

Policy, Legal, and Constitutional Implications of *Chaoulli v. Quebec*

**A Thesis Submitted to the
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By Bart Morley Johnson

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ABSTRACT

The central objective of this study is to examine the policy, legal, and constitutional implications resulting from the *Chaoulli v. Quebec* (2005 1 S.C.R. 791) both for the rights of Canadians within the scope of the publicly funded healthcare system and the configuration of that system. In examining the policy implications the thesis focuses on Quebec's Bill 33, Ralph Klein's "Third Way" proposal, and the development of national wait time benchmarks. In examining the legal implications the thesis focuses on the so-called 'copy-cat cases' triggered by the *Chaoulli* case, namely *Flora v. Ontario*, *Murray v. Alberta*, and *McCreith and Holmes v. Ontario*. In examining the constitutional implications of *Chaoulli* the thesis focuses on the expansion of the interpretation of Section 7 of the *Charter of Rights and Freedoms*, and the elevation of timely access to healthcare to a *Charter* right.

The study concludes with some observations regarding how Canada's publicly funded healthcare system could evolve in the future and the role of the courts in the evolution of the system. It provides a warning that if appropriate and timely action is not taken by federal and provincial officials to minimize wait times in the publicly funded healthcare system, the implications of *Chaoulli* will continue to expand through future litigation and judicial decisions. One of the potential outcomes of such litigation and decisions is development of a two-tier or multi-tier healthcare system in Canada.

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CHAPTER 1: INTRODUCTION

1.1 Background: *Chaoulli v. Quebec*

Many Canadians consider Canada's universal public healthcare system to be a defining attribute of our national identity. D. Martin Low, Q.C., Lydia Wakulowsky, and Geoff Moysa note that since the 1960s Canada has worn its "uniquely world-class" universal medicare system proudly on its sleeve.¹ Lloyd Axworthy and Jerry Spiegel (2002) agree that from the beginning Canadians have been devoted to health care equity, viewing universal access to care as a fundamental human right.²

Despite a number of problems with Canada's public health system, including long wait times in emergency rooms, a lack of specialists, inadequate diagnostic equipment, and disparities between provinces, Canadians still show an overwhelming amount of support for public healthcare.³ In 2000, Statistics Canada found that 84.4% of Canadians rated the quality of overall health services in Canada as being either excellent or very good.⁴

However, some Canadians have never been comfortable with Canada's universal healthcare system and would prefer a two-tier or private healthcare system. They argue

¹ Martin Low, Q.C. et al., "Failing on the Fundamentals: The *Chaoulli* Decision," *Law and Governance* (14 June 2005), accessed online at <http://www.longwoods.com/product.php?productid=17188&page=7> (Retrieved 12 December 2007).

² Lloyd Axworthy and Jerry Spiegel, "Retaining Canada's health care system as a global public good," *The Canadian Medical Association Journal* (CMAJ) (20 August 2002), accessed online at <http://www.cmaj.ca/cgi/content/full/167/4/365#R2-22> (Retrieved 12 December 2007).

³ Wendy Tso, "The Debate over Canada's Healthcare System," The Centre for Constitutional Studies: University of Alberta (2007), accessed online at <http://www.law.ualberta.ca/centres/ccs/Current-Constitutional-Issues/The-Debate-over-Canadas-Healthcare-System.php> (Retrieved 22 December 2007).

⁴ Canada, Government of Canada, Department of Health, "Healthy Canadians: A Federal Report on Comparable Health Indicators 2002," (31 March 2006), accessed online at http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2002-fed-comp-indicat/2002-health-sante7_e.html (Retrieved 12 December 2007).

that public health care acts an impediment to ensuring that Canadians receive timely access to the kind of medical services they deserve, and believe that a private system running alongside the current public system would provide more treatment options and more efficient cost effective services through competition.⁵ As a result, a profit vs. not-for-profit healthcare debate has been in existence since the beginning of medicare.⁶

The Canadian Independent Medical Clinics Association (CIMCA) notes that support for private healthcare initiatives has picked up steam in the past decade.⁷ Dr. Brian Day, President of the Canadian Medical Association (CMA), indicates that one reason for increased support has been increasingly long wait lists in the public system. In 2006 Day told the CIMCA that there are nearly a million people on waiting lists who are frustrated with the public system and tired of putting their lives on hold.⁸ Similarly, the Canadian Institute for Health Information (CIHI) found that 32% of Canadians were unsatisfied with wait times in 2002-03.⁹

Consequently, wait times began to become the focus of intense media coverage and public debate as they steadily increased following the large budget deficits and cuts to transfer payments in the 1990's.¹⁰ Lawrie McFarlane, Deputy Minister of Health for British Columbia (2005), indicates that most of the concern was on elective surgery and,

⁵ CBC News, "Public vs. private health care," *CBC In Depth: Healthcare* (1 December 2006), accessed online at http://www.cbc.ca/news/background/healthcare/public_vs_private.html (Retrieved 11 December 2007).

⁶ Roy Romanow, "Now's the Time to Stand up for Medicare," *The Globe and Mail* (10 June 2005), accessed online at <http://www.longwoods.com/product.php?productid=17187> (Retrieved 12 December 2007).

⁷ John G. Smith, "A Snapshot of Private Healthcare in Canada." *The Canadian Independent Medical Association (CIMCA)* (2006), accessed online at http://www.cimca.ca/newsletter/issue02_04.html (Retrieved 12 December 2007).

⁸ Ibid.

⁹ The Canadian Institute for Health Information (CIHI), "Waiting for Health Care in Canada: What We Know and What We Don't Know," Ottawa (2006), vii.

¹⁰ CBC News, "Introduction," *CBC In Depth: Healthcare* (22 August 2006), accessed online at <http://www.cbc.ca/news/background/healthcare/> (Retrieved 18 December 2007).

more specifically, orthopedic surgery. He noted that between 1995 and 2000 gynecologic procedures increased by 4%, urological surgery rose 7.7%, and neurosurgery rose 8%. Much more dramatically, hip replacement surgery rose by 42%, cataract by 66%, and knee replacement surgery by 92%. As a result of an unprecedented surge in procedure volumes, wait times increased correspondingly (See Appendix A for data on wait times).¹¹

Longer wait times produced an abundance of negative media attention. John G. Smith notes that almost every day there were examples of poor public service in the press, influencing public opinion. An evolving perception of the public healthcare system changed how many patients felt about universal healthcare. Smith found that many patients began to feel they were not receiving what they needed or expected from the public system.¹² It was out of this feeling of discontent that *Chaoulli v. Quebec (Attorney General)* emerged. One man felt that he waited longer than appropriate for a required orthopedic surgery, and argued that he should have access to a separate, private system. That man was George Zeliotis, and this thesis will discuss how his case changed the face of Canadian Medicare forever.

In 1996, George Zeliotis, a 73-year-old businessman from Quebec, required hip replacement surgery and was placed on a waiting list in Montreal for approximately one year. While on the waiting list, Zeliotis claimed to be in constant pain and discomfort and wanted to pay for his surgery through a private health care facility. He also wanted to purchase private health insurance in the event that he should have any future health

¹¹ Lawrie McFarlane, "Supreme Court slaps for-sale sign on medicare," *The Canadian Medical Association Journal* (2 August 2005), 173, accessed online at <http://www.cmaj.ca/cgi/content/full/173/3/269> (Retrieved 13 December 2007).

¹² Smith, "A Snapshot of Private Healthcare in Canada."

problems.¹³ However, Quebec law prohibited Zeliotis from using private insurance to pay for “medically necessary” services. His only options were to wait for the surgery in pain or pay for the surgery out of his own pocket.¹⁴

Dr. Jacques Chaoulli, a controversial physician who provided medical services to patients at their homes and had attempted to establish a private and autonomous hospital of his own, heard about Mr. Zeliotis’s pain and frustration and contacted him.¹⁵ Together, Dr. Chaoulli and Mr. Zeliotis challenged Quebec legislation that prohibited the purchase of private health insurance.

They took their case to the Quebec Superior Court in 1997, challenging section 11 of the *Hospital Insurance Act (HOIA)* and section 15 of the *Health Insurance Act (HEIA)* on the grounds that prohibitions against the right to purchase private health insurance violated Mr. Zeliotis’s freedoms under section 1 of the *Quebec Charter* and sections 7 and 15(1) of the *Canadian Charter* (to view these specific statutes see Appendix B).¹⁶

D. Martin Low, Q.C., a constitutional legal expert, summed up the crux of their argument thus—that forcing patients to wait extensive periods of time without recourse violates their rights to life and personal security. He isolated the vital question posed to the courts as “whether the prohibition is justified by the need to preserve the integrity of the public health system.”¹⁷

In February 2000, Justice Ginette Piche of the Quebec Superior Court rejected the claims made by Chaoulli and Zeliotis. She severely criticized the plaintiffs’ case,

¹³ Fasken Martineau DuMoulin LLP, “Chaoulli v. Quebec (Attorney General) A new frontier for Canadian health care?” *Health Law Bulletin* (June 2005), 2.

¹⁴ Low, et al., “Failing on the Fundamentals: The Chaoulli Decision.”

¹⁵ *Ibid.*

¹⁶ Graeme G. Mitchell (G.C.), “‘The Sky is Falling’: An Uncommon Perspective on Chaoulli v. Quebec (Attorney General) and its Progeny,” *Saskatchewan Legal Education Society Civil Law Charter Update* (March 2007), 3.

¹⁷ Low, et al., “Failing on the Fundamentals: The Chaoulli Decision.”

pronouncing that individual rights to private insurance were superceded by the collective rights of the population.¹⁸ In November 2001, Chaoulli and Zeliotis appealed their case to the Quebec Court of Appeal. However, their attempts were not rewarding, as all three appellate court judges upheld Justice Piche's decisions in concurrent decisions delivered in April 2002. Justices Delisle and Brossard stated that this was not a "section 7" case, inasmuch as economic rather than fundamental human rights were affected.¹⁹

Following this decision, Chaoulli and Zeliotis turned their efforts towards Canada's top court, the Supreme Court of Canada. In May 2003 they were granted leave to appeal, and by this time the case had moved from one man's lone crusade to a public debate about the future of health care in Canada.²⁰ Chaoulli and Zeliotis brought their case before the seven justices of the Supreme Court on June 8, 2004. One year later, on June 9, 2005, the Supreme Court delivered its judgment. In a controversial and narrow 4:3 decision, the Supreme Court overturned the Quebec courts and ruled in favor of Chaoulli, striking down Quebec laws that prohibited the sale of private health insurance on the basis that they violate *Quebec's Charter of Rights and Freedoms*. Of the 7 judges, 3 of them also found these laws to be in violation of section 7 of *the Charter of Rights and Freedoms*.²¹ Colleen M. Flood notes that as a result there is a prospect that comparable laws in other provinces could be struck down.²² Referring to the decision as a potential "constitutional coup d'etat on Medicare,"²³ D. Martin Low, Q.C., Lydia

¹⁸ Antonia Maioni and Christopher Manfredi, "When the Charter Trumps Health Care – A Collision of Canadian Icons," *Policy Options* (September 2005), 53.

¹⁹ Low, et al., "Failing on the Fundamentals: The Chaoulli Decision."

²⁰ Maioni and Manfredi. "When the Charter Trumps Health Care – A Collision of Canadian Icons," 54.

²¹ Colleen M. Flood, "Supreme disagreement: The highest court affirms an empty right," *The Canadian Medical Association Journal (CMAJ)* (20 June 2005), accessed online at <http://www.cmaj.ca/cgi/rapidpdf/cmaj.050759v1> (Retrieved 2 November 2007).

²² Ibid.

²³ Low, et al., "Failing on the Fundamentals: The Chaoulli Decision."

Wakulowsky and Geoff Moysa agree that the divided and complex judgment may be the genesis of private health insurance in Canada.²⁴

1.3 Focus, Objectives and Research Questions

When the Supreme Court of Canada ruled in favor of Jacques Chaoulli, a new chapter in the debate over Canada's approach to publicly funded healthcare began. As a result of the narrow 4-3 decision, defenders of Canada's single-payer system argue that the court's decision was like opening Pandora's Box. They believe that the Supreme Court's ruling will result in a parallel private system that will siphon health professionals from the publicly funded system, in turn reducing the overall quality of healthcare to Canadians who cannot afford private insurance.²⁵ However, critics of Canadian healthcare welcome the decision to uphold individual rights against a state monopoly, recognizing that the demand for health services will often exceed supply, and acknowledging the limits of Canadian Medicare.²⁶

The primary objective of this thesis is to put opinions aside and determine whether the *Chaoulli* decision started a revolution towards privatization that will inevitably destroy the public healthcare system as we know it, or whether it was merely a wake-up call for governments and citizens devoted to the idea of universal healthcare.²⁷ In order to achieve this objective, this thesis seeks to address the following research questions:

²⁴ Mark Kennedy, "Medicare Future at Stake: High Court rule on private-care ban legality," *The National Post* (Front Page) (8 June 2005), accessed online at <http://www.healthcoalition.ca/chaoulli-release.pdf> (Retrieved 12 December 2007).

²⁵ Patrick J. Monahan, "Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the 'Sixth Principle' of the Canada Health Act," (Toronto: C.D. Howe Institute Benefactors Lecture, 29 November 2006), Forward.

²⁶ *Ibid.*

²⁷ Steven Lewis, "Medicare's fate: Are we fiddlers or firefighters?" *Winnipeg Free Press* (15 June 2005).

1. What are the policy implications of *Chaoulli v. Quebec*?
2. What are the legal implications of *Chaoulli v. Quebec*?
3. What are the constitutional implications of *Chaoulli v. Quebec*?

For clarification purposes, the “policy implications” discussed in this thesis include any sort of statutory or programmatic reform that was developed in response to the *Chaoulli* decision, and any initiatives undertaken by any interest groups that have the potential to affect the development of public policy. The “legal implications” refer to subsequent court challenges in other provinces that attempt to expand the precedent set in *Chaoulli* across Canada, or to use the *Chaoulli* decision to challenge existing healthcare legislation. The “constitutional implications” address any changes in the way the *Charter of Rights and Freedoms* is interpreted, affecting the development of future court challenges and subsequent public policy.

1.4 Organization of Thesis

The policy, legal, and constitutional implications of *Chaoulli v. Quebec* are presented in five subsequent chapters:

Chapter 2, *Understanding Chaoulli – An Analysis of the Decision*, clarifies exactly what was decided in *Chaoulli* by examining the three sets of arguments of the Supreme Court justices. This analysis provides a necessary foundation for the discussion of the policy, legal, and constitutional implications of the decision.

Chapter 3, *Policy Implications of Chaoulli*, looks at the development of *Chaoulli*-specific policies since the Supreme Court’s decision was handed down on June 2005. In particular, three policy implications are discussed in this chapter. The first is the

examination of a statute passed by Quebec, namely, Bill 33, which was Quebec's response to *Chaoulli*. The second is the assessment of a provincial discussion paper, Ralph Klein's "Third Way" proposal, which was Alberta's response to *Chaoulli*. The third is the evaluation of a federal-provincial agreement, entitled "Wait Time Benchmarks," which was the Federal government's response to *Chaoulli*.

Chapter 4, *Legal Implications of Chaoulli*, examines the effect that *Chaoulli* has had on subsequent legal challenges in other provinces. More specifically, it focuses on three "copy-cat" cases. The first case, *Flora v. Ontario* ([2007] O.J. No. 91), unsuccessfully sought to use the precedent set in *Chaoulli* to recover lost funds for an out-of-country medical treatment. The second case, *Murray v. Alberta (Minister of Health)*, seeks to expand the precedent set in *Chaoulli* that prohibitions against private health insurance violates section 7 of the *Charter of Rights and Freedoms*. Likewise, *McCreith and Holmes v. Ontario (Attorney General)*, tests whether Ontario healthcare laws violate section 7 of the *Charter*.

Chapter 5, *Constitutional Implications of Chaoulli*, discusses the constitutional consequences that emerged as a result of the *Chaoulli* decision. These ramifications include the symbolic elevation of healthcare to a *Charter* right and the expansion of Section 7 of the *Charter* to healthcare. This chapter also illustrates how the implementation of the *Charter of Rights and Freedoms* set the stage for *Chaoulli* and future judicial activism.

Chapter 6, *Conclusion*, broadens the analysis to consider all of the implications of the *Chaoulli v. Quebec* decision for the healthcare system. It provides insight into the future of the Canadian Medicare system and offers suggestions for future research.

1.5 Contribution of Thesis

Due to the controversial nature of the *Chaoulli* decision, there is a substantial amount of literature that interprets the decision and discusses how it could affect the Canadian healthcare system. Most of the literature was written immediately following the judgment (June-September 2005), and is merely speculative about the potential implications of the decision.

However, since 2005 there have been a number of policy and legal developments that resulted from the *Chaoulli* decision, such as Bill 33 in Quebec and copycat cases such as *Flora v. Ontario*, *Murray v. Ontario* and *McCreith and Holmes v. Ontario*. These developments have had a significant impact on the Canadian healthcare system, and have not been effectively compiled. It is also important to discuss and document the constitutional implications of *Chaoulli*, as they are rarely discussed, but have the potential to alter the composition of Canada's political institutions. Some attention is also devoted to discussing the "Americanization" of the Supreme Court of Canada as a constitutional consequence of *Chaoulli*. This topic has not been properly documented in post-*Chaoulli* literature.

Basing my argument on existing literature, this thesis will make a contribution to existing *Chaoulli* literature by carefully examining the policy, legal, and constitutional implications of *Chaoulli v. Quebec*. In doing so, the implications of *Chaoulli* will be updated in light of recent developments and compiled into one concise thesis. This will elicit a better understanding of and clarify the impact that the *Chaoulli* decision has had on the Canadian healthcare and political systems from June 2005 to November 2007.

1.6 Methodology

This thesis is based largely on a content analysis of existing literature. This included primary and secondary sources such as government documents, journal articles, newspaper articles, books, government-initiated studies, court cases and the judicial decision on the case officially known as S.C.R. 791 *Chaoulli v. Quebec (Attorney General)*. Three sources were particularly influential in framing this thesis: *Access to Care, Access to Justice: The Legal Debate Over Private Insurance* (Flood et. al; 2006); *Chaoulli v. Quebec and the Future of Canadian Healthcare: Patient Accountability as the “Sixth Principle” of the Canada Health Act* (Monahan; 2006); and “*The Sky is Not Falling*”: *An Uncommon Perspective on Chaoulli v. Quebec (Attorney General) and its Progeny* (Mitchell; 2007). It was by reading these three separate, yet interrelated post-*Chaoulli* publications that led to the substantive focus of this thesis on the policy, legal, and constitutional implications of that historic judicial decision.

It is important to acknowledge that many of the sources used in the content analysis of this thesis were accessed via the Internet. The use of the World Wide Web was essential to this study as many of the government documents that were used in this thesis were only available in PDF format. The wealth of information available through the Internet in the form of e-books, scholarly journals, government institutions, and private associations contributed greatly to the development of this thesis.

