"The Last Line of Defence for [Which?] Citizens":

Accountability, Equality and the Right to Health in *Chaoulli*

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> Governments have promised on numerous occasions to find a solution to the problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens. - Justice Deschamps, *Chaoulli v. Québec (Procureur général)*[1]

I. Introduction

I have made a scholarly career of claiming that Canadian *Charter*[2]-based review of government decision-making in relation to health care and other social and economic rights is a legitimate and valuable accountability mechanism, that can also promote the fundamental *Charter* goal of substantive equality. As I argued in a discussion paper for the Romanow Commission on the Future of Health Care in Canada:

> Given the fundamental importance of health care to individual well-being and to the welfare of society as a whole, Canadians should be confident that health care decision making respects basic constitutional values and, in particular, the values of security, dignity, and equality that are at the heart of the Canadian health care system.[3]

Having been a direct participant in the *Chaoulli*[4] case, and now contemplating its immediate political and potential longer-term health policy consequences, I am forced to wonder whether my confidence in *Charter* review, at least of the type undertaken by the majority of the Court in

this instance, was ill-placed.

To be clear, I was counsel for the Charter Committee on Poverty Issues (CCPI) and the Canadian Health Coalition (CHC) in their intervention before the Supreme Court in *Chaoulli*, and co-counsel with Vincent Calderhead in CCPI/CHC's response to Québec's application for a stay in the case.[5] The Appellants in *Chaoulli*, Dr. Jacques Chaoulli and Mr. George Zéliotis, argued that given serious delays within the publicly funded system, the prohibitions on private health insurance under Québec's health and hospital insurance legislation[6] were unconstitutional. Their supporting interveners, including Senator Michael Kirby and the members of his Standing Senate Committee on Social Affairs, Science and Technology, a number of private health clinics from British Columbia, and the Canadian Medical Association, argued that governments were required to eliminate health care delays or allow private funding. As the Kirby Committee declared: "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."[7] In terms of remedy, the Appellants' supporting interveners unanimously endorsed the Appellants' request that the state's single-payer monopoly be struck down. For their part, the Respondent Québec and Canadian governments argued that the *Charter* did not include health care rights of the type being claimed by the Appellants, and that the entire issue of health care funding was non-justiciable under section 7 of the *Charter*. In the words of the Attorney General of Canada: "the measures at issue are rooted in choices the appropriateness of which is not for a court to debate."[8]

As for the CCPI/CHC, we asserted that the *Charter* does include health care rights. But, contrary to the Appellants and their supporting interveners, and consistent with Canada's international commitments in relation to health and human rights, we argued that section 7 guarantees access to care without barriers based on ability to pay. To the extent that the evidence in the case showed that the state's single-payer monopoly was necessary to safeguard that right, we maintained that Québec and other provinces' legislative restrictions on private health insurance and funding – far from offending the *Charter* – represented a positive measure, required by the *Charter*'s guarantees of equality and security of the person.

Clearly, four of seven Supreme Court of Canada Justices disagreed with us. In her ruling for the majority, Justice Deschamps found that Québec's prohibition on private health insurance, and the resulting limits on Québeckers' ability to buy private care, violated the right to "life", "personal security" and "inviolability" under section 1 of the Québec *Charter of Human Rights and Freedoms*.[9] She further concluded that the prohibition could not be justified in accordance with "democratic values, public order and the general well-being of the citizens of Québec", pursuant to section 9.1 of the *Québec Charter*.[10] Chief Justice McLachlin and Justices Major and Bastarache agreed with Justice Deschamps that Québec's prohibition on private insurance violated the *Québec Charter*.[11] They also found that, inasmuch as undue waiting times threatened individual life and security of the person, the impugned provisions violated section 7 of the Canadian *Charter*.[12] The majority characterized the restrictions on private insurance as arbitrary measures, which were not in accordance with section 7 principles of fundamental justice, and which could not be justified under section 1 of the *Charter*.[13]

The three dissenting Justices Binnie, LeBel and Fish, agreed with the Québec Superior Court and Québec Court of Appeal that, in view of the objectives of Québec's medicare regime: to ensure access to health care governed by need, rather than by status or wealth, the prohibition on private insurance was a rational, *versus* an arbitrary, measure.[14] On that basis, they held that the legislative provisions were in compliance with section 7 principles of fundamental justice and were demonstrably justified under the Québec and Canadian *Charters*.[15]

What, specifically, is the problem with the Supreme Court's judgment in *Chaoulli* from the point of view of accountability and substantive equality? And what might the decision's ultimate impact be on the future of health care rights in Canada?

II. Accountability in *Chaoulli*

In terms of accountability I have, as I suggested earlier, agued that the availability of *Charter* review of health care decision-making, at both the individual treatment and broader health policy and planning levels, represents an important accountability mechanism within the Canadian health care system. However, for *Charter* review to operate effectively in this regard judges must take seriously, and carry out with great care, their role of scrutinizing and weighing the evidence put forward by the parties in these highly complex cases.[16]

In *Chaoulli*, the trial judge thoroughly assessed the evidence submitted both by the Appellants Chaoulli and Zéliotis, and by the Respondent Québec and Canadian governments. Justice Piché

first considered the Appellants' expert evidence, provided by several Québec medical specialists in the fields of orthopaedics, ophthalmology, oncology and cardiology, who pointed to lengthy waiting lists in the province; shortage of operating room time, hospital staff and equipment; erratic decision-making and lack of planning within the publicly funded system.[17] As Justice Piché summarized it: "Tous ces médecins ont témoigné sur les difficultés qu'ils avaient, sur les listes d'attente trop longues, sur les délais d'opération, sur les efforts qu'ils font à tous les jours pour tenter de règler les problèmes, pour tenter de trouver des solutions au manque de cohésion, d'organisation et, disons-le, de vision du Régime de santé du Québec aujourd'hui."[18]

