

Misdiagnosis or Cure?

Charter Review of the Health Care System

Martha Jackman, Professor, Faculty of Law, University of Ottawa

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Following the Supreme Court of Canada's decision in *Eldridge v. British Columbia (Attorney General)*,¹ the potential application of the *Canadian Charter of Rights and Freedoms*² in the health care context has expanded significantly.³ While lower courts have generally been unsympathetic to health-related *Charter* claims, in several recent cases judges have shown greater receptivity to the argument that the right to "life, liberty and security of the person" includes health-related interests.⁴ Most notable is the Québec Superior Court decision in *Chaoulli v. Québec*,⁵ now before the Supreme Court of Canada.⁶ The appellants in the case, Georges Zélotis and Dr. Jacques Chaoulli, allege that lack of timely access to provincially funded health care services in Québec, coupled with legislative limits on the provision of private health and hospital insurance, violate their rights under section 7 of the *Charter*. In her decision, upheld by the Québec Court of Appeal,⁷ Justice Ginette Piché found that section 7 of the *Charter* guarantees the right to health care, but that statutory restrictions on private health insurance accord with the "principles of fundamental justice."⁸

¹ [1997] 3 S.C.R. 624.

² *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (U.K.)*, 1982, c. 11 [*Charter*].

³ M. Jackman, "The Application of the *Canadian Charter* in the Health Care Context" (2000) 9 *Health Law Review* 22.

⁴ See D. Greschner, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs? Discussion Paper No. 20* (Saskatoon: Commission on the Future of Health Care in Canada, 2002); M. Jackman, *The Implications of Section 7 of the Charter for Health Care Spending in Canada, Discussion Paper No. 31* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) [Jackman, "Implications of Section 7"].

⁵ *Chaoulli c. Québec (Procureure générale)*, [2000] J.Q. no. 479 (Cour supérieure du Québec – Chambre civil) [*Chaoulli (C.S.)*].

⁶ S.C.C. 29272. The *Chaoulli* appeal is scheduled to be heard by the Supreme Court on June 8, 2004. The author will be representing the Charter Committee on Poverty Issues and the Canadian Health Coalition in their intervention in the case.

⁷ *Chaoulli c. Québec (Procureur général)*, [2002] J.Q. no. 759 (Cour d'appel du Québec) [*Chaoulli (C.A.)*].

⁸ Section 7 provides that: "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."

Recent health care system reviews have underscored the importance Canadians attach to medicare as a defining social program and as a symbol of Canadian values.⁹ In the *Final Report* of the Commission on the Future of Health Care in Canada, Commissioner Roy Romanow observed that: “Canadians consider equal and timely access to medically necessary services on the basis of need as a right of citizenship, not as a privilege of status or wealth.”¹⁰ Notwithstanding increasing pressures placed upon it, Canadians have remained constant in their view that equality of access to health care must be preserved as a core and defining feature of the publicly funded health care system:

The Canadian approach to the provision of health care services continues to receive strong and passionate support. The public does not want to see any significant changes which would alter the fundamental principles of our health care system. They have an abiding sense of the values of fairness and equality and do not want to see a health care system in which the rich are treated differently from the poor.¹¹

At the same time, Canadians are increasingly concerned about problems within the publicly funded system, especially lengthening waiting times for some acute care

⁹ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) (Chair: Roy Romanow) at xvi [Romanow Commission]; Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Interim Report on the State of the Health Care System in Canada, Volume One – The Story So Far* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael Kirby) chap. 3 [Kirby Committee, *Interim Report*]; Commission d’étude sur les services de santé et les services sociaux, *Emerging Solutions: Report and Recommendations* (Québec: Ministry of Health and Social Services, 2001) (Chair: M. Clair) at 7; Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (Regina: Saskatchewan Health, 2001) (Chair: K.J. Fyke) at 5; Institute for Research on Public Policy Task Force on Health Care Reform, *Recommendations to First Ministers* (Montreal: Institute for Research on Public Policy, 2000) at 5.

¹⁰ Romanow Commission, *ibid.* at xvi.

¹¹ National Forum on Health, “Values Working Group Synthesis Report” in *Canada Health Action: Building on the Legacy, Volume II* (Ottawa: Minister of Public Works and Government Services, 1997) at 11 [National Forum on Health, “Values Working Group Synthesis Report”].

services.¹² These concerns have in turn resulted in increased attention, including from government appointed review bodies such as the Clair and Mazankowski commissions,¹³ to proposals for greater privatization of health funding and services as a means of increasing individual patient choice and of relieving pressure on the public system.

Against this backdrop, the following paper will consider the potential implications of section 7 of the *Charter* for current debates over health care funding and reform. To that end, the paper will first examine the facts and lower court rulings in the *Chaoulli* case, as a concrete illustration of the application of section 7 in the health care context. The paper will go on to assess the broader social implications of section 7 review of the health care system. The paper will conclude by considering the choices facing the Supreme Court of Canada in *Chaoulli*.

The Facts and Evidence in *Chaoulli*

At issue in *Chaoulli* is the constitutional validity of section 15 of Québec's *Health Insurance Act*¹⁴ and section 11 of the province's *Hospital Insurance Act*.¹⁵ These provisions, the equivalent to which exist in most other provinces,¹⁶ prohibit private insurance contracts for publicly insured health and hospital services, and thus effectively ensure a publicly funded, single-payer, system in Canada. In the context of resource

¹² Romanow Commission, *supra* note 9 at 138-39; Kirby Committee, *Interim Report*, *supra* note 9 at 45; Premier's Advisory Council on Health, *A Framework for Reform – Report of the Premier's Advisory Council on Health* (Edmonton: Premier's Advisory Council on Health, 2001) (Chair: Donald Mazankowski) at 19 [*Mazankowski Report*].

¹³ Clair Commission, *Supra* note 9; Mazankowski *Report*, *ibid*.

