Appellant Chaoulli's Factum

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PART I – FACTS

A. INTRODUCTION

1. Since 1970, section 15 of the *Health Insurance Act*, R.S.Q. c. A-29 ("15 HEIA") completely forbids a Quebec resident and a private insurer from entering into a contract for money for the purpose of covering health services already covered by the public regime, which are medically required services.

2. Moreover, section 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28 ("11 HOIA") completely forbids, first, that a Quebec resident and a physician enter a contract for consideration for the fees related to a medically required service provided in a hospital and, secondly, to a Quebec resident and a hospital to enter a contract for consideration for the hospital costs generated by the service, pursuant to *an Act modifying Various Legislative Dispositions concerning the Application of an Act Respecting Health and Social Services*, L.Q., 1992, c. 21, s. 98(3).

3. The appellant Chaoulli ("the appellant") acts as a citizen and physician. As a physician, in 1995 and 1996 he has lobbied the Minister of Health and Social Services and the Quebec Federation of General Practicioners (QFGP) without success, in order to have them acknowledge the right of a doctor, within the public health regime, to mainly do home consultations. With the help of an emergency vehicle authorized by the police services, he was making emergency visits at homes and public places, within the bounds of the public regime.

4. The appellant had noticed that for many years, within the public regime, patients were having difficulty gaining access to the services of doctors in their home and in public places, and that, as a result, lives were lost (Piché decision, pp. 16-17, appellants' joint file [hereinafter «A.J.F.»] – vol. I, pp. 32, 33, testimony of Chaoulli, 8 Sept. 1999, vol. II, pp. 356 to 359, 362, 365, 366 to 371, 372, 373, Chaoulli 14 Sept 1999, vol. IV, pp. 36, 37, Chaoulli 15 Sept 1999, vol. IV, pp. 600 to 602)

5. The appellant had started proceedings, arguing that an agreement reached by the Minister and the QFGP imposing a financial penalty to a doctor whose main activity was to make home visits was *ultra vires*; he had also challenged, before the arbitration decision, and all the way up to this Court, the jurisdiction of the arbitration council.

6. On December 4 2000, Justice LeBel, of this Court, ruling on the appellant's demand requesting among other things that three applications for leave be examined simultaneously had ruled that «largely, the three demands for leave are related to the same debate which has opposed, for a number of years, the appellant to the Quebec public health insurance regime» and had ordered that the three requests be referred to a same panel of this Court. One request challenged the jurisdiction of the arbitration council. In a decision handed down on February 22 2001, Justices L'Heureux-Dubé, Arbour and LeBel rejected the request and, as a consequence, the issue went before the arbitration council. In the same proceedings, this time following the arbitration decision, the appellant has filed a demand for leave before this court.

7. Since the month of September 1996, the appellant lobbies in favour of patients' rights to take private insurance and to pay for hospital services which are medically required.

In October 1996, the appellant has opted for the status of 'doctor not participating in the public regime (hereinafter "NP MD") and quickly realized that, outside of the public regime, some patients who are incapable of paying the fees of a NP MD for medical services provided outside a hospital, notably for the services of a home doctor, do not have access to these private medical services, because these patients cannot, without the possibility of penal retribution, take on private insurance in order to cover these fees.

8. From August 8 1997, in order to personally contribute to patients having access to private hospital services, the appellant has addressed to the Director of the «Régie Régionale de la Santé Montreal Centre» a request for deliverance of a permit for the opening of a «non-coventioned private establishment» for the exploitation of a hospital centre for general and specialized care. In September 1997, he has filed the present application for declaratory judgment, which is under appeal before this court. On March 19 1998, the Régie has refused to approve the appellant's request (Chaoulli, 14 Sept 1999, vol. IV, pp. 585, 586, 588, 489). Since July 15 1998, the appellant is once again a doctor participating in the public regime (Chaoulli, 14 Sept., vol. IV, p. 591).

9. He also militates for the principle of the supremacy of the law to be respected within the Quebec public health care regime. To this end, he had filed an application for a declaratory judgment before the Quebec Superior Court, in relation to which a motion for dismissal from the respondent the Attorney General of Quebec ("AGQ") was rejected. In this file, the honourable Chief Justice André Deslongchamps has suspended the procedures and hearing until this Court renders its final judgment.

10. As a citizen, the appellant feels great anguish at not being presently able to enter into the mentioned contracts and at, supposing that his condition requires it, being confronted with the difficulties of gaining access to services medically required as offered by the public system: he fears the possibility of pain and suffering, and even of losing his life. Notably, he cannot presently subscribe to private insurance so that, if he is within a 50 to 250 km radius of an urban centre and his state requires immediate access to a medically required service, he would be able to choose helicopter transport with an NP MD on board, rather than ground transport with only an ambulance technician on board (Piché decision, pp. 20, 21, vol. I, p. 36, 37).

B. THE SUPERIOR COURT'S JUDGMENT

11. The trial judge has stated that in 1988, the appellant did not have the right to begin practicing on the Montreal South Shore. She said that in 1996, the appellant faced heavy financial penalties for not having complied with the regulations of the Quebec «Régie de l'assurance-maladie» for having 'stubbornly' refused to respect the decisions of the Régie. All this prompted the judge to question the real motivations of the appellant in the present debate.

12. With respect to the division of powers, judge Piché was of the opinion that it was possible to refer to extrinsic evidence and then decided that s. 15 HEIA aimed at preventing an important part of health resources from migrating to the private sector and that it was a logical part of the regulation of the public health regime.

13. She also concluded that s. 11 HOIA aimed at discouraging the development of a private hospitalization system, in order to promote the public regime.

14. Judge Piché, following Chief Justice Dickson's opinion according to which criminal law aims at expressing society's collective reprobation of certain acts, was of the view, that ss. 15 HEIA and 11 HOIA were not aimed at prohibiting reprehensible conduct in itself (decision pp. 70, 76, 77, 78, 79, vol. I, p. 86, 92 to 95).

15. With respect to s. 7 of the *Charter*, the judge has concluded that, considering the costs involved, the economic right of a resident is incident to the rights to life, liberty and security of the person, that the right of a doctor to practice his profession without constraints in the private domain is a purely economic right, that there is no constitutional right to choose the origin of medically required care, and that there will not be an infringement of s. 7 if the public regime offers and makes accessible the same services (decision 111, 112, vol. I, p. 127, 128).

16. The judge concluded that waiting lists are too long, that there are grave problems in certain health care sectors, including waiting times in emergency rooms, that there is no real infringement of the rights to life, liberty and security of the person, but that the plaintiffs can complain of a potential and imminent infringement, thus concluding that there was an infringement of the rights to life, liberty and security of the person (decision, pp. 27, 112, 113, 116, 117, vol. I, p. 43, 128, 129, 132, 133).

17. The judge has held that over and above the provisions of the *Canada Health Act*, S.C. 1984, c. C-6, s. 7 of the *Charter* guarantees a right to public health care (decision, p. 109, vol. I, p. 125).

18. The judge has concluded that the impugned provisions had two purposes: 1) to prevent the establishment of a private health care system parallel to the public and universal health care system, so that all health resources be put in the public health care system (decision, p. 127, vol. I, p. 143), and 2) to ensure the adequate functioning of the public regime (decision, pp. 76, 78, 79, vol. I, pp. 92, 94, 95).

19. Judge Piché has held that, for all health resources to benefit all Quebeckers, «without discrimination», the establishment of a parallel private health care system had to be prevented. (decision, p. 127, vol. I, p. 143).

20. She then concluded that the establishment of a parallel private health care system would threaten the integrity, the smooth functioning and the viability of the public system. (decision, p. 127, vol. I, p. 143).

21. With respect to s. 12 of the Charter, the judge has held that the prohibition of 11 HOIA was not the source of the alleged pain and suffering by the appellant, that the state does not interact actively enough with the appellant for there to be 'treatment' and that s. 11 HOIA preserves the dignity of all Quebeckers (decision, pp. 134, 135, vol. I, p. 150, 151).

22. With respect to s. 15 (1) of the Charter, the judge has held that there was a distinction, that place of residence is mostly attributable to a decision taken by the individual, that

every resident can get care for free, and that Quebec residents are not demeaned by the impugned provisions, but that, to the contrary, their dignity is bolstered (pp. 141, 144, vol. I, pp. 157, 160).

C. THE QUEBEC COURT OF APPEAL'S JUDGMENT

23. The Quebec Court of Appeal has held that the purpose of ss. 11 HOIA and 15 HEIA is the regulation of the public health services regime and that they are logically integrated in their respective laws (decision, par. 17, vol. I, p. 180).

24. Justice Forget has maintained Judge Piché's evaluation of the evidence, according to which, without the possibility of entering into the relevant contracts, because of the costs engaged, access to private services is illusory, and held that there was an infringement of the rights guaranteed by s. 7 (appeal decision, par. 65, vol. I p. 187), but that the infringement was in accordance with the principles of fundamental justice.

25. Justice Delisle, on the other hand, has concluded that the relevant contracts are not fundamental to the life of the person, that they constitute a purely economic right, and Justice Brossard has held that «in the present case, it has not been demonstrated that the infringement to that right puts the appellant's fundamental right to health and to life in jeopardy». Like Judge Piché, Justice Delisle has held that there exists a fundamental right to receive public health services (appeal judgment, par. 25, Vol. I, pp. 181-182)

PART II – THE ISSUES

26. Did the impugned provisions really aim at prohibiting an act reprehensible in itself?

27. Could the HEIA have survived in the absence of 15 HEIA?

28. Has the HOIA survived between 1970 and 1992, in the absence of the modification made to s. 11 HOIA?

29. Do the impugned provisions infringe the right to life, liberty and security of the person protected by s. 7 of the Charter?

30. Does s. 7 of the Charter protect the freedom of a resident of Quebec to choose the source of medically required services, and does it protect the freedom of a NP MD, of a private insurer and of a private hospital, to enter into the relevant contracts?

31. Have the lower courts erred by omitting to recognize evidence showing that the distinction imposes a burden and a disadvantage to residents of Quebec?

32. Do the impugned provisions bolster the dignity of residents of Quebec?

33. With respect to the protection against cruel and unusual punishment, does the total prohibition imposed by the state on the appellant, under threat of penal repression, to buy a hospital service medically required, imply the deployment of an active state process which comprises the exercise of some control by the state over the appellant?

34. Supposing that the purpose of the impugned dispositions is the creation and maintenance of a universal public regime of health services, did Judge Piché err in her analysis of the balance between the interests of the individual and those of the community under s. 1 of the Charter?

35. Has judge Piché erred by justifying the impugned provisions following an analysis of the relationship between the impugned provisions and the prohibition of a private health system parallel to the universal public health regime?

PART III – ARGUMENTS

A. INTRODUCTION

36. In the present case, the same question is at the heart of the analysis for both the issue of division of powers and for the issues under ss. 7, 15(1) and 12 of the Canadian Charter of Rights and Freedoms: in the Quebec society of the 70's and 90's, was the value of equality in access to medically required services the same as the value of equality carried in the Canadian Charter of Rights and Freedoms since 1982?

37. In the division of powers analysis, at the time when the prohibitions were adopted, the evidence shows that it was socially undesirable that a resident of Quebec have better access to medically required services by paying for it outside of the public regime. In the analysis under s. 7, the appellant has the freedom to behave differently from others. In the analysis under s. 15(1) the distinction which imposes a burden and a disadvantage on the appellant is incompatible with his essential freedom. As to the analysis under s. 12, in the present case it consists in an extension of the s. 15(1) analysis: with respect to the total prohibition imposed by the state on the appellant, under threat of penal repression, to pay an NP MD and a private hospital outside of the public regime in order to obtain a medically required private hospital service, the disadvantage exposed under s. 15(1), imposed by the state on the appellant, entailed by the infringement of his freedom to enter into the relevant contracts, and in effect infringing, potentially and imminently, his right to life, is so serious that it amounts, to the imposition of cruel and unusual punishment by the state.

38. It is public knowledge that within Quebec civil society, with respect to problems of access to medically required services, a debate has opposed, on the one hand, those who argued in favour of the freedom to choose private medical services and, on the other hand, those who, holding a dichotomised view, denounced the spectre of what they called medicine for the rich and medicine for the poor. This debate exists since the adoption of the HEIA.

39. This opposition also expressed itself before the inferior courts. It involved a clash between two collections of values. Four authors have mentioned this opposition: the Canadian Bar Association 1994, pp. 114-16, Marco Laverdière 1998, pp. 138-40, Roy Romanow 2002, xxi to xxiii, and Thomas Courchene, I.R.P.P. 2003, pp. 18-9.

40. Following the definition of the word ideology: "collection of ideas, beliefs of an era, of a society" (Petit Robert Dictionary), it consisted therefore in the clash of two ideologies, both invoking social justice. Their difference was related to, and is still related to, two divergent conceptions of the value of equality. According to the first

conception, social justice required the creation of a universal public health care regime, financed through general taxation, within which no resident could be refused access to medically required services by reason of his incapacity to pay, and required the freedom to choose private medical services outside of the public regime. In the second conception, the creation of a universal public health care regime was necessary, but not sufficient: it wouldn't have been in accordance with the value of equality that a resident, by reason of his capacity to pay for private services outside of the universal public regime, have better access than another resident in the public regime. This ideology was founded, in the realm of medical services, on the total abolition of all privileges with respect to medical services, in the name of «the new Quebec reality» affirmed in the 1970's by the Parti Québécois and by all other groups except the «Ralliement des créditistes» party; it is this new Quebec reality that the era's provincial government has affirmed.

41. When Judge Piché, in her analysis of s. 7, held that in order to avoid all discrimination among Quebeckers, it was necessary to avoid the establishment of a parallel private system, and when she held that the infringement to the freedom to enter into the relevant contracts was fair, this meant that the infringement was fair to the extent which, from this infringement, there resulted equality between all Quebeckers in the domain of medical services. Hence, according to the lower courts, the distinction under s. 15(1) of the Charter and the state's action under s. 12 of the Charter are fair since the impugned provisions guarantee quality to all Quebeckers in the realm of medical services. The lower courts thus having concluded in an absence of injustice have also concluded that the impugned provisions were in accordance with human dignity. Thus, the appellant submits that the lower courts have repeated the same mistake in their analysis of ss. 7, 15(1) and 12 with respect to the values of equality and human dignity, which are related.

42. With respect, the appellant submits to this Court that, if there was an infringement of the rights guaranteed by s. 7, it would be useful to also respond to the issues raised by ss. 15(1) and 12 of the Charter, even before the analysis of the principles of fundamental justice, for the following reasons:

    42.1 The value of equality with respect to access to medical services is considered by Canadians to constitute a symbol of their cultural identity. (I-16, pp. 16 and 10, vol. XI, pp. 1943 and 1945).

    42.2 Section 15 HIA has been adopted long before the adoption of the Canadian Charter, in an era when the value of equality had been expressed in a manner which will be exposed in the analysis concerning the division of powers, so that it would be useful that this Court specify the ambit of the value of equality with respect to access to medically required services since the adoption of the Canadian Charter.

    42.3 Human dignity is the basis of the rights and freedoms guaranteed by ss. 7, 15(1) and 12 of the Charter.

    42.4 All Canadians are concerned by the appellant's allegations concerning ss. 7, 15 (1) and 12 of the Charter.

42.5 Following the opinion of Justice Wilson in *R. v. Morgentaler* [1988] 1 R.C.S. 30, p. 175, an infringement of the rights guaranteed by the first part of s. 7, which would at the same time infringe any other Charter right, would ipso facto violate the principles of fundamental justice. Justice Wilson quoted the following statements by Justice LaForest:

> . . . the *Charter* protects a complex of interacting values, each more or less fundamental to the free and democratic society that is Canada (*R. v. Oakes*, [1986] 1 S.C.R. 103, at p. 136), and the particularization of rights and freedoms contained in the *Charter* thus represents a somewhat artificial, if necessary and intrinsically worthwhile attempt to structure and focus the judicial exposition of such rights and freedoms. The necessity of structuring the discussion should not, however, lead us to overlook the importance of appreciating the manner in which the amplification of the content of each enunciated right and freedom imbues and informs our understanding of the value structure sought to be protected by the *Charter* as a whole and, in particular, of the content of the other specific rights and freedoms it embodies.

Justice Wilson continued:

> I believe, therefore, that a deprivation of the s. 7 right which has the effect of infringing a right guaranteed elsewhere in the *Charter* cannot be in accordance with the principles of fundamental justice.

