SUPREME COURT OF CANADA

CITATION: Chaoulli *v.* Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35

DATE: 2005-06-09
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BETWEEN:

Jacques Chaoulli and George Zeliotis
Appellants

v.

Attorney General of Quebec and Attorney General of Canada
Respondents

- and –

Attorney General of Ontario, Attorney General of New Brunswick, Attorney General for Saskatchewan, Augustin Roy, Senator Michael Kirby, Senator Marjory Lebreton, Senator Catherine Callbeck, Senator Joan Cook, Senator Jane Cordy, Senator Joyce Fairbairn, Senator Wilbert Keon, Senator Lucie Pépin, Senator Brenda Robertson and Senator Douglas Roche, Canadian Medical Association and Canadian Orthopaedic Association, Canadian Labour Congress, Charter Committee on Poverty Issues and Canadian Health Coalition, Cambie Surgeries Corp., False Creek Surgical Centre Inc., Delbrook Surgical Centre Inc., Okanagan Plastic Surgery Centre Inc., Specialty MRI Clinics Inc., Fraser Valley MRI Ltd., Image One MRI Clinic Inc., McCallum Surgical Centre Ltd., 4111044 Canada Inc., South Fraser Surgical Centre Inc., Victoria Surgery Ltd., Kamloops Surgery Centre Ltd., Valley Cosmetic Surgery Associates Inc., Surgical Centres Inc., British Columbia Orthopaedic Association and British Columbia Anesthesiologists Society
Interveners

OFFICIAL ENGLISH TRANSLATION: Reasons of Deschamps J.

CORAM: McLachlin C.J. and Major, Bastarache, Binnie, LeBel, Deschamps and Fish JJ.

REASONS FOR JUDGMENT: Deschamps J.
(paras. 1 to 101)

JOINT REASONS CONCURRING IN THE RESULT: McLachlin C.J. and Major J. (Bastarache J. concurring)
(paras. 102 to 160)

JOINT DISSENTING REASONS: Binnie and LeBel JJ. (Fish J. concurring)
(paras. 161 to 279)

English version of the reasons delivered by

1 DESCHAMPS J. — Quebeckers are prohibited from taking out insurance to obtain in the private sector services that are available under Quebec's public health care plan. Is this prohibition justified by the need to preserve the integrity of the plan?

2 As we enter the 21st century, health care is a constant concern. The public health care system, once a source of national pride, has become the subject of frequent and sometimes bitter criticism. This appeal does not question the appropriateness of the state making health care available to all Quebeckers. On the contrary, all the parties stated that they support this kind of role for the government. Only the state can make available to all Quebeckers the social safety net consisting of universal and accessible health care. The demand for health care is constantly increasing, and one of the tools used by governments to control this increase has been the management of waiting lists. The choice of waiting lists as a management tool falls within the authority of the state and not of the courts. The appellants do not claim to have a solution that will eliminate waiting lists. Rather, they submit that the delays resulting from waiting lists violate their rights under the *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12("*Quebec Charter*"), and the *Canadian Charter of Rights and Freedoms* ("*Canadian Charter*"). They contest the validity of the prohibition inQuebec, as provided for in s. 15 of the *Health Insurance Act*, R.S.Q., c. A-29 ("*HEIA*"), and s. 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28("*HOIA*"), on private insurance for health care services that are available in the public system. The appellants contend that the prohibition deprives them of access to health care services that do not come with the wait they face in the public system.

3 The two sections in issue read as follows:

> **15.** No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or a deemed resident of Québec or to another person on his behalf.

. . .

> **11.** (1) No one shall make or renew, or make a payment under a contract under which
>
> (*a*) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;
>
> (*b*) payment is conditional upon the hospitalization of a resident; or
>
> (*c*) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated insection 2.

4 In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state. For the reasons that follow, I find that the prohibition infringes the right to personal inviolability and that it is not justified by a proper regard for democratic values, public order and the generalwell-being of the citizens of Quebec.

5 The validity of the prohibition is contested by the appellants, George Zeliotis and Jacques Chaoulli. Over the years, Mr. Zeliotis has experienced a number of health problems and has used medical services that were available in the public system, including heart surgery and a number of operations on his hip. The difficulties he encountered prompted him to speak out against waiting times in the public health care system. Mr. Chaoulli is a physician who has tried unsuccessfully to have his home-delivered medical activities recognized and to obtain a licence to operate an independent private hospital. Mr. Zeliotis and Mr. Chaoulli joined forces to apply to the court by way of motion for a declaration that s. 15 *HEIA* ands. 11 *HOIA* are unconstitutional and invalid. Mr. Chaoulli argues, first, that the prohibition is within the federal government's legislative jurisdiction in relation to criminal law and, second, that the prohibition violates the rights to life and to personal security, inviolability and freedom protected by s. 1 of the *Quebec Charter* and ss. 7, 12 and 15 of the *Canadian Charter*. The respondents contested the motion both in the Superior Court and in the Court of Appeal.

6 The Superior Court dismissed the motion for a declaratory judgment: [2000] R.J.Q. 786. With respect to the province's power to enacts. 11 *HOIA* and s. 15 *HEIA*, Piché J. found that the purpose of the prohibition is to discourage the development of parallel private health care services and that it is not a criminal law matter.

7 On the subject of s. 7 of the *Canadian Charter*, she noted that according to this Court, its scope may include certain economic rights that are intimately connected with the right to life, liberty and security of the person. She found that the appellants had demonstrated a deprivation of the right to life, liberty and security of the person within the meaning of s. 7 of the *Canadian Charter*. Piché J. then considered whether this deprivation was in accordance with the principles of fundamental justice. She was of the opinion that the purpose of the *HOIA* and the *HEIA* is to establish a public health system that is available to all residents of Quebec. The purpose of s. 11 *HOIA* and s. 15 *HEIA* is to guarantee that virtually all ofQuebec's existing health care resources will be available to all residents of Quebec. In her opinion, the enactment of these provisions was motivated by considerations of equality and human dignity. She found no conflict with the general values expressed in the *Canadian Charter* or in the *QuebecCharter*. She did find that waiting lists are long and the health care system must be improved and transformed. In her opinion, however, the expert testimony could not serve to establish with certainty that a parallel health care system would solve all the current problems of waiting times and access.

8 In light of her conclusion regarding s. 7 of the *Canadian Charter*, Piché J. did not address the question of justification pursuant to s. 1 of the *Canadian Charter*. However, she did express the opinion that the s. 1 analysis would show that the impugned provisions constitute a reasonable limit in a free and democratic society. Although the arguments based on the *Quebec Charter* were raised formally and expressly argued, and although this ground was mentioned at the start of the judgment, Piché J. did not address them in her analysis.

9 With respect to s. 12 of the *Canadian Charter*, Piché J. found that the state's role with regard to the prohibitions is not sufficiently active for the prohibitions to be considered a "treatment" within the meaning of the *Canadian Charter*.

10 The argument based on s. 15 of the *Canadian Charter* relates to place of residence. The prohibition does not apply to non-residents but does apply to residents. Piché J. found that in the circumstances of this case, place of residence is not used to devalue certain individuals or to perpetuate stereotypes. She found that the guarantee of protection against discrimination had not been violated.

11 The Court of Appeal dismissed the appeal: [2002] R.J.Q. 1205. The three judges wrote separate reasons. Delisle J.A. considered all the arguments addressed by the Superior Court. He disagreed with Piché J. regarding s. 7 of the *Canadian Charter*. According to Delisle J.A., the right affected by s. 11 *HOIA* and s. 15 *HEIA* is an economic right and is not fundamental to an individual's life. In addition, in his opinion, the appellants had not demonstrated a real, imminent or foreseeable deprivation. He was also of the view that s. 7 of the *Canadian Charter* may not be raised to challenge a societal choice in court. Forget J.A. essentially agreed with the Superior Court judge. Like Piché J., he found that the appellants had demonstrated a deprivation of their rights under s. 7 of the *Canadian Charter*, but that this deprivation was in accordance with the principles of fundamental justice. Brossard J.A. agreed with Delisle J.A. regarding the economic nature of the right affected bys. 11 *HOIA* and s. 15 *HEIA*. However, he felt that a risk to life or security resulting from a delay in obtaining medical services would constitute a deprivation within the meaning of s. 7 of the *Canadian Charter*. He declined to express an opinion as to whether this deprivation was in accordance with the principles of fundamental justice. Although the arguments based on the *Quebec Charter* were mentioned in the notice of appeal and in Delisle J.A.'s statement of the grounds of appeal, none of the Court of Appeal judges addressed them.

12 The arguments based on the *Quebec Charter* were expressly raised before this Court.

13 Given that I have had the opportunity to read the reasons of Binnie and LeBel JJ., I think it would be appropriate to highlight the main points on which we agree and disagree before addressing the issues raised by the appellants.

14 As I mentioned at the beginning of my reasons, no one questions the need to preserve a sound public health care system. The central question raised by the appeal is whether the prohibition is justified by the need to preserve the integrity of the public system. In this regard, when my colleagues ask whether Quebec has the power under the Constitution to discourage the establishment of a parallel health care system, I can only agree with them that it does. But that is not the issue in the appeal. The appellants do not contend that they have a constitutional right to private insurance. Rather, they contend that the waiting times violate their rights to life and security. It is the measure chosen by the government that is in issue, not Quebeckers' need for a public health care system.

15 To put the problem in context, the legislative framework of the impugned provisions must first be explained. Considering the provisions in their legislative context will make it possible to address the division of powers argument. I will then explain why, in my opinion, the case must first be considered from the standpoint of the *Quebec Charter*. Next, I

will examine the appeal from the standpoint of s. 1 of the *Quebec Charter* before considering whether the prohibition is justified under s. 9.1 of the *Quebec Charter*. Because I conclude that the *Quebec Charter* has been violated, it will not be necessary for me to consider the arguments based on the *Canadian Charter*.

I. Legislative Context

16 Although the federal government has express jurisdiction over certain matters relating to health, such as quarantine, and the establishment and maintenance of marine hospitals (s. 91(11) of the *Constitution Act, 1867*), it is in practice that it imposes its views on the provincial governments in the health care sphere by means of its spending power: *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at para. 25; *YMHA Jewish Community Centre of Winnipeg Inc. v. Brown*, [1989] 1 S.C.R. 1532, at p. 1548; see also: P. W. Hogg, *Constitutional Law of Canada* (loose-leaf ed.), vol. 1, at p. 6-15; A. Lajoie, "L'impact des Accords du Lac Meech sur le pouvoir de dépenser", in *L'adhésion du Québec à l'Accord du Lac Meech* (1988), 163, at pp. 164 *et seq.* In order to receive federal funds, a provincial plan must conform to the principles set out in the *Canada Health Act*, R.S.C. 1985, c. C-6: it must be administered publicly, it must be comprehensive and universal, it must provide for portability from one province to another and it must be accessible to everyone. These broad principles have become the hallmarks of Canadian identity. Any measure that might be perceived as compromising them has a polarizing effect on public opinion. The debate about the effectiveness of public health care has become an emotional one. The Romanow Report stated that the *Canada Health Act* has achieved an iconic status that makes it untouchable by politicians (*Building on Values: The Future of Health Care in Canada: Final Report* (2002) (Romanow Report), at p. 60). The tone adopted by my colleagues Binnie and LeBel JJ. is indicative of this type of emotional reaction. It leads them to characterize the debate as pitting rich against poor when the case is really about determining whether a specific measure is justified under either the *Quebec Charter* or the *Canadian Charter*. I believe that it is essential to take a step back and consider these various reactions objectively. The *Canada Health Act* does not prohibit private health care services, nor does it provide benchmarks for the length of waiting times that might be regarded as consistent with the principles it lays down, and in particular with the principle of real accessibility.

17 In reality, a large proportion of health care is delivered by the private sector. First, there are health care services in respect of which the private sector acts, in a sense, as a subcontractor and is paid by the state. There are also many services that are not delivered by the state, such as home care or care provided by professionals other than physicians. In 2001, private sector services not paid for by the state accounted for nearly 30 percent of total health care spending (Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2003* (2003), at p. 16, Figure 13, "Public and Private Shares of Total Health Expenditure, by Use of Funds, Canada, 2001"). In the case of private sector services that are not covered by the public plan, Quebeckers may take out private insurance without the spectre of the two-tier system being evoked. The *Canada Health Act* is

therefore only a general framework that leaves considerable latitude to the provinces. In analysing the justification for the prohibition, I will have occasion to briefly review some of the provisions of Canada's provincial plans. The range of measures shows that there are many ways to deal with the public sector/private sector dynamic without resorting to a ban.

18 The basis for provincial jurisdiction over health care is more clear. The *Constitution Act, 1867* provides that the provinces have jurisdiction over matters of a local or private nature (s. 92(16)), property and civil rights (s. 92(13)), and the establishment of hospitals, asylums, charities and eleemosynary institutions (s. 92(7)). In Quebec, health care services are delivered pursuant to the *Act respecting health services and social services*, R.S.Q., c. S-4.2 ("*AHSSS*"). The *AHSSS* regulates the institutions where health care services are delivered and sets out the principles that guide the delivery of such services in Quebec. For example, under s. 5 *AHSSS*, Quebeckers are "entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate".

19 The other two main legislative instruments that govern the health care system in Quebec are the *HOIA* and the *HEIA*. The *HOIA* establishes access to hospital services in Quebec; it also regulates hospitals. The purpose of the *HEIA* is to ensure that Quebeckers have access to certain medical services that they need for health reasons.

20 Before discussing the effect of waiting times on human rights, I will address the question of whether the province has the power to impose a prohibition on private insurance.

II. Validity of the Prohibition in Relation to Provincial Jurisdiction

21 The appellant Chaoulli argues that the prohibition is a criminal law matter. In his submission, it was adopted because the provincial government of the time wished to impose an egalitarian system and to eliminate the opportunity for profit in the provision of health care services. He contends that the operation of a health care service for profit was regarded at that time as socially undesirable.

22 If the Court is to accept this argument, it must find, first, that the effect of the prohibition on private insurance is to exclude the private sector and, second, that the main

purpose of excluding the private sector, as distinct from the overall purpose of the *HOIA* and the *HEIA*, is to avert criminal conduct.

23 The Superior Court judge found that the purpose of the prohibition is to ensure that health care is available [TRANSLATION] "by significantly limiting access to, and the profitability of, the private system in Quebec" (p. 812). I will review later in these reasons the evidence accepted by the Superior Court judge in finding that the prohibition is useful having regard to the intended purpose, and so for the moment I reserve comment on this point. It is sufficient, at the stage of identification of the intended purpose, to determine whether ensuring access to health care services by limiting access to the private system is a valid objective for the provincial government. On this point, and based on the division of powers analysis in the preceding section, it is indisputable that the provincial government has jurisdiction over health care and can put mechanisms in place to ensure that all Quebeckers have access to health care.

24 It is difficult to see the argument that the provision of parallel private sector services was perceived as being socially undesirable as an independent objective, unconnected with the social policy pursued by the government in the area of health care. The appellants were alone in contending that the purpose of the prohibition was to eliminate morally reprehensible conduct. The Attorney General of Quebec argued that the prohibition resulted from a desire to pool the financial resources available for health care. This explanation coincides with the objective identified by the Superior Court judge, which is not, strictly speaking, a criminal law objective. Rather, it is a social objective that the provincial legislature may pursue in accordance with the powers conferred on it by s. 92 of the *Constitution Act, 1867*. In my opinion, the argument that the provincial government has trenched on the federal criminal law power cannot succeed.

III. Priority Given to Arguments Based on the *Quebec Charter*

25 The *Canadian Charter* is neither an ordinary statute nor an extraordinary statute like the *Canadian Bill of Rights*, R.S.C. 1985, App. III. It is a part of the Constitution: *Law Society of Upper Canada v. Skapinker*, [1984] 1 S.C.R. 357, at p. 365. As a result, the *Canadian Charter* is different from the *Quebec Charter* in that the *Quebec Charter* is the product of the legislative will of Quebec's National Assembly. In addition, while the *Quebec Charter* has no constitutional dimension, it is also different from ordinary statutes by virtue of its considerably broader purpose: to guarantee respect for human beings (see A. Morel, "La coexistence des Chartes canadienne et québécoise: problèmes d'interaction" (1986), 17 *R.D.U.S.* 49). The *Quebec Charter* protects not only the fundamental rights and freedoms, but also certain civil, political, economic and social rights. By virtue of s. 52, Quebec courts have the power to review legislation to determine whether it is

consistent with the rules set out in the *Quebec Charter*. The *Quebec Charter* has an identity that is independent of the statutes of Quebec.

26 In the case of a challenge to a Quebec statute, it is appropriate to look first to the rules that apply specifically in Quebec before turning to the *Canadian Charter*, especially where the provisions of the two charters are susceptible of producing cumulative effects, but where the rules are not identical. This is the approach suggested by Beetz J. in *Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, at p. 224:

> Thus, the *Canadian Bill of Rights* retains all its force and effect, together with the various provincial charters of rights. Because these constitutional or quasi-constitutional instruments are drafted differently, they are susceptible of producing cumulative effects for the better protection of rights and freedoms. But this beneficial result will be lost if these instruments fall into neglect.

27 In the instant case, s. 7 of the *Canadian Charter* and s. 1 of the *Quebec Charter* have numerous points in common:

Canadian Charter

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

Quebec Charter

> **1.** Every human being has a right to life, and to personal security, inviolability and freedom.

28 The similarities between these two provisions probably explain in part why the Superior Court and the Court of Appeal considered only the *Canadian Charter* in their decisions. With regard to certain aspects of the two charters, the law is the same. For example, the wording of the right to life and liberty is identical. It is thus appropriate to consider the two together. Distinctions must be made, however, and I believe that it is important to begin by considering the specific protection afforded by the *Quebec Charter* for the reason that it is not identical to the protection afforded by the *Canadian Charter*.

29 The most obvious distinction is the absence of any reference to the principles of fundamental justice in s. 1 of the *Quebec Charter*. The analysis dictated by s. 7 of

the *Canadian Charter* is twofold. Under the approach that is generally taken, the claimant must prove, first, that a deprivation of the right to life, liberty and security of the person has occurred and, second, that the deprivation is not in accordance with the principles of fundamental justice (*Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84, at para. 205, *per* Bastarache J.). If this is proved, the state must show under s. 1 of the *Canadian Charter* that the deprivation is justified in a free and democratic society.

30 According to established principles, the onus is on the claimant to prove a violation of constitutional rights: *R. v. Collins*, [1987] 1 S.C.R. 265, and *Rio Hotel Ltd. v. New Brunswick (Liquor Licensing Board)*, [1987] 2 S.C.R. 59; see also Hogg, at p. 44-3. Under s. 7 of the *Canadian Charter*, the claimant would thus have a dual burden. The effect of placing this burden of proof on the claimant is that it makes his or her task more onerous. There is no such dual burden of proof under the *Quebec Charter* because the principles of fundamental justice are not incorporated into s. 1 of the *Quebec Charter*. For this reason, the *Quebec Charter* has a scope that is potentially broader. This characteristic should not be disregarded.

31 Ruling on the points in issue by applying the *Quebec Charter* enhances an instrument that is specific to Quebec; this approach is also justified by the rules of Canadian constitutional law.