¹⁴ R.S.Q. c. A-29 [*Hospital IA*].

¹⁵ R.S.Q. c. A-28 [*Health IA*].

¹⁶ C.M. Flood & T. Archibald, "The Illegality of Private Health Care in Canada" (2001) 164(6) *Canadian Medical Association Journal* 825.

constraints and delays within the public system, the appellants in *Chaoulli* claim that, by making delivery of private care uneconomical and thereby effectively depriving them of access to it, these legislative provisions violate their right to health under section 7 of the *Charter*.

In her judgment at trial, Justice Piché began by describing the obstacles the appellants themselves faced in attempting to obtain, or to provide, health care services in Québec. Mr. Zéliotis, 67 at the time of trial and suffering from various health problems, complained of having to wait from June'94 – May'95 for a left hip replacement, and from February – September'97 for a right hip replacement.¹⁷ Dr. Chaoulli, who completed his medical training in France prior to immigrating to Québec in the late seventies, reported several unsuccessful attempts to obtain government approval and funding for a 24-hour ambulance service, a 24-hour physician house-call service, and a private not-for-profit hospital.¹⁸

After outlining the appellants' interactions with the publicly funded system, Justice Piché reviewed the expert evidence adduced by the appellants in support of their claim, including from a number of medical specialists in the fields of orthopaedic surgery, ophthalmology, oncology and cardiology. These experts pointed to lengthy waiting lists; shortage of operating room time; shortage of nursing staff; shortage of, and outdated, equipment; erratic decision-making; “politicking”; and lack of planning within the

¹⁷ *Chaoulli* (C.S.), *supra* note 5 at paras 19-23.

¹⁸ *Ibid.* at paras 24-39.

publicly funded system.¹⁹ The appellants also called Barry Stein, a Montreal lawyer who, faced with treatment delays in Québec, successfully challenged the provincial health insurance plan's refusal to reimburse him for the costs of obtaining cancer care in New York state.²⁰ Based on this evidence, Justice Piché agreed with the appellants' claim that waiting lists were too long. In her view: "... même si ce nest pas toujours une question de vie ou de mort, tous les citoyens ont droit à recevoir les soins dont ils ont besoin, et ce, dans les meilleurs delais."²¹

Justice Piché went on to consider the evidence put forward by the federal and Québec governments in response to the appellants' claim.²² Yale School of Management professor Dr. Ted Marmor, whom Justice Piché quoted at length, identified a number of recurring concerns in the expert evidence called by the federal government and the province. Dr. Marmor argued that allowing the development of a parallel private health insurance system in Québec and Canada generally would have a number of negative consequences. In particular, Dr. Marmor argued that introducing private insurance funding would lead to decreased public support for medicare and, in particular, to a loss of support from more affluent and thus politically influential groups most likely to exit the system.²³ As Dr. Marmor put it: "it is axiomatic that those who exit a public system no longer have a strong stake in its effective operation. This, in turn, can and frequently

¹⁹ *Ibid.* at paras 44-51.

²⁰ *Ibid.* at paras 52-54; for a discussion of the *Stein* case, see S. Hartt & P. Monahan, "The *Charter* and Health Care: Guaranteeing Timely Access to Health Care for Canadians" (2002) 164 C.D. Howe Institute Commentary 1-29.

²¹ (Translation: "... even if it isn't always a question of life or death, all citizens have the right to receive the care they need, and within the shortest possible delay.") *Chaoulli* (C.S.), *supra* note 5 at para. 50.

²² *Ibid.* at paras 71-115.

²³ *Ibid.* at paras 109-112.

does lead to an erosion of public support.”²⁴ Dr. Marmor also cited unfair subsidies to the private system and private providers resulting from past and future public investment in hospitals, capital improvements and research; diversion of financial and human resources away from, and lengthening of waiting lists in, the public system; increased government administrative costs required to regulate the private health insurance market; advantaging of those able to afford and to secure private coverage; and increased overall health spending with no clear improvement in health outcomes.²⁵ As Dr. Marmor concluded: “...the grounds used to bolster arguments for parallel insurance are uniformly weak empirically.”²⁶

Other experts called by the respondent governments pointed to the efficiency of the Canadian health insurance system relative to that in the United States, where administrative costs are almost four times higher;²⁷ the fact that rationing occurs in all health care systems – in the U.S. based on price, resulting in 39% of the U.S. population having no health insurance coverage;²⁸ the problem of “cream skimming” within the private system, where providers “siphon off high revenue patients and vigorously try to avoid providing care to patient populations who are at financial risk”;²⁹ and the overall contribution of the public health care system to social cohesion in Canada.³⁰

²⁴ *Ibid.* at para. 109.

²⁵ *Ibid.* at paras 102-115.

²⁶ *Ibid.* at para. 115.

²⁷ *Ibid.* at para. 75, per Dr. Fernand Turcotte.

²⁸ *Ibid.* at para. 89, per Dr. Howard Bergman; at para. 95, per Dr. Jean-Louis Denis.

²⁹ *Ibid.* at para. 91, per Dr. Charles Wright.

³⁰ *Ibid.* at para. 101, per Dr. Jean-Louis Denis.