Justice Piché went on to review the evidence submitted by the Québec and federal governments, and especially that of American health policy expert Dr. Theodore Marmor, whom she quoted at length. Dr. Marmor argued that allowing the development of a parallel private health insurance system would lead to decreased public support for medicare and, most significantly, to a loss of support from more affluent and thus politically influential groups most likely to exit the system.[19] Dr. Marmor also pointed to the problems of unfair subsidies to the private system and providers resulting from past and future public investment in hospitals, capital improvements, and research; diversion of financial and human resources away from the public system; increased government administrative costs required to regulate the private health insurance market; advantaging of those able to afford and to secure private coverage; and increased health spending overall, with no clear improvement in health outcomes.[20]

Other experts called by the Respondents cited the relative efficiency of the Canadian system, with the lowest administrative costs among Organisation for Economic Co-operation and Development (OECD) countries; the reality that rationing occurs in all health care systems – in the United States based on ability to pay, resulting in 39% of the population of that country lacking health insurance coverage; the problem of "cream skimming" in two-tier systems, where private providers "siphon off high revenue patients and vigorously try to avoid providing care to patient populations who are at financial risk"; and the overall contribution of the medicare system to social cohesion in Canada.[21]

Lastly, Justice Piché summarized the evidence of Dr. Edwin Coffey, a specialist in obstetrics-gynaecology and an executive member of the Québec Medical Association, called by the Appellants. Dr. Coffey argued, based on his own experience and a review of the situation in other OECD countries, 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."[22] Having earlier noted the Appellant's other experts' unwillingness to endorse the view that allowing parallel private care would provide a solution to waiting times and other access problems,[23] 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. As she put it: "le Dr. Coffey fait cavalier seul avec son expertise et les conclusions auxquelles il arrive." [24]

Based on her review of the evidence, Justice Piché accepted the Appellants' claim that health

care waiting lists in the province were too long. In her view: "même si ce n'est pas toujours une question de vie ou de mort, tous les citoyens ont droit à recevoir les soins dont ils ont besoin, et ce, dans les meilleurs délais."[25] Not surprisingly, however, given the Appellants' failure to submit evidence on this point, Justice Piché did not find that the prohibition on private insurance had an adverse impact on waiting times. Rather, the evidence she accepted suggested the converse: that eliminating the ban on private insurance would, by diverting energy and resources away from the public and into the private health care system, result in increased waiting times for publicly funded care.[26]

Based on this and the entirety of the evidence submitted by the parties, Justice Piché concluded that Québec's prohibition on private insurance was necessary to protect the integrity and viability of the public health care system upon which everyone, including those unable to pay for care, rely. In her words: "Il ne faut pas jouer à l'autruche. 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."[27] On the basis of these findings of fact, Justice Piché decided that Québec's prohibition on private insurance accorded with section 7 principles of fundamental justice and was a justifiable limit on the Appellants' health care rights under section 1 of the *Charter*.[28] The Québec Court of Appeal agreed with Justice Piché and dismissed Chaoulli and Zéliotis' appeal,[29] which a majority of the Supreme Court nevertheless allowed.

What evidence did Justice Deschamps and the other majority Justices rely upon to overturn Justice Piché's findings and decision on the relationship between the ban on private insurance

and waiting times, and on the impact of allowing private funding on the public health care system? As I read their judgment, on none at all.[30]

Like the courts below, Justice Deschamps identified the central question raised in the appeal as being whether Québec's prohibition on private health insurance was justified by the need to preserve the integrity of the public system.[31] Turning to the expert evidence at trial in relation to the impact on the public system of a loss of support from those exiting the system if the ban on private insurance was lifted, however, Justice Deschamps opined: "The human reactions described by the experts, many of whom came from outside Québec, do not appear to me to be very convincing..."[32] As for the other harmful effects of allowing the development of a parallel private insurance system, which Justice Piché found to have been proven, Justice Deschamps concluded: "Once again, I am of the opinion that the reaction of some witnesses described is highly unlikely in the Québec context."[33] Noting that other provincial medicare plans do not include a similar ban on private insurance,[34] and that other OECD nations had adopted a variety of different measures to protect their public systems,[35] Justice Deschamps concluded, in direct contradiction to Justice Piché's findings at trial, that: "the choice of prohibiting private insurance contracts is not justified by the evidence."[36]

Chief Justice McLachlin's decision is even more bereft of an evidentiary basis. Alluding briefly to the Appellants' and Respondents' arguments on the issue of whether Québec's ban on private insurance was arbitrary, the Chief Justice dismissed the significance of the expert evidence adduced at trial. As she put it: "To this point, we are confronted with competing but unproven

"common sense" arguments amounting to little more than assertions of belief."[37] Then, following a five paragraph review of the experience of other OECD countries drawn from the Kirby Committee's *Interim Report*,[38] the Chief Justice concurred with Justice Deschamps that: "the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care."[39]

Even more egregiously, since the Appellants led no evidence on this point, the Chief Justice attributed waiting lists in the public system to the ban on private insurance and the government's single-payer monopoly. At the outset of her judgment she stated: "This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person."[40] At the conclusion of her section 7 analysis she reiterated: "the denial of private insurance subjects people to long waiting lists and negatively affects their security of the person."[41] Ironically, as noted above, the evidence accepted by Justice Piché at trial suggested the opposite, that eliminating the ban on private insurance would in fact lead to longer waiting times within the public system.[42]

Justice Deschamp's insistence on the specificity of the Québec situation, and both her and Chief Justice McLachlin's cursory review of the comparative experience of other OECD countries,[43] does not remove from the fact that the majority simply set aside the findings of fact made by the trial judge. The majority dismissed the evidence accepted by Justice Piché about the impact of the ban on private insurance on health care waiting times as well as her findings on the issue of

whether the prohibition on private insurance was necessary to protect the integrity of the publicly funded system and its objective of ensuring equal access to health care services without barriers based on ability to pay. On the accountability score, then, the majority judgment in *Chaoulli* represents a clear and signal failure.

