It is these two *Charter* rights that

1 *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, Un Doc A/810 (1948) 71, art 25(1).

2 *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, Can TS 1976 No 46 (entered into force 3 January 1976, accession by Canada 19 May 1976) [*ICESCR*].

3 See generally Colleen M Flood & Aeyal Gross, eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (New York: Cambridge University Press, 2014).

4 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

5 For a more in-depth discussion of sections 7 and 15 in the health care context, see Martha Jackman, "*Charter* Review of Health Care Access" in Joanna Erdman, Vanessa Gruben & Erin Nelson, eds, *Canadian Health Law and Policy*, 5th ed (Markham: LexisNexis Canada, 2017) 71 [Jackman, "*Charter* Review"];

Dr. Brian Day has invoked in his constitutional challenge to British Columbia's single-payer health care system in *Cambie Surgeries Corporation v British Columbia (Attorney General)* (*Cambie*).[6] Dr. Day is arguing, on behalf of Cambie Surgeries Corporation, the Specialist Referral Clinic (Vancouver) Inc. (SRC), and four individual plaintiffs, that restrictions on private health care and funding in British Columbia are unconstitutional.[7] Like the medicare regimes in most other provinces, the impugned provisions of British Columbia's *Medicare Protection Act*[8] prohibit duplicative private insurance and physician dual practice, and cap private medical fees to the level of public fees in order to ensure compliance with the conditions of the *Canada Health Act*.[9]

The arguments in *Cambie* draw directly on the Supreme Court of Canada's highly criticized 2005 decision in *Chaoulli v Québec*

Martha Jackman, "The Future of Health Care Accountability: A Human Rights Approach" (2015–2016) 47 Ottawa L Rev 437 [Jackman, "Health Care Accountability"]; Martha Jackman, "Health Care and Equality: Is There a Cure?" (2007) 15 Health LJ 87.

6 *Cambie Surgeries v British Columbia (Medical Services Commission)*, (2015) Vancouver S090663 [*Cambie*]. In his interlocutory ruling in *Cambie Surgeries v British Columbia (Medical Services Commission)* 2015 BCSC 2169 at paras 14–28, Chief Justice Cullen provides a summary of the proceedings in the case to that date. A complete timeline and links to key legal documents in the *Cambie* case has been compiled by the BC Health Coalition, online: <http://savemedicare-bchealthcoalition.nationbuilder.com/court-documents>. See also Colleen Fuller, *Cambie Corp. Goes to Court: The Legal Assault on Universal Health Care* (Ottawa: Canadian Centre for Policy Alternatives, April 2015) [Fuller, *Cambie Goes to Court*].

7 *Cambie* (Fourth Amended Notice of Civil Claim) [*Cambie* (Civil Claim)]; *Cambie* (Plaintiffs' Opening Statement of the Plaintiffs, 6 September 2016) [*Cambie* (Plaintiffs' Opening Statement)].

8 *Medicare Protection Act*, RSBC 1996, c 286 [*MPA*], s 17(1), 13(6).

9 *Canada Health Act*, RSC 1985 C-6; *Cambie*, Statement of Defence at paras 66–71 [Cambie (Defence)]; *Cambie* (Opening Statement of the Defendants) at 10–21 [*Cambie* (Defendants' Opening Statement)]; Cambie (Opening Statement of the Coalition Interveners) at para 13 [*Cambie* (BC Physicians and Patients Coalition Opening Statement)]. See generally Collen M Flood & Bryan Thomas, "Modernizing the Canada Health Act" (2017) 39 Dal LJ 397; William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Tim Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy* (Markham: LexisNexis, 2011) 43; Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 61 CMAJ 825.

(Attorney General).[10] Four of seven justices ruled in *Chaoulli*[11] that Quebec's prohibition on private health insurance violated the right to life, personal security, and inviolability, guaranteed under section 1 of Quebec's *Charter of Human Rights and Freedoms*.[12] Three justices found that, by preventing timely access to medical treatment, limits on private insurance under the *Health Insurance Act*[13] and *Hospital Insurance Act*[14] also violated section 7 of the *Canadian Charter*.[15] In contrast, the three dissenting justices in *Chaoulli* concluded that the ban on private insurance was "a rational consequence of Quebec's commitment to the goals and objectives of the *Canada Health Act*."[16]

In this chapter, I consider the significance of the *Chaoulli* decision for the outcome of the constitutional challenge in the *Cambie* case. The first part summarizes the *Charter* arguments advanced by the plaintiffs in *Cambie*. In the second part, I briefly review the lower and Supreme Court of Canada decisions in *Chaoulli*. In the third and fourth parts I focus on two aspects of the *Chaoulli* decision that are of particular significance for the outcome of the *Cambie* challenge: first, the courts' approach to evidence about private health care funding; second, their attitude toward the substantive equality objectives of

10 *Chaoulli v Québec (Attorney General)*, 2005 SCC 35 [*Chaoulli* (SCC)]; rev'g [2002] RJQ 1205 (CA) [*Chaoulli* CA]; aff'g [2000] RJQ 786 (SC) [*Chaoulli* (SC)]. For critical commentary on the *Chaoulli* case, see, e.g., Marie-Claude Prémont, "L'affaire *Chaoulli* et le système de santé du Québec: cherchez l'erreur, cherchez la raison" (2006) 51 McGill LJ 167 [Prémont, "Cherchez l'erreur"]; Bruce Porter, "A Right to Health Care in Canada—Only if You Can Pay for it" (2005) 6:4 ESR Rev 8 [Porter, "Right to Health Care"]; Jeff A King, "Constitutional Rights and Social Welfare: A Comment on the Canadian *Chaoulli* Health Care Decision" (2006) 69:4 MLR 619; Martha Jackman, "'The Last Line of Defence for [Which?] Citizens': Accountability, Equality and the Right to Health in *Chaoulli*" (2006) 44 Osgoode Hall LJ 349 [Jackman, "Last Line of Defence"]; Robert G Evans, "Baneful Legacy: Medicare and Mr. Trudeau" (2005) 1:1 Healthcare Pol'y 20; Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) [Flood, *Access to Care*].

11 *Chaoulli* (SCC), *supra* note 10 at para 101 (per Deschamps J), para 159 (per McLachlin CJ, Major & Bastarache JJ).

12 *Charter of Human Rights and Freedoms*, RSQ c C-12 [Quebec *Charter*].

13 *Health Insurance Act*, RSQ, c A-29, s 15 [*Health Insurance Act*].

14 *Hospital Insurance Act*, RSQ, c A-28, s 11 [*Hospital Insurance Act*].

15 *Chaoulli* (SCC), *supra* note 10 at paras 123–124, 159 (per McLachlin CJ, Major & Bastarache JJ).

16 *Ibid* at para 164 (per Binnie, LeBel & Fish JJ).

the single-payer system. In conclusion I suggest that, even if this were desirable, governments and the health policy community can no longer maintain that wait times and other systemic barriers to care are beyond the purview of the courts. I contend that those seeking to defend medicare must instead advocate for a reading of the *Charter* that reinforces rather than undermines the publicly funded system and the domestic and international human rights principles it reflects.

1. The *Cambie* Challenge

In December 2008, Mariël Schooff and four other BC patients filed a petition in the BC Supreme Court[17] alleging that the BC Medical Services Commission and the provincial Ministry of Health were failing to enforce the provincial *Medicare Protection Act* (*MPA*) prohibitions against direct and extra-billing for medically required services.[18] The petitioners were among thirty patients who had complained to the commission that Cambie Surgery and the SRC had direct-billed them amounts ranging from $400 to $17,000 between 2001 and 2007 for health care services that were included as insured benefits under the *MPA*.[19] The *Schooff* petition, which sought an order of *mandamus* compelling the commission and the ministry to enforce the *MPA*, followed an unsuccessful attempt by the BC Nurses' Union to obtain public interest standing to bring a similar legal claim.[20]

A year and a half earlier, in May 2007, the commission had written to Vancouver orthopedic surgeon Dr. Brian Day about possible extra-billing at Cambie Surgery and SRC, of which Dr. Day is the president.[21] In September 2008, the commission advised Dr. Day it would be conducting an audit of both clinics.[22] In response, in January 2009, Cambie Surgery, SRC, and several other private Vancouver clinics launched an action against the commission, the minister of health, and the attorney general of British Columbia,

17 *Schooff v Medical Services Commission*, 2009 BCSC 1596 [*Schooff*].