Lastly, Justice Piché summarized the evidence of Dr. Edwin Coffey, a specialist in obstetrics and gynaecology and the Director of the Montreal District Executive of the Québec Medical Association, called by the appellants. Dr. Coffey argued, based on his own experience and a comparative review of the situation in other OECD nations, that prohibitions on private health insurance create a “unique and outstanding disadvantage that handicaps the health system in Québec and Canada” and “have contributed to the dysfunctional state of our present health system...”³¹ Having earlier noted the failure by the appellants’ other experts to endorse the view that allowing parallel private care would necessarily address waiting times and other access issues,³² Justice Piché concluded that Dr. Coffey’s opinion on the advantages of allowing private funding was inconsistent with the weight of expert evidence in the case: “le Dr. Coffey fait cavalier seul avec son expertise et les conclusions auxquelles il arrive.”³³

The Charter Analysis in *Chaoulli*

Justice Piché began her legal analysis of the appellants’ section 7 *Charter* claim³⁴ by reviewing existing Supreme Court of Canada jurisprudence on the scope of the right to life, liberty and security of the person under section 7, including in *Singh v. Canada*,³⁵ *R. v. Morgentaler*,³⁶ *Irwin Toy v. Québec (Attorney General)*,³⁷ and *Rodriguez v. British*

³¹ *Ibid.* at para. 119.

³² *Ibid.* at para. 51.

³³ (Translation: “Dr. Coffey is a lone horseman in his expertise and the conclusions to which he arrives.”) *Ibid.* at para. 120.

³⁴ The appellants also argued, unsuccessfully, that the prohibitions on private insurance were matters of federal criminal law and thereby exceeded provincial jurisdiction over health under sections 92(7),(13) (15) and (16) of the *Constitution Act, 1867*; that the provisions violated the guarantee against “cruel and unusual treatment or punishment” under section 12 of the *Charter*; and that they discriminated between Québec residents and non-residents, contrary to section 15(1) of the *Charter*.

³⁵ [1985] 1 S.C.R. 177 [*Singh*].

³⁶ [1988] 1 S.C.R. 30 [*Morgentaler*].

Columbia (Attorney General).³⁸ Based on her review of the case law, Justice Piché concluded that the Supreme Court had left the door open to recognizing economic rights intimately connected to life, liberty, or personal security.³⁹ In answer to the question whether access to health care services was such a right, she concluded in the affirmative. In her view: “S’il n’y a pas d’accès possible au système de santé, c’est illusoire de croire que les droits à la vie et à la sécurité sont respectés.”⁴⁰

On the specific question of whether the right to contract for private health and hospital insurance, restricted under the legislative provisions at issue, was also protected under section 7, Justice Piché also found the answer to be yes. To the extent that the legislative restrictions on private insurance created economic barriers rendering access to private health care illusory, Justice Piché held that the appellants’ rights to life, liberty and security were affected. As she explained: “... ces dispositions sont une entrave à l’accès à des services de santé et sont donc susceptibles de porter atteinte à la vie, à la liberté et à la sécurité de la personne.”⁴¹ In Justice Piché’s view however, limits on access to private health services would violate section 7 only where the public system was unable to effectively guarantee access to similar care. As Justice Piché put it: “Le tribunal ne croit pas par contre qu’il puisse exister un droit constitutionnel de choisir la provenance de soins médicalement requis.”⁴² Justice Piché acknowledged that the appellants were not in

³⁷ [1989] 1 S.C.R. 927 [*Irwin Toy*].

³⁸ [1993] 3 S.C.R. 519 [*Rodriguez*].

³⁹ *Chaoulli (C.S.)*, *supra* note 5 at para. 221.

⁴⁰ (Translation: “If there is no access to the health care system, it is illusory to think that rights to life and security are respected.”) *Ibid.* at para. 223.

⁴¹ (Translation: “... these provisions are an obstacle to access to health services and may therefore infringe life, liberty and security of the person.”) *Ibid.* at para. 225.

⁴² (Translation: “The Court does not think, however, that there is a constitutional right to choose where medically required health care will come from.”) *Ibid.* at para. 227.

actual need of health care, nor of services they had been unable to obtain within the publicly funded system. Rather, she accepted their claim that resource constraints within the public system, reflected in waiting lists and other access-related problems, combined with the impugned prohibitions on private insurance, meant that the appellants' future health care needs might not be met. Justice Piché agreed that this constituted a sufficient threat to the appellants' life, liberty, and security of the person: "... nous devons conclure, vu l'imprévisibilité de l'état de santé d'une personne, qu'il y a une menace d'atteinte imminente en l'espèce."⁴³

In light of her finding that the appellants' section 7 rights had been threatened, Justice Piché went on to consider whether the prohibition on private health insurance was "in accordance with the principles of fundamental justice." In doing so, she first reviewed the Supreme Court's decisions in *Rodriguez*⁴⁴ and other cases establishing that, in order to determine whether a violation of the right to life, liberty or security of the person is in accordance with the principles of fundamental justice, the interests of the individual must be balanced against those of the state and society as a whole.⁴⁵ Applying this balancing test, Justice Piché pointed out that Québec's health insurance legislation was designed to create and maintain a public health care system, universally accessible to all residents of the province without barriers related to individual economic circumstances.⁴⁶

Restrictions on the development of a parallel private system, she found, were put in place

⁴³ (Translation: "... we must conclude, given the unpredictability of a person's state of health, that there is an imminent threat of deprivation in the present case.") *Ibid* at para. 242.

⁴⁴ *Supra* note 37. As Justice Sopinka expressed it, at 594: "where the deprivation of the right in question does little or nothing to enhance the state's interest ... a breach of fundamental justice will be made out."

⁴⁵ *Chaoulli (C.S.)*, *supra* note 5 at para. 256.

⁴⁶ *Ibid.* at para. 258.

by the province to prevent a transfer of resources out of the public system, to the detriment of all members of society.⁴⁷ As she explained:

La preuve a montré que le droit d’avoir recours à un système parallèle privé de soins, invoqué par les requérants, aurait des répercussions sur les droits de l’ensemble de la population ... L’établissement d’un système de santé parallèle privé aurait pour effet de menacer l’intégrité, le bon fonctionnement ainsi que la viabilité du système public. Les articles [contestés] empêchent cette éventualité et garantissent l’existence d’un système de santé public de qualité au Québec.⁴⁸

This balancing of interests in favour of the collective benefit to all residents of Québec of preserving a viable and effective public health care system, Justice Piché found, was motivated by equality and dignity concerns, and was consistent with Canadian and Québec constitutional and human rights norms.⁴⁹ Such a legislative choice was therefore clearly in conformity with the principles of fundamental justice. Thus, Justice Piché concluded, restrictions on access to private insurance and private care under provincial health and hospital insurance legislation did not violate section 7 of the *Charter*.⁵⁰ While a section 1 justification was therefore not required, Justice Piché expressed the view that such an analysis would demonstrate that the provisions at issue constituted a reasonable limit in a free and democratic society.⁵¹

The Court of Appeal decision in *Chaoulli*

⁴⁷ *Ibid.* at para. 259.