CHAPTER 2: UNDERSTANDING CHAOULLI: AN ANALYSIS OF THE DECISION

2.1 Introduction

*“Chaoulli v. Quebec (Attorney General) is perhaps the most extraordinary judgment rendered to date by the Supreme Court of Canada in the Twenty-first Century.”*²⁸ –Graeme G. Mitchell, *Q.C.*

Chaoulli v. Quebec is widely considered to be one of the most controversial decisions in the history of the Supreme Court of Canada. Patrick J. Monahan, Dean of Osgoode Hall Law School, describes reactions to the 4:3 decision that struck down prohibitions on the purchase of private health insurance for publicly covered services as both striking and remarkable.²⁹ He notes that reactions to the decision ranged from being described as “astounding”³⁰ by Hamish Stewart, as “embodying a ‘Two-tier Magna Carta’”³¹ by Gregory P. Marchildon, and as a “Charter calamity waiting to happen”³² by Andrew Petter to being “worse than *Lochner*”³³ (a discredited 1905 decision by the U.S. Supreme Court that struck down legislation setting maximum work hours in bakeries) by Sujit Choudhry.

²⁸ Mitchell, “‘The Sky is Falling’: An Uncommon Perspective on *Chaoulli v. Quebec (Attorney General)* and its Progeny,” 2.

²⁹ Monahan, “*Chaoulli v. Quebec* and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act,” 1.

³⁰ Hamish Stewart, “Implications of *Chaoulli* for Fact-Finding in Constitutional Cases,” in [Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada](#), Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 207.

³¹ Gregory P. Marchildon, “The *Chaoulli* Case: Two Tier Magna Carta?” *Healthcare Quarterly*, 8(4) 2005: 49-52, accessed online at <http://www.longwoods.com/product.php?productid=17190&page=7> (Retrieved 18 October 2007).

³² Andrew Petter, “Wealthcare: The politics of the Charter Revisited,” in [Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada](#), Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 120.

³³ Sujit Choudhry, “Worse than *Lochner*.” in [Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada](#), Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 75.

Monahan refers to the *Chaoulli* decision as a “bombshell” that blindsided governments and the health policy community alike.³⁴ He explains that the health policy community had little, if any, warning that such an outcome was likely or even possible. He characterizes the decision as one that changed the ground rules governing Canada’s publicly funded healthcare system, but provided little guidance regarding what those changes ought to be.³⁵

According to Marlissa Tiedemann (2005), public reactions to *Chaoulli* range from highly optimistic to extremely pessimistic. Some see the decision as positive, believing that it will result in more consumer choice in health care. Others fear that it puts the publicly funded health system in jeopardy. Tiedemann notes that the latter perspective has been popularized by the media in particular: a common journalistic theme is that if private insurance is allowed to cover services that are insured by provincial health plans, a private parallel system will flourish at the expense of the publicly system.³⁶ Roy Romanow (2005) predicts that the *Chaoulli* decision could “sound the end of medicare we know it.”³⁷

It can be argued that that these contrasting views are the result of different interpretations of the significance of the *Chaoulli* judgment.³⁸ Thus, it is imperative that this thesis clarifies exactly what the Supreme Court decided in the case. To this end, three sets of arguments are important: the majority opinion (McLachlin C.J. and Major J.

³⁴ Monahan, “Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act,” 2.

³⁵ *Ibid.*, 2-3.

³⁶ Marlissa Tiedemann, “Health Care at the Supreme Court of Canada II: Chaoulli v. Quebec (Attorney General),” The Library of Parliament Law and Government Division (5 October 2005), 7.

³⁷ Tracy Tyler, “Romanow fears ‘end of medicare’; Romanow slams health ruling, says buying health care violates Charter,” *The Toronto Star* (17 September 2005).

³⁸ Monahan, “Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act,” 6.

(Bastarache J. concurring)), the dissenting opinion (Binnie and LeBel JJ. (Fish JJ. concurring)), and the tie-breaking opinion of Justice Marie Deschamps. In the following chapter, each set of arguments will be summarized and analyzed in order to clarify precisely what the court decided and did not decide.

2.2 Overview of the Decision

After two unsuccessful challenges before the Quebec Superior Court and the Quebec Court of Appeal, Dr. Jacques Chaoulli and George Zeliotis took their case to the Supreme Court of Canada. After careful consideration, the Supreme Court decided to hear their case, realizing that Chaoulli and Zeliotis's claim had "legal traction" and thus, had serious implications for the future of healthcare in Canada. The reason it had "legal traction" was its dealing with a "medically necessary procedure." If it had dealt with a "non-medically necessary procedure" the *Chaoulli* case would have had no such traction and the Supreme Court probably would not have taken it on. The rationale being, the state does not have a monopoly over elective, "non-medically necessary procedures," as they are permitted, but not insured under the Canada Health Act (CHA). Therefore, the plaintiffs would not have had a reasonable *Charter* challenge. However, such a monopoly over "medically necessary services"³⁹ was in existence, giving way to a serious and legitimate *Charter* challenge. With a governmental monopoly and no Canadian treatment alternatives available for "medically necessary procedures," a panel of seven Supreme Court justices (McLachlin, Major, Bastarache, Binnie, LeBel, Fish and

³⁹ Armine Yalnizyan, "Getting Better Health Care: Lessons from (and for) Canada," *The Canadian Centre for Policy Alternatives* (4 November 2007), accessed online at http://www.policyalternatives.ca/documents/National_Office_Pubs/2006/Getting_Better_Health_Care.pdf (Retrieved April 10 2008).

Deschamps) decided to hear Chaoulli and Zeliotis's appeal, producing three different sets of reasoning comprising 135 pages (SCC 35) in the process.

The majority decision was comprised of two separate sets of reasons. Chief Justice McLachlin and Justices Major and Bastarache held that the prohibition on private insurance violates both the Quebec and Canadian *Charters*. Justice Deschamps agreed that the prohibition violates the Quebec Charter. However, having found so, she declined to decide whether it violated the Canadian *Charter*.⁴⁰

The dissenting justices (Binnie, Lebel and Fish JJ.) held that the ban is valid because it is aimed at protecting the public health care system. Therefore, they determined that the prohibition on private insurance did not infringe on either the Quebec or Canadian *Charters*.⁴¹ As a result, a slim 4:3 majority struck down the provisions of the *Quebec Charter* that prohibited private health insurance. The particulars of the case will be summarized in the following sub-sections.

2.2.1. The Majority Opinion

Chief Justice McLachlin and Justice Major argued that the key difficulty in *Chaoulli* was that the government and legislature created a monopoly over medically necessary health services and then failed to deliver care in a timely fashion (Justice Bastarache concurred).⁴² Paragraphs 105 and 106 of their decision read as follows:

⁴⁰ Monahan, "Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the 'Sixth Principle' of the Canada Health Act," 2.

⁴¹ *Ibid.*, 1.

⁴² *Ibid.*, 6.

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*.⁴³

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.⁴⁴

Justices McLachlin and Major observed that the question in the *Chaoulli* case is not whether a two-tier system is preferable to a single-tier system, but rather, is essentially this: If the public health system fails to deliver “medically necessary” care in a timely manner, does the prohibition on private health insurance violate the section 1 and/or section 7 right to personal security?⁴⁵ Observing that access to a waiting list does not equate to access to health care, they stated that:

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 ... if the government chooses to act, it must do so properly.⁴⁶

Interestingly, both the Quebec Superior Court and Quebec Court of Appeal decided that the prohibition on private insurance was required to preserve the public

⁴³ *Chaoulli v. Quebec* (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35. Para. 105.

⁴⁴ *Ibid.*, Para. 106.

⁴⁵ *Ibid.*, Para. 108-123.

⁴⁶ *Ibid.*, Para. 158.

healthcare system, and thus, that the violation of the right to life and security of person was justified by the principles of fundamental justice.⁴⁷ However, Justices McLachlin and Major dismissed the argument as being a theoretical contention and stated that:

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.⁴⁸

The majority acknowledged that accessing private insurance alone might not shorten wait times.⁴⁹ They stated, however, that this was not the concern of the appellants, whose only burden was to prove that their right to life, liberty and security had been violated.⁵⁰

2.2.2 Dissenting Opinions

Justices Binnie and LeBel (Justice Fish JJ. concurring) declared that the courts should not remedy problems with the publicly funded healthcare system. They believed that it was beyond the expertise of judges to determine what constituted a reasonable wait for care.⁵¹ The dissenting judges noted that in *Auton v. British Columbia* (2004) the courts had an opportunity to determine the scope and nature of “reasonable health services,” but failed to do so because the task was too difficult.⁵² They further observed that the majority in the *Chaoulli* case had the same opportunity, but likewise failed to indicate what treatment “within a reasonable time” is, how short a waiting list has to be to

⁴⁷ Jim Simpson, “Supreme Court of Canada rules Quebec government health monopoly violates fundamental rights,” *The Ontario Medical Association (OMA)* (1 July 2005), accessed online at <http://www.oma.org/Health/medicare/05quebec.asp> (Retrieved 13 December 2006).

⁴⁸ *Chaoulli v. Quebec.*, Para. 140.

⁴⁹ *Ibid.*, Para. 100.

⁵⁰ *Ibid.*

⁵¹ Monahan, “Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act,” 13.

⁵² *Chaoulli v. Quebec.*, Para. 163.

be “short enough,” or how many MRIs the constitution required.⁵³ In paragraph 163 Binnie and LeBel indicated that:

The majority [laid] 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.⁵⁴

The dissenting judges strongly believed that the courts could not and should not handle the issue presented in *Chaoulli*. Their primary concern was that wait times are a social issue, not a legal one, and citing *R. v. Malmo-Levine (2003)*, they noted that elected politicians are more institutionally equipped to make these sorts of decisions.⁵⁵

Justices Binnie and LeBel also agreed that Quebec’s prohibition against private insurance was necessary to ensure the integrity of the current single-tier health system and to achieve the objectives of the *Canada Health Act*.⁵⁶ They found that there was a significant amount of evidence supporting the conclusion that an American-type two-tier system of health coverage would negatively affect wait times in the public system. They felt that the evidence presented in *Chaoulli* was insufficient to support private insurance as the appropriate solution.⁵⁷ In paragraph 176 the dissenting judges said:

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*.⁵⁸

⁵³ Ibid., Para. 163.

⁵⁴ Ibid.

⁵⁵ Ibid., Para. 164-176.

⁵⁶ Ibid., Para. 166.

⁵⁷ Ibid., Para 181.

⁵⁸ Ibid., Para. 176.

Finally, the dissenting judges indicated that there was a lack of accurate data surrounding wait lists in Canada, as research on this issue has generated contradictory and conflicting claims (Romanow Report, at p. 139, and the Kirby Report, vol. 4, at p. 41, and vol. 6, at pp. 109-10).⁵⁹ They also noted weaknesses in Chaoulli's main argument, namely that it was:

Based largely on generalizations about the public system drawn from fragmentary experience, an overly optimistic view of the benefits offered by private health insurance, and oversimplified view of the adverse affects 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.⁶⁰

2.2.3. The Tie-Breaking Decision

Justice Marie Deschamps decided in favor of the majority. She observed that, in provinces where parallel systems are authorized (i.e. Saskatchewan, New Brunswick, P.E.I., and Newfoundland and Labrador), public health services appear to be unthreatened by private insurance.⁶¹ However, she grounded her decision in the *Quebec Charter (Sec. 1)*, while the rest of the majority (McLachlin, Major and Bastarache) grounded their decision in the *Canadian Charter (Sec. 7)*.⁶² Justice Deschamps stated that:

⁵⁹ Ibid. Para. 217.

⁶⁰ Ibid., Para. 169.

⁶¹ Ibid., Para. 74.

⁶² Cassels Brock & Blackwell LLP, "Supreme Court Strikes Down Private Health Care Insurance Prohibition in Québec: *Chaoulli v. Québec (Attorney General)*," (2005), accessed online at <http://casselsbrock.com/publicationdetail.asp?aid=812> (Retrieved 6 October 2007).

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. Given the absence in s. 1 of the *Quebec Charter* of the reference to the principles of fundamental justice found in s. 7 of the *Canadian Charter*, the scope of the *Quebec Charter* is potentially broader than that of the *Canadian Charter*, and this characteristic should not be disregarded.⁶³

While Justice Deschamps determined that section 1 of the *Quebec Charter of Rights and Freedoms* was breached by the prohibition on private health insurance,⁶⁴ she was silent concerning its impact on section 7 of the *Canadian Charter*. She indicated that it was unnecessary to address the latter issue, since the appellants had proved infringement of their section 1 right to life and personal inviolability.⁶⁵

Chief Justice McLachlin and Justice Major concurred with Justice Deschamps concerning section 1 of the *Quebec Charter of Human Rights and Freedoms*.⁶⁶ However, they went one step further, adjudging that section 7 of the *Canadian Charter of Rights and Freedoms* had also been violated.⁶⁷ Since Justice Deschamps did not comment on whether restrictions against private insurance violated the *Canadian Charter of Rights and Freedoms*, the court was left divided 3-3 on the issue.⁶⁸

If Justice Deschamps had determined that the prohibition against private health insurance violated the *Canadian Charter*, the impact of the *Chaoulli* would have been 5-

⁶³ *Chaoulli v. Quebec.*, Para. 26-33.

⁶⁴ *Ibid.*, Para. 102.

⁶⁵ *Ibid.*, Para. 100.

⁶⁶ *Ibid.*, Para. 102.

⁶⁷ *Ibid.*

⁶⁸ CBC.ca, "Top court strikes down Quebec private health-care ban," (9 June 2005), accessed online at <http://www.cbc.ca/story/canada/national/2005/06/09/newscoc-health050609.html> (Retrieved 11 October 2007).

fold because the other five provinces with similar prohibitions (B.C., Alberta, Manitoba, Ontario, and Nova Scotia) would have been affected by the decision, not just Quebec.⁶⁹

2.3 Interpreting the decision: Why *Chaoulli* is controversial

Jeff A. King properly states that *Chaoulli v. Quebec* is one of the most controversial decisions in the history of the Supreme Court of Canada.⁷⁰ He indicates that it is controversial not only because the Supreme Court of Canada decided that a monopoly over health care violated section 1 of the *Quebec Charter*, but also because the Supreme Court failed to determine whether prohibiting private insurance violates section 7 of the *Charter of Rights and Freedoms*.

One reason that the court ended up in a 3-3 deadlock over the issue was because the majority failed to define what level of health care is “reasonable” and “sufficient” to comply with the *Charter of Rights and Freedoms*. As stated by Binnie and LeBel, the majority did not indicate what comprises treatment “within a reasonable time,” how short a waiting list has to be to qualify as “short enough,” or how many MRIs the constitution required.⁷¹ However, even though the majority failed to provide definitive, legally binding answers to the questions raised by Binnie and LeBel (i.e., what is a treatment within a reasonable time?), it is entirely possible that the majority inadvertently established a standard of care and created a binding social contract by indicating that there is a constitutional right for “timely access” to healthcare under section 7 of the

⁶⁹ Peter J. Carver, “Comment on *Chaoulli v. Quebec*,” *Law and Governance* (June 2005), accessed online at <http://www.longwoods.com/product.php?productid=17191> (Retrieved 22 January 2008).

⁷⁰ Jeff A. King, “Constitutional Rights and Social Welfare: A Comment on the Canadian *Chaoulli* Health Care Decision,” *Modern Law Review*, Vol. 69, No. 4, pp. 631-643 (July 2006), accessed online at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=913125 (Retrieved 5 October 2007).

⁷¹ *Chaoulli v. Quebec*, Para. 163.

Canadian Charter. But, whether or not this standard exists is just as contentious as whether the standard is manageable. Given the possibility that the general standard set by section 7 (“timely access”) could be extended to a point where individuals’ rights are constantly being violated, it may be impossible for the government to retain a single tier universal health care system that does not violate some individuals’ *Charter* rights.⁷² Nevertheless, that all depends on whether one agrees that a binding social contract exists.

The majority’s justification for private healthcare is also controversial. Sack GoldBlatt and Mitchell LLP (2007) point out that the majority failed to establish a rational connection between Quebec’s prohibition on private insurance and the goal of maintaining quality public healthcare.⁷³ More specifically, to support the view that a two-tier healthcare system would improve wait times, the majority relied on a survey of European Health Care systems that was included in Senator Kirby’s interim report on healthcare.⁷⁴ However, they ignored the fact that Senator Kirby rejected the notion that a two-tier healthcare system would resolve wait times and did not include that survey in his final report.⁷⁵

The majority also ignored the trial judge, who concluded that removing the ban on private insurance would lead to considerable growth in private health sector at the public sector’s expense.⁷⁶ As Justices Binnie, Lebel, and Fish pointed out:

⁷² Yu-Sung Soh, “Shooting from the Hip: The Health of Universal Health Care following Chaoulli,” *The Court* (8 March 2007), accessed online at <http://www.thecourt.ca/2007/03/08/shooting-from-the-hip-the-health-of-universal-health-care-following-chaoulli/> (Retrieved 9 October 2007).

⁷³ Sack GoldBlatt & Mitchell LLP, “SGM’s Analysis of Chaoulli v. Quebec (Attorney General),” (2007), accessed online at <http://www.sgmlaw.com/Page488.aspx> (Retrieved 11 October 2007).

⁷⁴ *Ibid.*

⁷⁵ Steven Shrybman, “Chaoulli v. Attorney General of Quebec: What the Supreme Court Really Said,” *The Council of Canadians*, (2005), accessed online at http://www.canadians.org/healthcare/documents/Shrybman_Health_05.pdf (Retrieved 12 October 2007).

⁷⁶ *Ibid.*

[T]he 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).⁷⁷

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, p. 17).⁷⁸

Theodore R. Marmor, a policy analyst who testified in the Quebec trial on behalf of Canada’s Attorney General, found the majority’s treatment of the international evidence to be problematic.⁷⁹ He explains that the majority had no justifiable reasons for their conclusions other than the findings of the highly contested *Kirby Report*. As this report relies on a descriptive rather than causal research design, Marmor suggests that it provides “evidence” that is not particularly conclusive.⁸⁰ Accordingly, he cautions the courts from turning to the *Chaoulli* decision for guidance on the use of cross-national research to support judicial decision making.⁸¹

Constitutional expert Francois Beland similarly argues that the majority justices based their decision on weak evidence. He notes that the dissenting judges characterized the evidence as unsubstantiated, common sense arguments,⁸² and suggests that it would have been better if they “just threw up their hands and held the debate in a strictly

⁷⁷ *Chaoulli v. Quebec*, Para. 243.

⁷⁸ *Ibid.*, Para. 245.

⁷⁹ Theodore R. Marmor, “Canada’s Supreme Court and its National Health Insurance Program: Evaluating the Landmark *Chaoulli* decision from a comparative perspective,” *Osgoode Law Journal*, Vol. 44 (2006), 316.

⁸⁰ *Ibid.*, 325.

