

(On appeal from a judgment of the Quebec Court of Appeal)

BETWEEN:

JACQUES CHAOULLI

-and-

GEORGE ZELIOTIS

APPELLANTS
(Appellants)

-and-

ATTORNEY GENERAL OF QUEBEC

RESPONDENT
(Respondent)

-and-

ATTORNEY GENERAL OF CANADA

RESPONDENT
(Mis-en-cause)

-and-

**ATTORNEY GENERAL OF BRITISH COLUMBIA
ATTORNEY GENERAL OF ONTARIO
ATTORNEY GENERAL OF MANITOBA
ATTORNEY GENERAL OF NEW BRUNSWICK
ATTORNEY GENERAL OF SASKATCHEWAN**

INTERVENERS

**FACTUM OF RESPONDENT (MIS-EN-CAUSE)
ATTORNEY GENERAL OF CANADA**

Jean-Marc Aubry, Q.C.

René LeBlanc

Department of Justice of Canada

284 Wellington Street, SAT-6045

Ottawa, Ontario K1A 0H8

Telephone: (613) 957-4663

Fax: (613) 952-6006

E-mail: jmaubry@justice.gc.ca

Counsel for respondent (mis-en-cause)

Attorney General of Canada

Christopher Rupar

Department of Justice

234 Wellington Street

East Tower, Room 1216

Ottawa, Ontario K1A 0H8

Telephone: (613) 941-2351

Fax: (613) 954-1920

E-mail: christopher.rupar@justice.x400.gc.ca

Agent of respondent (mis-en cause)

Attorney General of Canada

Philippe H. Trudel
Trudel & Johnston
Partners
85 de la Commune Street East, 3rd Floor
Montréal, Quebec H2Y 1J1
Telephone: (514) 871-8385
Fax: (514) 871-8800
E-mail: phtrudel@trudeljohnston.com
Counsel for appellant George Zélotis

Colin S. Baxter
McCarthy Tétrault, LLP
40 Elgin Street
The Chambers, Suite 1400
Ottawa, Ontario K1P 5K6
Telephone: (613) 238-2000
Fax: (613) 563-9386
E-mail: cbaxter@mccarthy.ca
Agent of appellant Zélotis

Jacques Chaoulli
21 Jasper Avenue
Montréal, Quebec H3P 1J8
Telephone: (514) 738-2377
Fax: (514) 738-5440
Appellant

Steven Levitt
Nelligan, O'Brien, Payne, LLP
66 Slater Street, Suite 1900
Ottawa, Ontario K1P 5H1
Telephone: (613) 231-8220
Fax: (613) 563-4960
E-mail: steven.levitt@nelligan.ca
Agent of appellant Chaoulli

Robert Monette
Bernard Roy & Associés
1 Notre Dame Street East, 8th Floor
Montréal, Quebec H2Y 1B6
Telephone: (514) 393-2336
Fax: (514) 873-7074
E-mail: rmonette@justice.gouv.qc.ca
Counsel for respondent
Attorney General of Quebec

Sylvie Roussel
Noël et Associés, s.e.n.c.
Partners
111 Champlain Street
Hull, Quebec J8X 3R1
Telephone: (819) 771-7393
Fax: (819) 771-5397
E-mail: s.roussel@noelassocies.com
Agent of respondent
Attorney General of Quebec

Attorney General of British Columbia
Parliament Building
Room 232
Victoria, British Columbia V8V 1X4
Telephone: (250) 387-1866
Intervener

Robert E. Houston, Q.C.
Burke-Robertson
70 Gloucester Street
Ottawa (Ontario) K2P 0A2
Telephone: (613) 236-9665
Fax: (613) 235-4430
E-mail: r.houston@burkerobertson.com
Agent of intervener
Attorney General of British Columbia

Attorney General of Ontario
720 Bay Street
Toronto, Ontario M5G 2K1
Telephone: (613) 326-4000
Fax: (613) 326-4016
Intervener

Robert E. Houston, Q.C.
Burke-Robertson
70 Gloucester Street
Ottawa (Ontario) K2P 0A2
Telephone: (613) 236-9665
Fax: (613) 235-4430
E-mail: r.houston@burkerobertson.com
Agent of intervener
Attorney General of Ontario

Attorney General of Manitoba
405 Broadway
Winnipeg, Manitoba R3C 0V8
Intervener

Henry S. Brown, Q.C.
Gowling, Lafleur, Henderson, LLP
160 Elgin Street, Suite 2600
Ottawa, Ontario K1P 1C3
Telephone: (613) 233-1781
Fax: (613) 563-9869
E-mail: henry.brown@gowlings.com
Agent of intervener
Attorney General of Manitoba

Attorney General of New Brunswick
P.O. Box 6000
Fredericton, New Brunswick E3B 5H1
Telephone: (506) 453-2222
Fax: (506) 453-3275

Henry S. Brown, Q.C.
Gowling, Lafleur, Henderson, LLP
160 Elgin Street, Suite 2600
Ottawa, Ontario K1P 1C3
Telephone: (613) 233-1781
Fax: (613) 563-9869
E-mail: henry.brown@gowlings.com
Agent of intervener
Attorney General of New Brunswick

Attorney General of Saskatchewan
355 Legislative Building
Regina, Saskatchewan S4S 0B3

Henry S. Brown, Q.C.
Gowling, Lafleur, Henderson, LLP
160 Elgin Street, Suite 2600
Ottawa, Ontario K1P 1C3
Telephone: (613) 233-1781
Fax: (613) 563-9869
E-mail: henry.brown@gowlings.com
Agent of intervener
Attorney General of Saskatchewan

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- *Territorial Hospital Insurance Services Regulations*, R.R.N.W.T. 1990, c. T-12, sections 14, 15 and 16, regulations made under the *Hospital Insurance and Health and Social Services Administration Act*, R.S.N.W.T., 1988, c. T-3, section 2873
- *Health Care Insurance Plan Act*, R.S.Y. 2002, c. 107, section 1478

INTERNATIONAL INSTRUMENTS

- *International Covenant on Economic, Social and Cultural Rights*, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 380
- General Comment No. 14 (2000) - E/C.12/2000/4 - (11 August 2000) of the United Nations Committee on Economic, Social and Cultural Rights100

OVERVIEW

1. Not forty years ago, sickness was of course a very difficult thing for people to deal with on a personal level, but it was also one of the main causes of financial ruin among Canadians. Determined to right the wrongs and eliminate the disastrous effects of a health care system based primarily on private insurance, Canadian society, through the concerted effort of the federal and provincial governments, created in every province and territory a universal public system of which one of the fundamental characteristics was that everyone would be assured access to medically necessary hospital and medical services, regardless of ability to pay.¹
2. To ensure the viability of the public system, it was determined that measures had to be taken to discourage the development of a parallel system of private health care. Essentially, it is the appropriateness of that political choice – a choice on which, incidentally, there has always been a very broad consensus in Canada – that the appellants wish to challenge in court. One of the appellants goes so far as to candidly acknowledge that their aim is to establish the right of *the more affluent* to obtain parallel health care services.
3. However, if they hoped to succeed in challenging that choice under section 7 of the *Canadian Charter of Rights and Freedoms* (“the Charter”), the appellants had to at least establish, for the purpose of assessing the validity of the breach that is the subject of their complaint, the existence of a *legal principle in respect of which there is a substantial consensus in society that it is essential to the effectiveness of the justice system*, yet they in no way discharged that burden.
4. In any event, the measures being challenged by the appellants are rooted in a valid legislative choice related to the preservation of a vital societal asset in an area – health

¹ In this factum, this group of public health insurance systems is referred to alternately as “the Canadian health care system” and the “public health care system”.