III. Substantive Equality in *Chaoulli*

What about on the substantive equality measure: to what extent does the majority judgment in *Chaoulli* promote the *Charter* and the Canadian health care system's equality objectives, especially as these relate to the interests of less advantaged members of Canadian society?

In her judgment at trial, Justice Piché found that Québec's ban on private insurance was designed to guarantee equal access to health care services for all Québeckers, and was motivated by considerations of equality and human dignity. On that basis, she concluded that there was no conflict between the impugned provisions and Canadian or Québec *Charter* values.[44] Whether or not supported by the evidence, a majority of the Supreme Court disagreed with Justice Piché's analysis, and held instead that the prohibition on private insurance violated rights to life and to security of the person under the Québec and Canadian *Charters*. People are languishing and indeed some are dying on health care waiting lists, the majority found. As the Chief Justice affirmed: "Inevitably, where patients have life-threatening conditions, some will die because of undue delay in awaiting surgery."[45] Or, as Justice Deschamps portrayed the situation: "Some patients die as a result of long waits for treatment in the public system when they could have gained prompt access to care in the private sector. Were it not for s. 11 *HOIA* and s. 15 *HEIA*,

they could buy private insurance and receive care in the private sector."[46] The appropriate response under the circumstances, the majority found, was to strike down the ban on private insurance.

The result of the majority's reasoning and choice of remedy in *Chaoulli* is that those with the ability to pay, and who otherwise qualify, can buy health insurance and care outside the public system. Those who are left however: those who lack the financial means, who are already ill, or who are disabled, and who can't therefore obtain private insurance, are effectively denied a remedy to the rights violation that the majority so fervently decried. They, in short, are left to languish and die on public waiting lists. At best, the majority's remedy is an under-inclusive one, enabling only those relatively advantaged individuals who qualify for and are able to afford private insurance, to jump the public queue. At worse, striking down the ban on private insurance will, as the evidence accepted by Justice Piché at trial warned, cause significant harm to the public system, upon which everyone else relies.

Even if the majority was correct in its skepticism about the adverse effects of legalizing private insurance, by endorsing a right to health care that is contingent on ability to pay, rather than on medical need, the majority's remedial approach is directly at odds with the underlying equality-based premises of the Canadian medicare system. Commissioner Roy Romanow described these principles in the following terms, in his *Final Report*: "our tax-funded, universal health care system provides a kind of "double-solidarity." It provides equity of funding between the "have" and "have-nots" in our society and it also provides equity between the healthy and the sick."[47]

In its 1997 report, the National Forum on Health put it more succinctly: "The public ... [has] 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."[48] The majority judgment in *Chaoulli* failed entirely to take into account the degree to which the publicly funded health care system reflects and promotes these fundamental equality objectives. As the minority put it:

> Taking the good with the bad, the Final Kirby Report recommended continuation of a single-tier health system (as did the Romanow Report) ... our colleagues' extracts of some of the *tour d'horizon* data published in the Interim Kirby Report do not displace the conclusion of the trial judge, let alone the conclusion of the Kirby Report itself. Apart from everything else, it leaves out of consideration the commitment in principle in this country to health care based on need, not wealth or status, as set out in the *Canada Health Act*.[49]

What is more, the majority's decision in *Chaoulli*, while referring to the comparative experience of other OECD nations, totally ignores the international law framework relating to health and human rights.[50] This legal framework includes commitments made by Canada and other States parties under the *International Covenant on Civil and Political Rights* (*ICCPR*)[51] and under the *International Covenant on Economic, Social and Cultural Rights* (*ICESCR*)[52] – both treaties ratified by Canada, with the approval of the provinces, in 1976. In particular, Article 12(1) of the *ICESCR* recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 12(2)(d) of the *ICESCR* sets out Canada and other State parties' obligations to take all steps necessary for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

More significantly, as relates to the majority decision in *Chaoulli*, Article 2(2) of the *ICESCR* requires governments to ensure that the right to health is enjoyed "without discrimination" and,

in particular, without discrimination based on "social origin, property, birth or other status." In similar terms, under Article 26 of the *ICCPR*, Canada and other State parties must ensure that all persons enjoy the "right to life", under Article 6(1) of the *ICCPR*, without discrimination based on "social origin, property, birth or other status." As the United Nations Committee on Economic, Social and Cultural Rights, which monitors compliance with the *ICESCR*, explains: "Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."[53] The majority's reasoning and remedial order in *Chaoulli*, which recognizes the health care rights only of the advantaged, and which ignores the rights of those who, by reason of poverty, chronic illness or disability, are forced to rely exclusively on the public system, is profoundly at odds with right to life, right to health, and equality guarantees set out under both the *ICCPR* and the *ICESCR*.

Finally, the majority judgment in *Chaoulli* violates Québec and Canadian *Charter* equality rights principles themselves. Section 10 of the *Québec Charter* explicitly prohibits discrimination based on social condition or disability.[54] In its section 15 Canadian *Charter* caselaw, the Supreme Court has promoted a contextual analysis of impugned government measures, that takes into account the actual circumstances and needs of disadvantaged groups.[55] The majority's remedial order in *Chaoulli*, relying as it does on a notion of formal equality of access to private health insurance, is meaningless and ineffective for those who are poor, chronically ill, or disabled. Interpreting the Québec and Canadian *Charters* to open the door to private health insurance does not guarantee equal enjoyment of the right to life or to security of the person for

the poor and for those who are medically ineligible for private insurance. Rather, as Justice Piché found at trial, such an approach directly undermines the health care rights of the less advantaged. As Justice Delisle admonished at the Québec Court of Appeal:

> Il ne faut pas inverser les principes en jeu pour, ainsi, rendre essentiel un droit économique accessoire auquel, par ailleurs, les gens financièrement défavorisés n'auraient pas accès. Le droit fondamental en cause est celui de fournir à tous un régime public de protection de la santé, que les défenses édictées par les articles [contestés] ont pour but de sauvegarder.[56]

In *R. v. Edwards Books and Art Ltd.*, 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."[57] This, as Justices Binnie, LeBel and Fish inferred in their dissenting opinion,[58] is precisely the effect of the majority judgment in *Chaoulli*. On the substantive equality score then, the *Chaoulli* decision also represents a perverse and profoundly disappointing result.