⁸¹ *Ibid.*

⁸² Francois Beland, “The Supreme Court Missed a Good Opportunity,” *Law and Governance* (June 2005), accessed online at <http://www.longwoods.com/product.php?productid=17234&page=1> (Retrieved 18 November 2007).

ideological forum.”⁸³

2.4 Conclusion

On June 9, 2005, the Supreme Court of Canada ruled 4 to 3 that the ban on private insurance for services that are covered under the provincial health plan violates the *Québec Charter of Human Rights and Freedoms* and was thus void and unenforceable.⁸⁴ All seven justices agreed that the evidence established, in some cases, that the prohibition against private health insurance put the personal health and security of Quebecers at risk.⁸⁵ However, the seven justices were unable to see eye to eye on whether or not this prohibition violated section 7 of the Canadian *Charter of Rights and Freedoms* and/or Section 1 of the *Québec Charter of Human Rights and Freedoms*.

Justices McLachlin, Major and Bastarache indicated that while not every waiting list case amounts to a violation of section 7, the evidence in *Chaoulli* demonstrated a degree of physical and psychological suffering that jeopardized the “security of person.”⁸⁶ This being so, they concluded that the state monopoly over the provision of “medically necessary” services was not legally justified and that the prohibition against private health insurance violated section 7 (the right to life and security of person) of the Canadian *Charter of Rights and Freedoms* and Section 1 of the *Quebec Charter of Human Rights and Freedoms* (right to life, and to personal security and inviolability).⁸⁷

⁸³ Ibid.

⁸⁴ William P. Georgas and Louise Shap, “Medical Services for Ontarians Outside of Canada,” *Law and Governance* Vol. 10 No. 2 (2006), accessed online at <http://www.longwoods.com/product.php?productid=18040> (Retrieved 2 November 2007).

⁸⁵ *Chaoulli v. Quebec*, Para. 191.

⁸⁶ Ibid., Para. 123.

⁸⁷ Ibid., Para. 159.

Justice Deschamps agreed with Justices McLachlin, Major and Bastarache that the prohibition on private health insurance violated section 1 of the *Quebec Charter*. However, she noted that the scope of section 1 of the *Quebec Charter* was potentially broader than section 7 of the *Canadian Charter* because *Quebec's* section 1 did not refer to “the principles of fundamental justice.”⁸⁸ As a result, she found it unnecessary to consider arguments based on the *Canadian Charter* and grounded her decision solely on the *Quebec Charter*.⁸⁹ Consequently, the decision is technically only applicable to the province of Quebec.

While Justices McLachlin, Major, Bastarache and Deschamps made up the majority, agreeing that the state monopoly on healthcare violated section 1 of the *Quebec Charter*, Justices Binnie, LeBel, and Fish disagreed. Rather, they concurred with Justice Ginette Piche (the trial judge) and the three appellate judges who determined that the ban on private health insurance did not violate section 1 of the *Quebec Charter* or section 7 of the *Canadian Charter*.⁹⁰ Stating that long waiting lists could not be resolved as a matter of constitutional law, they were critical of the evidence that the majority used to support their arguments (primarily volume three of the Interim Kirby Report). They also made it clear that the courts cannot adequately deal with complex-fact laden policy issues such as wait times (in chapter four the effects of the precedent of such judicial activism will be discussed).

⁸⁸ *Ibid.*, Para. 30.

⁸⁹ Monika Gehlen, “Health Law Bulletin: Supreme Court of Canada Decision in *Chaoulli v. Quebec* (Attorney General) 2005 SCC 35,” Davis and Company LLP (9 June 2005), accessed online at <http://www.davis.ca/publication/Health-Bulletin-Chaouli-Decision.pdf> (Retrieved 15 December 2007).

⁹⁰ Simpson, “Supreme Court of Canada rules Quebec government health monopoly violates fundamental rights.”

The fact that *Chaoulli* was decided by a 4:3 split decision is just one reason why *Chaoulli v. Quebec* is widely considered to be the most controversial decision in the Supreme Court's history. Other reasons include the fact that the court was left in a 3-3 deadlock on whether section 7 of the *Canadian Charter* was violated, the fact that the majority failed to define what "reasonable" or "sufficient" care entailed, and the argument advanced by Marmor that the court based its decision on inconclusive evidence.

It is easy to get caught up in a debate surrounding the controversial nature of the decision. Regardless of one's preference for what the Court should have done, however, it is important to examine the fallout from what the Court actually decided. In chapters three, four, and five, the policy, legal, and constitutional implications of *Chaoulli v. Quebec* will be discussed.

CHAPTER 3: POLICY IMPLICATIONS OF CHAOULLI

3.1 Introduction

Responses to the *Chaoulli* decision were far from uniform. In chapter two it was indicated that the decision was met with shock and surprise by a number of policy and legal experts, who referred to it as “astounding,” “worse than *Lochner*,” and “a political and legal bombshell.” Other experts such as Nadeem Esmail, manager of Health Data Systems at the Fraser Institute, were not as surprised as they were thrilled. In July, 2005 Esmail wrote *A Leap in the Right Direction*, which implied that the *Chaoulli* decision was beneficial for Canadians because it favored the introduction of private health insurance in Quebec (and potentially other provinces in the future). According to Esmail, the ban on private insurance and payment for healthcare is illegitimate and should not continue because a parallel private health sector, running in competition with the public sector, would lead to higher quality and more responsive health care in Canada.⁹¹

In spite of a few optimistic opinions such as Esmail’s, the *Chaoulli* decision was met mainly with shock and awe. Given that the public healthcare system is considered to be one of Canada’s most admired and politically-sensitive institutions, most provinces and political leaders attempted to downplay the implications of the case.⁹² Timothy Caulfield notes that then Manitoba Minister of Health, Tim Sale, responded to the

⁹¹ Nadeem Esmail, “A Big Leap in the Right Direction,” *The Fraser Forum* (July/August 2005), accessed online at http://www.fraserinstitute.org/Commerce.web/product_files/July05ff-pp3%20and%2011.pdf (Retrieved 19 December 2007).

⁹² Timothy Caulfield, “*Chaoulli v. Quebec (Attorney General): The Supreme Court of Canada Deals a Blow to Publicly Funded Health Care*,” (September 2005), accessed online at [http://www.law.uh.edu/Healthlaw/perspectives/September2005/\(TC\)ChaoulliComment.pdf](http://www.law.uh.edu/Healthlaw/perspectives/September2005/(TC)ChaoulliComment.pdf) (Retrieved 1 January 2008).

Chaoulli decision by vowing to fight tooth and nail for the universal healthcare system in concert with other provinces like Quebec and Saskatchewan.⁹³

Despite attempts by political leaders to minimize the potential fallout from the case, there were still a number of implications that resulted from the Supreme Court's landmark decision. Perhaps the most evident implication of *Chaoulli* is that it reinvigorated an intense public debate, which in turn spawned statutory and programmatic reform (policy developments) by Quebec (Bill 33), Alberta (The Third Way), and the Federal Government (Wait Time Benchmarks).⁹⁴ Furthermore, increased public debate rejuvenated the "pro-privatization" camp,⁹⁵ which produced a number of "copy-cat" cases that aimed to expand the *Chaoulli* precedent across Canada.

Both policy and legal implications are important to discuss in order to fully understand the impact that the *Chaoulli* judgment has had on the Canadian healthcare system. For simplicity, the following section of this chapter will discuss the policy implications of *Chaoulli*, namely Bill 33, The "Third Way" proposal, and Wait Time Benchmarks.

3.2 Quebec's Response: Bill 33

In *Chaoulli*, the Supreme Court gave Quebec one year to amend its healthcare legislation and rectify the violation of the *Quebec Charter*. However, the government of Quebec seriously contemplated invoking the "notwithstanding clause" (Section 33 of the *Canadian Charter* which provides an override to sections 2 and 5 to 15 of the *Canadian*

⁹³ Ibid.

⁹⁴ Mitchell, "'The Sky is Falling': An Uncommon Perspective on *Chaoulli v. Quebec (Attorney General)* and its Progeny," 25.

⁹⁵ Caulfield, "*Chaoulli v. Quebec (Attorney General)*: The Supreme Court of Canada Deals a Blow to Publicly Funded Health Care."

Charter) in an attempt to maintain the status quo and avoid legislative reforms that could potentially harm the public healthcare system. Given that Quebec has used the notwithstanding clause in the past, invoking it on a number of occasions to protect the French language and collective identity of Quebec, many assumed it would be a natural response to *Chaoulli*.⁹⁶

However, to the surprise of many, the Quebec National Assembly refrained from using one of its most powerful political tools in the context of the *Chaoulli* decision. Political scientists, legal scholars, and constitutional experts were among the few not taken aback by the decision. Constitutional and legal expert Christopher P. Manfredi explains that the government of Quebec had good reason to abstain from its use in *Chaoulli*, as it would have undermined the *Canadian Charter*. He suggests that doing so would have been political suicide, as the *Charter* is largely considered to be the “final word” in 21st Century political debates.⁹⁷ Further, the notwithstanding clause may not have provided Quebec with complete protection against court action, as the *Chaoulli* decision was, in large part, based on the Quebec Charter and thus would not have been covered under Section 33 of the *Canadian Charter*.

Since the government of Quebec failed to invoke the notwithstanding clause, it was obligated to respond to the Supreme Court’s ruling in *Chaoulli*. Quebec took legislative action on June 15, 2006, by setting out proposed amendments to its healthcare legislation with the tabling of Bill 33, titled “an Act to amend the Act respecting health services and social services and other legislative provisions.” On December 13, 2006, the

⁹⁶ Monahan, “Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act,” 20.

⁹⁷ Christopher P. Manfredi, “Déjà vu All Over Again: Chaoulli and the Limits of Judicial Policymaking,” in Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada, Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 140.

Quebec legislature passed Bill 33 as a means of addressing unreasonable wait times for some services by opening the door to private medical services and private health insurance (but only to a limited extent).⁹⁸ Davis LLP indicates that Bill 33 implements two interrelated solutions:

- 1) A six-month wait-time guarantee that applies to some elective surgeries (as defined by regulation but limited to hip, knee and cataract procedures) [which] provides patients not treated within the prescribed wait time of six months an opportunity to have their procedure performed in another establishment or a specialized clinic affiliated with the public sector. If the wait-time exceeds nine months, patients may have their operation performed outside Quebec or Canada, or by private providers, and the full cost of the surgery is covered by the provincial health care insurance plan.⁹⁹
- 2) The right to duplicative private insurance for the elective surgeries targeted in (1) provided health services are obtained from doctors who have opted out of the Provincially insured Medicare system.¹⁰⁰

Marie-Claude Premont explains that Bill 33 legalizes private hospitals called “Specialized Medical Centres” (for overnight and day surgery), private clinics, and private insurance.¹⁰¹ Under Bill 33 there are two types of proposed private hospitals:

- 1) Hospitals where services are paid for by taxpayers and will become a “private extension” of current public hospitals that will become known as “Associated Medical Clinics.”¹⁰² In essence, public services are simply contracted out to “for-profit private corporations.”¹⁰³

⁹⁸ Watson Wyatt Worldwide, “Quebec Passes Private Health Care Legislation,” *InfoFlash Canada* (February 2007), accessed online at <http://www.watsonwyatt.com/canadaenglish/pubs/Infoflash/showarticle.asp?ArticleID=17085&articledate=2/22/2007> (Retrieved 11 October 2007).

⁹⁹ Davis LLP, “Health Law Case Update: Chaoulli in 2006 and 2007,” (2007), 2, accessed online at <http://www.davis.ca/publication/Health-Law-Bulletin.pdf> (Retrieved 11 December 2007).

¹⁰⁰ *Ibid.*

¹⁰¹ Marie-Claude Premont, “Crunch time for public health care in Quebec,” *The Toronto Star* (17 November 2006), accessed online at <http://www.healthcoalition.ca/bill33b.pdf> (Retrieved 10 October 2007).

¹⁰² *Ibid.*

¹⁰³ *Ibid.*

- 2) Hospitals where services will have to be paid for “out of pocket.” Premont explains that, “this hospital will be staffed by opted-out physicians who ... will be able to offer (legally) authorized surgical services including overnight bed stay.” These “Specialized Medical Centres” are restricted in what surgeries they can perform (they can only perform surgeries that are specified by the government). They are presently restricted to knee replacements, hip replacements and cataract surgery, however, the list can be extended in the future by “simple regulatory changes by the Minister of Health.”¹⁰⁴

Like the *Chaoulli* decision, Bill 33 has left people divided on whether it will improve or dismantle the public system. Dr. Nicolas Duval, an orthopedic surgeon from Montreal, argues that the public system will benefit from private clinics because they will reduce demands on public resources.¹⁰⁵ However, Dr. Simon Turcotte, the spokesperson for the recently established Médecins pour l'accès à la santé (Doctors for healthcare access), argues that expanding the private sector will split doctors between the separate public and private systems, which will lead to further staffing shortages in the public system and put poorer patients at risk.¹⁰⁶

Dr. Turcotte also believes that Bill 33 fails to address the underlying problem that prompted the *Chaoulli* case: that the public hospital is inefficient, outdated, and unable to incorporate contemporary practice methods to keep up with demand. Rather than trying to fix problems with the public hospital system, he believes that Bill 33 merely identifies a point at which the system falters and sends the overflow to private hospitals and clinics. According to Dr. Turcotte, hospitals should use their own resources to fund publicly-owned ambulatory clinics rather than subcontracting the work out to the private sector.¹⁰⁷

¹⁰⁴ Ibid.

¹⁰⁵ Sam Solomon, “Quebec’s diverse response to Chaoulli: Doctors’ groups rally against Bill 33, private surgical centres,” *The National Review of Medicine*, Vol. 3 No. 17 (15-30 November 2006), accessed online at http://www.nationalreviewofmedicine.com/issue/2006/11_15-30/3_policy_politics03_17.html (Retrieved 9 October 2007).

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

In introducing Bill 33, the official position of the government of Quebec is that the private provision of healthcare will complement rather than compete with the publicly funded system.¹⁰⁸ As Yu-Sung Soh points out, the Act allows the Minister of Health to authorize the use of the private system if wait times in the public system become untenable.¹⁰⁹

Despite this, proponents of universal healthcare are still skeptical about Bill 33's intentions and feel it is the beginning of the end. As Antonia Maioni, Director of the McGill Institute for the Study of Canada, points out, the government of Quebec left the door open for expanding the role of the private clinics, which could make the option of "going solo" more attractive for doctors in the future.¹¹⁰ Ultimately, she argues only time can tell whether Bill 33 is a limited solution to address problems raised in *Chaoulli v. Quebec*, or whether it laid the groundwork for a two-tier healthcare system in Canada.¹¹¹

3.3 Alberta's Response: Ralph Klein's "Third Way"

Although most provincial governments tried to downplay the implications of *Chaoulli*, Alberta Premier Ralph Klein embraced the decision. On July 30, 2005, Klein stated that:

¹⁰⁸ Odette Madore, "Duplicate Private Health Care Insurance: Potential Implications for Quebec and Canada," *The Library of Parliament: Economics Division* (20 March 2006), accessed online at <http://www.parl.gc.ca/information/library/PRBpubs/prb0571-e.htm> (Retrieved 10 October 2007).

¹⁰⁹ Soh, "Shooting from the Hip: The Health of Universal Health Care following Chaoulli."

¹¹⁰ Solomon, "Quebec's diverse response to Chaoulli: Doctors' groups rally against Bill 33, private surgical centres."

¹¹¹ *Ibid.*

There can be little doubt that the Supreme Court of Canada decision has forever changed our health-care landscape. The challenge now is to embrace the change -- not to run from it. The challenge is to look at the ruling as an opportunity, and not as a threat.¹¹²

According to Klein, the answer to Canada's ailing health care system was not more money, but rather, more choice, which could be found in a supplementary insurance plan (two-tier system).¹¹³ Klein's government responded to *Chaoulli* by proposing a new health policy framework in February, 2006 that called for ten new directions of reform.¹¹⁴ The 2006 Policy Framework became known as "The Third Way," because it proposed a limited two-tiered system where doctors would be able to practice in both the public and private systems and patients would be able to pay for cataract surgery, hip replacements, and knee replacements.¹¹⁵

Gerard W. Boychuk, a political science professor at the University of Waterloo, notes that Klein's "Third Way" proposal was greeted with fanfare, if not hysteria, by the media. His summary of responses to the report noted that it marked "the beginning of the end of medicare as practiced today in Canada," signified "the end of the Canada Health Act, at least as conventionally interpreted," and represented "the end of the guarantee that only need, and never wealth, will determine who gets served first."¹¹⁶ There are two main reasons for these claims:

¹¹² Ralph Klein, "Time to embrace change in health care: Albertans have a right to more choices in obtaining the health care they need," *The Edmonton Journal* (Editorial) (30 July 2005), accessed online at <http://www.hatton.ca/50ehc/embrace.htm> (Retrieved 20 December 2007).

¹¹³ *Ibid.*

¹¹⁴ Davis LLP, "Health Law Case Update: Chaoulli in 2006 and 2007," 2.

¹¹⁵ CBC News, "Alberta unveils 'Third Way' plan for health care," (28 February 2006), accessed online at <http://www.cbc.ca/story/canada/national/2006/02/28/alberta-060228.html> (Retrieved 24 December 2007).

¹¹⁶ Gerard W. Boychuk, "Territorial Politics and Current Health Care Reforms in Canada," Presented June 2006 at the CPSA Annual Meeting: York University, accessed online at <http://209.85.165.104/search?q=cache:ruXdOKNugF0J:arts.uwaterloo.ca/~gboychuk/Calgary/CPSA06/Initial%2520Draft/boychuk-cpsa-draft.doc+Federal+response+chaoulli&hl=en&ct=clnk&cd=3&gl=us&client=safari> (Retrieved 20 December 2007).

- 1) The third way proposal sought to develop a two-tier healthcare system;
- 2) The clause that would allow doctors to concurrently work in both the public and private systems conflicted with the fifth principle of the *Canada Health Act (CHA)*, which ensures Accessibility (See Appendix C for more details about the Canada Health Act).¹¹⁷

Health care policy experts and federal officials were especially concerned that the proposal violated the CHA. In a three-page letter to Klein, Prime Minister Stephen Harper argued that Klein's "Third Way" proposal could legitimize queue-jumping and undermine public health care in rural Alberta by luring rural doctors to urban centres.¹¹⁸ Federal Health Minister Tony Clement responded to the proposal by indicating that the Federal Government would not support health care reforms that violated the CHA. He warned the province of Alberta that it risked forfeiting as much as \$1.75 billion in health transfers if it went ahead with the proposal without Ottawa's consent.¹¹⁹

Klein argued that Alberta had a legal and constitutional basis for the proposal by citing a study by the *Montreal Economic Institute (MEI)*, which indicated that the "Third Way" did not violate the CHA.¹²⁰ However, the proposal died in April 2006 after Klein received only 55% of delegate support in the review of his leadership at the annual Progressive Conservative Party Meeting.¹²¹ The rejection of Klein's "Third Way"

¹¹⁷ CBC News, "Alberta's 'Third Way' could mean health-care showdown with Ottawa," (28 February 2006), accessed online at <http://www.cbc.ca/story/canada/national/2006/02/28/thirdway060228.html> (Retrieved 20 December 2007).