OVERVIEW

care – where the state has to deal with complex social policy issues and undertake the allocation of limited resources.

5. The appellants' claim is made against the backdrop of the pressure to which public health care systems in general and access to health care services in particular have been subject in recent years, both in Canada and abroad. The public debate in Canada, echoing the experience in other industrialized countries, shows that there are no simple answers – and certainly no single answer – to this pressure, because the options depend on a set of social, economic, cultural, political, scientific and historical factors.
6. Governments are best equipped to make these complex, sensitive choices the appropriateness of which does not lend itself to judicial debate. In any event, the courts should refrain from endorsing a policy change that gives rise to as much inequity, particularly for the poorest in our society, as the change advocated by the appellants.

PART I – FACTS

7. As the first judge noted, the Attorney General of Canada (“the Attorney General”) believes it is useful in this matter to remember that the appellants are not currently, nor were they at the time they began their action, in need of health care.²
8. In that context, the appellants’ action is unique for the following reasons:
9. It is purely anticipatory in that it is based on the premise that the public health care system, as an institution, will not be able to assure them of timely access to health care services in the event they require care.
10. The appellants are critical of what they perceive to be its failings, but stop short of challenging the need for the public system. That is why the appellants’ approach is based on the premise that a parallel private health care system can be developed without harming the public system. That message is clearly conveyed in the factum of appellant Zeliotis³ and the report of the only expert who testified on behalf of the appellants, which states:

“Finally, a two speed/two tier system, and even a multispeed/multitier system is highly desirable **as long as it would not have the effect of lengthening the waiting time for people on waiting lists in the public sector.**”⁴ [emphasis added]

11. The appellants’ approach in this regard is best summed up by the following statement from one of the five experts who appeared for the respondents:

“In its strongest form, the argument for permitting private insurance for covered health care services is simply this: There are waiting lists in Canada. If some of those on waiting lists made private arrangement for care at their expense (but eased by insurance options), and there were no

² Trial judgment, Joint Appeal Docket (“JAD”), Vol. I, pp. 129 and 132.

³ Factum of appellant Zeliotis, pp. 1, 2 and 28.

⁴ Report of Dr. Edwin Coffey, JAD, Vol. X, p. 1794.

PART I – FACTS

change in Medicare, everyone would be better off. Those who jumped queues would be better off, as would the health care professionals who provided their care and received income. But even those remaining on queues would benefit, since the queues would be shortened. And so, why not permit the change?

[...]

The **key assumption** here is that **no change of consequence will take place in the public system, Canada’s Medicare, if a parallel privately financed system is allowed to develop.**⁵ [emphasis added]

12. Neither of these premises is supported by the facts in this matter.

⁵ Report of Professor Theodore R. Marmor, Record of respondent Attorney General of Canada {"RR"}, Vol. V, p. 768; see also JAD, Vol. XII, p. 2167.

PART II –QUESTIONS

13. The Attorney General plans to address the following questions included in the order setting out the constitutional questions issued by this court on August 15, 2003:
1. Does section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28, breach the rights guaranteed by section 7 of the *Canadian Charter of Rights and Freedoms*?
 3. Does section 15 of the *Health Insurance Act*, R.S.Q., c. A-29, breach the rights guaranteed by section 7 of the *Canadian Charter of Rights and Freedoms*?
 5. Is section 15 of the *Health Insurance Act*, R.S.Q., c. A-29, *ultra vires* the Quebec National Assembly under subsection 91(27) of the *Constitution Act, 1867*?
 6. Is section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28, *ultra vires* the Quebec National Assembly under subsection 91(27) of the *Constitution Act, 1867*?

PART III – ARGUMENTS

A. QUESTIONS 1 AND 3: SECTION 7 OF THE CHARTER

A.1. - BACKGROUND

14. The legislative provisions that are the subject of this challenge basically prohibit the use of private insurance for health care services already covered by Quebec’s public health care system [section 15 of the *Health Insurance Act*⁶] and the use of private service contracts for hospital services already covered by the public system [section 11 of the *Hospital Insurance Act*⁷].
15. The aim of these provisions is to discourage the development of a parallel private health care system that would undermine the viability and integrity of the public system because the fear is that a private system, competing directly with the public system, would take resources away from that system, weaken its ability to meet the demand for services and thus jeopardize one of the fundamental principles of universal health care, namely access to health care for all Canadians regardless of their ability to pay.
16. The provisions being challenged are not intended to and do not deprive anyone of the freedom to obtain health care services or choose their own physician or type of treatment.
17. The appellants nevertheless claim that these provisions undermine their right to choose, irrespective of the circumstances and even though they would use their own financial resources, care which they believe would be more appropriate given their condition and, in the absence of an alternative, could jeopardize the security of their person if the public system were unable to provide them in a timely manner with the care their condition might require.

⁶ R.S.Q., c. A-29, Factum of appellant Chaoulli, Vol. II, pp. 223, 229.

⁷ R.S.Q., c. A-28, Factum of appellant Chaoulli, Vol. III, pp. 268, 269.

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18. They understand section 7 of the Charter as giving them the right to use their own money to protect their health such that they are able to [1] choose the provider of the care their health might require and [2] obtain that care in a time frame which they believe is in line with their condition, a right they feel cannot be guaranteed other than by a parallel private health care system and not, they insist,⁸ the imposition of positive obligations on the state.

A.2 - ASSUMING THAT IT APPLIES IN THIS MATTER, THERE IS NO BREACH OF SECTION 7 OF THE CHARTER

A.2.1 - THE APPELLANTS DID NOT DISCHARGE THEIR BURDEN OF PROOF UNDER SECTION 7

A.2.1.1 Regarding breach of the right to liberty

19. Here, the appellants are claiming entitlement to an alternative to the public system. They are claiming the freedom to obtain health care services whether or not the public system is able to suitably meet their needs.
20. They do not shy away from saying⁹ that they are arguing for the right of *more affluent individuals* to obtain parallel health care services. In other words, they are arguing for recognition of the right to make a choice that depends first and foremost on the individual's wealth.
21. The right to liberty guaranteed by section 7 of the Charter, as defined in the context of the relationship between individuals and the administration of justice, protects the right to make personal choices in an *irreducible sphere of personal autonomy* without state intervention.
22. However, that protection basically applies only to decisions that are *fundamentally important* to the individual, that is, decisions which pertain to "*matters that can properly*

⁸ Factum of appellant Chaoulli, Vol. I, pp. 63, 64, paragraphs 195 to 199.

