N° 29272

**COUR SUPRÊME DU CANADA**
(EN APPEL DE LA COUR D'APPEL DE LA PROVINCE DE QUÉBEC)

ENTRE:

JACQUES CHAOULLI et GEORGE ZELIOTIS

APPELANTS
(Appellants)

- et-

PROCUREUR GÉNÉRAL DU QUÉBEC

INTIMÉ
(Intimé)

- et-

PROCUREUR GÉNÉRAL DU CANADA

INTIMÉ
(Mis en cause)

- et-

PROCUREUR GÉNÉRAL DE LA COLOMBIE-BRITANNIQUE, PROCUREUR GÉNÉRAL DE L'ONTARIO, PROCUREUR GÉNÉRAL DU MANITOBA, PROCUREUR GÉNÉRAL DU NOUVEAU-BRUNSWICK, PROCUREUR GÉNÉRAL DE LA SASKATCHEWAN, AUGUSTIN ROY, SENATOR MICHAEL KIRBY, SENATOR MARJORY LEBRETON, SENATOR CATHERINE CALLBECK, SENATOR JOAN COOK, SENATOR JANE CORDY, SENATOR JOYCE FAIRBAIRN, SENATOR WILBERT KEON, SENATOR LUCIE PÉPIN, SENATOR BRENDA ROBERTSON AND SENATOR DOUGLAS ROCHE, CANADIAN MEDICAL ASSOCIATION AND THE CANADIAN ORTHOPAEDIC ASSOCIATION, CANADIAN LABOUR CONGRESS, CHARTER COMMITTEE ON POVERTY ISSUES AND THE CANADIAN HEALTH COALITION, CAMBIE SURGERIES CORPORATION, FALSE CREEK SURGICAL CENTRE INC., DELBROOK SURGICAL CENTRE INC., OKANAGAN PLASTIC SURGERY CENTRE INC., SPECIALTY MRI CLINICS INC., FRASER VALLEY MRI LTD., IMAGE ONE MRI CLINIC INC., MCCALLUM SURGICAL CENTRE LIMITED, 4111044 CANADA INC., SOUTH FRASER SURGICAL CENTRE INC., VICTORIA SURGERY LTD., KAMLOOPS SURGERY CENTRE LTD., VALLEY COSMETIC SURGERY ASSOCIATES INC., SURGICAL CENTRES INC., THE BRITISH COLUMBIA ORTHOPAEDIC ASSOCIATION AND THE BRITISH COLUMBIA ANESTHESIOLOGISTS SOCIETY

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# PART I
# INTERVENER'S STATEMENT AS TO THE FACTS

## A. OVERVIEW OF THE INTERVENER'S POSITION

1. The Attorney General of Ontario's submissions relate to s. 7 of the *Charter*. In the case at bar, the Appellants do not seek access to health care *per se*. Publicly funded health care is available to them. Nor do the Appellants contend that they are in ill health and are being denied necessary medical treatment. They seek from this Honourable Court a determination that they have a constitutional right to purchase insurance to fund private health care. The essence of their complaint is that the impugned provisions are impediments to their obtaining health care in the fashion they desire; the treatment they want, from the physician they want, and at a time they want. They assert economic freedom for their individual health needs without due regard for the general welfare of others in the community, at the sacrifice of shared values and to the detriment of the common good.

2. The context of this constitutional challenge is highly significant and prudence should be exercised not to overshoot the purpose of the interests protected by the *Charter*. The impugned provisions deny the right to purchase private insurance or establish private hospitals; both are economic rights. It has not been proven that the provisions in question cause any denial of necessary medical treatments. Thus, no deprivation of life, liberty, or security of the person has been demonstrated.

3. This case does not raise the issue of whether s. 7 protects a general positive right to health care. The constitutional questions can be answered without addressing this complicated constitutional issue. The Court should follow its well-established practice of refusing to address constitutional issues that are not necessary to the determination of this appeal, especially when the record is incomplete on this issue.

## B. SUMMARY OF THE FACTS

4. The Attorney General of Ontario, accepts the facts as set out in the Respondents' facta. In addition, the following facts found by the trial judge are relied upon.

5. Neither of the Appellants' health is presently under threat. They do not suffer from any illness that requires medical care. Mr. Zeliotis' medical problems were properly treated and he did not experience all the problems and delays he has claimed:

> The truth is that, bearing in mind his personal medical obstacles, the fact that he was already suffering from depression, his indecision and his complaints which in many respects were unwarranted, it is hard to conclude that the delays incurred resulted from lack of access to public health services, and in fact even the complaints made by Mr. Zeliotis about the delays may be questioned...It is possible to sympathize with Mr. Zeliotis and understand the pain and anguish he felt, but it is difficult to conclude that the problems and delays he speaks of were caused solely by problems of access to Quebec health services... He believes that he would have had better access had there been a private system. We cannot say this is true, but that is his opinion and he is entitled to it.