32 Before getting into the heart of the debate regarding s. 1 of the *Quebec Charter*, I must address three preliminary arguments raised by the respondent Attorney General of Quebec: (a) that the protection of the right to freedom and life is limited to situations involving the administration of justice, (b) that the right asserted is economic and is not a fundamental right, and (c) that the appellants do not have standing.

IV. Preliminary Objections

A. *Scope of Section 1 of the Quebec Charter*

33 The trial judge adopted a liberal approach to applying the protection afforded by s. 7 of the *Canadian Charter*. She expressed the opinion that the protection is not limited to situations involving the administration of justice. This Court has not yet achieved a consensus regarding the scope of this protection. In *Gosselin*, at paras. 78 and 83, McLachlin C.J. did not consider it necessary to answer the question definitively. In my opinion, the same question of law does not arise in the context of

the *Quebec Charter*. The *Quebec Charter* has a very broad scope of application. It extends to relationships between individuals and relationships between individuals and the state. Limiting the scope of s. 1 of the *Quebec Charter* to matters connected with the administration of justice is not justified in light of the general scope of this quasi-constitutional instrument.

B. *Economic Right or Fundamental Right*

34 Delisle J.A. accepted the argument of the Attorney General of Quebec and declined to apply s. 7 of the *Canadian Charter* on the basis that the right in issue, which in his opinion is an economic right, is not protected by the *Canadian Charter*. This appeal does not require the Court to establish a general rule including or excluding economic rights in or from the scope of s. 1 of the *Quebec Charter*. The Superior Court judge made the following observation in this regard (at pp. 822-23):

> [TRANSLATION] . . . the economic barriers . . . are closely related to the possibility of gaining access to health care. Having regard to the costs involved, access to private care without the rights in question is illusory. Accordingly, those provisions are an impediment to access to health care services and therefore potentially infringe the right to life, liberty and security of the person. [Emphasis deleted.]

Piché J.'s analysis is correct. Limits on access to health care can infringe the right to personal inviolability. The prohibition cannot be characterized as an infringement of an economic right.

C. *Standing*

35 Clearly, a challenge based on a charter, whether it be the *Canadian Charter* or the *Quebec Charter*, must have an actual basis in fact: *Operation Dismantle Inc. v. The Queen*, [1985] 1 S.C.R. 441. However, the question is not whether the appellants are able to show that they are personally affected by an infringement. The issues in the instant case are of public interest and the test from *Minister of Justice of Canada v. Borowski*, [1981] 2 S.C.R. 575, applies. The issue must be serious, the claimants must be directly affected or have a genuine interest as citizens and there must be no other effective means available to them. These conditions have been met. The issue of the validity of the prohibition is serious. Chaoulli is a physician and Zeliotis is a patient who has suffered as a result of waiting lists. They have a genuine interest in the legal proceedings. Finally, there is no effective way to challenge the validity of the provisions other than by recourse to the courts.

36 The three preliminary objections are therefore dismissed. I will now turn to the analysis of the infringement of the rights protected by s. 1of the *Quebec Charter*.

V. Infringement of the Rights Protected by Section 1 of the *Quebec Charter*

37 The appellant Zeliotis argues that the prohibition infringes Quebeckers' right to life. Some patients die as a result of long waits for treatment in the public system when they could have gained prompt access to care in the private sector. Were it not for s. 11 *HOIA* and s. 15 *HEIA*, they could buy private insurance and receive care in the private sector.

38 The Superior Court judge stated [TRANSLATION] "that there [are] serious problems in certain sectors of the health care system" (p. 823). The evidence supports that assertion. After meticulously analysing the evidence, she found that the right to life and liberty protected by s. 7of the *Canadian Charter* had been infringed. As I mentioned above, the right to life and liberty protected by the *Quebec Charter* is the same as the right protected by the *Canadian Charter*. Quebec society is no different from Canadian society when it comes to respect for these two fundamental rights. Accordingly, the trial judge's findings of fact concerning the infringement of the right to life and liberty protected by s. 7 of the *Canadian Charter* apply to the right protected by s. 1 of the *Quebec Charter*.

39 Not only is it common knowledge that health care in Quebec is subject to waiting times, but a number of witnesses acknowledged that the demand for health care is potentially unlimited and that waiting lists are a more or less implicit form of rationing (report by J.-L. Denis, *Un avenir pour le système public de santé* (1998), at p. 13; report by Y. Brunelle, *Aspects critiques d'un rationnement planifié* (1993), at p. 21). Waiting lists are therefore real and intentional. The witnesses also commented on the consequences of waiting times.

40 Dr. Daniel Doyle, a cardiovascular surgeon, testified that when a person is diagnosed with cardiovascular disease, he or she is [TRANSLATION] "always sitting on a bomb" and can die at any moment. In such cases, it is inevitable that some patients will die if they have to wait for an operation. Dr. Doyle testified that the risk of mortality rises by 0.45 percent per month. The right to life is therefore affected by the delays that are the necessary result of waiting lists.

41 The *Quebec Charter* also protects the right to personal inviolability. This is a very broad right. The meaning of "inviolability" is broader than the meaning of the word "security" used in s. 7 of the *Canadian Charter*. In civil liability cases, it has long been

recognized in Quebec that personal inviolability includes both physical inviolability and mental or psychological inviolability. This was stated clearly in *Quebec (Public Curator)v. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 S.C.R. 211, at para. 95:

> Section 1 of the *Charter* guarantees the right to personal "inviolability". The majority of the Court of Appeal was of the opinion, contrary to the trial judge's interpretation, that the protection afforded by s. 1 of the *Charter* extends beyond physical inviolability. I agree. The statutory amendment enacted in 1982 (see *An Act to amend the Charter of Human Rights and Freedoms*, S.Q. 1982, c. 61, in force at the time this cause of action arose) which, *inter alia*, deleted the adjective "*physique*", in the French version, which had previously qualified the expression "*intégrité*" (inviolability), clearly indicates that s. 1 refers inclusively to physical, psychological, moral and social inviolability.

Furthermore, arts. 1457 and 1458 of the *Civil Code of Québec*, S.Q. 1991, c. 64, refer expressly to "moral" injury.

42 In the instant case, Dr. Eric Lenczner, an orthopaedic surgeon, testified that the usual waiting time of one year for patients who require orthopaedic surgery increases the risk that their injuries will become irreparable. Clearly, not everyone on a waiting list is in danger of dying before being treated. According to Dr. Edwin Coffey, people may face a wide variety of problems while waiting. For example, a person with chronic arthritis who is waiting for a hip replacement may experience considerable pain. Dr. Lenczner also stated that many patients on non-urgent waiting lists for orthopaedic surgery are in pain and cannot walk or enjoy any real quality of life.

43 Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays. In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at p. 59, Dickson C.J. found, based on the consequences of delays, that the procedure then provided for in s. 251 of the *Criminal Code*, R.S.C. 1970, c. C-34, jeopardized the right to security of the person. Beetz J., at pp. 105-6, with Estey J. concurring, was of the opinion that the delay created an additional risk to health and constituted a violation of the right to security of the person. Likewise, in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at p. 589, Sopinka J. found that the suffering imposed by the state impinged on the right to security of the person. See also *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, and *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 SCC 44, with respect to mental suffering. If the evidence establishes that the right to security of the person has been infringed, it supports, *a fortiori*, the finding that the right to the inviolability of the person has been infringed.

44 In the opinion of my colleagues Binnie and LeBel JJ., there is an internal mechanism that safeguards the public health system. According to them, Quebeckers may go outside the province for treatment where services are not available in Quebec. This possibility is clearly not a solution for the system's deficiencies. The evidence did not bring to light any administrative mechanism that would permit Quebeckers suffering as a result of waiting times to obtain care outside the province. The possibility of obtaining care outside Quebec is case-specific and is limited to crisis situations.

45 I find that the trial judge did not err in finding that the prohibition on insurance for health care already insured by the state constitutes an infringement of the right to life and security. This finding is no less true in the context of s. 1 of the *Quebec Charter*. Quebeckers are denied a solution that would permit them to avoid waiting lists, which are used as a tool to manage the public plan. I will now consider the justification advanced unders. 9.1 of the *Quebec Charter*.

VI. Justification for the Prohibition

46 Section 9.1 of the *Quebec Charter* sets out the standard for justification. It reads as follows:

> **9.1.** In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and thegeneral well-being of the citizens of Québec.
>
> In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law.

47 The Court had occasion to consider the scope of this provision in *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712. In its view, in the context of the relationship between citizens and the state, the provision is of the same nature as s. 1 of the*Canadian Charter* (at pp. 769-71):

> It was suggested in argument that because of its quite different wording s. 9.1 was not a justificatory provision similar to s. 1 but merely a provision indicating that the fundamental freedoms and rights guaranteed by the Quebec *Charter* are not absolute but relative and must be construed and exercised in a manner consistent with the values, interests and considerations indicated in s. 9.1 — "democratic values, public order and the general well-being of the citizens of Québec." In the case at bar the Superior Court and the Court of Appeal held that s. 9.1 was a justificatory provision corresponding to s. 1 of the Canadian *Charter* and that it was subject, in its application, to a similar test of

> rational connection and proportionality. This Court agrees with that conclusion. The first paragraph of s. 9.1 speaks of the manner in which a person must exercise his fundamental freedoms and rights. That is not a limit on the authority of government but rather does suggest the manner in which the scope of the fundamental freedoms and rights is to be interpreted. The second paragraph of s. 9.1, however — "In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law" — does refer to legislative authority to impose limits on the fundamental freedoms and rights. The words "In this respect" refer to the words "maintain a proper regard for democratic values, public order and the general well-being of the citizens of Québec". Read as a whole, s. 9.1provides that limits to the scope and exercise of the fundamental freedoms and rights guaranteed may be fixed by law for the purpose of maintaining a proper regard for democratic values, public order and the general well-being of the citizens of Quebec. That was the view taken of s. 9.1 in both the Superior Court and the Court of Appeal. As for the applicable test under s. 9.1, Boudreault J. in the Superior Court quoted with approval from a paper delivered by Raynold Langlois, Q.C., entitled "Les clauses limitatives des Chartes canadienne et québécoise des droits et libertés et le fardeau de la preuve", and published in *Perspectives canadiennes et européennes des droits de la personne* (1986), in which the author expressed the view that under s. 9.1 the government must show that the restrictive law is neither irrational nor arbitrary and that the means chosen are proportionate to the end to be served. In the Court of Appeal, Bisson J.A. adopted essentially the same test. He said that under s. 9.1 the government has the onus of demonstrating on a balance of probabilities that the impugned means are proportional to the object sought. He also spoke of the necessity that the government show the absence of an irrational or arbitrary character in the limit imposed by law and that there is a rational link between the means and the end pursued. We are in general agreement with this approach. . . . [I]t is an implication of the requirement that a limit serve one of these ends that the limit should be rationally connected to the legislative purpose and that the legislative means be proportionate to the end to be served. That is implicit in a provision that prescribes that certain values or legislative purposes may prevail in particular circumstances over a fundamental freedom or right. That necessarily implies a balancing exercise and the appropriate test for such balancing is one of rational connection and proportionality. [Emphasis in original.]

48 The interpretation adopted by the Court in that decision still applies today, and the analytical approach developed in *R. v. Oakes*, [1986] 1 S.C.R. 103, must be followed. This approach is well known. First, the court must determine whether the objective of the legislation is pressing and substantial. Next, it must determine whether the means chosen to attain this legislative end are reasonable and demonstrably justifiable in a free and democratic society. For this second part of the analysis, three tests must be met: (1) the existence of a rational connection between the measure and the aim of the legislation; (2) minimal impairment of the protected right by the measure; and (3) proportionality between the effect of the measure and its objective (*Egan v. Canada*,

[1995] 2 S.C.R. 513, at para. 182). It is the minimal impairment analysis that has proven to be the most delicate stage in the instant case. The other stages cannot, however, be bypassed.

A. *Purpose of the Statute*

49 The prohibitions are set out in the *HOIA* and the *HEIA*. The general objective of these statutes is to promote health care of the highest possible quality for all Quebeckers regardless of their ability to pay. Quality of care and equality of access are two inseparable objectives under the statutes. At trial, Claude Castonguay, who was Quebec's Minister of Health at the time when the *HEIA* was enacted, testified regarding the legislation's objectives:

> [TRANSLATION] . . . we wanted to ensure that everyone would have access to health care, regardless of their ability to pay. Also, because the Health Insurance Act was part of a whole — there was Bill 65 respecting health services — we wanted a thorough reform. We wanted access to health care to be as equal as possible everywhere in Quebec, regardless of place of residence, regardless of financial circumstances . . . .

50 The quality objective is not formally stated, but it seems clear that a health care service that does not attain an acceptable level of quality of care cannot be regarded as a genuine health care service. Low-quality services can threaten the lives of users. The legislature accordingly required that there be supervision of health care. That supervision is essential to guarantee not only the quality of care, but also public safety.

51 To ensure supervision of these services, the *AHSSS* provides for program planning (s. 346), organization of services (ss. 347 to 349), allocation of financial resources (ss. 350 and 351), coordination of health services and social services (ss. 352 to 370), and management of human, material and financial resources (ss. 376 to 385). An institution that provides services may be private and may receive government funding, in which case it is referred to as a "private institution under agreement". In such cases, the state delegates its responsibilities to a private sector service provider. The services of public institutions and private institutions under agreement relate, on the whole, to a single offer of services, namely the one established by the government. If a legal or natural person wishes to provide health services or social services contemplated by the *AHSSS* from an institution, the person must obtain a permit to operate an institution (ss. 316 and 437). Because private institutions are not prohibited by the *AHSSS*, the Minister may not refuse to issue a permit solely because he or she wishes to slow down the development of private institutions that are not under agreement (*Charles Bentley Nursing Home Inc. v. Ministre des Affaires sociales*, [1978] C.S. 30) (see M. Laverdière, "Le cadre juridique canadien et québécois relatif au développement parallèle de services privés de santé et l'article 7 de la *Charte canadienne des droits et libertés*" (1998-1999), 29 *R.D.U.S.* 117).

52 The *HOIA* and the *HEIA* provide that, within the framework they establish, the state is responsible for the provision and funding of health services. The *HEIA* provides (s. 3) that the state is to pay the cost of services rendered by a physician that are medically required as well as certain other services provided by, *inter alia*, dentists, pharmacists and optometrists. The insured services are funded by the state out of public moneys. The only contribution made by recipients of services toward the cost is through their income tax, if they are liable to pay income tax. The services covered must be provided by participating professionals or by professionals "who have withdrawn", although these professionals may not receive any fees in addition to those paid by the state (s. 22). The purpose of the *HOIA* is to ensure that hospital care is provided free of charge. The Act provides that hospital services are insured where they are medically required so that Quebeckers receive hospital services without charge and upon uniform terms and conditions (s. 2).

53 It can be seen from this brief review of the legislation governing health services that such services are controlled almost entirely by the state.

54 Although there are, at first glance, no provisions that prohibit the delivery of services by an individual or a legal person established for a private interest, a number of constraints are readily apparent. In addition to the restrictions relating to the remuneration of professionals, the requirement that a permit be obtained to provide hospital services creates a serious obstacle in practice. This constraint would not be problematic if the prevailing approach favoured the provision of private services. However, that is not the case. Not only are the restrictions real (Laverdière, at p. 170), but Mr. Chaoulli's situation shows clearly that they are. Here again, the executive branch is implementing the intention of the Quebec legislature to limit the provision of private services outside the public plan. That intention is evident in the preliminary texts tabled in the National Assembly, in the debate concerning those texts and, finally, in the written submissions filed by the Attorney General of Quebec in the instant case.

55 Section 11 *HOIA* and s. 15 *HEIA* convey this intention clearly. They render any proposal to develop private professional services almost illusory. The prohibition on private insurance creates an obstacle that is practically insurmountable for people with average incomes. Only the very wealthy can reasonably afford to pay for entirely private services. Assuming that a permit were issued, the operation of an institution that is not under agreement is the exception in Quebec. In fact, the trial judge found that the effect of the prohibition was to "significantly" limit the private provision of services that are already available under the public plan (p. 812). This observation relates to the effects of the prohibition. These effects must not be confused with the objective of the

legislation. According to the Attorney General of Quebec, the purpose of the prohibition is to preserve the integrity of the public health care system. From this perspective, the objective appears at first glance to be pressing and substantial. Its pressing and substantial nature can be confirmed by considering the historical context.

56 Government involvement in health care came about gradually. Initially limited to extreme cases, such as epidemics or infectious diseases, the government's role has expanded to become a safety net that ensures that the poorest people have access to basic health care services. The enactment of the first legislation providing for universal health care was a response to a need for social justice. According to Dr. Fernand Turcotte, [TRANSLATION] "it was recognized [during the 1920s] that illness had become the primary cause of impoverishment for Canadians, owing to the loss of work that almost always results from serious illness and the loss of family assets, which were inevitably swallowed up to pay for health care" (report by F. Turcotte, *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé du Canada* (1998), at p. 4). Since the government passed legislation based on its view that it had to be the principal actor in the health care sphere, it is easy to understand its distrust of the private sector. At the stage of analysis of the objective of the legislation, I believe that preserving the public plan is a pressing and substantial purpose.

B. *Proportionality*

(1) Rational Connection

57 The next question is whether the prohibition on private insurance has a rational connection with the objective of preserving the public plan. Does this measure assist the state in implementing a public plan that provides high-quality health care services that are accessible to all residents ofQuebec?

58 According to the trial judge, the effect of the measure adopted by the state is to "significantly" limit private health care. Although the effect of a measure is not always indicative of a rational connection between the measure and its objective, in the instant case the consequences show an undeniable connection between the objective and the measure. The public plan is preserved because it has a quasi-monopoly.

(2) Minimal Impairment

59 The trial judge made certain assertions that suggest she found that the measure met the minimal impairment test. However, her approach was not appropriate to s. 9.1 of the *Quebec Charter*. Her comments must therefore be considered in their context, not only because she failed to address the *Quebec Charter*, but also because she appears to have placed the onus on the appellants to prove that private insurance would provide a solution to the problem of waiting lists (at p. 796):

> [TRANSLATION] The Court further finds that although some of these specialists indicated a desire to be free to obtain private insurance, none of them gave their full and absolute support to the applicants' proposals, as they explained that it was neither clear nor obvious that a reorganization of the health system with a parallel private system would solve all the existing problems of delays and access. On the contrary, the specialists who testified remained quite circumspect about this complex and difficult question.

60 The burden of proof does not rest on the appellants. Under s. 9.1 of the *Quebec Charter*, the onus was on the Attorney General ofQuebec to prove that the prohibition is justified. He had to show that the measure met the minimal impairment test. The trial judge did not consider the evidence on the basis that there was a burden on the Attorney General of Quebec.

61 To determine whether the Attorney General of Quebec has discharged this burden, I will begin by analysing the expert evidence submitted to the Superior Court. I will then examine the situations in the other provinces of Canada and in certain countries of the Organization for Economic Cooperation and Development ("OECD"). Finally, I will address the deference the Court must show where the government has chosen among a number of measures that may impair protected rights.

(a) *The Experts Who Testified at Trial and Whose Evidence Was Accepted by the Superior Court Judge*

62 As can be seen from the evidence, the arguments made in support of the position that the integrity of the public system could be jeopardized by abolishing the prohibition can be divided into two groups. The first group of arguments relates to human reactions of the various people affected by the public plan, while the second group relates to the consequences for the plan itself.