⁹ Trial judgment, JAD, Vol. I, p.23.

PART III - ARGUMENTS

be characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence.”¹⁰

23. Applying that definition in the matter at hand, one can reasonably argue that deciding whether to obtain health care services from a public or a private source is a matter of fundamental personal choice. The appellants’ claim lies more in the realm of choices that those who can afford to do so make as to how to spend their own money; it has little to do with choices that go “*to the core of what it means to enjoy individual dignity and independence.*”

A.2.1.2 Regarding breach of the right to security of the person

24. The appellants essentially contend that the public health care system no longer gives them timely access to health care services and that in the absence of an alternative to that system, perhaps in the form of a parallel private health care system, the security of their person, even their life, is in jeopardy.
25. The Attorney General reiterates that the appellants are not currently in need of health care¹¹ and that their action is essentially anticipatory in the sense that it is based on the premise that the public health care system will not be able to assure them timely access to health care services in the event they require care.
26. In the context, if they hoped to establish breach of the right they claim in this matter, assuming that that right is protected by section 7 of the Charter, the appellants had to show at least three things:

¹⁰ *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, para. 51; *Godbout v. Longueuil*, [1997] 3 S.C.R. 844, para. 66.

¹¹ *Supra*, note 2.

PART III - ARGUMENTS

- a) that access to the services provided by the public health care system is so institutionally deficient that the health and well-being of the public are compromised;
 - b) that the development of a parallel private health care system would fill the gaps in the public system and guarantee the appellants better access to health care services; and
 - c) that the prejudice resulting from difficulty in accessing health care services invoked by the appellants is caused by the state.¹²
27. The appellants did not discharge that burden, as the evidence shows that a private health care system would not be a real alternative to the public system.
28. The evidence shows that **private systems**, because their primary objective is to generate profit, do not assume all the risks, do not cover all types of health care services and have their own forms of rationing. More specifically, in a “market” like Canada, with its unique geographic features and its widely dispersed population, insurance coverage under private plans could easily vary from region to region; witness the fact that the private sector is for the most part unable to guarantee better quality of care or better access to services than the public system.¹³
29. The organization and delivery of health care services do not lend themselves well to market rules,¹⁴ meaning there is no real alternative here to the public health care system, which is the result not only of the measures being challenged in this case, and therefore caused by the state, but also of the inherent limits of the private insurance market.

¹² *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, para 60.

¹³ Report of Dr. Charles J. Wright, *Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services*, RR, Vol. VI, p. 920; see also JAD, Vol. XIII, p. 2258; Report of Professor Jean-Louis Denis, *Un avenir pour le système public de santé*, JAD, Vol. XII, pp. 2071, 2072, 2076 and 2077.

¹⁴ Report of Dr. Fernand Turcotte, *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé au Canada*, JAD, Vol. XII, pp. 2210 to 2214; Report of Professor Jean-Louis Denis, *Un avenir pour le système public de santé*, JAD, Vol. XII, pp. 2075 and 2076; Conseil de la Santé et du Bien-Être du

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30. This highlights the overly broad nature of the appellants' claim, which does not target a specific medical or hospital service, and shows that it is impossible to make a determination in respect of that claim, particularly in terms of the causal link that must exist between the right of individuals who feel they are deprived – in this case of an alternative to the public system – and the government measure being challenged,¹⁵ which meets the parameters of sections 7 and 32 of the Charter and section 52 of the *Constitution Act, 1982*.
31. Too many variables and factors that have nothing to do with the state come into play in determining whether a parallel private system can, as the appellants claim, be a viable alternative to the public system. There is no evidence that sanctioning the state's conduct would make that alternative more appealing; as we will see later, such sanction would actually have an adverse effect on the entire Canadian health care system.
32. The same concern arises with regard to the state's accountability for the waiting times that are the subject of the appellants' complaint, because while the Canadian health care system is a single-payer system (the single payer being the state), doctors are private players with a key role in creating and organizing waiting lists. Whether or not a patient is put on a waiting list or priority list depends on the doctor's clinical judgment of the patient's needs and in some cases, as witnessed by the experience of appellant Zeliotis,¹⁶ circumstances unique to the patient.¹⁷ What this means is that waiting lists reflect medical priorities and are therefore used to make the health care system more effective.

Québec, *Évolution des rapports public-privé dans les services de Santé et les services sociaux*, report to the Minister of Health and Social Services, June 1997, JAD, Vol. IX, p. 1546.

¹⁵ *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, para. 60.

¹⁶ Trial judgment, JAD, pp. 29, 30.

¹⁷ Report of Dr. Charles J. Wright, *Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services*, RR, Vol. VI, pp. 910 and 911; see also JAD, Vol. XIII, pp. 2248 and 2249; most of these observations of factors beyond the control of the state that have the potential to affect waiting times and the absence of uniform standards for establishing and managing waiting lists were brought to light by the very recent commission of inquiry chaired by Roy Romanow and mandated to consider the future of health care in Canada; see Report of the Romanow Commission, *Building on Values: The Future of Health Care in Canada*, November 2002, Attorney General's book of authorities, Vol. II, Tab 15, pp. 420, 421.

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33. The appellants did not establish the parameters required for a discussion of the application and scope of the right to life and security of the person guaranteed by section 7 of the Charter in the context of access to health care services.

A.2.1.3 Regarding identification of the principles of fundamental justice

34. It is now well established that the burden of proof is on the applicant at every stage in the analysis of any claim based on section 7 of the Charter, including identification of the pertinent principles of fundamental justice, and that it is only where a breach of section 7 is proven that the state has to provide justification in accordance with section 1 of the Charter.¹⁸
35. The burden was therefore on the appellants to identify or specify a principle of fundamental justice pertinent to their claim, that is, “*a legal principle about which there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate*” and which is identified with sufficient precision “*to yield a manageable standard against which to measure deprivations of life, liberty or security of the person.*”¹⁹
36. Herein lies the difficulty in defining beyond the context of the administration of justice, as in the case at hand, a framework for analysis that does not alter the meaning or scope of the principles of fundamental justice.
37. The appellants have not identified any principle of fundamental justice against which the breach that is the subject of their complaint can be weighed and therefore have not overcome that difficulty.

¹⁸ *R. v. Malmo-Levine, R. v. Caine*, Neutral citation - 2003 SCC 74, para. 98.

¹⁹ *Idem*, para. 113.

