C A N A D A
PROVINCE OF QUEBEC
DISTRICT OF MONTRÉAL

S U P E R I O R C O U R T

No. : 500-05-035610-979

February 25, 2000

GINETTE PICHÉ J. PRESIDING

JACQUES CHAOULLI, residing and domiciled at 21, Avenue Jasper, Ville de Mont-Royal, district of Montréal, Quebec H3P 1S8 ;

and

GEORGE ZELIOTIS, residing and domiciled at 6481, boul. des Roseraies, city and district of Montréal, Quebec H1M 1T9,

applicants,

v.

ATTORNEY GENERAL OF QUEBEC, having an office at 1 Rue Notre-Dame Est, Bureau #8.00, city and district of Montréal, Quebec H2Y 1B6,

respondent,

and

ATTORNEY GENERAL OF CANADA, having an office at 200 boul. René-Lévesque, Tour Est, 9th floor, city and district of Montréal, Quebec H2Z 1X4,

mis-en-cause.

J U D G M E N T

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INTRODUCTION

"Those who forget history are doomed to repeat it."[1]

"Ignorer le passé, c'est être condamné à le répéter."

The present dispute concerning health and its current accessibility problems sometimes makes us forget the not too distant past, in which people who were sick did not obtain care because they simply did not have the means to do so. In a spirit of generosity and equality, Canadian society has decided that this shall no longer happen.

At the present time, [TRANSLATION] **"the public is expressing increasing concern about the short-term accessibility of health services"**.[2]

This has prompted questions about the public system and the reasons why it might be desirable to have a parallel private health care system.

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1 George Santayana, U.S. philosopher of Spanish origin who died in 1952.
2 Rapport Arpin, July 1999, Bibliothèque Nationale du Québec, p. 3.

Should there be private sources of financing to make good the discrepancies between needs and the government's financial resources? These are political questions which the Court cannot answer. Nevertheless, they were present throughout the discussion in the proceeding before the Court.

The applicants submitted to the Court **a motion for a declaratory judgment** asking it to rule that ss. 15 of the *Health Insurance Act* ("HIA")[3] and 11 of the *Hospital Insurance Act* ("HIA")[4] are unconstitutional. Those provisions prohibit insured services being paid for by private insurance when they are furnished in Quebec. The provisions read as follows:

> **Sec. 15.** No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident of Quebec or to another person on his behalf.
>
> **Sec. 11.** (1) No one shall make or renew, or make a payment under a contract under which
>
> (*a*) a resident is to provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;
>
> (*b*) payment is conditional upon the hospitalization of a resident; or
>
> (*c*) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

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[3] R.S.Q. c. A-29.
[4] R.S.Q. c. A-28.

The applicants asked the Court to be **allowed to obtain a private insurance policy to cover the costs inherent in private health services and hospital services** when the latter are furnished by physicians not participating in the Quebec public health system.

The present dispute has obliged the Court to reflect on what is at stake behind the questions raised. Counsel for the co-applicant George Zéliotis in fact said [TRANSLATION] “I am arguing for the right of more affluent people to have access to parallel health services”. Why could they not purchase private insurance? Why prevent them? – and it may be added that even if such a proposal does not meet with the sympathy of some individuals, it deserves consideration.

First, it should be noted that **not all** the provisions of the *Health Insurance Act* or the *Hospital Insurance Act* are being challenged, just two: ss. 15 (HIA) and 11 (HIA).

According to **Dr. Chaoulli**, these two provisions encroach on federal jurisdiction as their purpose is to prohibit and punish conduct. He spoke of [TRANSLATION] “disguised legislation”, prohibition, misappropriation of power, and said that the legislature has tried to criminalize the conduct mentioned in the disputed provisions. He argued

that these provisions do not logically fall within the scope of regulation of the public health insurance and hospital insurance system. It was in reality for considerations of a moral nature, in that the quest for profit might be a source of abuses, that private hospitals were prohibited. Dr. Chaoulli argued that aside from the créditiste supporters at the time, all the present parties and major union offices vigorously maintained that it would be unacceptable for patients to have greater access to health services by paying a non-participating physician. In his submission, Marxist-Leninist dogmas led to the egalitarian ideology that now exists and the adoption of the *Health Insurance Act* was adopted in these circumstances.

Further, according to Dr. Chaoulli, non-access is an obstacle to, and leads to situations inconsistent with, human dignity. He said he had been the victim of cruel and unusual treatment. [TRANSLATION] “Mental anguish” is cruelty, he said. As a physician, he related that he had gone so far as to endanger his own life by a hunger strike, and was seeking no economic advantage for himself, but referred to his code of medical ethics which required him to promote the availability of medical services.

The **co-applicant George Zéliotis** argued that it is clear that ss. 11 and 15 infringe s. 7 of the Charter, the right to life, liberty and security. People cannot have access to medical services within a reasonable time in Quebec, and he submitted that this infringes their

rights. He argued that the Act reflected a search for egalitarianism. In his view, ancillary economic rights were at issue here and the Supreme Court has not completely closed the door to such protection. The true purpose of the Act was to prohibit socially reprehensible profit-making. Finally, he submitted that the two provisions were not necessary in order to meet the conditions of access.

Were the applicants right to thus [TRANSLATION] "denounce" being unable to obtain private insurance? – and what about people who suffer lengthy delays before being operated on or, for example, receiving their chemotherapy treatments? Is all this not cruel? Will problems be solved by cutting away at the Canadian health system, the philosophy and principles of which, as we shall see, are altruistic and generous? Are the disputed provisions contrary to the principles of the Charter and would their disappearance lead in the more or less short term to the weakening and death of our present health system?

The Court will **first** identify the questions raised by this motion for a declaratory judgment. **Secondly**, the Court will consider the evidence submitted by the applicants and the respondents. We will examine the testimony of the many expert witnesses heard. Finally, and **thirdly**, the Court will answer the questions raised. Let us turn to our analysis and look at the questions raised by the applicants.

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1. QUESTIONS RAISED

Question one concerns the **criminal law: are ss. 15 and 11 not sections dealing with the criminal law and are they not contrary to ss. 26 of the *Health Insurance Act* and 6 of the *Health Services and Social Services Act*? It was submitted that this was not regulation but prohibition.**

Question two is as follows: **does the prohibition from obtaining a private insurance policy infringe the rights guaranteed by s. 7 of the Canadian Charter (right to life, liberty and security) and the rights protected by ss. 1, 4, 5, and 24 of the Quebec Charter?**

Question three is as follows: **is the prohibition from obtaining private insurance not cruel and unusual treatment within the meaning of s. 12 of the Canadian Charter, as being contrary to the equality right protected by s. 15 of the Charter?**

Those are the questions raised by the applicants.

* * *

PART I

II. EVIDENCE

(A) APPLICANTS' TESTIMONY

(1) Account by George Zéliotis

It should be noted at the outset that it appeared from Mr. Zéliotis's testimony and the review of his medical file that Mr. Zéliotis did not really undergo all the problems and delays he alleged in his motion. Mr. Zéliotis is a man 67 years of age. The last few years of his life have not been easy. After working for Canadian Chemicals for 33 years he found himself unemployed, had to be treated for depression in March 1993, suffered a heart attack and had to be treated by the psychiatrist Dr. Vacaflor and by the cardiologists Dr. Schlezinger and Dr. Latter. In January 1994 the cardiologist Dr. Schlezinger recommended heart surgery. Mr. Zéliotis was operated on by Dr. Latter on March 24, 1994. Serious hip problems appeared in June 1994. He was seen by Dr. Yeardon. As it is this whole question which is the essence of Mr. Zéliotis's complaints, it is important to see exactly how he was treated by the health system.

(a) First hip operation

Mr. Zéliotis was examined by Dr. Yeardon on June 23, 1994. He was then referred by his family physician Dr. Giannakis to Dr. Fisher, an orthopedist, who saw him on January 10, 1995 (Exhibit I-26). On January 11 Dr. Fisher made his recommendations. Mr. Zéliotis

himself hesitated: “I wanted a second opinion”. On February 28, 1995 Dr. Fisher saw him and announced that he was not an ideal candidate for an operation. On March 27 Mr. Zéliotis went to the emergency department. On April 11, Dr. Fisher saw him again. On May 18, 1995 Mr. Zéliotis was operated on for an arthroplasty of the left hip.

(b) <u>Mr. Zéliotis's other problems</u>

Between July 1995 and December 1996 Mr. Zéliotis consulted a number of people. In January 1996 he fell on his shoulder, in April he was operated on for a hernia, in February 1997 he met with Dr. Fisher, who decided that he should have an operation on his right hip. On September 4, 1997 an operation was finally performed on his other hip.

(c) <u>Discussion</u>

Mr. Zéliotis initiated a media campaign denouncing the delays in the health system. The truth is that, bearing in mind his personal medical obstacles, the fact that he was already suffering from depression, his indecision and his complaints which in many respects were unwarranted, it is hard to conclude that the delays that occurred resulted from lack of access to public health services, and in fact even the complaints made about the delays by Mr. Zéliotis may be questioned.

It was he who initially wanted a second opinion, it was his surgeon who hesitated because of his problems, and so on. Accordingly, his complaint to the director of professional services at the Hôpital Royal Victoria (Exhibit R-16) was not corroborated. An out-of-court examination made in connection with another case is puzzling: Mr. Zéliotis said he was in good health (Exhibit I-7, tab G); and so on.

It is possible to sympathize with Mr. Zéliotis, to understand the pain and anguish he felt, but one cannot conclude that the problems and delays he speaks of were solely caused by problems of access to Quebec health services. At the same time, the Court acknowledges that despite the fact that his medical file is not entirely conclusive he has an "interest" in the broad sense in bringing the instant proceedings. So far as he was concerned, he had real problems getting an operation and this caused him suffering. He felt he would have had better access if there were a private system. We cannot say this is true, but it is his opinion and he is entitled to it.

(2) <u>Account of Dr. Jacques Chaoulli</u>

(a) <u>Who is the applicant and what did he say?</u>

Dr. Chaoulli is 47 years old and obtained his doctorate in medicine in France. He is an immigrant and came to Quebec in 1977, first doing an M.Sc. in education at Laval University. He was denied the

opportunity to do his internship in medicine in Quebec because of the quota.

In early 1985, he was finally accepted at the Hôtel-Dieu in Québec and in 1986 obtained his licence to practise medicine in Quebec, after returning to France and practising there for eight months. When he came back to Quebec in 1986, he had as a completely new physician to practise for three years in a remote area from 1986 to 1989. He worked for two years at the Pontiac Hospital in Shawville. However, after two years he returned to Montréal. He explained his departure by saying that it was the director of professional services who released him after two years, telling him that he should not bill the RAMQ in an urban area for a year.

In June 1988 he went to the Montréal South Shore, working in emergency services for eight years. He obtained an emergency vehicle licence and created his own “Médecins à domicile Rive-Sud” service in 1991. He had difficulty recruiting physicians and realized it was impossible for him to offer a twenty-four-hour service to the South Shore area. He related that the LCHC and the Longueuil police often called on his services.

Dr. Chaoulli wanted recognition for “Médecins à domicile Rive-Sud”. He received some support but ran into a major problem: the refusal of the Régie régionale to recognize his services.

In January 1995 he organized a public demonstration with fifty of his patients in Québec to explain to the Minister the importance of recognizing house calls with twenty-four-hour service. [TRANSLATION] “I was not doing this for the money”, he said, “I was afraid I would no longer be able to provide this service”. The service made it possible to relieve the pressure on hospital emergency departments, he said. [TRANSLATION] “I was worried about the harmful consequences of the situation for my patients and my family”, he said.

Dr. Chaoulli described what he called the [TRANSLATION] “stages in my struggle”. “The Fédération des médecins did not support me”. “I tried to describe the patients’ situation.” In December 1994 he was seen in the office of the Minister, Hon. Rochon. He said he tried to explain his house call activity which he thought was essential. [TRANSLATION] “My problem”, he said several times, “was not primarily the question of the financial penalty. What I wanted was recognition of this house call service for the public. I experienced mental anguish”, Dr. Chaoulli said. [TRANSLATION] “I could have followed the system, I could have joined an LCHC team, but even those doctors could not make house calls”. “It was in fact the LCHCs which sent me the urgent calls so I could handle them.” There was no health emergency service

on the South Shore, there was a service that existed only for Montréal and Laval. One was urgently needed, he said.

In May 1996 he met with Dr. Raynald Dutil, who was then president of the Fédération des médecins ominipraticiens. He said the latter [TRANSLATION] “recognized that my activities were essential but told me that doctors did not want to go back to before 1970, when they were making house calls”. In June 1996 he received an initial financial penalty notice from the RAMQ and said that was when he realized there was no more hope. [TRANSLATION] “I had”, he again said, “a serious psychological trauma, not because of the financial aspect but because of the fact that the public could not have services at home. I felt a profound loss of esteem. I found it unfair that I could not give the public essential services”. It was in these circumstances that he took the decision by himself to initiate a hunger strike and claim, first, recognition of this activity, and secondly, a moratorium on the penalties. [TRANSLATION] “The hunger strike reflected my profound despair”, he said. “It was a serious psychological trauma for me”. When he said these words, Dr. Chaoulli had tears in his eyes.

He even said that the presence of his wife and daughter, who was five years old at the time, could no longer compensate for the problems he was having. [TRANSLATION] “I decided I would no longer

live in a society where the government was so inhumane." The hunger strike, he said, "was one reason I did not commit suicide. I knew that my life was threatened, that human lives would be threatened because of the inaction and refusal of the government".

In his opinion, not recognizing a house call service is criminal: human lives could be lost. At the end of the second week of his hunger strike he had himself taken to the Hôtel-Dieu in Québec to be rehydrated. He refused all food. He was sent to a psychiatrist, Dr. Anne Potvin, who found that he was rational. In the third week of the strike he went back to Parliament Hill to continue his strike. A verbal proposal was made to settle the financial penalty he had incurred in return for an end to his hunger strike. He refused: [TRANSLATION] "The proposal made was unacceptable". At the end of the third week, passers-by asked him to halt his strike. He finally agreed and decided to get out of the public system and try to set up a private service hoping that private insurance would get involved [TRANSLATION] "I wanted to provide medicine for everyone, I thought the government would agree".

On October 9, 1996 his status as a non-participant began. He decided to go to France and met there with a representative of the SAMU. [TRANSLATION] "I wanted to see the latest developments in pre-hospital services in France". When he got back to Quebec, he advertised his services as a non-participating physician. He tried to make himself available 24 hours a day and operate an ambulance vehicle with

rooflights and a siren. He had to have a licence. The Régie Régionale refused to give him the licence. He made house calls, and found that it was mostly wealthy people who called him. [TRANSLATION] “That is not what I was looking for”, he said.

He subsequently contacted Hon. Dingwall, to whom he proposed a private non-profit hospital. “I even suggested donating my already equipped emergency vehicle”, he said. On August 15, he received a reply from Hon. Allan Rock, who told him that his proposal was contrary to Canadian values. Canadians did not want a two-tier system. On August 8, he made a request to the Régie Régionale to be allowed to set up a private opted-out hospital. On March 19, 1998 he was again met with a refusal. The Régie did not recommend Dr. Chaoulli’s proposal.

Since January 1997, he said, [TRANSLATION] “I have significantly reduced my home medical practice. After Christmas 1997 I slowed down, I did not feel comfortable, either in the public or the private sector”. For fifteen months he withdrew and reduced his practice. “I devoted my efforts to analysing the situation in Canada, the U.S. and Japan so I could be more useful to people.” He became a participant once more in July 1998.

Since January 1997, by his own admission, he has considerably reduced his medical activities. He returned to the public system to operate a drop-in clinic.

He now says he feels great concern if he or his family were to fall ill. Dr. Chaoulli would like to obtain private insurance that could give him access to medical services and says he feels profound anguish that he cannot obtain private insurance.

As a citizen he wishes to be allowed to pay a non-participating physician, if he so desires, for medically necessary service in a private non-convention hospital. He wishes to be allowed to obtain private insurance for access to pre-hospital emergency service, including airborne medical assistance (a helicopter) if necessary, from a private insurance source. [TRANSLATION] “In the event that I fall seriously ill”, he concluded, “I want to be able to use my personal wealth to save my life rather than spend it on my funeral”.

That is the gist of the testimony heard.

(b) <u>Discussion</u>

The Court first notes that a significant portion of Dr. Chaoulli’s testimony dealt with the following question: **should there be a house call emergency service with an emergency vehicle equipped**

with a siren and rooflights? Perhaps there should, but it is not for the Court to answer this question. Additionally, **Dr. Chaoulli is currently facing significant penalties for not complying with the RAMQ regulations: could this have influenced his crusade?** Further, if Dr. Chaoulli really **wants to make house calls, what prevented and still prevents him from doing so?** Some physicians are still doing so now. Confronted as we know with all the emergency problems in Montréal, in 1988 Urgences-Santé was created to suggest new rules for ambulance transport in Quebec by limiting the ambulance service by a non-profit corporation to the metropolitan Montréal area.

On the South Shore, where Dr. Chaoulli practised, there was no ambulance service such as Urgences-Santé. What Dr. Chaoulli wanted was to create such a service. The Régie Régionale refused to give him a licence to do this. When he was asked why he could not nevertheless continue making emergency calls, Dr. Chaoulli was less persuasive. [TRANSLATION] “I cannot make ‘emergency calls’ without rooflights and a siren”, he said.

The Court questions such a response and cannot help raising questions about the **requirements** and **realism** of the **applicant, whose statements sometimes indicated a degree of emotionalism which is bound to seem strange**.

At the outset Dr. Chaoulli had to complete his initial contract in a remote region. He did not do this: he returned to Montréal and, contrary to what he was entitled to do, began practising on the South Shore. He then insisted on practising medicine as he wanted to do, disregarding what was decided by the Régie Régionale. Dr. Chaoulli also never testified that he received inadequate care or that the system did not respond to his personal health needs. He is still subject to significant penalties with the Régie de l'assurance-maladie of Quebec. He was released, returned to the public system, was still not satisfied. All of this leads the Court to raise questions about Dr. Chaoulli's real motives in this dispute. One cannot help being struck by the contradictions in the testimony and having the impression that Dr. Chaoulli embarked on a crusade which is now more than he can handle.