¹¹⁸ James Baxter, "Harper critical of Third Way proposals: Three-page letter to Klein expresses alarm," *The Calgary Herald*, A4 (7 April 2006), accessed online at <http://www.uofaweb.ualberta.ca/govrel/news.cfm?story=45023> (Retrieved 24 December 2007).

¹¹⁹ Kelly Cryderman, "It's the highway for 'third way': Disappointed Klein blames campaign of 'misinformation' that made Albertans fearful," *The Edmonton Journal* (21 April 2006), accessed online at <http://www.uofaweb.ualberta.ca/govrel/news.cfm?story=45404> (Retrieved 4 January 2008).

¹²⁰ Tso, "The Debate over Canada's Healthcare System."

¹²¹ Davis LLP, "Health Law Case Update: *Chaoulli* in 2006 and 2007," 2.

proposal indicated that, for the time being, Albertans were satisfied with the public system and did not desire private treatment alternatives. Alberta Health Minister Iris Evans announced that Alberta was not ready to proceed with private insurance at that time. However, she implied that the province would be prepared for private medicare in the near future.¹²²

While critics of private medicare hailed the decision to reject the “Third Way” as a victory, Harvy Voogd of the lobby group “Friends of Medicare,” contended that public health proponents should not be too relieved. He characterized healthcare privatization in Alberta as a zombie, implying that it was an issue that would keep coming back to life.¹²³ In fact, the resurrection occurred much more quickly than was expected. On September 8, 2006, just five months after the “Third Way” died, *Murray v. Alberta* emerged. The implications of *Murray v. Alberta* and other ‘copycat cases’ will be discussed in chapter four.

3.4 The Federal Response: Wait Time Benchmarks

Along with the majority of the provinces, Prime Minister Paul Martin (2003-2006) attempted to downplay the implications of *Chaoulli*. He indicated that the decision would not become the “thin edge of the wedge” in terms of establishing differing levels of health care for different socioeconomic sectors.¹²⁴ Martin told reporters on June 9, 2005 that the federal government would not permit the development of a two-tier health-

¹²² CBC News, “Alberta backs away from 'Third Way' health reforms,” (20 April 2006), accessed online at <http://www.cbc.ca/story/canada/national/2006/04/20/thirdway060420.html> (Retrieved 23 December 2007).

¹²³ Ibid.

¹²⁴ Kirk Makin, Jeff Sallot and Rheal Seguin, “The new face of medicare” *The Globe and Mail* (10 June 2005), accessed online at <http://www.brianday.ca/the-new-face-of-medicare.html> (Retrieved 4 January 2008).

care system in Canada, but rather, would work on strengthening the existing public system.¹²⁵

Martin and Health Minister Ujjal Dosanjh insisted that the federal government would stand behind and continue to invest in the single-payer system. On August 15, 2005, Dosanjh told the CMA that the \$41 billion in additional financing dedicated to health care reform under the *10-year Plan to Strengthen Health Care* published in 2004 would solve the problem of waiting lists that was raised in *Chaoulli*.¹²⁶ Dosanjh also indicated that the development of evidence-based benchmarks for “medically acceptable” wait times in five priority areas would be determined by the first ministers by December 31, 2005, with the goal of reducing wait times and improving the publicly funded system.¹²⁷

On December 12, 2005 the first ministers developed ten key benchmarks that attempted to reduce wait times for “medically necessary services.” Based on extensive research and clinical evidence, the provinces and territories indicated that they would strive to achieve the following benchmarks:

- ❖ Radiation therapy to treat cancer within four weeks of patients being ready for treatment;
- ❖ Hip fracture fixation within 48 hours;
- ❖ Hip replacements within 26 weeks;
- ❖ Knee replacements within 26 weeks;
- ❖ Surgery to remove cataracts within 16 weeks for patients who are at high risk;
- ❖ Breast cancer screening for women aged 50 to 69 every two years; and

¹²⁵ Daily News Central, “Canada’s National Health Care System in Peril,” *The International Herald Tribune* (12 June 2005), accessed online at <http://health.dailynewscentral.com/content/view/1035/0> (Retrieved 2 January 2008).

¹²⁶ Martha Jackman, “The Last Line of Defence for [Which?] Citizens: Accountability, Equality and the Right to Health in *Chaoulli*,” DRAFT: forthcoming in 2006 *Osgoode Hall Law Journal*, accessed online at <http://www.healthcoalition.ca/Jackman-CHC.pdf> (Retrieved 2 January 2008).

¹²⁷ Canada, Government of Canada, Department of Health, “Speaking Notes for The Honourable Ujjal Dosanjh Minister of Health,” Edmonton: Shaw Convention Centre (15 August 2005), accessed online at http://www.hc-sc.gc.ca/ahc-asc/minist/health-sante/speeches-discours/2005_08_15_e.html (Retrieved 2 January 2008).

- ❖ Cervical cancer screening for women aged 18 to 69 every three years after two normal tests;
- ❖ Cardiac bypass surgery within 2 weeks for Level I patients;
- ❖ Cardiac bypass surgery within 6 weeks for Level II patients;
- ❖ Cardiac bypass surgery within 26 weeks for Level III patients.¹²⁸

At the time the benchmarks were released, campaigning was well underway for the upcoming federal election scheduled for January 23, 2006, and the issue of wait times had become a key issue. Although the wait-time guarantees set by the first ministers were only goals and not legally enforceable, Conservative leader Stephen Harper came close to making such a commitment in his campaign in a promise to preserve the public system.¹²⁹ Harper told reporters that no patient would have to suffer an unacceptable wait for treatment under a Conservative government. He indicated that patients would be provided with the option of being treated in another hospital or even a private clinic outside of their province if they were not treated within an acceptable period of time.¹³⁰ Harper followed Martin's lead, indicating that all patients would be treated equally regardless of income, and that there would be no private, parallel system.¹³¹ However, unlike Martin, Harper and the Conservative Party did not speak out against private initiatives that were underway in Alberta, BC, and Quebec.¹³²

¹²⁸ Canada, Government of Ontario, Ontario Ministry of Health and Long-Term Care, "First Ever Common Benchmarks Will Allow Canadians To Measure Progress In Reducing Wait Times," (12 December 2005), accessed online at http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/nr_121205.html (Retrieved 2 January 2008).

¹²⁹ Robert Sheppard, "Waiting For the Cure," *CBC.ca Reality Check Team* (12 December 2005), accessed online at http://www.cbc.ca/canadavotes/realitycheck/wait_times.html (Retrieved 4 January 2008).

¹³⁰ *Ibid.*

¹³¹ CTV News, "Health care a key issue on campaign day four," (2 December 2005), accessed online at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20051201/election_day4_051202?s_name=&no_ds (Retrieved 3 January 2008).

¹³² Diana Gibson, "On health care: Stephen Harper doesn't walk the talk," *Parkland Institute: University of Alberta* (31 December 2005), accessed online at <http://www.straightgoods.ca/Election2006/ViewNews.cfm?Ref=12> (Retrieved 2 January 2008).

Harper won the election and was sworn in as Canada's 22nd Prime Minister on February 6, 2006. Contrary to his promises that there would be no private, parallel system, Harper took his first steps towards such a system just two weeks after he was sworn in, praising Quebec's motion to allow a limited role for private delivery and private insurance (Quebec's Response to *Chaoulli*: Bill 33). Describing Quebec's model as one that would effectively address the healthcare access problems, Harper told CTV that guaranteed wait times were likewise a priority for his government.¹³³

Despite Harper's election promise to reduce wait times, the issue slipped off the federal government's radar screen by July 2006. Paul Wells notes that Prime Minister Harper replaced the Conservative's fifth campaign priority of "work[ing] with the provinces to establish a Patient Wait Times Guarantee" with the more general goal of "strengthening our country."¹³⁴

Wells indicated that the reason for this was simple: the Harper government's health care policy was based on Paul Martin's 2004 healthcare deal with the provinces which sought to measure and shorten wait times. However, unlike Martin's deal, Harper wanted the deadlines to be met without any additional federal funding, forcing the provinces to provide more services than they initially agreed to.¹³⁵ Harper justified the change on the basis that he was satisfied with the progress being made by Minister Tony Clement concerning the wait-times guarantee.¹³⁶

¹³³ CTV News, "Harper praises Quebec health-care initiative," (21 February 2006), accessed online at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20060221/harper_health_060220/20060221?hub=TopStories (Retrieved 3 January 2008).

¹³⁴ Paul Wells, "Stephen Harper's new game: Hide-the-Priority-What happened to establishing a wait-times guarantee? That promise has disappeared," *MacLeans* (13 July 2006), accessed online at http://www.macleans.ca/article.jsp?content=20060724_130433_130433&source=srch (Retrieved 4 January 2008).

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*

On April 4, 2007, Harper told the press that he had fulfilled his election promise to establish Wait Time Guarantees across Canada.¹³⁷ At an Ottawa wait times conference, he reported that all ten provinces and three territories agreed to establish Patient Wait Times Guarantees by 2010. Under the yet-to-be crafted guarantee, Harper indicated that Canadians would be guaranteed “timely access” to health care in cancer care, hip and knee replacement, cardiac care, diagnostic imaging, cataract surgeries and primary care. He also announced that the Wait Time Guarantees would be supported by the 2007 Budget, which would set aside \$612 million for the Patient Wait Times Guarantee Trust and \$30 million for wait time pilot projects.¹³⁸

William P. Georgas and Lynne Golding consider the establishment of these benchmarks to be an important response to *Chaoulli*, because they could give the courts guidance in determining future health-related cases. However, they note that these benchmarks are not likely to be immune from judicial scrutiny, regardless of how well thought out they may be.¹³⁹ Georgas and Golding explain that because section 7 of the *Charter* protects individuals from physical and psychological harm, there may be cases in which a person’s right to security of person is violated even though a wait time falls within the established benchmark. Although they acknowledged that the benchmarks may not be the final word on what the courts consider to be “acceptable” for the timely

¹³⁷ Canada, Government of Canada, Office of the Prime Minister, “Canada’s New Government announces Patient Wait Times Guarantees,” (4 April 2007), accessed online at <http://pm.gc.ca/eng/media.asp?id=1611> (Retrieved 2 January 2008).

¹³⁸ *Ibid.*

¹³⁹ William P. Georgas and Lynne Golding, “Patient Wait Times: A Benchmark Issue in Healthcare” *Law and Governance* (2007), accessed online at <http://www.longwoods.com/product.php?productid=17808> (Retrieved 12 January 2008).

delivery of healthcare, they argued that the benchmarks could help prevent the development of private insurance.¹⁴⁰

Nonetheless, critics argue that the wait time deal falls short of Harper's 2006 election promise and leaves the door open to the development of private alternatives. Dr. Chris Simpson of the Canadian Cardiovascular Society warns that focusing exclusively on wait times is myopic, as other aspects of medicare may be compromised in the process.¹⁴¹ Dr. Brian Day, president of the Canadian Medical Association (CMA), agrees, and indicates that more health care professionals are needed to make the wait time guarantees effective. Day told CTV's Mike Duffy that benchmarks and standards are of little use if there is a shortage of professionals to deliver the service.¹⁴² A number of critics feel that the federal government needs to respond to *Chaoulli* with the same level of urgency as individual hospitals and health districts, many of which have increased efficiency through micro-level structural, functional, and procedural reform in an attempt to maintain an adequate standard of care.¹⁴³

However, despite a much needed cash injection of \$41 billion in additional financing dedicated to healthcare reform in 2004 (pre-*Chaoulli*) under the *10-year Plan to Strengthen Health Care*, the establishment of Wait-Time Guarantees remains the federal government's only response to wait times since *Chaoulli*. In a 2005 interview, the Honorable Roy Romanow warned politicians not to wait for the next court decision

¹⁴⁰ Ibid.

¹⁴¹ CTV News, "Critics say wait-times deal falls short of promise," (4 April 2007), accessed online at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070403/wait_times_070404/20070404?hub=CTVNewsAt11 (Retrieved 4 January 2008).

¹⁴² Ibid.

¹⁴³ Health Council of Canada, "Health Care Renewal in Canada: Measuring Up?" Annual Report to Canadians: 2006 (February 2007), accessed online at http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC_MeasuringUp_2007ENG.pdf (Retrieved 10 May 2008).

before acting.¹⁴⁴ However, it appears that the federal government has done just that. With two copycat cases on the horizon, the implications of policy inaction by the federal government may be more substantial than any policy action could have been. In chapter four, the legal responses to *Chaoulli*, including three court challenges, will be discussed and analyzed.

3.5 Conclusion

The statutory and programmatic responses to *Chaoulli* by Quebec, Alberta, and the federal government clearly illustrate the impact that the 2005 case has had on healthcare policy. Zolton Naggy, Executive Vice President of the Canadian Independent Medical Clinics Association (CIMCA), captures the essence of the argument in this chapter by stating that the Supreme Court's decision has far reaching implications and sends a clear message to governments: where wait times are concerned, "change or be changed."¹⁴⁵

In Quebec, the *Chaoulli* decision resulted in an unprecedented change in healthcare legislation. With the implementation of Bill 33, Quebec altered the way healthcare is financed and provided, thereby opening the door to private healthcare initiatives. University of Toronto Law Professor, Marie Claude Premont, believes that Bill 33 fundamentally altered core principles of Quebec's approach to healthcare, laying the foundation on which two-tier healthcare can and will gradually develop.¹⁴⁶ However,

¹⁴⁴ Kirk Makin, Jeff Sallot and Rheal Seguin, "The new face of medicare," *The Globe and Mail* (10 June 2005), accessed online at <http://www.brianday.ca/the-new-face-of-medicare.html> (Retrieved 4 January 2008).

¹⁴⁵ Zolton Naggy, "Chaoulli Decision Shapes Public Opinion," *The Canadian Independent Medical Clinics Association (CIMCA)* (2006), accessed online at http://www.cimca.ca/newsletter/issue02_01.html (Retrieved 10 October 2007).

¹⁴⁶ Marie-Claude Prémont, "Post-*Chaoulli* direction for healthcare: worrisome signs from Quebec," Health Law Workshop: University of Toronto (29 November 2007), accessed online at

it is equally possible that that Bill 33 is just a tailored solution to address the problems that were raised in *Chaoulli*. As Yu-Sung Soh points out, private insurance in Quebec is limited to certain specialized medical treatments (presently hip/knee replacements and cataract surgery).¹⁴⁷

Patrick J. Monahan feels that Bill 33 alone is an inadequate response to the issues raised in *Chaoulli*. In September 2007, he predicted that if governments fail to deal with these issues in a more direct, responsive and real way, healthcare reform may be activated and achieved by way of the judicial process instead.¹⁴⁸

The fact that the federal government's establishment of "Wait Time Benchmarks" is the only other response to *Chaoulli* attests to Monahan's claim that governments have maintained the status quo in the post-*Chaoulli* era. Monahan's argument carries considerably more weight when one considers the potential impact of *Chaoulli* "copycat cases" and increasing support for private healthcare initiatives. The progressionism of the Canadian Medical Association (CMA) is just one example of a private organization that has begun to support private healthcare alternatives in the post-*Chaoulli* era.

When *Chaoulli v. Quebec* was released in 2005, then CMA president, Dr. Albert Schumacher, issued a press release to the effect that CMA policy would continue to support and work to improve the publicly funded system.¹⁴⁹ However, just over two years later, in August 2007, the CMA's General Council (some 248 delegates

http://www.law.utoronto.ca/visitors_content.asp?itempath=5/5/0/0/0&cType=NewsEvents&specEvents=2469 (Retrieved 1 January 2008).

¹⁴⁷ Soh, "Shooting from the Hip: The Health of Universal Health Care following Chaoulli."

¹⁴⁸ Sam Solomon, "New lawsuit threatens Ontario private care ban: 'Ontario Chaoulli' case seeks to catalyze healthcare reform," *The National Review of Medicine* (30 September 2007), accessed online at http://www.nationalreviewofmedicine.com/issue/2007/09_30/4_policy_politics02_16.html (Retrieved 11 December 2007).

¹⁴⁹ Dr. Albert J. Schumacher, "The Chaoulli case and the CMA," *The Canadian Medical Association Journal* (CMAJ) (5 July 2005); 173 (1), accessed online at http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/CMA_Bulletin/English/2005/bulletinjul5.pdf (Retrieved 20 December 2007).

representing approximately 63,000 physicians) approved motions that called for private alternatives. These included a call to remove existing bans that prevent doctors from practicing concurrently in the private and public sectors or from “opting out” provided they do not “bail en masse.”¹⁵⁰ Dr. Collins-Nakai reacted to the motions thus:

The [motions] reflect the frustration doctors are feeling as they try to provide timely, quality care to patients. This frustration is driving physicians to ask [the] CMA to leave no stone unturned in providing access to better health and better care [including] private options as one possible mechanism to reduce wait-times.¹⁵¹

Moreover, Dr. Brian Day, a nationally renowned supporter of privately funded health care, referred to by his detractors as “Dr. Profit” and “the Darth Vader of health care,” was elected president of the CMA in August 2007.¹⁵² Many organizations, such as the Canadian Taxpayers Federation and Canadian Independent Medical Clinics Association, welcomed Dr. Day’s arrival as CMA president. Neil Desai, the Ontario Director for the Canadian Taxpayers Federation, believes that the election of Day demonstrates that the CMA is serious about improving the ailing Canadian health care system.¹⁵³ Zoltan Naggy agrees, and suggests that the decision by Canada’s physicians to elect Dr. Day CMA president is consistent with growing public support for an increased

¹⁵⁰ Barbara Sibbald, “Mixed message about public–private interface emerges from CMA,” *The Canadian Medical Association Journal* (CMAJ) (12 September 2006); 175 (6), accessed online at <http://www.cmaj.ca/cgi/content/full/175/6/565> (Retrieved 29 December 2007).

¹⁵¹ Ibid.

¹⁵² Jonathan Day, “Changes needed, but U.S. system isn’t for us,” *The Montreal Gazette* (1 November 2007), accessed online at <http://www.brianday.ca/gazette-health-care.html> (Retrieved 22 December 2007).

¹⁵³ Neil Desai, “Private health care works,” The Canadian Taxpayers Federation (CTF) (13 October 2006), accessed online at <http://www.brianday.ca/private-health-care-works.html> (Retrieved 27 December 2007).

role for the private sector.¹⁵⁴ He called Day's appointment a "great step toward health care choice and patient-centered care in Canada."¹⁵⁵

Despite growing support for private initiatives, the *Chaoulli* decision has not yet precipitated a dramatic shift in health policy.¹⁵⁶ The belief that the *Chaoulli* decision was the beginning of the end of universal healthcare is still more of a myth than a reality. In actuality, most Canadians still desire a publicly funded healthcare system. An Ipsos-Reid poll released on August 5, 2005 showed that 77% of Canadians favour a well-run, adequately funded, public health care system over a private pay/insurance option.¹⁵⁷ Moreover, the rejection of Ralph Klein's "Third Way" proposal is evidence of this claim.