IV. *Chaoulli* and the Future of the Right to Health in Canada

Having been proven wrong in my initial *Charter* hopes and optimism, I am left to consider what the longer-term implications of the *Chaoulli* decision might be for the health rights of those for whom the majority judgment decidedly failed to prove "the last line of defence", and in particular, for people living in poverty.

At a political level, the government of Québec has announced that Québec residents will be able to purchase private health insurance for provincially insured services when the twelve month

stay of the *Chaoulli* judgment expires in June 2006.[59] Some of Premier Jean Charest's colleagues in other provinces will no doubt also claim that "the Supreme Court made me do it" in relation to further privatisation of health care funding and delivery even though, strictly speaking, the Court's split Canadian *Charter* judgment in *Chaoulli* did not. Alberta Premier Ralph Klein, for example, has also indicated that his government is considering an expanded role for private health insurance in Alberta, in order to "ensure that his province's approach to health care remains consistent with the Supreme Court of Canada's ruling" in *Chaoulli*.[60] In contrast to this reaction, other political leaders have insisted that their governments stand behind and will continue to invest all necessary resources in the single-payer system.[61] As Prime Minister Paul Martin asserted during a Vancouver radio talk show shortly after the *Chaoulli* decision, referring to the federal government's promised infusion of $41 billion towards health care reform over the next decade: "I don't believe in a two-tier medicare system. What we're doing is putting our money into strengthening the public health-care system."[62] Whether the political response to the Supreme Court's decision is more health care privatisation or more acute health care spending, however, the health rights of people living in poverty are arguably most at risk from the *Chaoulli* fall-out.

In the current neo-liberal policy climate, both the call for increased health care privatization and the demand for ever more public funding for acute health care services have serious implications for the health rights of low income Canadians. Calls for greater private health care spending, including the demand for private health insurance in *Chaoulli*, represent a profound threat to access by the poor to the health care services that are currently delivered within the framework

of the *Canada Health Act*.[63] As the evidence accepted by Justice Piché at trial outlined, removing the ban on private health insurance will not only advantage those who are able to purchase private insurance and care, but will also draw human and financial resources away from, and erode public support for, the public system upon which poor people disproportionately rely. A Canadian Medical Association Journal editorial following the *Chaoulli* decision summarized the situation:

> The shining ideal of equality in health care access has been protected to perhaps a miraculous degree by complex, pragmatic and provincially variable checks on the growth of the private system. It is this delicate balance that the Supreme Court decision has made all the more unstable by enhancing the claim of the affluent to a fast-track to care.[64]

At the same time, public and stakeholder demands for more public spending on acute health care, coupled with Canadian governments' own deficit and tax cutting agendas, have provided a major impetus for significant reductions in social welfare spending across the country.[65] Ironically, these program and funding cuts have occurred without consideration of their impact on the physical and psychological health of those directly affected, or the broader social and economic costs in terms of public health and health care spending.[66] As Dr. Nuala Kenny has argued:

> The goal of equity in health care requires that we think carefully about more than just getting more money into acute care. It requires a reflection on the implications of the rising social inequity in Canadian society and its implications for health and well being. Without such a reflection and under the pressures of our dependence on scientific and technical fixes for moral questions of justice and care, and the forces of privatization which privilege the haves over the have-nots, we may reform an equitable health care system into a profoundly inequitable one.[67]

If Canadian governments respond to the *Chaoulli* decision in either of these ways: by opening up the public health care system to more private funding as Québec and Alberta appear to be poised

to do, or by indiscriminately increasing the amount of public spending on acute health care delivery, the decision will definitely warrant the barrage of criticism it has attracted, in terms of its ultimate health policy consequences quite apart from its more obvious doctrinal defects.[68]

It is important to note, however, that alternate responses to the *Chaoulli* case are also being actively debated within both government and health policy research circles. There is no doubt that *Chaoulli* has heightened what was already a serious and widespread preoccupation over health care waiting times in Canada. At trial, the Appellants painted a picture of a public health care system in utter disarray. The Appellants' experts provided gripping evidence of lack of human and financial resources within the system, deteriorating hospitals and equipment, and physicians' mounting frustration faced with their inability to provide effective and timely care. On the specific issue of waiting times, however, the Appellants adduced little concrete evidence beyond the testimony of their medical experts that health care delays were systemic and put patients' health and well-being at risk.[69]

For their part, the Respondent Québec and Canadian governments focussed much of their evidence in *Chaoulli* on the relative efficiency and equity of the Canadian single-payer system relative to two-tier systems in other countries, primarily the American, and on the question of what impact permitting private insurance and funding would have on the integrity of the medicare system. On the specific issue of waiting times, the Respondents filed several expert reports explaining that waiting lists in Canada are largely controlled by individual physicians or hospitals, with little or no coordination between the two; that no systematic management of

waiting lists are in place at the provincial or national levels; and that no general consensus exists on appropriate treatment time benchmarks.[70] The dissenting Justices in *Chaoulli* agreed with the Respondents' experts that: "the real picture concerning waiting lists in Canada is subject to contradictory evidence and competing claims".[71] Nevertheless, the majority attributed the problem of undue waiting times to the actions of government and, in particular, to the state's single payer monopoly.