(i) Human Reactions

63 1. Some witnesses asserted that the emergence of the private sector would lead to a reduction in popular support in the long term because the people who had private insurance would no longer see any utility for the public plan. Dr. Howard Bergman cited an article in his expert report. Dr. Theodore R. Marmor supported this argument but conceded that he had no way to verify it.

2. Some witnesses were of the opinion that the quality of care in the public plan would decline because the most influential people would no longer have any incentive to bring pressure for improvements to the plan. Dr. Bergman cited a study by the World Bank in support of his expert report. Dr. Marmor relied on this argument but confirmed that there is no direct evidence to support this view.

3. There would be a reduction in human resources in the public plan because many physicians and other health care professionals would leave the plan out of a motive for profit: Dr. Charles J. Wright cited a study done in the United Kingdom, but admitted that he had read only a summary and not the study itself. Although Dr. Marmor supported the assertion, he testified that there is really no way to confirm it empirically. In his opinion, it is simply a matter of common sense.

4. An increase in the use of private health care would contribute to an increase in the supply of care for profit and lead to a decline in the professionalism and ethics of physicians working in hospitals. No study was cited in support of this opinion that seems to be based only on the witnesses' common sense.

64 It is apparent from this summary that for each threat mentioned, no study was produced or discussed in the Superior Court. While it is true that scientific or empirical evidence is not always necessary, witnesses in a case in which the arguments are supposedly based on logic or common sense should be able to cite specific facts in support of their conclusions. The human reactions described by the experts, many of whom came from outside Quebec, do not appear to me to be very convincing, particularly in the context of Quebec legislation. Participation in the public plan is mandatory and there is no risk that the Quebec public will abandon the public plan. The state's role is not being called into question. As well, the*HEIA* contains a clear provision authorizing the Minister of Health to ensure that the public plan is not jeopardized by having too many physicians opt for the private system (s. 30 *HEIA*). The evidence that the existence of the health care system would be jeopardized by human reactions to the emergence of a private system carries little weight.

(ii) Impact on the Public Plan

65 1. There would be an increase in overall health expenditures: the alleged increase would come primarily from the additional expenditures incurred by individuals who decide to take out private insurance; the rest of the increase in costs would be attributable to the cost of management of the private system by the state.

2. Insurers would reject the most acute patients, leaving the most serious cases to be covered by the public plan.

3. In a private system, physicians would tend to lengthen waiting times in the public sector in order to direct patients to the private sector from which they would derive a profit.

66 Once again, I am of the opinion that the reaction some witnesses described is highly unlikely in the Quebec context. First, if the increase in overall costs is primarily attributable to the individual cost of insurance, it would be difficult for the state to prevent individuals who wished to pay such costs from choosing how to manage their own finances. Furthermore, because the public plan already handles all the serious cases, I do not see how the situation could be exacerbated if that plan were relieved of the clientele with less serious health problems. Finally, because of s. 1(*e*), non-participating physicians may not practise as participants; they will not therefore be faced with the conflict of interest described by certain witnesses. As for physicians who have withdrawn (s. 1(*d*) *HEIA*), the state controls their conditions of practice by way of the agreements (s. 1(*f*) *HEIA*) they are required to sign. Thus, the state can establish a framework of practice for physicians who offer private services.

67 The trial judge's assessment of the evidence was founded on the idea that the appellants had to prove that abolishing the prohibition would improve the public plan. She also analysed the case from the perspective of s. 7 of the *Canadian Charter*, which placed the burden on the appellants rather than on the Attorney General of Quebec. Furthermore, a number of witnesses failed to consider the legislation specific to Quebec. The combination of these three oversights or errors means that the findings must be qualified and adapted to s. 9.1 of the *Quebec Charter*.

68 Upon completing her analysis, the trial judge drew the following conclusion (at p. 827):

> [TRANSLATION] These provisions are based on the fear that the establishment of a private health care system would rob the public sector of a significant portion of the available health care resources. [Emphasis added.]

Thus, the judge's finding that the appellants had failed to show that the scope of the prohibition was excessive and that the principles of fundamental justice had not been violated was based solely on the "fear" of an erosion of resources or a [TRANSLATION] "threat [to] the integrity" of the system (p. 827 (emphasis deleted)). But the appellants did not have the burden of disproving every fear or every threat. The onus was on the AttorneyGeneral of Quebec to justify the prohibition. Binnie and LeBel JJ. rely on a similar test in asserting that private health care would likely have an impact on the public plan. This standard does not meet the requirement of preponderance under s. 9.1 of the *Quebec Charter*. It can be seen from the evidence that the Attorney General of Quebec failed to discharge his burden of proving that a total prohibition on private insurance met the minimal impairment test.

69 There is other evidence in the record that might be of assistance in the justification analysis. In this regard, it is useful to observe the approaches of the other Canadian provinces because they also operate within the financial framework established by the *Canada Health Act*.

(b) *Overview of Other Provincial Plans*

70 The approach to the role of the private sector taken by the other nine provinces of Canada is by no means uniform. In addition toQuebec, six other provinces have adopted measures to discourage people from turning to the private sector. The other three, in practice, give their residents free access to the private sector.

71 Ontario (*Health Care Accessibility Act*, R.S.O. 1990, c. H.3, s. 2), Nova Scotia (*Health Services and Insurance Act*, R.S.N.S. 1989, c. 197, s. 29(2)) and Manitoba (*Health Services Insurance Act*, R.S.M. 1987, c. H35, s. 95(1)) prohibit non-participating physicians from charging their patients more than what physicians receive from the public plan. In practice, there is no financial incentive to opt for the private sector. It is worth noting that Nova Scotia does not prohibit insurance contracts to cover health care obtained in the private sector. Ontario and Manitoba prohibit insurance contracts but refund amounts paid by patients to non-participating physicians.

72 Alberta (*Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20, s. 9(1)), British Columbia (*Medicare Protection Act*, R.S.B.C. 1996, c. 286, s. 18(2)) and

Prince Edward Island (*Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2, ss. 10, 10.1 and 14.1) have adopted a very different approach. In those provinces, non-participating physicians are free to set the amount of their fees, but the cost of the services is not refunded and contracts for insurance to cover services offered by the public plan are prohibited. This is the same policy as has been adopted byQuebec.

73 Saskatchewan (*Saskatchewan Medical Care Insurance Act*, R.S.S. 1978, c. S-29, s. 18(1.1)), New Brunswick (*Medical Services Payment Act*, R.S.N.B. 1973, c. M-7, s. 2.01(*a*), and *General Regulation — Medical Services Payment Act*, N.B. Reg. 84-20, Sch. 2, para. (*n.1*)), and Newfoundland and Labrador (*Medical Care Insurance Act, 1999*, S.N.L. 1999, c. M-5.1, s. 10(5), and *Medical Care Insurance Insured Services Regulations*, C.N.L.R. 21/96, s. 3) are open to the private sector. New Brunswick allows physicians to set their own fees. In Saskatchewan, this right is limited to non-participating physicians. The cost is not refunded by the public plan, but patients may purchase insurance to cover those costs. Newfoundland and Labrador agrees to reimburse patients, up to the amount covered by the public plan, for fees paid to non-participating physicians. In Newfoundland and Labrador, patients may subscribe to private insurance to cover the difference.

74 Even if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity. In fact, because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved. The example illustrated by a number of other Canadian provinces casts doubt on the argument that the integrity of the public plan depends on the prohibition against private insurance. Obviously, since Quebec's public plan is in a quasi-monopoly position, its predominance is assured. Also, the regimes of the provinces where a private system is authorized demonstrate that public health services are not threatened by private insurance. It can therefore be concluded that the prohibition is not necessary to guarantee the integrity of the public plan.

75 In the context of s. 9.1 of the *Quebec Charter*, I must conclude that a comparison with the plans of the other Canadian provinces does not support the position of the Attorney General of Quebec.

76 There are also many reports in the record on which to base an overview of current practices in several OECD countries.

(c) *Overview of Practices in Certain OECD Countries*

77 Mr. Chaoulli, echoed by at least one of the witnesses (Dr. Coffey), argued that Canada is the only OECD country to prohibit insurance for health care provided by non-participating physicians. This assertion must be clarified as it relates to Canada: it is true of only six provinces. It must also be qualified in the international context: while no such prohibition is found in any other OECD country, it should nonetheless be mentioned that measures to protect the public plan have been implemented in a number of countries, even some of the countries whose health care plans have been provided as models. There is no single model; the approach in Europe is no more uniform than in Canada.

78 In a number of European countries, there is no insurance paid for directly out of public funds. In Austria, services are funded through decentralized agencies that collect the necessary funds from salaries. People who want to obtain health care in the private sector in addition to the services covered by the mandatory social insurance are free to do so, but private insurance may cover no more than 80 percent of the cost billed by professionals practising in the public sector. The same type of plan exists in Germany and the Netherlands, but people who opt for private insurance are not required to pay for the public plan. Only nine percent of Germans opt for private insurance.

79 Australia's public system is funded in a manner similar to the Quebec system. However, Australia's system is different in that the private and public sectors coexist, and insurance covering private sector health care is not prohibited. The government attempts to balance access to the two sectors by allowing taxpayers to deduct 30 percent of the cost of private insurance. Insurance rates are regulated to prevent insurers from charging higher premiums for higher-risk individuals (C. H. Tuohy, C. M. Flood and M. Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations" (2004), 29 *J. Health Pol.* 359).

80 The United Kingdom does not restrict access to private insurance for health care (*The Health of Canadians — The Federal Role*, vol. 3,*Health Care Systems in Other Countries*, Interim Report (2002), at p. 38). Nor does the United Kingdom limit a physician's ability to withdraw from the public plan. However, physicians working full-time in public hospitals are limited in the amounts that they may bill in the private sector to supplement income earned in the public sector (p. 40). Only 11.5 percent of Britons had taken out private insurance in 1998 (Tuohy, Flood and Stabile, at p. 374), and only 8 percent of hospital beds in the United Kingdom are private (Quebec and France, *Health Indicators: International Comparisons: 15 years of Evolution: Canada, France, Germany, Québec, United Kingdom,*

United States (1998), at p. 55). New Zealand has a plan similar to that of the United Kingdom with the difference that 40 percent of New Zealanders have private insurance (Tuohy, Flood and Stabile, at p. 363).

81 Sweden does not prohibit private insurance, and the state does not refund the cost of health care paid for in the private sector. Private insurance accounts for only two percent of total health care expenditures and there are only nine private hospitals (*The Health of Canadians — The Federal Role*, at pp. 31-33).

82 It can be seen from the systems in these various OECD countries that a number of governments have taken measures to protect their public plans from abuse. The measures vary from country to country depending on the nature of their specific systems. For example, in the United Kingdom, there are limits on the amounts physicians may earn in the private sector in addition to what they receive from the public plan. Australia has opted to regulate insurance premiums, but it is alone in this respect.

83 As can be seen from the evolution of public plans in the few OECD countries that have been examined in studies produced in the record, there are a wide range of measures that are less drastic, and also less intrusive in relation to the protected rights. The Quebec context is a singular one, not only because of the distinction between participating physicians, non-participating physicians and physicians who have withdrawn (s. 1 *HEIA*), but also because the Minister may require non-participating physicians to provide health services if he or she considers it likely that the services will not be provided under uniform conditions throughout Quebec or in a particular region (s. 30 *HEIA*). A measure as drastic as prohibiting private insurance contracts appears to be neither essential nor determinative.

84 It cannot therefore be concluded from the evidence relating to the Quebec plan or the plans of the other provinces of Canada, or from the evolution of the systems in place in various OECD countries, that the Attorney General of Quebec has discharged his burden of proof under s. 9.1 of the *Quebec Charter*. A number of measures are available to him to protect the integrity of Quebec's health care plan. The choice of prohibiting private insurance contracts is not justified by the evidence. However, is this a case in which the Court should show deference?

(d) *Level of Deference Required*

85 In the past, the Court has considered the question of the basis of its power of judicial review (*Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145, at p. 155; *Vriend v. Alberta*, [1998] 1 S.C.R. 493, at para. 56;*Reference re Secession of Quebec*, [1998] 2 S.C.R. 217, at para. 98), and it is not necessary to retrace the source of the powers deriving from s. 52 of the *Constitution Act, 1982* and s. 52 of the *Quebec Charter*. Section 52 of the *Quebec Charter* reads as follows:

> **52.** No provision of any Act, even subsequent to the Charter, may derogate from sections 1 to 38, except so far as provided by those sections, unless such Act expressly states that it applies despite the Charter.

However, as can be seen from the large number of interveners in this appeal, differences of views over the emergence of a private health care plan have a polarizing effect on the debate, and the question of the deference owed to the government by the courts must be addressed. Some of the interveners urge the courts to step in, while others argue that this is the role of the state. It must be possible to base the criteria for judicial intervention on legal principles and not on a socio-political discourse that is disconnected from reality.

86 Under the charters, the government is responsible for justifying measures it imposes that impair rights. The courts can consider evidence concerning the historical, social and economic aspects, or any other evidence that may be material.

87 It cannot be said that the government lacks the necessary resources to show that its legislative action is motivated by a reasonable objective connected with the problem it has undertaken to remedy. The courts are an appropriate forum for a serious and complete debate. As G. Davidov said in "The Paradox of Judicial Deference" (2000-2001), 12 *N.J.C.L.* 133, at p. 143, "[c]ourts do not have to define goals, choose means or come up with ideas. They do not have to create social policies; they just have to understand what the other branches have created. No special expertise is required for such an understanding." In fact, if a court is satisfied that all the evidence has been presented, there is nothing that would justify it in refusing to perform its role on the ground that it should merely defer to the government's position. When the courts are given the tools they need to make a decision, they should not hesitate to assume their responsibilities. Deference cannot lead the judicial branch to abdicate its role in favour of the legislative branch or the executive branch.

88 The question submitted by the appellants has a factual content that was analysed by the trial judge. One part of her findings must be adapted to the context of s. 9.1 of the *Quebec Charter*. The other findings remain unchanged. The questions of law are not complex.

89 The courts have a duty to rise above political debate. They leave it to the legislatures to develop social policy. But when such social policies infringe rights that are protected by the charters, the courts cannot shy away from considering them. The judicial branch plays a role that is not played by the legislative branch. Professor Roach described the complementary role of the courts *vis-à-vis* the legislature as follows (K. Roach, "Dialogic Judicial Review and its Critics" (2004), 23 *Sup. Ct. L. Rev.* (2d) 49, at pp. 69-71):

> [Some] unique attributes of courts include their commitment to allowing structured and guaranteed participation from aggrieved parties; their independence from the executive, and their commitment to giving reasons for their decisions. In addition, courts have a special commitment to make sense of legal texts that were democratically enacted as foundational documents.
>
> . . . The pleader in court has a guaranteed right of participation and a right to a reasoned decision that addresses the arguments made in court, as well as the relevant text of the democratically enacted law. . . .
>
> Judges can add value to societal debates about justice by listening to claims of injustice and by promoting values and perspectives that may not otherwise be taken seriously in the legislative process.

90 From this perspective, it is through the combined action of legislatures and courts that democratic objectives can be achieved. In their analysis of the Quebec secession reference, Choudhry and Howse describe this division of constitutional responsibilities accurately (S. Choudhry and R. Howse, "Constitutional Theory and The *Quebec Secession Reference*" (2000), 13 *Can. J. L. & Jur.* 143, at pp. 160-61):

> [I]nterpretive responsibility for particular constitutional norms is both shared and divided. It is shared to the extent that courts are responsible for articulating constitutional norms in their conceptually abstract form. But interpretive responsibility is divided because beyond the limits of doctrine, constitutional interpretation is left to the political organs. The image which emerges is one of "judicial and legislative cooperation in the molding of concrete standards through which elusive and complex constitutional norms . . . come to be applied."

91 To refuse to exercise the power set out in s. 52 of the *Quebec Charter* would be to deny that provision its real meaning and to deprive Quebeckers of the protection to which they are entitled.

92 In a given case, a court may find that evidence could not be presented for reasons that it considers valid, be it due to the complexity of the evidence or to some other factor. However, the government cannot argue that the evidence is too complex without explaining why it cannot be presented. If such an explanation is given, the court may show greater deference to the government. Based on the extent of the impairment and the complexity of the evidence considered to be necessary, the court can determine whether the government has discharged its burden of proof.

93 The court's reasons for showing deference must always reflect the two guiding principles of justification: the measure must be consistent with democratic values and it must be necessary in order to maintain public order and the general well-being of citizens. The variety of circumstances that may be presented to a court is not conducive to the rigidity of an exhaustive list.

94 In past cases, the Court has discussed a number of situations in which courts must show deference, namely situations in which the government is required to mediate between competing interests and to choose between a number of legislative priorities (*Irwin Toy Ltd. v. Quebec(Attorney General)*, [1989] 1 S.C.R. 927, at pp. 993-94). It is also possible to imagine situations in which a government might lack time to implement programs or amend legislation following the emergence of new social, economic or political conditions. The same is true of an ongoing situation in which the government makes strategic choices with future consequences that a court is not in a position to evaluate.

95 In short, a court must show deference where the evidence establishes that the government has assigned proper weight to each of the competing interests. Certain factors favour greater deference, such as the prospective nature of the decision, the impact on public finances, the multiplicity of competing interests, the difficulty of presenting scientific evidence and the limited time available to the state. This list is certainly not exhaustive. It serves primarily to highlight the facts that it is up to the government to choose the measure, that the decision is often complex and difficult, and that the government must have the necessary time and resources to respond. However, as McLachlin J. (as she then was) said in*RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 136, ". . . care must be taken not to extend the notion of deference too far".

96 The instant case is a good example of a case in which the courts have all the necessary tools to evaluate the government's measure. Ample evidence was presented. The government had plenty of time to act. Numerous commissions have been established (Commission d'étude sur les services de santé et les services sociaux (Quebec) (Clair

Commission), 2000; Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments (Quebec) (Montmarquette Committee), 2001; Commission on the Future of Health Care in Canada (Canada) (Romanow Commission), 2002), and special or independent committees have published reports (Quebec, *Emerging Solutions: Report and Recommendations*(2001) (Clair Report); Quebec, *Pour un régime d'assurance médicaments équitable et viable* (2001) (Montmarquette Report); Canada, *The Health of Canadians — The Federal Role*, vol. 6, *Recommendations for Reform*, Final Report (2002) (Kirby Report); Canada, *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money??* (1998)). Governments have promised on numerous occasions to find a solution to the problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens.

97 For many years, the government has failed to act; the situation continues to deteriorate. This is not a case in which missing scientific data would allow for a more informed decision to be made. The principle of prudence that is so popular in matters relating to the environment and to medical research cannot be transposed to this case. Under the Quebec plan, the government can control its human resources in various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services (s. 30 *HEIA*) or by implementing less restrictive measures, like those adopted in the four Canadian provinces that do not prohibit private insurance or in the other OECD countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebeckers' right to security. The government has not given reasons for its failure to act. Inertia cannot be used as an argument to justify deference.

98 In the instant case, the effectiveness of the prohibition has by no means been established. The government has not proved, by the evidence in the record, that the measure minimally impairs the protected rights. Moreover, the evidence shows that a wide variety of measures are available to governments, as can be seen from the plans of other provinces and other countries.

