Court File No. 29272

**IN THE SUPREME COURT OF CANADA**
(On Appeal from the Court of Appeal for Québec)

**B E T W E E N:**

**JACQUES CHAOULLI and GEORGE ZELIOTIS**
**Appellants (Appellants)**

**- and -**

**THE ATTORNEY GENERAL IN RIGHT OF QUEBEC**
**Respondent (Respondent)**

**- and -**

**THE ATTORNEY GENERAL IN RIGHT OF CANADA**
**Party Intervener**

**- and -**

**THE ATTORNEY GENERAL OF BRITISH COLUMBIA, THE ATTORNEY GENERAL OF ONTARIO, THE ATTORNEY GENERAL OF MANITOBA, THE ATTORNEY GENERAL OF NEW BRUNSWICK, THE ATTORNEY GENERAL OF 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**
**Interveners**

## FACTUM OF THE INTERVENER CANADIAN LABOUR CONGRESS


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***"Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship. Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Building from these values, Canadians have come to view their health care system as a national program, delivered locally but structured on intergovernmental collaboration and a mutual understanding of values".***[1]

## PART I - OVERVIEW

1. This appeal raises the constitutionality of a fundamental and essential feature of the Canadian medicare system -- our collective commitment to a publicly funded health care system based on need, rather than ability to pay. It raises the question of the scope and nature of a right to health care under s. 7 of the *Canadian Charter of Rights and Freedoms*. Given its historical and ongoing commitment to a single-tier publicly funded and administered health care system, the Canadian Labour Congress (the "CLC") views the consequences of this appeal for the future of medicare as profound.

2. The CLC will focus its submissions on the following areas:

a) the contextual factors which should be considered in addressing the merits of the Appellants' claim that our single-tier, publicly funded medicare system is unconstitutional;

b) the scope and content of s. 7 in the health care context;

c) the extent to which the Appellants' claim is, in substance, economic in nature and therefore outside the scope of s. 7;

d) the absence of any causal nexus between the alleged deprivation of the Appellants' life liberty or security of the person and the statutory provisions they have challenged;

e) the extent to which the legislation promotes rather than offends the principles of fundamental justice; and

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[1] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, November 2002 (Romanow Commission), p. xvi

f) the extent to which any interference with the appellants s. 7 rights is justified under s. 1 of the Charter.

## PART II - SUBMISSIONS

### A. Contextual Factors Supporting the Constitutionality of Medicare

#### (i) The Legislative and Policy Framework for Health Care

3. In considering this challenge to the Quebec legislation which preclude individuals from gaining preferential access to health care through privately purchasing health care or private insurance, this Court must consider the impugned provisions of the *Hospital Insurance Act*, R.S.Q., c. A-29, and the *Health Insurance Act*, R.S.Q., c. A-28 in their overall statutory context and the broader public policy framework in which they operate.

4. Section 11 of the *Hospital Insurance Act* and section 15 of the *Health Insurance Act* are statutory elements of an integrated framework of policy, law and programs that establishes and provides public funding to Quebec's provincial health care insurance plan. That plan reflects the national consensus, embodied in the five criteria of the *Canada Health Act*: public administration, comprehensiveness, universality, accessibility and portability. Provincial health care insurance plans operate in accordance with these criteria and ensure that all insured persons have reasonable access to necessary medical and hospital services on uniform terms and conditions. Because these plans create a publicly administered, single payer insurance scheme, providing public services on universal terms, they are commonly described as creating a "single-tier" model for the delivery of insured services across Canada. The impugned provisions of the Quebec legislation operate as an integral part of this scheme.

*Canada Health Act*, R.S. 1985, c. C-6, s. 7-12

5. These characteristics of the health care system enjoy widespread public support, precisely because, as the historical record before this Court unequivocally demonstrates, our single-tier publicly funded health care system has immeasurably improved the ability

of all Canadians to access necessary medical and hospital services.[2] Indeed, it is precisely because of the demonstrated adverse health effects of a parallel private market for health care that elected legislatures across Canada collectively established our public system. It would be ironic indeed if this public system were to be dismantled as a result of the Charter, when the Charter itself is premised on the same fundamental values of human dignity and equal concern and respect, which also form the foundation of medicare.[3]

6. It must also be noted that the Appellants do not propose to give up all of the benefits provided by the publicly funded single-tiered health care system. Rather, they are content to continue to take advantage of all of the benefits the system provides but with a super-added right to obtain preferential access to health care at their own option. However, the Appellants could never really "opt out" of the public system. Even in the private market they wish to establish, they would continue to benefit from society's investment in health care professionals and from public funding of the entire health care infrastructure, while seeking to avoid the single-tier foundation of the system.[4]

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[2] See the factum of the Attorney General of Quebec, paras. 44 to 70.