18 *Ibid* at paras 1–2.

19 *Ibid* at para 51; *Canadian Independent Medical Clinics Assn. v British Columbia (Medical Services Commission)*, [2010] BCJ 1323 at para 5.

20 *British Columbia Nurses' Union v British Columbia (Attorney General)*, 2008 BCSC 321; *Canadian Independent Medical Clinics Assn. v British Columbia (Medical Services Commission)*, 2010 BCSC 927 at para 7.

21 *Schoof, supra* note 17 at para 45; *Cambie* (Defence), *supra* note 9 at paras 49–59.

22 *Schoof, supra* note 17 at para 54; *Cambie* (Defence), *supra* note 9 at para 57.

seeking to have sections 14, 17, 18, and 45 of the *MPA* declared unconstitutional.[23] The impugned provisions prohibit extra-billing, user charges, dual practice, and duplicative private health insurance, and impose fee caps for physicians who have opted out of the public system.[24] When the Ministry of Health's audit of Cambie Surgery and SRC finally took place, in 2012, the auditors reported "limited cooperation from the President, management and staff"[25] of the two clinics, and "significant evidence" of "frequent and recurring" extra-billing, direct billing, double billing, and charges by opted-out physicians exceeding the MPA fee caps, "contrary to the [*Medicare Protection*] *Act*."[26]

Dr. Day and his legal counsel have since admitted that Cambie Surgery and SRC are engaging in illegal billing practices.[27] Their defence is that provisions of the *MPA* prohibiting such practices are unconstitutional and should be struck.[28] In their opening statement at the 6 September 2016, hearing on the substance of the *Cambie* claim, the plaintiffs start from the position that there is "absolutely no doubt that people in the province are being harmed every day by the inability of our public health care system to provide timely medical services."[29] The plaintiffs point to the example of Walid Khalfallah, a thirteen-year-old boy suffering from scoliosis/kyphosis who, fourteen months after an urgent referral by his pediatrician, met with an orthopaedic surgeon at the BC Children's Hospital only to be advised there was a two-year wait for the surgery he needed.[30] While Khalfallah's surgery was ultimately scheduled for

23 *Schoof, supra* note 17 at paras 1–12; Fuller, *Cambie Goes to Court, supra* note 6 at 14–17.

24 *Schoof, supra* note 17, Appendix A; *Cambie* (Response to Fourth Amended Civil Claim) at paras 26–29 [*Cambie* (Response to Amended Claim)]; *Cambie* (Defendants' Opening Statement), *supra* note 9 at 15–18.

25 Ministry of Health, Billing Integrity Program, Audit and Investigations Branch, *Specialist Referral Clinic (Vancouver) Inc. and Cambie Surgeries Corporation Audit Report* (June 2012) at 5.

26 Ministry of Health, Billing Integrity Program, *Audit and Investigations Branch, Specialist Referral Clinic (Vancouver) Inc. and Cambie Surgeries Corporation Audit Report* (June 2012) at 4; Fuller, *Cambie Goes to Court*, *supra* note 6 at 12–13.

27 *Schoof, supra* note 17 at paras 63–64; *Cambie*, *supra* note 6 at para 24.

28 *Schoof, supra* note 17 at para 4; *Cambie* (Civil Claim), *supra* note 7 at para 98; *Cambie* (Plaintiffs' Opening Statement)], *supra* note 7 at para 1.

29 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 5.

30 *Cambie* (Civil Claim), *supra* note 7 at paras 54–56.

November 2011, the family decided to proceed with an earlier offer of free surgical care at the Shriners Hospital for Children in Spokane, Washington.[31] Due to complications during that surgery, which took place in January 2012, Khalfallah was left a paraplegic.[32]

Khalfallah's experience is contrasted to that of the three other individual plaintiffs in the case who, the *Cambie* claim alleges, obtained timely private care that "enabled them to avoid further harm from waiting for care in the public system."[33] For example, the *Cambie* claim describes the positive outcome for fourteen-year-old Chris Chiavatti who, in January 2009, suffered a knee injury in Grade 9 physical-education class.[34] At the end of October 2009, with Chiavetti still on a waiting list for a diagnostic consultation within the public system, his family booked an appointment with Dr. Day at the SRC.[35] Based on a clinical evaluation and an MRI done at the BC Children's Hospital, Dr. Day diagnosed a tear in Chiavetti's meniscus and, in mid-November 2009, performed day surgery at the SRC.[36] Chiavetti underwent physiotherapy for several weeks and returned to normal functioning within one month.[37] According to the *Cambie* claim, able to sleep, engage in extra-curricular activities, and focus on his studies again, Chiavetti's "academic achievements helped him to obtain an offer for placement at Yale University."[38]

Against the backdrop of these individual cases, the *Cambie* claim contends that the BC government must ration care to meet its health care budget, resulting in lengthy wait lists.[39] It characterizes private care as "a much needed safety valve"[40] for those who would otherwise be suffering physical and psychological harm waiting for care in the public system. The plaintiffs argue that, by restricting BC patients' ability to make decisions about their bodily integrity, to take steps to alleviate their pain and suffering, and to ensure their health and survival through timely access to private

31 *Ibid* at paras 60–63.
32 *Ibid* at para 64.
33 *Ibid* at para 17.
34 *Ibid* at paras 17–23.
35 *Ibid* at para 23.
36 *Ibid* at para 23.
37 *Ibid* at para 25.
38 *Ibid* at para 25.
39 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at paras 5–6, 224–227, 292.
40 *Ibid* at para 19.

care, the impugned provisions of the *MPA* violate section 7 of the *Charter*.[41] They contend that allowing private care would improve rather than harm the public system, rendering the prohibitions under the *MPA* arbitrary and, therefore, fundamentally unjust.[42] In their submission:

> The prohibition or severe restriction on access to private medical care for ordinary citizens by the operation of the … [*MPA*] are not necessary or related to the objective of the Government in preserving a publicly managed health care system in which individual access to necessary medical health care is based on need and not on an individual's ability to pay … There are options available which allow maintaining a vigorous public health system supported by private health services which, together, would allow the provision of reasonable health care within a reasonable time, and thus ensure the protection of *Charter* rights of all British Columbians.[43]

The plaintiffs further argue that regulatory exemptions for certain classes of patients,[44] such as those being treated for workplace injuries under the province's workers' compensation regime, are further proof that the *MPA* restrictions on private insurance and funding are not only arbitrary but discriminatory, based on disability and age, contrary to section 15 of the *Charter*,[45] and should be struck down.[46]

In their response to the *Cambie* claim, the Medical Services Commission, the Ministry of Health, and the attorney general of British Columbia reject the plaintiffs' arguments that British Columbia's prohibitions on private care violate sections 7[47] or 15[48] of the *Charter*. They contend that the "purpose of the *Act* is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based

41 *Cambie* (Civil Claim), *supra* note 7 at paras 103–117.
42 *Ibid* at paras 118–131.
43 *Ibid* at paras 119–120.
44 *Ibid* at para 86.
45 *Ibid* at paras 141–145.
46 *Ibid* at paras 98–99.
47 *Cambie* (Response to Further Amended Civil Claim) at Part 3 paras 3–4 [*Cambie* (Response)].
48 *Ibid* at Part 3 paras 19–23.

on need and not an individual's ability to pay."[49] "Were the Plaintiffs granted the relief they seek," the defendants warn,

> this would divert into a private system, available only to some, the resources needed to continue the effort to provide timely care for all in British Columbia's public health care system. It would negate much of what has been accomplished over many years creating and continually working to improve a public health care system supported by all according to their means and providing needed care to all residents in the province without regard wither to means or to medical history.[50]

In their intervention in the case, the BC Physicians and Patients Coalition, representing two patients and two physicians, the BC Health Coalition, and Canadian Doctors for Medicare, also contest the *Cambie* plaintiffs' claims about the consequences of striking down restrictions on private funding. Pointing out that "the *most vulnerable* beneficiaries of BC's health care system … would be disproportionately burdened by any weakening of the publicly funded health care system that would likely result from the development of a parallel private tier,"[51] the coalition argues that:

> Many of [the Coalition's] members would face insurmountable health and income barriers to accessing the kind of privately financed health care system the plaintiffs seek to impose. They are also very concerned that the shift to a parallel for-profit private system would reduce resources and capacity in the public health care system to provide for patients, would establish harmful incentives for longer wait time in the public system, and would make it even more difficult to implement the necessary reforms we need to improve the public system.[52]

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49 *Cambie* (Response to Amended Claim), *supra* note 24 at para 11; *Cambie* (Response), *supra* note 47 at Part 3 para 34.