**Judgment of Piché J., Case on Appeal, Vol. I, at p.14.**

6. Dr. Chaoulli, a 47 year old physician, had difficulties establishing his medical practice. When he was unable to start up an emergency service in Montreal, he became a non-participant in the public health care system for 3 months. Due to the reduction in his medical activities, he returned to the public system to work at a drop-in clinic:

> Also, Dr. Chaoulli never testified that he received inadequate health care or the system did not respond to his personal health needs. He is still subject to significant penalties with the *Regie de l'assurance-maladie du Quebec*. He became a non-participating physician, returned to the public system, still not satisfied. All of this leads the Court to question Dr. Chaoulli's real motives in this proceeding. One cannot help being struck by the contradictions in the testimony and with the impression that Dr. Chaoulli embarked on a crusade which is now more than he can handle.

**Judgment of Piché J., Case on Appeal Vol. I, at p. 21.**

7. The Quebec public health care system, like every other Canadian health system, does not have unlimited resources. The trial judge remarked on the specialist physicians who testified about the waiting lists in their field:

> Further, the Court notes that despite the fact that some of the specialists indicated a desire to be free to obtain private insurance, none of them completely and squarely endorsed the applicants' proposals, explaining that it was neither certain nor obvious that a rearrangement of the health system to accommodate a parallel private system would solve all the existing problems of delays and access. On the contrary, the specialists heard remained very cautious about an issue which is complex and difficult.
>
> **Judgment of Piché J., Case on Appeal Vol. I, at p. 27.**

8. The six expert witnesses supported a publicly funded health care system. Except for Dr. Coffey, a Montreal gynecologist/obstetrician called by the Appellants, all the experts who were medical academics, epidemiologist, and a health policy expert, agreed that to permit a parallel private system would adversely affect the universal health care system:

> The evidence has shown that the right to have access to a parallel private health care system, advocated by the applicants, would have repercussions on the rights of the entire population. We cannot bury our heads in the sand. The consequence of the establishment of a parallel private health care system would be to threaten the integrity, sound operation and viability of the public system. Sections 15 Health IA and 11 Hospital IA prevent that from happening and guarantee the existence of a quality public health care system.
>
> **Judgment of Piché J.,Case on Appeal Vol. I, at pp. 125-26.**

## PART II
## ISSUES ON APPEAL

9. The constitutional questions stated are:

   1. Does s. 11 of the *Hospital Insurance Act* R.S.Q. c. A-28, infringe the rights guaranteed by s. 7 of the *Canadian Charter of Rights and Freedoms?*
   2. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?
   3. Does s. 15 of the *Health Insurance Act* R.S.Q., c. A-29, infringe the rights guaranteed by s. 7 of the *Canadian Charter of Rights and Freedoms*?

4. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?
5. Is s. 15 of the *Health Insurance Act* R.S.Q., c. A-29, *ultra vires* the Quebec National Assembly, in light of s. 91(27) of the *Constitution Act,* 1867?
6. Is s. 11 of the *Hospital Insurance Act* R.S.Q., c. A-29, *ultra vires* the Quebec National Assembly, in light of s. 91(27) of the *Constitution Act,* 1867?
7. Does s. 15 of the *Health Insurance Act* R.S.Q., c. A-29, infringe the right to equality guaranteed by s. 15(1) of the *Canadian Charter of Rights and Freedoms*?
8. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?
9. Does s. 11 of the *Hospital Insurance Act* R.S.Q., c. A-29, infringe the right to equality guaranteed by s. 15(1) of the *Canadian Charter of Rights and Freedoms*?
10. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?
11. Does s. 11 of the *Hospital Insurance Act* R.S.Q., c. A-29, infringe s. 12 of the *Canadian Charter of Rights and Freedoms*?
12. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

10. The Intervener submits that constitutional questions #1, 3, 5, 6, 7, 9, 11, should be answered in the negative. It is not necessary to answer constitutional questions #2, 4, 8, 10, 12. In the alternative, if any of questions # 1, 3, 7, 9, or 11 is answered in positively, then the corresponding questions #2, 4, 8, 10 or 12 should be answered affirmatively.