B. THE MISTAKES MADE BY THE FIRST INSTANCE JUDGE

43. In the analysis of the purpose of the impugned provisions, Judge Piché erred with respect to s. 15 HEIA (decision pp. 71-72, vol. I, pp. 87-88) by omitting to analyse evidence submitted by the appellant, relevant to legislative and social facts and corroborated by expert witnesses, showing, at the time of adoption of s. 15 HEIA, the socially undesirable character of a parallel private health care system, and Judge Piché has erred in concluding that the prohibition of a parallel private health care system was motivated by the need to promote the public regime (Piché decision pp. 76-78, vol. I, p. 92-4). Had she analyzed this relevant evidence, she should have concluded that in 1970, when s. 15 HEIA was adopted, and then in 1992, there existed collective social reprobation for certain acts, namely the buying and selling of private medical services outside of the public regime, and she should have applied Justice Dickson's comment concerning the criminal law, quoted by Justice Piché (decision p. 79, vol. I, p. 95), as exposed at par. 14 of this factum.

44. The judge has also erred with respect to s. 11 HOIA by omitting to analyse relevant evidence concerning the circumstances preceding the modification to s. 11 HOIA in 1992. In the analysis of the freedom of an NP MD to enter into a private contract with a resident, the issue of the appellant's interest as a doctor is useful, to the extent that the prohibition of s. 11 HOIA applies not

only to a patient, but also to an NP MD and to a hospital, and to the extent that the appellant intends to open a private hospital not affiliated with the public system in Montreal, so that residents of Quebec will be able to access private hospital services in Quebec. Hence, the appellant clearly has an interest in having an NP MD be free to enter into a contract covered by s. 11 HOIA.

45. With respect to patients' access to medical services provided at home (p. 21 of judgment, vol. I, p. 37), the trial judge, by questioning the appellant's interest as a physician, has erred in law, for three reasons. First, by holding that in 1988 the appellant did not have the right to begin his practice on the Montreal South Shore, Judge Piché has exceeded her jurisdiction since neither she or any other court has ever been seized of proceedings against the appellant for breach of contract. Second, the judge has erred by holding that the appellant had not followed the regulations of the «Régie de l'Assurance-Maladie du Québec», because during the inquiry and the hearing, and until the evidence was closed, the appellant had informed the judge that these proceedings were already pending before another jurisdiction. (Chaoulli, 15 sept 1999, pp. 94-97, vol. IV, p. 596-599). Third, following Justice Gonthier's opinion in *Re Therrien* [2001] 2 R.C.S. 3, par. 108-111, judge Piché has erred by unjustifiably criticizing the appellant's motivations, when she wrote (decision pp. 21, 23, vol. I, p. 37-39):

> Dr. Chaoulli presently faces important penalties for not having followed the RAMQ's regulations; could this have influenced him in his crusade? (…) All this causes the court to be questioning the real motivations of Dr. Chaoulli in the present debate.

46. Judge Piché (pp. 47-61, vol. I, p. 63-77), erred by substituting expert witnesses Wright, Denis, Marmor and Coffey's written reports for their verbal testimonies, without having obtained the parties' consent, and by committing a serious typographic mistake, having written 'presented' instead of 'prevented' (Piché decision, p. 61, 3rd par., vol. I, p. 77), which had the effect of having the appellant's expert, Dr. Coffey, say the opposite of what he thought. In the case of *Massinon c. Ghys*, 1998, p. 10, the Quebec Court of Appeal had held:

> The expert report per se is not proof of its content, unless the parties have consented. It is the testimony of the expert that constitutes the evidence and which must be considered by the judge. According to art. 402.1 C.p.c., the filing of the report and its communication to the other party are prerequisites for the expert's testimony.

As concerns these experts' testimony, the mistake is even more flagrant because Judge Piché gave them great credibility.

C. MISTAKES MADE BY THE COURT OF APPEAL

47. Justice Delisle erred by holding that s. 1 cannot be used to judicially challenge the justice of a societal choice since, in the case of infringements to rights and freedoms, this is precisely the role of the Canadian Charter.

48. Justice Delisle erred in holding that there must exist a certain degree of proximity to the infringement, since in the present case, first, the materialisation of a risk renders the entering into an insurance contract impossible: *Civil Code of Quebec*, L.Q. 1991, c. 64, art. 2389, and second, the infringement of the freedom to buy private insurance is real and not potential and, third, an application for declaratory judgment has both preventive and curative scope. Moreover, an immediate and predictable infringement of the right to life would render all legal action useless, in light of the delays involved. By concluding that there exists a fundamental right to receive public health care, Justice Delisle has committed the same mistake as Judge Piché.

49. Justices Delisle and Brossard have reversed the trial judge's conclusion on the infringement of s. 7 rights. To the extent that, before the Court of Appeal, the respondents have not filed a counter-appeal, nor alleged a clear and serious mistake in the trial judge's evaluation of the evidence, Justices Delisle and Brossard have erred in law by concluding that the appellant had not shown an infringement caused by the prohibitions imposed by the impugned provisions. The trial judge has accepted the evidence put before her to the effect that a disease or accident can occur at any moment, and she has accepted the evidence showing that the costs of private services are such that the prohibition of private insurance renders access to private medical services illusory. Moreover, Justices Delisle and Brossard have not said how the trial judge would have erred in her evaluation of this evidence, so that the trial judge's conclusion concerning the infringement of the rights guaranteed by s. 7 of the Canadian Charter must prevail.

50. To the extent that, in the decision in *R.J.R. MacDonald Inc v. Canada (AG)* [1995] 3 R.C.S., 199, par. 140 and 141, this Court has held that a court of appeal has competence to review a conclusion of the trial judge concerning social and legislative facts, Justice Forget has erred by not reviewing relevant evidence, and by not proceeding to the analysis of the criteria listed in *Oakes*, *supra*.

D. DIVISION OF POWERS

51. It is not contested that if the impugned provisions aimed at suppressing a reprehensible act in itself, these provisions would be part of the criminal law. Here we are concerned with the acts of the four actors affected by the prohibitions i.e. 1) a resident of Quebec paying outside the public regime to obtain better care than in the public regime 2) an NP MD making profits 3) a private hospital making profits and 4) a private insurer making profits by covering medically required services. By virtue of the rule of incidental effects, the province was *intra vires* when it prohibited a participating physician from billing at the same time the public regime and a resident pursuant to 22 (4) (12) HEIA, by refusing to have the state reimburse a patient who consults an NP MD and by giving to the Minister the power to force an NP MD to participate in the public regime pursuant to 30 HEIA. Indeed, by creating a public regime prohibiting overbilling, (defined at R-72, p. 5, vol. IX p. 1689) by a participating physician, the moral aspect of these measures was

incidental to the province's jurisdiction with respect to the creation of a «free» public universal regime, and to the management of public funds. Similarly, in the presence of a parallel private system, the Minister's power to force a number of NP MD's to participate in the public regime was incidental to the maintenance of «free» access everywhere in the province. However, by trying to prohibit a resident from paying an NP MD outside of the public regime, under threat of penal repression, because of the socially undesirable nature of such an act, the province usurped the federal government's exclusive jurisdiction over criminal law.

52. In the criminal law, the nuisance is notably in relation with the existence of values such as an ideology or the attitudes of the public: Professor Jerome Hall (1960), pp. 215 to 217. This analysis has been the object of constant case law in this Court: *Re Combines Investigations Act and Section 498 of the Criminal Code*, [1929] S.C.R. 409, 413, *Morgentaler* [1988], *supra*, p. 70, *Knox Contracting Ltd. v. Canada* [1990] 2 S.C.R. 338, 347, 348, 355, *R v. Morgentaler* [1993] 3 S.C.R., p. 494 to 515, *Morgentaler v. New Brunswick* (A.-G.) [1995] 121 D.L.R. (4th) 431, p. 433, 434 (CA N-B), leave to appeal denied by this Court (No 24623), *R.J.R., supra*, par. 33 and 47, *R v. Hydro-Québec* [1997] 3 S.C.R. 213, par. 119, 122, 127, 148, and by the Quebec Court of Appeal in *Société Asbestos c. Société Nationale de l'Amiante* [1981] C.A. 43, 46, 47.

53. In *Morgentaler*, 1993, *supra*, pp. 484 and 485, concerning the circumstances surrounding the adoption of a law, this Court has noted:

> It is "not only permissible but essential" to consider the material the legislature had before it when the statute was enacted. […] The relevance of legislative history is obvious: it helps to place the statute in its context, gives some explanation of its provisions, and articulates the policy of the government that proposed it.

54. Judge Piché has erred by asking herself whether private medicine is presently considered to be socially undesirable (decision, p. 80, vol. I, p. 96), in that she should have referred to the two eras in which the prohibitions have been adopted, as stated in *R. v. Big M. Drug Mart Ltd* [1985] 1 S.C.R. 295, 335.

55. Supposing that the province acted *intra vires*, nothing would then prevent it, in the context of a new Quebec reality, from trying to suppress (why not) any contract for consideration aimed at getting food for oneself, which is essential to health and survival, and to authorize only food provided by the state, through general taxation, exclusively according to the needs of each individual, and not according to his or her capacity to pay.

56. In *R.J.R., supra*, par. 32 and 47, Justice LaForest, agreeing with the majority with respect to the division of powers issue, wrote :

> In my view, there is no question that it can. "Health", of course, is not an enumerated head under the

> *Constitution Act, 1867* (…) but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question (…)the definition of the criminal law is not "frozen as of some particular time".

57. To the extent that, in Canada, before 1970, to enter a contract for consideration for health services was never considered to constitute criminal behaviour, the validity of the impugned provisions is not, at first sight, doubtful. However, since according to the *Civil Code of Quebec*, L.Q. 1991, c. 64, art. 1381, a contract is onerous when each party obtains an advantage in return for his obligation, the attempt to suppress the impugned contracts in the province means necessarily an attempt to prevent each party from obtaining the advantage sought for. For these reasons, the appellant submits that it is here necessary to invoke the 'theory of colourability'. During parliamentary debates in 1970 and 1992, no one referred directly to the prohibitions included in the impugned provisions, so that it is necessary to proceed to a close analysis of the circumstances which have surrounded their adoption. In the evidence extracts reproduced in the present factum, the emphasis is that of the appellant.

58. On June 26 1970, on the topic of individuals who were already covered by private insurance, Minister Castonguay declared that these regimes will become without effect to the extent that they covered the same services as those covered by the Quebec regime. (R-97.3, p. 554, vol. X, p. 1840). Legally, this means that the previously signed contracts would no longer have obligatory force, and that was indeed the interpretation given by Justice Pigeon in *Fraternité des policiers de la Communauté urbaine de Montréal v. City of Montréal* [1980], 1 R.C.S. 740, 743, 749, when he held that an employer couldn't, since the adoption of the public health insurance regime in 1970, force its employees to pay for the business' private collective insurance. In that declaration from the Minister, nothing seemed to be suggesting that, in the future, those who wanted to purchase voluntary private insurance in order to cover the fees of an NP MD, would no longer have the right to do it, under threat of punishment.

LEGISLATIVE CONTEXT

59. In 1957, Parliament adopted the *Hospital Insurance and Diagnostic Services Act* 5-6 EL. II, 1957, ch. 28, s. 2 (a) (d) (h), 3(2)(a), 5 (1) (b), providing that uniform conditions were compatible with direct billing to patients for insured services; the amount of authorized fees, which would have to be specified by agreement between the federal government and a province, pursuant to s. 5 (1) (b), having never been specified.

60. In 1960, Quebec adopted the *Hospital Insurance Act*, R.S. R.E. II, 1960 c. 78, s. 10 (1) (a) and 10 (3) (b), which covered all residents for hospital costs, prohibiting any hospital from billing a resident for hospital costs, and authorizing all physicians to bill their patients for their fees. In 1964, the

appellant submits that the Hall Commission, created by the federal government, allowed for private voluntary insurances alongside of a mandatory public regime, when it wrote (I-39.1, p. 747, vol. XIII, p. 2447):

> As concerns the issue of obligatory participation, we believe that, as long as decisions of that nature (…) will enable citizens to freely choose a hospital and physician and to freely opt for other advantages which they will be able to secure though private provisions, we can be confident that our democratic ideals will not only be protected, but also fully realized. It is very meaningful that for a democratic society such as ours the *Hospital Insurance and Diagnostic Services Act* was adopted by a unanimous vote of MP's from all political parties represented in the Commons.

61. However, as shown subsequently, the vote in favour of the HEIA was not unanimous. In 1966, Parliament established the conditions of its financial participation to provincial spending by providing again that «uniform conditions» were compatible with the overbilling of patients by all doctors, pursuant to the *Medical Care Act* 1966, 14-15, El. II, ch. 64, art. 4 (1) b). Until then, the «uniform conditions» were complied with as soon as the provincial law provided for the payment, for all residents, of all insured services, and this even when doctors overbilled patients. Put differently, this conception of «uniform conditions» amounted to a safety net for all residents. In Quebec, this concept of safety net was broadened in 1964 by the *Public Assistance Act* R.S.Q. 1964, ch. 216 art. 1 (e), 18, 19 (3), and extended in 1966 by the *Medical Aid Act* S.Q., R.E. II, 1966, c. 11, art. 16, forcing all participating doctors to respect the public tariff, but authorizing a doctor to become a non-participant in the medical assistance regime, pursuant to s. 7 of this Act. Hence, between 1964 and 1966, for the poorest, the totality of costs of hospitalization and medical fees were already covered. Other elements of the legislative context in Quebec are exposed at par. 123 and 124 of this factum. Between 1966 and 1970, on a total of 6000 doctors, only a dozen dissociated themselves from this public medical assistance regime (I-39.5, p. 644, vol. XIV, p. 2523). In this same year 1966, the Castonguay Commission noted that «each doctor must be free to adhere or not to the health insurance plan» (R-97.9, Vol. I, p. 25, vol. X, p. 1864), as well as the socially undesirable nature of the 'moderating ticket' in Quebec (R-97.9, Vol. VII, pp. 20 and 27, vol. X, p. 1870 and 1872), both with respect to consumers and with respect to union groups, the activity of which was considered to be crucial everywhere in Canada:

> THE PREFERENCES OF CONSUMERS… Most important, it seems to us, is the opinion and action of union groups. These groups' action here and elsewhere in Canada has been crucial and, with respect to the problem which concerns us here, their activity suggests that union groups have felt the need and desire to become the interpreters of the aspirations of the «popular classes».

62. In 1970, the government of Quebec acknowledged the mixed nature, public and private, of the European health insurance regimes (R-97.10, pp. 11 and 12 vol. X, p. 1876-1877, R-97.11, Vol. IV, p. 17, vol. X, p. 1883). Following *Morgentaler*, [1993], *supra*, p. 483, legal effects are often a good hint as to the purpose of a text. This applies in the present case. In the 1970's, when all Canadian provinces, including Quebec, had created a universal public health care regime, the laws of certain provinces indicated, unlike in Quebec, the absence of social disapprobation with respect to the decision of a resident to seek care by an NP MD, in that a resident billed by an NP MD could still be reimbursed by the state, according to the public tariff, and no provision prohibited a resident from purchasing private insurance in order to cover exceeding costs which he had to pay. It was the case in Nova Scotia, pursuant to the *Act to Provide for Payment toward the Cost of Certain Medical Services*, S.N.S., 1968, ch. 9, s. 18, 21 (1) (2), in Newfoundland, pursuant to *An Act Respecting Insured Medical care Services in the Province* R.S.N.F., 1970, ch. 265, s. 23 (2) and 26 (3) (4), and in British Columbia, pursuant to *An Act Respecting Medical Services*, S.B.C., 1967, ch. 24, s. 10 (e).

63. At this stage the appellant wishes to open a parenthesis and notes that: 1) Today, in Newfoundland, the minister can authorize a doctor participating in the public regime to bill both the state and a resident, 2) neither private insurance nor NP MD's are prohibited, pursuant to the *Medical Insurance Act*, 1999, N.F. ch. M-5.1, s. 7 (3), 8 (2) (3), 10 (5) and 12 (1) b), and 3) that that province has decided not to intervene in the present affair.

64. In 1961, Saskatchewan authorized all doctors to completely dissociate themselves from the public regime, and authorized a specialist physician, in certain conditions to overbill a resident, while the latter was not prohibited from purchasing a private insurance in order to cover fees, pursuant to the *Saskatchewan Medical Care Insurance Act*, S.S., 1961, ch. 1, s. 28(3). Hence, in that province, there was no collective disapprobation towards a resident who chose to consult outside of the public regime, as reported in 1994 by the Canadian Bar Association, pp. 6 and 7. As concerns the Saskatchewan physicians' strike at the time, it was not necessary that the government of that province «close all the doors», to use the expression used by Mr. Castonguay at trial, in order to prevent their massive disengagement. Indeed, that province, no more than any other in the country, has never seen massive disengagement from its physicians.