[3] The Appellant Zeliotis seeks to avoid this conflict by arguing that the public system would suffer no detrimental effect if he were allowed to purchase health care services or insurance privately. However, the evidence before this Court is manifestly to the contrary: see para. 27 below and the factum of the Attorney General of Quebec, paragraphs 163 to 177.

[4] Evans, R. et al., *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare?*, March 2000, at p. 49:

> A truly *private* private tier of health care within Canada is thus impracticable and probably impossible in reality, and in any case is not what proponents are advocating. Rather they contemplate a private tier interwoven with the public - in effect a "public-private partnership" supported by various forms of more or less invisible public subsidies. Providers, working in both systems, could influence both access and productivity in the public system, steering patients as they saw fit. Meanwhile "those who can afford it" would have ready access to (actual or perceived) higher quality care, without necessarily having to pay its full cost, and without having to pay the taxes that would provide a similar standard for the rest of the population...

### (ii) Prohibition Against Two-Tiered Health Care Protects All Canadians, Including the Vulnerable and Disadvantaged

7. On the record before this Court, there can be no dispute that for most Canadians, including the most disadvantaged and vulnerable, access to necessary health care depends upon extensive governmental legislation, regulation and funding, all of which makes up our medicare system. This important social and economic context should inform this Court's approach to the s. 7 claim in this case. As Justice Cory noted:

> This Court has on several occasions observed that **the Charter is not an instrument to be used by the well positioned to roll back legislative protections enacted on behalf of the vulnerable.** This principle was first enunciated by Dickson C.J. for the majority in *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713. He wrote, at p. 779:
>
> > **In interpreting and applying the Charter** I believe that the courts must be cautious to ensure that it does not simply 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.
>
> ...It would be unfortunate indeed if the Charter were used as **a weapon to attack measures intended to protect** the disadvantaged and comparatively powerless members of society. It is interesting to observe that in the United States, courts struck down important components of the program of regulatory legislation known as "the New Deal". This so-called "Lochner era" is now almost universally regarded by academic writers as a dark age in the history of the American Constitution.
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> ... **The importance of the vulnerability concept as a component of the contextual approach ... should apply whenever regulatory legislation is subject to Charter challenge**. [emphases added]
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> *R. v. Wholesale Travel Group*, [1991] 3 S.C.R. 154 at 233-34
> *Slaight Communications Incorporated v. Davidson*, [1989] 1 S.C.R. 1030 at 1051
> *Irwin Toy Ltd. v. Quebec*, [1989] 1 S.C.R. 927 at 993

8. This Court should reject the Appellants' invitation to engage in a *Lochner*-type review of the wisdom of fundamental legislative protections in the realm of health care social and economic policy.[5] These are matters that are properly the subject of ongoing

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[5] The 1905 U.S. Supreme Court decision in *Lochner v. New York*, 198 U.S. 45 (1905) was subsequently applied to invalidate over 200 state and federal statutes including progressive income tax laws, minimum wage laws, health and safety protections and the right of workers to organize.

parliamentary and extra-parliamentary public debate, a debate which is currently taking place.[6] Under the Appellants' proposed approach, there would be a constitutionally protected right for those with the ability to pay to a private market for health care, but this at the detriment of a public system enacted to protect all Canadians, particularly the most vulnerable and disadvantaged, from the deficiencies of the private market. Indeed, implicit in the Appellants' approach is the *Lochner* view of government action as antagonistic to freedom and liberty. This approach is inconsistent with the contemporary recognition that in various areas of social and economic policy, including health care, state intervention to regulate and control the private market is both necessary and appropriate.

**B. Scope of Section 7 Rights in the Health Care Context**

9. Courts have recognized that, due to the intentional omission of a right to property in the Charter, rights and interests which are primarily of a contractual, commercial or economic nature are not encompassed by s. 7. However, the majority of this Court has expressly reserved on the question of whether s. 7 can apply to protect rights and interests wholly unconnected to the administration of justice, and on the question of whether s. 7

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The *Lochner* era ended only late into the New Deal when a majority of the U.S. Supreme Court upheld the *National Labour Relations Act*, ruled that social and economic regulatory laws and protective measures were constitutional, and affirmed the government's constitutional role in protecting societal health and welfare, which justified restrictions on the private marketplace. In short, the Supreme Court came to recognize what is the starting point under the Canadian Charter of Rights, namely that public needs come before individual property and economic rights.