## PART III
## BRIEF OF ARGUMENT

### A. THE CONTEXT OF THIS *CHARTER* CHALLENGE

11. The delivery of health care is highly complex with multi-faceted and polycentric relationships. Any change can have far-reaching, often unforeseeable consequences. Solutions to problems in the health system in general and to the problem of waiting lists in particular are not simple. Relatively recently, the comprehensive report of the Romanow Royal Commission on the Future of Health Care considered the very issue of health care coverage by private insurance. The Romanow Commission found that the publicly funded health system has delivered "affordable, timely, accessible and high quality care" on the basis of need and not income and recommended that solutions to problems should be found in the public system and not the private sector. The impugned provisions cannot be viewed in isolation from the comprehensive remedial scheme established for the benefit of all Canadians.

> **R. Romanow, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada,* November 2002, p. xvi, 8, 48 – 63**

12. The impugned provisions on their face deal with the regulation of economic contractual relationships in operation of the health system. They do not expressly speak to access to health care. Section 15 of the *Health Insurance Act* states:

> 15. No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident of temporary resident of Quebec or to another person on his behalf.

Section 11(1) of the *Hospital Insurance Act* states:

> 11(1). No one shall make or renew, or make a payment under a contract under which
> (a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;
> (b) payment is conditional upon the hospitalization of a resident; or
> (c) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

For breach of either provision, the penalty is a fine.

> **ss. 15, 76, *Health Insurance Act,* R.S.Q. c. A-29**
>
> **ss. 11(1), 15, *Hospital Insurance Act,* R.S.Q. c. A-28**

13. Ontario prohibits hospitals from charging insured patients for insured services and physicians from charging patients more than the amount payable by the Ontario Health Insurance Plan (OHIP). Subsection 14(1) of the *Health Insurance Act* prohibits private health insurance for any part of the cost insured services rendered in Ontario that is paid by OHIP. This subsection states:

> 14(1). Every contract of insurance, other than insurance provided under section 268 of the *Insurance Act*[1], for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,
>
> (a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;
>
> (b) compensation for loss of time from usual or normal activities because of disability requiring insured services;
>
> (c) any part of the cost that is not paid by the Plan for such other services as may be prescribed when they are performed by such classes of persons or in such classes of facilities as may be prescribed,
>
> performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract.

**s. 14, 15, *Health Insurance Act*, R.S.O. 1990, c. H. 6**

**s. 2, *Health Care Accessibility Act*, R.S.O., 1990, c. H. 3**

14. It is noteworthy that Ontario provides for full payment for services rendered out of country if the service is required (a) to avoid a delay in receiving service in Ontario that would result in death or medically significant irreversible tissue damage, or (b) if the service is not performed in Ontario by an identical or equivalent procedure.

**ss. 28.4 –28.6, Regulation 552, *Health Insurance Act*, R.S.O. 1990, c. H. 6**

## B. STEP 1: IS THERE A DEPRIVATION OF LIFE, LIBERTY, AND SECURITY OF THE PERSON?

### *(i). This Case is About an Assertion of Liberty*

15. It is the position of the Attorney General of Ontario that this case is essentially about the assertion of a right to liberty. For example, the Appellant Zeliotis argues "the appellant and all Quebecers should be able to freely exercise the choice to devote their

[1] This provision deals with contractual terms for accident benefits arising out of a motor vehicle liability policy.

own resources to preserving their health and the health of their dependants." Life and security of the person interests are not truly at stake. The Appellants do not require medical treatment. If they fall ill in the future, it is entirely speculative to conclude that they will not receive adequate and timely medical treatment from the publicly funded health care system. While waiting lists do exist for some treatments or services, to find that the Appellants would suffer a future unspecified illness or disability that could not be properly treated without a deprivation of life, liberty, or security of the person would open the door to hypothetical constitutional challenges and trivialize the *Charter*. There is no "deprivation" where the link between the actions of government and the alleged *Charter* violation is indirect, uncertain, speculative or hypothetical.

> ***Blencoe* v. *B.C. (Human Rights Commission),* [2000] S.C.R. 307at paras. 55-60**
> ***R. v. Operation Dismantle Inc.,* [1985] 1 S.C.R. 441**
> **Appellant Zeliotis' factum, para. 33**

16. The dominant characteristic of the impugned provisions is the interference with contractual rights. Given the existence of the public health care system, the prohibition of private insurance for publicly insured services cannot be equated with a denial of access to health care. In this case, the liberty interest has a dual economic component; the Quebec resident's economic interest in purchasing private health care insurance and the physician's commercial interest in privately providing medical services. Due consideration of the interests the Appellants are seeking to promote must recognize this significant economic aspect where on the facts, given the state of their health and well-being, their non-economic interests are minor and do not trigger s. 7.