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38. The international instruments cited in this connection by appellant Chaoulli (*International Covenant on Economic, Social and Cultural Rights* and various resolutions of the *United Nations Commission on Human Rights*) are of no help to him in identifying a principle of fundamental justice applicable in this matter.
39. With regard to the *International Covenant on Economic, Social and Cultural Rights*, a treaty that has not been incorporated into domestic Canadian law, examination of the provisions cited by appellant Chaoulli (articles 9 and 12) and the interpretation they may have been given by the *United Nations Committee on Economic, Social and Cultural Rights*, which was created to verify implementation of the international covenant by the states parties,²⁰ shows that:
- a) the first provision (Article 9) is not pertinent because it deals essentially with a right, namely the right to a livelihood in the event of sickness, which has little or nothing to do with the right claimed by the appellants in this matter; and
 - b) the values underlying the second provision (Article 12), namely access to health care services regardless of ability to pay and protection of vulnerable groups, are consistent with the values underlying the Canadian health care system.
40. The resolutions of the *United Nations Commission on Human Rights*,²¹ which deal with the right of every person to be as healthy as possible, are not only non-binding on an international level, but also so broad that they cannot reasonably be interpreted as expressing some recognition in international law of a right of access to a private health care system.

²⁰ General Comment No. 14 - E/C. 12/2000/4 - (11 August 2000), *United Nations Committee on Economic, Social and Cultural Rights*, Attorney General's factum, p. 100.

²¹ Factum of appellant Chaoulli, Vol. I, para. 140 and 189;

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41. International law, which in any event does not require states to include in their constitutional legislation the rules arising therefrom,²² is of no benefit to the claims made by appellant Chaoulli. On the contrary, it conveys values (access to health care services regardless of ability to pay and protection of vulnerable groups) that are foremost among the values of the Canadian health care system.

42. This is the fatal flaw in the appellants' case. As a majority of this court found in *Gosselin, supra*,²³ the Attorney General believes, in view of the preceding, that the circumstances of this case do not lend themselves to a new application of section 7 of the Charter.

A.2.2 IN ANY EVENT, IRRESPECTIVE OF WHICH PRINCIPLE OF FUNDAMENTAL JUSTICE MIGHT COME INTO PLAY, THE MEASURES BEING CHALLENGED ENTAIL SOCIETAL CHOICES WHICH REQUIRE CURIAL DEFERENCE

A.2.2.1 The appellants are questioning the wisdom of a political choice

43. The appellants' claim is clearly outside the parameters within which section 7 of the Charter has been applied to this point. It ultimately involves complex social policy issues where the state is called upon to allocate limited resources to one area, health care, where the demand for services is virtually limitless and, by necessity, to arbitrate between divergent interests.

44. The appellants' claim is made against the backdrop of the pressure to which public health care systems in general and access to health care services in particular have been subject in recent years, both in Canada and abroad. The public debate in Canada, echoing the

²² Article 2 of the *International Covenant on Economic, Social and Cultural Rights* states, "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures," Attorney General's factum. p. 81.

²³ *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, para. 83.

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experience in other industrialized countries, shows that there are no simple answers – and certainly no single answer – to this pressure, because the options depend on a set of social, economic, cultural, political, scientific and historical factors.

45. The appellants are basically making an extensive attack on the wisdom of a government policy aimed at discouraging the development of a parallel private health care system in order to ensure the viability of the Canadian health care system, which has also enjoyed very broad support within Canadian society.
46. This court reiterated very recently that the factor it has to consider in examining a claim under section 7 of the Charter is not the *wisdom* of the measure being challenged, but solely its *constitutionality*.²⁴
47. When, in an area as complex as health care, the state makes a reasonable determination of where to draw the line, especially if that determination requires the evaluation of complex and often contradictory scientific evidence and the allocation of limited resources, the courts must generally exercise deference.²⁵
48. As the professor wrote about the possible expansion of judicial review to socio-economic rights:

“The suggested role also involves a massive expansion of judicial review, since it would bring under judicial scrutiny all of the elements of the modern welfare state, including the regulation of trades and professions, the adequacy of labour standards and bankruptcy laws and, of course, the level of public expenditures on social programmes. As Oliver Wendell Holmes would have pointed out, these are issues upon which elections are won and lost; the judges

²⁴ *R. v. Clay*, Neutral citation: 2003 CSC 75, para. 4.

²⁵ *Irwin Toy Ltd v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927, 990; *R. v. Heywood*, [1994] 3 S.C.R. 761, 793 and 795.

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need a clear mandate to enter that arena, and s. 7 does not provide that clear mandate.”²⁶

49. In any event, the courts will not intervene in choices made by Parliament unless it is clear that those choices infringe the individual rights involved “*in a manner that is unnecessarily broad, going beyond what is needed to accomplish the governmental objective.*”²⁷
50. The Attorney General is of the opinion, assuming the appellants’ rights are being breached, that the measures at issue are rooted in choices the appropriateness of which is not for a court to debate and that in any event, the said measures are neither arbitrary nor excessive; in fact, quite the opposite is true.
51. This conclusion stems from examination of a number of contextual factors, including the inefficiency and unfairness of the solution advocated by the appellants, which is to give free rein to the development of a parallel private health care system in order to solve the problems with access to health care that are the focus of their claim.

A.2.2.2 Adverse effects of the political choice put forward by the appellants on the operation of the public system

52. No one in this day and age would dare suggest that the private health care sector be left entirely to market forces. In the vast majority of industrialized countries, the consensus is that the principles governing market mechanisms are incompatible with the delivery of health care services and that the state must therefore play a leading role in organizing and funding health systems.²⁸

²⁶ P.W. Hogg, *Constitutional Law of Canada*, Loose-leaf Edition, Toronto: Carswell, 2000, p. 44-12, Attorney General’s book of authorities, Vol I, Tab 13, p. 191.

²⁷ *R. v. Heywood*, [1994] 3 S.C.R., 761, 793 and 795.

²⁸ Report of Dr. Fernand Turcotte, *Le temps d’attente comme instrument de gestion du rationnement dans les services de santé au Canada*, JAD, Vol. XII, pp. 221 to 2213; Report of Professor Jean-Louis Denis, *Un avenir pour le système public de santé*, JAD, Vol. XII, p. 2064; Conseil de la Santé et du Bien-Être du Québec, *Évolution des rapports public-privé dans les services de Santé et les services sociaux*, report to the Minister of Health and Social Services, June 97, JAD, Vol. IX, p 1546.

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53. The benefits to individuals and the community of state involvement in the organization and funding of health systems are undeniable and translate into better control of overall spending on health care through better distribution of risks, fairer access to services and, ultimately, better social and health results for the entire population, with all that that implies in terms of national productivity.
54. This message was particularly clear in the 1999 report on world health released by the *World Health Organization* (WHO):

“Our values cannot support market-oriented approaches that ration health services to those with the ability to pay. Not only do market-oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well.

[...]

With the exception of only the United States, the high income market-oriented democracies mandate universal coverage. Their health outcomes are very high. They have contained expenditures to a much smaller fraction of GDP than has the USA (7–10% versus 14%). In the one country where it was studied – Canada – introduction of National Health Insurance resulted in increased wages, reduced unemployment and improved health outcomes. Therein lies a lesson.”²⁹

55. Advocating a “new universalism” that makes the state the central player in the organization and funding of health services, the WHO expressed the following reservations about private health care systems:

“The findings also lead away from market-oriented approaches that ration health services to those with the ability to pay. Not only do market-oriented approaches lead to intolerable inequity with respect to a

²⁹ The World Health Report - 1999, *Making a Difference*, World Health Organization, RR, Vol. X, p. 623; see also: Conseil de la Santé et du Bien-Être du Québec, *Évolution des rapports public-privé dans les services de Santé et les services sociaux*, report to the Minister of Health and Social Services, June 97, JAD, Vol. IX, p. 1552.