(B) TESTIMONY OF SPECIALIST PHYSICIANS

(1) The applicants called five specialist physicians: **Dr. Éric Lenczner**, orthopedic surgeon in Montréal, **Dr. Côme Fortin**, ophthalmologist in Granby, **Dr. Daniel Doyle**, a surgeon and cardiologist in Québec, **Dr. Abdenour Nabid**, an oncologist in the Centre communautaire de l'Estrie and **Dr. Michael Churchill-Smith**, an internist in Montréal. All these physicians testified about the problems they had, about excessively long waiting lists, operation delays, the efforts they made every day to try and solve problems, to try and find solutions for the lack of system, organization and, shall we say, vision in the present-day Quebec Régime de santé.

Dr. Lenczner spoke of “huge problems in terms of access” for orthopedic surgeons which, even if they are not [TRANSLATION] “fatal”, are very incapacitating for those who can no longer walk, work and enjoy a normal life. Dr. Lenczner does not have enough time for operating at the hospital where he practises. He could operate on more patients if he was given more surgery time.

Dr. Fortin, an ophthalmologist, spoke of people who have cataracts, for example, who can no longer see properly and whose wait for surgery is greatly affecting their quality of life. Because of the nature of the disease, he said, waiting may even result in loss of vision. He had one day a week for operating himself, but this was not true of all his colleagues. He admitted that certain patients, doctors’ children, and so on, were sometimes favoured. Nowadays, [TRANSLATION] “people have expectations, they want to be independent, they no longer want to wait”, he said.

Dr. Doyle is a thoracic and cardio-vascular surgeon and has been president of the cardio-vascular and thoracic surgeons of Quebec for five years. He now operates at the Hôpital Laval in Québec. He worked at the Hôpital Notre-Dame for ten years, now the CHUM, and is currently in Québec as he can have the desired operating time. He spoke of the priorities now existing for patients. Dr. Doyle explained that

in 1992 there were two thousand patients on the waiting lists but the situation has improved considerably, as the government increased facilities in fall 1997. He spoke of surgeons trained in Quebec who had left for Ontario or the U.S., and the aggressive recruiting that takes place. [TRANSLATION] “Here we quickly become exhausted”. He said that Quebec patients are all very easygoing. They do not complain of having to wait, people accept it, they tell themselves that they have no choice. Dr. Doyle said that waiting should not exist in cardiology, that it is often a question of life or death, as cardiac illness is unpredictable. There is also a lack of nurses, erratic decisions which are made and so on. Despite the funds that private foundations are prepared to give, he cannot go ahead with certain projects because the government is not ready to invest for start-up and follow-up costs. [TRANSLATION] “There are a lot of political factors, we are five years behind Ontarians”, he said. “Practising becomes demotivating”. At the same time, Dr. Doyle admitted that waiting exists everywhere. The population is growing older, it is now necessary to operate on people 85 years old. Dr. Doyle was not at all certain that the solution lay with private insurance. He related how, for example, insurance companies monitor patients who have operations with particular surgeons in the U.S., and so on.

Dr. Nabid was somewhat more pessimistic. He is a specialist in radio-oncology and has been president of the Quebec radio-oncology specialists for four years. He said there is a lack of planning. Waiting lists have existed for several years. As we know, the population

is growing older. There is a lack of technicians, a lot of pressure, a lack of equipment and of updating of equipment. [TRANSLATION] “Something is not working in the system when we have to send patients to Plattsburg”. He said one has to [TRANSLATION] “put oneself in the patients’ place, when they have been devastated by news of cancer”. For cancer patients, no delay is acceptable. [TRANSLATION] “We are dealing with human beings”. Like Dr. Doyle, he said that Quebecers are extremely likeable and easygoing people. Nevertheless, there should not be delays, he said.

Finally, **Dr. Churchill-Smith** testified. He is an internist, teaches at McGill and worked for ten years in the emergency department as a physician and department head at the Montréal General Hospital. Dr. Churchill-Smith has visited emergency departments in several countries, including France, where the approach is completely different from our own. There they have mobile emergency units which go to the patient. Currently, he said the government is studying various scenarios to find a solution. Money could be obtained from foundations to purchase helicopters, for example, if the operating costs could be guaranteed by the government.

(2) *DISCUSSION*

The Court concludes from this testimony, first, that the **physicians who testified were sincere and honest**, wished to change things and unfortunately were powerless in view of the excessively long waiting lists. The Court accepts that waiting lists are too long and that even if the question is not always one of life or death all individuals are entitled to receive the care they need as promptly as possible. Yes, Quebeckers are patient and easygoing, but this does not mean that the health system should not be improved and transformed. Dr. Nabid even spoke of his profession as a sacred trust.

Further, the Court notes that despite the fact that some of these specialists indicated a desire to be free to obtain private insurance, no one completely and squarely supported the applicants' proposals, explaining that it was neither clear nor obvious a reworking of the system with a parallel private system would solve all the existing problems of delays and access. On the contrary, the specialists heard remained very cautious about a question which is complex and difficult.

(C) OTHER TESTIMONY

(1) Barry Stein, Dr. André Roy

Among all the other witnesses heard there was the moving testimony of Barry Stein, a lawyer suffering from cancer whose sad story has been in the headlines.

Mr. Stein related the events that occurred after his illness was diagnosed. He said he went to the CHUM, the Hôpital St-Luc, and recounted that his surgery was postponed three times.

Mr. Stein said he went to the hospital to be operated on and was told that the operation would not take place that day. Finally, he decided to go and have an operation in New York. He contacted the Régie de l'assurance-maladie, which refused to pay for his surgery and hospitalization in New York. He went to court and obtained a judgment in his favour, ordering the RAMQ to pay his costs.

However, **Dr. André Roy** was the surgeon at the Hôpital St-Luc (CHUM) who saw Mr. Stein and his testimony was not to the same effect. It may be noted that Dr. Roy was not called as a witness in Mr. Stein's action against the Régie de l'assurance-maladie du Québec. Dr. Roy gave the Court a different story from that provided by Mr. Stein. According to him, Mr. Stein's surgery only had to be postponed once and he could have been operated on the following week. Dr. Roy testified with aplomb and sincerity, giving various explanations about what happened to Mr. Stein, his patient, at St-Luc. What should we think of this? The Court remains uncertain as to what actually happened in this case. At the very least, the story is not conclusive.

(2) Dr. Photios Giannakis, Marc Poulin, the coroner Pierre Carrier, Andrée Laberge

Dr. Photios Giannakis testified. He was Mr. Zéliotis's family physician and it was he who referred him to the specialist Dr. Fisher. He confirmed the problems his patient had and it was he who referred him to Dr. Vacaflor for depression. The Court considers that his testimony corresponds to his conclusions about Mr. Zéliotis's medical history. Another witness, Marc Poulin, a businessman dealing with helicopters, related that in 1987 and 1994 a helicopter ambulance project was proposed to the Government of Quebec but there was no further action despite the support of physicians and the support of the Hôpital de l'enfant-Jésus in Québec.

Mr. Poulin said that ten thousand lives a year could be saved in terms of sequelae, morbidity and days of hospitalization. The coroner Pierre Carrier confirmed that the system would be effective and appropriate for areas which are difficult of access and would suit the territory of Quebec. Andrée Laberge, of the Quebec Direction de la santé publique, explained (R-40) that delays vary greatly from one hospital to another and there was no doubt that risk increased with the delays incurred.

(3) Claude Castonguay

At the request of the applicants Clause Castonguay, Quebec Minister of Health in 1970, the "father of health insurance in Quebec" and chair of the Castonguay Commission of Inquiry on Health and Social Welfare, testified. He testified with aplomb and restraint. Mr. Castonguay first noted that the purpose of the health insurance legislation adopted on November 1, 1970 was to give all individuals equal access to health care regardless of their income. He still supports that objective.

Mr. Castonguay explained that, however, in 1970 Quebec was in a period of prosperity and it was thought that this would continue. Quebec's debt was small, income from taxation was good. The aim of health insurance was to provide equal access to care for everyone. Nowadays, he explained, the situation has changed, public finances have deteriorated and the population has grown older. Despite this, the fundamental purpose of the plan should not change, Mr. Castonguay insisted. Instead, **new solutions** should be found for the health system. Mr. Castonguay said that he had never advocated what Dr. Chaoulli was advocating. In his opinion, the Quebec health system should remain public and accessible to the entire Quebec population. To do this there would have to be a new partnership with physicians, better organization of medical clinics and new investment in the health sector. According to

Mr. Castonguay, a lot could be done to improve the present situation without adopting the solution advocated by the applicants.

Mr. Castonguay referred to the 1999 World Health Report (Exhibit I-17), which the Court feels may appropriately be considered here.

(4) WHO World Health Report 1999

The report by the World Health Organization is titled “Making a Difference” and examines the situation in the world at the present time.

This report results from the meeting of world Health Ministers and other leaders in Geneva in May 1999 for the last meeting of the World Health Assembly before the year 2000. Let us look at the statements by Dr. Brundtland, **director general of the WHO**:

> The world enters the 21st century with hope but also with uncertainty.
>
> . . . . .
>
> With vision, commitment and successful leadership, this report argues, the world could end the first decade of the 21st century with notable accomplishments.
>
> . . . . .

An historic conference in Alma-Ata in 1978 established the goal of Health for All by the year 2000. It defined this goal as **"the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life"**.[5]

To do this, it will be necessary:

. . . to develop more effective health systems.

. . . . .

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

. . . . .

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

This report advocates a "new universalism" that recognizes governments' limits but retains government responsibility for leadership, regulation and finance of health systems. The new universalism welcomes diversity . . . **At the same time it recognizes**

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[5] *World Health Report 1999, "Making a Difference", World Health Organization,* message by Director General, pp. vii and viii.

> **that if services are to be provided for all then not all services can be provided. The most cost-effective services should be provided first. The new universalism . . . entrusts the public sector with the fundamental responsibility of ensuring solidarity in financing health care for all**. It further calls for a strategic reorientation of ministries of health towards stewardship of the entire system through participatory, fair and efficient regulation.
>
> (Emphasis by Court.)

Three reports have had a profound influence on health systems around the world. The Alma-Ata Declaration was the first international model of a health system providing universal coverage.

(1) First there was the **Flexner Report** (U.S., 1910). There was concern at the time about the proliferation in North America of poor quality medical training programs. Since that report, the national standards imposed for admission to medical school have required four years' post-secondary training and the choice of a scientific study program lasting four years.

(2) The second report was the **Dawson Report** (U.K., 1920). This report described a district health service system based on general physicians and health centres, in which difficult cases were sent to university hospitals through first and second level health centres. Planning was based on the entire population of an area. These ideas influenced the development of local health systems for the rest of the century.

(3) Third, the **Beveridge Report** (U.K., 1942). This report was used as the justification and model for the welfare state in the United Kingdom after the war. This is what Dr. Coffey referred to in his testimony and a large part of which can be found in his report. The Beveridge Report used various state welfare programs and charitable organizations to develop a modern universal social protection

> system in which risks are shared by the entire population. The report served as the basis for the United Kingdom National Health Service created in 1948.

The **Alma-Ata Declaration** (1978) was adopted by the International Conference on Primary Health Care. It was intended by the report to give all peoples of the world a level of health by the year 2000 that would permit them to lead a socially and economically productive life.

At p. 33, the WHO report poses the fundamental question: **where do the values of WHO lead when combined with the available evidence?** The answer is given:

> **They lead away from a form of universalism that has governments attempting to provide and finance everything for everybody. This "classical universalism", although seldom advanced in extreme form, shape the formation of many European health systems. It achieved important successes. But classical universalism fails to recognize both resource limits and the limits of government.**
>
> *The findings also lead away from market-oriented approaches that ration health services according to the ability to pay*. Not only do market-oriented approaches to finance lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate them to be inefficient as well. . . . Health is an important component of national welfare. Achieving high health outcomes requires a

> combination of universal entitlement and tight control over expenditure.
>
> *This report advocates a "new universalism" that recognizes governments' limits but retains government responsibility for the leadership and finance of health systems*. The new universalism welcomes diversity and, subject to appropriate guidelines, competition in the provision of services. At the same time it recognizes that if services are to be provided for all then not all services can be provided. . . . The new universalism recognizes private providers as an important source of care in many countries: welcomes private sector involvement in supplying service providers with drugs and equipment; and it encourages increased public and private investment in generating the new drugs, equipment and vaccines that will underpin long-term improvements in health.
>
> . . . . .
>
> Efficiency concepts in health systems apply at several different levels. "Macroeconomic efficiency" refers to the total costs of health care in relation to aggregate measures of health status.
>
> . . . . .
>
> "Microeconomic efficiency" refers to the scope for achieving greater efficiency from existing patterns of resource use. Wastage and inefficiency occur in all health systems. Allocative inefficiency occurs when resources are devoted to the wrong activities.[6]
>
> (Emphasis by Court.)

According to the Report, the lesson to be drawn from the development of health systems in the 20th century is clear:

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[6] *Ibid.*, pp. 33-34.

> . . . spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met . . . Public intervention is necessary to achieve universal access. In any country, the greatest burden of ill-health and the greatest risk of avoidable morbidity or mortality are borne by the poor. While progress towards universal access to health care of an acceptable quality has been substantial in this century . . . the distribution of services in most countries of the world remains highly skewed in favour of the better-off. While the equity arguments for universal public finance are widely accepted, what is less well know is that this approach achieves greater efficiency as well.[7]
>
> **The market response to a user-fee based system is through the development of private insurance. Insurers see a profitable opportunity. People pre-pay through insurance premiums, so that they do not have to live with unpredictably large health care bills. This method of financing entails some pooling of risks among the insured, but creates access inequities between the insured, who will get preferential access to better care, and the non-insured. Experience with health insurance markets shows that they are both unstable and difficult to regulate, with each insurer constantly adjusting the risk profile of the beneficiary group in order to ensure that revenues are greater than expenditures.**[8]

The Report concludes that the key design features for progress **to a new universalism in health are the following**:

- **Membership is defined to include the entire population, i.e. it is compulsory.**

- **Universal coverage means coverage for all, not coverage of everything.**

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[7] *Ibid.*, p. 37.
[8] *Ibid.*, p. 41.

- **Provider payment is not made by the patient at the time he or she uses the health service.**

- **Services may be offered by providers of all types.**

And the following conclusion is reached:

> **To select key interventions and to reorient health services towards entire populations combines universalism with economic realism.**[9]

This leads us to examine the testimony of the other expert witnesses presented to the Court by the applicants, the Attorney General of Quebec and the Attorney General of Canada. Let us see what they said.

(D) EXPERT WITNESSES: THEIR OPINIONS AND VIEWPOINTS

The Court should first say that it felt privileged to have heard such remarkable men. They all contributed greatly to the Court's analysis. It should be recalled, and we tend to forget this, that in Canada before the introduction of health insurance the situation was not a rosy one. There are those who will say that it is no better now, but this assertion can be seen to be clearly false when we really look back.

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[9] *Ibid.*, p. 46.

A. Dr. Fernand Turcotte

Dr. Fernand Turcotte[10] first noted that health services and their provision have long been part of the field of social security. In fact, he said:

> [TRANSLATION]
>
> . . . the promotion of social security nearly always begins with health programs designed for the most vulnerable sub-groups of the population: the mentally ill, orphans and abandoned children, vagrants, the blind and elderly people without dependants.
>
> . . . . .
>
> In the early 1920s, it was recognized that illness had become the primary cause of the impoverishment of Canadians by the unemployment nearly always resulting from serious illness and by the using up of the family resources unavoidably resulting from the payment for care.[11]

Nowadays, Dr. Turcotte said, [TRANSLATION] "**people are no longer impoverished because they have to go to hospital**". In the mid-1960s, this was not the case. A person who was ill and was admitted

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[10] Fernand Turcotte is a physician and professor in the Faculty of Medicine at Laval University, holding degrees from the University of Montréal and Harvard, a specialist certified by the Royal College of Physicians and Surgeons of Canada, specializing in community medicine, and an Associate Member of the College. Dr. Turcotte is also the recipient of the De Fries medal, awarded for exceptional service to the public health of Canadians, in 1998. He is the author of a number of publications and research reports.

[11] Fernand TURCOTTE, *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé du Canada*, Department of Social and Preventive Medecine, Faculty of Medicine, Laval University, November 1998, p. 4.

to a private room might after 30 days find himself or herself in a public room in unsatisfactory conditions because he or she could no longer pay for the room. A woman who had to go to hospital to give birth could be faced with a bill for $5,000. Accordingly, costs had to be paid until Saskatchewan, Alberta and British Columbia decided to adopt a hospital insurance system. **Subsequently, in Quebec, people also wanted to have their own system and decided that they could afford one**. It was necessary to acquire universal insurance, transferable from one province to another. The provision of health services could not be viewed like the production of “jalopies”: planning was needed, Dr. Turcotte said. This implied rationing and distributing available resources. In fact, all countries ration them. In the U.S. it is by inability to pay, in the Soviet Union [*sic*] by hostile reception, and in Canada there is a waiting period after an initial rapid contact. In Quebec, physicians are relied on to manage waiting lists. Has the time come to give guidelines to physicians? Dr. Turcotte said that we must realize that all societies are faced with rationing.

It may be asked, Dr. Turcotte said, why participation in insurance has to be made compulsory. To this he replied:

> [TRANSLATION]
>
> Because in all societies there is always a part of the population which does not insure itself against the risks inherent in illness. Six groups of people make up this fraction: the poor, the chronically ill and the handicapped, those who are “difficult to insure”, those

> who do not believe in the value of health services, those who like living dangerously and opportunists.[12]

In Canada, the choice has been made to protect society against the catastrophe caused by illness by making insurance available to everyone, subsidizing those who could not pay for it and making participation compulsory for everyone.

> [TRANSLATION]
>
> This strategic choice frees insurance from the obligation to constantly adjust the prices of its services to its claim experience. The compulsory participation of all guarantees that the effect of bad actuarial risks will be minimized in the larger number of good risks which it is possible to assemble in a society. It also permits a saving to be made on all the costs inherent in advertising and continual recruiting of participants. This in part explains the tremendous administrative effectiveness of our health care system, the cost of managing which is nearly four times less than in the U.S.[13]

In his report Dr. Turcotte noted that the Royal Commission on Health Services, presided over by Emmet Hall J., was organized in 1960 **to determine whether the country's health services could respond to individual needs once financial accessibility to medical care** was guaranteed and to identify what needed to be added in order to make them able to cope, if problems were anticipated.[14] In 1964, the Hall Commission concluded that Canada could offer all its citizens protection

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[12] *Ibid.*, p. 10.
[13] *Ibid.*
[14] *Ibid.*

against catastrophe resulting from illness without affecting existing health services.