> **Reasons of the Quebec Court of Appeal, Case on Appeal, Vol. I, pp. 175 – 189**

17. In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code*, *infra,* this Court was urged to find that s. 7 protected a prostitute's right to practice their profession in order to provide for the basic necessities of life. In other words, it was argued that the state should not interfere with an individual's freedom to structure and organize their lives in order to meet their basic needs. The Appellants' argument regarding the prohibition against private health care insurance strikes a similar theme. These

individuals wish to be able to order their economic affairs for the purpose of meeting their health needs in the way they desire. While the majority of the Court in *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code* rejected the constitutional challenge on other grounds, Lamer J. (as he was then) rejected this expansive interpretation of s. 7:

> In short, then, I find myself in agreement with the following statement of McIntyre J. in *Ref. Re Pub. Service Employee Rel. Act (Alta), supra,* at p. 412 [S.C.R.]:
>
> It is also to be observed that the *Charter*, with the possible exception of s. 6(2)(b) (right to earn a livelihood in any province) and s. 6(4), does not concern itself with economic rights.
>
> ***Reference re ss.193 and 195.1(1)(c) of the Criminal Code (Man.),* [1990] 1 S.C.R. 1123 at p. 1170.**
>
> ***ILWU v. Can.,* [1994] 1 S.C.R. 150**

18. It has not been established that the prohibition against private insurance and private hospitals amounts to governmental interference with a fundamental personal decision or an effective bar to access medical treatment for a condition that represents a danger to life or security of the person. This case is distinguishable from *R. v. Morgentaler, infra*. In that case, the delay was caused by the legislative scheme rather than due to limited medical resources. Furthermore, it was not only a delay in obtaining an abortion that engaged security of the person interests, but it was also the use of a criminal sanction and the consequent criminal stigmatization to compel a woman carry an unwanted pregnancy to term that profoundly interfered with her bodily and emotional integrity. In the case at bar, both the purpose and effect of the impugned provisions support the publicly funded health system and enhance values of equality, dignity and autonomy. They do not adversely affect an individual's bodily and emotional integrity but are designed to protect them.

> ***Morgentaler v. The Queen,* [1988] 1 S.C.R. 30 at p. 56 per Dickson C.J.C.**

19. In assessing the Appellants' liberty claim, it must be noted that this Honourable Court has recognized that even within the concept of "liberty" there must be limits:

> On the one hand, liberty does not mean unconstrained freedom; see *Re. B.C. Motor Vehicle Act,* [1985] 2 S.C.R. 486 (per Wilson J., at p. 24); *R. v. Edward*

> *Books and Art Ltd.*, [1986] 2 S.C.R. 713 (per Dickson C.J. at pp. 785-86). **Freedom of the individual to do what he or she wishes must in any organized society, be subjected to numerous constraints for the common good. The state undoubtedly has the right to impose many types of restraints on individual behaviour and not all limitations will attract Charter scrutiny.** [Emphasis added]

***R.B. v. C.A.S of Toronto,* [1995] 1 S.C.R. 315 at para 80.**

20. The evidence is compelling that if a two-tier system is established, the quality of health care for those in the public health care system would deteriorate, threatening vulnerable and less advantaged individuals. Professor T. Marmor, a professor of Public Policy and Management at Yale University who has written extensively on health policy, testified that the following detrimental effects would result from the establishment of a private system:

- there would be decreased support for the publicly funded system from crucial groups of Canadians who exit Medicare;
- costs for both the public and private system will increase leading to an overall increase in health expenditure; and
- there would be an overall increase in administrative costs to run both systems.

Professor Marmor concluded:

> Finally, the grounds used to bolster the arguments for parallel insurance are uniformly weak empirically. On cost considerations, Canada has an exemplary record with the one structure of payment that facilitates rather than complicates social decisions about how much to spend on medical care: single-pipe financing. **Where data are available, they do not support the contention that other OECD nations have, through "safety valve" parallel systems, succeeded in increasing citizen support, improving health outcomes, or providing a more sustainable system of health insurance coverage.** Indeed, it is that stability of Canadian public health insurance, not its instability, that is the striking finding of comparative health policy research. [emphasis added]

**Report of Prof. Marmor, Nov. 9, 1998, Case on Appeal, Vol. XII, p. 2175**

**Evidence of Prof. Marmor, Case on Appeal, Vol. V, p. 906 l. 20 – p. 929 l. 39**

**Evidence of Dr. Turcotte, Case on Appeal, Vol. VI, pp. 1075 - 1170**

21. Dr. Charles Wright, a surgeon, a professor at the Centre for Health Services, Policy, and Research at the University of British Columbia, and the Director of Clinical Epidemiology at the Vancouver Hospital, testified that studies have shown that the existence of a two tier system has lead to "cream skimming" by private physicians and hospitals where high risk patients are refused coverage shifting those patients to the public sector to bear the costs. This distorts the service delivery patterns. The for-profit system siphons off high revenue patients and avoids patient populations with high risk, thus, contributing further to the problems of cost and access. Clinical care for those in the public system would deteriorate.