Because of its unwillingness and/or inability to rule that a parallel health care system is constitutionally mandated, Graeme G. Mitchell, Q.C. indicates that the Court has thrown the matter back into the political and governmental arena.¹⁵⁸ However, if governments do not make swift changes to the public system in a timely manner the emergence of a two-tier system could become a reality. If this does not occur from the *Chaoulli* decision directly, it is likely to be the result of copycat cases such as *Murray v. Alberta or McCreith and Holmes v. Ontario*, which are discussed in chapter four.

¹⁵⁴ Zolton Nagy, "Dr. Brian Day's stint as CMA president is a victory for health care choice... and a blow to the defenders of the health care monopoly," News Release, Vancouver (16 August 2007), accessed online at http://www.cimca.ca/newsletter/issue07_BD_Presidency.pdf (Retrieved 20 December 2007).

¹⁵⁵ *Ibid.*

¹⁵⁶ *Chaoulli v. Quebec.*, Para. 176.

¹⁵⁷ Tiedemann, "Health Care at the Supreme Court of Canada II: *Chaoulli v. Quebec (Attorney General)*," 11.

¹⁵⁸ Mitchell, G.C. "'The Sky is Falling': An Uncommon Perspective on *Chaoulli v. Quebec (Attorney General)* and its Progeny," 25.

CHAPTER 4: LEGAL IMPLICATIONS OF CHAOULLI: POST-CHAOULLI JURISPRUDENCE

4.1 Introduction

Following the release of the *Chaoulli* decision, then Prime Minister Paul Martin and Justice Minister Irwin Cottler insisted that the ruling did not jeopardize medicare because it only applies in a provincial context.¹⁵⁹ However, lawyers disagreed, in anticipation of comparable lawsuits in other provinces where duplicate private insurance is prohibited.¹⁶⁰ Cassels Brock & Blackwell LLP (2005) note that although the decision may technically apply only to the Province of Quebec, it still has the potential to transform Canada's public health care system because three of the seven Supreme Court Justices agreed that the *Canadian Charter* was violated.¹⁶¹ Michele Warner explains that because the court did not impose any positive obligations to provide healthcare within a specific time, difficult cases can be expected in the future.¹⁶² Some firms, such as the Canadian Taxpayers Federation (CTF), even encouraged people to come forward and challenge similar laws.

Further, Tracey Tremayne-Lloyd of the Health Law Group at Gardiner Roberts LLP, anticipated that *Chaoulli* may be a boon for the "business of health," including those involved in corporate and commercial lawyering. For example, legal expertise would be needed to structure, implement and enforce new health care delivery

¹⁵⁹ The Canadian Medical Association Journal, "Supreme Court strikes ban on private health insurance," (9 June 2005), accessed online at <http://www.cmaj.ca/cgi/rapidpdf/cmaj.050716v2> (Retrieved 16 January 2008).

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² John Jaffey, "Has *Chaoulli* created an interest in the 'business of health'?" *The Lawyers Weekly*. Vol. 27 No. 34 (2 March 2007), accessed online at <http://www.lawyersweekly.ca/index.php?section=article&articleid=432> (Retrieved 18 January 2008).

mechanisms, particularly in the areas of public/private investments and partnerships in the health sector.¹⁶³

In light of this new interest, a wave of legal challenges has been initiated across Canada. Sam Solomon, of the *National Review of Medicine*, found that within eighteen months after it was handed down the *Chaoulli* decision had already been cited in 31 cases in almost every province.¹⁶⁴ Most of these cases aim at reducing public wait times and improving public financing and care, rather than seeking freer access to private medical services. Few precedents have been set where the application of *the Chaoulli* case has been considered.¹⁶⁵ However, three cases have been initiated (one in Alberta and two in Ontario) that attempt to determine some of the *Charter* issues that were left outstanding by the Supreme Court in *Chaoulli*.¹⁶⁶ These three cases, that have the potential to apply the *Chaoulli v. Quebec* precedent across Canada, include: *Flora v. Ontario*, *Murray v. Alberta*, and *McCreith and Holmes v. Ontario*. Each of them is discussed in turn below.

4.2 *Flora v. Ontario* ([2007] O.J. No. 91)

Adolfo Flora, an Ontario resident, was diagnosed with advanced liver cancer and needed a living-related liver transplant (LRLT) to extend his life. The Ontario Health Insurance Plan (OHIP) did not authorize his surgery, classifying his treatment as “too high risk” given the advanced stage of cancer. With no alternative treatments, Mr. Flora flew to England in 2001 to undergo surgery, which cost him \$450,000. The surgery was

¹⁶³ Ibid.

¹⁶⁴ Sam Solomon, “Chaoulli copycat cases crop up across country,” *The National Review of Medicine* (15 January 2007), Volume 4, No. 1, accessed online at http://www.nationalreviewofmedicine.com/issue/2007/01_15/4_policy_politics02_1.html (Retrieved 4 October 2007).

¹⁶⁵ Mitchell, “‘The Sky is Falling’: An Uncommon Perspective on *Chaoulli v. Quebec* (Attorney General) and its Progeny,” 15.

¹⁶⁶ Davis LLP, “Health Law Case Update: *Chaoulli* in 2006 and 2007,” 2.

a success, and when he returned to Canada, he appealed to the OHIP review board. His appeal was unsuccessful, so he took the case to the Divisional Court of Ontario.¹⁶⁷

As reported by Graeme G. Mitchell, Mr. Flora advanced three arguments to the court. First, he argued that the Ontario Health Services Review Board incorrectly interpreted section 28.4(a) of Ontario's Health Insurance Regulations (See Appendix D to view section 28.4 of the Ontario Health Insurance Plan). This section allows for the reimbursement of out-of-jurisdiction medical expenses, provided the services received are medically necessary and are considered an acceptable treatment within the jurisdiction.¹⁶⁸ Second, he contended that the Board did not interpret section 28.4 in a manner consistent with section 7 of the *Charter*. Third, he alleged that section 28.4 itself is inconsistent with section 7 of the *Charter*.¹⁶⁹

Mr. Flora argued that the government, having chosen to provide universal health care, was required to do so in a manner that complies with the *Charter*. Since section 28.4(2) does not provide payment for a person who needs out-of-country medical treatment in order to save his life, it violates that person's right to life. Mr. Flora said he had to choose between impending death and funding his own care.¹⁷⁰ Despite Mr. Flora's constitutional claims that state inaction violated his section 7 rights, the Divisional Court rejected each of his assertions and unanimously dismissed his application for judicial review.¹⁷¹

¹⁶⁷ Mitchell, "The Sky is Falling': An Uncommon Perspective on Chaoulli v. Quebec (Attorney General) and its Progeny," 17.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Jaffey. "Has Chaoulli created an interest in the 'business of health?'"

¹⁷¹ Mitchell, "The Sky is Falling': An Uncommon Perspective on Chaoulli v. Quebec (Attorney General) and its Progeny," 17

In rejecting the claim, Epstein J. (the Ontario Divisional Court Judge) found that OHIP's reasons for denying coverage to Mr. Flora were reasonable because the LRLT for Mr. Flora was "too risky," and thus, not generally accepted as appropriate for a person in his situation.¹⁷² Epstein J. also cited *Chaoulli*, noting that OHIP's denial of funding did potentially threaten Mr. Flora's personal security, as it could have both physical and psychological consequences.¹⁷³ Despite this, Epstein J. ascertained that Mr. Flora's claim ultimately failed because, even though his section 7 rights might be infringed, the financial burden on the state cannot be limitless.¹⁷⁴

Flora v. Ontario is significant to *Chaoulli* because of the distinctions that Divisional Court of Ontario was able to draw between the two cases. Epstein J. found that since Ontario regulations do not prohibit people from procuring out-of-jurisdiction medical services on their own dime, the public system cannot be obligated to provide every life-saving service that may be possible.¹⁷⁵ According to Kathy O'Brien, Epstein's decision supports the *Chaoulli* decision in establishing that all Canadians have the right to privately obtain any health services that the public health care system does not make "reasonably available," and any legislation that prohibits such a right violates the Canadian *Charter*.¹⁷⁶

Graeme G. Mitchell points out that the fundamental issue in *Flora v. Ontario* is whether the *Charter* demands that all life saving medical treatment be publicly funded.

¹⁷² Ibid.

¹⁷³ Ibid., 18.

¹⁷⁴ Ibid., 19.

¹⁷⁵ Caroline Helbronner, "Canada: Pension and Employee Benefits – Recent Case Law Developments," Blake, Cassels & Graydon LLP (2007), accessed online at <http://mondaq.com/article.asp?articleid=51746> (Retrieved 11 October 2007).

¹⁷⁶ Kathy O'Brien and Michael Watts, "Business Opportunities in Private Health Care in Canada," *Osler Outlook* (Spring 2007), accessed online at <http://www.osler.com/resources.aspx?id=12262&NHP=SpotCB4> (Retrieved 11 October 2007).

While the judgment suggests that doing so is not a constitutional imperative, Mitchell suggested that OHIP still faced a moral dilemma: that it should reconsider its denial of Flora's claim because of the effective outcome of his treatment.¹⁷⁷ However, as judicial supremacy increases in the post-*Charter* era, being a constitutional dilemma may not be a problem for the courts as they proceed into the realm of public policy following the *Chaoulli* decision. In chapter five *Chaoulli* and the issue of judicial supremacy in the post-*Charter* era will be discussed.

4.3 Murray v. Alberta (Minister of Health)

Bill Murray, a 57-year-old Chartered Accountant from Calgary, suffered from severe osteoarthritis in his left hip. After enduring the pain for over a year he consulted with a specialist, who recommended that Birmingham hip resurfacing surgery was the best medical option to relieve his pain and enable him to return to an "active lifestyle."

Mr. Murray was denied the surgery by the government of Alberta because he was, at age 57, "too old" to enjoy the benefits of this surgery (if he had been younger than 55 the surgery would have been permitted).¹⁷⁸ Since private medical insurance was prohibited under Alberta law (similar to Quebec prior to Bill 33), Mr. Murray had no option but to pay out-of-pocket for this medically necessary surgery.¹⁷⁹

Although the surgery was a success, not long afterwards Mr. Murray began to experience worsening pain in his right hip. Once again Mr. Murray went to see a

¹⁷⁷ Mitchell, "The Sky is Falling': An Uncommon Perspective on *Chaoulli v. Quebec (Attorney General)* and its Progeny," 19.

¹⁷⁸ John Carpay, "Taking Canada's Medical Monopolies to Court," *The Fraser Forum* (February 2007), 2, accessed online at <http://www.canadianconstitutionfoundation.ca/files/pdf/fraserforum-02-01-2007.pdf> (Retrieved 11 December 2007).

¹⁷⁹ *Ibid.*

specialist, who also recommended Birmingham hip resurfacing. This time the Alberta government went so far as to deny him the in-province surgery, even if he paid for it himself. Mr. Murray eventually received treatment in Montreal and is now back to a “healthy lifestyle.”¹⁸⁰

In August 2006, Mr. Murray commenced a lawsuit, challenging provisions in the *Alberta Health Care Insurance Act* that prohibit private health insurance for publicly funded services.¹⁸¹ In the suit, he claimed that his section 7 *Charter* rights had been violated, inasmuch as the Alberta government failed to provide him “timely access to necessary medical treatment,” while also disallowing him from accessing private insurance to cover the cost of treatment in the private sector.¹⁸²

Mr. Murray’s goal in launching the court challenge is to expand the *Chaoulli* decision across Canada and help Canadians avoid preventable physical and emotional harm.¹⁸³ John Carpay, Executive Director of the Canadian Constitution Foundation, notes that in the *Chaoulli* decision, Justice Deschamps described the courts as the citizenry’s last line of defence to under-responsive government action.¹⁸⁴ Carpay states that this description has proven to be prophetic in the case of Bill Murray.¹⁸⁵

Although *Murray v. Alberta* is still in its preliminary stages, Cassels Brock & Blackwell LLP (2007) expect that the case, no matter what the decision, will be appealed to the Alberta Court of Appeal and then the Supreme Court of Canada because of what is

¹⁸⁰ Ibid.

¹⁸¹ Cassels Brock & Blackwell LLP, “Alberta Resident Brings Class Action Law Suit to Challenge Prohibition on Private Health Care Insurance,” Toronto (2007), accessed online at <http://casselsbrock.com/publicationdetail.asp?aid=1165> (Retrieved 12 October 2007).

¹⁸² Ibid.

¹⁸³ The Canadian Constitution Foundation, “Our Court Challenges: William Murray v. Alberta (Minister of Health),” (2006), accessed online at http://www.canadianconstitutionfoundation.ca/main/page.php?page_id=5 (Retrieved 12 October 2007).

¹⁸⁴ Carpay, “Taking Canada’s Medical Monopolies to Court,” 2.

¹⁸⁵ Ibid., 3.

at stake.¹⁸⁶ They believe that the legal ramifications of *Murray v. Alberta* are likely to exceed *Chaoulli v. Quebec* primarily because:

- 1) *Murray v. Alberta* is a class action lawsuit, which means that whatever the courts decide in the case will affect all Albertans that find themselves in a situation that is similar to Mr. Murray's situation, not only Mr. Murray directly (as in the *Chaoulli* case).¹⁸⁷
- 2) The premise of Mr. Murray's case is based on a breach of the *Canadian Charter of Rights and Freedoms* rather than a breach of a provincial law (i.e. Quebec Charter). As a result, the courts will have to determine whether or not Alberta's health legislation violated the *Charter of Rights and Freedoms* (this was not clear in *Chaoulli v. Quebec* because of Justice Deschamps' decision that left the court in a deadlock).¹⁸⁸

4.4 *McCreith and Holmes v. Ontario (Attorney General)*

Lindsay McCreith, a 66 year old retired auto body shop owner from Newmarket, Ontario, was told in early 2006 that he had a brain tumor. Mr. McCreith was told that the tumor did not have to be immediately treated, and was informed that he would have to wait four and a half months to get an MRI appointment to find out if the tumor was cancerous. Unwilling to wait four months for an MRI and risk further progression of the tumor, Mr. McCreith arranged to have an MRI conducted in Buffalo for a cost of about \$500. Unfortunately, the MRI found that the tumor was malignant.¹⁸⁹

With the diagnosis in hand, Mr. McCreith attempted to schedule an appointment with a neurosurgeon in Ontario. However, even with the diagnosis, Mr. McCreith was

¹⁸⁶ Cassels Brock & Blackwell LLP, "Alberta Resident Brings Class Action Law Suit to Challenge Prohibition on Private Health Care Insurance."

¹⁸⁷ Ibid.

¹⁸⁸ Ibid.

¹⁸⁹ Chris Donovan, "Chaoulli comes to Ontario," *The Court* (25 September 2007), accessed online at <http://www.thecourt.ca/2007/09/25/chaoulli-comes-to-ontario/> (Retrieved 12 December 2007).

told that he would have to wait three months just to get an appointment.¹⁹⁰ According to McCreith's family doctor, he would have had to wait an estimated eight months to get surgery.¹⁹¹ Fearful that eight months was enough time for a cancer to spread and progress to an irreversible stage, Mr. McCreith returned to Buffalo to have the cancerous brain tumor removed in March of 2006.¹⁹²

Lindsay McCreith is convinced that he would be dead today had he not paid the \$27,600 (\$U.S.) to obtain the surgery privately. Mr. McCreith told the Canadian Constitution Foundation that he was pursuing this lawsuit to prevent other citizens from suffering the dire consequences of waiting list purgatory.¹⁹³

Shona Holmes, a 43-year-old self-employed family mediator and married mother of two, had a similar experience with the Ontario healthcare system.¹⁹⁴ In March 2005, Ms. Holmes began to experience anxiety attacks, extreme fatigue, weight gain, high blood pressure, and extreme headaches.¹⁹⁵ She looked to the Ontario healthcare system for answers and assistance. She ended up waiting seven weeks for an MRI, which revealed that she had an 8-9 mm brain tumor, four months for a consultation with a neurologist, and six months for a consultation with an endocrinologist (a doctor who

¹⁹⁰ Ibid.

¹⁹¹ The Canadian Constitution Foundation (CCF), "Ontario's healthcare monopoly challenged in court," News Release: Calgary (2 May 2007), accessed online at <http://www.canadianconstitutionfoundation.ca/files/pdf/newsrelease-05-02-2007.pdf> (Retrieved 14 December 2007).

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Marni Soupcoff, "John Carpay: Suing the government for the right to see and live," *The National Post* (7 September 2007), accessed online at <http://network.nationalpost.com/np/blogs/fullcomment/archive/2007/09/07/john-carpay-suing-the-government-for-the-right-to-see-and-live.aspx> (Retrieved 10 December 2007).

¹⁹⁵ The Canadian Constitution Foundation (CCF), "Second Plaintiff Joins Lawsuit Over Timely Access to Health Care; Action Against Ontario Government Dubbed 'Ontario Chaoulli,'" News Release: Calgary (5 September 2007), accessed online at <http://www.canadianconstitutionfoundation.ca/files/pdf/Holmes%20news%20release%205%20September%202007.pdf>. (Retrieved 15 December 2007).

specializes in the system of the body which releases hormones into the blood stream).¹⁹⁶

Frustrated with long wait times and progressive vision loss, Ms. Holmes went to the Mayo Clinic in Arizona to get a diagnosis regarding her tumor. After extensive testing, several specialists (including an endocrinologist, a neurologist and a neurosurgeon, who is licensed to practice in Ontario) determined that a Rathke's cleft cyst was causing hormone and vision problems.¹⁹⁷ They indicated that if the tumor was not removed, she could risk permanent blindness and death.¹⁹⁸

Armed with the diagnosis, Ms. Holmes attempted to receive treatment in Ontario, but was told that she would have to wait for more appointments and tests. Unwilling to wait, Ms. Holmes decided to go back to the Mayo Clinic to have the tumor removed. The surgery was a success, and within ten days, Ms. Holmes' vision was completely restored. A post-operative MRI and visual field testing confirmed that the tumor had caused the vision loss.¹⁹⁹ Candice Chan notes that the cost for Holmes to obtain her diagnosis and treatment was in excess of \$95,000.²⁰⁰

Neither Mr. McCreith nor Ms. Holmes received compensation from the Ontario Health Insurance Plan (OHIP) for seeking "medically necessary" treatment. Together, McCreith and Holmes are arguing that Ontario legislation unduly limits competition and therefore supply in healthcare, which deprives Ontarions of their right to health, life and

¹⁹⁶ Ibid.

¹⁹⁷ Ibid.

¹⁹⁸ Candice Chan, "McCreith and Holmes v. Attorney General," *Health Matters*, Volume 17, No. 1 (October 2007), accessed online at http://www.oba.org/en/hea/newsletter_en/v17n1.aspx#a6 (Retrieved 11 December 2007).

¹⁹⁹ The Canadian Constitution Foundation (CCF). "Second Plaintiff Joins Lawsuit Over Timely Access to Health Care; Action Against Ontario Government Dubbed 'Ontario Chaoulli.'"