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fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well. [...] Health is an important component of national welfare. Achieving high health outcomes requires a combination of universal entitlement and tight control over expenditure.

This report advocates a ‘new universalism’ that recognizes governments’ limits but retains government responsibility for leadership, regulation and finance of health systems.”³⁰

56. Studies carried out by the OECD take a similar view and point up the risk to fair access to health services posed by health care models that draw on private funding.³¹
57. Ideally, the state would provide services to everyone, but current world economic conditions are such that states are unable to deliver the full spectrum of services. That is why no industrialized country has a fully public health care system.³²
58. Canada is in no different a situation and, like other countries, allows the private sector to be involved in the delivery of some health care services. However, the private sector’s role in health care is strictly complementary to the role played by the public system (prescription drugs, dental care and other services not covered by the public system). In other words, the two “systems” cover different and separate aspects of health services.³³
59. As stated earlier,³⁴ the appellants are not seeking privatization of the public system. Appellant Zeliotis even goes so far as to acknowledge *at the outset* the fundamental need

³⁰ The World Health Report - 1999, *Making a Difference*, World Health Organization, RR, Vol. X, p. 1664.

³¹ Health Policy Study No. 2, *La réforme des systèmes de santé, Analyse comparée de sept pays*, OECD, 1992, RR, Vol. III, pp 493, 494, 503 and 508; Health Policy Study No. 6, *À la recherche de mécanismes de marché, Les systèmes de santé au Canada, en Islande et au Royaume-Uni*, OECD, 1995, RR, Vol. IV, p. 543; Health Policy Study No. 8, *La Réforme des systèmes de santé - La volonté de changement*, OECD, 1996, RR, Vol. IV, pp. 666 and 708.

³² The World Health Report - 1999, *Making a Difference*, World Health Organization, RR, Vol. X, p. 1664; see also Conseil de la Santé et du Bien-Être du Québec, *Évolution des rapports public-privé dans les services de Santé et les services sociaux*, report to the Minister of Health and Social Services, June 1997, JAD, Vol. IX, p. 1549.

³³ Report of Professor Theodore R. Marmor, RR, Vol. V, p. 771; see also JAD, Vol. XII p. 2170.

³⁴ See paragraph 16 of this factum.

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for the public system and the fact that if the public system is to fulfil its mission, it must “[TRANSLATION] *be given on a priority basis all the resources it needs.*”³⁵

60. What the appellants want, in fact, is for the public and private systems to coexist in some areas of health care so that people who can afford to do so can turn somewhere other than the public system in order to meet their health care needs.
61. However, as our own expert acknowledged,³⁶ that approach is desirable only if it does not diminish the quality of and access to the services provided by the public system. The appellants failed to show that, not even from the very narrow perspective of the surplus capacity of the public system with which appellant Zeliotis broached the issue.
62. The evidence in this case shows, on the contrary, that the development of a parallel private health care system would not only drive up total health costs for all Canadians, but, more importantly, would shift resources from the public system to the private system, inevitably diminishing the quality of and access to the services provided by the public system.
63. The expert evidence accepted by the first judge is clear and unambiguous in this regard:
 - a) expert Turcotte:

“[TRANSLATION] There is no empirical evidence showing that a private system as an alternative reduces waiting times in the public system. On the contrary, the increase in access to private services generally seems to be associated with an increase in waiting lines in the public system, particularly where physicians practise in both systems at the same time, as happens in the United Kingdom.”³⁷

³⁵ Factum of appellant Zeliotis, p. 1, paragraphs 2 and 3.

³⁶ *Supra*, note 4.

³⁷ Report of Dr. Fernand Turcotte, *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé au Canada*, JAD, Vol. XII, pp. 2218 and 2219.

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b) expert Wright:

“Would Private Health Care Cause a Reduction in Public System Waiting Lists?”

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. Interviews with family practitioners and patients revealed that there are waiting lists for up to a year to be seen in the public system by a specialist, but almost immediate ‘private’ treatment by the same specialist for those prepared to pay. People were often given the ‘choice of long waits or the loss of life savings’. The report concludes that ‘there is a danger that some doctors are allowing their greed to distort health care in Britain. Either we as a profession accept this (as in the United States) or we put a stop to it from within the profession.’³⁸

[...]

The principal argument for permitting a second tier private alternative system, namely that this would cause better overall access to care and relieve pressure on the public system, is not supported by any data. The information and studies compiled here suggest the opposite, namely that the major effect of allowing a private alternative would be to shift energy and resources from the public system into the private system, causing deterioration of public system access. This would only be to the advantage of those who could afford to pay or to purchase additional private health care insurance.”³⁹

³⁸ Report of Dr. Charles J. Wright, *Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services*, RR, vol. VI, p. 918, voir aussi: JAD, vol. XIII, p. 2256;

³⁹ Report of Dr. Charles J. Wright, *Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services*, RR, Vol. VI, p. 927; see also JAD, Vol. XIII, p. 2265.

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c) expert Marmor:

“Thus I believe that allowing private insurance to be available as an alternative to Medicare would have profound negative impacts on the public system rather than none as is assumed. It would not increase availability of services in the public sector or reduce waiting lists. Instead, it would divert resources from the publicly financed program to be available to private activities and it would increase total Canadian expenditures on health. It also would give those able to secure private coverage an advantage over others.”⁴⁰

64. These observations are confirmed by a number of recent studies, in particular those conducted jointly by the Faculty of Law and the departments of Economics and Political Science at the University of Toronto, which looked at the experience of other OECD countries in managing their health care system, especially where a two-tier system was tried, and the results of which were released in the past two years:

“Turning now to sum up the evidence on the impact of the public/private mix on health outcomes, utilization, spending, and waiting times, the evidence generally points away from increased private financing as a means to achieve effective health care reform. There appears to be no relationship between increased private spending and improved health outcomes. In fact, we found a positive correlation between private health care spending as a percent of total health spending and potential years of life lost. This result has to be read with some caution as it is only a simple correlation at a point in time. However, one could hypothesize that this result reflects in part that private spending tends to be skewed towards the more well off individuals where the returns to spending on health are smaller and away from potentially more needy populations where the returns are larger. Country specific evidence on the effects of private, out of pocket cost sharing on access to care and health outcomes shows that co-payments do indeed create barriers to access and that these barriers can result in worse health outcomes for the poor. The evidence on the relationship between private financing and health care spending suggests that countries with higher levels of private financing such as the US have higher costs and higher cost growth than countries with predominantly public payers such as Canada. Furthermore, examining the impact of private financing on public health funding suggests that increases in

⁴⁰ Report of Professeur Theodore R. Marmor, RR, Vol. V, p. 769; see also JAD, Vol. XII, p. 2168.