> **Report of Dr. C. Wright, Oct. 26, 1998, Case on Appeal, Vol. XIII, pp. 2258-2259**
>
> **Evidence of Dr. Bergman, Case on Appeal, Vol. V, p. 758 - 820**
>
> **Silverman et al, "The Association between For Profit Hospital Ownership and Increased Medicare Spending". Vol. 34 New England Journal of Medicine, No. 6, 1999, Case on Appeal, Vol. XIII, pp. 2345 – 2354**

22. Dr. Wright further was asked to specifically address the question of whether permitting private health care would lead to the beneficial result of a reducing waiting lists in the public system by relieving the pressure on public resources:

> In theory, this could be an important result of making more services available through a private system. Unfortunately, there is substantial information which suggests the contrary. For instance, in those countries that have experience with a hybrid system (in which physicians are permitted to work both in the public and in a private system), there is a progressive deleterious effect on access within the public system. There is diversion of energy, commitment, and funding into the private facilities. A recent in-depth investigative report in Britain reveals the extent to which physicians progressively favor the private system and divert their commitment into it and away from the public system. ...A report issued in Australia "A Cutting Edge: Australia's Surgical Work Force 1994" concludes that delays in elective surgery in the public hospital system are caused largely by surgeons' reluctance to work in public hospitals and the fact that they encourage their patients to use the private system preferentially. In an analysis of the situation in Israel, it was noted: "the final layer in the black market is the duplicate clinics run by some of the physicians employed in the public clinics. The incentive for those physicians to maintain queues at the public clinics is obvious".... In the UK, the Audit Commission of the National Health Service conducts detailed analysis of health care services and health care provider's activities. The 1995 report on the work of hospital doctors in England and Wales is a damning indictment of the system that permits surgeons to work in private health care alongside the public system. The commission's data indicate that

> surgeons do on average " a third to half again as many operations for large private fees" than they do in the publicly funded system and that they deliberately spend less time than they are contracted for working in the public system in order to conduct private practice. "We have systematic evidence that British surgeons and anesthetists are short changing their patients and the National Health Service in order to stuff their pockets.

**Report of Dr. C. Wright, Oct. 26, 1998, Case on Appeal, Vol. XIII, pp. 2256 –2257**

**Evidence of Dr. C. Wright, Case on Appeal, Vol. VII, p. 1218 l. 10 – p. 1238 l. 40**

**Evidence of Dr. Bergman, Case on Appeal, Vol. V, p. 758 - 820**

23. This opinion was supported by the MacDonald/Lewis Report of 1998, commissioned by Health Canada, which studied the issue of waiting lists in this country, the UK, Sweden, Australia and New Zealand. The Report concluded:

> There is no evidence to suggest that private sector health care will result in shorter waiting lists and waiting times in the public sector. Providing access to private care for those who can afford and choose to pay has, if anything, perverse effects on waiting lists and waiting times in the public sector. Greater access to private care appears to be generally associated with LONGER public sector queues.

**McDonald, Shortt, et al " Waiting Lists and Waiting Times for Health Care in Canada: More Management! More Money?!", Health Canada, Case on Appeal, Vol. XIII, p. 2329**

24. Finally, it has been noted that those who take advantage of private insurance are not necessarily better off. In 1995, professor John Yates of the University of Birmingham, UK, studied private surgery done in the UK and concluded:

> Those who cannot afford to pay for treatment wait longer to get their treatment, get treated less frequently, are less likely to be operated on by a consultant and suffer greater levels of illness. The insured and the wealthy get treated more quickly, have more than their fair share of operations, are more likely to be operated on by a consultant, and are likely to have lower levels of illness. The latter group, however, is not without its problems. They pay extra money unnecessarily to jump false queues and undergo more than their fair share of unnecessary surgery.