⁴⁸ (Translation: “The evidence shows that the right, claimed by the plaintiffs, to have recourse to a parallel private health care system would have repercussions for the rights of the entire population ... The creation of a parallel, private health care system would threaten the integrity, the effective operation and the viability of the public system. The [challenged] provisions prevent such an occurrence and guarantee the existence of a quality, public health care system in Québec.”) *Ibid.* at para. 263.

⁴⁹ *Ibid.* at para. 260.

⁵⁰ *Ibid.* at para. 267.

⁵¹ *Ibid.* at para. 268. Section 1 of the *Charter* provides that: “The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”

Justice Piché's decision was upheld by the Québec Court of Appeal in three concurring judgments.⁵² Justice Delisle found that access to a publicly funded health care system was a fundamental right protected under section 7. In contrast to Justice Piché, he held that the right to contract for private health insurance being claimed by the appellants was a purely economic interest that was not essential to human life, and that was therefore excluded from section 7 of the *Charter*.⁵³ As Justice Delisle warned:

Il ne faut pas inverser les principes en jeu pour, ainsi, rendre essentiel un droit économique accessoire auquel, par ailleurs, les gens financièrement défavorisés n'auraient pas accès. Le droit fondamental en cause est celui de fournir à tous un régime public de protection de santé, que les défenses édictées par les articles précités ont pour but de sauvegarder.⁵⁴

Justice Forget agreed with Justice Piché that, while the appellants' section 7 health rights were affected by the statutory limits on private health insurance, the province's decision to favour the collective interest in maintaining the public health care system was in accordance with section 7 principles of fundamental justice.⁵⁵ For his part, Justice Brossard agreed with Justice Delisle that the contractual rights restricted under the health and hospital insurance provisions at issue were economic rights that were not fundamental to human life. To the extent the evidence failed to show that the statutory restrictions on private insurance had in fact imperilled the appellants' rights to life or health, Justice Brossard concluded that no violation of section 7 had been shown.⁵⁶

⁵² *Chaoulli (C.A.)*, *supra* note 7.

⁵³ *Ibid.* at para. 25.

⁵⁴ (Translation: "The principles at issue must not be inverted so as to make an ancillary economic right essential, and further, one to which economically disadvantaged people would not have access. The fundamental right at issue is that of providing a public health protection system to all, a right which the prohibitions set out under the abovementioned provisions are designed to safeguard.") *Ibid.* at para. 25.

⁵⁵ *Ibid.* at para. 63.

⁵⁶ *Ibid.* at para. 66.

The Broader Social Implications of Section 7 Review of the Health Care System

As noted at the outset of the paper, health care and the publicly funded health care system occupy a pre-eminent place in Canadian society. It therefore stands to reason that fundamental health-related interests should be constitutionally recognized, and that health care decision-making should respect basic constitutional norms. As Justice Piché affirmed, the right to life, liberty and security of the person has little meaning for a person who lacks access to medically necessary care in the event of sickness. To the extent that section 7 gives clear constitutional expression to the idea that “all are entitled – as a matter of citizenship – to equal access to quality care”,⁵⁷ and that compliance with section 7 norms is likely to generate more open, accountable and inclusive health care decision-making,⁵⁸ section 7 review can be characterized as a possible “cure” for some of the problems facing the current health care system.

From a broader, determinants of health perspective, however, the risks of a section 7 “misdiagnosis” of the health care system are also apparent. In recent years, health care has become the dominant social policy concern in Canada, for governments and the public alike.⁵⁹ While the 1995 federal budget repealed the national standards for social welfare programs and services that existed until that point under the *Canada Assistance*

⁵⁷ National Forum on Health, “Values Working Group Synthesis Report” *supra* note 11 at 11.

⁵⁸ See M. Jackman, “The Right to Participate in Health Care and Health Resource Allocation Decisions Under Section 7 of the *Canadian Charter*” (1995/96) 4 *Canadian Health Law Review* 3-11.

⁵⁹ Romanow Commission, *supra* note 9 at xvi; Kirby Committee, *Interim Report*, *supra* note 9 chap. 5; T.R. Marmor, K.G.H. Okma & S.R. Lathan, *National Values, Institutions and Health Policies: What Do They Imply for Medicare Reform, Discussion Paper No. 5* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 15-16 [Marmor et al., *National Values*]; National Forum on Health, “Values Working Group Synthesis Report”, *supra* note 11 at 5.

Plan,⁶⁰ national conditions under the *Canada Health Act*⁶¹ have been maintained and continue to be vigorously defended, if not necessarily enforced,⁶² by successive federal governments. The result is that in many parts of Canada, for those forced to rely on social assistance, almost the only certainty of food, clothing or shelter is to fall so ill as to require hospitalisation.⁶³

Notwithstanding overwhelming evidence that poverty and related social and economic factors such as education and unemployment, are the most significant determinants of health, Canadians remain wedded to the idea that access to biomedical services is the best guarantee of individual and public health.⁶⁴ At the same time, powerful groups, drawing significant media attention, reinforce the view that the publicly funded system is broken, and that more acute care spending, both by government and through increased

⁶⁰ R.S.C. 1985, c. C-1; M. Jackman, “Women and the Canadian Health and Social Transfer: Ensuring Gender Equality in Federal Welfare Reform” (1995) 8 *Canadian Journal of Women and the Law* 371-410.