As discussed above, the majority ignored the fact that the Appellants' own experts did not endorse private funding as a solution to the wait time problem, and it also discounted the evidence suggesting that private funding would in fact exacerbate the problem. Whatever the available evidence in *Chaoulli*, the Respondents were unable to effectively address or rebut the impression created by the Appellants, and shared by a growing number of Canadians, that waiting times are the single most serious health care issue in Québec and Canada, and that people are suffering and even dying in significant numbers on health care waiting lists. And, to the extent Canadian governments have failed to take more immediate action on an issue which has generated such a high level of public concern, they do bear significant responsibility for the wait time problem, and for fixing it.

As the Romanow Commission's *Final Report* noted, steps have already been taken to improve wait time management in some provinces and in some treatment areas.[72] In its application for a stay of the majority's judgment in *Chaoulli*, the Attorney General of Québec placed considerable emphasis on the measures the province planned to adopt to deal with wait times, including

reforms at the primary care, regional and province-wide levels.[73] In its *factum* supporting Québec's application for a stay, the Attorney General of Canada also underscored the degree to which new federal health funding was tied to wait-time reductions and related reporting requirements.[74] More concerted government action on wait time management will be a direct and potentially positive outcome of the *Chaoulli* decision. This will be especially true if efforts to improve wait time management and to develop criteria to ensure that care is in fact rationed based on greatest medical need, also address the real and perceived problem of queue jumping based on social status, if not on wealth. Such improvements to the current system will clearly be of very real benefit to those Canadians for whom the majority's proposed remedy to wait times in *Chaoulli* was worse than no solution at all.

Beyond the particular issue of waiting times, the *Chaoulli* case has also drawn attention to the broader problem of creeping health care privatisation in Canada, and to the question of what specific legislative and regulatory measures are necessary to combat it. In response to the *Chaoulli* decision, the federal New Democratic Party put forward a series of proposed amendments to the *Federal-Provincial Fiscal Arrangements Act*,[75] designed to prevent further growth in private health care by means of more stringent conditions on federal health transfers to the provinces. In particular, the NDP proposed that the *Act* be amended to prohibit the provinces from using federal funds to subsidize private providers; to prohibit provinces from allowing physicians delivering publicly funded care from also supplying private services; and to require provinces to report twice-annually on the allocation of federal transfers to the public system.[76]

Federal Health Minister Ujjal Dosanjh responded to the NDP's legislative proposals by launching a new "Canadian Public Health Care Protection Initiative"[77] in which the government announced that the "accessibility" criterion under section 12 of the *Canada Health Act*[78] would henceforth be interpreted and applied as precluding "the practice of physicians providing the same services on both a publicly insured and a privately paid basis." The Minister also signalled the government's intention to request the Health Council of Canada, together with Statistics Canada and the Canadian Institute for Health Information, to "investigate and report on the interface between public and private delivery of health care in Canada." Preventing cost-shifting and unfair subsidies between the public and private health care systems,[79] and better monitoring and reporting of private funding and health care activity,[80] have been identified by health economists as key measures to mitigate the potential adverse impact of any dismantling of the single-payer monopoly. Prohibiting physicians from engaging in dual-practice – that is, from providing services in both the private and public systems, is a particularly important measure to prevent "cream-skimming" and other harmful practices likely to result from the legalisation of private insurance.[81] Assuming it is implemented, this proposed new federal initiative, including the clarification of the *Canada Health Act*'s "accessibility" requirement in relation to dual-practice, represents a concrete measure to further strengthen the single-payer system – one that might not have occurred but for the heightened attention to the specific dynamics of health care privatisation, generated by the *Chaoulli* decision.

In terms of the longer term impact of *Chaoulli*, what happens next in Québec will be of

particular significance. Of special note are the recent interventions by the Groupe de réflexion sur le système de santé du Québec, a group of prominent Québec physicians, legal and other academics that has actively weighed into the debated surrounding the Charest government's response to the *Chaoulli* decision. Led by spokesperson and McGill law professor Marie-Claude Prémont, the Groupe de réflexion has argued that the *Chaoulli* judgment has been misread by academic and other commentators outside Québec, and that the Québec government is relying on a similar misinterpretation of the ruling to promote its own privatisation agenda.[82] What Justice Deschamps and the other majority Justices struck down, according to the Groupe de réflexion, was only the ban on private insurance for services delivered outside the public system by non-participating physicians. In the Groupe de réflexion's view:

> The legal structure of Quebec's health care system establishes the complete separation of medical practice between a publicly funded sector and a privately funded one… This boundary is so central and so obvious that the appeal courts did not have to repeat what the trial judge … explained [as] the scope of the lawsuit "The petitioners ask the court to grant them the possibility to purchase private insurance so as to cover inherent costs of health care and hospitalization when such services are provided by doctors who are not participating in Quebec's public healthcare system." Furthermore, Justice Marie Deschamps ... stated explicitly … that she was in agreement with striking down the prohibition against private insurance because, in any case, doctors may not practice on both sides of the fence that separates the publicly and privately funded systems.[83]

In sum, according to the Groupe de réflexion, the Québec government's proposal to allow physicians to provide services in both the public and private systems, thereby violating existing legislative prohibitions against dual-practice[84] that weren't at issue in *Chaoulli*, "is thus simply contrary to the Supreme Court's decision."[85] Rather than promoting further health care privatization, the Groupe de réflexion proposes that the Québec government adopt a series of measures to reinforce the medicare system's primary objective of guaranteeing universal access

to high quality public health care. In particular, the Groupe de réflexion recommends that public insurance coverage be provided for all medically required services, including diagnostic services, whether or not hospital-based; that the current statutory prohibition on dual-practice be maintained; that private fees be limited to the same level charged within the public system; that public hospital facilities be reserved for use by physicians working in the public system; that the current provincial cap on physicians' earnings be lifted in order to encourage physicians to remain within the public system; and that a reliable and transparent waiting-list reporting process be developed and put in place in the province.[86]