**Report of Dr. John Yates, "Private Eye, Heart and Hip, the Institute of Health Services Management" 1995, Exhibit I-41A, Case on Appeal, Vol. XV, at p. 2790**

25. In *R. B. v. C.A.S. of Metropolitan Toronto,supra,* it was alleged that liberty interests under s. 7 of the *Charter* protected the right of parents to choose or not choose medical treatment for their infant. By refusing a blood transfusion for religious reasons,

the infant child's right to life and security of the person would have been compromised if the parents were allowed to exercise their parental rights. Justices Iacobucci, Major and Cory found that the parents' liberty interest could not encompass a right that overrode their child's life and security of the person interest. This analysis has resonance in the case at bar. While the Appellants argue that there is a threat of deprivation if they do not have access to private health insurance, there is a greater threat to others if they are allowed to pursue their individual liberty interest. Acceptance of their interest as falling within the protection of s. 7 would have a direct and adverse effect on the rights of others.

> ***R. B. v. C.A.S. of Metropolitan Toronto, supra,*** **at paras. 215- 222, 233**

26. The ability to purchase private health care insurance in the context of a publicly funded health care system does not engage "the core of what it means to be an autonomous human being blessed with dignity and independence in 'matters that can properly be characterized as fundamentally or inherently personal'". The freedom to privately purchase health care has more to do economic freedom than bodily integrity and fundamental autonomy.

> ***Blencoe v. B.C. (Human Rights Commission), supra,*** **at paras. 49, 54**
> ***Rodriguez v. British Columbia (Attorney General),*** **[1993] 3 S.C.R. 519**
> ***R. v. Clay,*** **[2003] S.C.J. No. 80 at para. 31**
> ***R. v. Malmo-Levine,*** **[2003] S.C.J. No. 79 at paras. 86 –87**

### *(ii). Conclusion on the first step of the section 7 analysis*

27. The Appellants have failed to prove that the impugned provisions have deprived them of their life, liberty or security of the person. The Appellants are not arguing for a positive duty on the part of government to provide access to a minimum standard of health care in a timely fashion. The constitutional attack on the impugned provisions does not raise the issue of positive rights. Essentially, the Appellants are claiming a liberty interest in a free market for medical services. This claim is not protected by the *Charter*. As stated by Oliver Wendell Holmes, there is a distinction to be made between the roles of the judiciary and the legislatures in relation to social and economic rights:

> Some of these laws embody convictions or prejudices which judges are likely to share. Some may not. But a constitution is not intended to embody a particular economic theory, whether of paternalism and the organic relation of the citizen to the State or of laissez faire.

***Lochner* v. *New York* (1905), 25 S. Ct. 539 at para. 59**

## C. STEP 2: IF THERE IS A DEPRIVATION OF LIFE, LIBERTY, AND SECURITY OF THE PERSON, DOES IT ACCORD WITH THE PRINCIPLES OF FUNDAMENTAL JUSTICE?

### *(i). Is There a Justiciable Principle of Fundamental Justice?*

28. It is not enough to show that the state action or law has lead to a deprivation of life, liberty, or security of the person, no matter how significant the deprivation; such deprivation must be proven to be not in accordance with *the principles of fundamental justice*. While the principles of fundamental justice comprise both substantive and procedural justice, caution should be exercised in their definition:

> On the one hand, the Court must be conscious of its proper role in the constitutional make-up of our form of democratic government and not seek to make fundamental changes to longstanding policy on the basis of general constitutional principles and its own view of the wisdom of legislation. On the other hand, the Court has not only the power but the duty to deal with this question if it appears that the Charter has been violated. The power to review legislation to determine whether it conforms to the Charter extends to not only procedural matters but also substantive issues. The principles of fundamental justice leave a great deal of scope for personal judgment and the Court must be careful that they do not become principles which are of fundamental justice in the eye of the beholder only.

***Rodrigues v. B.C. (Attorney General), supra,* at pp. 589-90 per Sopinka J.**

29. The impugned provisions are not "manifestly unfair" or "overbroad." Indeed, the Appellants do not articulate any recognized principle of fundamental justice in their attack on the impugned provisions. This Honourable Court has recently provided the following guidelines regarding the content of these principles:

> Jurisprudence on s. 7 has established that a "principle of fundamental justice" must fulfill three criteria: *R. v. Malmo-Levine,* 2003 SCC 74, at paras. 113. First it must be a legal principle. This serves two purposes. First, it "provides

meaningful content for the s. 7 guarantee"; second, it avoids the "adjudication of policy matters": *Re B.C. Motor Vehicle Act,* [1985] 2 S.C.R. 486 at p. 503. Second, there must be sufficient consensus that the alleged principle is "vital or fundamental to our societal notion of justice": *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. 519 at p. 590. The principles of fundamental justice are the shared assumptions upon which our system of justice is grounded. They find their meaning in the cases and traditions that have long detailed the basic norms for how the state deals with its citizens. Society views them as essential to the administration of justice. Third, the alleged principle must be capable of being identified with precision and applied to situations in a manner that yields predictable results. Examples of principles of fundamental justice that meet all three requirements include the need for a guilty mind and for reasonably clear laws.