²⁰⁰ Chan, "McCreith and Holmes v. Attorney General."

liberty as guaranteed by section 7 of the *Charter*.²⁰¹ They further argue that the Government's monopoly over essential healthcare services forced them to seek care abroad, which caused them significant financial, emotional, and physical hardship.²⁰² In September 2007, Avril Allen, the lawyer representing the plaintiffs, asserted that:

Ontario has the most draconian prohibitions and penalties ... in all other provinces, doctors can elect to opt out of medicare. Our goal is to have the prohibitions invalidated. [Then] companies could start offering private health insurance, doctors could go out and start billing patients directly, and it could be the beginning of a private healthcare system.²⁰³

McCreith and Holmes v. Ontario is the most significant legal implication of the *Chaoulli* decision. John Carpay explains that although the justices in *Chaoulli* were divided 3-3 on the issue of whether a ban on private insurance was a violation of s. 7 of the *Charter of Rights and Freedoms*, all seven justices:

Recognized that the *de facto* government monopoly over health care causes Canadians to suffer – both physically and psychologically – while waiting for medical treatment ... [and] [a]ll agreed that a law forbidding people to spend their own money on private health insurance also imposes a risk of death, and a risk of irreparable harm to one's health.²⁰⁴

Further, in *Chaoulli*, Chief Justice Beverley McLachlin famously stated that “access to a waiting list is not access to health care.”²⁰⁵ In *McCreith and Holmes v. Ontario*, both plaintiffs similarly had access to a waiting list but not healthcare.²⁰⁶ As a result, *Chaoulli* set the stage for this case, which in turn has the potential to expand

²⁰¹ Statement of Claim, *McCreith and Holmes v. Attorney General for the Province of Ontario*, 5 September 2007, Para 62-63.

²⁰² Donovan, “*Chaoulli* comes to Ontario.”

²⁰³ Sam Solomon, “New lawsuit threatens Ontario private care ban: ‘Ontario *Chaoulli*’ case seeks to catalyze healthcare reform,” *The National Review of Medicine* (30 September 2007), accessed online at http://www.nationalreviewofmedicine.com/issue/2007/09_30/4_policy_politics02_16.html (Retrieved 11 December 2007).

²⁰⁴ Carpay, “Taking Canada’s Medical Monopolies to Court,” 2.

²⁰⁵ *Chaoulli v. Quebec*, Para. 123.

²⁰⁶ Carpay, “Taking Canada’s Medical Monopolies to Court,” 2.

across Canada the precedent that *Chaoulli* set in Quebec. According to Patrick J. Monahan, generalizability to other provinces is a fundamental issue of the case.²⁰⁷ Dr. Jacques Chaoulli concurs, describing *McCreith and Holmes* as a crucial case that has a high probability of success.²⁰⁸

McCreith and Holmes v. Ontario has the potential to be the beginning of the end for a single-provider public healthcare system. However, it is too early to tell whether the case will even make it to the Supreme Court, let alone dismantle universal healthcare as we know it.²⁰⁹ Chris Donovan of York University notes that even if it reaches the Supreme Court, the justices will have to answer the many questions that have lingered in the post-*Chaoulli* era (i.e. What is a reasonable wait time? What does the term “medically necessary” mean, and how broadly or narrowly should it be interpreted?). According to Donovan, the courts may provide answers to these questions in a way that does not necessarily sound the death knell for the single-provider healthcare system.²¹⁰

Further, there is no guarantee that *McCreith and Holmes* would be decided in the same way *Chaoulli* was. Since *Chaoulli*, the composition of the Supreme Court has changed dramatically. Sack Goldblatt and Mitchell LLP note that only seven Supreme Court Justices participated in the *Chaoulli* case, because it was heard and decided after the departure of Justices Arbour and Iacobucci and before the appointments of Justices Abella and Charon. As a result, *McCreith and Holmes v. Ontario* could be decided

²⁰⁷ Solomon, “New lawsuit threatens Ontario private care ban: ‘Ontario Chaoulli’ case seeks to catalyze healthcare reform.”

²⁰⁸ Ibid.

²⁰⁹ Donovan, “Chaoulli comes to Ontario.”

²¹⁰ Ibid.

differently in front of a full court.²¹¹

4.5 Conclusion

When the Supreme Court decided that prohibitions against private health insurance violated Section 1 of the *Quebec Charter* on June 9, 2005, the decision only had legal implications in the province of Quebec. However, the precedent that was set in *Chaoulli v. Quebec* gave rise to a number of piggyback cases that challenge the effectiveness of Canada's public healthcare system. *Flora v. Ontario*, *Murray v. Alberta*, and *McCreith and Holmes v. Ontario* are three examples of piggyback cases that highlight the vulnerability of Canada's universal healthcare system.

Of the three cases discussed in this chapter, *Flora v. Ontario* is the one that has been decided and the only one that did not attempt to spread the *Chaoulli* precedent across Canada. As Graeme G. Mitchell points out, *Flora v. Ontario* actually sought to use *Chaoulli* to provide better *public* funding and more timely care to Canadians. Unlike the other two copycat cases, *Flora* did not attempt to strike down provincial legislation that prohibits the sale of private health insurance, illustrating that not all post-*Chaoulli* jurisprudence is aimed at the development of private healthcare alternatives.²¹²

However, similar to *Chaoulli*, both *Murray v. Alberta* and *McCreith and Holmes v. Ontario* aimed at the elimination of government monopolies on essential healthcare services. The Canadian Constitution Foundation (CCF) publicly supports both cases and their objectives—which are to reduce harm caused to Canadians by an inefficient and

²¹¹ Sack GoldBlatt & Mitchell LLP, “SGM's Analysis of *Chaoulli v. Quebec* (Attorney General),” (2007), accessed online at <http://www.sgmlaw.com/Page488.aspx> (Retrieved 11 October 2007).

²¹² Mitchell, “‘The Sky is Falling’: An Uncommon Perspective on *Chaoulli v. Quebec* (Attorney General) and its Progeny,” 15.

unaccountable health care monopoly. In May 2007, the CCF told the *National Post* that if either *Murray v. Alberta* or *McCreith and Holmes v. Ontario* is successful, politicians will have to accept that they can no longer prevent private health care choices, thus effectively shortening waiting times and improving care.²¹³

Their argument that the success of the *Murray* and/or *McCreith and Holmes* cases will improve wait times in Canada by opening the door to private medicare is highly contested. In *Chaoulli*, Justices Binnie and LeBel (Fish JJ. concurring) stated that creating a two-tier system (which is the ultimate goal of the CCF and *Chaoulli*) might not reduce wait times as it would deprive the public system of vital resources²¹⁴ because doctors would have to divert energy and commitment from the public system to the more lucrative private option.²¹⁵ They used the Australian experience as an example, stating that delays in the Australian public system are largely the result of surgeons' reluctance to work in public hospitals.²¹⁶

The *Kirby Report* (2002) went so far as to say that allowing a private parallel system might actually make public waiting lines longer.²¹⁷ Jeremiah Hurley et al. explain that Canada has already experienced this in private ophthalmologic sectors in Manitoba and Alberta. In those provinces, wait lists in the public system were significantly longer for doctors who provided services through both the public system and private clinics than

²¹³ "Chaoulli Comes to Ontario," *The National Post* (3 May 2007), accessed online at <http://www.nationalpost.com/news/story.html?id=b9715c69-0a5b-44e3-8407-9c18436646cb&p=2> (Retrieved 19 January 2008).

²¹⁴ *Chaoulli v. Quebec.*, Para. 181.

²¹⁵ *Ibid.*, Para. 247.

²¹⁶ *Ibid.*, Para. 245.

²¹⁷ Michael J. L. Kirby, "The Health of Canadians – The Federal Role *Volume Four – Issues and Options*," The Standing Senate Committee on Social Affairs Science and Technology Interim Report on the state of the health care system in Canada, January 2002, 42.

they were for doctors who provided services only through the public system.²¹⁸

These three conflicting claims of the CCF, dissenting justices in *Chaoulli*, and the *Kirby Report* indicate the high level of uncertainty that surrounds the potential impact of two-tier medicare on wait times. However, the controversy that surrounds the public/private debate will not prevent a two-tier system from being adopted in Canada if either *Murray v. Alberta* or *McCreith and Holmes v. Ontario* are successful. As Yuh Sung Soh points out:

If either of the two current cases [are] successful, one can expect the floodgates to open to innumerable future actions. While provincial governments may respond to a single case by granting the particular benefit sought, they cannot do so if there are countless other claimants waiting in the wings. The only practical solution would be to allow everyone access to private health care insurance and to institute a two-tier system.²¹⁹

Thus, considering the impending implications of *Chaoulli* copycat cases, the consequences of the *Chaoulli* decision are possibly quite significant and severe. As Gregory P. Marchildon stated in 2005, “the [*Chaoulli*] decision d[id] not strike down any single-payer medicare system in any province, including Quebec, [however,] it is certainly capable of becoming the Magna Carta for two-tier (or even multi-tier) medicare through judicial interpretation and extension.”²²⁰

While Canada’s universal healthcare system remains intact for the time being, *Chaoulli* “copycat cases” have the potential to provide an impetus for change. It can not be contested that the Supreme Court’s decision in *Chaoulli* created a legal environment where proponents of private medicare can and will continue to use the courts in an

²¹⁸ Ibid.

²¹⁹ Soh, “Shooting from the Hip: The Health of Universal Health Care following *Chaoulli*.”

²²⁰ Marchildon, “The *Chaoulli* Case: Two Tier Magna Carta?”

attempt to achieve their goal of a two-tier healthcare system. However, it is too early to tell whether the cases discussed in this chapter will lead to the end of Canada's universal healthcare system, as it remains uncertain whether they will make it to the Supreme Court, yet alone be successful. Nevertheless, one must be leery of the future, because the *Chaoulli* decision is a strong precedent that has launched a movement against the status quo.

CHAPTER 5: CONSTITUTIONAL IMPLICATIONS OF CHAOULLI

5.1 Introduction

Prior to *Chaoulli*, the Supreme Court avoided direct intervention in health care-policy making, showing a strong preference to leave decisions concerning health care up to elected officials and the democratic process.²²¹ However, this posture significantly changed with the release of *Chaoulli* on June 9, 2005. In the 4:3 decision, the Supreme Court struck down Quebec laws that prohibited private health insurance on the basis that they violated *Quebec's Charter of Human Rights and Freedoms*. The decision altered the role of the courts with regards to public policy. Janet Minor, Counsel for Ontario's Attorney General in *Chaoulli*, believes that the decision illustrates the fact that the Supreme Court is not afraid to take on "hot-button social issues."²²² Colleen M. Flood agrees, and suggests that as a result, the courts will be fundamental in establishing the role that private health insurance will play in the post-*Chaoulli* era.²²³

The prospect of this level of "judicial activism" that, arguably, was unheard of prior to *Chaoulli*, implies that constitutional supremacy could become a major pillar of the Canadian political order in the foreseeable future. While the United States has a long-standing legacy of active judicial review, Canada has historically exercised "British style" restrained judicial review. In fact, judicial review and supremacy are not words that were typically used to describe Canada's judiciary before *Chaoulli*. However, this

²²¹ Jay Makarenko, "The Charter & Health Care in Canada," University of Alberta (1 July 2005), accessed online at <http://www.mapleleafweb.com/features/charter-health-care-canada> (Retrieved 5 January 2008).

²²² Tracey Tyler, "Health Care Crisis: Osgoode Summit Examines Chaoulli Ruling's Implications for the Future of Health Care," *Continuum: Osgoode Hall Law School Alumni Magazine*, Winter 2006, 19.

²²³ Colleen M. Flood, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access," *The Journal of Law, Medicine & Ethics*, (1 January 2005), accessed online at <http://www.allbusiness.com/legal/3587330-1.html> (Retrieved 6 January 2008).

changed dramatically following the release of the controversial decision in June 2005. In response to *Chaoulli*, Patrick Monahan said that the majority “show[ed] a new level of judicial activism,” McGill political scientist Christopher Manfredi said that the decision was, “one of the most stunning examples of judicial hubris”²²⁴ he had ever read, and Roy Romanow said that, “the Court move[d] from deciding questions of constitutional law to matters of major public policy.”²²⁵

The Supreme Court’s judicial activism in *Chaoulli* has been referred to as the “Americanization” of the Supreme Court. Although the “Americanization” of the Supreme Court is not an implication of *Chaoulli* but rather the effect of years of North American integration and an individual and group rights movement that resulted in the implementation of the *Charter of Rights and Freedoms*, the “Americanization” of the courts, nevertheless provided a political climate where the *Chaoulli* decision was possible. The activism of Canada’s high court in *Chaoulli*, which resulted from Canadians’ increasing desire to assert the full extent of their rights on a wide array of matters, not only resulted in the policy and legal implications discussed in Chapters three and four, but constitutional implications as well.

Most discussions about the impact of *Chaoulli* focus solely on the policy and legal consequences of the case. Attention must be devoted to the constitutional implications of *Chaoulli* because it brings into question the limits of rights of citizens and the responsibilities of governments not only in the health field, but also in other policy fields. This chapter will examine the constitutional implications of *Chaoulli*, namely the

²²⁴ Tyler, “Health Care Crisis: Osgoode Summit Examines Chaoulli Ruling’s Implications for the Future of Health Care,” 19.

²²⁵ Roy Romanow, “In Search of a Mandate?” in Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada, Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 522.

elevation of healthcare to a *Charter* right and the Supreme Court's expansion of Section 7 of the *Charter of Rights and Freedoms*. It also examines how the implementation of the *Charter* established a political context for the *Chaoulli* case to emerge, and for the nature of the judicial decision rendered in the case.

5.2 *Chaoulli* and the Elevation Health Care to a *Charter* Right

Roy Romanow, former Saskatchewan Premier and head of the 2002 Royal Commission into the Future of Health Care, describes the key legal effect of *Chaoulli* as being the expansion of judicial jurisdiction into social policy-making.²²⁶ As it evolved beyond its more traditional role as arbiter of constitutional and legal issues, University of Alberta Political Scientist Jay Makarenko suggests that the Supreme Court also elevated healthcare to a *Charter* right. Though Justice Deschamps explicitly said that the *Charter* does not indicate that there is a “freestanding constitutional right to healthcare,”²²⁷ Makarenko believes that healthcare was, at least symbolically, raised to a *Charter* right because the majority asserted that there is a right to timely access to health care under section 7 of the *Charter*.²²⁸ The findings of the *Kirby Report* (2002) are consistent with Makarenko's argument. In Volume Six, the *Kirby Report* states that:

²²⁶ Tracey Tyler, “Romanow fears 'end of medicare'; Romanow slams health ruling Says buying health care violates Charter Court ruling is 'body blow' to Canada,” *The Toronto Star*, A1, (17 September 2005), accessed online at <http://osgoode.yorku.ca/media2.nsf/83303ffe5af03ed585256ae6005379c9/bb07995acb4506ef8525708100627de0!OpenDocument> (Retrieved 22 January 2008).

²²⁷ *Chaoulli v. Quebec.*, Para. 104.

²²⁸ *Ibid.*, Para. 123.

Although the *Charter* makes no explicit references to health care ... section 7 has significant implications in the health care question. That is, while health care itself may not be a right, individuals do have the right not to be prevented by government from seeking timely health care elsewhere in Canada, if the service cannot be provided in a timely manner within the publicly funded system.²²⁹

Even though the *Chaoulli* decision was based on the *Quebec Charter of Rights* and not the *Canadian Charter* (there was a 3-3 tie over the issue), Romanow explains that the precedent that there is a right to timely access applies to the *Canadian Charter* as well, through “clear implication.”²³⁰ Janice Tibbetts agrees, and told *CanWest News* that the *Chaoulli* decision did, in fact, raise health care to a *Charter* right, effectively eliminating politicians’ ability to dictate health policy.²³¹ Similarly, Norman Anderson, the lawyer representing William Murray in *Murray v. Alberta*, told *Lexpert Magazine* that the evidence in *Chaoulli* indicates that “access to care” is a constitutional right under the *Charter*.²³²

Policy experts and legal scholars argue that the elevated status of healthcare in *Chaoulli* created a new paradigm for the delivery of healthcare, which includes the right to “timely care.” Patrick Monahan told the *Globe and Mail* that governments in the post-*Chaoulli* era need to keep the right to timely care “front and centre” as they make healthcare reforms, or else they will be forced to do so by the courts.²³³ Former Deputy

²²⁹ Michael J. L. Kirby, “The Health of Canadians –The Federal Role Volume Six: Recommendations for Reform,” The Standing Senate Committee on Social Affairs Science and Technology Final Report on the state of the health care system in Canada, October 2002, accessed online at <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/rep-e/repoct02vol6part2-e.htm> (Retrieved 18 January 2008).

²³⁰ CTV News, “Canadians warned they will pay for medicare ruling,” *Canadian Press* (17 September 2005), accessed online at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20050917/medicare_ruling_050917/20050917/ (Retrieved 20 January 2008).

²³¹ Janice Tibbetts, “Privatization could mean fewer doctors,” *Canwest News* (9 June 2004), accessed online at <http://www.healthcoalition.ca/chaoulli-release.pdf> (Retrieved 14 December 2007).

²³² Paul Webster, “The Price of Health,” *Lexpert Magazine* (2006), accessed online at <http://www.lexpert.ca/globe/article.php?id=970> (Retrieved 22 January 2008).

²³³ *Ibid.*

Attorney General of Ontario, Mark Freidman, added that another expected effect of the elevation of healthcare to a *Charter* right will be a considerable rise in petitions involving patients who want quick access to health care. Like many, Freidman and Monahan contend that the courts are going to play a significant role in resolving one of the most extensive and emotionally charged debates in Canadian history.²³⁴

As protectors of *Charter* rights, the courts now have a new and important role that they did not have before the *Chaoulli* decision. The courts are now responsible, at least in part, for determining the meaning of “timely access,” establishing standards for the delivery of care, and reviewing the public healthcare system to see if it meets those standards on a case-by-case basis.²³⁵ If the Supreme Court feels ill suited for this role or that it is inappropriate for the court to establish such definitive standards regarding what is “timely access”, it could defer the responsibility to elected officials as it has in the past with reference cases (i.e. *Reference re Secession of Quebec*, [1998] 2 S.C.R. 217).²³⁶ However, even if the Supreme Court decides to defer the definitive responsibilities to elected officials, the court would still be responsible for establishing guidelines that bureaucrats would have to follow when crafting the standards, as well as enforcing and interpreting the standards in any future legal disputes.²³⁷

Justices Binnie, LeBel and Fish were well aware of the emergence of this new role if the plaintiffs won. As a result, they were very critical of the majority, asserting that establishing such guidelines should remain the sole responsibility of the legislatures

²³⁴ Ibid.

²³⁵ Jay Makarenko, “Chaoulli: Broadening the Charter and the Role of the Court.” *ThePolitic.com*, (14 June 2005), accessed online at <http://www.thepolitic.com/archives/2005/06/14/chaoulli-broadening-the-charter-and-the-role-of-the-court/> (Retrieved 9 January 2007).

²³⁶ James T. McHugh, “Making Public Law, ‘Public’: An Analysis of the Quebec Reference Case and Its Significance for Comparative Constitutional Analysis,” *The International and Comparative Law Quarterly*, Vol. 49, No. 2 (April 2000), 460.