⁶¹ R.S.C. 1985, c. C-6.

⁶² Office of the Auditor General of Canada, “Federal Support for Health Care Delivery” in *1999 Report of the Auditor General of Canada* (Ottawa: Office of the Auditor General of Canada, 1999) chap. 19; S. Choudhry, “The Enforcement of the Canada Health Act” (1996) 41 *McGill Law Journal* 461-508.

⁶³ For an account the impact of social welfare changes over the past decade see: B. Porter, “ReWriting the Charter or Reading it Right: The Challenge of Poverty and Homelessness in Canada” in W. Cragg & C. Koggel, eds, *Contemporary Moral Issues* (Toronto: McGraw-Hill Ryerson, 2004) 373-86; J. Swanson, *Poor-Bashing: The Politics of Exclusion* (Toronto: Between the Lines, 2001); National Council of Welfare, *Another Look at Welfare Reform* (Ottawa: Minister of Public Works and Government Services Canada, 1997).

⁶⁴ Kirby Committee, *Interim Report*, *supra* note 9 chap. 5; D. Raphael, “From Increasing Poverty to Social Disintegration: The Effects of Economic Inequality on the Health of Individuals and Communities” in H. Armstrong, P. Armstrong & D. Coburn, eds, *Unhealthy Times: The Political Economy of Health Care in Canada* (Toronto: Oxford University Press, 2001) 223-46; M. Townson, *Health and Wealth – How Social and Economic Factors Affect Our Well Being* (Ottawa: Canadian Centre for Policy Alternatives, 1999); National Forum on Health, “Determinants of Health Working Group Synthesis Report” in National Forum on Health, *Canada Health Action: Building on the Legacy, Volume II* (Ottawa: Minister of Public Works and Government Services, 1997) at 5-6.

privatisation of health funding and services, is required to fix it.⁶⁵ As the Mazankowski Advisory Council on Health framed the issue:

If we continue to depend only on provincial and federal revenues to support health care services, we have few options other than rationing health care services. On the other hand, if we are able to diversify the revenue sources used to support health care, we have the opportunity of improving access, expanding health care services, and realizing the potential of new techniques and treatments to improve health.⁶⁶

In the current neo-liberal policy climate, both the demand for more public funding for acute health care services, and the call for increased health care privatisation, have serious negative implications for low-income Canadians. Public and stake-holder demands for more public spending on acute health care, coupled with governments' own deficit and tax cutting agendas, have provided a major impetus for significant reductions in social welfare spending. Over the past decade, as health spending has gone up, social assistance programs and benefits have been cut across the country by governments of all political stripes. Ironically, these social welfare cuts have occurred without consideration of their impact on the health of the individuals affected, or the broader economic and social costs in terms of public health and health care spending.⁶⁷

⁶⁵ R.G. Evans, *Raising the Money: Options, Consequences and Objectives for Financing Health Care in Canada, Discussion Paper No. 27* (Saskatoon: Commission on the Future of Health Care in Canada, 2002); M.-C. Premont, *The Canada Health Act and the Future of Health Care Systems in Canada, Discussion Paper No. 4* (Saskatoon: Commission on the Future of Health Care in Canada, 2002); R.B. Deber, "Getting What we Pay For: Myths and Realities About Financing Canada's Health Care System" (2000) 21 *Health Law in Canada* 9-40.

⁶⁶ Mazankowski *Report*, *supra* note 12 at 52.

⁶⁷ National Council of Welfare, *The Cost of Poverty* (Ottawa: Minister of Public Works and Government Services Canada, 2001) at 7-8; Raphael, "From Increasing Poverty to Social Disintegration", *supra* note 64; National Anti-Poverty Organization, *Government Expenditure Cuts and Other Changes to Health and Post-Secondary Education: Impacts on Low-Income Canadians* (Ottawa: National Anti-Poverty Organization, 1998), chap. 3.

Demands for increased private health care funding have equally significant negative implications for the poor, inasmuch as they represent a profound threat to the access of low-income Canadians to the health care services that are currently provided within the framework of the *Canada Health Act*. As the evidence accepted by Justice Piché in the *Chaoulli* case demonstrates, allowing the development of a parallel private insurance system will have serious adverse consequences for the health care rights of low-income Canadians, both by advantaging those who are able to purchase private insurance and care, and by drawing resources away from and eroding public support for the publicly funded system upon which people living in poverty disproportionately rely.⁶⁸

As the *Chaoulli* case illustrates, not only the argument for more public spending, but also the demand for increased private funding and privatisation of services, can find support under section 7 of the *Charter*. In their intervention before the Supreme Court of Canada in the *Chaoulli* case, for example, the Canadian Medical Association and the Canadian Orthopaedic Association,⁶⁹ along with a group composed of a number of private surgery and diagnostic clinics in British Columbia,⁷⁰ are supporting the appellants' claim, based on the argument that if governments are unwilling to devote the necessary resources to eliminate waiting periods for acute care, the system must be opened up to private funding as a matter of section 7 right. As the B.C. Clinics argue:

To the extent that individuals are given a reasonable opportunity to secure, in a timely manner, such medically necessary treatment as is not provided

⁶⁸ Evans, *Raising the Money*, *supra* note 65 at 37; National Anti-Poverty Organization, *Government Expenditure Cuts*, *ibid.*

⁶⁹ *Factum of the Interveners Canadian Medical Association and the Canadian Orthopaedic Association in Chaoulli v. Québec (Attorney General)* [*Factum of the Interveners CMA and COA*].