[6]In the Court of Appeal, Justice Delise noted that s. 7 should not be used to challenge the correctness of a social policy option in the courts, adopting the then-Chief Justice Lamer comment in *Reference re; 193 and 195.1(1)(c) of the Criminal Code (Man)*, [1990] 1 S.C.R. 1123 at 1176:

> ... [I]n the area of public policy what is at issue are political interests, pressures and values that no doubt are of social significance, but which are not 'essential elements of a system for the administration of justice....The courts must not, because of the nature of the institution, be involved in the realm of pure public policy; that is the exclusive role of the properly elected representatives, the legislators. To expand the scope of Section 7 too widely would be to infringe upon that role.

imposes a positive obligation on government to protect interests which may have an economic component but which also are fundamental to human life or survival.[7]

*Irwin Toy, supra*

10. This appeal requires the Court to consider the extent to which s. 7 comprehends a right to health or health care, and the scope and nature of any such right. In applying s. 7 of the Charter to a claim to receive health care, it is necessary to afford both a contextual and purposive interpretation. It is the CLC's position, for the reasons set out below, that to the extent s. 7 provides a right to health care, it should be interpreted as extending an equal right for all Canadians to access medically essential health care services, not as a right of the advantaged to obtain preferential access.

11. This approach is supported by fundamental Charter values which have informed constitutional interpretation in other contexts, including advancing human dignity and ensuring equal concern and respect. It is also reinforced by the text and purpose of s. 36 of the *Constitution Act, 1982,* which commits governments to certain objectives in the delivery of essential public services, particularly where the well-being of Canadians is concerned. Section 36(1) provides as follows:

> 36 (1) ... Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to
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> (a) **promoting equal opportunities for the well-being of Canadians**;
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> (b) furthering the economic development to reduce disparity in opportunities; and
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> (c) **providing essential public services of reasonable quality to all Canadians**. [emphasis added]

*Constitution Act, 1982*, s. 36(1)

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[7] This case does not necessarily require the Court to determine whether there is a positive obligation on the state to ensure that individuals receive a guaranteed level of health care consistent with their s. 7 rights. To be clear, the CLC would support the view that such a positive state obligation exists. Indeed, as set out below, in the CLC's view, the publicly funded, single-tier medicare system, far from being a threat to s. 7 interests, protects and advances those interests.

12. In this respect, the medicare system is one of, if not the most, fundamental "essential public service" provided to Canadians; its very essence is to improve the "well-being" of Canadians. Thus, in the specific context of any right to health care under s. 7, the emphasis in s. 36 on promoting equal opportunities for all Canadians should inform the scope and boundaries of the right. Any right to health care should be understood as a right to equal access to essential health care for all Canadians, and not as a right to preferential access to health care for some based on their ability to pay.

13. This approach is also consistent with the treatment of a right to health and health care under international treaties and obligations to which Canada is party. These treaties and obligations uniformly recognize the importance of equality and non-discrimination in access to health care and health services as the fundamental component of the right to health. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The equality component of the right to health is also recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (establishing "a right to public health"); article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (non-discriminatory access to health care); and in article 24 of the Convention on the Rights of the Child (establishing a right to health for all children). Furthermore, the International Covenant on Economic, Social and Cultural Rights provides in section 12 as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> ...
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

As the Commentary to Article 12 makes clear, health facility, goods and services must be accessible to everyone without discrimination, including the most vulnerable or marginalized sections of the population.

> General Comment No. 14 (2000), The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)
>
> See also World Health Organization, *World Health Report 1999: Making A Difference,* (Geneva, WHO, 1999) [relied upon by the trial judge at paragraphs 61-70]

14. Thus, to the extent that the interests protected by s. 7 extend to a right to health or to health care, this right should be interpreted and applied in a manner which recognizes these underlying equal access and non-discrimination values. In this context, far from interfering with the right to health under s. 7, the impugned provisions have both the purpose and effect of safeguarding equal access to health care for all Canadians, and ensuring that all available resources are marshalled within the public system for the overall benefit of all Canadians. A right to health care, as asserted by the Appellants, which privileges or advantages those with the means to purchase health services, is antithetical to these constitutional and international legal norms embodied in a right to health care.