Under the umbrella of the Coalition Solidarité Santé, a coalition of Québec community and labour groups has also launched a campaign to pressure the Québec government to respond to the *Chaoulli* decision, not by allowing greater health care privatisation or by invoking the *Québec Charter*'s notwithstanding clause, as the Parti Québécois has demanded,[87] but rather by strengthening the single-payer system in the province.[88] Among the measures being discussed by the Coalition is the entrenchment of an explicit right to health under the *Québec Charter*. This follows upon a recommendation made by the Québec Human Rights Commission in its twenty-fifth anniversary report on the *Québec Charter* in 2003.[89] In particular, the Commission recommended that *Québec Charter* guarantees relating to life, personal security and inviolability be augmented by an express recognition of the right to health. In the Commission's words:

> Dans un contexte où le viellissement de la population, les écarts entre riches et pauvres et les contraintes budgétaires posent des défis nouveaux à un système de santé par ailleurs en crise, la Commission estime que la reconnaissance du droit à la santé pour tous ... représentera une avancée importante sur le plan de la protection des droits de la personne.[90]

Were the *Québec Charter* to be amended, as the Commission proposes, to include an explicit right to health, this would represent a major step forward for the legal recognition of this fundamental social and economic right in Canada, as well a welcome repudiation of the majority of the Supreme Court's "thin and impoverished vision"[91] of the *Québec Charter* and of the right to health in *Chaoulli*.

V. Conclusion

In summary, at the political and health policy levels, the ultimate effects of the *Chaoulli* decision remain to be seen. As for the probable impact of the decision on the future evolution of health care rights under the *Charter*, this is also a matter for some debate. Since the adoption of the *Charter*, right to health claims brought forward under section 7 have fared relatively poorly before the courts. Such claims have been described by governments, including by the Respondents and other governments intervening in the *Chaoulli* case, as economic claims which, by virtue of the *Charter*'s legislative history, are beyond the ambit of section 7 review. As the Attorney General of Québec argued in *Chaoulli*: "l'article 7 ne peut garantir le droit à des bénéfices additionnels de nature économique, même s'ils ont un impact positif sur la qualité de la vie et de la sécurité des individus."[92] For the most part, Canadian courts have agreed, and have rejected the argument that the *Charter* protects individual health care rights on that basis[93].

In contrast, Justice Piché held in *Chaoulli* that: "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."[94] In

upholding Justice Piché's judgment on this point, Justice Deschamps explicitly rejected the traditional view of *Charter* health claims. As she put it: "Limits on access to health care can infringe the right to personal inviolability. The prohibition cannot be characterized as an infringement of an economic right."[95] In fact, Justice Deschamps affirmed what can be read as a positive obligation in relation to health care decision-making. As she asserted: "While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Québeckers right to security."[96]

The Court's decision in *Chaoulli* makes it clear that access to health care, and government decision-making relating to such access, fall directly within section 7 of the *Charter*. This explicit recognition of the constitutional status of a core social and economic right is, I would argue, a positive development in Canadian *Charter* jurisprudence. As Lorne Sossin has speculated:

> ... the decision may yet have a surprisingly progressive influence on *Charter* jurisprudence. By establishing the connection between deprivations of the basic necessaries of life and fundamental rights, *Chaoulli* may well be the first step through the doors left open in *Irwin Toy* and *Gosselin* ... If state obligations to those in need are not foreclosed under the Constitution ... then it is hard to imagine more compelling settings for elaborating such obligations than in the basic need for health care and sustenance of those dependent on state support.[97]

For its part, the minority in *Chaoulli* explicitly reaffirmed that the right to liberty under section 7 of the *Charter* does not include either freedom to contract for private medical insurance or freedom to deliver health care in a private context.[98] The minority did agree with Justice Piché and with the majority that: "the current state of the Québec health system, linked to the prohibition against health insurance for insured services, is capable, at least in the cases of some

individuals on some occasions, of putting at risk their life or security of the person."[99] Unlike the majority of the Court, however, the dissenting Justices factored in considerations of substantive equality in assessing whether Québec's ban on private insurance was in accordance with section 7 principles of fundamental justice. In the minority's view:

> ... we agree with the conclusion of the trial judge and the Quebec Court of Appeal that in light of the legislative objectives of the *Canada Health Act* it is not "arbitrary" for Quebec to discourage the growth of private sector health care. Prohibition of private health insurance is directly related to Quebec interest in promoting a need-based system and in ensuring its viability and efficiency.[100]

As noted earlier, the dissenting Justices also reiterated former Chief Justice Dickson's caution "that the *Charter* should not become an instrument to be used by the wealthy to 'roll back' the benefits of a legislative scheme that helps the poorer members of society."[101] They reminded the majority that "the impugned provisions were part of a system which is mindful and protective of the interests of all, not only of some."[102]

While this view of the *Charter* was shared only by the minority in *Chaoulli*, it represents an explicit and critical acknowledgement of the need to ensure that any newly minted *Charter* rights to health benefit the most, and not just the least, disadvantaged members of Canadian society. Will such a conception of the right to health ultimately prevail in Canadian *Charter* case law? Some would say no. Allan Hutchinson, for example, reads in the *Chaoulli* judgment an end to all *Charter* illusions, or delusions. As he argues:

> The dream – for that was what it was – of the Charter of Rights as something that would be interpreted generously to protect and advance the interests of ordinary Canadians is revealed as little more than, well, a dream and a fantastical one at that ... Any notion of the public or social good has been eclipsed by a privatised vision of social justice in which the privileges of the haves hold the have-nots

> hostage to their own economic freedom ... In terms of winners and losers, it can now be safely concluded that we have managed to craft for ourselves (or, at least, the courts and its apologists have) a screwed up constitution.[103]

In a similar vein, Andrew Petter affirms that: "In rising to new heights of judicial activism, the Supreme Court of Canada in *Chaoulli* has exposed the depth of the *Charter*'s regressive vision of rights."[104]