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private financing are associated with declines, over time, in public funds allocated to health care. Finally, the available evidence does not suggest that private financing is successful in improving waiting times for care. In fact, even in those countries, such as the UK, with a second private health care tier, public initiatives to improve waiting times in the primary tier have proven more successful"⁴¹.

The evidence presented in this paper suggests that increasing the private share of total health care expenditures does not offer a solution to the challenges facing publicly-financed systems. Increasing the private share provides some additional revenue, but it also substitutes in part for public finance, and raises important considerations of equity."⁴²

65. A very recent study of Australia's experience shows that a very cautious approach must be taken with any solution to the pressure on public health care systems that is based on the development of a parallel private system.⁴³
66. The recent commission of inquiry chaired by Roy Romanow, the mandate of which was to examine the future of health care in Canada (the *Romanow Commission*), strongly reaffirmed the validity and current applicability of the fundamental values and principles underlying the Canadian health care system, but made the same observation regarding the means proposed by the appellants to solve the problems with the public system:

“Early in my mandate, I challenged those advocating radical solutions for reforming health care – user fees, medical savings accounts,

⁴¹ Colleen M. Flood, Mark Stabile and Carolyn Hugues Tuohy, *The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care*, Case Western Reserve University Health Matrix: Journal of Law-Medicine, No. 297, Summer, 2002, Attorney General's book of authorities, Vol. X, Tab 18, p. 3462.

⁴² Carolyn Hugues Tuohy, PhD, Colleen M. Flood, SJD, and Mark Stabile, PhD, *How Does Private Finance Affect Public Health Care Systems, Marshalling the Evidence from OECD Nations*, Paper submitted to the Journal of Health Politics and Law, University of Toronto, article quoted in the report of the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Final Report, October 2002, Attorney General's book of authorities, Vol. I, Tab 14, pp. 221, 222.

⁴³ Jeremiah Hurley, Rhema Vaithianathan, Thomas F. Crossley, Doborah Cobb-Clark, *Parallel Private Health Insurance in Australia: A cautionary Tale and Lessons for Canada*, Centre for Health Economics and Policy Research Analysis, McMaster University, Discussion Paper No. 448, May 2002, previous version (December 2001) quoted in the report of the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Final Report, October 2002, Attorney General's book of authorities, Vol. III, Tab 17, p. 1087.

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delisting 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 copayment 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.” [emphasis added]

67. Nor was the development of a parallel private health care system the solution recommended by the Standing Senate Committee on Social Affairs, Science and Technology in its 2002 report on the state of Canada’s health care system to deal with the issue of waiting times for health care, which in the committee’s view are too long.”⁴⁴
68. Chaired by Senator Kirby, the committee, which like the *Romanow Commission* came down squarely in favour of preserving the principle of a single-payer (state) system, advocated a solution to waiting times that would improve the existing system and guarantee time frames for obtaining health care rather than open the system up to the private sector.⁴⁵
69. Even the *Canadian Life and Health Insurance Association*, which represents the interests of private health insurers in Canada and appeared before both the *Romanow Commission* and the *Standing Senate Committee on Social Affairs, Science and Technology*, does not advocate the solution sought by the appellants, preferring instead to focus on the

⁴⁴ Report of the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Final Report (Chapter 2), October 2002, Attorney General’s book of authorities, Vol. III, Tab 17, p. 1095; see also Appellant Chaoulli’s book of authorities, Vol. III, Tab 44.

⁴⁵ *Idem*, (Chapter 6), Vol. IV, Tab 17, pp. 1171 *et seq.*

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complementarity of the relationship between the private and public health care systems.⁴⁶

70. It is therefore clear that the development of a parallel private health care system is more likely to aggravate than solve the problems identified by the appellants. Allowing the public and private systems to operate in the same areas of health care is a solution that has yet to prove itself where it has been tried and that is fraught with unfairness. It has not only failed to solve the problems with the public system, but has actually made them worse, particularly in terms of access to health care.
71. Managing public health care systems, which includes improving access to health care services, is an extremely complex challenge for all industrialized countries. Canada is no exception; three major reviews of health care have been carried out in this country in the past 10 years.⁴⁷ A number of experiments, each linked to a set of social, economic, cultural, political, scientific and historical factors, have been conducted or are still under consideration, both in Canada and elsewhere, in a bid to improve access to health care.
72. Two findings emerge from these initiatives: (1) there are no simple solutions to what is basically a complex problem; and (2) models for organizing and delivering health care services that allow the development of a parallel private health care system are an ineffective and inequitable solution to the problem.

⁴⁶ Submission of the *Canadian Life and Health Insurance Association* to the *Romanow Commission, The Role of Supplementary Health Insurance in Canada's Health System*, November 2001, Attorney General's book of authorities, Vol. X, Tab 20, p. 3523.

⁴⁷ Final report of the National Forum on Health, *Canada Health Action: Building on the Legacy*, Volume I, JAD, Vol. XI; Report of the *Romanow Commission, Building on Values: The Future of Health Care in Canada*, November 2002, Attorney General's book of authorities, Vol. I, Tab 15, p. 225; Report of the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Final Report, October 2002, Attorney General's book of authorities, Vol. III, Tab 17, p. 1053.

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A.2.2.3 Barriers to the development of a parallel private health care system: a characteristic of the Canadian health care system

73. Barriers designed to discourage the development of a parallel private health care system are one of the characteristics of the Canadian health care system; they are rooted in the legislation of which the health care system is a product.
74. The most common measure is the measure being challenged in this case, that is, the one which prohibits the use of private insurance and the purchase of medical and hospital services for services already covered by the public system.
75. Quebec is not the only province with barriers of this type. The legislation of five other provinces – Ontario, Alberta, British Columbia, Manitoba and Prince Edward Island – and the three territories – Yukon, Northwest Territories and Nunavut – also contains barriers.⁴⁸
76. The other provinces (Saskatchewan, Nova Scotia, New Brunswick and Newfoundland and Labrador) have until now managed to use other means to stop the development of a parallel private health care system.
77. Those means include prohibiting doctors from practising in both the private sector and the public sector at the same time or limiting the amount of fees a doctor can be paid in the private sector to the amount provided for in the public system.

⁴⁸ **Ontario:** *Health Insurance Act*, R.S.O. 1990, c. H.6, subsection 14(1); **British Columbia:** *Medicare Protection Act*, RSBC 1996, Chapter 86, section 45; **Alberta:** *Alberta Health Care Insurance Act*, RSA 1980, Chapter A-24, subsection 17(2); **Prince Edward Island:** *Health Services Payment Act*, R.S.P.E.I. 1988, Chapter H-2, subsection 21(1); **Manitoba:** *Health Services Insurance Act*, C.C.S.M., c. H-35, subsection 96(1); **Yukon:** *Health Care Insurance Plan Act*, R.S.Y., 1986, Vol. 2, Chapter 81, section 14; **Northwest Territories** and **Nunavut:** *Hospital Insurance and Health and Social Services Administration Act*, R.S.N.W.T., 1990, c. T-12, sections 14, 15 and 16; Attorney General's factum, p. 77.