15. This Court's decision in *R. v. Morgentaler* is consistent with this understanding of the right to health care under s. 7. At issue in *Morgentaler* was a criminal prohibition preventing women from obtaining access to necessary health care services even where their life or health was in danger. In substance, the interest protected by this Court involved a woman's right to access the public health care system in order to obtain necessary medical care; this Court held that the *Criminal Code* provisions at issue operated in a manner which impeded or blocked equal access to medically necessary abortion services. However, there was no suggestion that the Court was extending protection to an indirect economic interest in privately purchasing health services.[8]

> *R. v. Morgentaler* [1988] 1 S.C.R. 30

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[8] Indeed, the interests of **all** women in safe and timely abortions can only be meaningful in the context of a public health care system. To the extent the Appellants' claim weakens or undermines the public system, the rights recognized in *Morgentaler* would be correspondingly diminished.

16. Indeed, interpreting s. 7 as extending to the Appellants a right to purchase health care privately or through private insurance would, as the evidence demonstrates, have an adverse and destructive effect on the s. 7 rights of all other Canadians who depend on the publicly funded medicare system. As found by the trial judge there would be significant adverse effects on the Quebec health care system if private insurance or private payment for medical and hospital care were allowed. An interpretation of s. 7 which would undermine the essential equal access core of the s. 7 guarantee in the health care context should be avoided, particularly where such an interpretation is neither compelled by the language of s. 7, nor is it consistent with its underlying purpose and with the larger purposes of the Charter itself.[9]

**C. Appellants' Interests Are Economic In Nature**

17. Section 7 does not protect economic, contractual or commercial interests. However, the impugned provisions in this case relate specifically to the entering into, or payment under, a contract of insurance for publicly insured medical services and the making of, or payment under, a contract, by insurance or otherwise, for publicly insured hospital services. They are key provisions in a broad statutory scheme that is intended to regulate the economic market for health insurance and health care.

18. With respect to publicly insured medical and hospital services, the legislation establishes a single public payer and insurer. The objective of this publicly administered health insurance system is to ensure that all persons have access to publicly insured, comprehensive, and accessible medical and hospital services on uniform terms and conditions. Thus, the legislation regulates the operation of the private and insurance markets for health services, precluding a market for publicly insured medical and hospital services, while permitting the private and insurance markets to provide certain other health services not covered by the public system.

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[9]As former Chief Justice Dickson observed in relation to freedom of religion, "protection of one religion and the concomitant non-protection of others.... imports disparate impact destructive of the religious freedom of the collectivity": *R. v. Big M Drug Mart*, [1985] 1 S.C.R. 295 at 337.

19. The establishment of the publicly administered health insurance system, which is operated on a not-for-profit basis, maximizes the resources available for publicly funded health services, minimizes administrative costs, and increases the transparency and accountability of the health insurance system. The efficacy of this approach can be measured by the significant cost efficiencies it offers compared to the unregulated market model for health care insurance that operates in the U.S., where the administrative costs associated with the health insurance system are much higher.[10]

Trial Judgment, paragraphs 89 and 100, *Appeal Record*, Vol. 1

20. In this context, the Appellants' claim must be viewed as essentially contractual and economic in nature. While they seek to characterize this contractual and economic claim as a claim for a right to health care, the provisions they challenge involve only the mode of payment for health care. They form part of a legislative scheme which is premised on public payment and insurance for the provision of essential health services to all residents of Quebec. In substance, the Appellants' real complaint is not with the loss of a right to receive health care, which the legislation actually enhances, but a right to privately contract for health care payment or insurance, i.e. a right to dictate the way in which the health care market is regulated. Nothing in s. 7 protects this fundamentally economic interest.

21. Where the state has implemented a public health care system which provides access to medical and hospital care based on patient need, the assertion of a right to purchase health services or private health insurance must be, by its very nature, an economic interest rooted in ability to pay. This is because only those individuals with sufficient economic means are able to assert (i.e. purchase) the right, and because the

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[10] See, for example, Woolhandler, Campbell and Himmelstein, "Costs of Health Care Administration in the United States and Canada", New England J. of Medicine, 2003; 349: 768-75; and see www.pnhp.org (Physicians for a National Health Plan) for a review of scholarly and other material documenting various concerns with the failure of the U.S. to shift to a single payer public insurance health care system.

right asserted is to obtain preferential access to health services based not upon need but upon economic capacity or status (i.e. ability to pay).[11]

22. Thus, the right to privately contract for health services is, in substance, an economic interest rooted in the ability to pay. It cannot be said that a right which can be asserted only by individuals of substantial economic means to gain preferential access to certain health services is fundamental to everyone's life, liberty and security of the person. Rather, to the extent that the interests protected by s. 7 extend to a right to access health care, the interest protected must be defined as one of equal access for all Canadians to needed health care services. As such, it must be universally available on a universal basis to all Canadians, and not just to those who are privileged by wealth.