As the first two sections of my paper describe, an assessment of the majority decision in *Chaoulli* in terms of its contributions to accountability and substantive equality in health care decision-making, most especially from the perspective of the "have-nots", certainly bears out these criticisms. The majority in *Chaoulli* was irresponsible and cavalier in its treatment of the evidence in the case, and it embraced a remedy which, as Colleen Flood has characterized it, promoted the rights of some by worsening the rights of many others.[105] The majority in *Chaoulli* adopted a very narrow definition of the right to health – one which, as I argue above, is profoundly discriminatory and disregardful of international human rights norms. As Sujit Choudhry has aptly commented: "It is impossible to say whether a class bias, unconscious or otherwise is at work. But, as they say in politics, the optics are bad."[106]

Those who agree that *Charter* adjudication "to make a silk purse of social justice out of the pig's ear of the *Charter* ... is in a 'critical condition' and, more to the point, is not worth saving"[107] can certainly rest on their "I told you so"s.[108] As for the rest of us – those of us who remain unwilling to concede that the Supreme Court's *Charter* wrongs must of necessity be conflated with *Charter* rights, there is always comfort to be taken in **my** Irish grandmother's adage:

“giving advice is easier, but picking up a shovel works better.”

Endnotes

1. *Chaoulli v. Québec (Procureur général)*, 2005 SCC 35 [*Chaoulli* (S.C.C.)] at para. 96, rev,g [2002] R.J.Q. 105 (C.A.) [*Chaoulli* (C.A.)], aff'g [2000] R.J.Q. 786 (S.C.) [*Chaoulli* (S.C.)].

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. Martha Jackman, "Section 7 of the *Charter* and Health-Care Spending" in Gregory P. Marchildon, Tom McIntosh & Pierre-Gerlier Forest, eds., *The Fiscal Sustainability of Health Care in Canada: Romanow Papers, Volume 1* (Toronto: University of Toronto Press, 2004) 110 at 133 [Jackman, "Section 7 of the Charter"]. See also Martha Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions Under Section 7 of the *Canadian Charter*" (1995/96) 4:2 Health L. Rev. 3.

4. *Chaoulli* (S.C.C.), *supra* note 1.

5. The CCPI/CHC factum and related documents can be found online: Canadian Health Coalition <http://www.healthcoalition.ca/>. Other *facta*, translations of the lower court decisions in *Chaoulli*, and scholarly commentary on the case can be found online: University of Toronto Faculty of Law <http://www.law.utoronto.ca/visitors_content.asp?itemPath'5/5/0/0/0&contentId'1109>; and online: Trudel & Johnston law firm <http://www.trudeljohnston.com/en/zeliotis/procedures.htm>.

6. *Health Insurance Act*, R.S.Q. c.A-29, ss. 15, 11.

7. Factum of the Interveners Senator Michael Kirby et al., Supreme Court of Canada no. 29282, *Chaoulli v. Quebec (Attorney General)* at para. 16.

8. Factum of the Respondent (Mis-en-cause) Attorney General of Canada, Supreme Court of Canada no. 29282, *Chaoulli v. Quebec (Attorney General)* at para. 50.

9. *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12 [*Québec Charter*]; *Chaoulli* (S.C.C.), *supra* note 1 at para. 45.

10. *Chaoulli* (S.C.C.), *ibid.* at para. 4.

11. *Ibid.* at para. 102.

12. *Ibid*.

13. *Ibid*. at para. 104.

14. *Ibid*. at para. 239.

15. *Ibid*. at paras. 265, 276.

16. For an in-depth discussion of this issue in the context of the *Auton v. British Columbia* case, see Donna Greschner & Steven Lewis, "*Auton* and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82 Can. Bar. Rev. 501.

17. *Chaoulli* (S.C.), *supra* note 1 at paras. 45-49.

18. (Translation) *Ibid.* at para. 44.

19. *Ibid.* at paras. 108-109.

20. *Ibid.* at para. 107.

21. *Ibid.* at paras. 89, 91-93, 95, 101.

22. *Ibid.* at para. 119.

23. *Ibid.* at para. 51.

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

25. *Ibid.* at para. 50 (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.").

26. *Ibid.* at paras. 93, 107.

27. *Ibid.* at para. 263 (Translation: "Il ne faut pas jouer a l'autruche. The creation of a parallel, private health care system would threaten the integrity, the effective operation and the existence of a quality, public health care system in Québec.").

28. *Ibid.* at paras. 267-268.

29. *Chaoulli* (C.A.), *supra* note 1.

30.For an in-depth analysis of this aspect of the *Chaoulli* decision, see: Colleen M. Flood, Mark Stabile & Sasha Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying, and Two-Tier Systems" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 296 [Flood, "Finding Health Policy 'Arbitrary'"].

31. *Chaoulli* (S.C.C.), *supra* note 1 at para. 14.

32. *Ibid*. at para. 64.

33. *Ibid*. at para. 66.

34. *Ibid*. at para. 74.

35. *Ibid*. at para. 83.

36. *Ibid*. at para. 84.

37. *Ibid*. at para. 138.

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

39. *Chaoulli* (S.C.C.), *supra* note 1 at para. 149.

40. *Ibid.* at para. 106.

41. *Ibid.* at para. 152.

42. *Chaoulli* (S.C.), *supra* note 1 at paras. xx.

43. For a critique of this aspect of the decision see Flood, "Finding Health Policy 'Arbitrary'", *supra* note 30; Paul M. Jacobsen, "Single Payer Health Insurance Works Best" (September 2005) Policy Options 57 at para. 62.

44. *Chaoulli* (S.C.), *supra* note 1 at para. 260.

45. *Chaoulli* (S.C.C.), *supra* note 1 at para. 112.

46. *Ibid.* at para. 37.

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

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

49. *Chaoulli* (S.C.C.), *supra* note 1 at para. 230.