(3) Proportionality

99 Having found that s. 15 *HEIA* and s. 11 *HOIA* do not meet the minimal impairment test, I do not need to consider proportionality. If the prohibition is not minimally impairing, it obviously cannot be regarded as a measure that sufficiently addresses the effect of the measure on the protected rights.

VII. Conclusion

100 The relief sought by the appellants does not necessarily provide a complete response to the complex problem of waiting lists. However, it was not up to the appellants to find a way to remedy a problem that has persisted for a number of years and for which the solution must come from the state itself. Their only burden was to prove that their right to life and to personal inviolability had been infringed. They have succeeded in proving this. The Attorney General of Quebec, on the other hand, has not proved that the impugned measure, the prohibition on private insurance, was justified under s. 9.1 of the *Quebec Charter*. Given that this finding is sufficient to dispose of the appeal, it is not necessary to answer the other constitutional questions.

101 For these reasons, I would allow the appeal with costs throughout and would answer the questions relating to the *Quebec Charter* as follows:

Question 1: Does s. 11 of the *Hospital Insurance Act*, R.S.Q., c. A-28, infringe the rights guaranteed by s. 1 of the *Quebec Charter*?

Answer: Yes.

Question 2: If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 9.1of the *Quebec Charter*?

Answer: No.

Question 3: Does s. 15 of the *Health Insurance Act*, R.S.Q., c. A-29, infringe the rights guaranteed by s. 1 of the *Quebec Charter*?

Answer: Yes.

Question 4: If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 9.1of the *Quebec Charter*?

Answer: No.

The reasons of McLachlin C.J. and Major and Bastarache JJ. were delivered by

102 THE CHIEF JUSTICE AND MAJOR J. — We concur in the conclusion of our colleague Deschamps J. that the prohibition against contracting for private health insurance violates s. 1 of the Quebec *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, and is

not justifiable under s. 9.1. On the argument that the anti-insurance provision also violates s. 7 of the *Canadian Charter of Rights and Freedoms* ("*Charter*"), we conclude that the provision impermissibly limits the right to life, liberty and security of the person protected by s. 7 of the *Charter* and has not been shown to be justified as a reasonable limit under s. 1 of the *Charter*.

103 The appellants do not seek an order that the government spend more money on health care, nor do they seek an order that waiting times for treatment under the public health care scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services.

104 The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*. We are of the view that the prohibition on medical insurance in 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 (see Appendix), violates s. 7 of the *Charter* because it impinges on the right to life, liberty and security of the person in an arbitrary fashion that fails to conform to the principles of fundamental justice.

105 The primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (s. 3). By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the *Charter*.

106 The *Canada Health Act*, the *Health Insurance Act*, and the *Hospital Insurance Act* do not expressly prohibit private health services. However, they limit access to private health services by removing the ability to contract for private health care insurance to cover the same services covered by public insurance. The result is a virtual monopoly for the public health scheme. The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person. Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so.

107 While the decision about the type of health care system Quebec should adopt falls to the Legislature of that province, the resulting legislation, like all laws, is subject to constitutional limits, including those imposed by s. 7 of the *Charter*. The fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance when citizens challenge it. As this Court has said on a number of occasions, "it is the high duty of this Court to insure that the Legislatures do not transgress the limits of their constitutional mandate and engage in the illegal exercise of power": *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, at p. 497, *per* Lamer J. (as he then was), quoting *Amax Potash Ltd. v. Government of Saskatchewan*, [1977] 2 S.C.R. 576, at p. 590, *per* Dickson J. (as he then was).

108 The government defends the prohibition on medical insurance on the ground that the existing system is the only approach to adequate universal health care for all Canadians. The question in this case, however, is not whether single-tier health care is preferable to two-tier health care. Even if one accepts the government's goal, the legal question raised by the appellants must be addressed: is it a violation of s. 7 of the *Charter* to prohibit private insurance for health care, when the result is to subject Canadians to long delays with resultant risk of physical and psychological harm? The mere fact that this question may have policy ramifications does not permit us to avoid answering it.

I. Section 7 of the *Charter*

109 Section 7 of the *Charter* guarantees that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." The disposition of this appeal therefore requires us to consider (1) whether the impugned provisions deprive individuals of their life, liberty or security of the person; and (2) if so, whether this deprivation is in accordance with the principles of fundamental justice: see, e.g., *R. v. Malmo-Levine*, [2003] 3 S.C.R. 571, 2003 SCC 74, at para. 83.

A. *Deprivation of Life, Liberty or Security of the Person*

110 The issue at this stage is whether the prohibition on insurance for private medical care deprives individuals of their life, liberty or security of the person protected by s. 7 of the *Charter*.

111 The appellants have established that many Quebec residents face delays in treatment that adversely affect their security of the person and that they would not sustain but for the prohibition on medical insurance. It is common ground that the effect of the

prohibition on insurance is to allow only the very rich, who do not need insurance, to secure private health care in order to avoid the delays in the public system. Given the ban on insurance, most Quebeckers have no choice but to accept delays in the medical system and their adverse physical and psychological consequences.

112 Delays in the public system are widespread and have serious, sometimes grave, consequences. There was no dispute that there is a waiting list for cardiovascular surgery for life-threatening problems. Dr. Daniel Doyle, a cardiovascular surgeon who teaches and practises in QuebecCity, testified that a person with coronary disease is [TRANSLATION] "sitting on a bomb" and can die at any moment. He confirmed, without challenge, that patients die while on waiting lists: A.R., at p. 461. Inevitably, where patients have life-threatening conditions, some will die because of undue delay in awaiting surgery.

113 The same applies to other health problems. In a study of 200 subjects aged 65 and older with hip fractures, the relationship between pre-operative delay and post-operative complications and risk of death was examined. While the study found no relationship between pre-operative delay and post-operative complications, it concluded that the risk of death within six months after surgery increased significantly, by 5 percent, with the length of pre-operative delay: A. Laberge, P. M. Bernard and P. A. Lamarche, "Relationships between the delay before surgery for a hip fracture, postoperative complications and risk of death" (1997), 45 *Rev. Epidém. et Santé Publ.* 5, at p. 9.

114 Dr. Eric Lenczner, an orthopaedic surgeon, testified that the one-year delay commonly incurred by patients requiring ligament reconstruction surgery increases the risk that their injuries will become irreparable (A.R., at p. 334). Dr. Lenczner also testified that 95 percent of patients in Canada wait well over a year, and many two years, for knee replacements. While a knee replacement may seem trivial compared to the risk of death for wait-listed coronary surgery patients, which increases by 0.5 percent per month (A.R., at p. 450), the harm suffered by patients awaiting replacement knees and hips is significant. Even though death may not be an issue for them, these patients "are in pain", "would not go a day without discomfort" and are "limited in their ability to get around", some being confined to wheelchairs or house bound (A.R., at pp. 327-28).

115 Both the individual members of the Standing Senate Committee on Social Affairs, Science and Technology who intervened in this appeal and the Canadian Medical Association cited a Statistics Canada study demonstrating that over one in five Canadians who needed health care for themselves or a family member in 2001 encountered some form of difficulty, from getting an appointment to experiencing lengthy waiting

times: C. Sanmartin et al., *Access to Health Care Services in Canada, 2001* (June 2002), at p. 17. Thirty-seven percent of those patients reported pain.

116 In addition to threatening the life and the physical security of the person, waiting for critical care may have significant adverse psychological effects. Serious psychological effects may engage s. 7 protection for security of the person. These "need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety": *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, at para. 60.

117 Studies confirm that patients with serious illnesses often experience significant anxiety and depression while on waiting lists. A 2001 study concluded that roughly 18 percent of the estimated five million people who visited specialists for a new illness or condition reported that waiting for care adversely affected their lives. The majority suffered worry, anxiety or stress as a result. This adverse psychological impact can have a serious and profound effect on a person's psychological integrity, and is a violation of security of the person (*Access to Health Care Services in Canada, 2001*, at p. 20).

118 The jurisprudence of this Court holds that delays in obtaining medical treatment which affect patients physically and psychologically trigger the protection of s. 7 of the *Charter*. In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, Dickson C.J. concluded that the delay in obtaining therapeutic abortions, which increased the risk of complications and mortality due to mandatory procedures imposed by the state, was sufficient to trigger the physical aspect of the woman's right to security of the person: *Morgentaler*, at p. 59. He found that the psychological impact on women awaiting abortions constituted an infringement of security of the person. Beetz J. agreed with Dickson C.J. that "[t]he delays mean therefore that the state has intervened in such a manner as to create an additional risk to health, and consequently this intervention constitutes a violation of the woman's security of the person": see *Morgentaler*, at pp. 105-6.

119 In this appeal, delays in treatment giving rise to psychological and physical suffering engage the s. 7 protection of security of the person just as they did in *Morgentaler*. In *Morgentaler*, as in this case, the problem arises from a legislative scheme that offers health services. In *Morgentaler*, as in this case, the legislative scheme denies people the right to access alternative health care. (That the sanction in *Morgentaler* was criminal prosecution while the sanction here is administrative prohibition and penalties is irrelevant. The important point is that in both cases, care outside the legislatively provided system is effectively prohibited.) In *Morgentaler* the result of the monopolistic scheme was delay in treatment with attendant physical risk and psychological suffering. In *Morgentaler*, as here, people in urgent need of care face the same prospect: unless they fall within the

wealthy few who can pay for private care, typically outside the country, they have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails. As in *Morgentaler*, the result is interference with security of the person under s. 7 of the *Charter*.

120 In *Morgentaler*, Dickson C.J. and Wilson J. found a deprivation of security of the person because the legislative scheme resulted in the loss of control by a woman over the termination of her pregnancy: see *Morgentaler*, at pp. 56 and 173.

121 The issue in *Morgentaler* was whether a system for obtaining approval for abortions (as an exception to a prohibition) that in practice imposed significant delays in obtaining medical treatment unjustifiably violated s. 7 of the *Charter*. Parliament had established a mandatory system for obtaining medical care in the termination of pregnancy. The sanction by which the mandatory public system was maintained differed: criminal in*Morgentaler*, "administrative" in the case at bar. Yet the consequences for the individuals in both cases are serious. In *Morgentaler*, as here, the system left the individual facing a lack of critical care with no choice but to travel outside the country to obtain the required medical care at her own expense. It was this constraint on s. 7 security, taken from the perspective of the woman facing the health care system, and not the criminal sanction, that drove the majority analysis in *Morgentaler*. We therefore conclude that the decision provides guidance in the case at bar.

122 In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, Sopinka J., writing for the majority, held that security of the person encompasses "a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress" (pp. 587-88). The prohibition against private insurance in this case results in psychological and emotional stress and a loss of control by an individual over her own health.

123 Not every difficulty rises to the level of adverse impact on security of the person under s. 7. The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged. Access to a waiting list is not access to health care. As we noted above, there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care. Where lack of timely health care can result in death, s. 7 protection of life itself is engaged. The evidence here demonstrates that the prohibition on health insurance

results in physical and psychological suffering that meets this threshold requirement of seriousness.

124 We conclude, based on the evidence, that prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person as protected by s. 7 of the *Charter*.

125 The remaining question is whether this inference is in accordance with the principles of fundamental justice. "[I]f the state [interferes] with security of the person, the *Charter* requires such interference to conform with the principles of fundamental justice": *Morgentaler*, at p. 54, *per* Dickson C.J.

B. *Deprivation in Accordance with the Principles of Fundamental Justice*

126 Having concluded that the ban on private medical insurance constitutes a deprivation of life and security of the person, we now consider whether that deprivation is in accordance with the principles of fundamental justice. Our colleagues Binnie and LeBel JJ. argue that the record here provides no ground for finding that the deprivation violates the principles of fundamental justice. With respect, we cannot agree.

127 In *Rodriguez*, at pp. 590-91 and 607, Sopinka J. for a majority of this Court defined the principles of fundamental justice as legal principles that are capable of being identified with some precision and are fundamental in that they have general acceptance among reasonable people.

128 The principle of fundamental justice implicated in this case is that laws that affect the life, liberty or security of the person shall not be arbitrary. We are of the opinion that the evidence before the trial judge supports a finding that the impugned provisions are arbitrary and that the deprivation of life and security of the person that flows from them cannot therefore be said to accord with the principles of fundamental justice.

(1) Laws Shall Not Be Arbitrary: A Principle of Fundamental Justice

129 It is a well-recognized principle of fundamental justice that laws should not be arbitrary: see, e.g., *Malmo-Levine*, at para. 135;*Rodriguez*, at p. 594. The state is not entitled to arbitrarily limit its citizens' rights to life, liberty and security of the person.

130 A law is arbitrary where "it bears no relation to, or is inconsistent with, the objective that lies behind [it]". To determine whether this is the case, it is necessary to consider the state interest and societal concerns that the provision is meant to reflect: *Rodriguez*, at pp. 594-95.

131 In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.

132 In *Morgentaler*, Beetz J., Estey J. concurring, found that the limits on security of the person caused by rules that endangered health were "manifestly unfair" and did not conform to the principles of fundamental justice, in reasons that invoke arbitrariness. Some of the limitations bore no connection to Parliament's objectives, in his view, while others were unnecessary to assure that those objectives were met (p. 110).

133 While cloaked in the language of manifest unfairness, this reasoning evokes the principle of fundamental justice that laws must not be arbitrary, and was so read in *Rodriguez*, at p. 594. Beetz J.'s concurring reasons in *Morgentaler* thus serve as an example of how the rule against arbitrariness may be implicated in the particular context of access to health care. The fact that Dickson C.J., Lamer J. concurring, found that the scheme offended a different principle of fundamental justice, namely that defences to criminal charges must not be illusory, does not detract from the proposition adopted by Beetz J. that rules that endanger health arbitrarily do not comply with the principles of fundamental justice.

(2) Whether the Prohibition on Private Medical Insurance is Arbitrary

134 As discussed above, interference with life, liberty and security of the person is impermissibly arbitrary if the interference lacks a real connection on the facts to the purpose the interference is said to serve.

135 The government argues that the interference with security of the person caused by denying people the right to purchase private health insurance is necessary to providing effective health care under the public health system. It argues that if people can purchase private health insurance, they will seek treatment from private doctors and hospitals, which are not banned under the Act. According to the government's argument, this will divert resources from the public health system into private health facilities, ultimately reducing the quality of public care.

136 In support of this contention, the government called experts in health administration and policy. Their conclusions were based on the "common sense" proposition that the improvement of health services depends on exclusivity (R.R., at p. 591). They did not profess expertise in waiting times for treatment. Nor did they present economic studies or rely on the experience of other countries. They simply assumed, as a matter of apparent logic, that insurance would make private health services more accessible and that this in turn would undermine the quality of services provided by the public health care system.

137 The appellants, relying on other health experts, disagreed and offered their own conflicting "common sense" argument for the proposition that prohibiting private health insurance is neither necessary nor related to maintaining high quality in the public health care system. Quality public care, they argue, depends not on a monopoly, but on money and management. They testified that permitting people to buy private insurance would make alternative medical care more accessible and reduce the burden on the public system. The result, they assert, would be better care for all. The appellants reinforce this argument by pointing out that disallowing private insurance precludes the vast majority of Canadians (middle-income and low-income earners) from accessing additional care, while permitting it for the wealthy who can afford to travel abroad or pay for private care in Canada.

138 To this point, we are confronted with competing but unproven "common sense" arguments, amounting to little more than assertions of belief. We are in the realm of theory. But as discussed above, a theoretically defensible limitation may be arbitrary if in fact the limit lacks a connection to the goal.

139 This brings us to the evidence called by the appellants at trial on the experience of other developed countries with public health care systems which permit access to private

health care. The experience of these countries suggests that there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system.

140 The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care.

141 In its report *The Health of Canadians — The Federal Role*, the Standing Senate Committee on Social Affairs, Science and Technology discussed in detail the situations in several countries, including Sweden, Germany and the United Kingdom. The following discussion of the health care systems in these three countries is drawn directly from the findings in volume 3 of that report (*The Health of Canadians — The Federal Role*, vol. 3,*Health Care Systems in Other Countries*, Interim Report (2002) ("Kirby Report")).

142 In Sweden, as in Canada, access to public health care is universal. The public health care system is financed predominantly by the public sector through a combination of general taxation and social insurance (i.e., employer/employee contributions) and employs a user fee mechanism. Unlike in Canada, private health care insurance that covers the same benefits as public insurance is "legal" in Sweden. However, only a small minority of the population purchase private insurance. The result is a system of public health care coverage that provides quality care on a broader basis than in Canada and encompasses physicians, hospital services, drugs and dental care: Kirby Report, vol. 3, at pp. 29-36. In Sweden, the availability of private health care insurance appears not to have harmed the public health care system.

143 In Germany, public health care insurance is administered by 453 Sickness Funds — private non-profit organizations structured on a regional task or occupational basis. Sickness Fund membership is compulsory for employees with gross incomes lower than approximately $63,000 Canadian, and voluntary for those with gross incomes above that level. Although all Sickness Funds are regulated at the federal level through what is known as the "Social Code Book", they are essentially run by representatives of employees and employers. As in Sweden, public health care coverage is broader in Germany than in Canada, including physician services, hospitals, prescription drugs, diagnostic services, dental care, rehabilitative care, medical devices, psychotherapists, nursing care at home, medical services by non-physicians (physiotherapists, speech therapists, occupational therapists, etc.) and income support during sick leave: Kirby Report, vol. 3, at p. 14.

144 In Germany, as in Sweden, private health insurance is available to individuals at a certain income level who may voluntarily opt out of the Sickness Funds. Private coverage is currently offered by 52 private insurance companies that are obliged to offer an insurance policy with the same benefits as the Sickness Funds at a premium that is no higher than the average maximum contribution to the Sickness Funds. Private health care coverage is also available to self-employed people who are excluded from the Sickness Funds and public servants who are *de facto* excluded from participating in Sickness Funds as their health care bills are reimbursed at the rate of 50 percent by the federal government. Private insurance covers the remainder: Kirby Report, vol. 3, at p. 15.

145 Despite the availability of alternatives, 88 percent of the German population are covered by the public Sickness Funds: this includes 14 percent to whom private insurance is available. Of the remaining 12 percent, only 9 percent are covered by private insurance and less than 1 percent have no health insurance at all. The remaining 2 percent are covered by government insurance for military and other personnel: Kirby Report, vol. 3, at p. 15.

146 The United Kingdom offers a comprehensive public health care system — the National Health Service (NHS) — while also allowing for private insurance. Unlike Canada, the United Kingdom allows people to purchase private health care insurance that covers the same benefits as the NHS if these services are supplied by providers working outside of the NHS. Despite the existence of private insurance, only 11.5 percent of the population have purchased it: Kirby Report, vol. 3, at pp. 37-44. Again, it appears that the public system has not suffered as a result of the existence of private alternatives.

147 After reviewing a number of public health care systems, the Standing Senate Committee on Social Affairs, Science and Technology concluded in the Kirby Report that far from undermining public health care, private contributions and insurance improve the breadth and quality of health care for all citizens, and it ultimately concluded, at p. 66:

> The evidence suggests that a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled countries to achieve broader coverage of health services for all their citizens. Some countries like Australia and Singapore openly encourage private sector participation as a means to ensure affordable and sustainable health services.

148 Nor does it appear that private participation leads to the eventual demise of public health care. It is compelling to note that not one of the countries referred to relies exclusively on either private insurance or the public system to provide health care coverage to its citizens. Even in the United States, where the private sector is a dominant participant in the field of health care insurance, public funding accounts for 45 percent of total health care spending: Kirby Report, vol. 3, at p. 66.