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78. A recent study of the private health care market in Canada confirmed that the provinces have not all taken the same measures, but they have managed to prevent the development of a private health care system that would compete directly with the public system:

“In our survey of health insurance legislation and regulations, we found that regulation of physicians’ ability to practise in the privately funded sector is complex and diverse across Canada’s 10 provinces. We found multiple layers of different kinds of regulation that seem to have as primary objective not to make private practice illegal but rather to prevent the development of a private sector that depends on subsidy from the public sector.

[...]

Rather, the lack of a flourishing private sector in Canada is most likely attributable to prohibitions on subsidization of private practice from the public plan, prohibitions that prevent physicians from relying on the public sector for the core of their incomes and turning to the private sector to top up their incomes.”⁴⁹

79. Contrary to the appellants’ claim, there is no provincial health care system in Canada, including the four provinces that have not yet proceeded with the type of prohibition being challenged in this case, where “free choice” is allowed, nor are there public and private systems competing against each other in the same area of health care services.
80. The *Canada Health Act* does not permit the development of a parallel private health care system.

⁴⁹ Colleen Flood, Tom Archibald, *The illegality of private health care in Canada*, Canadian Medical Association Journal, March 2001, Attorney General’s book of authorities, Vol. III, Tab 16, p. 1052; see also Carolyn Hugues Tuohy, PhD, Colleen M. Flood, SJD, and Mark Stabile, PhD, *How Does Private Finance Affect Public Health Care Systems, Marshalling the Evidence from OECD Nations*, supra, note 42, Attorney General’s book of authorities, Vol. I, Tab 14, p. 219; see also Report of the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Final Report, October 2002, Attorney General’s book of authorities, Vol. III, Tab 17, pp. 1082, 1083; see also Appellant Chaoulli’s book of authorities, Vol. III, Tab 44.

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81. Contrary to what the appellants say, the idea of developing a private system, although not **specifically** prohibited, appears to be at odds with the spirit of the *Canada Health Act*, particularly inasmuch as a private system is likely to undermine two of the general principles on which the legislation is based, namely *accessibility* and *public administration*.
82. The Attorney General reiterates that the *Canada Health Act* was passed at a time when extra billing⁵⁰ and user charges,⁵¹ which to that point had not been specifically prohibited by provincial health care systems, had become so widespread that Parliament decided they threatened one of the pillars of the Canadian health care system: *accessibility*.⁵²
83. The policy statement that preceded the legislation makes it crystal clear that the intent of the *Canada Health Act* was to discourage any practice likely to jeopardize the principle of *accessibility*:

“[TRANSLATION] Extra billing by doctors represents direct costs which the Government of Canada views as a threat to accessibility.

[...]

If better health care is available, the Government of Canada wants it to be available to everyone through medicare. Canadians cannot accept a partial program that would deliver the best care to those who can afford it and a lower standard of care to those who cannot.

[...]

⁵⁰ Section 2 of the *Canada Health Act* defines “extra-billing” as “the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province”, Factum of appellant Zélotis, p. 60.

⁵¹ Section 2 of the *Canada Health Act* defines “user charge” as “any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing”, Factum of appellant Zélotis, p. 58.

⁵² Report of Special Commissioner Emmett M. Hall, *Canada's National-Provincial Health Program for the 1980s*, August 1980, RR, Vol. II, p. 319.

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We cannot preserve medicare by making the sick pay or by encouraging doctors to practise outside health care systems, no more than we can do it by determining who is poor and who is not. The only way we can preserve medicare is to ensure that the basic principles of medicare are respected.”⁵³

84. The preamble to the *Canada Health Act* clearly states that commitment: Parliament recognizes that “*continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.*”
85. Barriers to the development of a parallel private health care system intended to preserve the integrity and effectiveness of the public system are therefore an integral part of the *body* of Canadian health legislation. Barriers may vary in substance from region to region, but to this point, they have had the same effect: no private health care system that competes directly with the public system has really been developed in Canada since the Canadian health care system was established.

A.2.2.4 Societal interests to be preserved

86. We reiterate that the aim of the measures being challenged by the appellants is to discourage the development of a parallel private health care system that would undermine the viability and integrity of the public system because the fear is that a private system, competing directly with the public system, would take resources away from that system, weaken its ability to meet the demand for services and thus jeopardize one of the fundamental principles of universal health care, namely access to health care for all Canadians regardless of their ability to pay.

⁵³ *Preserving Universal Medicare*, Government of Canada policy, 1983, JAD, Vol. IX, pp. 1697, 1698 and 1704.

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87. We also reiterate that these measures are not intended to and do not deprive anyone of the freedom to obtain health care services. Rather, they are part of a comprehensive social program⁵⁴ the objective of which is to use tax revenue to provide everyone with a full range of essential health care services free of charge so as to promote and ensure the well-being of the entire population.
88. The objectives of this program (the Quebec health care system) are similar to the objectives being pursued in other parts of Canada and are thus part of a broader context, namely the concerted effort of the federal and provincial governments to provide Canadian society with universal medicare.

Origin and general statutory context of the Canadian health care system

89. In the early 1920s, it was acknowledged that sickness had become the main cause of financial ruin among Canadians: a serious illness almost always meant that a person could not work, and the person's family would inevitably be overwhelmed by the cost of care.⁵⁵
90. With financial assistance from the federal government in some cases, the provinces gradually established social security programs designed to help the most vulnerable groups in society deal with sickness (disabled persons, orphans, abandoned children, homeless persons, blind persons, senior citizens with no dependents).⁵⁶
91. Established in 1961 to inquire into the state of health services in Canada, the *Royal Commission on Health Services* chaired by Mr. Justice Emmett M. Hall (the *Hall Commission*) found that, left to their own devices or protected only by the limited coverage of private insurance, almost half of all Canadians had to grapple with sickness

⁵⁴ The statutory foundation of the Quebec health care system comprises three statutes: the *Health Insurance Act*, R.S.Q., c. A-29, the *Hospital Insurance Act*, R.S.Q., c. A-28, and the *Act respecting health services and social services*, R.S.Q., c. S-4.2.

⁵⁵ Report of Dr. Fernand Turcotte, *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé au Canada*, JAD, Vol. XII, pp. 2209 and 2210.

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without enough insurance to cover the costs and that more than 7 million Canadians had no insurance.⁵⁷

92. For a large segment of the population, this meant reduced access – or no access at all – to health care services.
93. Drawing on the experience of the universal hospital insurance plans established in Saskatchewan and British Columbia a few years earlier, the *Hall Commission* concluded that *public action* was needed and recommended the *immediate mobilization* of the *nation's resources* to create *comprehensive universal* health care systems in the provinces and the territories.⁵⁸
94. Determined to set right a ruinous and socially inequitable situation, all of the other provinces and the territories, boosted by financial support from the federal government, quickly followed suit. By the early 1970s, a universal public system was in place in every province and territory to provide people with hospital and medical care.
95. And so took shape the Canadian health care system, considered to this day to be one of Canadian society's finest achievements and a power symbol of national identity, as witnessed by the recent report of the *Romanow Commission*.⁵⁹
96. The Canadian health care system is therefore the product of the joint effort of the provinces, which set about establishing medicare systems within the parameters of their general jurisdiction over health, and the federal government, which made a commitment as part of its inherent spending power to contribute financially to those systems and thus

⁵⁶ *Ibid.*

⁵⁷ Report of the *Hall Commission*, JAD, Vol. XIII, p. 2446.