65. To the contrary, in other provinces, collective disapprobation was selectively directed at residents who dealt with a doctor who participated in the public regime and who would bill both the state and a resident, in that all doctors participating in the public regime could bill both the state and residents, whereas the residents were prohibited from buying private insurance to cover the fees directly incurred. This was the case in Ontario, pursuant to *An Act respecting Health Services Insurance* S.O., 1968-69, ch. 43, s. 22 (1), 25 (1) and in Alberta, pursuant to *The Alberta Health Care Insurance Act*, 1969, S.A. ch. 43, s. 24 (1) b) and 29 (2) (3). Ontario and Alberta provided, however, for the partial reimbursement of a resident who would go to an NP MD, pursuant to s. 7(1) of the Ontario law and to s. 24 (1) (c) of the Alberta

law. Similarly Prince Edward Island provided for the reimbursement of a resident who would go to an NP MD, up to the amount of the public tariff, but the resident would be prevented from purchasing private insurance in order to cover the direct fees incurred, pursuant to *The Health Services Payment Act* 1970, The Acts of the General Assembly of P.E.I., ch. 24, s. 14 (2), 17 and 27 (1) (a) and (b).

66. The presentation of Manitoba' projected Act, on March 12 1970, is particularly useful, in that it was cited as an example by the QFGP before the Quebec National Assembly during the discussions surrounding the adoption of 15 HEIA, when Mr. Raymond Robillard, the then president of this Federation, expressed his disagreement with the suppression of a parallel private system which would be totally dissociated from the public regime, as explained subsequently. Indeed, three and a half months before the presentation of Bill 8 in Quebec, Manitoba had presented this Bill, similar to the HEIA, prohibiting private insurances and authorizing NP MD's, in the absence of a threat of strike by specialist physicians, and prohibiting the doctors participating in the public regime from billing both the state and a resident, whereas other provinces, and the federal parliament, had authorized such overbilling: *The Health Services Insurance Act*, S.M. 1970, c. 81, C. H. 35, s. 115 (1), 119 and 120 (1) (a) (b).

67. The Northwest Territories did not express as stark a feeling of collective disapprobation as in the harsh province of Manitoba, as the state could reimburse the amount that would have been billed by an NP MD to an insured person, up to the amount of the public tariff. Nevertheless, the insured person was prohibited from purchasing private insurance which would have covered the fees incurred, pursuant to the *Health Insurance Act* R.S.N.W.T. Ch. M-8, ss, 12 (1), 14 (3), 25, whose origins go back to 1974. In sum, depending on the province or territory, the various prohibitions on entering private contracts reflected the disapprobation of certain acts. It is to be noted that jurisdictions which presently prohibit private insurance have decided not to intervene in the present case, namely Alberta, Prince Edward Island, Yukon and the North West Territories, while New Brunswick, which has never adopted such prohibitions, has intervened.

68. Sure enough, the prohibition against private insurance prevented a parallel private health system which would have functioned through NP MD's, but the authorization for overbilling enabled all doctors who participated in the public regime to overbill their patients, which they have done without holding back, as noted by a report by the government of Canada in 1983 (R-72: pp. 5, 6, 19, 21, 22, vol. IX, p. 1689, 1690, 1695, 1697, 1698). This absence of restraint was facilitated by the total absence of provincial regulation of overbilling, although provincial laws authorized governments to regulate it, which they have abstained themselves from doing. Indeed, this all or nothing logic was criticized in 1997 by an agency of the government of Quebec, the Conseil de la santé et du bien-être (R-59, p. 13, vol. IX, p. 1557).

69. In countries which have a universal public regime financed through general taxation, such as England, which had maintained, in 1948, a private regime

parallel to the public one, a parallel private health system has not taken more than 15% of the market for medical services (Coffey 17 sept 1999, D.C.A., vol. VI, pp. 684, 685, Coffey, 21 sept 1999, vol. IV, pp. 756 and 757, Marmor, 28 sept, 1999, vol., VI, p. 1008, R-58, pp. 40, 48, 72, 74, vol. IX, pp. 1534 to 1537, R-72, pp. 12 and 13, vol. IX, p. 1692-1693), because such a private system is not competitive, in the sense that it does not give individuals the possibility to stop financing the public regime. For this reason, among others, it is not logical to argue that 15 HEIA was meant to avoid massive disengagement from doctors or to avoid the transfer of a great proportion of resources towards the private system.

THE TRUE PURPOSE OF S. 15 OF THE HEATH INSURANCE ACT

70. In the previously cited cases of *Morgentaler* [1993], pp. 482 to 494, and *Morgentaler* [1995], p. 434, this Court has established the way in which the true purpose of an impugned law must be found; and, concluding in the 1993 case that the prohibition of «free standing abortion clinics», then considered socially undesirable, was ultra vires, it said:

> The analysis of pith and substance necessarily starts with looking at the legislation itself, in order to determine its legal effect (…) Legal effect is often a good indicator of the purpose of the legislation (…) in one context practical effect may reveal the true purpose of the legislation …

71. In trying to determine what the position of the government which proposed s. 15 HEIA was, former Minister Castonguay said at trial that what he had said at the National Assembly in 1980, as reported in the Journal des Débats (Hansard), represented his government's position (Castonguay, 8 sept 1999, vol. III, p. 396-397). For this reason, the appellant respectfully submits that this Court should afford high probative value to the declarations which he has made before the National Assembly in 1970 as representing his government's position. Indeed, in the 1981 case of *Société Asbestos*, *supra*, p. 46 (leave to appeal denied by this Court) the Quebec Court of Appeal had held that it is appropriate to analyse ministerial declarations made during the debates which preceded the adoption of the impugned provisions.

72. However, at trial, Mr. Castonguay, when invited by the appellant to testify about the circumstances which have surrounded the adoption of s. 15 HEIA eluded the question of the social preoccupation of the era with the avoidance of a two-tiered health care system, has testified against the truth concerning the voting of the law, has failed to mention the reasons for opposition of two opposition parties and of the union leaders, proposed, in the name of his government, the adoption of the provision impugned by the appellant, and favoured the respondents at trial, by declaring having never favoured what is suggested by Dr. Chaoulli (Castonguay, vol, III, pp. 403, 404). For these reasons, the appellant considers it useful to identify and correct many mistakes committed by Mr. Castonguay at trial, in order to understand the true circumstances which have surrounded the adoption of s. 15 HEIA. In the division of powers analysis, the issue is not to know whether the legislator was right or wrong, or to know whether the ideology at the basis of this position was good or bad, but to know whether the

impugned provisions were adopted mainly because of the socially undesirable character of a given activity.

73. The extrinsic evidence shows that in 1966 the Castonguay Commission considered that making a profit in the realm of health care was unacceptable and proposed the quick suppression of for-profit establishments in the province. However, initially, from June 25 to July 8 1970, the government considered the existence of a parallel private health care system to be socially acceptable. And thereafter, from July 9 1970, following representations made by the Parti Québécois and union leaders based on ideological motivations, and following representations made by a Union Nationale MNA (and former health Minister), all opposed to the very principle of doctors' disengagement, and asking (sic) for the government to go back, the government realized the socially undesirable character of a parallel private health care system and, within two weeks, between June 25 and July 9, made a complete about face. From then on, it considered that, beyond the establishment of a universal public regime, a second objective was to annul, in practice, a doctor's power to dissociate himself from the public regime by preventing a resident from being in any way reimbursed, save in emergency situations (pursuant to s. 36 HEIA), so that a resident could not go to the private sector in order to have better access than another resident in the public system.

74. The extrinsic evidence shows that the MNA's fear of massive disengagement from doctors was alleviated by the adoption of s. 24 of the *Health Insurance Act*, S.Q. 1970, c. 37, which would become s. 30 HEIA. Hence, nothing suggests that the source of the hostility against a parallel private system was the fear that a great part of health resources would migrate to the private sector.

75. The social and legislative facts exposed hereafter have not been contested by the respondents, neither at trial nor in their facta before the Court of Appeal. Quite the contrary, the respondents' lawyers and expert witnesses, at trial and before the Court of Appeal, have often reiterated the importance of ideological considerations, which have largely been accepted by Judge Piché, as shown by her decision: first, the rejection of access, outside the public regime, based on capacity to pay, to prevent a two-tiered health care regime and, secondly, the rejection of profit in health care (decision, 44, 46, 48, 49, 56, Vol. I, p. 60, 62, 64, 65, 72).

76. Judge Piché has held that the legal effect of the impugned provisions was to apply a penal sanction to all individuals which entered into the relevant contracts, and she has held that the true practical effect of the application of the impugned dispositions was the absence of a parallel private system, when she concluded that the impugned provisions prevented precisely the establishment of a parallel private system, considering the costs, in the absence of private insurance (decision, pp. 111, 127, vol. I, p. 127, 143).

77. For the present analysis, it matters little that in 1970 Minister Castonguay, acting in the name of his government, was aware or not of the ideological reasons of his opponents, with whom his government *de facto* agreed when, on July 9 1970, he decided to try to suppress a parallel private health care system using NP MD's. This Court has made clear that in the analysis of the circumstances having surrounded the adoption of a law, it is necessary to analyse them in relation to one another, the same way one would try to reconstruct a puzzle, by going, if necessary, beyond the position expressed by the government at the time, in order to find what is hidden behind it.

78. In 1970, before the adoption of 15 HEIA, the for profit private sector represented 2.72% of the total of general hospital beds, (R-97.12, p. 19, vol. XI, p. 1896). This same year, when the president of the Castonguay Commission resigned in order to become Minister of Health, the Commission wrote (R-97.12, pp. 43-45, 56, vol. XI, pp. 1903, 1904, 1906):

> CRITICAL EVALUATION OF THE FOR-PROFIT SECTOR: What we believe is that hospitalization services and accommodation services must be compensated for their fair value, but without opening the door to the exploitation of man by man (…) The search for profit: source of abuse. The commercial entrepreneur has and can only have one priority: launch his business and ensure its profitability (…) the elimination of the for-profit sector can be realized rather quickly.

79. At trial, expert-witness Turcotte, for the respondent Attorney General of Quebec, corroborated the existence of this perception within the society of the time, when he declared (Turcotte, 29 sept, 1999, pp. 167, 174, vol. VI, pp. 1100 and 1107):

> And fundamentally, this decommercialization of health services was the dearest objective of Canadians at that time since it was said that health services could not be offered on the commercial market (…) In the case of health services, it goes without saying that the idea that the producers maximise their profits is almost obscene to think (sic) that establishments, in any event it is presently forbidden to for-profit establishments to exist.

80. Mr. Trudel, counsel for appellant Zeliotis, has cross examined the expert-witness Turcotte, as follows (Turcotte, 30 sept. 1999, p. 39, vol. VII, p. 1141):

> Q: Doctor, you've mentioned in your report (…) and this has drawn my attention in relation to the rationality of the behaviour: «The idea that producers of health services be profit maximizers is so repugnant that we require that all establishments be not-for-profit».
>
> R. I am referring mainly to the fact that in our society we have required when we have reformed health services in 1970, that all hospital establishments be owned solely by not-for-profit corporations (…) I am only noting that culturally, ok, it is repugnant for citizens to think that professionals be profit maximizers (…) I'm describing a phenomenon as it exists in society.

81. Appellant Chaoulli has also cross examined expert witness Turcotte (Turcotte, 30 sept. 1999, pp. 75, 76, vol. VII, p. 1154, 1155). Dr. Fernand Turcotte referred to the Castonguay report on for-profit establishments, *supra*, as follows:

> Q: You have also mentioned Doctor Turcotte that, faced with the possibility of private health producers maximizing profits, you've said, we have forbidden to a for-profit establishment to exist – when you said «we», who was «we»?
>
> R: Well, it was society… if my memory serves me well… in the Castonguay report,… there was a volume that dealt specifically with for-profit establishments and that was the Castonguay Commission's recommendation.

82. At trial, expert witness Coffey confirmed that at the time, profit in health services was perceived as socially undesirable (Coffey, 17 sept. 1999, pp. 6 to 8, vol. IV, pp. 673 to 675). However, from 1964 onwards, the legislator had conferred on the Lieutenant-Governor the power to adopt regulations concerning fees that could be claimed by private hospitals, pursuant to the *Hospital Act*, S.Q. 1964, Vol. III. Ch. 164, art. 21(i). Later, the deontological codes of professional orders, including that of physicians, being of a regulatory nature, forced professionals to ask for fees for which the amount is justified: *Code of Ethics of Physicians, Professional Code*, R.S.Q. c. C-26, a. 87; 2001, c. 78, a. 6, Decree 1213-2002, October 9th 2002, G.O. II. October 23 2002, 134th year, no 43, p. 7361, art. 104.

83. On June 25th 1970, a new Liberal (provincial) government recycled bill 8, initially created by the Union Nationale government, which provided for the maintenance of a private sector parallel to the universal public regime, and modified it by limiting to 3% the number of doctors authorized to bill their patients; the latter then received from the state a reimbursement of to up to 75%, and the bill contained provisions concerning disengagement, either by regions or by specialization (R-97.2, p. 432, vol. X, p. 1834, and R-97.4, pp. 644, 645, vol. X, pp. 1857, 1858). The latter provisions were put into the *Health Insurance Act* S.Q. 1970, c. 37, s. 24, and, later, in the revised statute, in s. 30 HEIA.

84. On June 26 1970, Minister Castonguay declared that the specific objectives of health insurance were to make health care financially accessible to the whole population, to offer benefits without limits, to improve the distribution of income and to reduce social inequalities (R-97.3, pp. 553-554, vol. X, pp. 1839-1840). As mentioned earlier, nothing in this declaration was announcing that in the future, people who wished to purchase voluntary private insurance to cover the fees of an NP MD would no longer have the right to do so, under threat of penal sanction. That same 26 of June, the Minister was presenting the bill. At the time, in Nova Scotia, Newfoundland and British Columbia, as mentioned earlier, the state provided for the partial reimbursement of a resident who consulted an NP MD, without prohibiting private insurance.

85. On July 2 1970, one week following the presentation of bill 8, the Parti Québécois vigorously announced its opposition to the very principle of physicians' disengagement and asked that the government reverse its course. MNA Charles Tremblay congratulated the union leaders for their position (R-97.4, p. 635, vol. X, p. 1854) and MNA Camille Laurin, representing the Parti Québécois, declared, among other things (R-97.4, pp. 622, 623, 628, 629, vol. X, pp. 1844, 1845, 1850, 1851):

> We must aim at completely replacing, today and even more tomorrow, private organization by public organization (…) French and English members of high society (…) in order to protect their privileges and their acquired rights, in order to enable private insurance regimes to gain an enviable place in the sun (…) have for a long time succeeded in containing the popular thrust (…) It is good that this race of demagogues be on the road to extinction (…) the population better realizes that in always helping private enterprise, these demagogues increase the power of the privileged classes which are opposed to democratic conquests and social progress… we are opposed to the very principle of disengagement (…) We would then return to the era of privileges and acquired rights which do not correspond anymore (…) to the new reality of Quebec (…) Here again, the other Canadian provinces' position breed an unjust and outdated form of liberalism (…) the protection of old privileges which are no longer acceptable (…) this rule of 75% reimbursement and 3% disengagement will cause enormous and complex difficulties when comes the time to apply it… This would be the very expensive recognition of a privilege that is no longer justifiable… We hope that this government will finally decide to reverse its course.

86. On July 2, former Minister of Health Jean-Paul Cloutier also expressed his hostility towards the principle of physicians' disengagement and agreed with Mr. Daoust, Vice-President of the Fédération des Travailleurs du Québec (FTQ) (R-97.4, p. 615, vol. X, p. 1842). The same day, Minister Castonguay defended bill 8 in the following terms (R-97.4, pp. 644, 645, vol. X, pp. 1857, 1848).

> Regarding the health insurance project in itself, the most touchy problem is that of disengagement or «conventionning» (…) There are physicians in this Chamber (…) Some of these physicians may want to keep a certain degree of freedom. Thus, there are many other reasons, apart from pure reasons of principle, which can militate in favour of disengagement in certain particular cases.
>
> It must also be remembered on this topic that, in the *Medical Aid Act* the same type of apprehension was expressed four years ago. Some have said: «Medical aid, with the possibilities offered to professionals to disengage, will once again be a half-measure (…) I remember all the arguments which were put forward at the time. The number of professionals which disengage from medical aid in the last four years, to my knowledge, has never gone beyond a dozen for the entire province of Quebec. In Saskatchewan, today, the number of doctors who do not adhere to the regime is extremely low. It is at around the limit which we have fixed in the law. I would also like to note that the provisions included in the bill concerning disengagement have created much confusion because,

> knowingly or not, people did not want, or could not, examine them objectively and see how they could function (…) I do not see how such reimbursing, which creates a certain disincentive for the population as concerns the use of the services of disengaged professionals, can, on the other hand, lead to the absence of medical services for a great part of the population (…) The government (…) has a number of quite impressive means to ensure that these populations will receive the care to which they have a right and which they could have a need for.