50. See Craig Scott's paper in this volume. See also: Charter Committee on Poverty Issues, *Submission by the Charter Committee on Poverty Issues to the Human Rights Committee on the Occasion of the Review of Canada's Fifth Periodic Report Under the ICCPR* (Geneva: October 17 & 18, 2005) at 7-9; Barbara von Tigerstrom, "Human Rights and Health Care Reform: A Canadian Perspective" in Timothy A. Caulfield & Barbara von Tigerstrom, eds., *Health Care Reform and the Law in Canada: Meeting the Challenge* (Edmonton: University of Alberta Press, 2002) 157 at 158-60; Brigit C.A. Toebes, *The Right to Health as a Human Right in International Law* (Oxford: Intersentia, 1999).

51.*International Covenant on Civil and Political Rights*, 16 December 1966, Can. T.S. 1976 No. 47 (entered into force 23 March 1976, accession by Canada 19 May 1976) [*ICCPR*].

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

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

54. *Québec Charter*, *supra* note 9. See generally Mary C. Hurley, *La condition sociale comme motif de discrimination* (Ottawa: Library of Parliament, 2001); Lucie Lamarche, *Social Condition as a Prohibited Ground of Discrimination in Human Rights Legislation: Review of the Quebec Charter of Human Rights and Freedoms* (Ottawa: Canadian Human Rights Act Review Panel, 2000).

55. *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143; *Law v. Canada*, [1999] 1 S.C.R. 497.

56. *Chaoulli* (C.A.), *supra* note 1 at para. 25 (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.").

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58.*Chaoulli* (S.C.C.), *supra* note 1 at para. 274.

59.Robert Dutrisac, "Santé: Charest ouvre la porte au privé" *Le Devoir* (10 November 2005)

online: Le Devoir <http://www.ledevoir.com/2005/11/10/94733.html>; Aaron Derfel, "Public-private split for MD's to spark clash: Quebec plan allows private practice once doctor's public quota filled" *Ottawa Citizen* (11 November 2005) A7.

60. Allison Dunfield, "Klein, Harper discuss private health care", *Globe and Mail* (21 November 2005). See generally Timothy Caulfield & Nola M. Ries, "Politics and Paradoxes: *Chaoulli* and the Alberta Reaction" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 413.

61. Antonella Artuso, "Ontario committed to universal care, premier says" *Ottawa Sun* (10 June 2005).

62. Dennis Bueckert, "Martin defends single-tier health care, despite Supreme Court Ruling" *Canadian Press* (21 June 2005).

63. *Canada Health Act*, R.S.C. 1985, c. C-6. See generally Marie-Claude Prémont, *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); Robert G. Evans et al., *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare?* (Vancouver: University of British Columbia Centre for Health Services and Policy Research, March 2000) [Evans, *Private Highway*].

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66. National Council of Welfare, *The Cost of Poverty* (Ottawa: Minister of Public Works and Government Services Canada, 2001) at 7-8; Dennis Raphael, "From Increasing Poverty to Social Disintegration: The Effects of Economic Inequality on the Health of Individuals and communities" in Hugh Armstrong, Pat Armstrong & D. Coburn, eds., *Unhealthy Times: The Political Economy of Health Care in Canada* (Toronto: Oxford University Press, 2001) 223; 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.

67. Nuala P. Kenny, *What Good is Health Care: Reflections on the Canadian Experience* (Ottawa: Canadian Hospital Association Press, 2002) at 182.

68. See generally the commentaries on the *Chaoulli* case collected in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) [Flood, *Access to Care*] ; Bruce Porter, "A Right to Health in Canada: If You Can Pay for It" (2005) 6:4 Social Rights Review, online: Community Law Centre (University of Western Cape) <http://www.communitylawcentre.org.za/ser/esr2005/2005nov_canada.php>.

69. *Chaoulli* (S.C.), *supra* note 1 at paras. 44-48.

70. See on this issue Charles J. Wright, "Different Interpretations of 'Evidence' and Implications for the Canadian Health Care System" in Flood, *Access to Care*, *supra* note 68 at 220; Steven Lewis, "Physicians, it's in your court now" (29 July 2005) 173(2) Canadian Medical Association Journal Online-1.

71. *Chaoulli* (S.C.C.), *supra* note 1 at para. 217.

72. Romanow Commission, *Final Report*, *supra* note 47 at 143-44.

73. *Mémoire du Procureur général du Québec pour nouvelle audition partielle* at para. 25.

74. *Réponse de l'Intimé le Procureur général du Canada, à la requête du Procureur général du Québec pour nouvelle audition partielle* at paras. 34-35.

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84. *Health Insurance Act*, *supra* note 6 ss. 1, 26, 28, 30.

85. Brun, *supra* note 83.

86. Aaron Derfel, "Group offers health plan alternative", *The Montreal Gazette* (23 November 2005) A6; André Noël, "Les médecins devront choisir leur camp, affirme une spécialiste", *La Presse* (11 November 2005) A11; Groupe de réflexion, *supra* note 82.

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92. Mémoire de l'intimé le procureur général du Québec, Cour suprême du Canada, No. 29282, *Chaoulli c. Québec (Procureur général)* at paras. 131-32. See also Factum of the Attorney General of Canada, *supra* note 8 at para. 23; Factum of the Intervener the Attorney General of Ontario in *Chaoulli v. Québec (Attorney General)* at para. 27.

93. See Jackman, "Section 7 of the *Charter*", *supra* note 3 at 115-16.

94. *Chaoulli* (C.S.), *supra* note 1 at para. 223 (Translation: "If there is no access to the health care system, it is illusory to think that rights to life and security are respected.").

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105. Flood, "Finding Health Policy Arbitrary", *supra* note 30 at 315.

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107. Hutchinson, *supra* note 103 at 115.

108. *Ibid.* at 101, 114.