50 *Cambie* (Defendants' Opening Statement), *supra* note 9 at 1.

51 *Cambie* (BC Physicians and Patients Coalition Opening Statement), *supra* note 9 at para 5.

52 *Ibid* at para 10.

2. The *Chaoulli* Decision

As suggested at the outset of the paper, the *Charter* challenge being pursued by Dr. Day in the *Cambie* case draws directly on the reasoning and outcome in the 2005 *Chaoulli* case.[53] The appellants in *Chaoulli*,[54] Georges Zéliotis, an elderly patient who faced delays obtaining two hip replacements in the mid-1990s, and Dr. Jacques Chaoulli, a Montreal-area physician unable to obtain Quebec Ministry of Health approval for a twenty-four-hour ambulance service, a twenty-four-hour house-call service, and a private not-for-profit hospital, challenged the prohibition on private insurance under section 15 of Quebec's *Health Insurance Act*[55] and section 11 of the province's *Hospital Insurance Act*.[56] The appellants argued that, given serious delays within the publicly funded system, the ban on private health insurance put them at risk of significant physical and psychological harm, and even death, thereby violating their Quebec and *Canadian Charter* rights.[57]

At trial,[58] Quebec Superior Court Justice Piché accepted the appellants' claim that health care waiting lists in the province were too long. In her view, "même si ce n'est pas toujours une question de vie ou de mort, tous les citoyens ont droit à recevoir les soins dont ils ont besoin, et ce, dans les meilleurs délais."[59] However, Justice Piché concluded that Quebec's prohibition on private insurance was necessary to protect the publicly funded system.[60] In her words: "Les dispositions attaquées visent à garantir un accès aux soins de santé qui est égal et adéquat pour tous les Québécois … et, de ce fait il est clair qu'il n'y a pas de conflit avec les valeurs générales véhiculées par la Charte canadienne ou de la Charte québécoise des droits et

53 The following discussion of the *Chaoulli* case draws on Jackman, "Last Line of Defence"; Martha Jackman, "Misdiagnosis or Cure? *Charter* Review of the Health Care System" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 58.

54 *Chaoulli* (SC), *supra* note 10 at paras 19–39; *Chaoulli* (SCC), *supra* note 10 at para 5.

55 *Health Insurance Act*, *supra* note 13.

56 *Hospital Insurance Act*, *supra* note 14.

57 *Chaoulli* (SC), *supra* note 10 at paras 193–196; *Chaoulli* (SCC), *supra* note 10 at para 5.

58 An unofficial edited English-language translation of Justice Piché's decision can be found in Flood, *Access to Care*, *supra* note 10 Appendix A at 531–558.

59 *Chaoulli* (SC) *supra* note 10 at para 50 ("Even if it isn't always a question of life or death, all citizens have the right to receive the care they need, and within the shortest possible time." [author's translation]).

60 *Ibid* at para 258.

libertés."[61] On that basis, Justice Piché decided that the ban on private insurance respected section 7 principles of fundamental justice[62] and section 15 equality rights guarantees,[63] as well as being justifiable under section 1 of the *Charter*.[64]

Justice Piché's decision was upheld by the Quebec Court of Appeal in three concurring judgments.[65] Justice Forget agreed with Justice Piché's section 7 analysis.[66] In Justice Brossard's view, having failed to show that restrictions on private insurance had imperilled their rights to life or health, the appellants' section 7 claim could not succeed.[67] Justice Delisle found that, while access to a publicly funded health care system was a fundamental right, the purely economic right to contract for private insurance being claimed by the appellants was not protected under section 7.[68] As he put it:

> Il ne faut pas inverser les principes en jeu pour, ainsi, rendre essentiel un droit économique accessoire auquel, par ailleurs, les gens financièrement défavorisés n'auraient pas accès. Le droit fondamental en cause est celui de fournir à tous un régime public de protection de la santé, que les défenses édictées par les articles [contestés] ont pour but de sauvegarder.[69]

61 *Ibid* at para 260 ("The impugned provisions are designed to guarantee equal and adequate access to health care for all Quebecers … and it is therefore evident there is no conflict with the general values promoted by the *Canadian Charter* or by the Quebec *Charter of Rights and Freedoms*" [author's translation]).

62 *Ibid* at para 267.

63 *Ibid* at paras 305–306.

64 *Ibid* at para 268. Section 1 provides that: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

65 *Chaoulli* (CA), *supra* note 10 at para 5. (An unofficial edited English-language translation of the Court of Appeal decision can be found in Flood, *Access to Care*, *supra* note 10 Appendix B at 559–564.)

66 *Ibid* at paras 55, 60.

67 *Ibid* at para 66.

68 *Ibid* at para 25.

69 *Ibid* at para 25 ("The principles at issue must not be inverted so as to make an ancillary economic right essential, and further, one to which economically disadvantaged people would not have access. The fundamental right at issue is that of providing a public health protection system to all, a right which the prohibitions set out under the abovementioned provisions are designed to safeguard." [author's translation]).

On appeal to the Supreme Court of Canada, the majority of the court overturned the trial and Court of Appeal judgments in a 4–3 split decision.[70] Limiting her analysis to the Quebec *Charter*, Justice Deschamps accepted the appellants' argument that the prohibition on private insurance, and the resulting limits on patients' ability to obtain private care, violated the right to "life," "personal security," and "inviolability" under section 1 of the Quebec *Charter*,[71] and were not in accordance with "democratic values, public order and the general well-being of the citizens of Québec" under section 9.1 of the Quebec *Charter*.[72] To the question "whether Québeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public system because of waiting lists may be validly prevented from doing so by the state,"[73] Justice Deschamps's answer was no.[74] As she declared: "Governments have promised on numerous occasions to find a solution to the problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens."[75] The appropriate judicial response, she concluded, was to strike down the ban on private insurance.[76]

Chief Justice McLachlin and Justices Major and Bastarache agreed with Justice Deschamps ruling under the Quebec *Charter*. They also found that "prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death" interfered with the right to life and security of the person under section 7 of the *Canadian Charter*.[77] The majority concluded that, since other OECD countries with multi-payer systems "have successfully delivered to their citizens medical services that are superior to and more

70 *Chaoulli* (SCC), *supra* note 10 at para 101, per Deschamps J; at para 159, per McLachlin CJ, Major & Bastarache JJ; at para 279, per Binnie, LeBel & Fish JJ, dissenting.

71 Quebec *Charter*, *supra* note 12; *Chaoulli* (SCC), *supra* note 10 at para 45.

72 *Chaoulli* (SCC) *supra* note 10 at para 99.

73 *Ibid* at para 4.

74 *Ibid* at para 100.

75 *Ibid* at para 96.

76 *Ibid* at para 100.

77 *Ibid* at para 124.

affordable than the services that are presently available in Canada,"[78] the prohibition on private insurance was an arbitrary measure that did not accord with section 7 principles of fundamental justice[79] and that could not be justified under section 1 of the *Charter*.[80]

In their dissenting opinion, Justices Binnie, LeBel and Fish noted that section 7 does not protect the right to practice medicine or to deliver private health care services.[81] But they concurred with the majority's view that Quebec's prohibition on private insurance was "capable, at least in the cases of some individuals on some occasions, of putting at risk their life or security of the person."[82] Given the objectives of the single-payer system, the dissenting justices agreed with Justice Piché that Quebec's ban on private insurance was a rational measure.[83] As they explained: "The consequences of a quasi-unlimited demand for health care coupled with limited resources, be they public or private is to ration services … In a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status."[84] In concluding that the impugned provisions were demonstrably justified under both the Canadian and Quebec charters, the minority cautioned that

> Those who seek private health insurance are those who can afford it and can qualify for it … They are differentiated from the general population, not by their health problems, which are found in every group in society, but by their income status. We share the view of Dickson C.J. that the *Charter* should not become an instrument to be used by the wealthy to "roll back" the benefits of a legislative scheme that helps the poorer members of society.[85]

78 *Ibid* at para 140.
79 *Ibid* at paras 152–153.
80 *Ibid* at paras 154–159.
81 *Ibid* at para 202, per Binnie J.
82 *Ibid* at para 200 [emphasis in original].
83 *Ibid* at paras 242, 256.
84 *Ibid* at paras 221, 223.
85 *Ibid* at para 274.