87. Hence, Saskatchewan, which did not have the impugned prohibitions, had not experienced massive disengagement by physicians. When the Minister, responding to MNA Camille Laurin, denounced those who had not objectively assessed the contents of bill 8, it seems that already opposition to the very principle of a parallel private health system was not motivated by a threat to the viability of the public regime, but only by ideological motivations, founded on the egalitarian concept exposed by Michael Quinn (pp. 32, 33); egalitarian and equality not being synonymous (Petit Robert Dictionary).

88. The next day, July 3rd 1970, Minister Castonguay's declaration shows that he understood, in the «new Quebec reality» described by MNA Camille Laurin, the socially undesirable character of a parallel private health system, when he declared that the capacity of a physician to dissociate himself from the public regime will, in reality, be nullified at the economic level, to the extent that a patient who would consult a disengaged physician would not be reimbursed at all (R-97.6, B-1030, B-1031, vol. X, pp. 1860, 1861).

89. On July 7 1970, before the permanent Commission on health, the Minister said that the government had chosen not to accept representations from public organizations, but that since the members of union groups had come to follow the debate, they should be heard. Such extrinsic evidence corroborates the testimony made at trial by expert-witness Coffey, when he stated that union groups used physical force in order to enter in the premises where the Commission was sitting (R-88, p. B-1037, vol. X, p. 1711, testimony of expert-witness Coffey, September 27, 1999, p. 7, vol. X, p. 836). In 1970, Dr Coffey had personally observed these events (Coffey, 16 sept. pp. 20 to 23, vol. IV, pp. 616-619, and 21 sept. pp. 41, 51, vol. IV, p. 745, 755). The union leaders, presenting themselves as the spokespersons for «popular classes», as the Castonguay Commission had already noted in 1966, requested the suppression of any form of private medicine alongside the universal public health care regime. In a 1988 book, York University political science professor Norman Penner described the influence that the Communist Party of Canada had in the 1960's over the Confédération des Syndicats Nationaux (CSN), the Fédération des Travailleurs du Québec (FTQ) and the Centrale de l'Enseignement du Québec (CEQ).

90. On July 7, Mr. Pépin, leader of the CSN, whose ideological evolution was also described in 1981 by Université de Montréal History Professor Jacques Rouillard in a book co-published by the CSN (pp. preface, 215, 221, 226 to 231) went as far as to . brandish the threat of revolution if their demands were not met (R-88, p. B-1045, vol. X, p. 1719):

> I have a problem in this thing… it is the question of disengagement… I say to the National Assembly and to this Commission that it is inadmissible for you to adopt a bill in this way. If you do it, in my view, it will be a ferment of revolution, because you treat physicians in a privileged way… I do not think that people can accept, normally, to pay twice for a service for which they should pay only once, in my view. It will be sufficient that they pay at one place.

91. Mr. Laberge, leader of the FTQ, stated similar views (R-88, p. B-1039, vol. X, p. 1713):

> We are ready to pay what is needed, but we would want, once and for all, that if we pay for health insurance, we not be obliged, moreover, to deal with physicians' bills (…) Insurance must cover all benefits, and the doctors should not be able to charge outside it.

92. Mr. Laliberté, leader of the CEQ, denounced a «medicine of classes» (R-88, p. B-1044, vol. X, p. 1718):

> The whole system of disengagement that you have created is a system that, in the end, will perpetuate classes. The poor going to the engaged doctor and the others paying for the best possible care with the big wigs of Quebec medicine.

93. Mr. Henri-Paul Proulx, leader of the UCC (Union Catholique des Cultivateurs), was also opposed to the disengagement of doctors (R-88, p. B-1044, vo. X, p. 1718)

94. Expert-witness Coffey has testified about the circumstances which lead the government to reverse its course (Coffey, 21 Sept. 1999, pp. 40 to 51, vol. IV, pp. 744 to 755). Following union leaders on July 7th, the president of the QFGP, Mr. Raymond Robillard, declared (R-88, pp. B-1049 and B-1050, vol. X, pp. 1722 and 1723):

> As concerns disengagement (…) we want to adhere voluntarily to a regime. We do not want to be conscripted (…) We also want that the special notoriety of a doctor be, in exceptional cases, recognized (…) and, for some of them, which do not amount to many, the capacity to express their total independence from the regime, their *non serviam* and their desire to interact directly with the patient. We have asked for the open right of a doctor to «deconventionnalize», we have asked for it in the same spirit as other provinces, knowing and demonstrating at the negotiation table that this right that doctors would have to disengage would not be used except in exceptional cases. That is what happened in Manitoba, in British Columbia and everywhere else. However, we acknowledge that the situation in Quebec is peculiar, we have had a demonstration this morning and all through the debate that has been taking place for several days. We are aware of the

> political situation in Quebec, we are therefore ready to recognize that the principle of regime universality, that accessibility to care must be preserved and we are ready to concede (…) that there must be guarantees written in the legislation. This we accept (…) We do not like (…) a mechanism which leaves «deconventionnalizing» and its abolition from 3% to 0% up to the complete discretion of ministers (…) There must be a formula which will recognize the freedom of all doctors, even a relative freedom, because we are ready to make concessions on this point (…) Finally, the restrictions on disengagement must be predictable, known, expressed in a convention or in the law and not discretionary.

95. Put differently, by demonstrating at the negotiation table that, like in Manitoba, the right of doctors to disengage would not be used, the QFGP expressed its agreement with the Minister and with the four union leaders with respect to the avoidance of a parallel private system which would have used NP MD's. What the FMSP sought was the right for all specialist physicians participating in the public regime to bill, for a medically required service, both the state and the patients, as was the case in other Canadian provinces. The Parti Québécois, through the voice of Camille Laurin, invoking the need to respect «the evolution of mentalities» and «social justice» (I-39.6, p. B-1058, vo. XIV, pp. 2549) and of Marcel Léger, denouncing a «medicine for the rich», supported the positions of union leaders (I-39.6, p. B-1057 to 1059, B-1064, B-1065, B-1067, B-1068, Vol. XIV, pp. 2548 to 2550, 2555, 2556, 2558, 2559). For his part, Mr. Saindon, a member of the governing party, described the positions of Mr. Laurin as leading to a «form of socialist government» (I-39.6, p. B-1061, vol. XIV, p. 2552). Despite the Minister's declaration on July 3rd, to the effect that he would refuse any reimbursement to a disengaged doctor's patient, he still maintained, on July 7th, (but it would not be for long) his project enabling 3% of doctors to overbill (I-39.6, pp. B-1061 to B-1064, vol. XIV, pp. 2552 to 2555).

96. The same day, on July 7th, the government had s. 15 HEIA, prohibiting private insurance contracts, adopted (I-39.6, p. B-1071, B-1072, vol. XIV, pp. 2562, 2563) so that the suppression of a parallel private health care system, which would have been totally dissociated from the public regime, was a done deal; this suppression having been sought by the Parti Québécois and by the union leaders, and accepted by the QFGP, as shown before. Nonetheless, the issue of the right of participating doctors to overbill remained.

97. On July 8, the Minister declared that Mr. Pépin and Dr. Robillard wanted to discuss among themselves and that the discussion was going to continue between the other union leaders and the president of the QFGP. For this sole reason, the government suspended the debates of the National Assembly on the right of participating doctors to bill both the state and a resident, otherwise called overbilling (R-88, p. B-1096, vol. X, p. 1727).

98. On July 9th, the Minister made public the existence of a disagreement between the QFGP and the union leaders and announced his decision to take out the 3% and 75% clauses, thereby forbidding all doctors participating in the public regime from overbilling patients (I-39.6, pp. B-1118, B-1142 to B-1145, vol. XIV, pp. 2570, 2572 to 2575), invoking the need to avoid «two levels of medicine» (I-39.6, p. B-144, vol.

XIV, p. 2574), using precisely that expression, whereas at trial he had said that this expression did not exist at the time (Castonguay, 8 sept 1999, vol. III, p. 401), thereby denying, at trial, the socially undesirable character, at the time, of a two-level medicine, and having pretended that the attempt to suppress a parallel private health system by the adoption of 15 HEIA resulted from the QFGP's refusal to negotiate. Thus, this testimony from Mr. Castonguay at trial is in major contradiction with the contents of the Journal des Débats, as it fails to mention the request for an about-face made by the Parti Québécois and by former Minister Cloutier of the Union Nationale. With all due respect to Mr. Castonguay, the analysis of parliamentary debates shows that the QFGP's influence on adjustments to the law, as described by Mr. Castonguay at trial, was limited, for the government, to allow the QFGP's demand for a total disengagement of doctors in exceptional cases, which results from the combined effects of s. 26 HEIA, authorising NP MDs, and 15 HEIA, forbidding a parallel private health system., thereby leaving a very small number of doctors, isolated and completely dissociated from the public health care regime.

99. As was said by Mr. Castonguay (Castonguay, vol. II, p. 378), all specialist physicians wanted to bill both the state and patients, but as opposed to what he said at trial, it is because of the strong opposition expressed by the Parti Québécois, the union leaders, and because of former Minister Cloutier's opposition to the very principle of disengagement, and not because of a fear of massive disengagement from specialists, that the government decided in favour of these opponents, by completely forbidding overbilling to doctors participating in the public regime, pursuant to the *Health Insurance Act*, S.Q. 1970, c.37, ss. 18 (2d par) and 6, which would become s. 22(4) (11) (12) LAM (I-39.6, pp. B-1143, B-1144, vol. XIV, pp. 2573-2574).

100. As written by Judge Piché in her decision, the legislator used the prohibition of private insurance in order to suppress a private health system parallel to the public regime. Indeed, on July 10 1970, the Minister confirmed (R-29, p. 939, vol. VIII, p. 1345):

> On the one hand, the purpose of the law is to guarantee to all Quebeckers accessibility to the insured services according to uniform financial conditions. In that sense and in order to reach that objective, the great majority, if not the totality of health care professionals who provide a category of insured services, must be conventioned.

101. Hence, this conception of uniform conditions of accessibility at the financial level was in opposition with the Hall Commission's report of 1964, *supra*. This conception went beyond guaranteeing to all access to a public regime. It announced an additional goal, namely that the patient's financial capacity not be one of the reasons enabling him or her to have a greater access to health care than another patient.

102. This governmental intention would be confirmed on October 15 1970, as exposed later, and corroborated at trial by expert witness Dr. Bergman, for the respondent PGQ, when he invoked the value of «absolute equity» as the basis of the provincial health care regime, and testified to the effect that «the system was developed in accordance with certain values and following certain group forces».

103. The same day, the Minister invoked the amendment which would become s. 24 of the *Health Insurance Act*, S.Q. 1970, c.37, and then s. 30 HEIA, giving the Minister the power, in case of necessity, to force some NP MD's to submit themselves to the public regime, in order to guarantee to all, everywhere at the same time, «free» access to medical services (R-29, pp. 940 and 941, vol. VIII, pp. 1346-1347).

104. On July 10, the bill was voted on on third reading. From reading the Journal des Débats, which identifies MNA's and their voices, it seems that all MNA's from the party of the Ralliement des créditistes, as well as all MNA's from the Parti Québécois, voted against the bill, and that this lack of unanimity reflected the ideological dispositions expressed by these two parties with respect to private medicine, and which (sic) are found in the evidence (R-29, pp. 942 to 947, vol. VIII, pp. 1348 to 1351). The Parti Québécois had invoked ideological reasons in order to request that even exceptional, isolated, cases of NP MD's not be authorized to dissociate from the public regime, whereas the créditistes, for opposite ideological motives, asked for freedom for patients and doctors, while at the same time accepting a universal health insurance regime. It is only much later, at the end of the month of August 1970 that specialist doctors, asking for the capacity to overbill for all participating doctors, went on strike and were quickly called back to work through a special bill (Castonguay, vol. III, p. 379).

105. On October 15 1970, MNA Cloutier expressed his satisfaction with respect to s. 24 of the *Health Insurance Act*, which guaranteed «free» access to all everywhere in the province (R-30, p. 1413, vol. VIII, p. 1359). In the middle of the October crisis, MNA's Camille Samson and Armand Bois, of the parti du Ralliement des créditistes, proposed an amendment to Minister Castonguay, so that a patient who would choose to consult an NP MD could be reimbursed by the state up to the amount of the public tariff, provided that the fees imposed by such a professional did not exceed 15% of the state's allocations. MNA's Samson, Bois and Roy, of the parti du Ralliement des créditistes, addressed a warning against the punishing of patients who would choose to consult an NP MD by refusing to grant them state reimbursement, when these patients would continue to financially sustain the public regime through general taxation. The Minister immediately rejected that amendment (R-30, pp. 1403, 1411, 1412, 1413, vol. VIII, pp. 1353, 1357 to 1359).

106. The fact that on July 9 the government suddenly decided to take back such state reimbursement from patients', even with the 75% maximum evoked by the Minister on July 2, was contributing nothing towards the guaranteeing of a universal public health care regime, as the Minister had indeed himself explained on July 2 when he had defended bill 8, as explained at paragraph 86 of the present factum. This sudden decision from the government had as its only logical foundation the expression of the collective disapprobation of society for the behaviour of a resident who would consult an NP MD. On this subject, MNA Fabien Roy declared (R-30, p. 1412, vol. VIII, p. 1358):

> (…) If the government does not accept the amendment, it is not the doctor that is penalized and I would like that it be understood, in this Chamber, that it is the ill individual that is penalized, because instead of paying 15%, the government forces him to pay 100%.

107. As mentioned earlier in *Morgentaler* [1993], in the present case, the practical effect of the provisions indicates their pith and substance. By analogy, appellant submits that parents who send their children to a private school are not the object of collective disapproval, to the extent that the state, by subsidizing private schools, reduces education fees for these parents.

108. It is only in 1984, pursuant to the *Canada Health Act*, S.C., 1984, ch. C-6, ss. 18 and 19, that the Parliament of Canada has incited provinces to completely prohibit overbilling from doctors participating in the public regime as well as moderating fees by hospitals financed through public funds.

109. As for patients from Quebec, in 1970, they in effect had almost completely lost the possibility to enter a contract for consideration with a doctor, because of the combined effects of the *Health Insurance Act*, 1970, *supra*, ss. 18 and 19, whose s. 12, prohibiting private insurance, suppressed a parallel private health care system which would have used NP MD's. On October 15, 1970, MNA Camille Samson declared (R-30, pp. 1411, vol. VIII, p. 1357):

> We have entered and we enter today the path of a socialism from which there is no return (…) we will conscript everyone in order to finally reach a situation where it will be Mao's cousins which will lead the province of Quebec (…) If we follow the road that is a one way road to socialism, we will never come back (…)

To which Minister Claude Castonguay replied (R-30, p. 1411-1412, vol. VIII, p. 1357-1358):

> We have said, when the Health Insurance Act was presented in the month of July, that one of the goals of this Act was that the financial capacity of the patient not be a reason which enables him to have greater access to care than another patient; that <u>access to care should be solely dependent on the availability of services and not on the capacity to pay</u>.

110. As mentioned earlier, on June 25, the government was favourable to private medicine, but on July 9, realizing the socially undesirable character not only of a private system completely dissociated from the public system, but also of the state's reimbursement of a patient which consulted an NP MD, it became also opposed to any form of reimbursement. The *Health Insurance Act* entered into force on November 1 1970 (Castonguay, vol. III. P. 395).

111. As mentioned before, in 1970, almost all doctors were already participating in the public health assistance regime created in 1966 by the *Loi de l'assistance médicale*, so that such a small private sector, before the adoption of the HEIA, could not have logically constituted a threat to the establishment of a universal public health care regime. At trial, this extrinsic evidence demonstrating the socially undesirable character of a parallel private system was corroborated by the respondents. On August 15 1997, the federal Health Minister wrote to the appellant that for «many decades» a two-tiered medicine has been contrary to Canadian values (R-4.10, vol. VIII, p. 1319). Apart from the corroborations provided by testimonies given at trial, as exposed

before, expert witness Wright, for the respondent AGC, denounced «the sordid pursuit of money». The experts have confirmed that the need to prohibit private insurances was based, from the beginning, on values perceived to be fundamental by Canadians: Wright, October 1 1999, vol. VII, pp. 1255, 1256, 1267, 1272, 1293, 1299, 1302, Turcotte, *supra*. As for expert witness Denis, for the respondent AGQ, when he referred to the stakes around social policies in that debate, he underlined oppositions founded on an «ideology» (Denis, 27 sept 1999, vol. V, pp. 885 to 887).

112. Respondents have filed a report by the «National Forum on Health» which denounced a two-tiered medicine as «intolerable» and «unacceptable» (I016, pp. 10-11, vol. XI, pp. 1971-1972) and they filed an editorial piece entitled «When Money is the Mission» (I-37, p. 446, last paragraph, vol. XIII, p. 2354) in which the author assimilated profits made through the sale of medical services to profits made through the sale of children and wives.