⁷⁰ *Factum of the Interveners Cambie Surgeries Corporation, False Creek Surgical Centre Inc. and Others in Chaoulli v. Québec (Attorney General)* [*Factum of the Interveners Cambie Surgeries Corporation et al.*].

by the state, the failure of the state to provide such treatment does not result in a deprivation of s. 7 rights. Personal autonomy in that case would be protected.

...

Likewise, the current public health care provisions aimed at preventing the development of a parallel private health care system, including the bar on private health insurance, would arguable not violate the liberty and security of individuals provided that unlimited, or at least adequate, health care resources were available from the state.⁷¹

For their part, Committee Chair Michael Kirby and other members of the Senate Standing Committee on Social Affairs, Science and Technology, are advancing similar arguments in their intervention in *Chaoulli*. While professing support for the publicly funded system, the Kirby Committee argues that “Health Care Guarantees” would be sufficient to preserve its main features, and that Québec’s private health insurance prohibitions should be struck down.⁷² The inference is that governments can bring themselves into compliance with section 7, either by increasing public funding to reduce waiting times to a level the Committee deems acceptable, or by allowing the introduction of private funding to achieve the same results. As the Committee repeatedly asserts: “governments can no longer have it both ways – they cannot fail to provide access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means.”⁷³

⁷¹ *Ibid.* at paras 26-27; *Factum of the Intervenors CMA and COA*, *supra* note 69 at para. 19.

⁷² *Factum of the Intervenors Senator Michael Kirby, Senator Marjory Lebreton, Senator Catherine Callbeck, Senator Joan Cook, Senator Jane Cordy, Senator Joyce Fairbarin, Senator Wilbert Keon, Senator Lucie Pepin, Senator Brenda Robertson, and Senator Douglas Roche in Chaoulli v. Québec* at paras 24, 62 [*Factum of the Intervenors Senator Michael Kirby et al.*]

⁷³ *Ibid.* at paras 7, 16; Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Final Report, Volume 6: Recommendations for Reform* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael Kirby) at 120.

Quite apart from the fact that the Committee’s benign assessment of the effects of striking down the impugned provisions is contradicted by the evidence, neither the choice of more public spending on acute care services, nor the prospect of increased private funding, reflect the interests of low-income Canadians. Canadians living in poverty continue to suffer the consequences of governments’ overemphasis on acute health care and their corresponding under-investment in social welfare programs, social services, and other positive measures to address social determinants of health. People living in poverty also have the most to lose from a move to private funding and a two-tiered health care system.⁷⁴

The Choices Facing the Supreme Court in *Chaoulli*

To her credit, Justice Piché did not limit her analysis in *Chaoulli* to the narrow issue of individual autonomy and choice that the rhetoric of health care privatisation relies on, and that a narrow reading of section 7 of the *Charter* permits. Rather, she considered the broader social policy issues raised in the case. In examining the scope of section 7 and the meaning of fundamental justice within the health care context, Justice Piché considered the life, liberty and security of the person interests of those Canadians for whom access to health care is contingent on rationing that is unrelated to ability to pay.⁷⁵ To put it more starkly, Justice Piché’s judgment recognizes that, from the perspective of people living in poverty, a system that imposes some waiting period for all is infinitely preferable to a system in which poor people may wait forever, or never receive care at all.

⁷⁴ NAPO, “Government Expenditure Cuts”, *supra* note 67; see also National Coordinating Group on Health Care Reform and Women, Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care in Canada for Women at 7-11.

⁷⁵ *Chaoulli* (C.S.) *supra* note 5 at para. 262.

In deciding the *Chaoulli* case, the Supreme Court of Canada can either uphold or reverse Justice Piché’s decision and the judgment of the Québec Court of Appeal. Whether or not the Court adopts Justice’s Piché’s interpretation of section 7, in light of its decision in *Gosselin v. Québec (Attorney General)*,⁷⁶ the Court should be expected to defer to her conclusions of fact as to the impact of striking down the current restrictions on private health and hospital insurance funding. As Dr. Marmor pointed out in his testimony at trial, opponents of the single-tier system portray the introduction of parallel private insurance funding as being a reform option with no downside:

The case for changing the present Canadian prohibition against parallel private health insurance for core medical services rests upon an appealing, but unrealistic theory. It is the view that parallel insurance can be introduced and operated so that no one in Canada would be worse off ... This “win-win” theory has a surface plausibility ... however, a closer examination reveals its theoretical and empirical flaws.⁷⁷

Justice Piché accepted the evidence presented at trial that striking down the prohibition on private health and hospital insurance would have serious negative consequences for the public system.⁷⁸ Nevertheless, the appellants and supporting interveners continue to argue before the Supreme Court, that the harm of striking down the impugned provisions has not been proven. For example, the B.C. Clinics contend that: “the evidence simply does not support the proposition that the public health care system in Canada will suffer significantly if private payment for insured services is permitted.”⁷⁹ The Kirby Committee makes a similar assertion that: “A declaration that the impugned legislation

⁷⁶ [2002] 4 S.C.R. 429.

⁷⁷ *Ibid.* at para. 104.

⁷⁸ *Chaoulli (C.S.)*, *supra* note 5 at paras 91-93; 103-115.

⁷⁹ *Factum of the Intervenors Cambie Surgeries Corporation et al.*, *supra* note 70 at para. 56.

will not sound the death knell for the Canadian system of publicly funded health care for medically necessary services...”⁸⁰ The Supreme Court’s decision whether or not to accept the appellants’ arguments on this point over Justice Piche’s findings of fact, will undoubtedly have a major impact on the outcome of the case.