3. The Evidence Relating to Private Funding

With the retirement of Chief Justice McLachlin, none of the Supreme Court justices who participated in *Chaoulli* remain on the court. Unlike Dr. Chaoulli's challenge, which flew largely under the radar outside Quebec until it reached the Supreme Court of Canada, *Cambie* is being litigated in English and, thanks to ongoing publicity by pro-medicare groups such as the BC Health Coalition[86] and Canadian Doctors for Medicare,[87] and Dr. Day's own efforts,[88] the case has attracted widespread attention in and outside the province. The government defendants in *Cambie* have underscored the fact that the evidence in *Chaoulli* related to the health care system in Quebec almost twenty years ago,[89] and that the Supreme Court's section 7 jurisprudence has also evolved in the intervening period. In their opening statement in *Cambie*, the defendants contend that "the decision in *Chaoulli* provides the backdrop to the present case, but that case involved a significantly different challenge to a different legislative scheme in the context of a very different approach by government to the problems of wait times, and it was decided on the basis of a very different *Charter*."[90]

This attempt to distinguish *Chaoulli* draws support from the Alberta Court of Appeal's 2015 decision in *Allen v Alberta*.[91] The appellant in that case was in severe pain after injuring his knee and lower back playing hockey. Facing a possible two-year wait in Alberta, he underwent surgery in Montana at a cost of over $77,000.[92] Relying on *Chaoulli*, he applied for a declaration that Alberta's ban on private health insurance violated section 7 of the *Charter*.[93] The

86 "The Legal Attack on Public Health Care" (2017), online: *BC Health Coalition* <www.bchealthcoalition.ca/what-we-do/protect-medicare/case-backgound>.

87 "Cambie Trial: Frequently Asked Questions," online: *Canadian Doctors for Medicare* <www.canadiandoctorsformedicare.ca/Table/Cambie-Trial/>.

88 "Former BC Premier Campbell believes more private access will improve health outcomes" (2016), online: *Dr. Brian Day* <www.brianday.ca/>.

89 *Cambie* (Defendants' Opening Statement), *supra* note 9 at 54.

90 *Ibid* at 47.

91 *Allen v Alberta*, 2014 ABQB 184 [*Allen* (QB)], aff'd *Allen v Alberta*, 2015 ABCA 277 [*Allen* (CA)]. The *Allen* case was supported by Alberta's Justice Centre for Constitutional Freedoms. See "Access to Health Care: Darcy Aleen's Story" (2013), online: *Justice Centre for Constitutional Freedoms* <www.jccf.ca/access-to-health-care-darcy-allens-story/>.

92 *Allen* (QB), *supra* note 91 at paras 2–21; *Allen* (CA), *supra* note 91 at paras 2–7.

93 *Allen* (QB), *supra* note 91 at para 39; *Allen* (CA), *supra* note 91 at para 7.

Alberta Court of Queen's Bench dismissed the appellant's claim on the grounds he had failed to provide any evidence that the ban on private insurance created or exacerbated wait times or impeded access to care.[94] With reference to *Chaoulli*, Justice Jeffrey affirmed: "I am not bound to apply a conclusion of mixed fact and law from a Supreme Court of Canada case to another case that merely shares a similar allegation but offers no evidence."[95] The Court of Appeal agreed with Justice Jeffrey's analysis. Justice Slatter explained:

> The result in *Chaoulli* is dependent on the factual findings. Notwithstanding the Supreme Court's usual insistence on deference to fact findings of trial judges, the majority of the court came to the opposite conclusion on the fundamental issue of the potential impact of private insurance on the public system. The existence, length and reasonableness of wait times in Québec were also a key to the decision. It cannot be said that the same factors are so obviously present in Alberta in 2015 that *Chaoulli* can be applied.[96]

Notwithstanding significant differences in factual and doctrinal context, two aspects of the *Chaoulli* case remain particularly relevant to the *Cambie* claim and its likelihood of success. The first, as the decision in *Allen v Alberta* illustrates, is the courts' approach to the evidence relating to the implications for the single-payer system of allowing private funding, including as a solution to wait times for care. As outlined below, Justice Piché's findings at trial and Justice Deschamps and Chief Justice McLachlin's reading of the same evidence at the Supreme Court produced irreconcilable differences in reasoning and outcomes in *Chaoulli*, with major consequences for the publicly funded system in Quebec.[97]

Justice Piché began her lengthy review of the evidence in *Chaoulli*[98] with a summary of the evidence provided in support of the appellants' claim by several Quebec medical specialists in the fields of orthopaedics, ophthalmology, oncology, and cardiology. These experts described the difficulties they faced delivering care

94 *Allen* (QB), *supra* note 91 at para 53.

95 *Ibid* at para 48.

96 *Allen* (CA), *supra* note 91 at para 442.

97 See generally Marie-Claude Prémont, "Clearing the Path for Private Health Markets in Post-*Chaoulli* Québec" (2008) Health LJ 237.

98 *Chaoulli* (SC), *supra* note 10 at paras 44–121.

within the publicly funded system: long waiting lists; shortage of operating-room time, hospital staff, and equipment; erratic decision making; and lack of planning.[99] As Justice Piché summarized it: "Tous ces médecins ont témoigné sur les difficultés qu'ils avaient, sur les listes d'attente trop longues, sur les délais d'opération, sur les efforts qu'ils font à tous les jours pour tenter de régler les problèmes, pour tenter de trouver des solutions au manque de cohésion, d'organisation et, disons-le, de vision du Régime de santé du Québec aujourd'hui."[100]

Justice Piché went on to review the evidence submitted by the Quebec and federal government respondents, including the testimony of Yale University health policy expert Dr. Theodore Marmor, whom she quoted at length.[101] Dr. Marmor argued that allowing the development of a parallel private health insurance system would lead to decreased public support for medicare and, most significantly, to a loss of support from more affluent and thus politically influential groups most likely to exit the public system.[102] Dr. Marmor also pointed to the problems of unfair subsidies to the private system and providers resulting from past and future public investment in hospitals, capital improvements, and research; diversion of financial and human resources away from the public system; increased government administrative costs required to regulate the private health insurance market; and increased health spending overall, with no clear improvement in health outcomes.[103] Other experts called by the respondents cited the relative efficiency of the Canadian system; the reality that rationing occurs in all health care systems—in private systems like the United States, based on ability to pay; the problem of "cream skimming" in two-tier systems, where private providers "siphon off high revenue patients and vigorously try to avoid providing care to patient populations who are at financial risk"; and

99 *Ibid* at paras 45–49.

100 *Ibid* at para 44 ("All of these physicians testified about the difficulties they faced, about waiting lists that are too long, about delayed operations, about their daily efforts to deal with these problems, to try to find solutions to the lack of cohesion, of organization, and let's be frank, of vision in Quebec's current health care regime." [author's translation]).

101 *Ibid* at paras 102–115.

102 *Ibid* at paras 108–109.

103 *Ibid* at para 107.

the overall contribution of the medicare system to social cohesion in Canada.[104]

Lastly, Justice Piché summarized the evidence of Dr. Edwin Coffey, a Montreal OB/GYN specialist and executive member of the Quebec Medical Association, called by the appellants.[105] Drawing on his own experience and a review of the situation in other OECD countries, Dr. Coffey argued that prohibitions on private health insurance create a "unique and outstanding disadvantage that handicaps the health system in Québec and Canada" and "have contributed to the dysfunctional state of our present health system."[106] Having earlier noted the appellants' other experts' unwillingness to endorse the view that allowing parallel private care would provide a solution to wait times and other access problems,[107] Justice Piché determined that Dr. Coffey's opinion on the advantages of allowing private funding was inconsistent with the weight of expert evidence in the case. In her assessment, she said, "le Dr. Coffey fait cavalier seul avec son expertise et les conclusions auxquelles il arrive."[108]

Justice Piché accepted the appellants' claim that health care waiting lists in Quebec were too long.[109] She did not, however, find that the ban on private insurance had an adverse impact on wait times. Rather, the evidence presented at trial suggested the converse: that eliminating the prohibition on private insurance would, by diverting energy and resources away from the public and into the private system, result in increased wait times for publicly funded care.[110] These evidentiary findings led Justice Piché to the doctrinal conclusion that Quebec's ban on private insurance was fully in accordance with section 7 principles of fundamental justice, as well as section 15 *Charter* equality guarantees. She explained: "La seule façon de garantir que toutes les ressources en matière de santé bénéficieront à tous les Québécois, et ce sans discrimination, est d'empêcher

104 *Ibid* at paras 89, 91–93, 95, 101.