23. In any event, at the very least, to become an interest protected under s. 7, an economic right must be essential or necessary to the right to life, liberty and security of the person.[12] On the substantial body of evidence adduced in this case, there is no such essential or necessary connection. The relationship between the right to contract privately for health care services and actual access to such services is at best speculative, remote and uncertain. Indeed, as set out below, the evidence establishes that timely access is enhanced by the preclusion of a private market, and that the removal of the impugned provisions would be detrimental to the public system's capacity to provide care.

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[11] The characterization of the right asserted by the Appellants as essentially economic is supported by the nature of their claim and the remedy they seek. The Appellants' do not seek an order directing the Minister of Health to provide timely care, but only the right to purchase care privately. This economic right is not protected by s. 7.

[12] This is consistent with this Court's decision that, in order for economic rights to be protected, they must be fundamental to human life or survival: *Irwin Toy, supra*, p. 1003-1004.

## D. No Interference with Any Constitutionally Protected Health Interests the Appellants May Have

### (i) Impugned Provisions Promote Overall Access to Health Care

24. In the alternative, to establish an interference with a s. 7 interest, the Appellants must demonstrate that there is a real or imminent threat to that interest, as opposed to one that is hypothetical and speculative. Given the absence of any demonstrated imminent or actual threat to their interests, the Appellants' constitutional claims are necessarily systemic in nature. Consequently, they must demonstrate (assuming, without accepting, that they have public interest standing to do so) that the impugned provisions, on a systemic basis, constitute a threat to the public's s. 7 interests, i.e. that the existing Quebec medicare system poses a greater imminent threat to access to essential health care services than the alternative parallel scheme of private insurance and private payment they propose.[13] To the contrary, as set out in the Respondent and intervener factums, and as summarized in paragraph 27 below, the evidence is a parallel private system would undermine both equal access, and quality of care, within the public system.

### (ii) No Causal Relationship Between Impugned Provisions and Alleged Breach

25. Furthermore, the Appellants have failed to meet the evidentiary burden of establishing that the impugned provisions, viewed in their proper and overall context, cause the alleged delay in accessing timely health care services. This Court has been clear that, even if a s. 7 interest is potentially affected by legislation, the legislation must be the cause of the deprivation of those s. 7 interests.

> See eg., *R. v. Morgentaler, supra*, at p. 60;
> *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, [2000] 2 S.C.R. 1120,at para. 43-44

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[13] It is to be noted that the Appellants are not seeking individual remedies under s. 24 (1) of the Charter, but a declaration of general invalidity under s. 52 of the *Constitution Act, 1982*. In *Morgentaler,* former Chief Justice Dickson noted that it is the overall general effects of legislation that is relevant to determining its constitutionality where the challenge is to the effect of the legislative scheme as a whole and not its impact on an individual (p. 62-63).

26. The evidence before the Court does not establish that the prohibition on private payment or private insurance causes waiting lists in the public system or that any denial of timely care which may exist in the Quebec system is caused by, or inherent in, the statutory scheme. There are many possible causes of delay or waiting lists ranging from new technology, to shortages of physicians or other health care personnel, to informational asymmetries, lack of coordination and centralization, inadequate reporting mechanisms, etc. Indeed, waiting lists exist in various health care systems in other countries regardless of the mix of private and public funding or insurance.

27. As found by the trial judge, there is a virtual consensus of expert opinion that allowing access to a parallel private system would likely exacerbate, not alleviate, pressures on the public system. The adverse consequences identified by the expert evidence before the Court and relied upon in the factual findings of the trial judge, include the following:

(i) shifting energy and resources from the public system into the private system, increasing waiting times for the majority who continue or have no choice but to depend on it;[14]

Trial Judgment, paragraphs 85-86, 91-93, 107-108, Appeal Record, Vol. 1

(ii) the establishment of a multi-tiered system of health care in which access to high quality services increasing becomes dependent upon ones ability to pay for those services;

Trial Judgment, paragraph 82, Appeal Record, Vol. 1

iii) deterioration of the clinical quality of care available to those remaining in the public system;

Trial Judgment, paragraph 88, Appeal Record, Vol. 1

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[14] Indeed, as the Romanow Commission found, "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" (p. 139)

(iv) increasing the costs of administering the health care system, in part because of the need for increased regulation of parallel providers;

Trial Judgment, paragraphs 89 and 110, Appeal Record, Vol. 1

(v) increasing pressure on the public system will also arise from cream skimming practices by those operating outside the publicly funded system who concentrate service delivery on easy to treat patients, and procedures with higher profit margins leaving most costly care to be delivered by the public system; and

Trial Judgment, paragraph 92, Appeal Record, Vol. 1

(vi) undermining public confidence in and the willingness to support the publicly funded system, particularly among economic privileged Canadians who will resist having to pay for two health care systems.