***Canadian Foundation for Children, Youth and the Law v. Canada,* [2004] S.C.J. No. 6 at para. 8**

30. In the case at bar, no legal principle is advanced by the Appellants; their criticism of the lack of choice in meeting their health care needs is a matter of policy. Section 7 of the *Charter* does not authorize the courts to review the wisdom of legislative policy. Courts have recognized that they have limited institutional competence in matters of broad social and economic policy making. As recently stated by this Honourable Court in *R. v. Malmo-Levine, supra*:

> These are matters of legitimate controversy, but the outcome of that debate is not for the courts to determine. The Constitution provides no more than a framework. Challenges to the wisdom of a legislative measure within that framework should be addressed to Parliament.

***R. v. Malmo-Levine, supra,* at para. 5**

31. The record reflects that the provincial governments have taken a number of health care initiatives. In the future, governments may wish to employ new approaches and not all will enjoy the same level of success. The Court should be reluctant to interpret section 7 in a manner that would constrain and discourage necessary innovation in medical programs. The Romanow Report in pointing out that the guarantee of timely care as advocated by the Kirby Committee as problematic, was concerned about the consequences of such a similar intrusion:

> But provincial and territorial health care systems need flexibility in managing these surgeries effectively. That flexibility could be lost if care guarantees were rigidly applied. It also would be unfortunate to see provincial and territorial health care systems handcuffed into care guarantees for elective or non-life-saving services that could, in practice, mean they would have to reallocate resources away from life-saving surgery or treatment in order to meet the care guarantees for other services.

**R. Romanow, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada,* November 2002, p. 144**

***R.* v. *Mills*, [1999] 3 S.C.R. 668 at pp. 711-13**

***Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143 at p. 194**

32. In addition, the second criterion for a principle of fundamental justice is not met. There is no public consensus that private insurance should be available for health care nor is it fundamental to societal notions of justice. Consistent with the evidence at trial, the Romanow Commission has made it clear that permitting a parallel private health care system would have a deleterious effect on the publicly funded health system:

> Early in my mandate, I challenged those advocating radical solutions for reforming health care – user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system – to come forward with evidence that these approaches would improve and strengthen our health care system. *The evidence has not been forthcoming.* I have also carefully explored the experiences of other jurisdictions with co-payment models and with public-private partnerships, and have found these lacking. There is no evidence these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets). More to the point, the principles on which these solutions rest cannot be reconciled with the values at the heart of medicare or with the tenets of the *Canada Health Act* that Canadians overwhelmingly support. It would be irresponsible of me to jeopardize what has been, and can remain, a world-class health care system and a proud national symbol by accepting anecdote as fact or on the dubious basis of making a "leap of faith".

**R. Romanow, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada,* November 2002, p. xx**

***Canadian Foundation for Children, Youth and the Law v. Canada, supra,* at paras. 10**

33. The third requirement that the alleged principle of fundamental justice be "capable of being identified with some precision" and to provide a justiciable standard is

not met here. Private health insurance is not an answer to difficulties of timely access to medical treatment in the public health care system. The answers to the question of when is it too long to wait for medical treatment are inexact and highly complex. The Romanow Report highlighted the difficulty of the debate:

> While the concerns of Canadians are clear, the debate over waiting times and wait lists is anything but. The debate has become clouded by contradictory evidence and conflicting claims by health care professionals, managers health policy experts, and governments at all levels across the country...The current debate appears to be polarized between two extreme and incompatible positions:
>
> - Those who look at the way wait lists are managed across the country and conclude either that it is impossible to say whether there is a problem or that the problem is more perception than reality; and
> - Those who use incomplete information to conclude that the problems are so severe that the only solution is to allow parallel private facilities in which individuals can use their own funds to purchase some services and, in their view, "take some pressure off the public system."
>
> The Commission rejects both of these positions.
>
> In response to the first view, the problem is not just one of perception. There is evidence to suggest that there are problems in waiting times for some services but not in others. A comprehensive examination of the situation in Manitoba, for example, showed that the provincial system was dealing well with life-saving surgeries such as bypass operations, but not as well with non-life-threatening elective surgeries...
>
> In response to the second view, those who argue that the public system is no longer able to manage the situation fail to take into account the progress that is being made in some jurisdictions. In addition, private facilities may improve waiting times for the select few who can afford to jump the queue, but may actually make the situation worse for other patients because much-needed resources are diverted from the public health care system to private facilities

**R. Romanow, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada,* November 2002, p. 139**

35. The Appellants also contend that the law is overly broad. Before a law is so overly broad that it infringes s. 7, it must be grossly disproportionate to any state interest. The Appellants' argument that it is manifestly unfair to prevent them from obtaining health care outside the public system if they do not deprive it of any resources parallels an argument rejected by the Court in the case of *R. v. Malmo-Levine, supra.* In that case, the appellants argued that unless the state could show the use of marijuana was harmful to others, simple possession could not comply with the principles of fundamental justice.