105 *Ibid* at paras 116–120.

106 *Ibid* at para 119.

107 *Ibid* at para 51.

108 *Ibid* at para 120 ("Dr. Coffey is a lone ranger in his expertise and the conclusions he arrives at." [author's translation]).

109 *Ibid* at para 50.

110 *Ibid* at para 93, 107.

l'établissement d'un system de soins privés parallèles. Voilà précisément ce que font les dispositions attaquées en l'espèce."[111]

At the Supreme Court, Justice Deschamps came to the opposite conclusion on the key evidentiary question of whether Quebec's ban on private insurance was justified by the need to safeguard the single-payer system.[112] Looking to the expert evidence at trial on the impact of a loss of support from those exiting the public system if the ban on private insurance were lifted, Justice Deschamps said: "The human reactions described by the experts, many of whom came from outside Québec, do not appear to me to be very convincing."[113] On the other harmful effects of allowing parallel private insurance, Justice Deschamps concluded: "Once again, I am of the opinion that the reaction that some witnesses described is highly unlikely in the Québec context."[114] Noting that not all provinces ban private insurance,[115] and that other OECD nations have adopted a variety of measures to protect their public systems,[116] Justice Deschamps concluded, in direct contradiction to Justice Piché's findings at trial, that "the choice of prohibiting private insurance contracts is not justified by the evidence."[117] The consequence, in Justice Deschamps view, was that the ban on private insurance must be struck down.[118]

In her analysis of whether Quebec's ban on private insurance was arbitrary, and so contrary to the principles of fundamental justice under section 7 of the *Canadian Charter*, Chief Justice McLachlin also disregarded the expert evidence adduced at trial. In her view: "To this point, we are confronted with competing but unproven 'common sense' arguments amounting to little more than assertions of belief."[119] Following a summary review of the experience of other OECD countries drawn from a report by the Standing Senate Committee on Social Affairs, Science, and Technology chaired by

111 *Ibid* at para 264 ("The only way to ensure that all health resources benefit all Quebecers, and this without discrimination, is to prevent the establishment of a parallel private system. That is precisely what the impugned provisions in this case do." [author's translation]).

112 *Chaoulli* (SCC), *supra* note 10 at para 14.

113 *Ibid* at para 64.

114 *Ibid* at para 14.

115 *Ibid* at para 74.

116 *Ibid* at para 83.

117 *Ibid* at para 66.

118 *Ibid* at para 100.

119 *Ibid* at para 138.

Senator Michael Kirby,[120] the chief justice concurred with Justice Deschamps that "the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care."[121] Although the appellants submitted no direct evidence on this point, Chief Justice McLachlin, like Justice Deschamps, attributed waiting lists in the public system to the ban on private insurance and Quebec's single-payer system.[122] Noting at the outset of her judgment that: "This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person,"[123] the chief justice closed her section 7 analysis by reiterating that "the denial of private insurance subjects people to long waiting lists and negatively affects their security of the person."[124]

Neither Justice Deschamps's insistence on the specificity of the situation in Quebec, nor her and Chief Justice McLachlin's reliance on the Kirby Committee's review of the comparative experience in other OECD countries,[125] remove from the fact that the majority in *Chaoulli* set aside Justice Piché's findings on the actual evidence presented by the parties at trial. The majority dismissed Justice Piché's conclusion that Quebec's ban on private insurance was necessary to protect the integrity of the publicly funded system and its objective of ensuring equal access to health care services without barriers based on ability to pay. The majority in *Chaoulli* also found, in the absence of any supporting evidence, that the single-payer monopoly was itself the cause of unacceptable delays, and that striking down

120 Canada, Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role, Volume Three: Health Care Systems in Other Countries, Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002).

121 *Chaoulli* (SCC), *supra* note 10 at para 149.

122 *Ibid* at para 111.

123 *Ibid* at para 106.

124 *Ibid* at para 152.

125 For a critique of this aspect of the decision see Colleen M Flood, Mark Stabile & Sasha Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying and Two-Tier Systems" in Flood, *Access to Care, supra* note 10 at 296. See also Colleen M Flood & Amanda Haughan, "Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care" (2010) 5:3 Health Econ Pol'y & L 319.

the ban on private health insurance was the appropriate remedy for the *Charter* violations created by undue wait times.

The submissions in the *Cambie* case about the need to strike down provincial limits on private care in British Columbia as a solution to wait times, and about the consequences of allowing private funding generally, parallel the arguments that were rejected by Justice Piché but accepted by the majority of the Supreme Court in *Chaoulli*. First, like in *Chaoulli*, the *Cambie* claim contends that restricting private payment harms the public system and the patients who rely on it. In particular, the *Cambie* claim draws a direct link between the ban on private funding and wait times in British Columbia, arguing that "the prohibition on private insurance overburdens the public health care system, increasing wait times for everyone and decreasing the overall quality of care."[126] Like in *Chaoulli*, the *Cambie* plaintiffs contend that, because British Columbians "are prohibited from obtaining insurance, they are forced to languish on a waiting list, with the resulting physical, psychological, emotional and economic harm that this entails."[127]

Second, the *Cambie* claim repeatedly asserts that restrictions on private funding under the *MPA* are unnecessary because allowing private payment and care will not harm the public system[128] or impair access for those who rely on it.[129] Like the majority justices in *Chaoulli*, the *Cambie* claim points to the experience of health care systems elsewhere as evidence that removing restrictions on private care in British Columbia will in no way threaten its single-payer system:

> Based on comparison with other health systems in Canada and internationally, allowing individuals to choose to obtain private insurance and permitting and facilitating access to a private healthcare system does not jeopardize the existence of a strong public healthcare system. The experiences in other jurisdictions demonstrate that a hybrid private-public health care system allows the public system to thrive and provide better care to patients.[130]

126 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 1772.

127 *Ibid* at para 40.

128 *Ibid* at paras 20, 49, 194, 208, 426, 1942–1945.

129 *Ibid* at paras 185, 300.

130 *Ibid* at paras 20, 197, 200, 413, 457–458, 468; *Cambie* (Civil Claim), *supra* note 7 at para 120.

Noting that "the Supreme Court of Canada in *Chaoulli* held that it was neither legally acceptable nor necessary for Québec to prohibit people from accessing private health care,"[131] the *Cambie* claim makes the same argument that "the guiding principles of the health care system of British Columbia … do not require, as a matter of law or fact, that patients be restricted or prohibited from accessing private health care."[132]

Third, the *Cambie* claim suggests that allowing private funding will in fact help the public system. The plaintiffs insist that, with a parallel private regime in place, access to the public system "can only be improved by having fewer patients to deal with."[133] The *Cambie* claim goes even further in positing the positive impact of private funding on the public health care system:

> Private medical facilities are beneficial for overall health care in the Province. They provide needed additional assessment, consultation, operating and diagnostic facilities; attract specialist doctors to the Province and help retain them by providing them with additional access to operating time, which is rationed in the public hospitals, offer flexible work hours to nurses and have helped to attract nurses back into the workforce and retain them in the Province, encourage improvements and efficiencies in the public health care system and provide patients with speedier access to health care, resulting in reduced pain and disability, improved health outcomes and increased life expectancy.[134]

In *Chaoulli*, Justice Piché concluded, based on the evidence, that allowing private funding would threaten the viability and effectiveness of the public system to the detriment of all residents of the province. As she explained:

> La preuve a montré que le droit d'avoir recours à un système parallèle privé de soins, invoqué par les requérants, aurait des répercussions sur l'ensemble de la population. Il ne faut pas jouer à l'autruche. L'établissement d'un système de santé

131 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 322.
132 *Cambie* (Civil Claim), *supra* note 7 at para 130.
133 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 185.
134 *Cambie* (Civil Claim), *supra* note 7 at para 14.