> [TRANSLATION]
>
> It recommended using types of insurance designed in the manner of a social security program rather than a system of protection against disaster as provided in commercial insurance. Accordingly the Hall Commission objectives recommended including in a medical insurance program:
>
> - **universal coverage;**
> - **protection against all medically required services;**
> - **transferability of benefits from one province to another;**
> - **management of the system by public non-profit organizations.**[15]
>
> (Emphasis by Court.)

The Hall Commission concluded that instead of nationalizing all health services, it would only be necessary to alter the financing system. In fact, in its mandate the Hall Commission had to find alternative means for correcting the deficiencies of the existing health services program. The mandate was based on the Canadian Health Charter proposed for adoption by the Royal Commission on Health Services.

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[15] *Ibid.*

A. Dr. Howard Bergman

Dr. Howard Bergman[16] dealt with expectations for health care and said it was necessary to remember the basic assumptions that existed when public systems were introduced, from the first by Bismarck in 1883 to the most recent in the early 1970s. During that period, he said:

> [TRANSLATION]
>
> . . . it was considered that by making an initial investment to remove the financial obstacle to health care, the health of the population would be greatly improved. Still more the desire was to direct citizens to hospitals, which from their concentration of expertise were seen as the ideal consumption points. It was thought that the costs initially incurred by universal access would "naturally stabilize", so that part of the investment would be gradually recovered.[17]

This expectation proved to be unfounded.

> [TRANSLATION]
>
> Nowadays, it is assumed that demand is almost limitless or at least exceeds what any Western society is prepared to invest. **The fact is that the question of cost control has put itself on everyone's agenda since the late 1970s**.[18]

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[16] Howard Bergman is a physician and a director of the geriatrics department at the Montréal General Jewish Hospital. At McGill University he is director of the geriatrics division and associate professor in the department of medicine and family medicine. He is a fellow of the American Geriatric Society and an associate professor of the University of Montréal, in the health administration department. He has prepared and participated in many publications and conferences.

[17] Howard BERGMAN. . .

[18] *Ibid.*, p. 4.

At the present time, Dr. Bergman said, **overall expenditure control has become a subject of great concern**. Canada is not the only country where this is happening. Thus, for example, in the U.S. the major concern is still overall expenditure, even though over 50% is private. At the same time, [TRANSLATION] "when a public system like our own is placed alongside the system of the former communist bloc, the comparison is ridiculous".[19]

He noted that:

> [TRANSLATION]
>
> **Currently the Quebec health care system is one of the systems in which the private share is the largest.** Over 30% of expenditure is private in Quebec, a proportion which has become one of the highest in the OECD.
>
> . . . . .
>
> For the essential portion of medically necessary services, the Quebec health care system relies on a single payer and single management in which private participants are involved. Access is not based on the ability to pay.[20]

Dr. Bergman voiced his concern at the erosion of the role of the government as single payer. **Opening financing up to private sources would lead to a multi-speed system depending on the type of insurance each person could afford.**

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[19] *Ibid.*, p. 5.
[20] *Ibid.*, p. 6.

> [TRANSLATION]
>
> The unity of powerful social groups which enjoy alternatives will be reduced. There will be services for the poor only, or "services designed only for the poor will be almost inevitably be low in quality and will not receive the political support necessary for adequate provision" (p. 73, 1993 World Bank World Development Report).[21]

In fact, in all countries, whether health systems are more or less private, there are always three types of concern: 1. cost or cost control; 2. the quality of care; and 3. accessibility.

Without private financing, deficiencies in the ability to have access to care will tend to vary inversely with needs.

Dr. Bergman said that "handicapped" persons might be excluded, as in Switzerland where, for example, mutual insurance companies have withdrawn from the poorest cantons. In cases where there are two systems, the public one becomes a "safety net" where private hospitals transfer the worst economic risks.

> [TRANSLATION]
>
> In Manitoba, it has been shown that health care providers who serve both private and public clientele give priority to the former, thereby lengthening the waiting period of patients in the public sector. France is also experiencing a similar situation, when "cases" are seen as financially more advantageous. Once again, the

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[21] *Ibid.*, pp. 6-7.

> U.S. may serve to illustrate the extreme situations that can occur. Hospitals there have two waiting rooms, the first serving private patients who “go through” at once, the second being reserved for “Medicaid” patients, who are poor and have public coverage: these patients are served “otherwise” and act as a reservoir when the first waiting room empties, so as to absorb overhead.[22]

Dr. Bergman related that already certain insurance companies are installing their offices on the second floor, with no elevator, to avoid having elderly or ill persons going to their offices to make insurance claims. On the second floor, it is thus possible to avoid applications by people who are short of breath or suffering from orthopedic problems. The insured must be young and in good health. What will happen to people who have AIDS or are suffering from heart ailments? The private system will make a hip replacement, but it is the public system which will cope if there are complications, Dr. Bergman said.

What must be done **is to introduce the dynamism of the private sector into the public systems**. [TRANSLATION] “The intention is that the choice of users should ‘pressure’ the systems”.[23]

Dr. Bergman admitted that changes connected with current reforms **have prompted a feeling of insecurity in the minds of the public**. The introduction of privatization (priority access depending on

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[22] *Ibid.*, p. 8.
[23] *Ibid.*

ability to pay) will not necessarily provide the answers sought, Dr. Bergman said. Thus, the clinical quality of care will tend to deteriorate for those remaining in the public system. The costs of administering the system will increase and accessibility will gradually be controlled and restricted by bureaucratic measures. There will be the "healthy" and the "wealthy", Dr. Bergman said. The truth, in fact, is that there will never be any "free lunch".

According to Dr. Bergman, the solution advocated by Dr. Chaoulli is an illusion. Control of expenditure will always be a major concern both for the government and private insurers. In the U.S., 39% of the population has no coverage. Social unity will be shaken, whereas today there is equity not based on the ability to pay. Will those who are going to pay for private insurance want to pay for the public system? In Dr. Bergman's opinion, **our organization method** must be changed.

B. Dr. Charles J. Wright

Dr. Charles J. Wright,[24] another expert witness heard by the Court, noted that the values underlying the Canadian health care

[24] Charles J. Wright is a physician specialized in surgery. He is a director of the Centre for Clinical Epidemiology, Evaluation at the Vancouver Hospital, Health Sciences Centre Faculty Member at the University of British Columbia and of the British Columbia Office of Health Technology. He was professor of surgery at the University of Saskatchewan and Head of the General Surgery at the Saskatchewan University and Hospital. He has given a large number of presentations at local, national and international meetings on Canadian health management.

system are, *inter alia*, **universality**, **transferability** and **accessibility**. At p. 2 of his report, he explained that:

> Uniquely among developed nations, Canadians decided that equity was a very high level value and consequently the Canadian system imposes controls on the establishment of privately financed health care systems for necessary medical services, although provincial legislation on this issue varies in detail. It is also very important to note that these values and principles have been repeatedly endorsed over the last two decades by the Canadian people.
>
> The Canada Health Act was a seminal piece of legislation defining the values on which the system would be built, expressly seeking equity and social justice and denying priority access to health care services by ability to pay.[25]

Dr. Wright said that our health care system is one of the most effective in the world in terms of "ratio of productivity to administrative costs". The Court feels that it must look here at what Dr. Wright said about the introduction of a private system alongside the public system.

> **Once again the experience is contrary to the blandishments of those wishing to permit physician access to an alternative private system. The 'cream skimming' that goes on in the United States proprietary hospitals and in the health care insurance industry in the USA is well recognized. Certain occupations are blacklisted, and high-risk patients often refused coverage completely.** In the hybrid system these costs would of course be borne by the public sector. In Britain, where there is no legal impediment to access to public or private systems, the private hospitals are definitely not the preferred place of

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[25] Charles Wright, "Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services", report prepared for the Department of Justice, Canada, October 26, 1998.

> treatment for complex or risky surgery or serious illness. They rarely have students or residents, nor do they have a full range of complex supporting services. In another analysis it was noted that for-profit hospitals do not provide care anymore efficiently or with greater public benefit than do nonprofit institutions, but they definitely distort service delivery patterns. They siphon off high revenue patients and vigorously try to avoid providing care to patient populations who are a financial risk. In the 1991 prestigious Shattuck lecture, Dr. Arnold Relman, the editor of the New England Journal of Medicine, stated that '. . . the investor owned hospitals did not use their alleged corporate advantages for the public benefit. In fact, by seeking to maximize the revenues and avoid uninsured patients, they contributed to the problems of cost and access our health care system now faces'.[26]

In fact, Dr. Wright said:

> . . . the existence of a dual system permits some insurance companies, business investors,and health care providers **to reap more profit on the basis of the lower acuity level of the services that they provide**. This shifts the overall load on the public system to the more complex high acuity end of the health care spectrum with consequent increased rather than decreased demand in the public system for certain services.[27]

In concluding his report, Dr. Wright explained that:

> The principal argument for permitting a second tier private alternative system, namely that this would cause better overall access to care and relieve pressure on the

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[26] *Ibid.*, p. 17.
[27] *Ibid.*, p. 18.

> public system, **is not supported by any data**. The information and studies compiled **here suggest the opposite, namely that the major effect of allowing a private alternative would be to shift energy and resources from the public system into the private system, causing deterioration of public system access**. This would only be to the advantage of those who could afford to pay or to purchase additional private health care insurance.[28]

According to Dr. Wright, as a society we are capable of introducing the reforms now needed without rejecting the important principles of universal access that underlie our health care system.

C. Prof. Jean-Louis Denis

Prof. Denis[29] explained that the health system must be regulated to ensure its development with the other areas of governmental intervention. Accordingly to Prof. Denis, there is simply no health system in which no form of rationing applies.[30] [31]

> [TRANSLATION]
>
> In the case of the American health system, rationing operates primarily by cost. Additionally, the health management system known as "managed care" is

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[28] *Ibid.*, p. 24.

[29] Jean-Louis Denis is a doctor in community health, "health services organization" specialty, from the University of Montreal. He has impressive professional experience and is an associate professor at the University of Montréal. He has a number of publications and research documents to his credit in the field of health and is a member of the American Public Health Association, among others, the Academy of Management and so on.

[30] R. Klein, (1992) "Dilemmas and Decisions", *Health Management Quarterly*, vol. XIV, Mo. 2:2-5.

[31] R. Klein, (1994) "Can we Restrict the Health Care Menu?", *Health Policy*, vol. 27: 103-112.

> subject to the exercise of significant controls over the medical profession.[32]
>
> . . . . .
>
> In such a system, insurers must apply strict controls to maintain the cost of acceptable benefits for businesses which pay a large part of the cost of insurance premiums.[33]

The question of waiting lists is a thorny question in our health system.

> [TRANSLATION]
>
> This is a form of rationing which weakens public confidence in our system.[34]

Prof. Denis noted that the health system is an **important community asset**:

> [TRANSLATION]
>
> It was created to enable everyone to have access to medical care and to protect individuals from the insecurity and uncertainty that may result from illness. It also helps to promote a certain image of life in society based on the principle of common interest.[35]

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[32] Jean-Louis Denis, "Un avenir pour le système public de santé", University of Montréal G.R.I.S., November 16, 1998.
[33] *Ibid.*, p. 12.
[34] *Ibid.*, p. 13.
[35] J. March, J.P. Olsen (1995), *Democratic Governance*, New York, The Free Press.

. . . . .

> The solution contemplated to remedy these evils was of course privatization of the system, that is deregulation in favour of private corporate and economic interests. The legitimacy of this type of solution derives largely from a process of idealizing the American health system. That system, like our own, has to cope with implicit forms of rationing. The American health system is organized to distribute the resources devoted to health not to all individuals but in terms of the recipient's ability to pay.[36]

In the U.S. context, he explained that the system of "managed care" operates at the expense of the quality of service offered to patients. The "managed care" system is in general a great success, but the problem is that patients seem to detest the system.[37]

> [TRANSLATION]
> . . . this system is considered non-competitive and is subject to administrative costs much greater than those of the Canadian health system.[38]

He said that in order to begin resolving the problems with our health system new types of organization and incentive must be introduced.

According to Prof. Denis, the ideal of community responsibility **must continue to be supported rather than defending a rule of individual responsibility for care**. In fact, Prof. Denis explained

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[36] J.-L. DENIS, *supra*, note 32, p. 15.
[37] *Ibid.*, p. 16.
[38] *Ibid.*, p. 17.

that there is more private financing in Canada than in many OECD countries. He said people should be wary of propositions which may lead to the destruction of the health system.

Prof. Denis concluded his report as follows:

> [TRANSLATION]
>
> The political struggle taking place around the preservation or overthrow of the fundamental principles of the public health system is thus critical for the development of our society. It has to do with our ability to maintain an original but fragile social development model in the North American economic and political context. In all these discussions, we must also think about the part played by such community institutions in building social order. An increasing number of analysts of contemporary society see institutions with a community function as an important catalyst for the smooth operation of a society and the reduction of conflicts and tensions. **At the present time, we can assume that the public health system contributes positively to the structure of our society and its sound operation.**[39]

D. Prof. Theodore R. Marmor

The Crown called Prof. Theodore R. Marmor,[40] who is an expert on health systems with a worldwide reputation.

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[39] *Ibid.*, p. 24.

[40] Theodore M. Marmor is professor of Public Policy and Management, School of Management, Yale University Professor of Political Science, Department of Political Science and Institution for Social and Policy Studies, Yale University, Ph.D. from Harvard university, in Politics and History, Graduate Research Fellow from Oxford. He is the author of books and edited volumes on health care reforms and has been an expert witness in numerous hearings in the United States and Canada and overseas.

Prof. Marmor was asked the following question: ***"What would be the likely effects of permitting a parallel, private, regulated health insurance system to develop in Canada, one which would be permitted to pay for core services, now covered under the Canada Health Act, and accompanying provincial legislation?***"

He answered as follows, at p. 3 of his report:

> I do not believe it plausible that a private, parallel system of health insurance could be instituted in Canada without a number of undesirable side effects. By undesirable side effects I mean decreased support for Medicare from crucial groups of Canadian citizens, increased cost pressures on both systems, and increased administrative costs that regulating private insurance requires . . .
>
> 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. On the analogy of 'gains from trade,' the assumption is that Canadians willing to pay for private coverage can exit the public system, free up space in waiting lists thereby . . . The implicit assumptions behind this latter optimistic claim are that regulation can prevent the private system from growing too rapidly and that, given such constraints, a [*sic*] exit of anyone from the public insurance waiting lists must improve the chances to get care for Canadians left on those lists.
>
> This 'win-win' theory has a surface plausibility and, in some special contexts, might suggest a reasonable course of action. However, a closer examination reveals its theoretical and empirical flaws . . .[41]

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[41] Theorodore R. MARMOR, "Expert Witness Report", November 9, 1998, pp. 3-4.

Prof. Marmor added:

> Doubts about the plaintiffs' assumptions are not only based on theoretical concerns. There is also considerable empirical basis for such skepticism. My studies of health care and financing systems in the OECD countries provides [*sic*] real world demonstrations of the dynamics that might well occur in Canada if a parallel system of private insurance were permitted to develop. In France, for example, there is continuous dispute about the role of cost sharing by patients in restraining demand for services in a fair and effective way.[42]

Prof. Marmor then addressed the argument of waiting lists. The argument is as follows, Prof. Marmor explained:

> There are waiting lists in Canada. If some of those on waiting lists made private arrangements for care at their expense (but eased by insurance options), and there were no change in Medicare, everyone would be better off. Those who jumped queues would be better off, as would the health care professionals who provided their care and received income. But even those remaining on queues would benefit, since the queues would be shortened. And so, why not permit this change?[43]

Prof. Marmor **explained that it is completely mistaken to think that there would be no change in our health system if a**

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[42] *Ibid.*, p. 4.
[43] *Ibid.*, p. 5.

parallel private system were allowed to develop. He explained his conclusions as follows:

> . . . waiting lists would persist in the public sector, and perhaps lengthen, as the number of patients in that system declined, since fewer hospital beds and professional staff would be serving them. (If resources were not diverted from the public system, unit costs would rise as fewer patients were treated in the same facilities, and new resources would be needed to service the private sector, increasing total Canadian spending on medical care.) Furthermore, the argument takes for granted that privately funded services can be organized as "free-standing units". Otherwise, such privately funded services would be unfairly subsidized by past and present public investment in research, capital improvements, and the easy availability of well-equipped modern hospitals.
>
> Thus I believe that allowing private insurance to be available as an alternative to Medicare would have profound negative impacts on the public system rather than none as is assumed. It would not increase availability of services in the public sector or reduce waiting lists. Instead, it would divert resources from the publicly financed program to be available to private activities and it would increase total Canadian expenditures on health. It also would give those able to secure private coverage an advantage over others.[44]

Having a parallel private insurance system would produce substantial changes and damage the health system in Canada. In addition to the argument of fairness, therefore, there is this second argument. At p. 6 of his report Prof. Marmor said:

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[44] *Ibid.*, pp. 5-6.

> There are in fact several additional reasons why a parallel private health insurance system would not leave Medicare unaffected: first, as explained in the 'Exit, Voice, and Loyalty' reasoning introduced earlier, those who would exit (or could afford to exit) would no longer have as strong a stake in the public health insurance system; second, unless it led to a cutback of service in the public system, private health would increase overall health spending, and third, the management and regulation of the combined health insurance system would be significantly complicated, leading to additional administrative costs.

Among other things, the support given to the public system in Canada would **erode**.

> It is axiomatic that those who exit a public system no longer have as strong a stake in its effective operation. This, in turn, can and frequently does lead to an erosion of public support. An examination of regulations and policies governing health care in OECD countries provides useful illustrations of this axiom.[45]

There are cases, as in the United Kingdom or Australia, where a country has what may be called "double-cover health insurance". What is meant by this is that persons who leave the system and pay for private insurance continue to pay for public insurance. Prof. Marmor also said that:

> In this setting, either support for the public system erodes or the private market requires extensive

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[45] *Ibid.*, p. 6.

regulation and subsidy or, even with subsidies and regulation, the private health insurance fails to develop sensibly.[46]

This is what has happened in Australia:

Australia stops its insurers from charging the elderly more than younger people with the predictable result that older people are buying the policies and younger people are not. The Australian government is now offering younger people large subsidies – up to 30% of premiums – to switch to private insurance, but there are few takers. Younger people tend not to need the queue-jumping, non-emergency health care that is the main attraction of Australia's private insurance. What they want most is cover in an emergency – which the state health-care system provides free.[47]

The Australian experience, Prof. Marmor said,

. . . illustrates the difficulties with double coverage arrangements. The ban on age-rating (requiring a common premium) is an example of governmental unwillingness to bear the consequences of unregulated commercial insurance. The wealthy and older are those most able and inclined to exit a public system, but their expected use of a new privately insured system would produce prohibitively high premiums without regulation. With rate regulation, the government removes the core mechanism of private commercial insurance: namely risk rating. Consequently, the young and the healthy who would be most drawn to inexpensive, private insurance stay away from Australia's community-rated arrangements. More generally, where willingness to exit depends on income and health status, unregulated, private insurance markets cannot offer an alternative to public pooling of risk that is or has been acceptable to most OECD industrial democracies.