149 In summary, the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care.

150 Binnie and LeBel JJ. suggest that the experience of other countries is of little assistance. With respect, we cannot agree. This evidence was properly placed before the trial judge and, unless discredited, stands as the best guide with respect to the question of whether a ban on private insurance is necessary and relevant to the goal of providing quality public health care. The task of the courts, on s. 7 issues as on others, is to evaluate the issue in the light, not just of common sense or theory, but of the evidence. This is supported by our jurisprudence, according to which the experience of other western democracies may be relevant in assessing alleged arbitrariness. In *Rodriguez*, the majority of this Court relied on evidence from other western democracies, concluding that the fact that assisted suicide was heavily regulated in other countries suggested that Canada's prohibition was not arbitrary: pp. 601-5.

151 Binnie and LeBel JJ. also suggest that the government's continued commitment to a monopoly on the provision of health insurance cannot be arbitrary because it is rooted in reliance on "a series of authoritative reports [that analysed] health care in this country and in other countries" (para. 258); they are referring here to the reports of Commissioner Romanow (*Building on Values: The Future of Health Care in Canada: Final Report*(2002)), and Senator Kirby. We observe in passing that the import of these reports, which differ in many of their conclusions, is a matter of some debate, as attested by our earlier reference to the Kirby Report. But the conclusions of other bodies on other material cannot be determinative of this litigation. They cannot relieve the courts of their obligation to review government action for consistency with the *Charter* on the evidence before them.

152 When we look to the evidence rather than to assumptions, the connection between prohibiting private insurance and maintaining quality public health care vanishes. The evidence before us establishes that where the public system fails to deliver adequate care, the denial of private insurance subjects people to long waiting lists and negatively affects their health and security of the person. The government contends that this

is necessary in order to preserve the public health system. The evidence, however, belies that contention.

153 We conclude that on the evidence adduced in this case, the appellants have established that in the face of delays in treatment that cause psychological and physical suffering, the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice.

II. Section 1 of the *Charter*

154 Having concluded that the prohibition on private health insurance constitutes a breach of s. 7, we must now consider whether that breach can be justified under s. 1 of the *Charter* as a reasonable limit demonstrably justified in a free and democratic society. The evidence called in this case falls short of demonstrating such justification.

155 The government undeniably has an interest in protecting the public health regime. However, given the absence of evidence that the prohibition on the purchase and sale of private health insurance protects the health care system, the rational connection between the prohibition and the objective is not made out. Indeed, we question whether an arbitrary provision, which by reason of its arbitrariness cannot further its stated objective, will ever meet the rational connection test under *R. v. Oakes*, [1986] 1 S.C.R. 103.

156 In addition, the resulting denial of access to timely and effective medical care to those who need it is not proportionate to the beneficial effects of the prohibition on private insurance to the health system as a whole. On the evidence here and for the reasons discussed above, the prohibition goes further than necessary to protect the public system: it is not minimally impairing.

157 Finally, the benefits of the prohibition do not outweigh the deleterious effects. Prohibiting citizens from obtaining private health care insurance may, as discussed, leave people no choice but to accept excessive delays in the public health system. The physical and psychological suffering and risk of death that may result outweigh whatever benefit (and none has been demonstrated to us here) there may be to the system as a whole.

158 In sum, the prohibition on obtaining private health insurance, while it might be constitutional in circumstances where health care services are reasonable as to both quality and timeliness, is not constitutional where the public system fails to deliver reasonable services. Life, liberty and security of the person must prevail. To paraphrase Dickson C.J. in *Morgentaler*, at p. 73, if the government chooses to act, it must do so properly.

159 We agree with Deschamps J.'s conclusion that the prohibition against contracting for private health insurance violates s. 1 of the Quebec*Charter of Human Rights and Freedoms* and is not justifiable under s. 9.1. We also conclude that this prohibition violates s. 7 of the *CanadianCharter of Rights and Freedoms* and cannot be saved under s. 1.

160 We would allow the appeal, with costs to the appellants throughout.

The reasons of Binnie, LeBel and Fish JJ. were delivered by

BINNIE AND LEBEL JJ. (dissenting) —

I. Introduction

161 The question in this appeal is whether the province of Quebec not only has the constitutional authority to establish a comprehensive single-tier health plan, but to discourage a second (private) tier health sector by prohibiting the purchase and sale of private health insurance. The appellants argue that timely access to needed medical service is not being provided in the publicly funded system and that the province cannot therefore deny to those Quebeckers (who can qualify) the right to purchase private insurance to pay for medical services whenever and wherever such services can be obtained for a fee, i.e., in the private sector. This issue has been the subject of protracted debate across Canada through several provincial and federal elections. We are unable to agree with our four colleagues who would allow the appeal that such a debate can or should be resolved as a matter of law by judges. We find that, on the legal issues raised, the appeal should be dismissed.

162 Our colleagues the Chief Justice and Major J. state at para. 105:

> By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the [*Canadian*] *Charter*. [Emphasis added.]

163 The Court recently held in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78, that the government was not required to fund the treatment of autistic children. It did not on that occasion address in constitutional terms the scope and nature of "reasonable" health services. Courts will now have to make that determination. What, then, are constitutionally required "reasonable health services"? What is treatment "within a reasonable time"? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard. The public cannot know, nor can judges or governments know, how much health care is "reasonable" enough to satisfy s. 7 of the *Canadian Charter of Rights and Freedoms* ("*Canadian Charter*") and s. 1 of the *Charter of Human Rights and Freedoms*, R.S.Q. c. C-12("*Quebec Charter*"). It is to be hoped that we will know it when we see it.

164 The policy of the *Canada Health Act*, R.S.C. 1985, c. C-6, and its provincial counterparts is to provide health care based on need rather than on wealth or status. The evidence certainly established that the public health care system put in place to implement this policy has serious and persistent problems. This does not mean that the courts are well placed to perform the required surgery. The resolution of such a complex fact-laden policy debate does not fit easily within the institutional competence or procedures of courts of law. The courts can use s. 7 of the *Canadian Charter*to pre-empt the ongoing public debate only if the current health plan violates an established "principle of fundamental justice". Our colleagues McLachlin C.J. and Major J. argue that Quebec's enforcement of a single-tier health plan meets this legal test because it is "arbitrary". In our view, with respect, the prohibition against private health insurance is a rational consequence of Quebec's commitment to the goals and objectives of the*Canada Health Act*.

165 Our colleague Deschamps J. states at para. 4:

> In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state. [Emphasis added.]

This is so, but of course it must be recognized that the liberty and security of Quebeckers who do not have the money to afford private health insurance, who cannot qualify for it, or who are not employed by establishments that provide it, are not put at risk by the absence of "upper tier" health care. It is Quebeckers who have the money to afford private medical insurance and can qualify for it who will be the beneficiaries of the appellants' constitutional challenge.

166 The Quebec government views the prohibition against private insurance as essential to preventing the current single-tier health system from disintegrating into a *de facto* two-tier system. The trial judge found, and the evidence demonstrated, that there is good reason for this fear. The trial judge concluded that a private health sector fuelled by private insurance would frustrate achievement of the objectives of the *Canada Health Act*. She thus found no legal basis to intervene, and declined to do so. This raises the issue of *who* it is that *should* resolve these important and contentious issues. Commissioner Roy Romanow makes the following observation in his Report:

> Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care.
>
> (*Building on Values: The Future of Health Care in Canada: Final Report* (2002) ("Romanow Report"), at p. xx)

Whether or not one endorses this assessment, his premise is that the debate is about social values. It is not about constitutional law. We agree.

167 We believe our colleagues the Chief Justice and Major J. have extended too far the strands of interpretation under the *Canadian Charter* laid down in some of the earlier cases, in particular the ruling on abortion in *R. v. Morgentaler*, [1988] 1 S.C.R. 30 (which involved criminal liability, not public health policy). We cannot find in the constitutional law of Canada a "principle of fundamental justice" dispositive of the problems of waiting lists in the Quebec health system. In our view, the appellants' case does not rest on constitutional law but on their disagreement with the Quebec government on aspects of its social policy. The proper forum to determine the social policy of Quebec in this matter is the National Assembly.

168 Our colleagues the Chief Justice and Major J. write:

> The task of the courts, on s. 7 issues as on others, is to evaluate the issue in the light, not just of common sense or theory, but of the evidence. [para. 150]

This, of course, is precisely what the learned trial judge did after weeks of listening to expert testimony and argument. In general, we agree with her conclusions. There is nothing in the evidence to justify our colleagues' disagreement with her conclusion that the general availability of health insurance will lead to a significant expansion of the private health sector to the detriment of the public health sector. While no one doubts that the Quebec health plan is under sustained and heavy criticism, and that at least some of the criticisms were supported by the trial judge on the basis of the evidence, the trial judge rejected the appellants' contention (now accepted by our colleagues the Chief Justice

and Major J.) that the prohibition on private insurance is contrary to the principles of fundamental justice. The trial judge's conclusion was endorsed by Justice Forget of the Quebec Court of Appeal. As a matter of law, we see no reason to interfere with their collective and unanimous judgment on this point. Whatever else it might be, the prohibition is not arbitrary.

169 We can all support the vague objective of "public health care of a reasonable standard within a reasonable time". Most people have opinions, many of them conflicting, about how to achieve it. A legislative policy is not "arbitrary" just because we may disagree with it. As our colleagues the Chief Justice and Major J. fully recognize, the legal test of "arbitrariness" is quite well established in the earlier case law. In our view that test is not met in this case, for reasons we will develop in some detail. Suffice it to say at this point that in our view, the appellants' argument about "arbitrariness" is based largely on generalizations about the public system drawn from fragmentary experience, an overly optimistic view of the benefits offered by private health insurance, an oversimplified view of the adverse effects on the public health system of permitting private sector health services to flourish and an overly interventionist view of the role the courts should play in trying to supply a "fix" to the failings, real or perceived, of major social programs.

A. *The Argument About Adding an "Upper Tier" to the Quebec Health Plan*

170 The nature of a two-tier system is explained as follows:

> In the broad sense, a two-tier system refers to two co-existing health care systems: a publicly funded system and a privately funded system. This definition implies that there is a differential access to health services based on one's ability to pay, rather than according to need. In other words, those who can afford it may either obtain access to better quality care or to quicker care in the privately funded system, while the rest of the population continues to access health care only through the publicly funded system. [Emphasis added.]
>
> (*The Health of Canadians — The Federal Role*, vol. 4, *Issues and Options*, Interim Report (2001) ("Kirby Report"), at p. 67)

It is evident, of course, that neither Quebec nor any of the other provinces has a "pure" single-tier system. In the area of uninsured medical services, for example, the private sector is the dominant supplier. In other cases, the private sector may perform the service but is paid by the state. The issue here, as it is so often in social policy debates, is where to draw the line. One can rarely say in such matters that one side of a line is "right" and the other side of a line is "wrong". Still less can we say that the boundaries of the Quebec health plan are dictated by the Constitution. Drawing the line around social programs properly falls within

the legitimate exercise of the democratic mandates of people elected for such purposes, preferably after a public debate.

B. *Background to the Health Policy Debate*

171 Prior to 1961, only 53 percent of Canadians were covered by some form of health insurance, leaving approximately 8 million Canadians without insurance coverage (*Voluntary Medical Insurance and Prepayment* (1965) ("Berry Commission"), at pp. 177-78). At that time, health care costs were the number one cause of personal bankruptcy in Canada.

172 In these circumstances, the people of Quebec, through their elected representatives, opted for a need-based, rather than a wealth-based, health care system. In the Castonguay-Nepveu Report, said to be the foundation of the public health care system in Quebec, it was stated:

> The maintenance of the people's health more and more is accepted as a collective responsibility. This is not surprising since it must be admitted that without vigorous State action, the right to health would remain a purely theoretical notion, without any real content. [Emphasis added.]
>
> (*Report of the Commission of Inquiry on Health and Social Welfare*, vol. IV, *Health*, t. 1, *The Present Situation* (1970) ("Castonguay-Nepveu Report"), at p. 30)

173 The Kirby Report noted in 2001 that "Canadians' attachment to a sense of collective responsibility for the provision of health care has remained largely intact despite a shift towards more individualistic values" (vol. 4, at p. 137); see also *Emerging Solutions: Report and Recommendations* (2001) ("Clair Report"), at p. 243; *La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec: Rapport du groupe de travail* (1999) ("Arpin Report"), at p. 34. Both the Kirby Report and the Romanow Report contained extensive investigations into the operations and problems of the current public health systems across Canada. They acknowledged that the financing of health care is putting a growing stress on public finances and national resources. For fiscal year 2004-2005, federal/provincial/territorial spending on health care is estimated to be about $88 billion (Finance Canada, *Federal Support for Health Care: The Facts* (September 2004)). Whether this growing level of expenditure is sustainable, justified or wise is a matter on which we all have opinions. In the absence of a violation of a recognized "principle of fundamental justice", the opinions that prevail should be those of the legislatures.

174 Not all Canadian provinces prohibit private health insurance, but all of them (with the arguable exception of Newfoundland) take steps to protect the public health system by discouraging the private sector, whether by prohibiting private insurance (Quebec, Ontario, Manitoba, British Columbia, Alberta and Prince Edward Island) or by prohibiting doctors who opt out of the public sector, from billing their private patients more than the public sector tariff, thereby dulling the incentive to opt out (Ontario, Manitoba and Nova Scotia), or eliminating any form of cross-subsidy from the public to the private sector (Quebec, British Columbia, Alberta, Prince Edward Island, Saskatchewan and New Brunswick). The mixture of deterrents differs from province to province, but the underlying policies flow from the *Canada Health Act* and are the same: i.e., as a matter of *principle*, health care should be based on need, not wealth, and as a matter of *practicality* the provinces judge that growth of the private sector will undermine the strength of the public sector and its ability to achieve the objectives of the *Canada Health Act*.

175 The argument for a "two-tier system" is that it will enable "ordinary" Canadians to access private health care. Indeed, this is the view taken by our colleagues the Chief Justice and Major J. who quote the appellants' argument that "disallowing private insurance precludes the vast majority of Canadians (middle-income and low-income earners) from accessing" private health care (para. 137). This way of putting the argument suggests that the Court has a mandate to save middle-income and low-income Quebeckers from themselves, because both the Romanow Report and the Kirby Report found that the vast majority of "ordinary" Canadians want a publicly financed single-tier (more or less) health plan to which access is governed by need rather than wealth and where the availability of coverage is not contingent on personal insurability. Our colleagues rely in part on the experience in the United States (para. 148) and the fact that public funding in that country accounts for only 45 percent of total health care spending. But if we look at the practical reality of the U.S. system, the fact is that 15.6 percent of the American population (i.e., about 45 million people) had no health insurance coverage at all in 2003, including about 8.4 million children. As to making health care available to medium and low-income families, the effect of "two-tier" health coverage in the U.S. is much worse for minority groups than for the majority. Hispanics had an uninsured rate of 32.7 percent, and African Americans had an uninsured rate of 19.4 percent. For 45 million Americans, as for those "ordinary" Quebeckers who cannot afford private medical insurance or cannot obtain it because they are deemed to be "bad risks", it is a matter of public health care or no care at all (C. DeNavas-Walt, B. D. Proctor and R. J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (2004), at pp. 56-59).

176 It would be open to Quebec to adopt a U.S.-style health care system. No one suggests that there is anything in our Constitution to prevent it. But to do so would be contrary to the policy of the Quebec National Assembly, and its policy in that respect is shared by the other provinces and the federal Parliament. As stated, Quebec further takes the view that significant growth in the private health care system (which the appellants advocate)

would inevitably damage the public system. Our colleagues the Chief Justice and Major J. disagree with this assessment, but governments are entitled to act on a reasonable apprehension of risk of such damage. As noted by the majority in *R. v. Malmo-Levine*, [2003] 3 S.C.R. 571, 2003 SCC 74, at para. 133:

> Members of Parliament are elected to make these sorts of decisions, and have access to a broader range of information, more points of view, and a more flexible investigative process than courts do.

While the existence of waiting times is undoubted, and their management a matter of serious public concern, the proposed constitutional right to a two-tier health system for those who can afford private medical insurance would precipitate a seismic shift in health policy for Quebec. We do not believe that such a seismic shift is compelled by either the *Quebec Charter* or the *Canadian Charter*.

II. Analysis

177 The appellants' principal argument is that the existence of waiting lists in Quebec and the concurrent prohibition on private health insurance violate s. 7 of the *Canadian Charter*, which guarantees everyone the right to life, liberty and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

178 The *legal* question raised by our colleagues the Chief Justice and Major J. under the *Canadian Charter* is whether or not the Quebechealth plan violates a *principle of fundamental justice* and, if so, whether the plan can nevertheless be saved under s. 1.

179 The reasons of our colleague Deschamps J., on the other hand, are limited to s. 1 of the *Quebec Charter* which protects the right of every human being to life and to personal security, inviolability and freedom. The *Quebec Charter* does not talk explicitly about "principles of fundamental justice". Nevertheless, in our view, the legislative limits fixed by the *Quebec Charter* are no more favourable to the appellants' case than are those fixed by the *Canadian Charter*. Rights under the *Quebec Charter* are to be exercised with "proper" regard to "democratic" values (including those of the electorate) "public order and the general well-being of the citizens of Québec" (including those who cannot afford, or may not qualify for, private health insurance coverage). We address this issue below starting at para. 266.

180 Our colleagues the Chief Justice and Major J. agree with the appellants that there is a violation of s. 7 of the *Canadian Charter*. As mentioned earlier, their opinion rests in substantial part on observations made by various members of this Court in *Morgentaler*. At issue in that case was the criminal liability of doctors and their patients under s. 251 of the *Criminal Code*, R.S.C. 1970, c. C-34, for performing abortions. The nub of the legal challenge was that in creating the abortion offence Parliament had qualified the charge with a "therapeutic abortion" defence, but the defence was not working. The factual and legal issues raised in that criminal law problem are, we think, far removed from the debate over a two-tiered health system. *Morgentaler* applied a "manifest unfairness" test which has never been adopted by the Court outside the criminal law, and certainly not in the context of the design of social programs. The *Morgentaler* judgment fastened on internal inconsistencies in s. 251 of the *Code*, which find no counterpart here. In our view, with respect, *Morgentaler* provides no support for the appellants in this case, as we discuss commencing at para. 259.

181 As stated, we accept the finding of the courts below that a two-tier health care system would likely have a negative impact on the integrity, functioning and viability of the public system: [2000] R.J.Q. 786, at p. 827; reasons of Forget J.A., [2002] R.J.Q. 1205, at p. 1215. Although this finding is disputed by our colleagues the Chief Justice and Major J. (a point to which we will return), it cannot be contested that as a matter of *principle*, access to private health care based on wealth rather than need contradicts one of the key social policy objectives expressed in the *Canada Health Act*. The state has established its interest in promoting the equal treatment of its citizens in terms of health care. The issue of arbitrariness relates only to the validity of the *means* adopted to achieve that policy objective. Counsel for the appellant Zeliotis was not oblivious to the potential danger posed by the re-allocation of health resources to the private sector. In opening his oral submissions to the Court, he acknowledged the need as a matter of social policy to protect the public health system:

> [TRANSLATION] May a person use his or her own resources to obtain medical care outside the public system if the public system is unable to provide medical care within an acceptable time and if doing so *would not deprive the public system of the resources it needs*? . . .
>
> . . . we recognize that it is perfectly legitimate for the state to make sure that the public system has on a priority basis all the resources it needs to function. *Thus, we concede that, if this were in fact impossible, our appeal should fail.* [Emphasis added.]
>
> (Oral Transcript, Mr. Trudel, at p. 25)

While Quebec does not outlaw private health care, which is therefore accessible to those with cash on hand, it wishes to discourage its growth. Failure to stop the few people with ready cash does not pose a structural threat to the Quebec health plan. Failure to stop private health insurance will, as the trial judge found, do so. Private insurance is a condition precedent to,

and aims at promoting, a flourishing parallel private health care sector. For Dr.Chaoulli in particular, that is the whole point of this proceeding.