Trial Judgment, paragraphs 89 and 112, Appeal Record, Vol. 1

See also Canadian Healthcare Association Policy Brief, *The Private-Public Mix in Funding and Delivery of Health Services in Canada: Challenges and Opportunities* (Ottawa: CHA Press, 2001), at pp. 35-50

28. Other interveners fault the publicly funded health care system for not establishing care guarantees that insured persons will receive certain procedures according to a predetermined time schedule. But no market for health care services is perfect, as the evidence adduced at trial clearly demonstrates; all health care systems ration services in one way or another (see, for example, the evidence of Professeur Jean-Louis Denis referred to in para. 95 of trial judgment). In effect, these interveners argue an economic right to buy health services privately is infringed because the publicly funded and regulated health care services market is not perfect. However, this is a standard that no market, including the hybrid version they propose, can achieve. In fact, as found by the trial judge:

> 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 consequences of the establishment of a parallel private health care system would be to threaten the integrity, sound operation and viability of the public system. [translation]

Trial Judgment, paragraph 263, *Appeal Record*, Vol. 1

## E. Any Deprivation Accords with Principles of Fundamental Justice

29. This Court has consistently recognized that "the requirements of fundamental justice are not immutable; rather, they vary according to the context in which they are invoked." In this case, the context involves a constitutional challenge to one of the foundations of Canada's most important and successful social program, and one that enjoys very broad popular support. Moreover, the single-tier publicly funded medicare system is the product of historic, longstanding and extensive public and parliamentary debate and study. In this context, there is a very heavy onus on those who would suggest that one of the core features of medicare - the prohibition on a two-tiered health care system - does not accord with the principles of fundamental justice, whether fundamental justice is understood procedurally or substantively.

*R. v. Lyons*, [1987] 2 S.C.R. 309 at 361

30. This Court has held that a principle of fundamental justice must be a legal principle, avoid the adjudication of policy matters and reflect a consensus fundamental to our societal notions of justice. Under the guise of applying the principles of fundamental justice, the Appellants invite this Court to adjudicate on matters of significant public policy, through the application of non-legal principles, to impose public policy imperatives on government in a manner wholly inconsistent with a longstanding societal consensus and to do so on complex social and economic matters in respect of which the Court has limited expertise. If any legislative initiative or social program is cherished by Canadians as reflecting fundamental values, it is the medicare system, and the corresponding restrictions, found in one form or another across Canada and reflected in the federal *Canada Health Act*, on the establishment of a two-tiered health care system.

*Canadian Foundation for Children, Youth and the Law v. Canada (Attorney-General)*, 2004 SCC 4, at para. 8

*Re B.C. Motor Vehicle Act Reference*, [1985] 2 S.C.R. 486, per Lamer C.J. at p. 503, explaining that the principles of fundamental justice lie in "the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system."

31. It cannot be inconsistent with the principles of fundamental justice for Government to enact legislative measures which protect the s. 7 interests of the collectivity. Allowing the Appellants to access a scheme of private payment or private insurance for medicare services would interfere with the s. 7 interests of the collectivity to equal access to a reasonable level of heath care. Further, the fact that the legislative scheme advances the s. 15 equality interests of disadvantaged groups provides additional support for concluding that the legislative scheme is consistent with the principles of fundamental justice.

32. Even assuming that standards of fundamental justice developed in the criminal law context are equally applicable to social and economic legislation enacted for the public benefit, the Appellants have failed entirely to demonstrate that the impugned limitations are arbitrary, irrational or grossly disproportionate so as to offend against principles of fundamental justice. Other respondents and interveners have detailed the evidence before the Court which provides overwhelming support for the conclusion that the legislative provisions at issue are reasonable, measured and appropriate, given the overall equality, accessibility efficiency and quality objectives of the legislative scheme.