²³⁷ Ibid.

and the democratic process because it is a difficult thing to do in a court of law.²³⁸ They indicated that the majority did not and could never properly determine what comprises “reasonable health services” or “timely care,” as they are too circumstantial.²³⁹ In Paragraph 163 Binnie and LeBel asked:

What 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 healthcare is “reasonable” enough to satisfy section 7 of the Canadian Charter of Rights and Freedoms (“Canadian Charter”) and section 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.²⁴⁰

Dr. Francois Beland, of McGill University agrees with the dissenting justices and said that the Supreme Court’s inability to discuss essential points of a debate on a public policy is evidence that the judiciary has no place in that debate, and proves that the courts are not well equipped to handle complex policy issues.²⁴¹

Similarly, Antonia Maioni and Christopher Manfredi contend that there are several problems with the courts’ new role. They argue that legislators do a better job of dealing with various aspects of complex policy issues such as healthcare, for three main reasons:

- 1) The articulation of policy demands in the form of constitutional rights can exclude alternative policy choices from consideration.
- 2) The adversarial nature of litigation is best suited for resolving concrete disputes between two parties by imposing retrospective remedies. Complex policy issues – like health care – involve multiple stakeholders, constantly changing facts and evidence, and predicative assessments of the future impact of decisions.

²³⁸ *Chaoulli v. Quebec.*, Para. 164.

²³⁹ *Ibid.*

²⁴⁰ *Ibid.*, Para. 163.

²⁴¹ Beland, “The Supreme Court missed a good opportunity.”

- 3) Rights-based litigation, particularly at the Supreme Court level, by definition imposes national solutions on inherently local problems. These solutions can ignore differences among provinces and suppress the provincial experimentation necessary to find innovative approaches to policy problems. In this particular instance, it further exacerbates growing tensions between Quebec and Ottawa over who is responsible for health care and who decides what the future of the system will look like.²⁴²

Like many, Antonia Maioni and Christopher Manfredi condemn the court for its American-style activism that elevated the constitutional status of healthcare. They maintain that the Supreme Court's decision put two cherished icons of Canadian public policy, the *Charter of Rights and Freedoms* and the public healthcare system, on a collision course.²⁴³ They believe that, rather than making sweeping judgments about complex social policy, the court should stick to deciding individual constitutional issues.²⁴⁴

However, on the other side of the debate is the view expressed by Justice Deschamps, who stated that:

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.²⁴⁵

Stanley Hartt supports this view and contends that the *Chaoulli* decision was justified because governments have failed to resolve problems that have ailed the healthcare system for years. He argues that *Chaoulli* is a wonderful wakeup call for our society because the Canadian government now has to invest in, or lose the public health system, thus, forcing the government to "put its money where its mouth is." Hartt acknowledged

²⁴² Ibid.

²⁴³ Ibid.

²⁴⁴ Amy Smeltzer, "Chaoulli revives public health care debate," *Ultra vires* (18 October 2005), 6, accessed online at <http://www.ultravires.ca/pdf/UVOct05.pdf> (Retrieved 22 January 2008).

²⁴⁵ *Chaoulli v. Quebec.*, Para. 96.

that allowing private Medicare would primarily benefit the wealthy. However, he suggests that it is not the role of the courts, but rather the role of government, to ensure that access to health care is relatively equal. Hartt believes that the court's only job is to make sure rights are not being violated, and that since the courts did their job, the government should be embarrassed.²⁴⁶

Despite much criticism and some praise for the decision, the precedent set in *Chaoulli* stands and the constitutional status of healthcare has been raised. As a result, future cases such as *Murray v. Alberta* and *McCreith and Holmes v. Ontario* will have to deal with many questions that were left unanswered in *Chaoulli*, such as: What are reasonable health services? What constitutes medically necessary services? And what is treatment within a reasonable time? Sujit Choudhry points out that until these questions are decided, *Chaoulli* has designated the courts as the arbitrators of “reasonable wait times” for “medically necessary services” on a case-by-case basis. Choudhry concludes that *Chaoulli* has created an “institutional quagmire, a constitutional quicksand that will severely test the lower courts.”²⁴⁷

5.3 *Chaoulli* and the Expansion of Section 7 of the *Charter of Rights and Freedoms*

When the *Charter of Rights and Freedoms* was accepted by the Federal and Provincial governments (except Quebec) in 1982, it was understood that it would be a “constitutional vehicle” that would protect vulnerable Canadians from harm, just as Canada's universal public healthcare system protects those who are unable to afford

²⁴⁶ Smeltzer. “Chaoulli revives public health care debate,” 6.

²⁴⁷ Choudry, “Worse than Lochner,” 93.

necessary medical treatment.²⁴⁸ However, it was also understood that rights under the *Charter* were limited. As Roy Romanow explains, the *Charter* was not intended to protect against “economic deprivations or guarantee benefits” that may enhance an individual’s section 7 rights to life, liberty, or security of person (i.e. cosmetic or non-medically necessary surgery). Nevertheless, the Supreme Court’s decision in *Chaoulli* did just that, expanding section 7 of the *Charter*.²⁴⁹

Despite the fact that Justice Deslisle J.A, of the Quebec Court of Appeal distinguished economic claims like the right to purchase private health insurance from fundamental section 7 rights, the Supreme Court interpreted section 7 in a way that extended it to include a right to purchase private insurance.²⁵⁰ William P. Georgas and Lynne Golding indicate that all seven justices that sat on *Chaoulli*, not just the slim majority, acknowledged that a lack of timely access to healthcare may infringe a patient’s section 7 rights to “life” and “security of person” in at least some instances.²⁵¹ Thus, the entire Supreme Court bench determined that a denial of health services for medically necessary procedures, within a “reasonable time,” could violate an individual’s section 7 rights.²⁵²

Nola Ries, a research associate at the University of Alberta Health Law Institute, does not find the expansion of section 7 into health matters overly surprising. Ries indicates that the courts have been dealing with health issues since 1988 with *R. vs. Morgentaler*, and have continued to do so up to the *Chaoulli* decision in 2005 (i.e. *Rodriguez v. British Columbia* (1993), *Hitzig et al. v. Her Majesty the Queen* (2003), and

²⁴⁸ Romanow, “In Search of a Mandate?” 523.

²⁴⁹ *Ibid.*

²⁵⁰ *Ibid.*

²⁵¹ Georgas and Golding, “Patient Wait Times: A Benchmark Issue in Healthcare.”

²⁵² *Ibid.*

Auton v. Attorney General of British Columbia (2004)).²⁵³ Given previous section 7 claims, she believed that *Chaoulli* was inevitable. Similarly, volume six of the *Kirby Report* notes that a number of legal experts recognized that section 7 has application to healthcare, and that it was merely a matter of time before its parameters would be explored more thoroughly in the courts. Patrick Monahan and Stanley Hartt, authors of *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadian*, similarly predicted the expansion of section 7. They maintained that:

An individual's decisions with respect to his or her medical care are fundamental personal decisions affecting health, life and death and are therefore protected under the section 7 liberty guarantee. Consequently, when governments effectively prevent individuals from obtaining health care outside the publicly funded system, they have a concomitant obligation to ensure that timely care is provided within that system.²⁵⁴

However, one's level of surprise or foresight does not change the fact that the expansion of section 7 in *Chaoulli* opened up the possibility of a further broadening of the *Charter* into social and economic rights. For example, there are presently no "constitutionalized social rights" other than healthcare ("access to timely care"), which may change in the post-*Chaoulli* era. In Romanow's response to *Chaoulli*, in the article titled *In Search of a Mandate?*, he says that the Supreme Court's decision to expand section 7 may be an indication that the Court wants to put its touch on other public programs and policies as well, and not necessarily in a way that is consistent with fundamental Canadian values.²⁵⁵

Jay Makarenko illustrates the expansive and destructive potential of Section 7 in the following example:

²⁵³ Peter Jaworski, "Dr. Jacques Chaoulli, Freedom Fighter," *Western Standard*, (October 2004), 33.

²⁵⁴ Kirby, "The Health of Canadians –The Federal Role Volume Six: Recommendations for Reform."

²⁵⁵ Romanow. "In Search of a Mandate?," 523.

Take a situation in which a person is unable to access medical treatment because they cannot pay for it. Timely access to health care is definitely limited in this case - in fact, the person cannot receive medical treatment at all. Further, this would seem to trigger the Section 7 interests of life and security of the person (as the majority has defined them in the *Chaoulli*). If one cannot access health care at all, then there is a great risk of suffering and death. The courts could then, and with little further justification, extend the right to include situations in which other barriers (besides the absence of opportunity) limit persons' access to timely medical treatment. This would definitely make the Section 7 right to timely access a full-fledged social right.²⁵⁶

He suggests that if section 7 were expanded in such a manner, the argument could be made that private medicare could exist, as long as the public healthcare system took care of those who are unable to afford private insurance. However, the government would be obligated to provide care that was consistent with the right to equality under Section 15 of the *Charter*. Therefore, if a parallel system came into existence, the quality of service would have to be comparable or else people could assert that they were being discriminated against on the grounds of income or wealth. Makarenko adds that it is questionable whether it is even possible to provide "healthcare equality" in a country as regionally diverse as Canada, and that efforts to provide such equality would entail be astronomical economic and social costs.²⁵⁷

Finally, Makarenko contends that prior to *Chaoulli*, such an extension of the *Charter* was not possible because one could not make arguments about extending section 7, let alone section 15. As Romanow explains, past section 7 cases have been treated with caution and sensitivity, in recognition of its "potentially expansive content."²⁵⁸ However, this sensitivity was abandoned in *Chaoulli*, setting a precedent under which the

²⁵⁶ Makarenko, "Chaoulli: Broadening the Charter and the Role of the Court."

²⁵⁷ Ibid.

²⁵⁸ Romanow, "In Search of a Mandate?," 524.

Charter could be further expanded in the future.²⁵⁹ Byron Williams, Director of the Public Interest Law Centre, concludes that:

Regardless of one's views on the public health care system in Canada and whether the Supreme Court was right or wrong in its deliberations, *Chaoulli* is extremely important ... [because it] broadened the scope of s. 7 considerably by entering into the health care realm, a matter not, some would argue, typically considered to fall within "the administration of justice." The door may have been opened sufficiently wide enough for future cases that challenge any legislative scheme that infringes upon one's rights to life, liberty and/or security or the person in an arbitrary manner.²⁶⁰

5.4 The implementation of the *Charter of Rights and Freedoms*: Setting the stage for the "Americanization" of the courts, *Chaoulli*, and future activism

The implementation of the *Charter of Rights and Freedoms* in 1982 forever altered the functioning and operations of the Supreme Court of Canada and helped set the stage for the *Chaoulli* decision. Former Chief Justice Antonia Lamer refers to the introduction of the *Charter* as being "nothing less than a revolution on the scale of the introduction of the metric system, the great medical discoveries of Louis Pasteur, and the invention of penicillin and the laser."²⁶¹

With the implementation of the *Charter*, the Supreme Court was given the institutional framework required to become an effective protector of basic rights of disadvantaged groups and individuals. Through this new power, the court's traditional function of adjudicating disputes involving federalism and the separation of powers changed to making decisions regarding fundamental rights and liberties, such as

²⁵⁹ Ibid.

²⁶⁰ Byron Williams, "The Canadian Charter of Rights and Freedoms - The First 25 Years from an Applicant's Perspective, The Public Interest Law Centre (2007), accessed online at http://publicinterestlawcentre.ca/Charter_25_years.pdf (Retrieved 24 January 2008).

²⁶¹ Ran Hirschl and Christopher L. Eisgruber., "Prologue: North American constitutionalism?," *International Journal of Constitutional Law*, April 2006, Vol. 4, Issue 2, pp. 203-212.

expression, religion, and due process.²⁶² Peter Russell illustrates this change by indicating that constitutional law has become the most significant “legal category” on the Supreme Court’s docket in the *Charter* era.²⁶³

Constitutional experts Ran Hirschl and Christopher L. Eisgruber indicate that as a result of the shift, the Supreme Court has become one of Canada’s most important policy-making bodies, much like it is in the United States. Further, they point out that, since 1982, the role of Canadian courts has evolved from merely mediating disputes between governments to making decisions that have serious implications for the policy-making powers of the legislature and executive. Hirschl and Eisgruber suggest that the Supreme Court’s willingness to settle controversial political questions (not legal questions) is evidence of this claim. Some contentious political questions the Supreme Court of Canada has made judgment on in recent years include: the rights of indigenous peoples, same-sex marriage, language rights, the political and cultural distinctness of Quebec, and the topic of discussion in this thesis, the right to private healthcare.²⁶⁴

The newfound willingness of the Supreme Court of Canada to deal with these complex political and social issues is more characteristic of an American-style of adjudication than a traditional Canadian one, a fundamental symptom of the “Americanization” of the Canadian judicial system. Stephen Brooks describes “Americanization” as a process in which the promotion of individual rights trumps

²⁶² Ibid.

²⁶³ Peter H. Russel, “The Supreme Court and the Charter: Quantitative Trends Continuities and Discontinuities,” Research Project: Canada Watch from the Robarts Centre for Canadian Studies, vol. 6 (4,5,6) (1998), accessed online at <http://www.yorku.ca/robarts/projects/canada-watch/> (Retrieved 14 January 2008).

²⁶⁴ Hirschl and Eisgruber, “Prologue: North American constitutionalism?”

deference to political authority.²⁶⁵ Brooks suggests that since the implementation of the *Charter*, Canadians consider themselves to be more “rights bearing” and increasingly “differential” towards politicians. Consequently, they become more reliant on the courts than parliament for important political decisions (i.e. the right to private health insurance). According to Brooks, this behavioral shift has altered the role of Canada’s political institutions, specifically the judiciary, to become more American-like.

Christopher P. Manfredi agrees, and contends that the so-called “Americanization” of the judicial system is the direct and progressive result of the *Charter*. Manfredi suggests that without the *Charter*, the Supreme Court would have never been able to deal with complex policy issues like it did in *Chaoulli*. He explains that the *Charter* has increased the judicial policymaking power of the courts by expanding the range of social and political issues that are subject to the court’s jurisdiction. He argues, therefore, that an outcome like *Chaoulli* should be expected, as it is a commensurate expansion of the Court’s decision making capacity.²⁶⁶ Andrew Petter, Dean of Law at the University of Victoria, concurs, and suggests that the political decision-making of the Supreme Court in *Chaoulli* should come as no surprise. After all, politicians and scholars have nurtured the Court’s power since the inception of the *Charter* in 1982, and as such have empowered the court to make judgments on political issues.²⁶⁷

²⁶⁵ Stephen Brooks, “Political Culture in Canada: Issues and Directions,” in *Canadian Politics*, 4th Edition, ed., James Bickerton and Alain Gagnon (Peterborough: Broadview Press, 2004), 75.

²⁶⁶ Christopher P. Manfredi, “Déjà vu All Over Again: Chaoulli and the Limits of Judicial Policymaking,” in *Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada*, Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 140.

²⁶⁷ Andrew Petter, “Wealthcare: The politics of the Charter Revisited,” in *Access to Care Access to Justice: The Legal Debate Over Private Health Insurance in Canada*, Eds. Flood et al., (Toronto: University of Toronto Press, 2005), 120.

Petter believes that this type of American style judicial activism will persist in the future, as politicians increasingly look to the courts to solve problems they cannot win in the political arena.²⁶⁸ Charles Wright agrees, and indicates that the reason the government failed to resolve waiting list problems prior to *Chaoulli* was because of the political cost involved. Wright asks: “How do you get governments and politicians to face tough decisions that may lose them next election?”²⁶⁹ Judicial activists argue that the only way to do this is through the courts. As the *Harvard Law Review* suggests, even if the judiciary did not advocate an adequate solution (private insurance) to the ailments of the public healthcare system, *Chaoulli* nevertheless forced governments to respond to the situation. The *Harvard Law Review* argues that if the issue was simply deferred to the legislature rather than the courts, little would have been done to improve wait lists and the unacceptable status quo would have been legitimized.²⁷⁰

Regardless of whether one prefers the American-style of judicial activism used by the Supreme Court of Canada in *Chaoulli*, the fact remains that *Chaoulli* heightened the policy-making powers of the courts within the Canadian polity. As Hirschl and Eisgruber suggest, *Chaoulli v. Quebec* brings Canada closer to judicial convergence with the United States with respect to judicial activism, the judicialization of politics, and the scope of its constitutional rights jurisprudence.²⁷¹ This convergence is commonly referred to as the “Americanization” of the judicial system and has fundamentally altered the role and behavior of the courts.

²⁶⁸ Ibid.

²⁶⁹ Smeltzer, “Chaoulli revives public health care debate,” 6.

²⁷⁰ The Harvard Law Review, “Due Process - Right to Medical Access - Supreme Court of Canada Holds That Ban on Private Health Insurance Violates Quebec Charter of Human Rights and Freedoms - *Chaoulli v. Quebec*,” Vol. 119 Issue 2, 677-684.

²⁷¹ Ibid.

Many hope that the Supreme Court will recalibrate its approach in future cases and steer clear of public policy issues and political decision-making. However, the battle looks tough for these hopefuls, as the courts have set in motion a chain of events that will be hard to undo. As Allen C. Hutchinson points out, the judiciary has been responsible for dealing with an increasing number of political controversies that used to be resolved in the House of Commons.²⁷² Consequently, Patrick Monahan's suggestion that the precedent of *Chaoulli* means that healthcare reform might be achieved through the courts instead of legislators is entirely possible.

4.5 Conclusion

Before *Chaoulli*, virtually all decisions regarding how and when patients could access medical services were considered to be beyond the purview of the *Charter* and the courts, and solely the responsibility of the democratic legislatures.²⁷³ However, this all changed with the *Chaoulli* decision, when four Supreme Court Justices ruled that prohibitions against private health insurance violated section 1 of the *Quebec Charter*, three of whom also ruled that the prohibitions violated section 7 of the *Canadian Charter*.²⁷⁴ The Supreme Court's decision to directly intervene in healthcare policymaking showed an unprecedented level of judicial activism, which resulted in a number of constitutional implications.

²⁷² Allan Hutchinson, "Three for thought: what you need to read about the Charter of rights and freedoms," *The Globe and Mail*, D23 (14 April 2007), accessed online at <http://osgoode.yorku.ca/media2.nsf/83303ffe5af03ed585256ae6005379c9/64ce7416eaae3dae852572ba00658f3a!OpenDocument>. (Retrieved 16 January 2007).

²⁷³ Makarenko, "Chaoulli: Broadening the Charter and the Role of the Court."

²⁷⁴ *Ibid.*

The most visible of these implications is the elevation of healthcare to a “*Charter* right.” While the elevated status of healthcare is merely symbolic, the effects of its elevation are very real and have the potential to completely transform the Canadian healthcare system. Healthcare’s constitutional promotion now forces governments to deliver “timely care” to patients. Failing that, they risk further court challenges and the possibility of being forced into adopting a two-tier healthcare system, since the justices determined that individuals have a constitutional right to timely healthcare under Section 7 of the *Charter of Rights and Freedoms*.