> parallèle privé aurait pour effet de menacer l'intégrité, le bon fonctionnement ainsi que la viabilité du système public. Les articles [attaqués] empêchent cette éventualité et garantissent l'existence d'un système de santé public de qualité au Québec.[135]

The majority of the Supreme Court's rejection of these evidentiary findings met with widespread criticism, within both the legal and health policy communities.[136] As Hamish Stewart described it, the majority reversed Justice Piché's evidentiary conclusions "without making clear the basis on which, in its view the trial judge erred in her fact-finding … [embarking] on a fresh fact-finding process, based largely on evidence that was … not tested in an adversarial context."[137] In his estimation, the "decision may well be bad for medicare; it is certainly bad for constitutional adjudication in an adversarial trial system."[138] Marie-Claude Prémont also points to the lack of any evidence before the court to support striking down the ban on private insurance as a remedy for undue wait times: "Rien n'indique que les listes d'attente qui affligent le réseau de santé trouvent leur origine dans l'interdiction de l'assurance privée pour les soins assurés. *A contrario*, rien n'indique que l'introduction de l'assurance santé pour ces mêmes services pourrait apporter une quelconque solution au problème que retient l'attention du tribunal."[139] For his part, Morris Barer captures why the absence of a sound evidentiary

135 *Chaoulli* (SC), *supra* note 10 at para 263 ("The evidence has shown that the right to access a parallel private health care system invoked by the claimants would have consequences for the entire population. We can't stick our heads in the sand. The creation of a parallel, private health care system would threaten the integrity, the effective operation, and the existence of a quality, public health care system in Quebec." [author's translation]).

136 See, e.g., Ted Marmor, "An American in Canada—Making Sense of the Supreme Court Decision on Health Care" (September 2005) Pol'y Options 41; Charles J Wright, "Different Interpretations of 'Evidence' and Implications for the Canadian Health Care System" in Flood, *Access to Care, supra* note 10 at 220; Prémont, "Cherchez l'erreur," *supra* note 10.

137 Hamish Steward, "Implications of *Chaoulli* for Fact-Finding in Constitutional Cases" in Flood, *Access to Care, supra* note 10 at 207, 212.

138 *Ibid*.

139 Prémont, "Cherchez l'erreur," *supra* note 10 at 181 ("Nothing suggests that waiting lists afflicting the health system can be attributed to the ban on private insurance for insured services. Conversely, nothing suggests that allowing private insurance for the same services would bring about any kind of solution to the problem that attracted the court's attention." [author's translation]).

basis for the decision in *Chaoulli* was so problematic from a health policy perspective:

> Claims about the wonders of private insurance have been around for half a century at least, and have repeatedly shown to be specious. Yet they persist, they are promoted, and the Supreme Court justices, or at least enough of them, bought the story, hook, line and sinker and evidence be damned … In this, the majority were simply irresponsible. But … [i]t is the rest of us who will pay, and pay, and pay. …[140]

Examining the evidence since *Chaoulli*, Colleen Fuller affirms that "private provision and financing of care have not made a significant contribution to wait time reductions in the public system—anywhere,"[141] but, according to numerous studies, have had the opposite effect.[142] Nevertheless, the plaintiffs in *Cambie* have built their case around the same highly contested evidentiary claims accepted by the majority in *Chaoulli*, that private funding offers a solution to wait times, and that striking down restrictions on private care will have a benign impact on the public system. Like in *Chaoulli*, the BC courts' approach to these evidentiary claims will no doubt have a decisive impact on the outcome of the constitutional challenge to British Columbia's single-payer system in the *Cambie* case.

4. The Substantive Equality Objectives of the Single-Payer System

A second important aspect of the *Chaoulli* decision, of direct relevance to the *Cambie* challenge, is the weight accorded to the substantive equality objectives of the single-payer system in the courts' assessment of the constitutionality of the ban on private funding. The trial court and Supreme Court of Canada's differing approaches to this issue in *Chaoulli* and, more specifically, to the overarching principle that access to health care should not depend on individual economic

140 Moris Barer, "Experts and Evidence: New Challenges in Knowledge Translation" in Flood, *Access to Care, supra* note 10 at 216, 218.

141 Fuller, *Cambie Goes to Court, supra* note 6 at 22.

142 *Ibid* at 20.

means, had a direct bearing on the outcome in the *Chaoulli* case, and the same will likely be true in *Cambie*.

Justice Piché prefaced her judgment in *Chaoulli* with a reminder that "Le présent débat concernant la santé et ses problèmes actuels d'accessibilité nous fait oublier parfois le passé pas si lointain où les gens maladies ne se faisait pas soigner, car ils n'en avaient tout simplement pas les moyens. La société Canadienne dans un élan de générosité et d'égalité, a voulu que ceci n'arrive plus."[143] In deciding whether Quebec's restrictions on private insurance were arbitrary, Justice Piché noted that no health system in the world has unlimited resources, and that all must engage in some form of rationing, which in Quebec occurs based on need.[144] Justice Piché was of the opinion that the impugned restrictions on private funding under Quebec's health- and hospital-insurance legislation were designed to guarantee equal access to health care services for all, without discrimination based on individual economic circumstances.[145] She therefore found no conflict between the ban on private insurance and section 7 principles of fundamental justice.[146]

Measured against the *Charter*'s section 15 equality guarantee, Justice Piché held that "ces dispositions ne servent aucunement à dévaloriser certains individus … elles servent plutôt à promouvoir des intérêts sociaux légitimes et à rehausser la dignité des Québécois en leur garantissant des soins médicaux."[147] In sum, Justice Piché concluded:

> Les dispositions attaquées ont été adoptées en se basant sur des considérations d'égalité et de dignité humaine et elles ne sont pas en conflit avec les valeurs véhiculées par la *Charte*. Il est pleinement justifiable qu'un gouvernement ayant les meilleurs

143 *Chaoulli* (SC), *supra* note 10 at para 2 ("The current debate over health and problems of access sometimes causes us to forget the not-so-distant past, when people who were ill weren't treated because they simply didn't have the means. Canadian society, in an impetus of generosity and equality, wanted to ensure this no longer happened." [author's translation]).

144 *Ibid* at para 306.

145 *Ibid* at para 258.

146 *Ibid* at para 267.

147 *Ibid* at para 306 ("The provisions in no way devalue certain individuals … rather they promote legitimate social interests and enhance the dignity of Quebecers by guaranteeing medical care" [author's translation]).

> intérêts de la population à cœur adopte une solution visant à favoriser le plus grand nombre d'individus.[148]

In dissent at the Supreme Court, Justices Binnie, LeBel, and Fish agreed with Justice Piché's characterization of the government's objectives in limiting private funding to protect the single-payer system:

> Quebec wants a health system where access is governed by need rather than wealth or status. Quebec does not want people who are uninsurable to be left behind. To accomplish this objective endorsed by the Canada Health Act, Quebec seeks to discourage the growth of private-sector delivery of "insured" services based on wealth and insurability … Quebec bases the prohibition on the view that private insurance, and a consequent major expansion of private health services, would have a harmful effect on the public system.[149]

In contrast, the majority justices rejected Justice Piché's finding that the underlying objectives of the single-payer system justified a violation of the *Charter* rights of the appellants and others seeking access to private care. Justice Deschamps saw no individual or collective benefit from the ban on private insurance. In her view: "Some patients die as a result of long waits for treatment in the public system when they could have gained prompt access to care in the private sector. Were it not for [the impugned provisions] they could buy private insurance and receive care in the private sector."[150] Remarking that the *Canada Health Act* "has achieved an iconic status that makes it untouchable by politicians,"[151] Justice Deschamps characterized the dissenting justices' concerns over the impact on the poor of striking down the ban on private insurance as "indicative of [the] type of emotional reaction" generated by "any measure that

148 *Ibid* at paras 311–312 ("The impugned provisions were adopted based on considerations of equality and human dignity and they are not in conflict with the values conveyed by the *Charter*. It is entirely justifiable that a government with the best interests of the population at heart adopts a solution that will benefit the greatest number of individuals." [author's translation]).