A. *Preliminary Objections*

182 The Attorneys General made two preliminary objections: first, that the claims raised on this appeal are not properly justiciable; and second, that neither Dr. Chaoulli nor Mr. Zeliotis has standing to bring their claim. These objections should be rejected.

(1) Justiciability

183 The Attorneys General of Canada and Quebec argue that the claims advanced by the appellants are inherently political and, therefore, not properly justiciable by the courts. We do not agree. Section 52 of the *Constitution Act, 1982* affirms the constitutional power and *obligation* of courts to declare laws of no force or effect to the extent of their inconsistency with the Constitution. Where a violation stems from a *Canadian Charter* breach, the court may also order whatever remedy is "appropriate and just" in the circumstances under s. 24. There is nothing in our constitutional arrangement to exclude "political questions" from judicial review where the Constitution itself is alleged to be violated.

184 Nevertheless, a correct balance must be struck between the judiciary and the other branches of government. Each branch must respect the limits of its institutional role. As stated in *Vriend v. Alberta*, [1998] 1 S.C.R. 493, "the courts are to uphold the Constitution and have been expressly invited to perform that role by the Constitution itself. But respect by the courts for the legislature and executive role is as important as ensuring that the other branches respect each others' role and the role of the courts" (para. 136).

185 In the present case, the appellants are challenging the legality of Quebec's prohibition against private health insurance. While the issue raises "political questions" of a high order, the alleged *Canadian Charter* violation framed by the appellants is in its nature justiciable, and the Court should deal with it.

(2) Standing of Dr. Chaoulli and Mr. Zeliotis

186 Article 55 of the *Code of Civil Procedure*, R.S.Q., c. C-25, requires that the party bringing an action have a "sufficient interest" in the litigation. In our view, for the

reasons given by the trial judge, as previously mentioned, Mr. Zeliotis has not demonstrated that systemic waiting lists were the cause of his delayed treatment.

187 Dr. Chaoulli's situation is different. He offers himself as an advocate for private health insurance. He is a medically trained individual who has a history of conflict with the Quebec health authorities and of disobedience to their rules governing medical practice. The trial judge found Dr.Chaoulli's motives to be questionable:

> [TRANSLATION] At first, Dr. Chaoulli was supposed to complete his initial contract in a remote region. He did not do so but returned to Montréal and, contrary to what he was entitled to do, began practising on the South Shore. He then obstinately insisted on practising medicine as he pleased, disregarding the regional board's decisions. Dr. Chaoulli never testified that he had received inadequate care or that the system had not responded to his personal health needs. He still faces substantial penalties at the Régie de l'assurance-maladie du Québec. He was released from his obligations, returned to the public system, and is still not satisfied. All this leads the Court to question Dr. Chaoulli's real motives in this dispute. It is impossible not to be struck by the contradictions in his testimony and by the impression that Dr. Chaoulli has embarked on a crusade that now raises questions transcending his own personal case. [p. 795]

188 Nevertheless, we accept that the appellants have a sufficient interest in the constitutional questions to be given public interest standing. In *Minister of Justice of Canada v. Borowski*, [1981] 2 S.C.R. 575, at p. 598, Martland J. wrote that to qualify in that regard, a person must satisfy three requirements:

> [T]o establish status as a plaintiff in a suit seeking a declaration that legislation is invalid, if there is a serious issue as to its invalidity, a person need only to show that he is affected by it directly or that he has a genuine interest as a citizen in the validity of the legislation and that there is no other reasonable and effective manner in which the issue may be brought before the Court.

See also *Canadian Council of Churches v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236.

189 All three of these conditions are met in the present case. First, there is a serious challenge to the invalidity of the impugned provisions. Access to medical care is a concern of all Quebec residents. Second, Dr. Chaoulli and Mr. Zeliotis are both Quebec residents and are therefore directly affected by the provisions barring access to private health insurance. Third, the appellants advance the broad claim that the Quebec health plan is

unconstitutional for *systemic* reasons. They do not limit themselves to the circumstances of any particular patient. Their argument is not limited to a case-by-case consideration. They make the generic argument that Quebec's chronic waiting lists destroy Quebec's legislative authority to draw the line against private health insurance. From a practical point of view, while individual patients could be expected to bring their own cases to court if they wished to do so, it would be unreasonable to expect a seriously ailing person to bring a systemic challenge to the whole health plan, as was done here. The material, physical and emotional resources of individuals who are ill, and quite possibly dying, are likely to be focussed on their own circumstances. In this sense, there is no other class of persons that is more directly affected and that could be expected to undertake the lengthy and no doubt costly systemic challenge to single-tier medicine. Consequently, we agree that the appellants in this case were rightly granted public interest standing. However, the corollary to this ruling is that failure by the appellants in their systemic challenge would not foreclose constitutional relief to an individual based on, and limited to, his or her particular circumstances.

B. *Canadian Charter of Rights and Freedoms*

190 The Chief Justice and Major J. would strike down the Quebec legislation on the basis of s. 7 of the *Canadian Charter*, which provides:

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

191 Like our colleagues McLachlin C.J. and Major J., we accept the trial judge's conclusion that in *some* circumstances *some* Quebeckers may have their life or "security of the person" put at risk by the prohibition against private health insurance. However, unlike our colleagues, we agree with the trial judge and the Quebec Court of Appeal that this situation, however deplorable, is not capable of resolution as a matter of constitutional law. At the same time, we reject some of the constraints that the Attorney General of Quebec would place on the Court's analysis.

(1) The Application of Section 7 to Matters Not Falling Within the Administration of Justice

192 The Attorney General of Quebec argues that s. 7 does not protect economic rights. This is true, but is somewhat beside the point. The appellants seek access to a two-tier health system. The fact it will cost money to the people in the "upper tier" is an incidental (although important) aspect of their challenge, which is principled in nature.

193 Section 7 gives rise to some of the most difficult issues in *Canadian Charter* litigation. Because s. 7 protects the most basic interests of human beings — life, liberty and security — claimants call on the courts to adjudicate many difficult moral and ethical issues. It is therefore prudent, in our view, to proceed cautiously and incrementally in applying s. 7, particularly in distilling those principles that are so vital to our society's conception of "principles of fundamental justice" as to be constitutionally entrenched.

194 At first blush, 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, seem far removed from the usual concerns of s. 7 of the *Canadian Charter*. The provisions sought to be invalidated provide:

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

195 The present challenge does not arise out of an adjudicative context or one involving the administration of justice. Sections 11 and 15 are plainly not adjudicative provisions. Nor are they administrative provisions in the sense of being part of the administrative scheme for the provision of health services, though they do form part of the regulatory health regime. Section 11 is a *civil* prohibition against the making or renewing of a contract for insurance for "insured services" and against the payment under such a contract for "insured services". Any contract entered into in contravention ofs. 11 and s. 15 would be absolutely null and unenforceable because it is contrary to the general interest: art. 1417 of the *Civil Code of Québec*, S.Q. 1991, c. 64. Although small fines may be imposed for the breach of these provisions, we think that regulations providing for such fines, which are wholly incidental to the regulatory purpose, would not create a sufficient nexus with the adjudicative context to ground the application of s. 7 on that basis.

196 It will likely be a rare case where s. 7 will apply in circumstances entirely unrelated to adjudicative or administrative proceedings. That said, the Court has consistently left open the possibility that s. 7 may apply outside the context of the administration of justice: *Gosselin v. Quebec(Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84, at paras. 78-80 and 414.

197 The Court has been moving away from a narrow approach to s. 7, which restricted the scope of the section to legal rights to be interpreted in light of the rights enumerated in ss. 8 to 14: see, e.g., *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123 ("*Prostitution Reference*"), at pp. 1171-74. In *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 SCC 44, the majority held that s. 7 can apply outside of the criminal context. Further, in *Winnipeg Child and Family Services v. K.L.W.*, [2000] 2 S.C.R. 519, 2000 SCC 48, the Court noted that it had held in *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315, that the wardship provisions of the *Child Welfare Act*, R.S.O. 1980, c. 66, denying parents the ability to choose medical treatment for their infants, implicated the s. 7liberty interests of parents.

198 Placing s. 7 under the heading "Legal Rights" in the *Canadian Charter* does not narrow or control its scope. Such a result would be unduly formalistic and inconsistent with the large, liberal and purposive interpretation of s. 7 that has been the hallmark of this Court's approach since*Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486. This is evidenced by the refusal of the majority in that case to restrict "principles of fundamental justice" solely to procedural guarantees. Lamer J. observed that "the principles of fundamental justice are to be found in the basic tenets and principles, not only of our judicial process, but also of the other components of our legal system" (p. 512 (emphasis added)).

199 Claimants whose life, liberty or security of the person is put at risk are entitled to relief only to the extent that their complaint arises from a breach of an identifiable principle of fundamental justice. The real control over the scope and operation of s. 7 is to be found in the requirement that the applicant identify a violation of a principle of fundamental justice. The further a challenged state action lies from the traditional adjudicative context, the more difficult it will be for a claimant to make that essential link. As will become clear, that is precisely the difficulty encountered by the claimants here: they are unable to demonstrate that any principle of fundamental justice has been contravened.

(2) Which Section 7 Interests Are Engaged?

200 Section 7 interests are enumerated as life, liberty and security of the person. As stated, we accept the trial judge's finding that the current state of the Quebec health system, linked to the prohibition against health insurance for insured services, is capable, at least in the cases of someindividuals on some occasions, of putting at risk their life or security of the person.

201 We do not agree with the appellants, however, that the Quebec Health Plan puts the "liberty" of Quebeckers at risk. The argument that "liberty" includes freedom of contract (in this case to contract for private medical insurance) is novel in Canada, where economic rights are not included in the *Canadian Charter* and discredited in the United States. In that country, the liberty of individuals (mainly employers) to contract out of social and economic programs was endorsed by the Supreme Court in the early decades of the 20th century on the theory that laws that prohibited employers from entering into oppressive contracts with employees violated their "liberty" of contract; see, e.g., *Lochner v. New York*, 198 U.S. 45 (1905), at p. 62:

> . . . a prohibition to enter into any contract of labor in a bakery for more than a certain number of hours a week, is, in our judgment, so wholly beside the matter of a proper, reasonable and fair provision, as to run counter to that liberty of person and of free contract provided for in the Federal Constitution.

Of this line of cases, which was not brought to an end until *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937), Professor L. H. Tribe has written that the Supreme Court of the United States:

> . . . relied on the Fourteenth Amendment's Due Process Clause to strike down economic legislation that the Court saw as improperlyinfringing on contractual liberty, but in which the Court was widely (even if not always correctly) perceived to be substituting its own judgment, in the absence of any actual constitutional mandate, for that of the legislature. [Emphasis added.]
>
> (*American Constitutional Law* (3rd ed. 2000), vol. 1, at p. 1318)

202 Nor do we accept that s. 7 of the *Canadian Charter* guarantees Dr. Chaoulli the "liberty" to deliver health care in a private context. The trial judge correctly concluded that [TRANSLATION] "*s. 7* of the Canadian charter does not protect a physician's right to practise his or her profession without restrictions in the private sector. That is a purely economic right." (p. 823 (emphasis in original)) The fact that state action constrains an individual's freedom by eliminating career choices that would otherwise be available does not in itself attract the protection of the liberty interest under s. 7. The liberty interest does not, for example, include the right to transact business whenever one wishes: *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, at p. 786. Nor does it protect the right to exercise

one's chosen profession: *Prostitution Reference*, at p. 1179, *per* Lamer J. We would therefore reject Dr. Chaoulli's claim on behalf of care providers that their liberty interest under either the *Canadian Charter* or the *Quebec Charter* has been infringed by Quebec's single-tier public health system.

(3) Is There a Constitutional Right to Spend Money?

203 Reference has already been made to the question raised by our colleague Deschamps J. at para. 4 of her reasons:

> In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state.

While we do not accept that there is a constitutional right "to spend money", which would be a property right, we agree that if the public system fails to deliver life-saving care and an individual is simultaneously prevented from seeking insurance to cover the cost of that care in a private facility, then the individual is potentially caught in a situation that may signal a deprivation of his or her security of the person.

204 This is not to say that every encounter with a waiting list will trigger the application of s. 7. The interference with one's mental well-being must not be trivial. It must rise above the ordinary anxiety caused by the vicissitudes of life, but it need not be so grave as to lead to serious mental anguish or nervous breakdown. Some individuals that meet this test are to be found entangled in the Quebec health system. The fact that such individuals do not include the appellants personally is not fatal to their challenge because they come here as plaintiffs purporting to represent the public interest.

205 The Court has found a deprivation of one's psychological integrity sufficient to ground a s. 7 claim in a range of cases. In *Morgentaler*, the majority held that the impugned abortion provisions seriously compromised a woman's physical and psychological integrity in a manner that constituted an infringement of her security of the person: at pp. 56-57, *per* Dickson C.J. (Lamer J. concurring), at pp. 104-5, *per* Beetz J. (Estey J. concurring); at pp. 173-74, *per* Wilson J. The Court subsequently held that the criminal prohibition against assisting someone to commit suicide constituted an impingement of the claimant's physical and psychological integrity that amounted to a deprivation of the right to security of the person under s. 7; the claimant in that case was suffering from Lou Gehrig's disease, a rapidly deteriorating condition, which results in paralysis and eventually requires invasive life-prolonging measures to be taken: *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519. More recently, in *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, the Court was unanimous in saying that removal of a

child from parental custody by the state pursuant to its wardship jurisdiction constituted a serious interference with the psychological integrity of the parent that deprived the parent of the security of the person.

206 It may also be that a lack of timely medical intervention will put the *physical* security of the patient at risk. The condition of a cardiac or cancer patient, for example, may seriously deteriorate if treatment is not available quickly.

207 As stated, the principal legal hurdle to the appellants' *Canadian Charter* challenge is not the preliminary step of identifying a s. 7 interest potentially affected in the case of some Quebeckers in some circumstances. The hurdle lies in their failure to find a fundamental principle of justice that is violated by the Quebec health plan so as to justify the Court in striking down the prohibition against private insurance for what the government has identified as "insured services".

C. *Principles of Fundamental Justice*

208 For a principle to be one of fundamental justice, it must count among the basic tenets of our legal system: *Re B.C. Motor Vehicle Act*, at p. 503. It must generally be accepted as such among reasonable people. As explained by the majority in *Malmo-Levine*, at para. 113:

> The requirement of "general acceptance among reasonable people" enhances the legitimacy of judicial review of state action, and ensures that the values against which state action is measured are not just fundamental "in the eye of the beholder only": *Rodriguez*, at pp. 607 and 590 . . . . In short, for a rule or principle to constitute a principle of fundamental justice for the purposes of s. 7, it must be a legal principle about which there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate, and it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty or security of the person. [First emphasis in *Rodriguez*; subsequent emphasis added.]

See also *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, [2004] 1 S.C.R. 76, 2004 SCC 4, at para. 8.

209 Thus, the formal requirements for a principle of fundamental justice are threefold. First, it must be a legal principle. Second, the reasonable person must regard it as

vital to our societal notion of justice, which implies a significant societal consensus. Third, it must be capable of being identified with precision and applied in a manner that yields predictable results. These requirements present insurmountable hurdles to the appellants. The aim of "health care of a reasonable standard within a reasonable time" is not a legal principle. There is no "societal consensus" about what it means or how to achieve it. It cannot be "identified with precision". As the testimony in this case showed, a level of care that is considered perfectly reasonable by some doctors is denounced by others. Finally, we think it will be very difficult for those designing and implementing a health plan to predict when its provisions cross the line from what is "reasonable" into the forbidden territory of what is "unreasonable", and how the one is to be distinguished from the other.

(1) The Experts Recognized That the Potential Market for Health Services Is Almost Limitless, and the Supply Must Therefore Be Rationed Whether by Governments in the Public Sector or Insurers or Other Health Care Providers in the Private Sector

210 Much of the argument pursued by the Chief Justice and Major J., as well as by Deschamps J. in her reasons relating to the *QuebecCharter*, revolves around the vexing issue of waiting lists, which have notoriously fuelled major public debates and controversies.

211 The case history of the appellant Zeliotis illustrates why rationing of health services is necessary and how it works. The trial judge, having heard all the evidence, concluded that the delays Mr. Zeliotis experienced in obtaining hip surgery were caused not by excessive waiting lists but by a number of other factors, including his pre-existing depression and his indecision and unfounded medical complaints (p. 793):

> [TRANSLATION] The truth is that, in light of his personal medical impediments, the fact that he was already suffering from depression, his indecision and his complaints, which in many respects were unwarranted, it is hard to conclude that the delays that occurred resulted from lack of access to public health services, and in fact even Mr. Zeliotis's complaints about delays are questionable. It was he who initially wanted a second opinion, it was his surgeon who hesitated because of his problems, and so on. Thus, his complaint to the director of professional services at the Royal Victoria Hospital . . . was not corroborated. An out-of-court examination in connection with another case is puzzling, as Mr. Zeliotis said he was in very good health . . . .

Mr. Zeliotis sought a second opinion, which he was entitled to do, and this further delayed his surgery. More importantly, his physician believed that Mr. Zeliotis was not an "ideal candidate" for the surgery because he had suffered a heart attack and undergone bypass surgery earlier that year. Accordingly, neither the mere existence of waiting lists, nor the fact that certain individuals like Mr. Zeliotis feel unfairly dealt with, necessarily points to a constitutional problem with the public health system as a whole.

(a) *There Is No Consensus About What Constitutes "Reasonable" Waiting Times*

212 A review of the expert evidence and the medical literature suggests that there is no consensus regarding guidelines for timely medical treatment. Dr. Wright remarked:

> So the issue of defining what is a reasonable waiting list is a very difficult one because if you have a hundred (100) surgeons, you have a hundred (100) opinions, it's very difficult to come to a consensus on these questions. [A.R., at p. 1186]

There are currently no national standards for timely treatment: see C. Sanmartin et al., "Waiting for medical services in Canada: lots of heat, but little light" (2000), 162 *C.M.A.J.* 1305; S. Lewis et al., "Ending waiting-list mismanagement: principles and practice" (2000), 162 *C.M.A.J.* 1297; N. E. Mayo et al., "Waiting time for breast cancer surgery in Quebec" (2001), 164 *C.M.A.J.* 1133.

213 It is therefore convenient to look further into the expert evidence, not to dispute the existence of waiting list problems or to understate the level of public anxiety they create, but simply to illustrate the complexity of the situation and the dangers of oversimplification.