The Court measured the alleged harm principle and found it wanting. It concluded that there was no consensus that harm is the sole reason for the use of the criminal law and found the harm principle to be an unmanageable standard to gauge deprivations of life, liberty or security of the person against. It further found that the harms that did exist to vulnerable groups engaged a sufficient state interest to shield the law from charges of irrationality. As stated by the majority:

> We do not agree with Prowse J.A. that harm must be shown to the court's satisfaction to be "serious" and "substantial" before Parliament can impose a prohibition. Once it is demonstrated, as it has been here, that the harm is not de minimis, or in the words of Braidwood J.A., the harm is not insignificant or trivial", the precise weighing and calculation of the nature and extent of the harm is for Parliament. Members of Parliament are elected to make these sorts of decisions, and have access to a broader range of information, more points of view, and a more flexible investigative process than courts do. A "serious and substantial" standard of review would involve the courts in micromanagement of Parliament's agenda. The relevant constitutional control is not micromanagement but the general principle that the parliamentary response must not be grossly disproportionate to the state interest sought to be protected, as will be discussed.

If the harm principle is rejected as a prerequisite for criminal law, *a fortiori* it cannot be a prerequisite for the exercise of regulatory authority.

***R. v. Malmo-Levine, supra,* at paras. 133, 169**

36. The Appellants contend that other countries have not adopted the route chosen by Quebec in prohibiting private insurance for publicly insured services. Whether another legislature or jurisdiction has decided to deal with the issue through different means is of little analytical significance in an over breadth analysis.

***R. v. Jones*, [1986] 2 S.C.R. 284, at para. 41**

***R. v. Malmo-Levine, supra,* at para. 113**

37. Not only have the Appellants failed to prove the impugned provisions are grossly disproportionate, the evidence have shown they are demonstrably sound. In interpreting and apply the *Charter,* the courts must be cautious to ensure that it does not become an instrument of better-situated individuals to roll back legislation which has as its object the improvement of the condition of less-advantaged persons.

***Edwards Books & Art Ltd. v. R.,* [1986] 2 S.C.R. 713**

***(ii). Conclusion on Principles of Fundamental Justice***

38. An ideal model of health care is not a principle of fundamental justice because it is not a legal principle; it is a quintessential policy issue on which there is no consensus except on the highest level of abstraction. As such, it is too imprecise to provide any measure of guidance to the judicial system in assessing the competing claims in the health care system. Consequently, even if there were a deprivation of life, liberty, or security of the person, it has not been shown that such deprivation is not in accordance with the principles of fundamental justice.

## D. POSITION ON THE OTHER CONSTITUTIONAL QUESTIONS

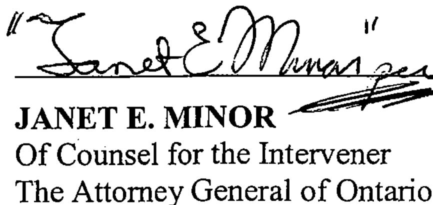
39. The Intervener the Attorney General of Ontario adopts the submissions of the Respondents on the other constitutional questions.

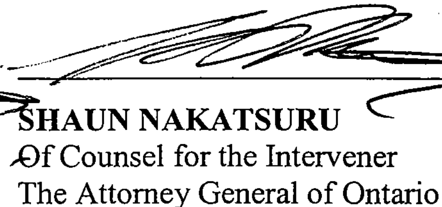
## PART IV
## ORDER REQUESTED

40. The Intervener submits that constitutional questions #1, 3, 5, 6, 7, 9, 11, should be answered in the negative. It is not necessary to answer constitutional questions #2, 4, 8, 10, 12.

41. In the alternative, if any of questions # 1, 3, 7, 9, or 11 is answered in positively, then the corresponding questions #2, 4, 8, 10 or 12 should be answered affirmatively.

**ALL OF WHICH IS RESPECTFULLY SUBMITTED BY:**





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**DATED** AT TORONTO this 13th day, of February, 2004.