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[46] *Ibid.*, p. 7.

[47] "A Survey of Social Insurance", *The Economist*, October 24, 1998, p. 18.

. . . . .

> In the Canadian case, exiters would still be paying for public health insurance and thus would have a financial stake in reducing its funding. It is also the case that those who exit would be more likely to be affluent. As such, they a) have political influence disproportionate to their numbers; and b) currently finance a disproportionate share of Medicare, and would therefore have an especially strong interest in restraining its budget. From a social insurance standpoint, this degree of financial redistribution is fair, a mechanism for separating the provision of needed care from the financing of that care. But the expected impact of such a parallel system in Canada, given its current arrangements, would be an *erosion* of support, not its augmentation.[48]

There will also be an increase in "health costs". Prof. Marmor said:

> . . . what is proposed for Canada is not a cost-*reducing* innovation, but a cost-*shifting* program. And it is one that on the arguments proposed would almost certainly inflate overall Canadian health expenditures.

. . . . .

> Finally, Canada now has what health economists metaphorically term 'single pipe' financing for basic medical care. The dominant view of health economists is that such funding with a global budget offers greater cost control.[49]

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[48] T. MARMOR, *supra*, note 41, pp. 7-8.
[49] *Ibid.*, p. 9.

Finally, **the health system** will be increasingly complex, as will regulatory and administrative costs.

> . . what we have called 'double coverage' arrangements inevitably raises complex regulatory matters.
>
> . . . . .
>
> Private health insurance and public health insurance follow . . . 'different principles and a different logic'. Private insurers have to react to market forces and, as with risk rating, exclusions of pre-existing conditions, and similar practices, they contend with adverse selection and moral hazard. To make such private insurance operate in a socially acceptable manner, governmental regulation is required . . . Experts agree that Canada's administrative costs are the lowest of the OECD countries. Any complication of that system will necessarily increase those costs.[50]

Prof. Marmor concluded his report by saying:

> **Finally, the grounds used to bolster the arguments for parallel insurance are uniformly weak empirically . . . Indeed, it is the stability of Canadian public health insurance, not its instability, that is the striking finding of comparative health policy research**.[51]

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[50] *Ibid.*, p. 10.
[51] *Ibid.*, p. 13.

E. Dr. J. Edwin Coffey

Finally, the applicant's expert witness, Dr. J. Edwin Coffey,[52] testified.

Dr. Coffey submitted a voluminous report and testified at length. At p. 37 of his report he explained what he meant by the reform he was advocating:

> . . . By structural reform, I mean a change in the method of financing and delivering health care and health insurance services, from an integrated system like the Quebec one ("système intégré") to a system based on contracting ("système du contrat") or to a system based on reimbursement ("système du remboursement") . . .[53]
>
> . . . . .
>
> In Quebec efficiency will only be reached after the government decides to introduce a health care system based on contracting or reimbursement. (p38).[54]

Dr. Coffey testified at length on **the situation in the OECD countries** (Organization for Economic Cooperation and Development).

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[52] J. Edwin Coffey is a graduate of McGill University in medicine specialized in obstetrics and gynecology. Fellow of the Royal College and of the American College of obstetricians and gynecologists. Established his practice in Montréal. Was Associate Professor in the Faculty of Medicine at McGill University. Interested in the political, economic and legislative affairs of the health care system since 1979. Served on the Executive Committee of the Council of Physicians and Dentists at the Montréal General Hospital and became ex-officio member of the Board of Directors. Director of the Montréal District Executive of the Quebec Medical Association.

[53] *Ibid.*, p. 37.

[54] *Ibid.*, p. 43.

His conclusions compared the situation in Quebec and Canada with that of certain OECD countries.

In his view:

> The deteriorating health care and health insurance systems in Quebec and Canada are out of step with the health systems in other OECD countries. Quebec and Canada have failed to appreciate and apply many of the benefice [*sic*] public and private health system policies and reforms that the citizens of these OECD countries enjoy.
>
> . . . In comparison to the health systems of all other OECD countries, and pointed out by the OECD reports, the unique and outstanding disadvantage that handicaps the health system in Quebec and Canada is the legislated prohibition of voluntary private health insurance and private hospital services that are medically necessary.
>
> . . . . .
>
> The ideologic and politically driven myths, that surround the Quebec and Canadian health systems, have overshadowed and presented [*sic*] evidence-based and practical reforms in the financing, insuring and delivery of medical and hospital services and have contributed to the dysfunctional state of our present health system . . .

The Court notes that in his expert opinion and the conclusions at which he arrived, Dr. Coffey stood alone.

Before concluding, the Court should note that it felt it advisable to review here the gist of the testimony given by the

experts heard. It quickly appeared to the Court that the issues were much broader than those discussed and it was the whole question of introducing a private health system parallel to the public system that was discussed by the applicants. In the circumstances, it became essential to look at both sides of the coin and see what the various experts heard in the course of the trial thought about it.

* * *

It is now time to answer the questions raised.

PART II

III. QUESTION ONE

(A) PARTIES' ARGUMENTS

Question one concerns the **criminal law**. The applicants submitted that ss. 15 and 11 are provisions relating to the criminal law and are contrary to ss. 26 of the *Health Insurance Act* and 6 of the *Health Services and Social Services Act*. **The applicants submitted that this is not regulation, but prohibition**.

For her part, the Attorney General submitted that a law is not criminal simply because it contains a prohibition, makes non-compliance an offence and imposes a penalty on the offender. Section 92(15) of the *Constitution Act, 1867* authorizes the provinces to prohibit the commission or omission of certain acts subject to penalties.

Legislation will be criminal in nature only if its primary purpose is to prohibit and punish conduct which by its nature affects the social order or has a harmful effect on the public.

In the Attorney General's opinion, prohibiting the obtaining of a private insurance policy to cover the costs inherent in private health and hospital services, pursuant to ss. 15 of the HIA and 11 of the HIA, is not of this nature.

This prohibition is not designed to penalize conduct which is socially reprehensible as such. Its purpose is rather to bring about a state of things which falls exclusively within the jurisdiction of the province, namely the creation of a hospital insurance and health insurance program.

(B) DISCUSSION

(1) Principles

As we know, in Canada we live under a federal system made up of two levels of government. The legislative powers set out in the Constitution allow governments to legislate over certain very clearly defined areas, those described in ss. 91 and 92 of the *Constitution Act, 1867*.

It is true that both levels of government must observe the limits of the powers conferred on them by the Constitution. Legislation which is not consistent with the distribution of powers principle will be *ultra vires* and will be ruled invalid by Canadian courts.

Having said that, it should be borne in mind that any legislation adopted by the federal government or by a province benefits

from a presumption of validity.[55] In other words, the Court must regard legislation as valid in terms of the distribution of powers until the contrary is proven by whoever argues that it is invalid. Whoever alleges that legislation is *ultra vires* thus has the burden of proof.

Analysis of the legislative provision itself is undertaken in two stages.

The first stage involves **identifying the subject-matter dealt with by the disputed legislation**, and the second **associating this subject-matter with one of the heads of jurisdiction set out in the *Constitution Act, 1867***.

In the words of Prof. Peter W. Hogg:

> **For purposes of analysis it is necessary to recognize that two steps are involved: the characterization of the challenged law (step 1) and the interpretation of the power-distributing provisions of the Constitution (step 2)**.[56]

It is the generally the first stage, that of determining the subject-matter, which will have the greatest impact on the validity of the

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[55] Peter W. HOGG, *Constitutional Law of Canada*, Toronto, Carswell, 1997, pp. 396-397; *Nova Scotia Board of Censors v. McNeil*, [1978] 2 S.C.R. 662, at 687-688 (Ritchie J.); *Severn v. The Queen* (1878), 2 S.C.R. 70, 103 (n-vidi); *Reference re The Farm Products Marketing Act*, [1957] S.C.R. 198, at 255 (Fauteux J.).

[56] P.W. HOGG, *Constitutional Law of Canada*, *op. cit.*, note 3, p. 382.

legislation. Classifying the provision thus takes on critical importance in any analysis involving the distribution of powers.

To classify the subject-matter dealt with by a statute, the Court must focus on identifying its principal objective.[57] In general terms, the Court must determine what the statute relates to. Various terms are used for identification here: for example, the courts speak of a statute's true nature, its general scope or its "**pith and substance**".[58]

This concept is clearly explained in *Ville de Val-D'Or*:[59]

> [TRANSLATION]
>
> The question of the validity of legislation in relation to the distribution of powers essentially raises the problem of how they should be classified in terms of the powers conferred by the Canadian Constitution on one or other of the two levels of government. A search for the true nature of the disputed legislation involves identifying the subject-matter to which it essentially relates. This classification is made in terms of the real purpose of the legislation or regulation, not its declared or apparent purpose.[60]

The Court must identify the true nature of the statute:

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[57] Henri Brun and Guy Tremblay, *Droit constitutionnel*, 3d ed., Cowansville, Éditions Yvon Blais, 1997, pp. 461 *et seq.*;P.W. Hogg, *Constitutional Law of Canada*, *op. cit.*, note 3, p. 383 *et seq.*; André Tremblay, *Droit constitutionnel: Principes*, Montréal, Éditions Thémis, 1993, pp. 266 *et seq.*

[58] See *Union Colliery v. Bryden*, [1989] A.C. 580, 587 (n-vidi).

[59] *Ville de Val-D'Or v. 2550-9613 Québec Inc.*, [1997] R.J.Q. 2090 (C.A.).

[60] *Ibid.*, 2094 (Chamberland J. A. for the Court).

> [TRANSLATION]
>
> . . . essentially the question of the validity of legislation raises the problem of classifying it in relation to the heads of jurisdiction conferred on the federal government and provinces respectively. The cardinal rule in classifying legislation in this regard is that of its "true nature".[61]

The Supreme Court has many times held that it is necessary to determine the true nature of the statute before ruling on its constitutional validity.[62]

It is thus this true nature that will be used in assessing the validity of a statute in terms of the constitutional distribution of powers.

This concept of the true nature or real scope is all the more important as legislation may often more or less incidentally affect several areas at the same time.[63] The fact remains that **only the true nature of the statute will affect its validity in terms of the distribution of powers**.

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61 H. Brun and G. Tremblay, *Droit constitutionnel*, *op. cit.*, note 5, p. 461.

62 *Lord's Day Alliance*, [1959] S.C.R. 497, at 503 (Kerwin J.); *R. v. Swain*, [1991] 1 S.C.R. 933, at 998 (Lamer J.); *RJR-MacDonald Inc. v. Canada (A.G.)*, [1995] 3 S.C.R. 199, at 241 (La Forest J.); *Nova Scotia Board of Censors v. McNeil*, *supra*, note 3, at 695 (Ritchie J.); *Ville de Val-D'Or v. 2550-9613 Québec Inc.*, *supra*, note 7, at 2094.

63 H. Brun and G. Tremblay, *Droit constitutionnel*, *op. cit.*, note 5, pp. 462-463; *Schneider v. The Queen*, [1982] 2 S.C.R. 112, at 143 (Estey J.).

The best illustration of this can be seen in analysis and comparison of *R. v. Big M Drug Mart*[64] and *R. v. Edwards Books*.[65] Those two cases concern, *inter alia*, the validity in terms of the distribution of powers of legislation prohibiting businesses from opening on Sundays. In *Big M*, the *Lord's Day Act*[66] dealt with the closing of businesses on Sundays for religious reasons. The Supreme Court of Canada held that it was *intra vires* the federal Parliament by virtue of its criminal law power[67] since its purpose was to promote respect for the Sabbath. In *Edwards Books*, on the other hand, the *Retail Business Holidays Act*[68] was held to be *intra vires* the province of Ontario because it was enacted for the secular purpose of providing uniform holidays for retail workers and so fell within s. 92 of the *Constitution Act, 1867*. The purpose of each statute thus determined its validity in terms of the distribution of powers.

Accordingly, the Court must seek to determine the principal purpose of the disputed legislation rather than aspects of it which are only of an incidental nature. **It is the primary purposes of the Act which will determine its validity in terms of the distribution of powers, not its incidental consequences**. As Profs. Brun and Tremblay explain:

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64 [1985] 1 S.C.R. 295.
65 [1986] 2 S.C.R. 713.
66 R.S.C. 1970, c. L-13.
67 *Constitution Act, 1867*, 91(27).
68 R.S.O. 1980, c. 453.

> [TRANSLATION]
>
> . . . One must look at what the statute relates to, not what it affects. In other words, to determine the true nature of a statute one is concerned only with the field to which it essentially applies, not taking into account any field it may incidentally affect.[69]

Once the subject-matter of the Act is identified, the Court then only needs to associate it with one of the heads of jurisdiction mentioned in the *Consitution Act, 1867*, to finally determine what level of government has jurisdiction in the matter.

(2) Application

Let us now apply these principles and see what the true nature of the legislation at issue is.

2.1 Real nature of legislation

At first sight, **the HIA is a statute designed to set up a public health service system available to all Quebec residents**.

To clarify the reasons for the adoption of this statute, the courts have held[70] that it is possible to refer to extrinsic evidence. Sopinka J. makes this point in *R. v. Morgentaler*:[71]

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[69] H. Brun and G. Tremblay, *Droit constitutionnel*, *op. cit.*, note 5, p. 463.

[70] *Re: Anti-inflation Act*, [1976] 2 S.C.R. 373, at 437 *et seq.*, (Ritchie J.); *R. v. Morgentaler*, [1993] 3 S.C.R. 463, at 483-84 (Sopinka J.); *RJR-MacDonald Inc. v. Canada (A.G.)*, *supra*, note 10, at 242-244 (La Forest J.).

[71] *Ibid.*

> **In determining the background, context and purpose of challenged legislation, the court is entitled to refer to extrinsic evidence of various kinds provided it is relevant and not inherently unreliable: *Reference Re Residential Tenancies Act, 1979*, [1981] 1 S.C.R. 714, at p. 723, *per* Dickson J. This clearly includes related legislation . . . and evidence of the "mischief" at which the legislation is directed: *Alberta Bank Taxation Reference*,[72] *supra*, at pp. 130-33. It also includes legislative history, in the sense of the events that occurred during drafting and enactment; as Ritchie J., concurring in *Reference Re Anti-inflation Act*, *supra*, wrote at p. 437, it is "not only permissible but essential" to consider the material the legislature had before it when the statute was enacted**.[73]

Prof. Hogg offers the following comment:

> **. . . since 1976 the permissive rule has become firmly established. Legislative history is now routinely admitted for the three purposes described in the previous paragraph [including analysis of validity in terms of the distribution of powers]. All categories of legislative history are admissible, including parliamentary debates (Hansard)**.[74]

Let us therefore look at the explanatory notes accompanying the HIA when it was adopted:

> **Explanatory notes**

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[72] [1939] A.C. 117 (P.C.).
[73] *R. v. Morgentaler*, *supra*, note 18, at 483-484.
[74] P.W. Hogg, *Constitutional Law of Canada*, *op. cit.*, note 3, p. 1387.

> [TRANSLATION]
>
> **The purpose of this proposal is to create a health insurance system in Quebec whereby the cost of medical services, oral surgery in a hospital and optometric services mentioned in the bill will be paid pursuant to the provisions of the Act and Regulations by a public body already established with the name of the Régie de l'assurance-maladie du Québec.**
>
> **Everyone residing in Quebec may benefit from this system.**
>
> . . . . .
>
> **Private health insurance plans will become obsolete in so far as they offer the same services as the Quebec plan; if a private plan provides other services, it will remain in effect for those other services . . .**

It can thus be said that the HIA **was designed to make health services available to everyone**. The apparent controlling purpose was thus the **availability of care**.

Let us now look at the provision in dispute in the case at bar.

> **Section 15 HIA**
>
> **Coverage under contract of insurance prohibited.**
>
> **15. No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is**

> **furnished or under which all or part of the cost of such a service is paid to a resident of Quebec or to another person on his behalf**.

What is prohibited by s. 15 HIA is any private insurance contract in so far as it applies to the same services as those insured by the public system. **Section 76 HIA provides for the imposition of a fine** in the event of non-compliance.

The effect of this provision is to discourage the development of a private parallel health system, in view of the costs relating to care and the impossibility of obtaining insurance for it. Only people who have the means to do so could make use of the private system.

The following question thus arises: **why did the Quebec legislature adopt this provision? What is its real meaning?**

Dr. Chaoulli argued that the HIA was inspired by the Marxist-Leninist thinking popular in the mid-twentieth century. In his view, the public health system reflects that philosophy in its egalitarian nature, guaranteeing access to care for all Quebecers.

Dr. Chaoulli further argued that the purpose of the HIA was not only to create a public health service system, but also, through s. 15 HIA, the abolition of any parallel private health system. Section 15, he maintained, is so restrictive that it constitutes disguised legislation for the purpose and effect of preventing the existence of a private system and the making of a profit.

According to Dr. Chaoulli this prohibition of a private system is even prompted by moral considerations. The prohibition contained in s. 15 reflects the Quebec's government feeling that it is immoral to pay for health care.

Dr. Chaoulli asserted that since the prohibition in s. 15 was prompted by such considerations, it is not constitutionally valid. In his submission, it is a provision that falls within the criminal law and only the federal government may legislate in this area.

In support of his arguments he referred, *inter alia*, to *Henry Birks and Sons Ltd. v. City of Montréal*,[75] *Switzman v. Elbling*[76] and *Westendorp v. The Queen*.[77]

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[75] [1955] S.C.R. 799.
[76] [1957] S.C.R. 285.
[77] [1983] 1 S.C.R. 43.

In *Birks* the Supreme Court held that a statute adopted by the Quebec legislature was *ultra vires*. The legislation in question delegated to municipalities the power to adopt by-laws ordering that stores be closed on certain dates corresponding to Roman Catholic religious festivals. The true nature of the statute was identified as promoting the observance of religious festivals,[78] and as such was within Parliament's jurisdiction over the criminal law.