(b) *The Experts Accepted by the Trial Judge Relied on More Than Just "Common Sense"*

214 Our colleagues the Chief Justice and Major J. dismiss the experts accepted by the trial judge as relying on little more than "common sense" (para. 137). Although we agree that the experts offered "common sense", they offered a good deal more. The experts heard by the trial court included Mr. Claude Castonguay, who was Quebec's Minister of Health in 1970 (the [TRANSLATION] "father of Quebec health insurance") and who chaired the Commission of Inquiry on Health and Social Welfare, as well as a number of other public health experts, including Dr. Fernand Turcotte, a professor of medicine at Laval University, who holds degrees from the University of Montreal and Harvard and has been certified by the Royal College of Physicians and Surgeons of Canada as a specialist in community medicine; Dr. Howard Bergman, Chief of the Division of Geriatric Medicine at Montreal's Jewish General Hospital, Director of the Division of Geriatric Medicine and a professor in the departments of Internal Medicine and Family Medicine at McGill University, a fellow of the American Geriatrics Society and an associate professor at the University of Montreal in the department of health administration; Dr. Charles J. Wright, a physician specialized in surgery, Director of the Centre for Clinical Epidemiology & Evaluation at the Vancouver Hospital & Health Sciences Centre, and a faculty member of the University of British

Columbia and of the British Columbia Office of Health Technology Assessment; Professor Jean-Louis Denis, a community health doctor of the University of Montreal's [TRANSLATION] "health services organization"; Professor Theodore R. Marmor, a professor of public policy and management and of political science at Yale University, who holds a PhD from Harvard University in politics and history and is a graduate research fellow at Oxford; and Dr. J. Edwin Coffey, a graduate of McGill University in medicine who specializes in obstetrics and gynecology, a fellow of the Royal College of Physicians and Surgeons of Canada and of the American College of Obstetricians and Gynecologists, and a former associate professor in the McGill University Faculty of Medicine. The respondent's experts testified and were cross-examined. The trial judge found them to be credible and reliable. We owe deference to her findings in this respect.

215 The trial judge, having heard the evidence, concluded as follows:

> [TRANSLATION] . . . although some of these specialists indicated a desire to be free to obtain private insurance, none of them gave their full and absolute support to the applicants' proposals, as they explained that it was neither clear nor obvious that a reorganization of the health system with a parallel private system would solve all the existing problems of delays and access. On the contrary, the specialists who testified remained quite circumspect about this complex and difficult question. [Emphasis added; p. 796.]

The exception to the consensus was the appellants' expert, Dr. Coffey, who stated that in his opinion the development of a private insurance scheme would not affect the public health scheme. This is the argument accepted by our colleagues the Chief Justice and Major J. However on this point the trial judge observed, as on others, [TRANSLATION] "*that Dr. Coffey stood alone in both his expert evaluation and the conclusions he reached*" (p. 808 (emphasis in original)).

216 In addition, the Court was presented with a number of government reports and independent studies. They bear out the wisdom of the comment in *Un avenir pour le système public de santé* (1998) ("Denis Report"), at p. 20: [TRANSLATION] "It is important that we quickly distance ourselves from a position advocating simple solutions to complex problems."

(c) *The Lack of Accurate Data*

217 How serious is the waiting-list problem? No doubt it is serious; but *how* serious? The first major evidentiary difficulty for the appellants is the lack of accurate data. The major studies concluded that the real picture concerning waiting lists in Canada is subject to contradictory evidence and conflicting claims (Romanow Report, at p. 139, and the Kirby Report, vol. 4, at p. 41, and vol. 6, at pp. 109-10). This can also be seen

from the evidence of the experts who testified at trial in the present case (see *Waiting Lists in Canada and the Potential Effects of Private Access to Health Care Services* (1998) ("Wright Report"), at p. 7; *Le temps d'attente comme instrument de gestion du rationnement dans les services de santé du Canada* (1998) ("Turcotte Report")), and from the available literature (see *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money??* (1998) ("McDonald Report")). At trial, Dr. Wright also discounted the value of random opinion surveys:

> The information is based on no formal structured data collection of any kind and has no credibility whatever with any health service researcher or epidemiologist.
>
> (Wright Report, at p. 8)

218 In a commentary for the *Canadian Medical Association Journal*, S. Lewis et al. observed:

> The waiting-list "nonsystem" in Canada is a classic case of forced decision-making in the absence of good management information. There is a surfeit of nonstandardized data and a dearth of usable, policy-oriented information about waiting lists. The most serious consequence is that information and management defects are almost always prematurely diagnosed as financial shortages. [p. 1299]

219 Professor Marmor also subscribed to the view that waiting lists cannot serve as a "simple indicator" of a failing health care system (*Expert Witness Report* (1998) ("Marmor Report"), at p. 11) in part because studies of waiting lists have demonstrated that up to one third of patients on lists no longer need to be on them because the procedure has already been performed elsewhere; the patient has already been admitted on an emergency basis; the patient no longer wishes the procedure to be performed; the procedure is no longer medically necessary; the patient has already been called in to have the procedure but refused for personal reasons or due to inconvenient timing; or the patient is on multiple waiting lists at different hospitals thereby inflating numbers (Wright Report, at pp. 7-8).

(d) *The Impact of Waiting Times on Individual Patients*

220 It is even more difficult to generalize about the potential impact of a waiting list on a particular patient. The most comprehensive overview of the literature on waiting lists available to the trial judge was the McDonald Report, at p. 14. It presents a review of studies of patients' experiences while awaiting surgery. That review prompted the authors to conclude, among other things, that patients awaiting care for a range of procedures — including knee and hip replacement, cardiac care and cataract care — may experience

"emotional strains such as increased levels of anxiety due to a range of factors including lack of information and uncertainty regarding the timeline for care" (p. 267 (emphasis added)) or the "normal" anxiety or apprehension felt by anyone faced with a serious surgical procedure. In other words, waiting lists may be serious in some cases, but in how many cases and how serious?

(e) *The Need to Ration Services*

221 Waiting times are not only found in public systems. They are found in all health care systems, be they single-tier private, single-tier public, or the various forms of two-tier public/private (see, e.g., Kirby Report, vol. 1, at p. 111). Waiting times in Canada are not exceptional (see Kirby Report, vol. 4, at p. 41). The consequence of a quasi-unlimited demand for health care coupled with limited resources, be they public or private, is to ration services. As noted by the Arpin Report, *Constats et recommandations sur les pistes à explorer: Synthèse*, at p. 37:

> [TRANSLATION] In any health care system, be it public or private, there is an ongoing effort to strike the proper balance. . . . For a public system like our own, waiting lists, insofar as priority is given to urgent cases, do not *in themselves* represent a flaw in the system. They are the inevitable result of a public system that can consequently offer universal access to health services within the limits of sustainable public spending. Thus, to a certain extent, they play a necessary role. [Emphasis in original.]

222 The expert witnesses at trial agreed that waiting lists are inevitable (*Expertise déposée par Howard Bergman* (1998) ("Bergman Report"), at p. 5; Marmor Report, at p. 11). The only alternative is to have a substantially overbuilt health care system with idle capacity (Wright Report, at p. 6). This is not a financially feasible option, in the public *or* private sector.

(f) *Who Should Be Allowed to Jump the Queue?*

223 In a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status (see, e.g., Turcotte Report, at pp. 4 and 10; Denis Report, at p. 11; Clair Report, at p. 129; *Rapport de la Commission d'enquête sur les services de santé et les services sociaux* (1988) ("Rochon Report"), at p. 651). As a result, there exists in Canada a phenomenon of "static queues" whereby a group of persons may remain on a waiting list for a considerable time if their situation is not pressing. Patients who are in greater need of health care are prioritized and treated before those with a lesser need (Kirby Report, vol. 5, at pp. 56-57; see also Turcotte Report, at p. 12). In general, the evidence suggests that patients who need immediate medical care receive it. There are of course exceptions, and these

exceptions are properly the focus of controversy, but in our view they can and should be addressed on a case-by-case basis.

(g) *Availability of Public Funding for Out-of-Province Medical Care*

224 Section 10 of the *Health Insurance Act* provides that in certain circumstances Quebeckers will be reimbursed for the cost of "insured services" rendered outside Quebec but in Canada (*Regulation respecting the application of the Health Insurance Act*, R.R.Q. 1981, c. A-29, s. 23.1), or outside Canada altogether (s. 23.2). There is no doubt that the power of reimbursement is exercised sparingly, and on occasion unlawfully; see for example *Stein v. Tribunal administratif du Québec*, [1999] R.J.Q. 2416 (S.C.). One of the difficulties in assessing the effectiveness of this individual remedy is that neither Dr. Chaoulli nor Mr. Zeliotis is before the Court with an actual medical problem. (The trial judge, as stated, dismissed Mr. Zeliotis' personal health complaints as unsubstantiated.) The reimbursement scheme for out-of-province services exists as a form of safety valve for situations in which Quebec facilities are unable to respond. As *Stein* shows, there are lapses of judgment, as there will be in the administration of any government plan. The existence of the individual remedy, however, introduces an important element of flexibility, if administered properly.

(h) *The Evidence Relied on by the Chief Justice and Major J. Did Not Satisfy the Trial Judge and Is Not, in Our View, Persuasive*

225 The Chief Justice and Major J. cite Dr. Lenczner as an authority at para. 114 but the trial judge pointed out that Dr. Lenczner had not been qualified as an expert witness and counsel for Mr. Zeliotis agreed (A.R., at pp. 330-31). Dr. Lenczner's comments were largely anecdotal and of little general application. He described a patient who was a golfer, and thus lost his access to his golf membership for that season. He also stated that a tear can increase over time and get to the point of being irreparable, but no studies or general evidence was adduced to show the incidence of such cases in Quebec. Our colleagues comment at para. 112 that "a person with coronary disease is [TRANSLATION] 'sitting on a bomb' and can die at any moment". This is true, of course. He or she can die at home, or in an ambulance on the way to a hospital. Again, our colleagues write, "patients die while on waiting lists" (para. 112). This, too, is true. But our colleagues are not advocating an overbuilt system with enough idle capacity to eliminate waiting lists, and such generalized comments provide no guidance for what in practical terms *would* constitute an appropriate level of resources to meet their suggested standard of "public health care of a reasonable standard within a reasonable time" (para. 105).

226 We have similar concerns about the use made by the appellants of various reports in connection with other OECD countries. These "country" reports were included in

an Interim Kirby Report but not in its final version. The Final Kirby Report's recommendation was to stick with a single-tier system. We think the Court is sufficiently burdened with conflicting evidence about our own health system without attempting a detailed investigation of the merits of trade-offs made in other countries, for their own purposes. A glance at the evidence shows why.

227 Our colleagues the Chief Justice and Major J. state, at para. 142, that in Sweden only a very small minority of the population actually utilize private insurance. Yet, the Interim Kirby Report goes on to take note of more recent trends:

> *The growing rate of the number of insured, or people on private health care insurance, is some 80% or something like that now. It is growing very fast due to the normal waiting lists and the problems within the system today*. [Emphasis in original.]
>
> (Interim Kirby Report, vol. 3, at pp. 31-32)

228 With respect to the United Kingdom, the Interim Kirby Report states:

> *One of the major reasons given by people who take private insurance is they want the peace of mind of being able to have elective operations for themselves or their families more quickly or at more convenient times than if they must depend on the National Health Service. That is seen, of course, as a cause of unfairness, which is one of the reasons that the government is committed to bringing down waiting times for National Health Service patients as rapidly as it can.* [Emphasis in original.]
>
> (Interim Kirby Report, vol. 3, at p. 38)

In fact, in the actual conclusion of vol. 3 of the Interim Kirby Report on *Health Care Systems in Other Countries*, the report's authors state (at p. 73):

> Canadians may find some consolation in the fact that Canada is not alone in confronting complex health care issues. Everywhere in the industrialized world health care policy is thoroughly intertwined with the political, social, and even cultural life of each country. As such, every health care system is unique. Therefore, no single international model constitutes a blueprint for solving the challenges confronted by the Canadian health care system. However, experts told the Committee that careful consideration must be given to the repercussions in Canada of introducing, on a piecemeal basis, changes undertaken in other countries.

229 We are not to be taken as disputing the undoubted fact that there are serious problems with the single-tier health plan in Canada. Our point is simply that bits of evidence must be put in context. With respect, it is particularly dangerous to venture selectively into aspects of foreign health care systems with which we, as Canadians, have little familiarity. At the very least such information should be filtered and analysed at trial through an expert witness.

230 Taking the good with the bad, the Final Kirby Report recommended continuation of a single-tier health system (as did the Romanow Report). The authors of the Kirby Report were fully aware of the extracts from their interim report relied upon by our colleagues the Chief Justice and Major J., yet they specifically rejected two-tier health care:

> Repeated public opinion polling data have shown that having to wait months for diagnostic or hospital treatment is the greatest concern and complaint that Canadians have about the health care system. The solution to this problem is not, as some have suggested, to allow wealthy Canadians to pay for services in a private health care institution. Such a solution would violate the principle of equity of access. The solution is the care guarantee as recommended in this report. [Emphasis added.]
>
> (Final Kirby Report, vol. 6, at p. 321)

We thus conclude that our colleagues' extracts of some of the *tour d'horizon* data published in the Interim Kirby Report do not displace the conclusion of the trial judge, let alone the conclusion of the Kirby Report itself. Apart from everything else, it leaves out of consideration the commitment in principle in this country to health care based on need, not wealth or status, as set out in the *Canada Health Act*.

(2) Arbitrariness

231 Our colleagues the Chief Justice and Major J. take the view that a law which arbitrarily violates life or security of the person is unconstitutional. We agree that this is a principle of fundamental justice. We do not agree that it applies to the facts of this case.

232 A deprivation of a right will be arbitrary and will thus infringe s. 7 if it bears no relation to, or is inconsistent with, the state interest that lies behind the legislation: *Rodriguez*, at pp. 619-20; *Malmo-Levine*, at para. 135. As Sopinka J. explained in *Rodriguez*, at pp. 594-95:

> Where the deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems to me that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose. . . . It follows that before one can determine that a statutory provision is contrary to fundamental justice, the relationship between the provision and the state interest must be considered. One cannot conclude that a particular limit is arbitrary because (in the words of my colleague, McLachlin J. at pp. 619-20) "it bears no relation to, or is inconsistent with, the objective that lies behind the legislation" without considering the state interest and the societal concerns which it reflects. [Emphasis added.]

233 We agree with our colleagues the Chief Justice and Major J. that a law is arbitrary if "it bears no relation to, or is inconsistent with, the objective that lies behind [the legislation]" (para. 130). We do not agree with the Chief Justice and Major J. that the prohibition against private health insurance "bears no relation to, or is inconsistent with" the preservation of access to a health system based on need rather than wealth in accordance with the *Canada Health Act*. We also do not agree with our colleagues' expansion of the *Morgentaler* principle to invalidate a prohibition simply because a court believes it to be "unnecessary" for the government's purpose. There must be more than that to sustain a valid objection.

234 The accepted definition in *Rodriguez* states that a law is arbitrary only where "it bears no relation to, or is inconsistent with, the objective that lies behind the legislation". To substitute the term "unnecessary" for "inconsistent" is to substantively alter the meaning of the term "arbitrary". "Inconsistent" means that the law logically contradicts its objectives, whereas "unnecessary" simply means that the objective could be met by other means. It is quite apparent that the latter is a much broader term that involves a policy choice. If a court were to declare unconstitutional every law impacting "security of the person" that the court considers unnecessary, there would be much greater scope for intervention under s. 7 than has previously been considered by this Court to be acceptable. (In *Rodriguez* itself, for example, could the criminalization of assisted suicide simply have been dismissed as "unnecessary"? As with health care, many jurisdictions have treated euthanasia differently than does our *Criminal Code*.) The courts might find themselves constantly second-guessing the validity of governments' public policy objectives based on subjective views of the*necessity* of particular means used to advance legitimate government action as opposed to other means which critics might prefer.

235 Rejecting the findings in the courts below based on their own reading of the evidence, our colleagues the Chief Justice and Major J. state (at para. 128):

> We are of the opinion that the evidence before the trial judge supports a finding that the impugned provisions are arbitrary and that the deprivation of life and

security of the person that flows from them cannot therefore be said to accord with the principles of fundamental justice.

We note that our colleagues refer to the evidence before the trial judge rather than the view taken of that evidence by the trial judge. The trial judge reached a contrary conclusion on the facts, and deference is due to her view of that evidence; see *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235, 2002 SCC 33. In any event, with respect, we accept the contrary conclusions of the trial judge and the Quebec Court of Appeal. We approach the issue of arbitrariness in three steps:

(i) What is the "state interest" sought to be protected?

(ii) What is the relationship between the "state interest" thus identified and the prohibition against private health insurance?

(iii) Have the appellants established that the prohibition bears no relation to, or is inconsistent with, the state interest?

We will address each question in turn.

(a) *What Is the "State Interest" Sought To Be Protected?*

236 Quebec's legislative objective is to provide high quality health care, at a reasonable cost, for as many people as possible in a manner that is consistent with principles of efficiency, equity and fiscal responsibility. Quebec (along with the other provinces and territories) subscribes to the policy objectives of the *Canada Health Act*, which include (i) the equal provision of medical services to all residents, regardless of status, wealth or personal insurability, and (ii) fiscal responsibility. An overbuilt health system is seen as no more in the larger public interest than a system that on occasion falls short. The legislative task is to strike a balance among competing interests.

237 The appellants do not challenge the constitutional validity of the objectives set out in the *Canada Health Act*. Thus our job as judges is not to agree or disagree with these objectives but simply to determine whether the *means* adopted by Quebec to *implement* these objectives are arbitrary.

(b) *What Is the Relationship Between the "State Interest" Thus Identified and the Prohibition Against Private Health Insurance?*

238 The relationship lies both in principle and in practicality.

239 In principle, Quebec wants a health system where access is governed by need rather than wealth or status. Quebec does not want people who are uninsurable to be left behind. To accomplish this objective endorsed by the *Canada Health Act*, Quebec seeks to discourage the growth of private-sector delivery of "insured" services based on wealth and insurability. We believe the prohibition is rationally connected toQuebec's objective and is not inconsistent with it.

240 In practical terms, Quebec bases the prohibition on the view that private insurance, and a consequent major expansion of private health services, would have a harmful effect on the public system.

241 The trial judge put her conclusion this way (at p. 827):

> [TRANSLATION] The *Health Insurance Act* ["HEIA"] and the *Hospital Insurance Act* ["HOIA"] are pieces of legislation whose*purpose is to create and maintain a public health care plan open to all residents of Quebec*. These enactments *are intended to promote the overall health of all Quebeckers without discrimination based on economic circumstances*. In short, they constitute a government action whose *purpose is to promote the well-being of all the people of the province*.
>
> Plainly, s. 15 HEIA and s. 11 HOIA erect economic barriers to access to private health care. However, these measures are not really intended to limit access to health care; rather, their *purpose is to prevent the establishment of a parallel private system*. These provisions are based on the fear that the establishment of a private health care system would rob the public sector of a significant portion of the available health care resources. *The Quebec government enacted s. 15 HEIA and s. 11 HOIA to guarantee that virtually all the existing health care resources in Quebec would be available to all the people of Quebec. That is clear.*
>
> *The purpose* of the impugned provisions *is to guarantee equal and adequate access* to health care *for all Quebeckers*. The enactment of s. 15 HEIA and s. 11 HOIA *was motivated by considerations of equality and human dignity, and it is therefore clear that there is no conflict with the general values expressed in the Canadian Charter or in the Quebec Charter of human rights and freedoms*. [Emphasis in original.]