## F. Section 1 of the *Charter*

33. The commitment to a single payer publicly funded health care system, as reflected in the Quebec legislation, is a quintessential reflection of those core Charter values essential to a free and democratic society which this Court has, since its seminal decision in *R. v. Oakes*, [1986] 1 S.C.R. 103, recognized as a foundation of the s. 1 analysis. The medicare system is premised on a concern for the inherent dignity of the human person, a commitment to social justice and equality and a desire to enhance the ability of individuals to participate in society (particularly since health is a precondition to any such participation). Medicare is also the product of a democratic consensus within our social and political institutions. These considerations form the overall context in which s. 1 should be applied in this case.

34. All of the factors which this Court has consistently identified as warranting deference in the application of s. 1 apply to the legislative choice of the Legislature as to how best to provide essential health care to all Canadians.[15] First, the legislative and policy scheme governing the overall design of the health care system, including the determination of the appropriate role for and mix of private and public funding and delivery,[16] requires the legislature to strike a balance between the claims of many different competing groups and interests. As the record demonstrates, the health care systems of OECD countries differ markedly in their design and structure, in terms of a myriad of features, including how services are delivered, choice of health care provider, method of provider payment, scope of publicly insured services, scope of services which can be privately insured or purchased, supply and distribution of health care providers, taxation measures, and the like. Some features promote greater efficiency, while others promote equity, quality, accessibility, provider autonomy, and so forth. Each health care system is comprised of a delicate mix and balance of these different and competing features, none of which exist in isolation. Altering one feature will impact on all the others, sometimes with predictable consequences, other times with unintended consequences. These involve choices among competing values and policy objectives are part of the delicate and complex balance inherent in the design of a health care system, and for that reason are more appropriately left to be determined by the Legislature.

35. Second, as emphasized above, one of the core objectives of our single-tier, publicly funded medicare system is to promote and protect the interests of the disadvantaged and vulnerable in equal access to essential health care, and to ensure that the health care system fairly, equitably and efficiently allocates resources based on medical need and not

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[15] For a summary of these factors, see for example *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877.

[16] Contrary to popular perception, relative to some other OECD countries, private payment for health care services in Canada, which represents approximately 30% of overall health care costs, is quite high, and almost twice that of Britain: CHA Policy Brief, *supra*, at p. xii; Trial Judgment, para. 81.

ability to pay. Thus, to the extent the legislation is specifically aimed at protecting disadvantaged and vulnerable groups, a considerable degree of deference is owing.

36. Third, the issue of whether the Legislature's decision to remedy the undesirable consequences of a private market for essential health services can be justified necessarily requires the Court to assess the validity of health and social science evidence. As it turns out, on the record on this appeal, the evidence overwhelmingly supports the validity of the legislative objective and the proportionality of the legislative remedy. However, even if there had been a real conflict on the evidence, that in itself would attract judicial deference. In any event, this is a case where the Court is being asked to redesign fundamental elements of the health care system, a task which falls outside the Court's institutional expertise.

37. Fourth, the interests restricted by the impugned provisions, even if falling within s. 7, have a large economic component and, in substance involve the assertion of a right to purchase health services based on ability to pay rather than need. In this respect, the Appellants are asserting a right to jump the queue and obtain preferential access to health care. Even if this interest was constitutionally protected, it is clearly an interest of limited social and moral value.

38. With respect to the application of the s. 1 test, there can be no question that the objective of the impugned provisions serve pressing and substantial objectives, including ensuring that all individuals have equal access to health care based on medical need and regardless of their income, and maximizing the resources available through a single payer public health care system. Moreover, as set out above, and in the factums filed by the respondent and supporting interveners, the evidence establishes that permitting the development of a private market for the purchase of publicly insured medical and hospital services would have severe, adverse consequences for the attainment of those objectives. Certainly, it was reasonable for the Legislature to determine that the detrimental effects of permitting a private payment for insurance market, and shifting to a health care system which ties access to care to ability to pay rather than medical need, far outweigh any

possible benefits which might result from removal of the impugned provisions. As the trial judge concluded, the only way to ensure that all health resources will benefit all Quebecers without discrimination is to prevent a parallel private care system from being established.

39. Certain interveners before this Court argue that a less restrictive alternative means would be some form of "care guarantee". Whether or not a "care guarantee" is feasible, upon which there is limited, if any, evidence before this Court,[17] it is not an alternative sought by the Appellants. A less restrictive alternative means must, by its very nature, involve some modification to the measure which has been found to infringe a Charter right or freedom. Here, the Appellants argue that the infringing measures are the impugned legislative restrictions on private payment and insurance. However, with or without a care guarantee, these provisions would remain intact, so it can hardly be said that a "care guarantee" would be a lesser restriction on what the Appellants assert is their right, namely to purchase private care outside of the publicly funded system.