Beyond the weight of expert evidence, the Supreme Court has been clear that private contractual rights of the type being claimed by the appellants in *Chaoulli* are not included under section 7 of the *Charter*.⁸¹ In essence, the appellants and supporting interveners are arguing, not only that they have a right to purchase private insurance, but that governments cannot legislate in such a way that it becomes economically unattractive for the market to provide it. The idea that section 7 includes private corporate-commercial rights of this nature was firmly rejected by the Court in *Irwin Toy*.⁸² The argument that physicians, and by analogy other private health care providers, have a section 7 right to provide health care services has also been dismissed.⁸³

However, as the appellants and supporting interveners in *Chaoulli* argue effectively, the idea that an individual should be able to choose private care, and that such a choice is fundamental to personal autonomy and dignity, finds significant support in Supreme Court case law. The Court has recently reiterated that the right to liberty under section 7 “grants the individual a degree of autonomy in making decisions of fundamental

⁸⁰ *Factum of the Intervenors Senator Michael Kirby et al.*, *supra* note 72 at para. 62.

⁸¹ *Irwin Toy*, *supra* note 36 at para. 1004.

⁸² *Ibid.*

⁸³ Jackman, “The Implications of Section 7 of the Charter”, *supra* note 4 at 9-10.

importance, without interference from the state.”⁸⁴ The appellants and supporting interveners invoke this jurisprudence in support of a purely negative conception of section 7 as a guarantee against measures that “prevent individuals from utilizing their own resources” to obtain private care.⁸⁵ As the B.C. Clinics assert: “there is no right to have one’s health care ... paid for by the government. However ... the individual has a right to be protected from government interference with his or her ability to take care of his or her own health.”⁸⁶ Or, as the members of the Kirby Committee state their position: “These interveners are not asserting a free-standing constitutional right to health care. Rather, these interveners assert a constitutional right not to be prevented from obtaining “timely access to medically necessary care” in Canada that is not currently available through the publicly-funded system.”⁸⁷

In this regard the appellants and supporting interveners are proposing an under-inclusive and discriminatory interpretation of the section 7 right to health: one that recognizes and protects the health care rights of the economically advantaged while denying those of the poor, whose access to health care depends on the existence of the public system. This approach to the right to health care is incompatible both with domestic equality rights principles,⁸⁸ and with health and equality guarantees under international treaties ratified by Canada, which the Court has identified as an important guide for section 7 principles

⁸⁴ *R. v. Malmo-Levine; R. v. Caine*, [2003] 3 S.C.R. 571 at para. 85 citing *Morgentaler*, *supra* note 35 at 166; *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 at para. 66; *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at para. 80.

⁸⁵ *Factum of the Intervenors Cambie Surgeries Corporation et al.*, *supra* note 70 at para. 9; *Factum of the Intervenors CMA and COA*, *supra* note 69 at para. 22.

⁸⁶ *Factum of the Intervenors Cambie Surgeries Corporation et al.*, *ibid.* at para. 26.

⁸⁷ *Factum of the Intervenors Senator Michael Kirby et al.*, *supra* note 72 at para. 32.

⁸⁸ Greschner, “How Will the Charter Affect Health Care Costs”, *supra* note 4 at 21; *Factum of the Charter Committee on Poverty Issues and the Canadian Health Coalition in Chaoulli v. Quebec*.

of fundamental justice,⁸⁹ and for *Charter* interpretation generally.⁹⁰ In particular, an interpretation of section 7 that entrenches the right to buy private care free from state interference, but not the right to health care *per se*, is inconsistent with Canada's international treaty obligations under the *International Covenant on Economic, Social and Cultural Rights*, to guarantee "medical service and medical attention in the event of sickness" without discrimination based on "... social original, property, birth or other status."⁹¹

The appellants' and supporting interveners' definition of the right to health is considerably narrower than the one adopted by Justice Piché, who held that section 7 protects the right to access to health care services and the health care system generally.⁹² On appeal, Justice Delisle also found that that the right guaranteed under section 7 is to publicly funded care, and rejected the appellants' argument precisely because it amounted to a claim to a right that would be inaccessible to low-income people.⁹³ The Supreme Court's choice of either the narrow and decontextualized reading of section 7 put forward by the appellants, or an interpretation of the right to health informed by equality and international human rights principles, will be a determining factor, not only for the outcome of the *Chaoulli* case, but for the future application of section 7 in the health care context.

⁸⁹ *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 487 at 503; *United States v. Burns*, [2001] 1 S.C.R. 283 at paras. 79081; *Malmö-Levine*, *supra* note 84 at para. 270.

⁹⁰ *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817 at para. 70.

⁹¹ 993 U.N.S. 3 (1966); Can. T.S. 1976 No. 47, Articles 2(2), 12(2)(d). For a discussion of the right to health under international law see B. von Tigerstrom, "Human Rights and Health Care Reform: A Canadian Perspective" in T.A. Caulfield and B. von Tigerstrom, eds, *Health Care Reform and the Law in Canada – Meeting the Challenge* (Edmonton: University of Alberta Press, 2002) 157-85; B.C.A. Toebes, *The Right to Health as a Human Right in International Law* (Oxford: Intersentia – Hart, 1999).

⁹² *Chaoulli (C.S.)*, *supra* note 5 at para. 223.

⁹³ *Chaoulli (C.A.)*, *supra* note 7 at para. 25.

In addition to defining the right to health more narrowly, the interveners supporting the appellants point out that the balancing approach to fundamental justice adopted by Justice Piché at trial was thrown into doubt by the Supreme Court's recent decision in *R. v. Malmo-Levine*; *R. v. Caine*, where the Court cautioned that:

The balancing of individual and societal interests within section 7 is only relevant when elucidating a particular principle of fundamental justice ... Once the principle of fundamental justice has been elucidated, however, it is not within the ambit of s. 7 to bring into account such "societal interests" as health care costs. Those considerations will be looked at, if at all, under s. 1.⁹⁴

While section 7 may no longer allow for the balancing approach applied by Justice Piché, the evidence makes it clear that, aside from promoting broader collective interests in a viable publicly funded health care system, Québec's decision to prohibit private health and hospital insurance is neither arbitrary, irrational nor inconsistent with fundamental social values – the principal requirements of fundamental justice identified by the Court in *Malmo-Levine*.⁹⁵ As Justice Piché found, the prohibitions accord with fundamental justice by ensuring that both individual treatment and broader health policy and resource allocation decisions are based on need, rather than dictated by market pressures shown to generate not only inequitable, but inefficient and irrational health care choices.⁹⁶ By ensuring that access to health care is not conditional upon ability to pay, the impugned provisions also reflect and promote the fundamental *Charter* value of respect for human

⁹⁴ *Malmo-Levine*, *supra* note 84 at para. 98.