We agree.

(c) *Have the Appellants Established That the Prohibition Bears No Relation to, or Is Inconsistent With, the State Interest?*

242 The trial judge considered all the evidence and concluded that the expansion of private health care would undoubtedly have a negative impact on the public health system (at p. 827):

> [TRANSLATION] The evidence has shown that the right of access to a parallel private health care system claimed by the applicants*would have repercussions on the rights of the population as a whole. We cannot bury our heads in the sand. The effect of establishing a parallel private health care system would be to threaten the integrity, proper functioning and viability of the public system*. Section 15 HEIA and s. 11 HOIA prevent this from happening and secure the existence in Quebec of a public health care system of high quality.
>
> As well, the Court finds that s. 15 HEIA and s. 11 HOIA *are not overbroad*. The only way to guarantee that all the health care resources will benefit all Quebeckers without discrimination is to prevent the establishment of a parallel private health care system. That is in fact the effect of the impugned provisions in the case at bar. [Emphasis in original.]

These findings were explicitly adopted by Forget J.A. of the Court of Appeal and implicitly endorsed by the other judges of that court. The trial judge relied on the reports available to her in rejecting the appellants' constitutional challenge, and none of the material that has since been added (such as the Romanow Report) changes or modifies the correctness of her conclusion, in our view. We therefore agree with the trial judge and the Quebec Court of Appeal that the appellants failed to make out a case of "arbitrariness" on the evidence. Indeed the evidence proves the contrary. We now propose to review briefly some of the evidence supporting the findings of the trial judge.

(i) A Parallel Private Regime Will Have a Negative Impact on Waiting Times in the Public System

243 The appellants' argument in favour of a parallel private regime is one of a "win/win" prediction; i.e., that waiting times in the public regime will be reduced if those who can afford private insurance leave the public waiting lists in order to receive private health care. However, the Kirby Report states flatly that "allowing a private parallel system will . . . make the public waiting lines worse" (vol. 4, at p. 42 (emphasis added)). This conclusion is supported by the Romanow Report (p. 139: "[P]rivate facilities may improve waiting times for the select few . . . but . . . worse[n them for the many]"), the Turcotte Report (pp. 13-14), and the expert witnesses at trial (Marmor Report; Wright Report; and Bergman Report).

244 A study of a Manitoba pilot project found that in the case of cataract operations, public health patients who went to surgeons working in both private and public clinics waited far longer than patients who went to surgeons working only in the public system. The same private sector patient preference is evident from other studies and experience: See Wright

Report, at p. 17; Bergman Report, at p. 8; J. Hurley et al., *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada* (2002); C. DeCoster, L. MacWilliam and R. Walld, *Waiting Times for Surgery: 1997/98 and 1998/99 Update* (2000); W. Armstrong, *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft* (2000); Canadian Health Services Research Foundation, *Mythbusters — Myth: A parallel private system would reduce waiting times in the public system* (2001); Québec, Rapport du Conseil de la santé et du bien-être social, *Le financement privé des services médicaux et hospitaliers* (2003), at p. 30.

245 The Australian experience, as reported by Dr. Wright, is that at present delays in the Australian public system are caused largely by surgeons' reluctance to work in public hospitals and by their encouragement of patients to use the private system on a preferential basis (Wright Report, at p. 15; Hurley, at p. 17).

246 The same is true for the United Kingdom, which has a two-tier health system where physicians who want to practise privately are required to practise a minimum number of hours in the public system. There, an Audit Commission of the National Health Service reported that surgeons do on average a third to half again as many operations for private fees as they do in the public system, and that they spend less time than they are contracted for working in the public system in order to conduct private practice (Wright Report, at p. 16; see also *Le financement privé des services médicaux et hospitaliers*, at p. 30).

247 Both the Romanow Report and the Kirby Report examine the current shortage of health care professionals in Canada (Kirby Report, vol. 2, at p. 76, and vol. 4, at pp. 7 and 107; Romanow Report, at p. 92), and in rural parts of Canada in particular (Kirby Report, vol. 2, at p. 137; Romanow Report, at p. 166). Dr. Wright testified that the experience in all jurisdictions with two-tier health care systems (e.g., the United Kingdom, Australia, New Zealand and Israel) demonstrates a diversion of energy and commitment by physicians and surgeons from the public system to the more lucrative private option (Wright Report, at pp. 15 and 22). This evidence is supported by the Romanow Report (at p. 92), the Kirby Report (vol. 1, at p. 105) and a 2003 Quebec report (*Le financement privé des services médicaux et hospitaliers*, at p. 6). See also Marmor Report (at p. 5) and Denis Report (at p. 14). Furthermore, the experts testified that there are no firm data whatsoever showing that a parallel private system would enhance potential for recruiting highly trained specialists (see Wright Report, at p. 19).

(ii) The Impact of a Parallel Private Regime on Government Support for a Public System

248 The experience in other OECD countries shows that an increase in private funding typically leads to a decrease in government funding (*Le financement privé des services médicaux et hospitaliers*, at p. 7; Marmor Report, at p. 6). At trial, Dr. Bergman explained that a service designed purely for members of society with less socio-economic power would probably lead to a decline in quality of services, a loss of political support and a decline in the quality of management (Bergman Report, at pp. 6-7; see also Marmor Report, at pp. 6 and 8; Denis Report, at p. 5).

(iii) Private Insurers May "Skim the Cream" and Leave the Difficult and Costly Care to the Public Sector

249 The evidence suggests that parallel private insurers prefer to siphon off high income patients while shying away from patient populations that constitute a higher financial risk, a phenomenon known as "cream skimming" (Wright Report, at p. 17; Kirby Report, vol. 6, at p. 301). The public system would therefore carry a disproportionate burden of patients who are considered "bad risks" by the private market by reason of age, socio-economic conditions, or geographic location.

250 Similarly, private insurers may choose to avoid "high-risk" surgery. The public system is likely to wind up carrying the more complex high acuity end of the health care spectrum and, as a consequence, increase rather than reduce demand (proportionately) in the public system for certain services (Wright Report, at p. 18).

(iv) The U.S. Two-Tier System of Health Coverage

251 Reference has already been made to the U.S. health care system, which is the most expensive in the world, even though by some measures Americans are less healthy than Canadians (Kirby Report, vol. 1, at p. 101, and vol. 4, at p. 28; Romanow Report, at p. 14). The existence of a private system has not eliminated waiting times. The availability, extent and timeliness of health care is rationed by private insurers, who may determine according to cost, not need, what is "medically" necessary health care and where and when it is to occur (Kirby Report, vol. 3, at p. 48; Denis Report, at pp. 12 and 16). Whether or not the private system in the U.S. is better managed is a matter of debate amongst policy analysts. The point here is simply that the appellants' faith in the curative power of private insurance is not borne out by the evidence put before the Court.

(v) Moreover the Government's Interest in Fiscal Responsibility and Efficiency May Best Be Served by a Single-Tier System

252 The expert witnesses at trial (other than the appellants' witness Dr. Coffey), the Romanow Report and the Kirby Report all agree that the most cost-effective method of providing health care is through public single-tier financing. Dr. Wright testified at trial that the "public administration criterion [of the *Canada Health Act*] renders the Canadian Health Care System one of the most efficient in terms of the ratio of productivity to administrative costs in the world" (Wright Report, at p. 2; see also Marmor Report, at p. 9; Denis Report, at p. 8; Kirby Report, vol. 3, at p. 67, and vol. 4, at p. 23; Romanow Report, at p. 43; *The World Health Report 1999: Making a Difference* (1999); Report of the National Advisory Council on Aging, *The NACA Position on the Privatization of Health Care* (1997), at p. 14).

253 In particular, much is saved in a single-tier public system as a result of lower administrative costs and advertising expenses, the absence of overhead and the fact that the risk is spread over the entire population (see Romanow Report, at pp. 60ff; Kirby Report, vol. 4, at p. 31).

254 Not only is there "no evidence [that the] adoption [of a private health care system] would produce a more efficient, affordable or effective system" (Romanow Report, at p. xxiv), there is also no clear evidence that private surgical services are more efficient or less costly (Wright Report, at p. 14; Romanow Report, at p. 8; *Le financement privé des services médicaux et hospitaliers*, at pp. 23 and 33).

255 With respect to the impact on the financial resources of the public system, the experts testified that the introduction of a parallel private health regime would likely increase the overall cost of health care to Canadians (Marmor Report, at pp. 8 and 10; Bergman Report, at p. 7; Turcotte Report, at p. 11; see also *Le financement privé des services médicaux et hospitaliers*, at p. 24).

(vi) Conclusion on "Arbitrariness"

256 For all these reasons, we agree with the conclusion of the trial judge and the Quebec Court of Appeal that in light of the legislative objectives of the *Canada Health Act* it is not "arbitrary" for Quebec to discourage the growth of private sector health care. Prohibition of private health insurance is directly related to Quebec's interest in promoting a need-based system and in ensuring its viability and efficiency. Prohibition of private insurance is not "inconsistent" with the state interest; still less is it "unrelated" to it.

257 In short, it cannot be said that the prohibition against private health insurance "bears no relation to, or is inconsistent with" preservation of a health system predominantly based on need rather than wealth or status, as required by the *Rodriguez* test, at pp. 594-95.

258 As to our colleagues' dismissal of the factual basis for Quebec's legislative choice, the public has invested very large sums of money in a series of authoritative reports to analyse health care in this country and in other countries. The reports uniformly recommend the retention of single-tier medicine. People are free to challenge (as do the appellants) the government's reliance on those reports but such reliance cannot be dismissed as "arbitrary". People are also free to dispute Quebec's strategy, but in our view it cannot be said that a single-tier health system, and the prohibition on private health insurance designed to protect it, is a legislative choice that has been adopted "arbitrarily" by the Quebec National Assembly as that term has been understood to date in the *Canadian Charter* jurisprudence.

(3) The *Morgentaler* Case Is Not Applicable

259 Our colleagues the Chief Justice and Major J. rely substantially on comments made by Beetz J. (concurred in by Estey J.) in *Morgentaler*when he invoked a principle of "manifest unfairness". Nowhere in his analysis pertaining to the principles of fundamental justice did Beetz J. use the words "arbitrary" or "arbitrariness". Moreover the context for his remarks was the prospect of a criminal prosecution of a pregnant woman. Section 251(2) of the *Criminal Code* stated that a pregnant woman who used "any means or permit[ted] any means to be used" for the purpose of procuring her own miscarriage was guilty of an indictable offence punishable with imprisonment for two years. Parliament provided a defence if the continued pregnancy would or would be likely to, in the opinion of a therapeutic abortion committee, "endanger her life or health" (s. 251(4)(*c*)). The Court struck down the criminal prohibition because the prohibition was designed to operate only with the statutory defence, and the Court found that in practice these committees operated unevenly and that the statutory scheme "contain[ed] so many potential barriers to its own operation that the defence it create[d would] in many circumstances be practically unavailable to women who would *prima facie* qualify . . . ." (pp. 72-73, *per* Dickson C.J.). For Beetz J., too, a key issue was that a significant proportion of Canada's population is not served by hospitals in which therapeutic abortions could lawfully be performed (pp. 94-95).

260 At page 81, Beetz J. went on to say that "s. 7 of the *Charter* must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction" (emphasis added). The context of this appeal is entirely different. This case, on the contrary, invites the application of the *dictum* of Dickson C.J. in *Morgentaler* "that the courts should avoid 'adjudication of the merits of public policy'" (p. 53).

261 There were two aspects of s. 251 which caused Beetz J. particular concern. Firstly, s. 251 required that abortions be performed in an "eligible hospital", and not in clinics like those operated by Dr. Morgentaler (p. 114). This limitation, he found, had no logical connection with the state's avowed interest "in the protection of the foetus" (p. 115), i.e., the termination of the foetus would be the same wherever the abortion was performed. Secondly, Beetz J. objected to "the requirement that the committee come from the accredited or approved hospital in which the abortion is to be performed" (p. 119). He said:

> It is difficult to see a connection between this requirement and any of the practical purposes for which s. 251(4) was enacted. It cannot be said to have been adopted in order to promote the safety of therapeutic abortions or the safety of the pregnant woman. Nor is the rule designed to preserve the state interest in the foetus. [p. 119]

262 There is, we think, a world of difference between the sort of statutory analysis conducted by Beetz J. in *Morgentaler* and the re-weighing of expert evidence engaged in by our colleagues the Chief Justice and Major J. in this case. Having established that the s. 251 requirements had nothing to do with the avowed state interest in the protection of the foetus, all that remained in *Morgentaler* was to show that these requirements were inconsistent with the competing state interest in preserving the life and health of the mother. We see no parallel between the analysis of Beetz J. in*Morgentaler* and what is asked of the Court by the appellants in this case.

263 On the contrary, given its goal of providing necessary medical services to all Quebec residents based on need, Quebec's determination to protect the equity, viability and efficiency of the public health care system is rational. The chosen means are designed to further the state interest and not (as in *Morgentaler*) to contradict it.

264 The safety valve (however imperfectly administered) of allowing Quebec residents to obtain essential health care outside the province when they are unable to receive the care in question at home in a timely way is of importance. If, as the appellants claim, this safety valve is opened too sparingly, the courts are available to supervise enforcement of the rights of those patients who are directly affected by the decision on a case-by-case basis. Judicial intervention at this level on a case-by-case basis is preferable to acceptance of the appellants' global challenge to the entire single-tier health plan. It is important to emphasize that rejection of the appellants' global challenge to Quebec's health plan would not foreclose individual patients from seeking individual relief tailored to their individual circumstances.

(4) Conclusion Under Section 7 of the *Canadian Charter*

265 For the foregoing reasons, even accepting (as we do) the trial judge's conclusion that the claimants have established a deprivation of the life and security of some Quebec residents occasioned in some circumstances by waiting list delays, the deprivation would not violate any legalprinciple of fundamental justice within the meaning of s. 7 of the *Canadian Charter*. On that point, too, we share the opinion of the trial judge and theQuebec Court of Appeal, as previously mentioned.

D. *The Appellants' Challenge Under the Quebec Charter*

266 The *Quebec Charter* is a major quasi-constitutional instrument. Our colleague Deschamps J. finds a violation of s. 1, which provides:

> **1.** Every human being has a right to life, and to personal security, inviolability and freedom.
>
> He also possesses juridical personality.

267 Section 1 of the *Quebec Charter* must be read with s. 9.1:

> **9.1** In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Québec.
>
> In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law.

268 The factual basis of the opinion of our colleague Deschamps J. seems to rest largely on her view of the problem of waiting lists in Quebec, a matter we have already discussed, commencing at para. 210.

269 As to the legal principles applicable under the *Quebec Charter*, our Court in *Irwin Toy Ltd. v. Quebec (AttorneyGeneral)*, [1989] 1 S.C.R. 927, noted a functional analogy between s. 1 of the *Canadian Charter* and s. 9.1 of the*Quebec Charter*. However, s. 9.1 has the added feature of placing on the claimant the obligation to exercise *Quebec Charter* rights with "proper" regard to "democratic values, public order and the general well-being of the citizens of Québec". These

limitations have particular relevance to the public health system context of the present claim.

270 Within the legislative jurisdiction of the National Assembly of Quebec, absent an express provision to the contrary, other statutes may not derogate from its ss. 1-38 (s. 52). It was adopted and came into force several years before the *Canadian Charter*. It applies not only to state action but also to many forms of private relationships. It often covers the same grounds as the *Canadian Charter*. Nevertheless, it remains distinct in its drafting and methodology (A. Morel, "La coexistence des Chartes canadienne et québécoise: problèmes d'interaction" (1986), 17 *R.D.U.S.* 49, at pp. 80-81; *Godbout v. Longueuil (Ville de)*, [1995] R.J.Q. 2561 (C.A.), at p. 2568, *per* Baudouin J.A.).

271 Section 1 of the *Quebec Charter*, in essence, covers about the same ground as s. 7 of the *Canadian Charter*, but it does not mention the principles of fundamental justice. As stated earlier, it reads:

> **1.** Every human being has a right to life, and to personal security, inviolability and freedom.
>
> He also possesses juridical personality.

272 Under s. 1 of the *Quebec Charter*, as at the first stage of a s. 7 analysis, the claimant bears the burden of establishing, on a balance of probabilities, that the impugned law infringes his or her protected rights and interests. If such a claim is made out, the focus of the analysis may shift tos. 9.1 of the *Quebec Charter* in order to determine whether the claimed exercise of the right is made with due regard for "democratic values, public order and the general well-being of the citizens of Québec".

273 In our view, on the evidence, the exercise by the appellants of their claimed *Quebec Charter* rights to defeat the prohibition against private insurance would not have "proper regard for democratic values" or "public order", as the future of a publicly supported and financed single-tier health plan should be in the hands of elected representatives. Nor would it have proper regard for the "general well-being of the citizens of Québec", who are the designated beneficiaries of the health plan, and in particular for the well-being of the less advantaged Quebeckers.

274 Those who seek private health insurance are those who can afford it and can qualify for it. They will be the more advantaged members of society. They are differentiated

from the general population, not by their health problems, which are found in every group in society, but by their income status. We share the view of Dickson C.J. that the *Canadian Charter* should not become an instrument to be used by the wealthy to "roll back" the benefits of a legislative scheme that helps the poorer members of society. He observed in *Edwards Books*, at p. 779:

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

The concern, of course, is that once the health needs of the wealthier members of society are looked after in the "upper tier", they will have less incentive to continue to pressure the government for improvements to the public system as a whole.

275 The comments of Dickson C.J. are even more relevant to the *Quebec Charter* given its broad scope and its potential application to a wide range of private relationships.

276 This is not a case, in our view, where the onus of proof determines the outcome. The evidence amply supports the validity of the prohibition of private insurance under the *Quebec Charter*. The objectives are compelling. A rational connection is demonstrated. The decision boils down to an application of the minimal impairment test. In respect of questions of social and economic policy, this test leaves a substantial margin of appreciation to the Quebec legislature. Designing, financing and operating the public health system of a modern democratic society like Quebecremains a challenging task. It calls for difficult choices. In the end, we find that the choice made a generation ago by the National Assembly ofQuebec remains within the range of options that are justifiable under s. 9.1. Shifting the design of the health system to the courts is not a wise choice.

277 In this respect, we should bear in mind that the legislative provisions challenged under s. 1 concern all citizens of Quebec. They address concerns shared by all and rights belonging to everyone. The legislative solution affects not only individuals but also the society to which all those individuals belong. It is a problem for which the legislature attempted to find a solution that would be acceptable to everyone in the spirit of the preamble of the *Quebec Charter*:

> WHEREAS every human being possesses intrinsic rights and freedoms designed to ensure his protection and development;

> Whereas all human beings are equal in worth and dignity, and are entitled to equal protection of the law;
>
> Whereas respect for the dignity of the human being and recognition of his rights and freedoms constitute the foundation of justice and peace;
>
> Whereas the rights and freedoms of the human person are inseparable from the rights and freedoms of others and from the common well-being;
>
> . . .

278 The evidence reviewed above establishes that the impugned provisions were part of a system which is mindful and protective of the interests of all, not only of some.

279 We would dismiss the appeal.