40. The Appellants have argued that the introduction of a parallel private system would not have adverse consequences for the public system and indeed would relieve pressure on the public system. Not only is this contrary to the expert evidence before this Court, but it is also contrary to logic and common sense. As the distinguished health care economist Robert Evans has observed, writing for the Romanow Commission:

> The argument that governments cannot afford to meet growing health care needs is often presented under the label of "relieving the pressure on the public system", but the extent to which private financing could do so depends upon the assumed

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[17] The Romanow Report expressed concern about the effectiveness and utility of a care guarantee, noting the difficulty in ranking the urgency of different medical conditions, the potential to skew the allocation of health care resources, and the need for flexibility in managing health care, which could be lost if care guarantees were rigidly applied (p. 144). In sum, the causes and cures of problems associated with wait lists, which exist under many different health care systems, are complex and inter-related (see, for example, Wright Report, *Appeal Record*, Vol. XIII, p. 2247-2260) and are likely not amenable to a single quick-fix, such as a care guarantee. Rather, the best solution, as advocated by the Romanow Commission, involves coordinated and integrated strategies focusing on improving management of the health care system. Certainly the Romanow Commission did not believe that opening up a private market would reduce waiting times.

source of that pressure. If the public system is constrained by shortages of personnel, it is unclear how increased private financing could relieve this pressure. A "parallel" private system would just draw personnel away from the public system by offering higher incomes, paid for from higher prices charged private patients, and reducing the capacity of the public system. As in any private market, "Who Gets?" are those most able and willing to pay...

What can, however, be stated with some confidence is that "separate but equal" public and private facilities will be neither separate nor equal, for perfectly straightforward economic reasons. If a separate, private tier of care were to "take the pressure off the public system" to the extent that access and perceived quality were the same in both settings, no rational person would pay out-of-pocket to use the private system. The differences between the two, perceived or real, must be sufficient to maintain a price differential.

Nor will those distinctions be difficult to maintain, if as is common in two-tiered systems the same practitioners are permitted to work in both the public sector and the private sector. The economic incentives are obvious: to manipulate access to the public system so as to steer patients toward the more remunerative private care, and to limit the time and effort put into the public system. Whether it is the Medicaid system for the poor in the United States, or the National Health Service in Britain, or Australia, or Israel, or Greece.... the same stories emerge.

Evans, R., *Raising the Money: Options, Consequences, and Objectives for Financing Health Care in Canada*, Commission on the Future of Health Care in Canada, Discussion Paper No. 27, October, 2002, p. 28-29

Evans, R. et al., *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare?*, March 2000, at pp. 32 to 49

## PART III - ORDER REQUESTED

41. The CLC requests that this Court dismiss this appeal.

**ALL OF WHICH IS RESPECTFULLY SUBMITTED**

March 17, 2004

Steven Barrett / Steven Shrybman
Ethan Poskanzer / Vanessa Payne

**SACK GOLDBLATT MITCHELL**
Counsel for the Intervener Canadian Labour Congress

## PART IV - AUTHORITIES

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**Cases**



**Articles and Reports**

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Convention on the Rights of the Child, November 20, 1989 ..... 7

United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (2000)* The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) ..... 8

International Convention on the Elimination of All Forms of Racial Discrimination, March 7, 1966 ..... 7

International Covenant on Economic, Social and Cultural Rights, December 16, 1966 ..... 7

Universal Declaration of Human Rights ..... 7

## PART V - STATUTORY PROVISIONS

### *Canada Health Act* R.S. 1985, c. C-6, s. 3,4,7-13, 18-20:

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

...

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions

11.(1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

12.(1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(*c*) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (*a*), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(*b*) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

...

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

19.(1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

***Canadian Charter of Rights and Freedoms*, s. 1 and 7:**

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set our in it subject only to such reasonable limits prescribed by law as can be justified in a free and democratic society.

7. Everyone has 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.

***Constitution Act, 1982*, s. 36**

36 (1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to

(a) promoting equal opportunities for the wellbeing of Canadians;

(b) furthering the economic development to reduce disparity in opportunities; and

(c) providing essential public services of reasonable quality to all Canadians.

***Health Insurance Act*, R.S.Q., c. A-29, s. 15:**

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 or temporary resident of Québec or to another person on his behalf.

***Hospital Insurance Act*, R.S.Q., c. A-28, s. 11:**

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.

...