113. The trial judge was impressed by the «worldwide reputation on health care systems» of expert-witness Marmor, for the respondent AGC (Piché decision, p. 53, vol. I p. 69). During his cross-examination by Mr. Bruce Johnson, and then by the appellant Chaoulli, this expert-witness characterised the official declarations and the rules of the Canadian health care system as follows (Marmor, 28 sept 1999, vol. VI, pp. 932 and 1016):

> Q: Now do you agree with me that Canadians are remarkable in that they're the only ones in the world providing this egalitarian form of fairness?
>
> R: What I am really saying is that Canadians have a standard of egalitarianism in medical care which puts it at one point of the spectrum… Yes, Canada is distinguishable by the degree of egalitarianism in its official pronouncements about medical care and its rules.
>
> Q: And the point on the spectrum where you place it is at the end, right; the most?
>
> R: The most formally egalitarian, yes, for covered services (…)
>
> Q: I will tell you, Professor Marmor, why I'm asking you about the Soviet Union… It's because in your report you mentioned and also this morning on several occasions about egalitarian concept…
>
> R: But my reference group was entirely of other OECD countries. My claim was that in the statutes among OECD countries, Canada was unique. If you expand the question to say, is there any place in the world that has a statute that is egalitarian, the answer is certainly the case. Communist regimes are the most egalitarian in theory in the world.

114. In light of all the facts exposed before, and with all due respect for the witness Claude Castonguay, the argument which he has invoked at trial in order to justify the prohibition of private insurance, namely the threat of massive disengagement from specialist doctors, does not hold when confronted to reasoning based on logic. Over and above the arguments evoked earlier, this threat was addressed, first by a special bill ordering them to go back to work and, second, permanently, by the adoption of s. 30 HEIA, which gave the Minister the discretionary power to renew, by successive periods of three months, the obligation imposed on every doctor, that would have just opted for the status of NP MD, to participate in the public regime. Logically, and as is shown by the debates at the National Assembly on this point, it is 30 HEIA which has prevented, and still prevents, a massive disengagement from doctors, whereas 15 HEIA merely lowers the possibility of developing a parallel private system, from 15% of the market to zero.

115. At trial, former Minister Claude Castonguay, admitting that the unions had participated in the debates at the National Assembly, while wrongly emphasizing the leading role of specialist doctors in the adoption of 15 HEIA, testified as to the socio-political context, in 1970, of union requests (Castonguay, vol. III, pp. 390 to 392):

> Q: Could you maybe remind us, or refresh our memory as to what were these events of October? Had it taken… had an important place at the time?
>
> R: Yes… And following the assassination of Pierre Laporte, the climate of… the very difficult climate that imposed itself on Quebec, the army's arrival, the… the enforcement of the War Measures Act, the union manifestations in favour of… almost, you know, of… in favour, in any case, of contesting the government. So the climate was extremely difficult, extremely perturbed, and it is in this context that the specialist doctors' strike has taken place for a good while.
>
> Q: Did these union manifestations to which you have referred represent a certain mood at the time, of opinions in favour of certain, how should I say, socio-political considerations of the time?
>
> R: Well (…) the phenomenon of contesting was very generally present in most countries of the Western world, and Quebec… Canada and Quebec were no exceptions in this respect. The objectives were truly objectives aiming at the creation, I would think, in the simplest possible terms, of socialist states in those countries where several protesters belonged, let's say, to the Marxist-Leninist doctrine.

116. At trial, expert-witness Coffey corroborated this part of former Minister Castonguay's testimony (Coffey, 27 sept. 1999, vol. V, pp. 836 to 839):

> Q. And could you tell the Court on which ground did you base yourself for your statement about the unions?

> R: Well, on page (…) B-1039 and on page B-1044. I should tell you that the general atmosphere of the public at that time was in July 1970, and the first, the Bill 8 (…) had just been introduced (…) Mr. Castonguay had decided, or the cabinet, I guess, had decided there would be no general public meetings to bring in information, the trade unions physically forced their way to the commission and demanded to be heard (…) the trade unions were very much against the passage of the Heatlh Act primarily because it allowed for an opting out of physicians (…) some of the comments by the unions were, as Mr. Castonguay had eluded two weeks ago, the political-economic rhetoric was of the Marxist nature (…) In other words, it was a very marxist approach (…) It was very well reported in the press and media.

117. Hence, one of the goals of the HEIA was the establishment of a «free» universal public regime with participating doctors, valid with respect to the division of powers, while the other goal, that of 15 HEIA, was an attempt to eliminate the private practice of medicine dissociated from the public regime, solely because of its socially undesirable character.

True Purpose of the Modification of s. 11 of the Hospital Insurance Act

118. In addition to what was said before, since there are no parliamentary debates on this modification, it is appropriate to look at governmental reports. In 1980, the Hon. Emmet M. Hall, thereby reversing the position he had expressed in 1964, then favourable to one's freedom to pay more, expressed his agreement with a prohibition on all Saskatchewan physicians to request fees which they fixed as they wished from their patients. (I-39.7, pp. 28 to 30, vol. XIV, pp. 2601 to 2603) In 1983 the government of Canada followed suit by failing to distinguish between, on the one hand, a participating doctor charging both the public regime and a resident and, on the other hand, an NP MD charging exclusively a resident (R-72, pp. 22, 23, vol. IX, pp. 1698-1699):

> Canadians cannot accept a partial program which would guarantee the best care to those who can pay for it when they are ill and lesser quality care for those who cannot pay (…) The provinces will have to decide which is the best way to use to get rid of overbilling. Quebec has decided to make it practically impossible by ordering that patients who consult non-participating doctors not be reimbursed by the provincial regime. The result is that overbilling is, for all intents and purposes, non-existing in this province.

119. The Rochon Commission (1988) has expressed a form of dichotomised thinking (I-39.8, pp. 651, 652, vol. XV, pp. 2670-2671):

> Comparable services must be available to all, whatever the level of income. A system with different classes of services, one for the rich, one for the poor, is therefore unthinkable if we

take the principle of equitable rationing into account. Thus, the expansion of a parallel private system, underpinned by private insurance, cannot be promoted.

120. In 1992, the prohibition of s. 11 HOIA did not logically fit in the hospitalization-insurance scheme's framework, because the law had always authorized NP MD's, as explained at par. 123 and 124 of this factum.

121. At trial, as well as before the Quebec Court of Appeal, the respondents have argued that the position of the government of Quebec was to prevent «two-tiered» medicare. These considerations are found in the procedures filed by the respondents: amended contestation of Attorney General of Quebec, July 15 1998, paragraph 43 (vol. II, p. 217), and contestation of Attorney General for Canada, October 28 1998, par. 15 (vol. II, p. 221).

Severity of Penalties

122. Although in *Morgentaler* [1993], p. 511 and 512, this Court gave little weight to the severity of the punishment, before a resident has the occasion to infringe the prohibition against the purchase of private insurance, there must be have been a private insurer, also covered by 15 HEIA, who has begun to offer prohibited coverage on the market. Now, for obvious reasons related to insurance risk-spreading, an insurer who would have decided to infringe 15 HEIA would not sell his coverage to one client only, but to tens or hundreds of thousands of clients, and therefore the 1000$ penalty contained in the *Health Insurance Act*, S.Q., 1970, c. 37, art. 61, and then by 76 HEIA would be multiplied by as many times, so that the penalty imposed on a private insurer would be considerable. This exceptional degree of seriousness may be taken into consideration in the qualification of the impugned legislation. As for the penalties imposed on the contracting parties with respect to hospital services, they are serious to the extent that, if imposed each time that a resident were to buy a hospital service, the repetition of the offence could lead to an injunction which, if ignored, would be followed by jail time, to the extent that one could not, by the repetitive payment of fines, buy the right to disobey to a law: *Coutu c.Ordre des pharmaciens du Québec* [1984] R.D.J. (C.A.), 298, p. 313.

Colourable Legislation

123. In Quebec, in 1964, there was a law which provided for public hospitals, authorized private hospitals and provided for their regulation: *Hospitals Act*, R.S. R.E. II, 1964, c. 164, ss. 1(c), 13(1), 21 (i), 24, a law authorizing private hospitals: *Private Hospitals Act* R.S. R.E. II, 1964, c. 217, ss. 2(1), 3, 7, 12; and the state could enter into an agreement with a private hospital for the delivery of insured hospital services; doctors could still bill patients: *Hospital Insurance Act*, S.R.Q., 1964, ch. 163, ss. 2, 10 (1) (a), 10 (3) (b); and the poorest benefited from the *Public Aid Act supra*, par. 61.

124. In Quebec in 1970, at the time of the establishment of the universal public health insurance regime, NP MD's kept the right to bill a resident for their fees, both inside and outside a hospital, pursuant to the *Hospital Insurance Act* R.S.Q., 1964, ch. 163, ss. 2, 10 (1) (a), 10 (3) (b). At the time of adoption of the HEIA, the legislator preserved the authorization for a doctor to completely dissociate himself from the

public regime, pursuant to the *Health Insurance Act*, S.Q. 1970, c. 37, art. 20. Moreover, in 1971, the legislator replaced the two 1964 laws, *supra*, by a law which still authorized a private, for profit, hospital: *An Act respecting Health Services and Social Services*, S.Q. 1971 c. 48, ss. 1, 1 (c), 8, 12, 142, 149, 150, still to this day *Loi sur les services de santé et les Services sociaux*, L.R.Q. c. S-4.2, art. 79 (2), 97, 99 (2) (hereinafter AHSSS), but for which hospital costs had to remain public. It can therefore logically be asked why, in 1970, the legislator did not prohibit the private practice of medicine inside and outside a hospital.

125. It is clear that for NP MD's, both the state's refusal to reimburse patients up to 75% and the prohibition on private insurance negated their main source of income, as confirmed by witness Castonguay at trial, when he said that his government had tried to close all doors, including the private insurance door (Castonguay vol. III, p. 393-394), so that in 1970, without officially prohibiting the private practice of medicine, the lawmakers tried, by indirect means, to block access to a parallel private health care system based on capacity to pay. In contrast, Cuba has officially prohibited the private exercise of medicine (World Health Organization 2000, hereinafter «WHO 2000», see compendium of sources, vol. III, tab 48, p. 142).

The Theory of Severability

126. Severance is possible if the remaining valid part can survive independently and could have been adopted separately; *Morgentaler* [1993], *supra*, p. 515, *Westendorp v. The Queen* [1983] 1 S.C.R. 43, 45, 51 to 54 and *Knox Contracting Ltd. v. Canada* [1990] 2 S.C.R. 338, 355. In the present case, severance is possible for the following reasons. At trial Mr. Castonguay has admitted that the provisions of the HEIA other than 15 HEIA were sufficient in order to guarantee a universal public health care regime (Castonguay, vol. III, p. 392). These provisions were ss. 1a, 1g, 1.g.1, 1c, 1d., 3 to 8, 22 and 30 HEIA. Moreover, according to the WHO, based on «reactivity» factors and on the global performance of health care systems, several OECD countries, in the absence of the impugned prohibitions and with a private regime parallel to a universal public regime, rank ahead of Canada (WHO 2000, R.S., vol. III, pp. 169, 206, 222).

127. As for the prohibition of contracts for hospital services pursuant to the 1992 modification to 11 HOIA, the respondents have not questioned the fact that the universal public hospitalization regime had survived between 1970 and 1992, which shows that as concerns the HOIA, severance was present in Quebec for 22 years.

128. The legislative history of other provinces also shows that the remaining part has been adopted separately, and that this remaining valid part has survived, in that since 1970 all Canadian provinces have kept a universal provincial public regime for medical services.

129. As for private insurance contracts, Saskatchewan, British-Columbia and Nova Scotia have established a universal public health care regime in, respectively, 1961, 1967 and 1968, without prohibiting private insurance contracts, and while authorizing NP MD's, pursuant to *The Saskatchewan Medical Care Insurance Act*, S.S., 1961, Cap. 1, s. 28, the *Medical Services Act*, R.S.B.C. 1967, c. 24, s. 10 and *An Act to Provide for Payment toward the Cost of Certain Medical Services*, S.N.S., 1968, ch. 9, s. 18. For 25 years, the universal public regimes of Saskatchewan and British

Columbia have survived, and the Nova Scotia public regime, which still authorizes private insurance contracts, has survived.

130. It is only in 1996 that Saskatchewan, through the *Health Facilities Licensing Act*, S.S. 1996, c. H-0.02, ss, 3(1) and 12(3), has adopted a prohibition equivalent to that adopted in Quebec in 1992 by the modification of 11 HOIA; and it is only in 1992 that British Columbia has prohibited private insurance contracts, through the *Medical and Health Care Services Act*, R.S.B.C., 1992, c. 76, art. 39 and 40, causing a total absence of NP MD's in British Columbia (Wright, Oct. 1st 1999, vol. VII, p. 1303). As to New Brunswick, it has never adopted prohibitions equivalent to the impugned provisions and the public health insurance regime has survived to this day: *Health Services Act*, N.B., 1971, c. 6, and *Health Services Act*, R.S.N.B., 1973, c. H-3.

131. As concerns any medically required service, in 1969, Ontario established a universal public regime which authorized NP MD's, pursuant to the *Health Services Insurance Act*, S.R.O., 1969, c. 43, s. 22. It is only 17 years later that this province has adopted a prohibition on any private medical service, pursuant to the *Health Care Accessibility Act*, S.R.O., 1986, c.20 s. 2. However, over these 17 years, the universal public regime has survived. Likewise, Manitoba established a universal public regime in 1970, authorizing NP MD's, pursuant to *The Health Services Insurance Act*, 1970, ch. 81, Cap. H35, s. 115 (1). And it is only 17 years after that the province adopted a prohibition against any private medical service, pursuant to *The Health Services Insurance Act*, Re-Enacted Statutes of Manitoba, 1987, ch. H-35, section 96 (1). Alberta also established a universal public regime in 1969 which authorized NP MD's, pursuant to *The Alberta Insurance Act*, S.A., 1969, c. 43, s. 24 (b). This province has never adopted a prohibition equivalent to 11 HOIA, and the universal public regime has survived nonetheless.

132. Moreover, the respondents have not questioned the fact that all universal public health care regimes of OECD states have survived, without ever using such prohibitions.

133. The legal effect of the 1992 modification to 11 HOIA is to add an additional total prohibition to that of 15 HEIA: even by paying the whole bill of an NP MD and of a private non-conventioned hospital in Quebec, a Quebec resident cannot, under threat of penal sanction, use his own resources in order to protect his own life and health. The social purpose which was aimed at through this legislative change in 1992 was, in the face of difficulties of access to hospital services in the public sector, as observed by Judge Piché, to avoid any resurgence of private hospital medicine in the province, once again because private medicine was deemed socially undesirable in Quebec.

134. The practical effect of the modification to 11 HOIA, as held by Judge Piché, was a total absence of a parallel private practice of hospital medicine in Quebec (Coffey, 21 sept., vol. IV, p. 757). Therefore, this effect is an infringement of the rights to life, liberty and security of the person, as held by Judge Piché, following the testimonies of Mrs. Laberge, Dr. Doyle and Dr. Nabid, accepted by Judge Piché (Piché decision, pp. 24, 25, 29, vol. I, pp. 40, 41, 45).

135. In the same way that in *Morgentaler* [1988], pp. 144 and 145, Justices MacIntyre and LaForest tried to examine whether, within the framework of criminal

law, abortion was considered to be socially undesirable in other countries, it is useful here to see whether in other countries, private medicine has ever been considered to be socially undesirable. According to the WHO, the practice of private medicine is still officially forbidden in Cuba (WHO report 2000, vol. III, p. 142). Now, it is common knowledge that this state, for ideological reasons, considered any private activity to be socially undesirable. The appellant submits that the fact that the WHO, relying on information provided by governments, does not consider Canada to be a country which officially prohibits the private practice of medicine, corroborates the colourable nature of the prohibition on private insurance contracts.

Conclusions on the Division of Powers

136. The appellant submits that the evidence in the file shows that the attempt to suppress a parallel private health care system with the help of penal sanctions was solely motivated by its socially undesirable character and has in no way contributed to the establishment and maintenance of a universal and public health care regime. For these reasons, Judge Piché has erred when she held that the impugned prohibitions did not attempt to forbid intrinsically reprehensible behaviour (decision p. 79, vol. I, p. 95). In particular, following Professor Jean Leclair (vol. III, tab 43, pp. 141, 142), the criterion of ends, in the present case a prohibitive end meant to suppress a human activity, overrides the three other criteria, namely that of the intrinsically criminal act, of the criminal nature and of stigma. Appellant submits that this opinion by Professor Leclair is logical, since the analysis consists in determining what the National Assembly really wanted to accomplish through the impugned provisions. Professor François Chevrette has also emphasized the importance of the criterion of ends (vol. II, tab 34, p. 42).