⁵⁸ *Idem*, p. 2449.

⁵⁹ Report of the *Romanow Commission*, *Building on Values – The Future of Health Care in Canada*, November 2002, Attorney General's book of authorities, Vol. I, Tab 15, p. 242.

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help provide to ensure that all Canadians are able to obtain health care services without charge.⁶⁰

97. Based initially on the combined effect of the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Services Act* of 1966, the federal government's action on health care has since 1984 been guided by the *Canada Health Act*,⁶¹ which sets out the terms and conditions governing the payment of federal contributions for the operation of health care systems established by the provinces.

Objectives and values of the Canadian health care system

98. The Canadian health care system is basically intended to protect, promote and improve the physical and mental well-being of Canadians and to use tax revenue to facilitate satisfactory access to hospital and medical services delivered by the health care systems established by the provinces.
99. The system centres on five main principles largely defined by the *Hall Commission* and consolidated to some extent in the *Canada Health Act*. Those principles, which the provinces are free to implement as they see fit, are:
- a) *public administration*, which means that the provinces' health care insurance plans must be administered and operated on a non-profit basis by a public authority;⁶²
 - b) *comprehensiveness*, which means that the provinces' health care insurance plans must insure all hospital and medical services;⁶³

⁶⁰ *Eldridge v. B.C. (A.G.)*, [1997] 3 S.C.R. 624, at 646, 647.

⁶¹ R.S.C. 1985, c. C-6, Factum of appellant Zélotis, p. 57.

⁶² *Canada Health Act*, section 8, Factum of appellant Zélotis, pp. 61, 62.

⁶³ *Idem*, section 9, Factum of appellant Zélotis, p. 62.

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- c) *universality*, which means that the provinces' health care insurance plans 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;⁶⁴
 - d) *portability*, which means that Canadians are not to be penalized for receiving in another province a health care service insured by the public plan of their province of residence;⁶⁵ and
 - e) *accessibility*, which means that health services must be provided to Canadians 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.⁶⁶
100. The Canadian health care system is essentially aimed at putting a portion of our collective wealth to work for everyone, regardless of their condition, as part of the fight against the lack of security sickness can create.⁶⁷
101. These values continue to be embraced by the vast majority of Canadians, as witnessed by the recent report of the *Romanow Commission*:⁶⁸
- “In their discussions with me, 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.”
102. The Canadian health care system is rooted to some extent in values that are essential to a society which views itself as fair, free and democratic and that are embodied in the

⁶⁴ *Idem*, section 10, Factum of appellant Zélotis, p. 62.

⁶⁵ *Idem*, section 11, Factum of appellant Zélotis, pp. 62, 63.

⁶⁶ *Idem*, section 12, Factum of appellant Zélotis, pp. 63, 64.

⁶⁷ Report of Special Commissioner Emmett M. Hall, *Canada's National-Provincial Health Program for the 1980s*, August 1980, RR, Vol. II, pp. 555, 556; see also JAD, Vol. XIV, pp. 2593, 2594.

⁶⁸ Report of the *Romanow Commission, Building on Values – The Future of Health Care in Canada*, November 2002, Attorney General's book of authorities, Vol. I, Tab 15, p. 242.

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Charter itself: respect for the inherent dignity of the human person, commitment to social justice and equality, solidarity, equal opportunity, compassion and fairness.⁶⁹

103. Built on these all-important values, the Canadian health care system remains, as the *Romanow Commission* points out and despite the pressure that has been brought to bear on it and all health care systems in industrialized countries in recent years, one of the best systems in the world:

“I am pleased to report to Canadians that the often overheated rhetoric about medicare’s costs, effectiveness and viability does not stand up to scrutiny. Our health outcomes, with a few exceptions, are among the best in the world, and a strong majority of Canadians who use the system are highly satisfied with the quality and standard of care they receive. Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of Canadians on the basis of need, not income. It has contributed to our international competitiveness, to the extraordinary standard of living we enjoy, and to the quality and productivity of our work force.”

104. It is hard to imagine a societal asset as important as and more inspired by the highest forms of civilization than the Canadian health care system, and even harder to imagine that we could sacrifice the integrity of the principles which underlie that system, in particular the principle of universal access to health care, in favour of a solution, namely the development of a parallel private health care system, that cannot be a valid alternative to the public system and cannot meet the challenges presented by managers of public health care systems.

B. QUESTIONS 5 AND 6: DIVISION OF POWERS

105. Appellant Chaoulli claims that the measures being challenged are legislative provisions in criminal law and are therefore *ultra vires* the powers of the Quebec National Assembly under section 91(27) of the *Constitution Act, 1867*.

⁶⁹ *R v. Oakes*, [1986] 1 S.C.R. 103.

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106. The truth of the matter is that the *Health Insurance Act* and the *Hospital Insurance Act* fall within the confines of the province's general jurisdiction over health under subsections 92(7), 92(13) and 92(16) of the *Constitution Act, 1867*.⁷⁰
107. The provisions being challenged support the objectives of the two statutes and fall within the province's jurisdiction under subsection 92(15) of the *Constitution Act, 1867*, which authorizes the provinces to punish by fine, penalty or imprisonment the commission or omission of certain acts.

⁷⁰ *Eldridge v. B.C. (A.G.)*, [1997] 3 S.C.R. 624, 646 (La Forest); *Schneider v. The Queen*, [1982] 2 S.C.R. 112, 141 and 142 (Estey); *Bell Canada v. Quebec (CSST)*, [1988] 1 S.C.R. 749, 761 (Beetz).

PART IV – COSTS

108. The Attorney General has no representations to make on the subject of costs.

PART V – ORDERS SOUGHT

109. The Attorney General contends that the constitutional questions discussed in this factum warrant the following answers:

Question 1: Does section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28, breach the rights guaranteed by section 7 of the *Canadian Charter of Rights and Freedoms*?

Answer: No.

Question 3: Does section 15 of the *Health Insurance Act*, R.S.Q., c. A-29, breach the rights guaranteed by section 7 of the *Canadian Charter of Rights and Freedoms*?

Answer: No.

Question 5: Is section 15 of the *Health Insurance Act*, R.S.Q., c. A-29, *ultra vires* the Quebec National Assembly under subsection 91(27) of the *Constitution Act, 1867*?

Answer: No.

Question 6: Is section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28, *ultra vires* the Quebec National Assembly under subsection 91(27) of the *Constitution Act, 1867*?

Answer: No.

OTTAWA, this 15th day of January 2004

JEAN-MARC AUBRY, Q.C.
RENÉ LEBLANC
Counsel for Respondent (Mis-en-Cause)
Attorney General of Canada

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