149 *Chaoulli* (SCC), *supra* note 10 at paras 239–240.

150 *Ibid* at para 37.

151 *Ibid* at para 16.

might be perceived as compromising" the principles of that legislation.[152] While insisting that "no one questions the need to preserve a sound public health care system,"[153] she declared that "[t]he courts have a duty to rise above political debate"[154] and that the appellants had proven their rights had been infringed.[155]

Chief Justice McLachlin was also unqualified in her criticism of the province's ban on private insurance and the resulting "virtual monopoly for the public health scheme."[156] Having found, contrary to the evidence accepted by Justice Piché at trial, that such "a monopoly is not necessary or even related to the provision of quality public health care,"[157] the chief justice rejected the Quebec government's argument that the ban could be justified as a reasonable limit under section 1 of the *Charter*. In her view, "the benefits of the prohibition do not outweigh the deleterious effects … The physical and psychological suffering and risk of death that may result outweigh whatever benefit (and none has been demonstrated to us here) there may be to the system as a whole."[158]

In the final report of the Royal Commission on the Future of Health Care in Canada, delivered in 2002, Roy Romanow, the former premier of Saskatchewan who chaired the commission, explains that "our tax-funded, universal health care system provides a kind of "double-solidarity." It provides equity of funding between the "have" and "have-nots" in our society and it also provides equity between the healthy and the sick."[159] Unlike Justice Piché's trial decision, the majority judgment in *Chaoulli* fails to take into account the degree to which, by rationing care based on need rather than ability to pay, the single-payer system reflects and promotes these substantive equality objectives.[160] In the words of Justices Binnie, LeBel, and Fish: "Apart

152 *Ibid*.

153 *Ibid* at para 14.

154 *Ibid* at para 89.

155 *Ibid* at para 100.

156 *Ibid* at para 106.

157 *Ibid* at para 140.

158 *Ibid* at para 157.

159 Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada—Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 31 (Chair Roy J Romanow) [*Romanow Commission*].

160 See generally Porter, "Right to Health Care," *supra* note 10; Prémont, "Cherchez l'erreur," *supra* note 10; Jackman, "'Last Line of Defence," *supra* note 10; Lorne

from everything else, it leaves out of consideration the commitment in principle in this country to health care based on need, not wealth or status, as set out in the *Canada Health Act*."[161]

Like in *Chaoulli*, the plaintiffs in the *Cambie* case take issue with the underlying premise of the single-payer system: that it is necessary to prohibit private funding to ensure equal access to care, and that it is legitimate to prohibit rationing based on ability to pay, even for those who have the means to bypass the public system. Instead, they make the startling claim that "[e]quity will be improved by allowing more British Columbians, instead of just the wealthy as is currently the case, to access private health care," [162] and that "[w]hile Canadians pride ourselves on our ability to provide for those in need … prohibition on private health care does not contribute to a just health care policy."[163] Like the majority in *Chaoulli*, the plaintiffs in *Cambie* discount any equality-based concerns that allowing private funding will adversely affect less-advantaged patients, who must rely on the publicly funded system. They counter that "[f]or those who cannot afford private insurance … they still have a universal public health care system … they lose nothing by allowing BC residents to make a personal choice relating to their own health about whether to acquire private insurance."[164]

Similar to *Chaoulli*, the *Cambie* plaintiffs emphasize that "they are not seeking to compel the government to provide more and better medical services to prevent harm, they ask only that the Government stop interfering with their right to act and choose for themselves how best to address their own health care needs."[165] Characterizing British Columbians as "captives"[166] of the single-payer system, the *Cambie* claim affirms that "[c]learly, it is necessary for the Courts to step in to protect BC residents from the harm they're suffering from a monopoly health care system, as they did in *Chaoulli*."[167] In calling for all restrictions on private funding and care in British Columbia

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Sossin, "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Flood, *Access to Care, supra* note 10 at 161.

161 *Chaoulli* (SCC), *supra* note 10 at para 230 [emphasis in original].

162 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 187.

163 *Ibid* at para 465.

164 *Ibid* at paras 185–186.

165 *Ibid* at para 1628.

166 *Ibid* at para 499.

167 *Ibid* at para 501.

to be struck down, the *Cambie* claim decries what it describes as the "fanatical commitment to some pure form of equality of suffering" animating the single-payer system:

> The justification for the drastic restrictions in the *Act* … is based on a dogmatic commitment to a perverse ideological position: that because the Government has not and cannot take steps to ensure that everyone has access to necessary and timely medical treatment in the public system, everyone should be forced to suffer equally … that it would be better to ensure that no one is advantaged, even if it means everyone must be made worse off.[168]

The debate over the privatization of medicare does indeed reflect two competing ideological conceptions of equality and its role as an animating principle within the health care system. The plaintiffs in *Cambie* rely on the majority's inference in *Chaoulli* that the *Charter* imposes no obligations on governments to ensure access to timely care based on need but only access based on ability to pay. As the many critics of the *Chaoulli* decision have underscored, this interpretation reflects what the Supreme Court itself has characterized as a "thin and impoverished" vision of equality,[169] entirely at odds with the *Charter*'s guarantees of equal protection and benefit of the law.[170] The BC Physicians and Patients Coalition summarize what is at play in *Cambie*:

> [T]he challenged protections comprise the central tenets of a complex socio-economic benefit and protective regulatory scheme. These protections operate … a universal, sustainable and publicly funded health care system available to all British Columbians on *equal* terms and conditions. This legislation is intended to protect the right to life and security of the person of all British Columbians, including the vulnerable and silent rights-holders whose equal access to quality health care depends upon the challenged protection.[171]

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168 *Ibid* at para 1946–1947.

169 *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 at para 73.

170 See generally Porter, "Right to Health Care," *supra* note 10; Andrew Petter, "Wealthcare: The Politics of the *Charter* Revisited" in Flood, *Access to Care*, *supra* note 10 at 116; Jackman, "Last Line of Defence," *supra* note 10.

171 *Cambie* (Opening Statement of the BC Physicians and Patients Coalition) at para 20.

As outlined above, in making the case for the blanket repeal of all restrictions on private funding and care in British Columbia, the *Cambie* claim relies on the evidentiary approach as well as the reasoning and rhetoric of the majority judgment in *Chaoulli*. Whether or not the BC courts are convinced by the *Cambie* plaintiffs' evidence and arguments about the positive impact of private funding, or the logic of striking down restrictions on private care as a solution to wait times in the province, judicial attitudes toward the single-payer system and its substantive equality objectives are likely to be as significant a factor in *Cambie* as they were in *Chaoulli*.

Conclusion

The Supreme Court has repeatedly affirmed that "the *Charter* should generally be presumed to provide protection at least as great as that afforded by similar provisions in international human rights documents which Canada has ratified."[172] While referring to the comparative health care systems of other OECD countries, the majority judgment in *Chaoulli* completely ignored the international human rights regime to which Canadian governments are accountable in relation to the health care system: the *International Covenant on Economic, Social and Cultural Rights* (*ICESCR*).[173] Ratified by Canada in 1976, article 12(1) of the *ICESCR* recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." [174] Article 12(2)(d) sets out Canada's obligations to take all steps necessary for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[175] And Article 2(2) of the *ICESCR* requires Canadian governments to ensure that the right to health is enjoyed "without discrimination," and, in particular, without discrimination based on "social origin, property, birth, or other

172 *Reference Re Public Service Employee Relations Act (Alberta)*, [1987] 1 SCR 313 at 349; *Slaight Communications v Davidson*, [1989] 1 SCR 1038; *Health Services and Support—Facilities Subsector Bargaining Assn v British Columbia*, 2007 SCC 27, 2 SCR 391 at para 70; *Divito v Canada (Public Safety and Emergency Preparedness)*, 2013 SCC 47 at para 19.

173 *ICESCR*, *supra* note 2.

174 *Ibid*.