In *Switzman*, the Supreme Court struck down a Quebec statute the purpose of which was to prevent the propagation of communist ideas in Quebec and to punish those who engaged in such activity.[79] A majority of the Court held that the statute was within the criminal law field.

Westendorp concerned the validity of a provision contained in a municipal by-law dealing with street use. The provision in question prohibited solicitation for prostitution purposes and was found by the Supreme Court to be *ultra vires*. The Court considered that it was not logically part of street regulation but was actually intended to penalize prostitution and so was within the field of the criminal law.

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[78] *Supra*, note 23, at 807 (Fauteux J.)
[79] *Supra*, note 24, at 288 (Kerwin J.)

In these cases, the Supreme Court of Canada thus struck down the provincial statutes in question as their purpose was actually the prohibition of criminal conduct. The applicant's argument in the case at bar is to the same effect.

The Court does not agree with the reasoning put forward by Dr. Chaoulli.

First, whether the HIA was inspired by Marxist-Leninist ideas or not is not of any particular relevance. The Court must limit itself to identifying **the identifiable purposes of the statute so as to determine its validity in accordance with the constitutional distribution of powers**.

It is clear that the Quebec government intended to promote the health of its population by establishing a public health service system open to everyone. This implies that the public system should be able to offer quality services. To achieve this end, the government had to provide a system that would prevent the loss of a significant part of health resources to the private sector. The viability of the public system depended on the availability of health resources (personnel, equipment and so on) to the population as a whole. The purpose of s. 15 HIA is to guarantee this availability by significantly limiting the availability and profitability of the private system in Quebec.

The Court further considers that **s. 15 HIA is not in any way disguised legislation for the purpose of implementing Marxist-Leninist policy and excluding any capitalist or other concepts**. The real scope of the HIA is to create and regulate a comprehensive public health system and s. 15 contributes to attaining those purposes. It is a measure adopted by the National Assembly to provide all citizens with an optimal health plan.

Accordingly, a distinction must be made with *Birks, Switzman* and *Westendorp* because in those cases the legislation was truly “criminal”, whereas in the case at bar s. 15 HIA is a logical part of the regulation of the public health system.

As to the HIA, this legislation is designed to create a public system for financing hospital services in Quebec. The purpose of this statute is the regulation of hospitals. Section 11 of the Act prohibits contracts contemplating the payment for or reimbursement of costs relating to hospitalization when the latter are insured by the public system. Section 15 of the HIA provides for the imposition of a fine in the event that s. 11 HIA is not observed.

Section 11 HIA

Contracts prohibited

11. (1) No one shall make or renew, or make a payment under a contract under which

(*a*) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;

(*b*) payment is conditional upon the hospitalization of a resident; or

(*c*) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

Like s. 15 HIA, s. 11 HIA is a measure designed to discourage the development of a private hospital system so as to promote the public system.

The HIA is accordingly legislation designed to **regulate** a public hospital service system and **make it viable**. Section 11 HIA is designed to attain the same end.

The function of s. 11 HIA is thus similar to s. 15 HIA and it follows that s. 11 is also not within the field of the criminal law.

It should be borne in mind that, although it is difficult to assign it a precise meaning,[80] the criminal law is generally **intended to prohibit and denounce conduct which is reprehensible as such**. Dickson C.J. had this to say about the criminal law:

> **The criminal law is a very special form of governmental regulation, for it seeks to express our society's collective disapprobation of certain acts and omissions.**[81]

Additionally, one of the characteristic features of criminal law offences is the stigma that attaches to them. As Lamer C.J. observed:

> **Criminal law is primarily stigmatization of offenders and restriction of their liberty**.[82]

According to Profs. Brun and Tremblay:

> [TRANSLATION]
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> **To these somewhat vague guidelines we feel one that is more apparent may be added: the fact that the conduct being prohibited merits the stigma of criminality. The nature of the criminal law is that it applies to conduct for its own sake. The criminal law**

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80 P.W. Hogg, *Constitutional Law of Canada, op. cit.*, note 3, pp. 477 *et seq.*; Gérald-A. Beaudoin, *La constitution du Canada*, Montréal, Éditions Wilson & Lafleur Ltée, 1990, pp. 539 *et seq.*

81 *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at 70 (Dickson C.J.).

82 *Re Young Offenders Act (P.E.I.)*, [1991] 1 S.C.R. 252, at 267 (Lamer J.).

> **implies disapproval or dishonour for anyone infringing it**.[83]

In the case at bar, the Court considers that ss. 15 HIA and 11 HIA were not designed to prohibit conduct which is reprehensible as such. The Court cannot conclude that in adopting these sections the Quebec government sought to criminalize private medicine. The purpose of the sections, we repeat, **is to ensure the sound operation of the public health service system**.

As we said earlier, ***the Court has to assume that a statute is valid in constitutional terms****. It must therefore be* ***assumed*** *that ss. 15 HIA and 11 HIA were adopted for regulatory purposes and not to prohibit conduct the government regarded as immoral. The prohibition contained in ss. 15 HIA and 11 HIA is not a purpose in itself, it is related to the viability of the public system. The disputed provisions do not exist to prohibit and penalize private medicine*.

Can we say that a person contravening these sections is "stigmatized" in the eyes of the community? The Court does not think so. There is no deprivation of liberty, since ss. 76 HIA and 15 HIA provide only for **fines**.

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[83] H. Brun and G. Tremblay, *Droit constitutionnel, op. cit.*, note 5, p. 502.

It has to be said that there is a certain moral aspect to ss. 15 HIA and 11 HIA. In this sense, they contribute to the attainment of objectives regarded as beneficial to the community.

However, the Supreme Court of Canada has made a distinction between legislation which incorporates a certain moral dimension and that which is purely criminal. In the regulation of matters within provincial jurisdiction, provinces may introduce provisions having a certain moralizing content.[84]

In *Val-D'Or* the Court of Appeal said:

> [TRANSLATION]
>
> **Morality and criminality are not synonymous where the distribution of legislative powers is concerned. Morality is not a field of constitutional jurisdiction. The two levels of government may therefore adopt legislation with moral content in so far as, and in my opinion that is the case here, the statute, read as a whole and with a view to its true nature, is within the jurisdiction of the government adopting it. In this sense, morality and criminality are not the same thing.**[85]

Of the majority judges on the Supreme Court in *Nova Scotia Board of Censors*, Ritchie J. said the following:

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[84] See *Nova Scotia Board of Censors v. McNeil*, *supra*, note 3 and *Val D'Or v. 2550-9613 Québec Inc.*, *supra*, note 7.

[85] *Val D'Or v. 2550-9613 Québec Inc.*, *supra*, note 7, at 2096.

> **As the decision of the Appellate Division depends upon equating morality with criminality, I think it desirable at this stage to refer to the definitive statement made by Lord Atkin in this regard in the course of his reasons for judgment in *Proprietary Articles Trade Association v. Attorney-General of Canada*, where he said, at p. 324:**
>
> > **Morality and criminality are far from coextensive; nor is the sphere of criminality necessarily part of a more extensive field covered by morality – unless the moral code necessarily disapproves all acts prohibited by the State, in which case the argument moves in a circle. It appears to their Lordships to be of little value to seek to confine crimes to a category of acts which by their very nature belong to the domain of 'criminal jurisprudence' . . .**
>
> **I share the opinion expressed in this passage that morality and criminality are far from coextensive . . .**[86]

Finally, the sections at issue are not criminal in nature simply because they contain a prohibition accompanied by a penal sanction in the event of non-compliance. **Under 92(15) the provinces have an incidental power to adopt provisions of this type to enforce legislation which is otherwise valid in terms of the distribution of powers.**[87]

The writers Brun and Tremblay offer the following comments:

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[86] *Ibid.*, 691-692.
[87] Section 92(1) of the *Constitution Act, 1867*.

[TRANSLATION]

A provincial or municipal measure adopted pursuant to any of the subsections of s. 92 may very well take the form of a prohibition treated as a penal offence. See *Ville de Beaconsfield v. Bourbonnière*, [1995] R.J.Q. 1997 (C.A.), at 2000, and the cases there cited. The fact that a provincial statute takes the form of a simple prohibition, in the absence of any regulation, does not make it invalid: *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, at 741; and the Court was unanimous on this point.[88]

Ritchie J. dealt with it in this way:

In conformity with this authority, Judson J. stated in *O'Grady v. Sparling* (*supra*), at p. 810:

> **What meaning can one attach to such phrases as 'area of criminal law' or 'domain of criminal law' in relation to such a subject-matter? A provincial enactment does not become a matter of criminal law merely because it consists of a prohibition and makes it an offence for failure to observe the prohibition; . . .**

I conclude from these decisions that if the legislation is found to have been enacted for a valid provincial purpose the prohibition is equally valid.[89]

In *Schneider*[90] Estey J. said:

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[88] H. Brun and G. Tremblay, *Droit constitutionnel*, *op. cit.*, note 5, p. 499.
[89] *Nova Scotia Board of Censors v. McNeil*, *supra*, note 3, at 697.
[90] *Schneider v. The Queen*, *supra*, note 11.

> **The power of the province to enact quasi-criminal legislation must be predicated upon the existence of an otherwise valid provincial legislative program. The offences created for the enforcement or establishment of such a program have been historically treated by the Court as being ancillary to the power of the provincial legislature invoked by the principal legislation. Without the existence of the prerequisite provincial authority independent of the offence creating provisions, the legislation would be invalid as trenching upon the exclusive federal jurisdiction in criminal law. Thus we see that provincial enforcement provisions may be validly adopted in the context of schemes clearly provincial as for example in the field of regulation of highways or the regulation of trading in securities.**[91]

2.2 Field of jurisdiction

As the Court has determined the real nature of the disputed legislation, it must now associate this subject-matter with one of the powers mentioned in ss. 91 and 92, *Constitution Act, 1867*.

According to s. 92(7), (13) and (16) and the case law, the power to legislate on health matters belongs to the provincial governments. As the writers Lajoie and Molinari point out:

> [TRANSLATION]
>
> **The principal basis for the provincial powers over health, as elaborated by the Quebec courts, affirmed by the Quebec Court of Appeal, adopted by the British Columbia courts and often asserted but**

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[91] *Ibid.*, 143.

> **never challenged since, except by isolated minority judgments or *obiters*, is not s. 92(7) of the *BNA Act, 1867*, which expressly mentions among the provincial powers "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals", but subs. 16 of that section, dealing with "Generally all Matters of a merely local or private Nature in the Province".**
>
> **The power is thus a quite general one over health, health being understood in general as a purely local or private matter, and as such within provincial jurisdiction within the limits and with the exceptions specified in s. 91 of the *BNA Act*.**[92]

In *Schneider* the Supreme Court of Canada was also of the same view:

> **Thus historically, at least, the general jurisdiction over public health was seen to lie within the provinces under s. 92(16) "Generally all Matters of a merely local or private Nature in the Province" although the considerable dimensions of this jurisdiction were unlikely foreseen in 1867.**
>
> **This view that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either ancillary to the express heads of power in s. 91 or the emergency power under peace, order and good government) has prevailed and is not now seriously questioned (see *Rinfret v. Pope* (1886), 12 Q.L.R. 303 (Que. C.A.), *Re Bowack*, *supra*, *Labatt Breweries of Canada Ltd. v. Attorney General of Canada*, [1980] 1 S.C.R. 914, *per* Estey J.)**[93]

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[92] André Lajoie and Patrick A. Molinari, "Partage constitutionnel des compétences en matière de santé au Canada" (1978), 56 *Can. Bar Rev.* 579, at 596-598.

[93] *Schneider v. The Queen, supra*, note 11, at 137.

Prof. Gérald Beaudoin says this about provincial legislatures:

> [TRANSLATION]
>
> **Section 92(7) provides that provincial legislatures have exclusive jurisdiction over the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the province. Under s. 91(11), the federal parliament has exclusive authority over quarantine and marine hospitals.**
>
> **Provincial legislatures therefore have the right to organize a hospital system and create a health insurance and hospital insurance program.**
>
> . . . . .
>
> **In *Canadian Indemnity Company*, the Supreme Court confirmed the provinces' jurisdiction under s. 92(13) to create a compulsory and universal automobile insurance program. This principle also applies to health insurance. In accordance with the principle recognized in *Reference Re Social Insurance*, a province may create a social assistance program.**[94]

In view of the preceding conclusions about the purposes of ss. 15 HIA and 11 HIA the Court concludes that the **latter fall within provincial jurisdiction over health.**

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[94] Gérald-A. Beaudoin, *La constitution du Canada*, *op. cit.*, note 27, pp. 509-510.

(C) CONCLUSION

In answer to question one, the Court considers that ss. 15 HIA and 11 HIA **are valid in terms of the distribution of powers**. The purpose of these provisions is the **regulation of the public health services system and they logically form part of their respective statutes**. They were validly adopted by the provincial government pursuant to s. 92(7), (13), (15) and (16) of the *Constitution Act, 1867*.

IV. QUESTION TWO

The second question presented to the Court is the following: **does the prohibition from obtaining a private insurance policy infringe the rights guaranteed in s. 7 of the Canadian Charter (right to life, liberty and security) and the rights mentioned in ss. 1, 4, 5 and 24 of the Quebec Charter?**

(A) PARTIES' ARGUMENTS

The applicants argued that ss. 15 HIA and 11 HIA infringe the rights protected by s. 7 of the Charter and the rights mentioned in the Quebec Charter.

> **Sec. 7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The applicants alleged that the public health system limits access to medically required care in terms of the available human, physical and financial resources. In their submission this fact, taken together with a prohibition from making use of a parallel private care system, infringes the right to life and security of the person.

They further argue that the right to liberty mentioned in s. 7 of the Charter extends to the individual's right to autonomy in the making of the personal decisions which he or she must make.

In their submission, certain ancillary economic rights are capable of protection by s. 7 of the Charter. The applicants argued that the right to obtain private insurance or to pay for hospital services is an **ancillary right** relating directly to their right to obtain the health care which they need.

The Attorney General of Quebec, for her part, emphasized that anyone alleging an infringement of the Charter must present evidence of it on a balance of probabilities. It was argued that only an immediate or imminent risk to life, liberty or the security of the person is capable of infringing s. 7 and this was not established by the applicants to be the case. In the submission of the Attorney General of Canada, the infringement is entirely hypothetical and unsupported by the evidence.

The Attorney General of Quebec argued that in any case the "rights" denied by ss. 15 HIA and 11 HIA are purely economic and cannot benefit from the protection of s. 7 of the Charter.

Finally, it was alleged that if there was an infringement of life, liberty or security in the case at bar, such infringement was consistent with the principles of fundamental justice, as the Court must exercise restraint toward governmental policy over health, weighing all the rights involved and the purposes sought by the disputed legislation.

(B) DISCUSSION

As the Supreme Court has often said, **analysis of the compatibility of legislation with the protection provided by s. 7 of the Charter must be undertaken in two stages**. The first stage will thus consist here of determining whether the disputed provisions infringe the right to life, liberty or security of the person, while the second will involve determining whether such infringement is contrary to the rules of fundamental justice.[95] If there is still an infringement, the latter must be analysed in terms of s. 1 of the Charter.

(A) <u>Infringement</u>

Before discussing the infringement alleged by the applicants, it is worth taking a brief look at the rights which are

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[95] *R. v. S. (R.J.)*, [1995] 1 S.C.R. 451, at 479 (Iacobucci J.); *Pearlman v. Manitoba Bar Society*, [1991] 2 S.C.R. 869, at 881 (Iacobucci J.); Peter W. Hogg, *Constitutional Law of Canada*, 4th ed., Carswell, Toronto, 1997, 1064-1065; Henri Brun and Guy Tremblay, *Droit constitutionnel*, 3d ed., Les Éditions Yvon Blais, Cowansville, 1997, 1027.

guaranteed by s. 7 of the Charter in order to define the protection offered by that provision.

(i) Interpretation of rights contained in s. 7 of Charter

(a) Method of interpreting Charter provisions

The wording of s. 7 of the Charter indicates that everyone has the right to life, liberty or security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. To arrive at a suitable interpretation of this provision, the Court must take into account the purposes of the Charter as a whole.[96] As the writers Brun and Tremblay point out:

> [TRANSLATION]
>
> **The Supreme Court has repeated many times that the definition of a right should be based on the identification of its purpose. This must be determined in accordance with the interests to be protected, the character and larger objects of the Charter, the language chosen and the historical origins of the concepts, and finally, the meaning and purpose of the other rights. See, for example, *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145, at 157; *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at 344; *R. v. Therens*, [1985] 1 S.C.R. 613, at 641; *Reference re British Columbia Motor Vehicle Act*, [1985] 2 S.C.R. 486, at 499-500. In other words, the question is as to the reason for the rights. The search for historical origins will thus help in placing the rights in the context of the**

[96] *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at 344 (Dickson J.).

> **Canadian and British legal tradition and the social and political background from which they emerged.**
>
> **Consideration of the character and larger objects of the Charter and the meaning and purpose of the other rights requires that the Charter be taken as a whole. A constitutional charter must be interpreted as a system in which every component contributes to the meaning as a whole and the whole gives meaning to its parts: *Dubois v. The Queen*, [1985] 2 S.C.R. 350, at 365.**[97]
>
> (Emphasis by Court.)

According to Wilson J. in *Morgentaler*,[98] the principles underlying the Charter are to be defined as follows:

> **The Charter is predicated on a particular conception of the place of the individual in society. An individual is not a totally independent entity disconnected from the society in which he or she lives. Neither, however, is the individual a mere cog in an impersonal machine in which his or her values, goals and aspirations are subordinated to those of the collectivity. The individual is a bit of both. The *Charter* reflects this reality by leaving a wide range of activities and decisions open to legitimate government control while at the same time placing limits on the proper scope of that control. Thus, the rights guaranteed in the *Charter* erect around each individual, metaphorically speaking, an invisible fence over which the state will not be allowed to trespass. The role of the courts is to map out, piece by piece, the parameters of the fence.**
>
> **The *Charter* and the right to individual liberty guaranteed under it are inextricably tied to the concept of human dignity.**[99]
>
> (Emphasis by Court.)

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97 H. Brun and G. Tremblay, *Droit constitutionnel, op. cit.*, note 1, p. 915.
98 *R. v. Morgentaler*, [1988] 1 S.C.R. 30.
99 *Ibid.*, 164 (Wilson J.)

(b) Purely economic rights and s. 7

The Court must point out that because of the range of meanings which may be given to the words used in s. 7, there has been no consensus as to the scope of this provision in the Supreme Court of Canada. Despite that, there is one rule that enjoys universal acceptance, namely that **s. 7 was not designed to protect purely economic rights**.