The elevation of healthcare also had an effect on the operation of the courts, as they now have a new role to play in the field of health policy. The courts now have the responsibility to determine what timely access means and to review the health system to see if it meets those standards. In effect, the courts will act as arbitrators of “reasonable wait times” on a case-to-case basis. Although it is argued that this is not the proper role of the courts, the precedent set in *Chaoulli* bestows the courts with a constitutional responsibility to deal with future healthcare issues.

A separate but related constitutional implication regards the Supreme Court’s expansion of Section 7 of the *Charter*. While the constitutional and political negotiators involved in the creation of the *Charter* never intended section 7 to protect the “economic rights” of citizens, the justices in *Chaoulli* ignored section 7’s original intent and extended it to include such rights. Consequently, it can be argued that justice in *Chaoulli* was calculated by personal preference rather than broader social need, using section 7 to protect the right of one and jeopardizing the rights of many. The potential for further expansion of the *Charter* exists, however, it is uncertain whether or not this decision will

be a major turning point in how the court deals with future cases regarding medicare and other public policies.²⁷⁵ However, Romanow is especially convinced that the Supreme Court's decision to expand section 7 in *Chaoulli* set in motion a chain of events that will ultimately lead to a litigious attack on the fundamental values of Canadians, redistributing social justice and adversely affecting other public policies and programs.²⁷⁶

It is important to note that the *Chaoulli* case would never have been decided the way that it was if the *Charter of Rights and Freedoms* had not been in place. The implementation of the *Charter* in 1982 fundamentally altered the behavior of the judiciary, giving the courts the power it needed to make decisions such as *Chaoulli*. Although the decision to deal with health policy in *Chaoulli* is surrounded by controversy, academics and policy experts agree that the decision was the predictable consequence of progressive judicial liberation. Constitutional experts accordingly contend that *Chaoulli v. Quebec* is just one step further towards judicial convergence with the United States. Further, they believe that the decision drastically changed how the court will look at social policy and *Charter* rights in the future. In this respect, it is possible that *Chaoulli* could have implications well beyond the health sector. However, this is also open to debate. Given the fact that *Chaoulli* was decided 4-3 and there was a shortened bench (7 justices rather than 9), it is entirely possible that the next time a charter issue is raised regarding the "deprivation of social and economic rights" a slightly different set of justices may decide that the courts should not be involved in such issues. Therefore, *Chaoulli v. Quebec* may not be the key singular case that determines the role

²⁷⁵ Romanow, "In Search of a Mandate?," 523.

²⁷⁶ Ibid.

of the courts with regard to social and economic policy. But, if it turns out to be that case, *Chaoulli* could have implications well beyond the health sector.

CHAPTER 6: CONCLUSION

6.1 Introduction

The central objective of this thesis has been to examine the policy, legal, and constitutional implications of *Chaoulli v. Quebec (Attorney General)* with a view to determining the effects that the Supreme Court's decision has had both on the rights of Canadians within the scope of the publicly funded healthcare system and on the structure of that system. In the preceding chapters, the policy, legal, and constitutional effects of *Chaoulli* have been discussed separately. The primary objective of this concluding chapter is to summarize and analyze the findings and to provide some suggestions for further research.

6.2 Summary of Major Findings

The *Chaoulli* decision has done more than just instigate public debate surrounding the future of the Canadian healthcare system. It has resulted in adjustments to federal and provincial healthcare policies, additional court cases on the rights of individuals to health care, and the expansion of the importance of the Canadian and Quebec Charters of rights and freedoms for the operation of Medicare in Canada. However, despite these implications it is still too early to tell whether the *Chaoulli* decision was the start of a revolution towards privatization of health and hospital care that will result either in a two-tier system or the complete demise of the public healthcare system.

The enactment of Bill 33 in Quebec, which permitted the establishment of private hospitals and associated medical clinics, is evidence that the door to private health

insurance and a two-tier system has been opened. Marie-Claude Prémont notes that, prior to Bill 33, Quebec's provincial government assured its constituents that maximum financial and human resources would be channeled towards a healthcare system that was devoted to the "whole of the population," not a private system that caters to only a small portion of the population. Like many, she believes that the structure set in place by Bill 33 established a foundation on which a two-tier system can and will develop.²⁷⁷

However, whether Bill 33 is merely a limited solution to address wait times and nothing more than Quebec's required response to *Chaoulli*, or whether it is a key measure in moving toward the development of a two-tier system, is open to debate. The extension of Bill 33 in Quebec to other health services and the development of a two-tier system in Canada is highly dependent on the future responses of the provincial and federal governments in meeting the health care needs of citizens. Thus, it remains unclear whether *Chaoulli* triggered political responses that will fundamentally alter the face of medicare or whether it is merely a court decision in which the legal and constitutional implications are still unclear.

The only other official policy response to *Chaoulli* besides Bill 33 was the promise by the provinces and territories to establish "Patient Wait Guarantees" by 2010. The establishment of these "legally enforceable guarantees of timely access to medical care" is absolutely essential in protecting legislative prohibitions on accessing private healthcare and preventing the development of a two-tier system.²⁷⁸ If these guarantees are either not established or are considered to be inadequate by the judiciary, it is likely that constitutional challenges in other provinces such as *Murray v. Alberta* and *McCreith*

²⁷⁷ Prémont, "Post-*Chaoulli* direction for healthcare: worrisome signs from Quebec."

²⁷⁸ Monahan, "Chaoulli v Quebec and the Future of Canadian Healthcare: Patient Accountability as the 'Sixth Principle' of the Canada Health Act," 24.

and *Holmes v. Ontario* will be successful because the *Chaoulli* decision affirmed that Canadians cannot be denied access to timely care.

The Supreme Court's affirmation of this right in *Chaoulli* has many implications. The primary effect of *Chaoulli* is that the right to timely care cannot be confined to the province of Quebec. As Patrick J. Monahan states:

Post-*Chaoulli*, it is simply not sustainable politically for political leaders outside of Quebec to suggest that their citizens lack basic rights to timely care that are available only in Quebec ... political discussions that have occurred over the past year have implicitly accepted that the result of *Chaoulli* applies across the country, rather than in a single province.²⁷⁹

The emergence of *Flora v. Ontario*, *Murray v. Alberta*, and *McCreith and Holmes v. Ontario* validate Monahan's argument that the implications of *Chaoulli* are widespread and appear to be growing with time. These copycat cases further indicate that if governments do not establish legally enforceable limits on waiting times for medically necessary services, the courts will require them to provide individuals with the opportunity to purchase private insurance for required services. In the words of Monahan, *Chaoulli* created a "new paradigm for the delivery of healthcare that includes the right of patients to timely care." Like many other observers, he believes that if they fail to keep such rights "front and centre" in health care planning, governments will be forced to do so by the courts through jurisprudence in other provinces (i.e. *Murray v. Alberta* and *McCreith and Holmes v. Ontario*).²⁸⁰

Another effect of affirming that Canadians have a constitutional right to "timely care" has to do with the role of Canada's judiciary. As a result of the *Chaoulli* ruling, the courts are now partially responsible for determining what "timely access" means and for

²⁷⁹ Ibid., 23-24.

²⁸⁰ Webster, "The Price of Health."

reviewing the healthcare system to see if it meets those standards. Prior to *Chaoulli*, the Supreme Court judges were very careful to focus on constitutional and legal principles and to avoid dealing with social policies. However, the intervention of the courts into the realm of health policy in *Chaoulli* altered the historical role of the courts because, according to Romanow, “the court ventured beyond constitutional and legal principles and into complex social policy.”²⁸¹

In doing so, the justices in *Chaoulli* expanded Section 7 of the *Canadian Charter* so that it now, at least symbolically, applies to healthcare. Even though the *Chaoulli* decision was decided based on Section 1 of the potentially broader *Quebec Charter* (4-3), rather than Section 7 of the *Canadian Charter* (3-3) policy and legal experts agree that the *Canadian Charter* applies to healthcare through “clear implication” because of the similarities between Section 1 of the *Quebec Charter* and Section 7 of the *Canadian Charter* (See Appendix B). As a result, the courts must now deal with this “new right” (the right to ‘timely care’) by acting as arbitrators, determining whether wait times are “reasonable” on a case-to-case basis. Not only does this transfer authority from elected officials to appointed judges, but it also threatens the very existence of Canada’s universal healthcare and other social programs. Simply put, the precedent set in *Chaoulli* indicates that the application of Section 7 could be applied to other social policies, none of which are now “off limits” to the courts.

Taking the expansive potential of Section 7 into consideration, the implications of *Chaoulli* seem limitless. However, just three years after the Supreme Court decision was handed down, the full implications of the case are still unclear. One can only speculate as

²⁸¹ Tyler, “Romanow fears ‘end of medicare’”.

to whether the *Chaoulli* decision will inevitably lead to the development of a two tier healthcare system or merely to substantive reform to the single payer system.

In the post-*Chaoulli* era, the future of the Canadian healthcare system lies in the hands of elected and appointed officials, including judges. It is up to these officials to either improve the universal single-payer system by providing timely access to care and establishing performance benchmarks, or to allow the introduction of private alternatives. The progress and pace of healthcare reform will determine which option will prevail.

It remains to be seen whether Canadians will “stand up for Medicare”²⁸² While there is still time to do so, if swift action is not taken by governments the implementation of a two-tier healthcare system in Canada is only a matter of time. Odette Madore states that:

The *Chaoulli* decision has [legally] opened the door to the development of a two-tier system ... it is no longer possible to simply debate whether or not a private market for health care insurance should exist ... the question now is how best to make use of the duplicate private health care insurance market given the lessons learned from other countries’ experience.²⁸³

There is no denying that the *Chaoulli* decision opened the door to private health insurance in Quebec with the implementation of Bill 33, and created the possibility for “copycat cases” to produce similar results in the rest of Canada. However, it can be argued that *Chaoulli* is not the end of Medicare in Canada. While the Supreme Court affirmed that adequate and timely health care is a constitutional right of all Canadians, it did not make a definitive ruling as to whether a parallel health care system is

²⁸² Roy Romanow, “Now’s the Time to Stand up for Medicare,” *The Globe and Mail*, 10 June 2005, accessed online at <http://www.longwoods.com/product.php?productid=17187> (Retrieved 12 December 2007).

²⁸³ Madore, “Duplicate Private Health Care Insurance: Potential Implications for Quebec and Canada.”

constitutionally mandated. Thus, it effectively returned the matter to the federal and provincial governments.

As a result, the federal and provincial governments have been granted an opportunity to modernize Medicare by shortening wait times and providing timely access to Canadians. In 2005, Steven Lewis aptly said “The choice is ours: We can be fiddlers or firefighters [for Medicare] as Rome [ha]s [been] set ablaze.”²⁸⁴ In the future, Canadians will have to determine whether they want to improve the public system by devoting more resources and/or maximizing the utility of existing resources to reduce wait times and improve care or have the courts rule in favor of the emergence of a two-tier health system.²⁸⁵

6.5 Suggestions for Future Research

In addition to research to examine more fully the implications of *Chaoulli* and the “copy cat cases” for the various provincial and territorial health care systems in Canada in the near and distant future, some further research should be undertaken regarding two-tier and multi-tier health care systems. Previous studies conducted by the Honorable Roy J. Romanow (the Commission on the Future of Health Care in Canada) and Honorable Michael J.L. Kirby (The Standing Senate Committee on Social Affairs, Science and Technology) have already examined foreign health systems and the potential advantages and disadvantages of adopting a two-tier or multi-tier healthcare system in Canada. Future research should not duplicate these comprehensive studies, but rather use the information collected in both studies, along with supplementary research, to determine

²⁸⁴ Lewis, “Medicare’s Fate: Are We Fiddlers or Firefighters.”

²⁸⁵ Kirby, “The Health of Canadians - The Federal Role Volume Six: Recommendations for Reform,” 303.

what type of two-tier or multi-tier healthcare system would be preferable in the event that Canada has to allow private insurance due to judicial decisions.

Future research must re-examine foreign healthcare systems to develop a two-tier or multi-tier model that attempts to minimize the negative effects (i.e. cream skimming, longer wait lists, and queue jumping) and maximize the benefits (i.e. efficiency, consumer choice, and responsiveness) associated with such systems. In doing so, it is important to consider the effects that private medicare could have on different provinces, given that provinces such as Saskatchewan and New Brunswick already permit supplementary private insurance but do not have a market that could sustain a system of private health care, whereas densely populated provinces such as Alberta and Ontario could easily sustain a system of private health care.

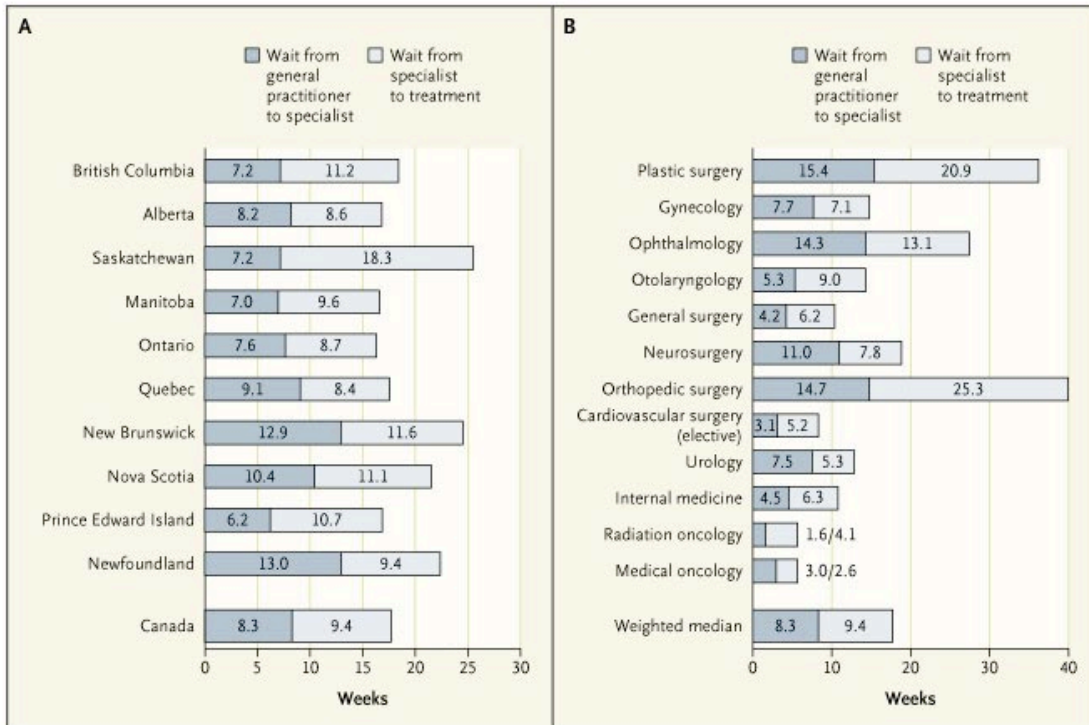
Such research is even more necessary now than it was when the reports produced by Kirby and Romanow were released in 2002 (pre-*Chaoulli*). Given the *Chaoulli* decision and the pending decisions on *Murray v. Alberta and McCreith* and *Holmes v. Ontario*, it is vital that the federal and provincial governments be prepared to adopt a two-tier or multi-tier healthcare system in case either challenge is successful. If governments are not adequately prepared, they could be forced by the courts into developing a two-tier or multi-tier system regardless of whether they are adequately prepared to do so.

Future research also needs to be conducted on whether the adoption of a two-tier or multi-tier system will prevent future *Charter* challenges like *Chaoulli v. Quebec* and *Murray v. Alberta*. Considering that section 7 was extended in *Chaoulli* and the demand

for health care is potentially limitless,²⁸⁶ it is possible that citizens could continue to make demands on the state for more extensive and substantial health care services. It may be wrong to assume, as some do, that if Canada adopts a two-tier or multi-tier system, there will be no more *Charter* challenges in the realm of healthcare. *Chaoulli* may have let the genie out of the bottle, and getting it back into the bottle may be impossible.

²⁸⁶ Marchildon, “The Chaoulli Case: Two Tier Magna Carta?”

Appendix A: Wait Time Data (2005)



Median Wait from Referral by General Practitioner to Treatment in 2005, According to Province (Panel A) and Specialty (Panel B).

From: Robert Steinbrook. "Private Health Care in Canada." *In the New England Journal of Medicine*. Volume 354:1661-1664. April 20, 2006. Number 16. <http://content.nejm.org/cgi/content/full/354/16/1661>. (Retrieved 13 December 2007).

Appendix B: Laws Challenged in *Chaoulli v. Quebec*

Section 11 of the Hospital Insurance Act, R.S.Q., c. A-28: No one shall make or renew, or make a payment under a contract under which

- (a) A resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;
- (b) Payment is conditional upon the hospitalization of a resident; or
- (c) Payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

Section 15 of the Health Insurance Act, Sec. R.S.Q., c. A-29: 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.

Section 1 of the Quebec Charter: Every human being has a right to life, and to personal security, inviolability and freedom.

Section 7 of the Charter of Rights and Freedoms: 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.

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

From: *Fasken Martineau DuMoulin LLP. "Chaoulli v. Quebec (Attorney General) A new frontier for Canadian health care?" in Health Law Bulletin. June 2005.*

Government of Canada. "Your Guide to the Canadian Charter of Rights and Freedoms Special Edition." Ottawa, 2002.

Appendix C: The Five Principles of the Canada Health Act (CHA)

- 1. Public Administration:** This criterion applies to the health insurance plans of the provinces and territories. The health care insurance plans are to be administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions.
- 2. Comprehensiveness:** The health insurance plans of the provinces and territories must insure all insured health services* (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners. *See definition under Health Care Services Covered by the Act.
- 3. Universality:** One hundred percent of the insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.
- 4. Portability:** Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" province during any minimum waiting period, not to exceed three months, imposed by the new province of residence. After the waiting period, the new province or territory of residence assumes health care coverage.

Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to entitle one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, insured services are to be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

In some cases, coverage may be extended for elective (non-emergency) service in another province or territory, or out of the country. Prior approval by one's health insurance plan may also be required.

5. Accessibility: The health insurance plans of the provinces and territories must provide:

- Reasonable access to insured health care services on uniform terms and conditions, unprecluded, unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (age, health status or financial circumstances);
- Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
- Reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- Payment to hospitals to cover the cost of insured health care services.

From: *Health Canada*. "Canada Health Act Overview." 25 November 2002. <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2002/2002_care-soinsbk4_e.html>. (Retrieved 2 January 2008).

Appendix D: Section 28.4 of the Ontario Health Insurance Plan

For out-of-country reimbursement for health services Section 28.4 of the Ontario Health Insurance Plan lays out the test that applicants must meet to receive compensation:

(2) Services that are part of a treatment and that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

(a) The treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and

(b) Either,

(i) That kind of treatment that is not performed in Ontario by an identical or equivalent procedure, or

(ii) That kind of treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.

Source: *David Baker and Faisal Bhabha. "Universality and Medical Necessity: Statutory and Charter Remedies to Individual Claims to Ontario Health Insurance Funding." In Health Law Review. Volume 13. No. 1. 2004. Pg. 28.*

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