137. In *Morgentaler* [1993], *supra*, p. 494, all the parties were agreed that the complete prohibition of abortion would exceed the province's jurisdiction. Also, p. 491, all were agreed that the provinces have exclusive jurisdiction over questions concerning the nature of the health system and the privatisation of medical services. It is useful to note that in that case, pp. 510, 511, the question was raised in the context of the public regime, which Dr. Morgentaler had never left, whereas in the present case, the question relates to a parallel private regime, exclusively financed privately and working exclusively through NP MD's. The expression «private clinic» merely referred to the private ownership of the clinic, and the «privatisation» of medical services did not mean the private financing of medical abortion services, but merely payment by the state of an abortion clinic's running fees. Dr. Morgentaler's fees were still exclusively paid by the state. In this respect, in 1997, the Conseil de la santé et du bien être (R-59, p. 5, vol. IX, p. 1549), as well as author Laverdière (vol. III, tab 42, p. 124), recalled that privatisation is the result of the state's initiative and not of the autonomous action of the private sector.

138. Hence, in the present case, the province did not attempt to prevent the privatisation of medical services, but rather tried to suppress private activity outside of the public regime which would be exclusively financed by patients and delivered through NP MD's. Also, this Court has established that the criminal law applies to corporations as much as to natural persons: *Canadian Dredge and Dock Co. v. R* [1985] 1 S.C.R. 662, p. 692, so that Parliament could legislate in order to define a criminal offence applying to a corporation, without prejudging, at this stage of the

analysis, whether such legislation would survive Charter scrutiny. The fact that respondent AGC has emphasised the importance, for all Canadians, to avoid «two-tier» health care goes against the suggestion that the matter is of a purely local and private nature in the province.

139. The fact that in the present case the federal and provincial authorities both argue in favour of provincial jurisdiction does not resolve the constitutional question: *Schneider c. R* [1982] 2 S.C.R. 112, 138. The issue raised in the present case, concerning the federal structure of our Constitution, is of a lesser intensity than issues which would relate to the national interest: *R. v. Hydro, supra,* paragraph 110. For these reasons, the appellant submits that a declaration of *ultra vires* would not negate the possibility for a province to regulate its provincial health care regime, in conformity with its jurisdiction, so that the constitutional balance between the federal and provincial jurisdictions would be preserved. The appellant adds that given the high symbolic value of the Canadian health care regime for Canadian identity, supposing that this Court rule that the suppression of a parallel private system working through NP MD's is a matter of federal jurisdiction, and that it declares that the impugned provisions are inoperative due to their violation of the *Charter*, Parliament would be the only jurisdiction to invoke, or not, the notwithstanding clause found in s. 33 of the *Constitution Act* 1982, so that, one way or another, all Canadians will once and for all know what to expect (I-39.7, p. 30, vol. XIV, p. 2603).

E. INTRODUCTION: INFRINGEMENTS OF RIGHTS GUARANTEED BY THE CANADIAN CHARTER

140. Following *Baker v. Canada* [1999] 2 S.C.R. 817 at par. 69 to 71, the appellant submits that when the issue concerns medically required services, it is relevant to interpret the right to freedom of contract under s. 7 and the right to equality under s. 15(1), in a manner that is compatible with international documents. Moreover, the U.N. High Commission on Human Rights, commenting on the International Covenant on Economic, Social and Cultural Rights (hereinafter Covenant) in its General Observation no. 14 (hereinafter «Observation 14»), s. 60, 61, encourages courts to protect the right to health in all Canadian provinces and territories by directly invoking the Covenant: Covenant, s. 28. This Covenant defines the right to health as an obligation imposed on the state to: 1) assure to all, within the limits of available resources, medical services: Covenant, art. 12 (1) d), 2) respect the right of everyone to the enjoyment of the highest attainable standard of health: Covenant, art. 12 (1); this right is founded, among other things, on the initial socioeconomic situation of each individual and on the right to public and private operators: Observation 14, art. 9 and 12 b) iii), 3) respect the right to social security Covenant, art. 9, which must be interpreted as including both the right to health insurances mandated by the law and the right to voluntary private insurances, as argued earlier, and as was expressed by the WHO (WHO 2000, vol. III, p. 40, 1st par.), and because all OEDC states, except Canada, allow voluntary private insurances, and 4) eradicate discrimination in relation to access to installations and services: Covenant, art. 2 (2) and Observation 14, note 1, art. 8, 12 b) i), 18 and 19; these rights being entailed by the dignity inherent to the human person: Covenant, preamble.

F. RIGHTS AND FREEDOMS PROTECTED BY S. 7

141. Judge Piché and Justice Delisle have erred by holding that the infringement of the right to liberty is not real. Indeed the appellant, as a citizen, is truly deprived from the liberty to purchase private insurance in order to cover the fees of an NP MD who practices outside a hospital. And an NP MD is truly deprived of his liberty to offer her services to Quebec residents, for consideration, for hospital services.

142. The appellant respectfully submits that, to the extent that a physician's duty is to protect her patients' lives, it is useful to rule on his interest to act as a physician, not only in relation to home visits in the private sector, but also in a situation where he believes that a patient requires a medically required hospital service, within reasonable delays and in appropriate conditions. Indeed, beyond the appellant's person as a physician, 11 HOIA concerns patients' freedom to enter into a contract with a NP MD and also, of course, the liberty of a NP MD to enter into a contract with that same patient for a private hospital service. As exposed, earlier, the trial judge has erred in law by exceeding her jurisdiction by questioning the appellant's motivations to appear as a physician on the basis of his professional activities in 1988 and on the basis of his legal fight with the RAMQ in 1995 concerning his home visit activities.

143. A pure economic right is a right that is not related to an individual's right to life or right to security. The appellant submits that a person's freedom to contract, be it a natural or a legal person, is protected by s. 7 of the Canadian Charter when it is related to a person's rights to life and security.

144. The appellant respectfully submits that it would be appropriate to reason on the basis of a resident's need to enter a contract in order to protect his life and his security, so that his co-contracting parties' freedom of contract, under s. 7, must be analyzed as being related to the rights to life and security. By analogy, a sick person's freedom to use marijuana is related to appellant Hitzig's (sic) freedom to sell it to a sick person: *Hitzig et al. v. O.* O.C.A., 7. 10. 2003, par. 3, 18, 20, 61, 70, 95, 103, 161, 165. The freedom to contract is an incident of the right to life in many situations. In fact, could it be conceivable to forbid a grocery store, under threat of penal sanctions, to enter contracts for consideration with a person in order to sell him food, or to forbid a pharmacy from selling drugs, and to force residents to solely get these goods from the state, by imposing on them a form of state-imposed rationing, even if death could ensue? In *The Constitution of Liberty*, Professor F.A. Hayek, jurist and winner of the Nobel prize for economy in 1972, had warned against the establishment of a state monopoly in the realm of health, pp. 260, 297 and 298 (2nd par. of each page) and had discussed freedom (p. 6 3rd. par.), as required in the free and democratic society mentioned at s. 1 of the *Charter*, as follows:

> We must show that liberty is not merely one particular value,
> but that it is the source and condition of most moral values.

145. The legal effect of the impugned provisions being a total prohibition which targets not only a resident but also a doctor, a private insurer and a hospital, to hold that in these contract relations only the freedom of a resident is protected by s. 7 of the Charter would render a resident's freedom illusory, to the extent that the State could then adopt a prohibition solely against physicians, private insurers or hospitals, thereby depriving a resident from effective freedom.

146. For instance, s. 22 (4) (12) HEIA only penalises a health professional who receives payment from a beneficiary for an insured service; the absolute voidness of an offending agreement only penalises the participating physician, receiving the payment, and not the patient who has made the payment. That said, appellant acknowledges that no right is absolute. This freedom to enter a contract of NP MD's, private insurers and private hospitals may be subject to restrictions, but not to a total prohibition.

147. The state could, as British Columbia had done, regulate private hospitals: *A.G.B.C. v. Parklane* [1975] 2 S.C.R. 47, pp. 52 to 56.

148. The appellant submits that a patient's freedom to choose the source of medical services, as well as the freedom of an NP MD to deliver such services, is akin to the constitutional protection implicitly conferred by this Court on women and physicians in *Morgentaler* [1988] i.e. to contract for abortion services. Put differently, the appellant submits that the Constitution of Canada protects parties entering into a contract the object of which is to protect the life and health of an individual. Moreover, this Court has already recognized the fiduciary nature of the patient-physician relationship: *McInerney v. MacDonald* [1992] 2 S.C.R. 138, 149, LaForest J. This description has also been accepted by the Canadian Bar Association (p. 115) (vol. II, tab 33). Section 7 protected Barry Stein's freedom to enter into a contract in Quebec (*Civil Code of Quebec*, art. 1387) by accepting, in Quebec, the offer of another party, situated in New York, before going there to receive a private service the source of which he had chosen.

149. A patient's freedom to choose the origin of medically required care includes, among other things, the freedom to choose between a public hospital and a private hospital financed exclusively through private money. Indeed, risks vary from one hospital to another, and it is certain that the risks are rising with the current delays (judgment, p. 29 col. I, p. 45). The evidence also shows that with private hospitals an individual could choose that in which the risk that he dies is smaller (Coffey, Sept. 20, vol. IV, pp. 718 to 720 and 733 to 739).

150. Judge Piché erred in holding that there will be an infringement of a person's physical integrity only in the case where the public regime is incapable of efficiently guaranteeing such access (decision, p. 111, vol. I, p. 127), since the infringement of security also includes a person's psychological integrity, and since access to public hospital services, leaving one on a stretcher in the corridors of a public hospital's emergency ward, without any intimacy, for periods of up to 48 hours (R-54, pp. 5 to 7, vol. VIII, p. 1475 to 1478), for a person who is already ill, leads, following *Morgentaler* [1988], *supra*, and Observation 14, art. 12 c), *supra*, at par. 140 of the factum, to an infringement of the right to the security of the person.

151. Hence, supposing that the appellant's health were to require same day hospitalization, the prohibitions contained at ss. 15 HEIA and 11 HOIA completely prevent him from choosing to address himself to an NP MD who exercises in a «non-conventionned» private hospital, who could take him directly in a room rather than in the conditions previously described.

152. In emergency situations occurring either at home or elsewhere, for which each minute counts (R-46, vol. VIII, p. 1414), the evidence accepted by Judge Piché has

shown that the freedom to choose is an incident of the right to life, so that these situations are different from those concerning waiting lists for diagnoses or therapeutic interventions, which are scheduled in advance. For instance, at any moment, the appellant, being within a 50 to 250 km radius from an urban centre, could suffer an accident, either on the road or on a private property, or exhibit heart attack symptoms. To the extent that each minute counts, the appellant respectfully submits that s. 7 guarantees the liberty to take, in advance, private insurance in order to be able to choose, when the time comes, and in order to preserve his own life, to call an ambulance helicopter in which there would be an NP MD (R-27, pp. 6 to 9, vol. VIII, pp. 1338 to 1341, R-41, pp. 11 to 13, vol. VIII, p. 1376 to 1378) rather than a ground ambulance on which there will only be a paramedic. Indeed, the evidence has shown that the presence of a doctor is necessary in order to reduce the mortality rate (according to the deputy minister of Health and Social Services and according to the French government's former junior health minister (R-77, vol. IX, p. 1708, Chaoulli, 14 sept, vol. IV, pp. 575 to 578). The evidence accepted by the trial judge has shown that the absence of ambulance-helicopter services causes the loss of ten thousand lives per year (judgment p. 29, vol. I, p. 45) and that such ambulance-helicopter services with a physician on board, independent from the State, exist in Germany and in Switzerland, among other things because of private insurance (R-57, vol. IX, p. 1527-1528 and R-27, pp. 46, 47, vol. VIII, p. 1342-1343). The effect of section 15 HEIA is to truly deprive the appellant from the freedom to subscribe to a private insurance policy which would enable him to protect his life by means of medical help provided through emergency helicopter service.

153. This mistake is even more patent because the judge has adopted a large and liberal interpretation of s. 7. The appellant submits that an individual who believes that the care offered by the state does not suit him has the fundamental freedom, pursuant to s. 7, to use his own resources in order to choose to purchase, on the private market, the care which he considers to be appropriate. In *O v. Parker* [2000], par. 95 and 135, the Ontario Court of Appeal has held that the total prohibition on the possession of marijuana amounted to an infringement of the freedom to choose the origin of medically required care, and that:

> The capacity to decide in an autonomous manner what is best for his or her own body is a fundamental attribute of the person and of a human being's dignity.

154. In the majority opinion in *Rodriguez v. C.-B.* [1993] 3 S.C.R., 519, 588, Justice Sopinka has stated:

> That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law.

In *B.(R) v. Children's Aid Society of Metropolitan Toronto* [1995] 1 S.C.R. 315, 370, Justice Laforest, concurring with the majority, said:

> […T]he right to nurture a child, to care for its development, and to make decisions for it in fundamental matters such as medical care, are part of the liberty interest of a parent.

155. The appellant respectfully submits that in order to show an infringement of the right to liberty, he simply had to prove, as he has done, that in many cases, in the public sector, services are not provided in accordance with the conditions which are appropriate to him.

156. Following Justice Wilson's opinion in *Morgentaler* [1988], *supra*, the appellant suggests that the issues regarding ss. 15(1) and 12 of the *Charter* now be analyzed. If the Court concludes that there has been an infringement of one of the rights protected by these two provisions it could then, supposing that the raising of constitutional questions 1 to 4 leads to the analysis of the principles of fundamental justice, readily conclude to their violation under s. 7.

G. RIGHT PROTECTED BY Section 15 (1)

157. Judge Piché, with whom the Court of Appeal agreed, has first held that the impugned distinctions clearly create a distinction. Secondly, with respect, she has erred by holding that one's place of residence is mainly a decision made by the individual, since in the present case we are concerned with the country of residence and not with an individual's place of residence within the national territory.

158. According to the U.N., 2% of the world's population is interested in cross-border migratory movements (United Nations, 2003, Press Release). Hence, whereas the number of immigrants is high in pure numerical terms, the percentage is rather low. It is thus logical to conclude that one's country of residence is mainly related to one's place of birth. Now, in *Benner v. Secretary of State for Canada* [1997] 1 S.C.R. 358, par. 52, this Court has held that to be born in a foreign territory is as much an element of status as colour of skin, or ethnic and religious origin.

159. Thirdly, with respect for Judge Piché and for the Court of Appeal, a close reading of *Law v. Canada (Minister of Employment and Immigration*) [1999] 1 S.C.R. 497, par. 88, favours the appellant, even if he does not invoke additional criteria as hinted at by the Court, since the Court had proposed two factors for analysis which are applicable in the present case: does the difference in treatment have the effect of imposing a burden or disadvantage on Quebec residents? Moreover, the «unjust treatment» factor has been mentioned by the Court of Appeal (appeal decision, par. 44, vol. I, pp. 184-185).

160. In its s. 15 analysis, the Court has assimilated a distinction to a difference in treatment, so that Judge Piché's decision with respect to the existence of a distinction amounts to deciding that there exists a difference in treatment. The concept of real inequality may be defined through its discriminatory effect: *Law, supra*, par. 87.

161. The purpose of s. 15 of the Charter is to prevent the infringement of fundamental human dignity and freedom, notably through the imposition of a disadvantage or burden, and to promote a society in which all are equally recognized by the law as members of Canadian society deserving of the same level of respect.

162. The persons favoured by such a distinction are not only foreign citizens coming to Quebec for the sole purpose of receiving medical care, but also persons sojourning in Quebec and considered to be non-residents according to s. 15. HEIA, being Canadian citizens or citizens from elsewhere, pursuant to the *Health Insurance Act*, R.S.Q. c. A-29, s. 5.0.2, and … c. A-29, r. 0.01, Order 1470-92, 1992, G.O. 2, 6236, ss. 3 and 6.

163. The appellant submits that these persons, deemed to be non-residents pursuant to the HEIA, are part of Canadian society for the duration of their stay in Quebec, since foreign citizens staying in Quebec are subject to the same laws as Canadian citizens, pursuant to the *Citizenship Act*, R.S.C., 1985, ch. C-29, s. 39, and since Canadian citizens who stay for less than six months in Canada may, following certain conditions, vote in Canadian elections, pursuant to the *Canada Election Act*, S.C., 2000, ch. 9, s. 11 (d).

164. The appellant submits that there is a conflict between the effects of the impugned law and the purpose of s. 15(1). Indeed, *Law*, *supra*, does not only mention stereotypes and prejudices as factors of discrimination, but also the burden and disadvantageous effects on the relevant group. For the comparative analysis, this Court has held that it is generally the plaintiff who chooses the group with which he wants to be compared for the discrimination analysis. It has also held that for the determination of an infringement to the plaintiff's fundamental freedom and dignity, the central standard is both objective and subjective. In that respect, the appellant submits that individuals included in the non-resident group are in a situation that is comparable to that of those included in the resident group since all require, or could require, medically required services on the territory of Quebec.