175 *Ibid*.

status."[176] The UN Committee on Economic, Social, and Cultural Rights explains: "Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."[177]

Notwithstanding Canada's explicit obligations under the *ICESCR*, federal, and provincial governments have consistently maintained that the *Charter*'s life, liberty, security of the person, and equality guarantees do not protect the right to health or guarantee access to health care at the domestic level.[178] In rebutting the appellants' *Charter* claim in *Chaoulli*, for example, the Quebec government submitted that "les prétentions constitutionnelles des appelants portent sur des enjeux sociaux qui relèvent essentiellement du domaine politique et n'ont pas de lien de rattachement suffisant avec les système judiciaire."[179] Underlining that "the state has to deal with complex social policy issues and undertake the allocation of limited resources,"[180] the attorney general of Canada declared in *Chaoulli* that "[g]overnments are best equipped to make these complex, sensitive choices the appropriateness of which does not lend itself to judicial debate."[181] Likewise, the BC government's position in *Cambie* is that "s. 7 cannot apply in the context of this case, because the provisions that are challenged by the Plaintiffs do not in any way engage the justice system and its administration."[182] The government defendants

176 *Ibid*. In similar terms, Article 26 of the *International Covenant on Civil and Political Rights*, 16 December 1966, Can TS 1976 No 47 (entered into force 23 March 1976, accession by Canada 19 May 1976), requires Canada to ensure that all persons enjoy the "right to life," under Article 6(1) of the *Covenant*, without discrimination based on "social origin, property, birth or other status."

177 Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN ESCOR, 2000, UN Doc E/C.12/2000/4 (11 August 2000) at para 12(b). See also Committee on Economic, Social and Cultural Rights, *General Comment No 5: Persons with Disabilities*, UN ESCOR, 1994, UN Doc E/C.12/1994/13 at para 5.

178 See generally Jackman, "*Charter* Review," *supra* note 10; Jackman, "Health Care Accountability," *supra* note 5.

179 *Chaoulli* (SCC), *supra* note 10 at para 110 ("The appellants' constitutional submissions relate to social issues falling within the political realm and that do not have a sufficient connection with the judicial system." [author's translation]).

180 *Chaoulli* (SCC) (Factum of the Respondent (Mis-en-cause) Attorney General of Canada) at para 4.

181 *Ibid* at para 6.

182 *Cambie* (Defendants' Opening Statement), *supra* note 9 at 23.

in *Cambie* further contend that section 7 "does not guarantee a right of access to necessary and appropriate health care within a reasonable time."[183]

The presumption that individual rights are not implicated, and that the *Charter* should not apply to the publicly funded system, also prevails within the broader Canadian health policy community. Christopher Manfredi maintains, for example, that "[t]he question of what kind of health care system Canada should have is simply not amenable to resolution through the language of legal rights."[184] Health care, according to Romanow, "is not a legal construct but rather, a political construct."[185] Not surprisingly, as Donna Greschner observes, the Romanow commission's final report[186] "omits almost completely any discussion of one primary method of regulating relationships between governments and citizens: rights."[187]

There is, however, no doubt that life, liberty, security of the person, and equality interests of both individuals and disadvantaged groups are affected by health care decisions and choices to which the *Charter* directly applies.[188] In the words of Justice Piché, "s'il n'y a pas d'accès possible au système de santé, il est illusoire de croire que les droits à la vie et à la sécurité sont respectés."[189] If wait times and other systemic barriers and inequities in access to care threaten the lives and the physical and psychological security of people who are ill, governments and the health policy community

183 *Cambie* (Response), *supra* note 47 Part 3, para 3.

184 Christopher P Manfredi, "Déjà Vu All Over Again: *Chaoulli* and the Limits of Judicial Policymaking" in Flood, *Access to Care, supra* note 10 at 154.

185 Roy J Romanow, "In Search of a Mandate?" in Flood, *Access to Care, supra* note 10 at 528.

186 *Romanow Commission, supra* note 159.

187 Donna Greschner, "Public Law in the Romanow Report" (2003) 66 Sask L Rev 565 at 568.

188 Section 32(1) of the *Charter* states that the *Charter* applies "in respect of all matters within the authority" of federal and provincial/territorial legislatures and governments. In its decision in *Eldridge v British Columbia*, [1997] 3 SCR 624, the Supreme Court ruled that the scope of *Charter* review in the health care context extends beyond government health ministries, authorities, and service providers to the provision of publicly funded care by non-governmental entities. See generally Martha Jackman, "The Application of the Canadian *Charter* in the Health Care Context" (2001) 9 Health L Rev 22.

189 *Chaoulli* (SC), *supra* note 10 at para 304 ("If access to the health care system is not available, it is a fiction to believe that rights to life, liberty and security of the person are respected." [author's translation]).

cannot continue to proclaim that these are simply matters of social policy, falling within the sole purview of legislatures, and beyond the ambit of *Charter* review by the courts. This position is incompatible with Canada's *ICESCR* and other international and domestic human rights obligations.[190] Even if it were defensible from a human rights perspective, the *Chaoulli* and *Cambie* cases show that this argument is no longer a tenable one. As the advocacy groups Charter Committee on Poverty Issues and the Canadian Health Coalition affirmed in their intervention before the Supreme Court in *Chaoulli*, Canadian courts are "constitutionally mandated to remedy *Charter* violations in health care as in any other area of law or policy":

> Where the publicly funded health care system is found to violate the right to health under the *Charter* … the appropriate remedy is to order governments to take whatever measures are required to respect, protect and fulfill the right to health for all members of Canadian society … [C]onstitutional remedies can be fashioned to provide effective remedies for *Charter* violations while respecting the legislature's competence to choose the most appropriate means of providing necessary services.[191]

Commenting on the outcome in *Chaoulli*, Andrew Petter posited that, "by handing the imprimatur of constitutional rights to advocates of private medicine and two-tier health care, the court has dealt a serious blow to the legitimacy of the single-payer model of health insurance and the values of collective responsibility and social equality that it seeks to uphold."[192] Dr. Day and his supporters are counting on this in the *Cambie* case, attacking the "very structure" of

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190 United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on Canada*, E/C 12/1993 (10 June 1993) at para 21; United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on Canada*, E/C.12/1/Add.31 (10 December 1998) at para 14, 15; see generally Jackman, "Health Care Accountability," *supra* note 5; Porter, "Right to Health Care," *supra* note 10.

191 *Chaoulli* (SCC) (Factum of the Interveners the Charter Committee on Poverty Issues and the Canadian Health Coalition) at paras 46, 48. The author represented CCPI and the CHC in *Chaoulli*.

192 Andrew Petter, "Wealthcare: The Politics of the *Charter* Revisited" in Flood, *Access to Care, supra* note 10 at 131; see Peter H Russell, "*Chaoulli*: The Political versus the Legal Life of a Judicial Decision" in Flood, *Access to Care, supra* note 10 at 15.

the single-payer system[193] and alleging that the government of British Columbia "is politically incapable of doing more to reform the system to protect constitutional rights without an order from the court to do so."[194] But instead of ceding the *Charter* to Dr. Chaoulli, Dr. Day, and others pursuing *Charter* litigation as a means of dismantling the single-payer system, those who believe in medicare, and want to make it better, must call on governments and the courts alike to interpret the *Charter* in a way that reflects and reinforces the systemic equality and other human rights objectives of the single-payer system. As Kent Roach observed in his critique of the majority's decision to strike down limits on private funding as the remedy for undue wait times in *Chaoulli*:

> The majority of the Court may have simply opened the system to more private health insurance that may benefit those who can afford it while doing nothing for the less advantaged who must rely on the public system. From the vantage point of those who cannot or do not contract out of the public system in the new world created by *Chaoulli*, the problem may actually be too little judicial activism.[195]

Rather than arguing that constitutional rights are not engaged by government funding and other health care choices, we must advocate for an approach to the *Charter* that is animated by the same principles as the medicare system itself—in the words of Justice Binnie in *Chaoulli*, one that is "mindful and protective of the rights of all, not only of some."[196] Contrary to the regressive reading of the *Charter* put forward in the *Cambie* case, we must demand that governments and courts affirm and protect the life, liberty, security of the person, and equality rights of every person in Canada to access health care based on need and not ability to pay.

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193 *Cambie* (Plaintiffs' Opening Statement), *supra* note 7 at para 1979.

194 *Ibid* at para 1960.

195 Kent Roach, "The Courts and Medicare: Too Much or Too Little Judicial Activism?" in Flood, *Access to Care*, *supra* note 10 at 186.

196 *Chaoulli* (SCC), *supra* note 10 at para 278.