The comments of McIntyre J. in *Re Public Service Employee Relations Act* are an illustration of this:[100]

> **For obvious reasons, the *Charter* does not give constitutional protection to all activities performed by individuals. There is, for instance, no *Charter* protection for the ownership of property, for general commercial activity, or for a host of other lawful activities.**[101]

McIntyre J. said that the Charter is concerned primarily with individual, political and democratic rights:

> **The omission of similar provisions in the *Charter*, taken with the fact that the overwhelming preoccupation of the *Charter* is with individual, political and democratic rights with conspicuous inattention to economic and property rights, speaks strongly against any implication of a right to strike.**[102]

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[100] *Re Public Service Employee Relations Act*, [1987] 1 S.C.R. 313.
[101] *Ibid.*, at 405 (McIntyre J.).
[102] *Ibid.*, at 413 (McInryre J.).

(Emphasis by Court.)

Two years later, in *Irwin Toy Ltd. v. Quebec (A.G.)*,[103] a majority of the Supreme Court again ruled on the absence of any protection for economic rights provided by s. 7:

> **What is immediately striking about this section is the inclusion of "security of the person" as opposed to "property". This stands in contrast to the classic liberal formulation, adopted, for example, in the Fifth and Fourteenth Amendments in the American Bill of Rights, which provide that no person shall be deprived "of life, liberty or property, without due process of law". The intentional exclusion of property from s. 7, and the substitution therefor of "security of the person" has, in our estimation, a dual effect. First, it leads to a general inference that economic rights are as generally encompassed by the term "property" are not within the perimeters [sic] of the s. 7 guarantee. This is not to declare, however, that no right with an economic component can fall within "security of the person". Lower courts have found that the rubric of "economic rights" embraces a broad spectrum of interests, ranging from such rights, included in various international covenants, as rights to social security, equal pay for equal work, adequate food, clothing and shelter, to traditional property – contract rights. To exclude all of the these at this early moment in the history of *Charter* interpretation seems to us to be precipitous.**[104]
>
> (Emphasis by Court.)

It can be said that **the Supreme Court, when it began interpreting the Charter, did not wish to limit the guarantee in s. 7 in advance**. At the same time, it was clear that purely economic rights should in principle not benefit from constitutional protection.

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[103] *Irwin Toy v. Quebec*, [1989] 1 S.C.R. 927.
[104] *Ibid.*, at 1003 (Dickson C.J. and Lamer and Wilson JJ.).

In the recent Court of Appeal judgment, *Gosselin v. Québec (Procureur Général)*,[105] Baudoin J.A. analysed s. 7 of the Charter in terms of economic rights:

> [TRANSLATION]
>
> **However, I note that the decisions of the Supreme Court, including *Irwin Toy v. Attorney General of Quebec*, *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)* and *R.B. v. Children's Aid Society of Metropolitan Toronto*, like those of this Court, *Béliveau v. Comité de discipline du Barreau du Québec, Schnaiberg v. Metallurgistes unis d'Amérique, section locale 8990 and Centrale de l'enseignement du Québec v. Procureur général du Québec*, are to the contrary, concluding, in view of the context in which the word "security" is used in the Charter, that the latter is simply intended to guarantee each Canadian citizen the right not to be be subject to unjust coercion of his or her person. The right for which the appellant seeks protection is a right of a purely economic nature and, as *Irwin Toy Ltd. v. Attorney General of Quebec* made clear, economic rights are not in principle within the protection offered by s. 7, although Dickson C.J. left the door open when he wrote:**
>
> > **We do not, at this moment, chose to pronounce upon whether those economic rights fundamental to human life or survival are to be treated as though they are of the same ilk as corporate-commercial economic rights.**
>
> **I concur on this point in the comments of Prof. Peter W. Hogg when he writes:**
>
> > **It has been suggested that "security of the person" includes the economic capacity to satisfy basic human needs. Whyte says that**

[105] *Gosselin v. Quebec (A.G.)*, [1999] R.J.Q. 1033 (C.A.).

> **"state action which deprives a person of all (or a substantial portion) of his or her capacity to produce an income could be seen as invading security of the person." He gives the examples of "the removal of a person from the welfare scheme, the confiscation of property (tools, equipment, etc.) essential to a person's work, or the cancellation of a licence which is esssential to the pursuit of one's occupation (taxi driver, lawyer or engineer)." The trouble with this argument is that it accords to s. 7 an economic role that is incompatible with its setting in the legal rights portion of the Charter – a setting that the Supreme Court of Canada has relied upon as controlling the scope of s. 7. The suggested role also involves a massive expansion of judicial review, since it would bring under judicial scrutiny all of the elements of the modern welfare state, including the regulation of trades and professions, the adequacy of labour standards and bankruptcy laws and, of course, the level of public expenditures on social programmes. As Oliver Wendell Holmes would have pointed out, *these are the issues upon which elections are won and lost; the judges need a clear mandate to enter that arena, and s. 7 does not provide that clear mandate.*[106]**
>
> (Emphasis by Court.)

The question now is whether s. 7 **is capable of protecting certain rights which have an economic dimension, which may be called "ancillary economic rights"**, and which have a close connection to the right to life, liberty and security of the person.

(c) Limiting interpretation of s. 7

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[106] *Ibid.*, 1042-1043 (Baudoin J.A.)

For some Supreme Court judges, especially Lamer C.J., s. 7 should not be given too broad a meaning. In his view, s. 7 is clear. The wording does not open the way to an interpretation that goes beyond infringements of individuals' physical integrity. In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*,[107] he compares s. 7 of the Charter with the Fourteenth Amendment to the U.S. Constitution and concludes as follows:

> **Further, it is my view that work is not the only activity which contributes to a person's self-worth or emotional well-being. If liberty or security of the person under s. 7 of the *Charter* were defined in terms of attributes such as dignity, self-worth and emotional well-being, it seems that liberty under s. 7 would be all inclusive. In such a state of affairs there would be serious reason to question the independent existence in the *Charter* of other rights and freedoms such as freedom of religion and conscience or freedom of expression.**
>
> **In short then I find myself in agreement with the following statement of McIntyre J. in the *Reference re Public Service Employee Relations Act (Alta.)*, *supra*, at p. 412:**
>
> > **It is also to be observed that the *Charter*, with the possible exception of s. 6(2)(*b*) (right to earn a livelihood in any province) and s. 6(4), does not concern itself with economic rights.**
>
> **I therefore reject the application of the American line of cases that suggest that liberty under the Fourteenth Amendment includes liberty of contract. As I stated earlier these cases have a specific historical context, a context that incorporated into the American**

[107] *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code*, [1990] 1 S.C.R. 1123.

> **jurisprudence certain *laissez-faire* principles that may not have a corresponding application to the interpretation of the *Charter* in the present day. There is also a significant difference in the wording of s. 7 and the Fourteenth Amendment. The American provision speaks specifically of a protection of property interests while our framers did not choose to similarly protect property rights . . .**[108]
>
> (Emphasis by Court.)

In *B.(R). v. Children's Aid*,[109] Lamer C.J. repeats his position on the scope of s. 7. He explains that the word "liberty" in ordinary speech may refer not only to physical liberty but to a broader and more abstract idea of liberty. However, an interpretation of s. 7 that encompassed this abstract idea of "liberty" would not be consistent with the overall context of the Charter. This is what he said:

> **I agree with my colleague La Forest J. that the word "liberty" in its broadest sense does not mean the mere absence of physical restraint. In French, this word certainly includes two distinct dimensions, the physical and the abstract or intangible.**
>
> **. . . . .**
>
> **Moreover, since most laws have the effect of limiting a freedom, the same approach could mean, depending on the facts, that a large proportion of the legislative provisions in force could be challenged on the ground that they infringe the liberty guaranteed by s. 7 of the *Charter*. It would then be for the courts, in each case, to decide whether or not the freedom invoked was a fundamental freedom in our free and democratic society, whether the limit complied with the principles of fundamental justice which, as I noted, often do not apply, or whether the limit was reasonable and could be justified**

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[108] *Ibid.*, at 1170-1171 (Lamer J.).
[109] *B.(R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.

> **in a free and democratic society. We must keep in mind, first, that what may be important and fundamental to one person may very well not be to another, including the judge who hears the case, and second, that by adopting this approach the judiciary would inevitably be legislating, when this is not its function. With respect, I believe that this situation does not reflect the purpose of the *Charter* or of s. 7, or the intention of Parliament.**
>
> **To summarize my opinion, I would simply say that extending the scope of the word "liberty" in s. 7 to include any type of freedom other than that which is connected with the physical dimension of the word "liberty" would not only be contrary to the structure of the *Charter* and of the provision itself, but would also be contrary to the scheme, the context and the manifest purpose of s. 7. Furthermore, it would have the effect of conferring *prima facie* constitutional protection on all eccentricities expressed by members of our society under the rubric of "liberty", in addition to taking away all legitimacy or purpose from other provisions of the *Charter* such as s. 2 or s. 6, for example, since they would be redundant. It seems apparent to me that this cannot be the purpose of s. 7, or of the *Charter* itself, which is a constitutional instrument. It must also be clearly understood that this approach would inevitably lead to a situation where we would have government by judges. This is not the case at present, but I would emphasize again that it must not become the case.**[110]
>
> (Emphasis by Court.)

(d) Broad and liberal interpretation of s. 7

There is another interpretation which extends the scope of the guarantee contained in s. 7. For example, in *Singh v. M.E.I.*,[111] *R. v. Jones*[112] and *R. v. Morgentaler,*[113] Wilson J. adopted a broader and more

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[110] *Ibid.*, at 347-348 (Lamer C.J.).
[111] *Singh v. M.E.I.*, [1985] 1 S.C.R. 177.
[112] *R. v. Jones*, [1986] 2 S.C.R. 284.
[113] *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

liberal interpretation of the protection offered. As early as *Singh*, she was referring *obiter* to a certain economic aspect of the right to security of the person:

> **The Law Reform Commission, in its Working Paper No. 26, *Medical Treatment and Criminal Law* (1980), suggested at p. 6 that:**
>
> > **The right to security of the person means not only protection of one's physical integrity, but the provision of necessaries for its support.**
>
> **The Commission went on to describe the provision of necessaries in terms of art. 25, para. 1 of the *Universal Declaration of Human Rights* (1948) which reads:**
>
> > **Every one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.**
>
> **. . . . .**
>
> **For purposes of the present appeal it is not necessary, in my opinion, to consider whether such an expansive approach to "security of the person" in s. 7 of the *Charter* should be taken.**[114]

Dissenting in *Jones*, she said the following:

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[114] *Singh v. M.E.I.*, *supra*, note 17, at 207 (Wilson J.).

> **I believe that the framers of the Constitution in guaranteeing "liberty" as a fundamental value in a free and democratic society had in mind the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his own character, to make his own choices for good or ill, to be non-conformist, idiosyncratic and even eccentric – to be, in today's parlance, "his own person" and accountable as such. John Stuart Mill described it as "pursuing our own good in our own way". This, he believed, we should be free to do "so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it". He added:**
>
> > **Each is the proper guardian of his own health, whether bodily *or* mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest.**
>
> . . . . .
>
> **Of course, this freedom is not untrammelled. We do not live in splendid isolation. We live in communities with other people. Collectivity necessarily circumscribes individuality and the more complex and sophisticated the collective structures become, the greater the threat to individual liberty in the sense protected by s. 7.**[115]
>
> (Emphasis by Court.)

In *Morgentaler*, she made the following comments:

> **The idea of human dignity finds expression in almost every right and freedom guaranteed in the *Charter*. Individuals are afforded the right to choose their own religion and their own philosophy of life, the right to choose with whom they will associate and how they will**

[115] *R. v. Jones*, *supra*, note 18, at 318-319 (Wilson J.).

> **express themselves, the right to choose where they will live and what occupation they will pursue. <u>These are all examples of the basic theory underlying the *Charter*, namely that the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life</u>.**
>
> **Thus, an aspect of the respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty. <u>Liberty, as was noted in *Singh*, is a phrase capable of a broad range of meaning. In my view, this right, properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance</u>.**[116]
>
> (Emphasis by Court.)

Wilson J. thus interpreted the word “liberty” so as to cover a vast range of personal choices. **We may note that in her view, “liberty” grants the individual a degree of autonomy, of independence, in making decisions of fundamental personal importance**.

What Wilson J. said ties in with what was said in *Children’s Aid*.[117] La Forest J. said the following about the scope of the word “liberty” in s. 7 of the Charter:

> **One particular provision which affords a clue to what liberty means is s. 1 of the *Charter*, the general balancing provision. It is useful to recall its wording: the**

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[116] *R. v. Morgentaler, supra*, note 19, at 166 (Wison J.).
[117] *B(R.) v. Children’s Aid*, *supra*, note 15.

Charter guarantees the rights and freedoms set out in it subject only to such reasonable limits as can be demonstrably justified in a free and democratic society. In _R. v. Oakes_, [1986] 1 S.C.R. 103, Dickson C.J. stated the following (at p. 136):

> **The Court must be guided by the values and principles essential to a free and democratic society which I believe embody, to name but a few, respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society. The underlying values and principles of a free and democratic society are the genesis of the rights and freedoms guaranteed by the _Charter_ and the ultimate standard against which a limit on a right or freedom must be shown, despite its effect, to be reasonable and demonstrably justified.**

The type of balance I have in mind was well expressed by Dickson J. (as he then was) in _R. v. Big M Drug Mart Ltd._, [1985] 1 S.C.R. 295. In that case, Dickson J. gave a liberal interpretation of the word "freedom", albeit in the context of s. 2(_a_) of the _Charter_ (at pp. 336-37):

> **Freedom can primarily be characterized by the absence of coercion or constraint. If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free. One of the major purposes of the _Charter_ is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to**

> **protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.**

Although the English version of the *Charter* employs two different words, "freedom" and "liberty", both emanate from the same concept. In French, the term "*liberté*" is used in s. 2 as well as in s. 7.

The above-cited cases give us an important indication of the meaning of the concept of liberty. On the one hand, liberty does not mean unconstrained freedom; see *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 713 (*per* Wilson J., at p. 524); *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 (*per* Dickson C.J., at pp. 785-86). Freedom of the individual to do what he or she wishes must, in any organized society, be subjected to numerous constraints for the common good. The state undoubtedly has the right to impose many types of restraints on individual behaviour, and not all limitations will attract *Charter* scrutiny. On the other hand, liberty does not mean mere freedom from physical restraint. In a free and democratic society, the individual must be left room for personal autonomy to live his or her own life and to make decisions that are of fundamental personal importance. In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, Wilson J. noted that the liberty interest was rooted in the fundamental concepts of human dignity, personal autonomy, privacy and choice in decisions going to the individual's fundamental being. She stated, at p. 166:

> **Thus, an aspect of the respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty. Liberty, as was noted in *Singh*, is a phrase capable of a broad range of meaning. In my view, this right, properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance.**

While I was in dissent in that case, I agree with this statement, and, indeed, I later observed in *R. v. Beare*, [1988] 2 S.C.R. 387, at p. 412, that I was

> **sympathetic to the view that s. 7 of the *Charter* included a right to privacy.**[118]
>
> (Emphasis by Court.)

Accordingly, liberty does not only mean the absence of any physical constraint. The Supreme Court broadened the scope of s. 7 **by guaranteeing a measure of autonomy to individuals who have to make personal choices that concern them.**

In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code*,[119] a judgment concurred in by La Forest and Sopinka JJ., Dickson C.J. returned to the idea he had put forward in *Irwin Toy* that all rights having an economic dimension are not necessarily excluded from Charter protection:

> **With respect to the first component of s. 7, the strongest argument that can be made regarding an infringement of liberty derives from the fact that the legislation contemplates the possibility of imprisonment. Because this is the case, I find it unnecessary to address the question of whether s. 7 liberty is violated in another, "economic", way. I wish to add here that this case does not provide the appropriate forum for deciding whether "liberty" or "security of the person" could ever apply to any interest with an economic, commercial or property component.**[120]

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[118] *Ibid.*, at 367-369.
[119] *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code, supra*, note 13.
[120] *Ibid.*, at 1140-1141 (Dickson C.J.).

Finally, we may note the opinion of Muldoon J. of the Federal Court in *Rollinson v. Canada*:[121]

> **In regard to s. 7, it is true that it does not accord entrenched rights in and to property. There are, however, certain kinds of property which are of a nature to transcend that salutary general principle and relate directly to the security of the person: necessary drugs and medicines; a coronary pacemaker with the power source and other necessary parts of the apparatus; a respirator device; and of course, that physical property which affords warmth and shelter and requires the State to respect it and to enter only upon proper previous judicial authorization, a person's dwelling [emphasis by Court]; and necessary clothing appropriate to the season. Some of the above comprehend both "life" and "security of the person". In any event, no one is to be deprived of those transcendant [*sic*] kinds of property when, at the same time the support "life" and "security of the person," except in accordance with principles of fundamental justice.**[122]
>
> (Emphasis by Court.)

(e) Conclusions on scope of rights protected by s. 7

In light of the preceding analysis, the Court feels that certain conclusions can be drawn regarding the guarantee contained in s. 7 of the Charter. **First**, it is clear that the Charter is not designed to protect purely economic rights. **Second**, it must be said that there is a body of opinion on the Supreme Court that **would extend the scope of s. 7 to guarantee greater independence to individuals and, conversely, would prevent undue interference by the state in**

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[121] *Rollinson v. Canada*, [1991] 3 F.C. 70.
[122] *Ibid.*, at 108.

people's personal choices. The door is thus not closed to recognition of certain rights intimately bound up with and inseparable from the right to life, liberty and security of the person. This will mean some measure of protection for rights known as "ancillary economic rights".

(ii) Sections 15 HIA and 11 HIA and infringement of rights mentioned in s. 7 of Charter

Is the right to receive health care a fundamental right which is protected in Canada by s. 7 of the Charter? In a Master's degree program in health law at the University of Sherbrooke, Marco Laverdière wrote a very interesting analysis on the point, and answered this question in the affirmative.[123] Similarly, according to the writer Martha Jackman:

> **Aside from the statutory conditions of accessibility and universality set out under the *Canada Health Act*, a credible claim can be made that section 7 of the *Charter* guarantees a constitutional right to health care. In practical terms, a right to life and to security of the person is meaningless without access to health care, both in a preventive sense, and in the event of acute illness.**[124]

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[123] Marco Laverdière, "Le cadre juridique canadien et québécois relatif au développement parallèle de services privés de santé et l'article 7 de la *Charte canadienne des droits et libertés*" (1998-99), 29 R.D.U.S. 117, at 182 *et seq.*; Martha Jackman, "The Regulation of Private Health Care Under the Canada health Act and the Canadian Charter", [1995] 6: 2 *Forum constitutionnel* 54, at 56.