165. In relation to s. 7, Judge Piché has concluded that because of the excessive length of waiting lists, the appellant could complain of a potential threat to his life, security and liberty. Concerning liberty, she has adopted a large and liberal interpretation, because an aspect of the respect for human dignity, on which the Charter is founded, is the right to take personal decisions without the state's intervention. Hence, to the extent that Judge Piché has concluded to an infringement of liberty, by necessary implication, under s. 15(1), the judge's conclusion that the impugned provisions favour the dignity of Quebec residents is in contradiction with the infringement of rights and freedoms under s. 7.

166. In the present case, a reasonable person would find the existence of this distinction to be unacceptable. This is indeed what the Arpin Committee, created by the government of Quebec, and whose report was filed by respondent AGQ, has written concerning the sale of hospital services to foreign residents (I-38, Working Group's Report, pp. 86-87, vol. XIII, pp. 2388-2389).

> Because of the Charter of Rights and Liberties of The Person, we could not refuse to hospitalize Quebec residents who are able to pay the costs of their treatment and asking for the same treatment (…) Quebeckers would not, in our view, accept that their public health care system spend a part of the resources which have

> required important fiscal efforts in order to satisfy the health needs of well-to-do foreign clients, especially in light of the fact that their system has difficulties in responding to their own needs.

167. The importance of equality of access for all Canadians was also noted by the National Forum on Health, established by the Government of Canada (I-16, p. 10, vol. XI, p. 1971), as mentioned previously. In *Law*, *supra*, par.77 and 88 (10), this Court has held that, the more serious and localised a provision's effects on the affected group, the more probable it will be that the difference in treatment that is at the source of these effects will be discriminatory pursuant to s. 15(1), and the more likely it is that the Court will conclude to a violation of s. 15 (1), even in the absence of proof of a burden or disadvantageous effect, since the court can take judicial notice of certain facts and conclude to the presence of discrimination through logical reasoning.

168. In any event, Judge Piché has omitted to take into account relevant evidence which had not been refuted by the respondents: whereas Quebec residents who are put on a waiting list do not get a set date (Lenczner, 7 Sept, 1999, vol. II, p. 342, and Wright, Oct. 1st 1999, vol. VII, p. 1274-1275), and whereas doctors in hospitals do not get supplementary surgery time to operate foreign residents, these in fact obtain an appointment by paying (Carignan, 10 Sept. 1999, vol. III, pp. 471, 475, 476, 489 and R-83, vol. IX, p. 1709.

169. The evidence has shown that 208 foreign residents had non-urgent surgeries in the hospitals of the Montreal-Centre region, including St-Luc hospital, where the witness Stein waited for a surgical procedure which was moved at the last moment (a pathetic story, according to Judge Piché). In the meantime, Saudi Sheiks and South American Prime Ministers, who were allowed to pay, were being given appointments and operated upon in Quebec private hospitals, all this while the waiting times for Quebec residents were of the order of several months (Carignan, 10 Sept 1999, vol. III, pp. 473, 474, 486, 487, R-51, vol. VIII, pp. 1418-1419, R-52, vol. VIII, pp. 1461 to 1463, R-41, pp. 6, 12 , 81, vol. VIII, pp. 1398 to 1400). It is thus reasonable to conclude that the distinction has the effect of lengthening waiting times for Quebec residents, thereby preventing access to health care services. Also, according to the Canadian Bar Association (p. 58), the invocation of s. 15 is justified by s. 3 of the *Canada Health Act* which provides that Canadian health policy has as its objective, among other things «to facilitate access to health care services without financial or other obstacles». The appellant submits that s. 15 is also justified by the *Covenant*, as shown at par. 140 of the factum.

170. The distinction also imposes a burden by forcing a resident who wishes to have access to private hospital services to go abroad, as was suggested by the testimony of Mr. Barry Stein, who had to go to New York to get the required services (Piché decision, pp. 27, 28, vol. I, pp. 43-44)

171. As concerns private medical services offered outside a hospital, the prohibition on voluntary private insurance forces their direct payment. Following the opinion expressed by the WHO (WHO Report 2000, vol. III, Tab 48, pp. 38-40 and 210), such a situation goes against fairness.

172. The appellant submits that the above-described context leads to the conclusion that the system is not respectful of both Quebec residents' dignity and of their freedom to enter into the impugned contracts, the latter being protected by the Canadian Charter, as held by Judge Piché.

173. With respect to s. 1, for the same reasons as those invoked in relation to s. 7, at par. 188 to 190 of the factum, the appellant submits that since the true purpose is not valid, the infringement is not saved by s. 1 of the Charter. Alternatively, the appellant submits that the respondents have not shown that there exists a rational connection between the purpose i.e. the establishment of a public health care regime, and a distinction the effect of which is to lengthen waiting times for Quebec residents.

174. As shown by the above-mentioned evidence, to the extent that a Saudi Sheik, by paying, has the right to get an appointment with a physician in order to use the surgical facilities of a public hospital, whereas a Quebec resident is forced to wait in order to undergo surgery, which creates a potential and imminent threat to his or her right to life and security, it is illogical and unreasonable to totally deprive a Quebec resident of this same right, unless it is considered that on the territory of Quebec, a Quebec resident deserves less consideration than a non-resident. In a free and democratic society, this cannot be so.

175. The appellant submits that the appropriate remedy should be taken by the legislator, and that, as concerns access to private medical services on the territory of Quebec, this consists of, firstly, circumscribing the rights conferred on a non-resident and, secondly, to confer on a Quebec resident at least the same rights as those conferred to non-residents.

H. RIGHT PROTECTED BY S. 12 OF THE CHARTER

176. Section 11 HOIA totally forbids a Quebec resident, under threat of penalty, from directly paying, in Quebec, a medically required hospital service. Judge Piché has held that s. 12 may be applied in criminal and quasi-criminal matters, which is the case here. The appellant submits that the opinion expressed by the WHO (WHO 2000, vol. III, Tab 48, p. 38, 4th par) concerning the unfair character of direct payment refers to a system that <u>forces</u> direct payment rather than prepayment by way of obligatory health insurance. Here, the issue concerns the total prohibition, not only of private voluntary insurance, but also of direct payment, for a hospital service.

177. The Judge's conclusion according to which s. 11 HOIA was not the source of the suffering alleged by plaintiffs and that s. 11 HOIA was compatible with human dignity is irreconcilable with her own conclusion concerning the infringement of the rights protected by s. 7.

178. The Judge has erred by holding that the state did not intervene directly enough towards the appellant to conclude that there was «treatment» pursuant to s. 12. Indeed, if the appellant was getting out of a hospital after having paid a NP MD for a medical service he could be arrested by police and receive a notice of offence pursuant to the penal provision relating to s. 11 HOIA (s. 15 HOIA). Hence, the appellant is subjected to the state's legal system.

179. In *Rodriguez*, *supra*, pp. 611, 612, Justice Sopinka, for the majority, held that medical treatment imposed without their consent on mentally handicapped patients has been considered to constitute «treatment» pursuant to s. 12, and he expressed his agreement with Justice Dickson of the New Brunswick Court of Queen's Bench, who had held that a total prohibition on smoking in a penitentiary establishment amounted to cruel and unusual treatment. In *Morgentaler* [1988], *supra*, p. 61, this Court has accepted testimony according to which the mental anguish experienced by a woman placed on a waiting list for an abortion amounted to cruelty and it has held that the mere possibility of infringement sufficed in order to trigger s. 7. The appellant respectfully submits that since Judge Piché had noted the appellant's «deep anguish» in relation to the state's prohibitions (judgment, pp. 20, 21, vol. I, pp. 36-37), s. 12 should apply.

180. Would it not then be reasonable to conclude that the appellant, faced with the possibility of having to be put on a waiting list for a medically required service, and knowing that his life and security would be threatened because of the waiting delays, also experiences mental anguish caused by the total prohibition? If it is cruel to adopt a total prohibition with respect to a woman who is waiting for an abortion, isn't it also cruel to adopt a total prohibition against a Quebec resident who is waiting for a medically required service?

181. With respect, to the extent that Judge Piché has held that 11 HOIA constitutes an infringement of the right to life, to pretend that 11 HOIA protects the dignity of all Quebec residents goes against all common sense. Indeed, when faced with a Quebec resident who is placed on a waiting list and who would rather use his own financial resources in order to save his life, how can it be pretended that a state that threatens such an ill person with penalties and that, therefore, forces this ill person to wait until he eventually dies, does not inflict cruel and unusual treatment pursuant to s. 12 of the Charter?

182. The treatment is unusual in that Canada is the only country within the free and democratic societies of the OEDC to inflict such prohibition on its citizens. This evidence was admitted by expert-witness Marmor, as exposed at par. 113 of the factum.

183. As concerns s. 1, for the reasons exposed at par. 188 to 190 of the factum, the appellant submits that the objective is not valid. In the alternative, the respondents have not shown the existence of a rational connection between the objective of a universal public regime of hospital insurance and such cruel and unusual punishment. Indeed, in *Rodriguez*, *supra*, this Court has held that the right to life is sacred and that it has lead to the abolition of the death penalty. Since Canadian society has concluded that the infringement of the right to life of a person guilty of a crime amounts to cruel and unusual punishment, the appellant submits that, a fortiori, there is no rational connection between the valid purpose and such cruel and unusual punishment. In the alternative, the minimal impairment criterion is not met, in that the state could have regulated the access to private medical services in the Province instead of prohibiting them completely. For instance, it could have limited such access to private hospitals financed exclusively through private money and run by NP MD's.

184. Following the opinion of Justice Wilson, *supra*, if this Court concludes that there has been no infringement to the rights guaranteed through s. 15(1) and 12 of the Charter, we must continue the analysis in order to conclude on s. 7.

I. PRINCIPES OF FUNDAMENTAL JUSTICE AND SECTION 7

185. The appellant submits that the formulation of the constitutional questions # 1 to 4 exempts him from the burden of proving non-conformity with the principles of fundamental justice. Otherwise, in civil matters, the rights protected by s. 7 would be less protected than the rights protected by ss. 2 and 6 of the Canadian Charter. In the alternative, if he is not exempted from this burden, the appellant makes the following submissions. In *R v. Mills*, [1999] 3 S.C.R. 668, par. 66-67, this Court has held that the most important difference between the s. 7 and s. 1 analyses is that under s. 7 rights are being defined and the issue is whether the state's action was fundamentally unjust, whereas under s. 1 the issue is whether the violation of the rights can be justified in a free and democratic society. Following that case, in view of the difference of burden between the appellant and the respondents, the nature of the questions and interests to be balanced is not the same under s. 7 and s. 1. The appellant's burden is not as heavy as that of the respondents who must show that the limit is reasonable in a free and democratic society.

186. In the present case, for the 8 reasons hereinafter exposed the appellant submits that the infringement of the rights to life, security and liberty are fundamentally unjust:

186.1 To the extent that in Canada the infringement of the right to life of a person who has been found guilty of a criminal offence is considered to be contrary to the sacred character of life (Justice Sopinka, for the majority in *Rodriguez, supra*, pp. 595 and 605, having written that the sacred nature of life was reflected in the policy which forbids the death penalty), a fortiori, an infringement, through the legislator's actions, of to the right to life of good citizens, will never be in accordance with the principles of fundamental justice.

186.2 To the extent that the state allows the appellant to spend his money in order to purchase health services for a domestic pet, it is unjust and against human dignity for the state to forbid him to spend his money in order to protect his own life and health, as well as the life and health of the members of his family.

186.3 Following *R. v. Heywood* [1994] 3 S.C.R. 761, 794, to the extent that, at the moment of adoption of 15 HEIA, the legislator had also given the government an instrument, pursuant to 22 (4) (11) (12) and 30 HEIA, in order to guarantee, at all times and everywhere in the province, «free» access to medically required services, the total prohibitions go beyond what was necessary to reach the legislator's purpose i.e. a universal public health system (Castonguay, 8 sept. 1999, vol. III, p. 392). They are thus unjust.

186.4 To the extent that the state authorizes the appellant to purchase products which are bad for his health, such as tobacco and alcohol, it is unjustified to forbid him from buying services which are useful with regards to his health. The appellant submits that the value of equality underpins the four following arguments:

186.5 To the extent that the evidence has shown that for medical services already covered by the public regime and provided through doctors participating in the public health regime, some Quebec residents benefit from the equivalent of a collective private insurance scheme, namely the CSST (Commission de la santé et de la sécurité du travail and the SAAQ (Société de l'assurance automobile du Québec (Castonguay, vol. III, pp. 410 and 413, and that VIPs and the CSST and SAAQ's clients benefit from privileged access within the public regime (Council on Health and Well-Being R-59, pp. 27 and 29, vol. IX, pp. 1571 to 1573, and Senatorial Committee, vol. III, Tab 44, ch. 16.3), and to the extent that there exists, depending on a resident's capacity to pay, privileged service to an MRI diagnostic exam done in-office by a physician participating in the public regime (Bergman, 22 Sept. 1999, vol. V, pp. 822 to 827), it is unjust to prevent Quebec residents from taking private insurance in order to cover the fees of an NP MD.

186.6 As concerns hospital services, to the extent that a Quebec resident who is rich enough and who wishes to receive a timely and appropriate service, has the right to go abroad in order to purchase that service, as shown by the testimonies of Mr. Barry Stein (Piché judgment pp. 27, 28, vol. I pp. 43-44) and of Mr. Yvon Brunelle, representing the AGQ (July 28 1998, vol. II, pp. 241, 245 and 246), and to the extent that those who do not benefit from such financial means cannot access these services in Quebec, under threat of penal sanction, and cannot have access to them elsewhere unless they sell their house (when they have one), the impugned prohibitions are unjust. Following the opinion expressed by the WHO, when it comes to supplementary spendings, fairness is compatible with prepayment by means of voluntary private insurance (WHO Report 2000, vol. III, Tab 48, pp. 38 to 40).

186.7 To the extent that the legislator wanted to favour accessibility to medically required services for all, and to the extent that, for services provided outside of a hospital, the combination of 15 HEIA and 26 HEIA has the effect of favouring patients who are wealthy enough to directly pay the fees of an NP MD and of preventing less wealthy patients from having access to such services (because of the total prohibition on prepayment through private insurance, Piché judgment p. 19, vol. I, p. 35), the absolute prohibition found at 15 HEIAis unjust, as was suggested by the opinion of the WHO (WHO 2000, vol. III, Tab 48, p. 40, 1st par and p. 210).

186.8 To the extent that judge Piché has held that, within the public health regime, access in a timely fashion is sometimes based on the influence of those who know the right persons (Piché judgment, p. 24, vol. I, p. 40, based on the testimony of Dr. Fortin), it is unjust to prevent citizens who do not benefit from such influence to at least use their own resources, outside the public regime, in order to also obtain care in a timely fashion and according to conditions that suit them.

187. If this Court finds that there is an infringement that is not in accordance with the principles of fundamental justice, Justice Lamer, in *Reference re BC Motor Vehicle Act* [1985] 2 S.C.R. 486, 518, has said, in *obiter*, that as concerns criminal law, under s. 1, such an infringement would only be saved in exceptional circumstances.

J. RESTRICTION TO THE RIGHTS GUARANTEED BY SECTION 7: SECTION 1 ANALYSIS

Objective

188. In *Big M Drug Mart*, *supra*, p. 361-362, Justice Wilson has written that the objective invoked in support of a reasonable limit pursuant to s. 1 necessarily reflects the purpose of the law invoked in relation to the division of powers analysis.

189. The true purpose of the impugned provisions was to eliminate parallel private medicine, in other words, to ensure that all health resources be in the public regime (Piché, p. 127, vol. I, p. 143) i.e. a state monopoly, and thus to limit Quebec resident's freedom to enter into the impugned contracts. Judge Piché having decided that the prohibitions constituted an infringement of the freedom protected by s. 7, the appellant submits that the true purpose is to infringe on a Charter-protected freedom, so that it is not valid. Indeed, to attempt to suppress a fundamental freedom cannot constitute a valid purpose in a free and democratic society. To this effect, author Marco Laverdière, *supra*, has invoked the possibility of an invalid purpose in the present case (vol. III, Tab 42, pp. 207 to 210). Moreover, all Canadian provinces had undertaken to protect arts. 9 to 12 of the Covenant: General Observation No. 14, par. 9, 12 (a) (b) (i) (iii), 18 and 19. Article 9 provides for the right of every person to social insurance, which includes voluntary private insurance, as suggested at par. 140 of the present factum, and art. 12 provides for a person's right to benefit from the best state of health possible. However, Quebec, as well as all other Canadian provinces who have similar prohibitions, have omitted to report the impugned prohibitions to the United Nations, via the government of Canada: *Report of Canada on art. 6 to 9*, August 1980, pp. 1, 345 to 352. *Report of Canada on the Implementation of art. 10 to 12 of the Covenant*, December 1982, pp. 426 to 434, *Second Report*, December 1987, pp. 84-85, *Second Report articles 10 to 15*, 1992, pp. 25, 26, 77 and 78, and *Third Report*, April 1997, and this despite *Committee on Economic, Social and Cultural Rights, General Comment 1*, 1989, par. 3 and 5 (*infra*, vol. IV, pp. 564 and ff., *Comment 3*, 1990, par. 3 and 8 (vol. IV, pp. 567 and ff.) *Decision of High Commission on Human Rights 2002/31*, introduction pars. 2, 5, 7, and Nos 3, 4, 5 a) c), 10 (vol. IV pp. 621 and ff.) repeated in *Economic and Social Council Decision 2002|259* (vol. IV, pp. 624 and ff.) and *High Commission on Human Rights Resolution 2003/28* (Vol. IV, pp. 626 and ff.).