⁹⁵ *Ibid.* at paras 113, 135.

⁹⁶ *Chaoulli (C.S.)*, *supra* note 5 at paras 66, 76; Evans, *Raising the Money*, *supra* note 65.

life, recognized as a matter of societal consensus by the Court in *Rodriguez*,⁹⁷ as well as the widely shared Canadian value that access to health care should be determined by need, not wealth.⁹⁸

As Justice Piché’s judgment recognizes, and Justice Delisle reiterates on appeal, a failure by governments to ensure access to health care services without barriers based on ability to pay would have a discriminatory impact on the life, liberty and security of the person of people living in poverty and others for whom access to publicly funded health care is crucial. In his decision in *Eldridge v. British Columbia (Attorney General)*, outlining the positive obligations imposed by the *Charter* in the context of health care services for the Deaf, Justice LaForest argued that: “If we accept the concept of adverse effect discrimination, it seems inevitable, at least at the s. 15(1) stage of analysis, that the government will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services.”⁹⁹ On that basis, it is not the impugned prohibitions on private health and hospital insurance, as the appellants allege, but rather the absence of legislative measures to ensure equal access to health care, that should give rise to constitutional question under the *Charter*.

⁹⁷ *Rodriguez*, *supra* note 37 at 608.

⁹⁸ Romanow Commission, *supra* note 9 at xvi; National Forum on Health, “Values Working Group Synthesis Report”, *supra* note 11 at 11; Marmor et al., *National Values*, *supra* note 59 at v.

⁹⁹ [1997] 3 S.C.R. 624 at para. 77.

Conclusion

A recent CBC national broadcast declared that, while health care dominates political debate in Canada, “the most important decision about the future of health care is actually taking place inside the halls of the Supreme Court of Canada” in *Chaoulli*.¹⁰⁰ As suggested at the outset of the paper, lower courts in Canada have generally been unwilling to consider health care issues as justiciable under section 7 of the *Charter*.¹⁰¹ As the B.C. Court of Appeal summarily concluded in a recent case: “When the *Charter* was first presented considerable debate ensued as to whether it could apply to provide a positive entitlement to health care. In my view ... it does not.”¹⁰² In this regard, Justice Piché’s decision represents a clear change in direction and, as the CBC media clip highlights, the *Chaoulli* hearing before the Supreme Court of Canada, a major turning point both for the *Charter* and for the Canadian health care system.

From a health policy perspective, section 7-based review of health care decision-making represents a potential cure for some of the problems within the current health care system. Compliance with section 7 principles of fundamental justice may generate more open, accountable and participatory decision-making. Section 7 can also provide a basis for challenging the irrational and potentially discriminatory under-inclusiveness of the public system, which restricts funding largely to physician and hospital services while failing to adequately support homecare, pharmacare, mental health and other services

¹⁰⁰ The Current, “Medical Special” (26 May 2004) online: CBC Radio One <http://www.cbc.ca/thecurrent/2004/200405/20040526.html>.

¹⁰¹ Jackman, “The Implications of Section 7” *supra* note 4 at 5.

¹⁰² *Auton (Guardian ad Litem of) v. British Columbia (Minister of Health)*, [2002] B.C.J. 2258 at para. 73.

which are equally essential to life, liberty and security of people living in poverty and other disadvantaged groups in Canadian society.

As suggested earlier, however, section 7 review of the health care system runs the very real risk of focusing not on the systemic inadequacies and inequities within the public system, but rather on a narrow conception of individual autonomy and choice that fails to acknowledge the positive and collective dimensions of health care entitlements. As outlined above, this danger is clearly illustrated in the *Chaoulli* case. To the extent that *Charter* review of the health care system contributes to, or exacerbates the current disconnect between acute health care and broader social welfare and determinants of health as a focus of government concern and spending, section 7 review risks producing a serious misdiagnosis of the system. In particular acceptance of the appellants' and supporting interveners' claim in *Chaoulli*, that restrictions on private insurance funding are unconstitutional and must be struck down, would represent a serious perversion of the right health – one from which the patient, be it the publicly funded health care system or section 7 of the *Charter*, would not easily recover.

In the early *Charter* case of *R. v. Edwards Books and Art Ltd.*,¹⁰³ former Chief Justice Brian Dickson warned that: “In interpreting and applying the *Charter* ... 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 conditions of less advantaged persons.” More recently, in a discussion paper for the Romanow Commission examining the distributional implications of various health

¹⁰³ [1986] 2 S.C.R. 713 at 779.

funding options currently under consideration in Canada, health economist John Evans explained support for increased privatisation of health care services and funding as follows: “The real motive underlying proposals for more private financing is very simple. “The more private funding we have, the more those with high incomes can assure themselves of first class care without having to pay taxes to help support a similar standard of care for everyone else.”¹⁰⁴ Consistent with its recent decision in *Harper v. Canada (Attorney General)*,¹⁰⁵ it is to be hoped that in hearing the *Chaoulli* case the Supreme Court will prove as sensitive as Justice Piché was at trial to the life, liberty and security-related health interests of all Canadians, and not simply of the most advantaged.

¹⁰⁴ Evans, “Raising the Money”, *supra* note 65 at 42.

¹⁰⁵ 2004 SCC 33.