[124] M. Jackman, "The Regulation of Private Health Care Under the Canada Health Act and the Canadian Charter", *loc. cit.*, note 29, p. 56.

One cannot help agreeing with this statement. **If access to the health system is not possible, it is illusory to think that rights to life and security are respected.**

The Court thus comes to the important question raised by the applicants: **Can it then be concluded that the right to obtain private insurance or the right to contract for hospital care, rights prohibited by ss. 15 HIA and 11 HIA, are ancillary economic rights protected by s. 7 of the *Charter*?**

The Court submits **that such an interpretation is possible. The Court considers that the economic barriers set up by ss. 15 HIA and 11 HIA are closely linked to the opportunity to have access to health care**. Without these rights, in view of the cost involved, access to private care is illusory. **In this sense, these provisions are an obstacle to access to health services and are thus capable of infringing the life, liberty and security of the person**.

However, it should pointed out that **s. 7** of the Charter does not protect a physician's right to practise his profession without constraint in the private sector.[125]

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[125] *Ibid*., at 56-57. This is a purely economic right.

Additionally, limitation of recourse to the private sector for care constitutes an infringement of the physical integrity of the person **only in the event that the public system is not capable of effectively guaranteeing such access**. If the public system makes the care in question available, there will not be any infringement of s. 7 of the Charter. The Court does not believe that a constitutional right exists to choose the source from which the medically required care will be obtained.[126]

Sections 15 HIA and 11 HIA will thus not really infringe s. 7 if the public health system offers the same care and makes it accessible.

The Attorney General of Quebec clearly showed that ss. 15 HIA and 11 HIA constitute economic barriers only as regards care offered by the public system. In principle, these provisions do not deny access to care, they deny access to care from the private sector.

The applicants, for their part, alleged that the public health system **does not have unlimited resources and so there will be gaps and deficiencies in the availability of medically required care**. *In*

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[126] *Ibid.*, at 57; for the contrary view, see M. Laverdière, *loc cit*, note 29, at 182, 185 *et seq.*

support of their arguments, they pointed to the waiting periods in emergency rooms and elsewhere. For these reasons, they submitted that obstacles to access to the private sector infringed their physical and psychological integrity.

Question: **Does the public system make all care services covered by the prohibition contained in ss. 15 HIA and 11 HIA accessible?**

The evidence was that there are serious problems in certain health sectors.

(iii) <u>Real or potential, and imminent, infringement</u>

However, before concluding that there is an infringement of the right to life, liberty and security of the person, **it should be noted that in the case at bar the applicants are not currently in a situation where their state of health requires care**. They argued with reference to the future, when they will need care and the public system will not be able to respond to their needs. The infringement has not yet occurred: **it is instead "anticipated" by the applicants**.

In the Court's opinion, in view of the nature of the rights involved in s. 7, especially the rights to life and security of the person,

this provision should be capable of offering preventive protection when an infringement is feared. The writers Brun and Tremblay have this to say on the point:

> [TRANSLATION]
>
> **The right to life, and to a certain extent the right to security, have no real meaning unless they are given a preventive aspect. This has been recognized by the Supreme Court, provided however that the infringement of the right of a person alleging s. 7 has a degree of certainty that approaches probability . . .**[127]

The comments of Wilson J. in *Singh et al. v. M.E.I.*[128] support this viewpoint:

> **It seems to me that . . . "security of the person" must encompass freedom from the threat of physical punishment or suffering as well as freedom from such punishment itself.**[129]

She further commented in *Morgentaler*:[130]

> **. . . we have already stated in *Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, that security of the person even on the purely physical level**

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[127] *Op. cit.*, note 1, at 1031.
[128] *Singh v. M.E.I.*, *supra*, note 17.
[129] *Ibid.*, at 207 (Wilson J.).
[130] *R. v. Morgentaler, supra*, note 19.

> **must encompass freedom from the <u>threat</u> of physical punishment or suffering as well as freedom from the actual punishment or suffering itself. In other words, <u>the fact of exposure is enough to violate the security of the person</u>**.[131]
>
> (Emphasis by Court.)

However, if s. 7 of the Charter protects against a threat to one of the listed rights, **there must still be a threat**. In other words, **the threat must be capable of realisation and should not exist at a purely conjectural or imaginary level**.[132] In *R. v. Swain*,[133] Lamer C.J. said:

> **In order to invoke the protection of s. 7, an individual must establish an <u>actual or potential deprivation</u> of life, liberty or security of the person**.[134]
>
> (Emphasis by Court.)

In this connection, Iacobucci J. made the following comment in *R. v. S. (R.J.)*:[135]

> **An analysis under this provision can logically proceed in stages. First, it can be determined whether there exists a <u>real or imminent</u> deprivation of an interest or interests recognized in the section.**
>
> **. . . . .**

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[131] *Ibid.*, at 162-163 (Wilson J.).
[132] See *Operation Dismantle v. The Queen*, [1985] 1 S.C.R. 441.
[133] *R. v. Swain*, [1991] 1 S.C.R. 933.
[134] *Ibid.*, 969 (Lamer C.J.).
[135] *R. v. S. (R.J.)*, [1995] 1 S.C.R. 451.

> **Section 7 of the *Charter* is engaged by deprivations in respect of life, liberty, or security of the person. To date, this Court has recognized that an interest is subject to deprivation, in this context, if there is either an <u>immediate or imminent</u> threat to the interest . . .**[136]
>
> (Emphasis by Court.)

This viewpoint was later expressed by a majority of the Supreme Court again in *R. v. Jobin*:[137]

> **For the reasons we expressed in *S. (R.J.)*, *supra*, the liberty interest is engaged when a <u>deprivation is imminent</u> . . .**[138]
>
> (Emphasis by Court.)

It can thus be concluded from the extracts reproduced above **that the guarantee contained in s. 7 of the Charter will apply when a deprivation is actual or potential and is imminent**.

In the case at bar, the applicants' state of health is not under threat. They are not suffering from any illness for which they require medical care. However, they alleged the "threat" of a deprivation in the event that their state of health requires care. Nevertheless, this is

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[136] *Ibid.*, 479-480 (Iacobucci J.).
[137] *R. v. Jobin*, [1995] 2 S.C.R. 78.
[138] *Ibid.*, at 92 (Sopinka and Iacobucci J.J.).

a threat which cannot really be described as actual, although it may be described as potential.

It is difficult to determine whether the **threat is imminent** simply because it is impossible to foresee the future state of health of an individual with certainty. In particular, it is impossible to predict in the majority of cases when an accident causing injury will occur. In view of this uncertainty we must conclude, as a person's state of health is unforeseeable, that there is an imminent threat of deprivation in the case at bar.

(iv) Conclusion

In light of the foregoing discussion, the **Court comes to the following conclusions: (1) the Supreme Court has expressed the view that s. 7 of the *Charter* might embrace certain rights of an economic nature** intimately bound up with the right to life, liberty and security of the person; (2) the right to obtain private insurance or the right to contract in the private sector to obtain health care, prohibited by ss. 15 HIA and 11 HIA, are capable of protection by s. 7 of the Charter when the care is not available through the public system; (3) the applicants can complain of a potential and imminent threat of deprivation.

The Court concludes that **there is, first, an infringement of the applicants' rights to life, liberty and security of the person**

under s. 7. It remains to be seen **whether such an infringement is in accordance with the rules of fundamental justice. As we have seen, the two parts of s. 7 are related and must be analysed together.**

(B) <u>Principles of fundamental justice</u>

To determine whether an infringement of the right to life, liberty or security of the person is contrary to the principles of fundamental justice reference must be made *inter alia* to the background of the legislation:

[TRANSLATION]

. . . in the common law, the background of the legislation involved, a review of practice, its reason for being and the principles underlying it.

The interests of the state and those of the individual must also be weighed, looking at policies on the point:

> **It is also necessary to weigh the interests of the state and those of the individual by examining "the applicable principles and the policies which have been reflected in the legislative and judicial practice in the area". These rules concern not only individual rights but protection of society and tend to maintain "a fair balance . . . from the point of view of substance as well as form".**

These rules of fundamental justice have no exhaustive content, and this makes them difficult to define. They have a residual function and are often meant to reinforce

> **principles contained in the other provisions of the Charter, so as to make a coherent whole.**[139]

The Supreme Court has ruled to this effect on many occasions. For example, in *R. v. Lyons*:[140]

> **In *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, this Court held that the phrase "principles of fundamental justice" sets out the parameters of the right not to be deprived of life, liberty and security of the person. <u>These principles were stated to inhere in the the basic tenets and principles not only of the judicial system but also of the other components of our legal system</u> (at p. 512, *per* Lamer J.) Hence, to determine whether Part XXI violates the principles of fundamental justice by the deprivation of liberty suffered by the offender, <u>it is necessary to examine Part XXI in light of the basic principles of penal policy that have animated legislative and judicial practice in Canada and common law jurisdictions</u>.**[141]
>
> (Emphasis by Court.)

In *R. v. Beare*,[142] La Forest J. made the following comment:

> **In *Re B.C. Motor Vehicle Act, supra* at p. 512, this Court stated that <u>the principles of fundamental justice are to be found in the basic tenets and principles not only of our judicial system but also of the other components of our legal system</u>. Consistent with this approach, the Court in *R. v. Lyons*, [1987] 2 S.C.R. 309, at p. 327, held that to determine whether a legislative scheme for an indeterminate detention of dangerous offenders violated the principles of fundamental justice, it was necessary to examine that scheme in light of the basic principles of**

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[139] Patrice Garant, "Vie, liberté, sécurité et justice fondamentale", in *Charte canadienne des droits et libertés*, ed. Gerald-A. Beaudoin and Errol P. Mendes, Wilson and Lafleur, Montréal, 1996, p. 471; see case law cited.
[140] *R. v. Lyons*, [1987] 2 S.C.R. 309.
[141] *Ibid.*, at 327 (La Forest J.).
[142] *R. v. Beare*, [1988] 2 S.C.R. 387.

> **penal policy that had animated legislative and judicial practice in Canada and other common law jurisdictions.**[143]
>
> (Emphasis by Court.)

In *Thomson Newspapers v. Director of Investigation and Research*,[144] La Forest J. again wrote:

> **Textually, then, it is clearer than in many other cases that, to borrow the words of Lamer J. in *Re B.C. Motor Vehicle Act, supra,* at p. 503, "the principles of fundamental justice are to be found in the basic tenets of our legal system" (emphasis added). And in attempting to determine what these basic tenets are, one must, as this Court did in *R. v. Lyons, supra*, at p. 327, and *R. v. Beare, supra*, at pp. 402-3, "consider [the impugned measure] against the applicable principles and policies that have animated legislative and judicial practice in the field".**
>
> **What these practices have sought to achieve is a just accommodation between the interests of the individual and those of the state, both of which factors play a part in assessing whether a particular law violates the principles of fundamental justice; see *R. v. Lyons, supra*, at pp. 327 and 329; *R. v. Beare, supra*, at pp. 403-5; also my reasons in *R. v. Corbett*, [1988] 1 S.C.R. 670, at p. 745 (dissenting on another point); see also *R. v. Jones*, [1986] 2 S.C.R. 284, at p. 304, *per* La Forest J. (Dickson C.J. and Lamer J. concurring).**[145]
>
> (Emphasis by Court.)

Let us recall the rule:

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[143] *Ibid.*
[144] *Thomson Newspapers v. Director of Investigation and Research*, [1990] 1 S.C.R. 425.
[145] *Ibid.*, at 538-539 (La Forest J.).

> **Achieving a just accommodation between the interests of the applicants Chaoulli and Zéliotis and those of the state.**

But what are the interests of the two parties? Is there not here a desire and an obligation by the state to protect all Quebecers and permit them access to the health system without any monetary question arising?

That is what our analysis leads us to see: **achieving a just accommodation**.

In *R. v. Hébert*,[146] McLachlin J. offered the following comments:

> **The *Charter* through s. 7 seeks to impose limits on the power of the state over the detained person. It thus seeks to effect a balance between the interests of the detained individual and those of the state. On the one hand s. 7 seeks to provide to a person involved in the judicial process protection against the unfair use by the state of its superior resources. On the other, it maintains to [*sic*] the state the power to deprive a person of life, liberty or security of person [*sic*] provided that it respects fundamental principles of justice. The balance is critical. Too much emphasis on either of these purposes may bring the administration of justice into disrepute – in the first case because the state has improperly used its superior power against the individual, in the second because the state's legitimate interest in law enforcement has been frustrated without proper justification.**[147]

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[146] *R. v. Hébert*, [1990] 2 S.C.R. 151.
[147] *Ibid.*, at 180 (McLachlin J.).

(Emphasis by Court.)

In *Cunningham v. Canada*,[148] McLachlin J. said this on the point:

> **Having concluded that the appellant has been deprived of a liberty interest protected by s. 7 of the *Charter*, we must determine whether this is contrary to the principles of fundamental justice under s. 7 of the *Charter*. In my view, <u>while the amendment of the *Parole Act* to eliminate automatic release on mandatory supervision restricted the appellant's liberty interest, it did not violate the principles of fundamental justice. The principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited, but with the protection of society. Fundamental justice requires that a fair balance be struck between these interests, both substantively and proceduraly</u> (see *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, at pp. 502-3, *per* Lamer J.; *Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, at p. 212, *per* Wilson J.; *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 S.C.R. 869, at p. 882, *per* Iacobucci J.). In my view the balance struck in this case conforms to this requirement.**[149]
>
> (Emphasis by Court.)

In *Rodriguez v. B.C. (A.G.)*,[150] Sopinka J. said this:

> **I cannot subscribe to the opinion expressed by my colleague, McLachlin J., that the state interest is an inappropriate consideration in recognizing the principles of fundamental justice in this case. This Court has**

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[148] *Cunningham v. Canada*, [1993] 2 S.C.R. 143.
[149] *Ibid.*, at 151 (McLachlin J.).
[150] *Rodriguez v. Canada*, [*sic*], [1993] 3 S.C.R. 519.

> **affirmed that in arriving at these principles, a balancing of the interest of the state and the individual is required**.[151]
>
> (Emphasis by Court.)

In *R. v. Heywood*,[152] Cory J. made the following observation on behalf of the majority:

> **Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.**
>
> **Reviewing legislation for overbreadth as a principle of fundamental justice is simply an example of the balancing of the State interest against that of the individual. This type of balancing has been approved by this Court: see *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, *per* Sopinka J., at pp. 592-95; *R. v. Jones*, [1986] 2 S.C.R. 284, *per* La Forest J., at p. 298; *R. v. Lyons*, *supra*, *per* La Forest J., at pp. 327-29; *R. v. Beare*, [1988] 2 S.C.R. 387, at pp. 402-3; *Thomson Newspapers Ltd. v. Canada (Director of Investigation and Research, Restrictive Trade Practices Commission)*, [1990] 1 S.C.R. 425, at pp. 538-39; and *Cunningham v. Canada*, [1993] 2 S.C.R. 143, at pp. 151-53.**[153]
>
> (Emphasis by Court.)

In undertaking an analysis of the principles of fundamental justice, therefore, the Court must consider **the factors underlying the**

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[151] *Ibid.*, at 592 (Sopinka J.).
[152] *R. v. Heywood*, [1994] 3 S.C.R. 761.
[153] *Ibid.*, at 792 (Cory J.).

impugned legislation to see whether they are consistent with the values of the Charter. Further, it must take into account the balance which should exist between the protection of individual rights and the protection of society so as to determine whether the scope of the impugned legislation is overbroad and unreasonable.

The reasons for and principles underlying ss. 15 HIA and 11 HIA and their respective legislation have already been considered.

The *Health Insurance Act* and the *Hospital Insurance Act* are legislation **designed to create and maintain a public health system open to all residents of Quebec**. They are legislation which **seeks to encourage the overall health of all Quebecers without discrimination on the basis of their economic situation**. In short, it is a measure by the government **intended to promote the well-being of its population as a whole**.

Clearly, ss. 15 HIA and 11 HIA raise economic barriers against access to private care. However, these are not really measures designed to limit access to care, but **measures intended to prevent the creation of a parallel private care system**. Underlying these provisions is the fear that the establishing of a private care system would have the effect of diverting a substantial portion of health resources at the

expense of the public sector. **The Quebec government adopted ss. 15 HIA and 11 HIA to guarantee that virtually all health resources existing in Quebec would be at the disposal of the Quebec population as a whole. That is clear.**

The disputed provisions **seek to guarantee access to health care which is equal and adequate for all Quebecers.** The adoption of ss. 15 HIA and 11 HIA **was prompted by considerations of equality and human dignity, and hence it is clear that there is no conflict with the general values expressed by the *Canadian Charter* or the Quebec *Charter of Human Rights and Freedoms*.**

In closing, let us consider the question of the **balance that should exist between individual rights and those of society**.

The Quebec public health system does not enjoy unlimited and inexhaustible resources; all the expert witnesses said so. The same might indeed be said for every health system existing in the world. In such circumstances, it is entirely justifiable for a government, having the best interests of its people at heart, to **adopt a health policy solution which is designed to favour the largest possible number of people**. The government limits the rights of a few to ensure that the rights of all citizens in the society will not be adversely affected.

The evidence showed that the right to have recourse to a parallel private health care system, advocated by the applicants, **would have repercussions on the rights of the public as a whole. We cannot act like ostriches. The result of creating a parallel private health care system would be to threaten the integrity, sound operation and viability of the public system.** Sections 15 HIA and 11 HIA prevent this from happening and guarantee the existence of a quality public health system in Quebec.

Further, the Court considers that ss. 15 HIA and 11 HIA **do not have an overbroad application**. The only way of ensuring that all health resources will benefit all Quebecers without discrimination is to prevent a parallel care system from being established. That is precisely what the disputed provisions in the case at bar do.