190. Alternatively, if it is decided that the impugned provisions had as their purpose the two objectives that Minister Castonguay had announced in 1970, exposed at par. 109 of the factum, one object being to establish a universal public regime and another being to prevent a resident from getting private services outside the public regime, the latter object is not valid. Indeed, in addition to what has been said before, using a contextual analysis, the ground of this second purpose is not in accordance with the value of equality which is conveyed by the Charter. In 1989, this Court has established in *Andrews v. Law Society of British Columbia* [1989] 1 S.C.R. 1453, p. 163 to 165, that the concept of equality does not mean a general guarantee of equality, and that the right to equality does not require equality between individuals in a general sense. Hence, the appellant submits that only one purpose needs to be invalid in order to conclude the analysis under s. 1 of the Canadian Charter.

191. In the alternative, if the true purpose of 15 HEIA and 11 HOIA was to establish a universal public health care regime (Piché decision pp. 76 vol. I, p. 92), this purpose is valid, urgent and real, and it is then appropriate to continue the analysis under s. 1.

192. In *R.J.R., supra*, at pars 132. 135, 136, 140 and 141, this Court has held that when there is an infringement of a right protected by the Canadian Charter the notion of respect towards the legislature must not be pushed too far. It has also held that a Court of Appeal is not bound by the conclusions of the trial judge with respect to social or legislative facts which have been presented by expert witnesses.

Rational Connection

193. In the case law, rational connection has been defined as either the connection between the impugned law and its objective or as the connection between the impugned law and its effect. The appellant submits that these two approaches amount essentially to the same analysis, namely whether the impugned law can find an explanation following reason or logic. This Court has followed several approaches. The appellant submits that there is no rational connection, based on six arguments:

193.1 With respect to the total prohibition imposed on Quebec residents to purchase private insurance which covers medically required services (15 HEIA), to the extent that in 1970, following the adoption of 15 HEIA, a resident could choose to pay an NP MD for a medically required service, either outside or inside a hospital, it was not logical to forbid the purchase of private insurance for private services, the sale of which was legal. For this reason, 15 HEIA does not pass the rational connection test. With respect to the total prohibition imposed on Quebec residents on the purchase of medical services from an NP MD who practices in a hospital (11 HOIA), since the establishment of the universal public regime of hospital insurance in 1961, and since the establishment of the universal public health care regime in 1970, a resident has always had the right to purchase medical services to an NP MD who practices in a hospital, until 1992. As the purpose, a universal public regime of health and hospital insurance, had been attained for a long time, the fact of suddenly adopting such a total prohibition in 1992 was certainly not logical. For this reason, 11 HOIA does not pass the rational connection test.

193.2 The respondents had to demonstrate that the infringement of the rights to life, security and liberty caused by 15 HEIA and 11 HOIA is rationally connected to the purpose of establishing a public health care regime open to all. But, to the extent that this purpose aims at permitting individuals to protect their life and health, the infringement has no rational connection with the legislator's purpose: *R.J.R., supra*, par. 153, Andrea Karr, p. 537).

193.3 The respondents had to show a connection, based on reason or logic, between 15 HEIA and 11 HOIA and the establishment of a public health care regime open to all. They had to prove that in 1970 and 1992, the impugned provisions were carefully tailored in order to reach the objective of the establishment, and maintenance, of a universal and public health care regime and of a universal public regime for hospital insurance. The respondents have not met their burden of proof: *Oakes, supra*, p. 139. Indeed, the question asked by the respondents to

their expert witnesses, and the only evidence tendered by the respondents, i.e. the effects of a parallel private health system on the public health care regime, could not help them to meet their burden of proof. The respondents have not introduced any evidence showing that authorizing private insurance would have prevented the establishment of a universal public health care regime. To the contrary, uncontested evidence has shown that in comparable countries such an authorization has not prevented the establishment of a universal public regime. Moreover, a report from the OEDC 2003, footnote no 3 of par. 37, p. 17 (vol. III Tab 47), shows that the appellant's submission is well-founded. Hence, it would be irrational to deduce that these prohibitions contributed to the establishment of a universal public regime.

193.4 The appellant submits that when in *Oakes*, *supra*, p. 139, this Court has talked of the legislator's means to attain its objective, it was referring to the link between the impugned law and its object. To the extent that the object would not be the suppression of a parallel private system but rather the establishment of a universal public regime, the analysis of the rational connection cannot be the analysis of a link between, on the one hand, the total prohibition on private insurance and the total prohibition on private hospital services and, on the other hand, the avoidance of a private parallel system. Judge Piché has found a connection between the impugned provisions and the avoidance of a parallel private system, but here the respondents' burden was not to prove a rational connection between these two elements, since, in that reasoning, which is secondary to that of the division of powers, such avoidance is not the object of the impugned provisions.

193.5 To the extent that, in 1970, at the time of adoption of 15 HEIA, the legislator allowed for doctors practicing either in or outside a hospital to exit the public regime, and authorized the government, pursuant to 30 HEIA, to limit their numbers, it was irrational for the state to discourage doctors from leaving the public regime.

193.6 Following *Oakes*, *supra*, p. 139, 15 HEIA must not be unfair. But it is unfair, and the appellant refers the Court to his sixth argument in relation to the principles of fundamental justice. On this point, Judge Piché omitted to take into consideration the appellant's testimony showing that he had asked the Minister to provide vouchers to individuals who did not have money, so that all would be able to have access to private at-home services (Chaoulli, 14 sept. 1999, vol. IV, pp. 573, 579 to 581). Here again, the value of equality is underlying the argument.

Minimal Impairment and Proportional Effects

194. In the alternative, the appellant agrees with the arguments submitted by Counsel for appellant Zeliotis concerning minimal impairment and the proportionality of effects.

CONSTITUTIONAL REMEDY

195. If this Court concludes that there was an infringement of the rights protected by the Charter, and that the infringement is not saved by s. 1, it must, pursuant to s. 52 (1), declare the impugned provisions invalid.

196. The reasoning of Judge Piché (decision pp. 109, 110, vol. I, pp. 125-6), maintained by Justice Delisle and by many authors, is to the effect that s. 7 of the Charter protects the right to receive public health care. If Judge Piché was right, following *Schachter v. Canada*, [1992] 2 S.C.R. 709, 710, this Court could, as a remedy pursuant to s. 52 (1) of the Constitution Act, over and above a declaration of invalidity, and notwithstanding any legislative provision authorizing the government to reduce spending on health care, order the government to provide the insured services in a timely manner and in accordance with the modalities which suit residents. On the contrary, other authors believe that the Charter does not confer a right to public health services: Canadian Bar Association, pp. 21 to 28, Senatorial Committee, vol. III, Tab 44, ch. 5, p. 8, Stanley H. Hartt and Patrick J. Monahan, vol. II, Tab 40, p. 3.

197. The appellant submits that, in the present case, s. 7 does not impose such an obligation on the state, but that it forbids the state from preventing a resident from using his own resources to purchase private health services. However, from the moment when a law provides a right to public health care, s. 7 obliges the state, or one of its agents, to make them available to an individual within the limits of the law, in conformity with fundamental procedural justice. Indeed, in *Reference re Canada Assistance Plan (B.-C.)* [1991] 2 S.C.R. 525, p. 568, this Court has recognized the right of the federal level of government to reduce its financial contributions to established programs. As for s. 15 (1), it obliges the state to provide health services only as a remedy to a situation where the state would deliver health services in a discriminatory manner.

198. Judge Piché's solution, with which Justice Delisle agreed, would lead to an indefensible encroachment on financial decisions, which would cause a substantial modification of the legislative regime, in that governments have a panoply of legislative and regulatory means which enable them to lower the offer for medical services, such as the *Act Respecting Health and Social Services*, R.S.Q. c. S-4.2, s. 13, and see Hartt and Monahan, *supra*, p. 26, P.A. Molinari, pp. 73 to 87, *Schachter*, *supra*, p. 709, 710. On this issue, the appellant, as a taxpayer, has an interest in not having this Court inappropriately encroach on financial decisions, thereby causing a substantial modification of the legislative regime.

199. Because of the rise of costs, and because of the fact that the public health regime does not benefit from unlimited resources (Piché decision, p. 126, vol. I, p. 142), to conclude that s. 7 does not confer a fundamental right to receive public health services would first imply that this Court would decide who, the federal or provincial levels of jurisdiction, or both, must spend the most, as well as the proportion which should be assumed by each level, and would also quickly lead governments, first to leave other essential sectors of socioeconomic life such as education, agriculture or defence, and would finally lead to financial bankruptcy. Moreover, this Court would not be in a position to evaluate whether such a remedy, for instance through guarantees of care, would effectively be respected by the state, or whether it would be efficient: Report OEDC 2003, vol. III, Tab 47, p. 41, par. 133, p. 42, par. 135, 136,

and p. 47, par. 163. This Court has often interpreted the right to equality, under s. 15 (1), in such a way that the state was almost put in the position of having to spend more, in order to repair the disadvantages caused by an illegal distinction. But, to the contrary, this Court has interpreted the rights and liberties under s. 7 like a protection against the state's coercive action.

200. Following *Schachter*, *supra*, p. 719, the Court could suspend the effects of the declaration of invalidity, if the nullification of the provision presents a danger for the public or affects the Rule of Law. In the present case, following *Hitzig*, *supra*, par. 153, 167, 168, 169 and 175, the appellant submits respectfully that a temporary suspension could present a danger for the public. In fact, to the extent that there exists a threat of potential and imminent infringement of the rights to life and security, the appellant submits that it would be reasonable to immediately enable Canadians to enter into the impugned contracts, in order to enable them to protect their life and security, and so that the appellant can usefully follow through with the judicial proceedings which he launched against the Regie Régionale Montreal-Centre concerning his request for a permit for establishing a private «non-conventioned» hospital, pursuant to the *Act respecting Health Services and Social Services*, R.S.Q. c. S. 4-2, ss. 79, 81, 94, 97, 99 and 441.

201. In favour of the immediate effect of a declaration of invalidity the appellant submits that the *Covenant*, *supra*, art. 28, and Observation 14, art. 30 and 31, oblige the provinces and territories of Canada to immediately respect the rights and freedoms invoked by the appellant. Moreover, the existing legislative provisions enable the government of Quebec to limit, if necessary, the development of a parallel private medicine, for the following reasons:

201.1 Section 30 HEIA authorizes the Minister, if he considers it useful, to force NP MD's to participate in the public health care regime. Also, other forms of regulation exist: Report OEDC 2003, vol. III, Tab 47, p. 28, par. 73, 74, 75, and p. 46, par. 156.

201.2 Section 441 AHSSS enables a Régie Régionale and the Minister to refuse to grant a private hospital permit if they exercise their discretion in a non-abusive, non-arbitrary way.

201.3 The Minister and the QFGP have agreed, through an agreement, as provided for in the law, that an NP MD can exercise in a public hospital, and an agreement binds the establishments and the Régies régionales: *Agreement General Practitioners*, art. 8.05, HEIA, s. 19 (12)

201.4 The evidence has shown that a private sector parallel to a universal public regime for medical services would only represent a small part of all medical services.

201.5 The appellant submits that even if the Court provided for an immediate declaration of invalidity, in practice enough time will pass before Canadian residents effectively have access to private hospital services; such a delay is already too long for a person who faces a potential threat to her right to life and to security.

201.6 Of course, a declaration of invalidity with immediate effect could affect political agendas, but the appellant submits that the balance of inconvenience points undoubtedly towards Canadians whose life and security are potentially and imminently threatened through legislative action.

201.7 Supposing that the appellant establishes a private hospital in Quebec, the evidence shows that he has already expressed the intention to propose to the state that he receive, at the state's expense, Quebec patients (Chaoulli, 14 sept. 1999, vol. IV, pp. 582 to 586) who otherwise would be forced to go abroad, far from their loved ones, to receive the same private health services, at a price possibly less advantageous for all Canadian taxpayers (Nabid, Sept. 10 1999, vol. III, pp. 554, 555, 561, 562). Indeed, the law authorizes the State to contract with a private hospital, pursuant to the *Act respecting Health Services and Social Services*, R.S.Q., c. S-4.2, ss. 475 and 476; and according to a recent report of the OEDC, which analysed 12 comparable States, including Canada, voluntary private insurance and private hospitals have helped reducing waiting times in the public sector: OEDC 2003, vol. III, Tab 47, p. 9, par. 5, pp. 25-26, par. 62, pp. 32-33; par. 86 to 89 and 91, pp. 34-35, par. 97, p. 38, par. 114, 115, pages 39-40, par. 119 to 123, p. 47, par. 161.

202. Although the present appeal only concerns the legislative provisions of the province of Quebec, it is reasonable to believe that the other provinces and territories, which have adopted similar prohibitions, will feel bound by a decision of this Court. As for provinces who prohibit private insurance while allowing NP MD's, such as British Columbia, Alberta and Prince Edward Island, governments there possess a large regulatory power, and the situation would be comparable to that of Quebec. As for jurisdictions that prohibit NP MD's, such as Saskatchewan, Manitoba and Ontario, governments there also possess vast regulatory powers, and they will be able to limit the number of NP MD's if they find this to be necessary. Finally, in Canada, no jurisdiction prohibits the establishment of a private hospital, and the quality of care in such hospital is not worse than in a public hospital. (I-37 A, p. 425, vol. XIII, p. 2350, Coffey, Oct. 4 1999, vol. VII, pp. 1305 to 1311, R-96, p. 71, vol. X, p. 1827 and Committee of the Senate, vol. III, Tab 47, ch. 2.7, pp. 3 to 6).

203. If this Court decides to temporarily suspend a declaration of invalidity, the appellant respectfully submits, for the reasons expressed earlier, that the duration of the suspension should be as short as possible.

PART IV – ARGUMENTS CONCERNING COSTS

204. If this court allows this appeal, following the opinion of Justice L'Heureux-Dubé in *B.(R.) v. Children Aid Society of Metropolitan Toronto*, *supra*, pars. 143 to 156, 164 and 182, the appellant submits that costs should be allowed to him before all instances, including expert fees, since Dr. Coffey has done, by himself, considerable work on a debate for which the respondents have hired five expert witnesses.

205. If this Court rejects the present appeal, the appellant submits that it should reject it without costs, before all instances, for the following reasons: the degree of complexity of the case was very high; the issues were very important; the respondents

have called a high number (5) of experts; the Permanent Committee of the Senate on Social Affairs's position implicitly favoured the appellant's position (Senate Committee, vol. III, Tab 44, ch. 5.3, pp. 15, 16); and *Rodriguez, supra*, should be followed.

PART V – REQUESTED ORDERS

OVERTURN the decisions of the Quebec Court of Appeal and of the Quebec Superior Court.

DECLARE s. 15 of the *Health Insurance Act*, R.S.Q. c. A-29 and s. 11 of the *Hospital Insurance Act*, R.S.Q. c. A-28, *ultra vires* the Quebec National Assembly, pursuant to s. 91 (27) of the *Constitution Act 1867*.

DECLARE that s. 15 of the *Health Insurance Act* and s. 11 of the *Hospital Insurance Act* violate s. 7 of the *Canadian Charter of Rights and Freedoms* and that they are inoperative in light of s. 52(1) of the *Constitution Act 1982*.

DECLARE that s. 15 of the *Health Insurance Act* and s. 11 of the *Hospital Insurance Act* violate s. 15(1) of the *Canadian Charter of Rights and Freedoms* and are inoperative in light of s. 52(1) of the *Constitution Act 1982*.

DECLARE that s. 11 of the *Hospital Insurance Act* violates s. 12 of the *Canadian Charter of Rights and Freedoms* and is inoperative in light of s. 52(1) of the *Constitution Act 1982*.

CONDEMN the respondents to the costs before all instances, including expert fees.

MONTREAL, November 7 2003