Finally, the Court refers to the comments of Cory J. in *Heywood*[154] about the **deference** which **courts** should show **towards a choice made by the legislature**:

> **In analyzing a statutory provision to determine if it is overbroad, a measure of deference must be paid to the means selected by the legislature. While the courts have a constitutional duty to ensure that legislation conforms with the *Charter*, legislatures must have the**

[154] *Ibid.*

> **power to make policy choices. A Court should not interfere with legislation merely because a judge might have chosen a different means of accomplishing the objective if he or she had been the legislator.**
>
> **. . . . .**
>
> **. . . <u>before it can be found that an enactment is so broad that it infringes s. 7 of the *Charter*, it must be clear that the legislation infringes life, liberty or security of the person in a manner that is unnecessarily broad, going beyond what is needed to accomplish the governmental objective</u>.**[155]
>
> (Emphasis by Court.)

In the Court's opinion the infringement of the right to life, liberty and security of the person in the case at bar is not "unnecessarily broad, going beyond what is needed to accomplish the governmental objective".

Consequently, the infringement of the right to life, liberty and security of the person in the case at bar is done in accordance with the principles of fundamental justice.

(C) <u>Section 1 of Charter</u>

In view of the fact that there is no infringement of s. 7 or of the Quebec Charter, the Court considers that there is no need to analyse s. 1 of the Charter. At the same time, the Court considers that an

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[155] *Ibid.*, at 793-794 (Cory J.).

analysis under s. 1 would show that the impugned provisions in the case at bar are a reasonable limit in a free and democratic society.

V. QUESTION THREE

Question three is as follows: **is the prohibition from obtaining private insurance not cruel and unusual treatment within the meaning of s. 12 of the Canadian Charter, as being contrary to the equality right protected by s. 15 of the Charter?**

(A) PARTIES' ARGUMENTS

The applicants alleged that s. 11 HIA is a breach of s. 12 of the *Canadian Charter of Rights and Freedoms*.[156] Section 12 of the Charter reads as follows:

> **12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment**.

They argued that the prohibition contained in s. 11 HIA, which prohibits any payment to a non-participating physician in a private hospital for a medically required hospital service constitutes cruel and unusual treatment.

The applicants argued that the effect of this provision is to cause them serious psychological suffering by preventing them from having access to private hospital services. They feel that the public

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[156] Hereinafter "the Charter".

health system will not be able to provide them with the care they need at the proper time in the event of illness. They expressed their concern at the idea they would die while waiting for the care offered by the public system.

As to s. 12 of the Charter, they argued that it is not limited to penal situations and so could be applied in the case at bar.

In their submission, the prohibition contained in s. 11 HIA constitutes “treatment” within the meaning of the Charter and that treatment is cruel and unusual since it causes them severe mental anguish.

Finally, they maintained that the infringement of the Charter in the case at bar cannot be redeemed by means of s. 1. There is no rational connection between the objective sought by the legislature and the means adopted to attain it. Further, they added that s. 11 HIA does not meet the minimal deprivation test.

For her part, the Attorney General of Quebec considered that s. 12 of the Charter applies primarily in penal situations. She further alleged that a mere prohibition by the state cannot constitute “treatment” within the meaning of the Charter and that it is actually the applicants’

particular situation which is the source of any suffering alleged in the case at bar. She maintained that the state does not play a sufficiently active part to constitute “treatment” where the applicants are concerned.

Finally, it was argued that if there is treatment in the case at bar, it cannot be regarded as cruel and unusual. In the submission of the Attorney General of Quebec, this is not an extreme case to which s. 12 of the Charter should be applied.

(B) DISCUSSION

First, it should be noted that s. 12 of the Charter generally applies to penal matters. However, the Supreme Court **has not ruled out the application of this protection outside a penal or quasi-penal context**.[157]

> **For the purposes of the present analysis, I am prepared to assume that “treatment” within the meaning of s. 12 may include that imposed by the state in contexts other than that of a penal or quasi-penal nature. However, it is my view that a mere prohibition by the state on certain action, without more, cannot constitute “treatment” under s. 12. By this I should not be taken as deciding that only positive state actions can be considered to be treatment under s. 12; there may well be situations in which a prohibition on certain types of actions**

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[157] *Chiarelli v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 711, at 735; *Rodriguez v. Attorney General of British Columbia*, [1993] 3 S.C.R. 519, at 609-611.

> **may be "treatment" as was suggested by Dickson J. of the New Brunswick Court of Queen's Bench in *Carlston v. New Brunswick (Solicitor General)* (1989), 43 C.R.R. 105, who was prepared to consider whether a complete ban on smoking in prisons would be "treatment" under s. 12. The distinction between that case and all of those referred to above, and the situation in the present appeal, however, is that in the cited cases the individual is in some way within the special administrative control of the state. In the present case, the appellant is simply subject to the edicts of the *Criminal Code*, as are all other individuals in society. The fact that, because of the personal situation in which she finds herself, a particular prohibition impacts upon her in a manner which causes her suffering does not subject to "treatment" at the hands of the state. The starving person who is prohibited by threat of criminal sanction from "stealing a mouthful of bread" is likewise not subjected to "treatment" within the meaning of s. 12 by reason of the theft provisions of the *Code*, nor is the heroin addict who is prohibited from possessing heroin by the provisions of the *Narcotic Control Act*, R.S.C., 1985, c. N-1. There must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question, whether it be positive action, inaction or prohibition, to constitute "treatment" under s. 12.**[158]

Further, as appears from the last passage, a majority of the Supreme Court considered that a mere prohibition by the state will rarely constitute "treatment" within the meaning of s. 12 of the Charter. For there to be genuine "treatment", the state must intervene in some substantial way. If the prejudicial effect of the prohibition is due largely to

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[158] *Rodriguez v. Attorney General of British Columbia*, *supra*, note 2, at 611 (Sopinka J.).

the individual's particular situation, not to the legislation itself, it is not possible to speak of "treatment" within the meaning of the Charter.

In the case at bar, s. 11 HIA prohibits the conclusion of certain specific contracts relating to hospital services when the latter are included in the public system. This prohibition is not the source of the suffering alleged by the applicants. Rather, the "suffering" results from the applicants' subjective belief that the public system will not respond to their medical needs at the proper time. It is the applicants' perception which causes their mental anguish.

Further, the Court considers that *Carlston v. New Brunswick (Solicitor General)*[159] cannot apply in the case at bar for the same reasons stated by Sopinka J. in *Rodriguez*. In *Carlston* the issue was a measure imposed in a penitentiary situation, where the state plays a very active part. In the case at bar, the state is not intervening actively enough in respect of the applicants to conclude that there is "treatment" within the meaning of s. 12.

Additionally, even if this were "treatment", **it could not be regarded as cruel and unusual.** In *R. v. Smith*,[160] the Supreme Court set out the test for determining whether punishment or treatment is cruel or unusual. In the words of Lamer J.:

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[159] (1989) 43 C.R.R. 105 (N.B.Q.B.).
[160] [1987] 1 S.C.R. 1045.

> **The criterion which must be applied in order to determine whether a punishment is cruel and unusual within the meaning of s. 12 of the *Charter* is, to use the words of Laskin C.J. in *Miller and Cockriell*, *supra*, at p. 688, "whether the punishment prescribed is so excessive as to outrage standards of decency". In other words, though the state may impose punishment, the effect of that punishment must not be grossly disproportionate to what would have been appropriate**.[161]

As mentioned above, s. 11 HIA **is a measure designed to ensure that the public health system is viable**. This provision cannot be so constraining as to outrage standards of decency **as it is a measure taken to preserve the dignity of all Quebecers by guaranteeing them adequate health care.**

The Court would like to adopt the analysis of s. 12 of the Charter by Rousseau-Houle J.A. of the Court of Appeal in *Centrale de l'enseignement du Québec v. Québec (Procureur général)*.[162] She said:

> [TRANSLATION]
>
> **The use of the word "grossly" to characterize the disproportionality test reflects the concern the Supreme Court had, as La Forest J. noted in *R. v. Lyons*,[163] "not to hold Parliament to a standard so exacting . . . as to require punishments to be perfectly suited to accommodate the moral nuances**

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[161] *Ibid.*, at 1072 (Lamer J.).
[162] [1998] R.J.Q. 2897 (C.A.).
[163] [1987] 2 S.C.R. 309.

> **of every crime and every offender". These remarks were adopted by Gonthier J. in *R. v. Goltz*,[164] who concluded that it followed from *Edward Dewey Smith* and *Lyons*, *supra*, that the words used and purposes sought by the legislatures should not be easily countered in a challenge based on s. 12.**
>
> **These principles, concluding that it is difficult to infringe s. 12, are supported by *Steele v. Mountain Establishment*,[165] in which Cory J. said for the Court:**
>
> > **It will only be on rare and unique occasions that a court will find a sentence so grossly disproportionate that it violates the provisions of s. 12 of the *Charter*. The test for determining whether a sentence is disproportionately long is very properly stringent and demanding. A lesser test would tend to trivialize the *Charter*.**[166]

The case at bar is quite clearly not an extreme case that requires application of the guarantee contained in s. 12 of the Charter.

The Court accordingly concludes that s. 11 HIA does not infringe s. 12 of the Charter. **The question then is whether it is contrary to the equality right protected in s. 15 of the Charter**.

(C) EQUALITY RIGHT

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[164] [1991] 3 S.C.R. 485.
[165] [1990] 2 S.C.R. 1385, at 1417.
[166] *Centrale de l'enseignement du Québec v. Québec (Procureur général), supra*, note 7, at 2915-2916.

The applicants alleged that ss. 15 HIA and 11 HIA infringe the equality right contained in s. 15 of the Charter. Section 15(1) of the Charter reads as follows:

> **15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.**

The applicants considered that the impugned provisions create an unlawful distinction between Quebec residents and residents of other provinces, since the latter have the option of paying for or obtaining insurance for private medical care.

The Attorney General of Quebec objected that there is no real distinction because all Quebec residents are treated in the same way. Further, she argued that Quebec residents are not an isolated group which is the subject of prejudices or stereotypes.

(D) DISCUSSION

In *Law v. Canada*,[167] the Supreme Court recently clarified the protection provided by s. 15(1) of the Charter. The Court, *per*

[167] [1999] 1 S.C.R. 497.

Iacobucci J., laid down guidelines for the application of this guarantee. According to the Court, when a challenge under s. **15 comes before a court it should make three inquiries**:

> **First, does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is differential treatment for the purpose of s. 15(1). Second, was the claimant subject to differential treatment on the basis of one or more of the enumerated and analogous grounds? And third, does the differential treatment discriminate in a substantive sense, bringing into play the purpose of s. 15(1) of the *Charter* in remedying such ills as prejudice, stereotyping, and historical disadvantage? The second and third enquiries are concerned with whether the differential treatment constitutes discrimination in the substantive sense intended by s. 15(1).**[168]

Accordingly, in order to conclude that there has been a breach of s. 15(1) of the Charter, there must (i) **have been a distinction**; (ii) **it must have been based on an enumerated or analogous ground**; (iii) **it must discriminate in a substantive sense as being contrary to the purpose of s. 15(1).**

In the case at bar ss. 15 HIA and 11 HIA make a distinction between Quebec residents and non-residents. A Quebec resident cannot

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[168] *Ibid.*, at 524.

obtain private insurance for medical care when the latter is offered by the public health system, and he cannot contract with a non-participating physician for medically necessary hospital services in a private hospital. A non-resident is not affected by this prohibition. The statute thus clearly makes a distinction between Quebec residents and non-residents.

Can the place of residence be a ground analogous to those enumerated in s. 15(1) of the Charter?

Profs. Henri Brun and Guy Tremblay explain:

> [TRANSLATION]
>
> **The Supreme Court has told us that analogous grounds are grounds which, like those enumerated, refer to the personal characteristics of individuals, and in particular, relatively immutable characteristics, which are not the result of the individual's free choice and cannot be readily altered.**[169]
>
> (Emphasis by Court.)

Can we say that a place of residence is an immutable characteristic of the individual? *Prima facie* it would appear that, apart from economic factors, an individual is entirely free to choose his place of residence.

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[169] Henri Brun and Guy Tremblay, *Droit constitutionnel*, 3d ed. Cowansville, Les Éditions Yvon Blais, 1997, p. 1069.

The comments of Prof. Peter W. Hogg on the point are apposite:

> **The listed grounds are "race, national or ethnic origin, colour, religion, sex, age or mental or physical disability". These are all *personal characteristics* of individuals. Moreover, all but one[170] are personal characteristics that are *immutable*, at least in the sense that they cannot be changed by the choice of the individual.**
>
> . . . . .
>
> **Another way of looking at immutability as the common element of the listed personal characteristics is to notice that the characteristics are inherent, rather than acquired. They do not reflect a voluntary choice by anyone, but rather an involuntary inheritance. They describe what a person is, rather than what a person does. Section 15 prohibits laws that distinguish between people on the basis of their inherent attributes as opposed to their behaviour.**[171]

A place of residence results partly from a combination of circumstances but is chiefly due to a decision made by the individual and so is not an immutable characteristic.

In *R. v. Turpin*,[172] the Supreme Court had to consider an allegation of discrimination based on the place of residence. The appellants pointed to the fact that under ss. 427, 429 and 430 of the

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[170] Religion.
[171] Peter W. Hogg, *Constitutional Law of Canada*, 4th ed. Toronto, Carswell, 1997, p. 1254.
[172] [1989] 1 S.C.R. 1296.

Criminal Code, they could not be tried before a judge in Ontario sitting alone, whereas if they resided in Alberta they could be. Although the appeal was dismissed, Wilson J., writing the Court's opinion, noted that in certain circumstances place of residence might be an analogous ground within the meaning of s. 15(1) of the Charter:

> **I would not wish to suggest that a person's province of residence or place of trial could not in some circumstances be a personal characteristic of an individual or group capable of constituting a ground of discrimination.**[173]

Prof. Peter W. Hogg gave the following explanation of this statement by Wilson J.:

> **This is a rather opaque statement, from which it is probably unwise to draw any strong inferences. However, she does imply that province of residence could "in some circumstances" be an analogous ground. Clearly, as she notes, it is a personal characteristic, and the question is whether it is sufficiently immutable to qualify as similar to the listed grounds. I would have thought that place of residence is a matter of personal choice, and is not immutable for that reason.**

It must therefore be assumed that in some cases place of residence is capable of being regarded as a ground analogous to those enumerated in s. 15(1) of the Charter.

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[173] *Ibid.*, at 1333.

In *Law*, Iacobucci J. undertook to analyse the purpose of s. 15(1) of the Charter and came to the following conclusion:

> **It may be said that the purpose of s. 15(1) is to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration. Legislation which effects differential treatment between individuals or groups will violate this fundamental purpose where those who are subject to differential treatment fall within one or more enumerated or analogous grounds, and where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, or otherwise has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society.**[174]
>
> (Emphasis by Court.)

The purpose of s. 15 of the Charter is thus to promote **the idea that people are equal before the law in Canada and deserve the same consideration. It is also to prevent individuals being treated differently because they have certain presumed or stereotyped personal characteristics**. In short, this provision is designed to avoid certain groups or individuals being underrated or being the object of measures that perpetuate the view that they are less worthy of respect.

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[174] *Law v. Canada, supra*, note 1, at 529.

In light of the foregoing, can we conclude that the purpose or effect of ss. 15 HIA and 11 HIA are not consistent with s. 15 of the Charter? The Court does not think so.

It is hard to see how all Quebec residents are victims of discrimination in the case at bar. The applicants argued that non-residents have the opportunity of paying for care in Quebec. This is true, but they must pay for this care whereas any Quebec resident may receive it free of charge.

Further, there does appear to be either in the purpose or the effect of the disputed provisions any conflict between them and the intent of s. 15 of the Charter. The effect of these provisions is in no way to underrate certain individuals or to perpetuate stereotypes. **Instead, their effect is to promote legitimate social interests and to enhance the dignity of Quebecers by guaranteeing them medical care.** There is no inconsistency between the provisions at issue and the guarantee contained in s. 15 of the Charter, and there can therefore be no infringement. This answers question one.

CONCLUSIONS

The Court **has answered the questions raised in the negative.**

First, the Court indicated that s. 15 HIA and 11 HIA are **valid** in terms of the distribution of powers as their purpose is to regulate the public health system.

Secondly, the Court found that the **Supreme Court has left the way open to extending the scope of s. 7 of the Charter** so as to guarantee greater autonomy to individuals without excessive interference by the state. The Court also considers that **if access to the health system is not possible, it is illusory to think that rights to life and security are respected**. The Court feels that the economic barriers created by ss. 15 HIA and 11 HIA are related to the opportunity of access to health care.

In the case at bar, the applicants are not in a situation where their state of health requires care. At the same time, the Court considers that the right to health and even to some extent the right to security **has no real meaning unless it is given a preventive scope**. The “threat” or deprivation must be real or imminent. **Here it is imminent, but the infringement is done in accordance with the**

principles of fundamental justice and so cannot be regarded as conflicting with s. 7 of the Charter.

The disputed provisions were adopted on the basis of considerations of equality and human dignity and are not in conflict with the values embodied in the Charter or the Quebec *Charter of Human Rights and Freedoms*.

It is entirely understandable that a government with the best interests of the public at heart should adopt a solution that will benefit the largest number of individuals.

The question of whether being unable to obtain private insurance constitutes cruel and unusual treatment **was answered by the Court in the negative**. The Supreme Court considers that "treatment" will only very rarely be similar to a mere prohibition. Here the penalty inflicted is not so excessive as to be inconsistent with human decency.

Finally, **there is no infringement of s. 15 of the Charter**. This is clearly demonstrated by the Supreme Court's analysis in *Law*.[175]

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[175] [1999] 1 S.C.R. 497.

The impugned provisions serve to promote legitimate social interests. There is no inconsistency with the principles found in the Charter. The Court notes what the highest court in the land said in *Edwards Books and Art Ltd.*:

> **In interpreting and applying the *Charter* I believe that the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons.**[176]
>
> (Emphasis by Court.)

Before concluding, the Court should say that solutions to the problems in the health system are not to be found through legal channels. Thirty years have passed since health insurance was introduced. In *La Presse* of November 17, 1999, Claude Castonguay wrote [TRANSLATION] "**a revision of the Quebec system is inevitable and we will have to change the way we do things**".

At the start of this judgment, the Court noted that we should not forget past times in which persons with illness could not obtain health care because they lacked the means. "**Those who forget history are doomed to repeat it**".

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[176] *Ibid.*, at 779.

The expert witnesses heard stated that the Canadian health care system is an altruistic and generous effort by society and its problems will not be solved by undermining its foundation. Does this also mean that there is no scope for reform?

The Court will say no more on this question, as it is a political question which the Court cannot answer, that being the function of legislature.

FOR THESE REASONS, THE COURT:

DISMISSES the motion;

WITH costs.

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