No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO, WALID KHALFALLAH, by his litigation guardian DEBBIE WAITKUS and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANT

(cont'd on following page)

WRITTEN SUBMISSIONS OF THE COALITION INTERVENORS

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A. Overview

1. The intervenors Dr. Duncan Etches, Dr. Robert Woollard, Glyn Townson, Thomas McGregor, British Columbia Friends of Medicare Society and Canadian Doctors for Medicare (the "**Coalition Intervenors**") intervene in this trial pursuant to orders of this Court dated November 20, 2009, January 10, 2013, and May 21, 2014. These orders granted the Coalition Intervenors leave to submit legal argument and tender two expert reports (Professor Marie-Claude Prémont and Dr. David Himmelstein).[1]

2. The Coalition Intervenors represent some of the most vulnerable beneficiaries of BC's universal public health care system, who together with many others depend on the benefits and protections afforded by the challenged measures, and stand the most to lose if those benefits and protections, including those contained in ss. 14, 17, 18 and 45 of the *Medicare Protection Act* (the "**challenged measures**")[2] are struck down. The Coalition Intervenors also represent physician providers of health care committed to the principles of universality and equal access. Together with their patients, these physicians would shoulder the damaging consequences if BC's publicly funded single payer Medicare system is undermined or dismantled.

3. In the Coalition's submissions, the specific and unique context of this case drives the analysis of each aspect of the constitutional analysis advanced by the Coalition Intervenors. Specifically, and unlike the cases that the plaintiffs rely on, what is at stake is the constitutional validity *not* of a criminal prohibition, but of the Province's most comprehensive health and social benefit scheme through which the Province seeks to safeguard the lives and health of British Columbians.

4. Moreover, as the record before this Court demonstrates (and as extensively set out in the factums of the AGBC and AGC), BC's publicly funded health care system has been implemented in order to overcome the deficiencies of a private market for health care, and has immeasurably improved the ability of its residents, who depend entirely upon the public health care system to provide necessary medical services. This includes the vulnerable disadvantaged and other lower income residents who could not afford private insurance.

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[1] Expert Report of Professor Marie-Claude Prémont, dated June 29, 2014 ("**Prémont Report**"), Ex 158; Expert Report of Dr. David Himmelstein, dated June 26, 2014 ("**Himmelstein Report**"), Ex 199

[2] *Medicare Protection Act*, RSBC 1996, c 286 [***MPA*** or the ***Act***]

5. Furthermore, as the historical record demonstrates, it is precisely because of the adverse effects of permitting the growth of a parallel private market for health care that elected legislatures across Canada, including BC, have collectively established our public medicare system and enacted measures similar to the challenged measures, aimed at discouraging the growth of a parallel private or two-tiered system.

6. In short, the challenged measures are part of a legislative and public policy scheme which is intended to provide all British Columbians with equitable access to essential medical services based on need and not ability to pay. It would be ironic indeed if this public system were to be dismantled as a result of the *Charter*, when the *Charter* itself is premised on the same fundamental values of human dignity and equal concern and respect for all which form the foundation of BC's publicly funded medicare system.

7. This court should reject the plaintiffs' invitation to engage in a *Lochner*-type review of the wisdom of fundamental legislative protections in the realm of health care social and economic policy.[3] Under the plaintiffs' proposed approach, there would be a constitutionally protected right, only for those with the ability to pay, to access a private market for health care, but at the detriment of a public system enacted to protect all Canadians. This approach is inconsistent with the widespread recognition that, in various areas of social and economic policy, including health care, state intervention to regulate and control the private market in the public interest (including regulating the price for medical services and the ability to practice in both a private and publicly funded system) is both necessary and appropriate. It is also inconsistent with the deliberate decision not to protect property or economic rights within the ambit of s. 7 of the *Charter*.

8. The plaintiffs' heavy reliance on the majority decision in *Chaoulli*[4] rests on a very dubious premise.. As Professor Sujit Choudhry opines:

> Perhaps the real explanation for the judgment is the Court's sense that the political process has failed to address the problem of waiting lists. And so the Court took it upon itself to force governments to act.
>
> But if that is the true reason for the Court's otherwise indefensible ruling, it is a flimsy one indeed. To be sure, the idea that judicial review should redress the inadequacies of democratic

[3] see Sujit Choudhry, "Worse than Lochner?", in Flood, Roach and Sossin, *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) [**Choudhry**]
[4] *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 [***Chaoulli***]

> politics is one of the principal justifications for the *Charter*. But it is important to carefully define the circumstances under which one can honestly say that politics systematically and unfairly disadvantages certain interests. One strand of the post-*Lochner* approach to constitutional adjudication in the United States was that courts should selectively intervene to protect 'discrete and insular minorities' whose interests are likely to be systematically disregarded in majoritarian politics. This idea makes sense of an aggressive approach to constitutional adjudication in the defence of the rights of gays and lesbians, criminal accused, and aboriginal peoples.
>
> But *Chaoulli* was exactly the opposite sort of case. It was a challenge to a *universal* social program. And the design feature of the program at issue – the legal and practical inability to opt out of waiting lists – potentially affects everyone at some stage of their lives. The persons on wait lists are not a small minority of Canadians lacking in political power. They are our mothers and fathers, our brothers and sisters, our friends and co-workers, and, indeed, ourselves. To be sure, politics can be difficult and slow. But this was an easy case for the Court to leave to the political process, instead of attempting to save Canada from itself. [5]

9. In this case it is our clients and those many other vulnerable and marginalized persons in their situation who are the "discrete and insular minority" that the challenged provisions are designed to protect. It is also the case that the challenged provisions are for the benefit of all British Columbians. Some of us, maybe all of us, from time to time may wish to have our medical conditions addressed more quickly than the system allows. That is understandable. But having to wait one's turn is not unconstitutional.

10. The Coalition Intervenors adopt the submissions of the AGBC and the AGC, on s. 7, s. 15 and the application of s. 1. In these submissions, the Coalition Intervenors focus on the following:

a. the relevant context for interpreting and applying the *Charter* to the challenged measures;

b. the absence of a sufficient causal connection between any alleged s. 7 harms suffered and the challenged measures;

c. the multiple objectives served by the challenged measures, including the preservation of a publicly managed health care system, the preservation of a fiscally sustainable health care system for BC, and the maintenance of a health care system in which access to medically necessary medical care is based on need and not an individual's ability to pay;

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[5] Choudhry, at pp 95-96 [emphasis added]

d. the extent to which there is a connection between those objectives and the challenged measures, such that there is no inconsistency with the s. 7 principles of fundamental justice; and

e. even if a breach of s. 7 or 15 could be established, this is a case in which the requirements for s. 1 justification have been met given the contextual circumstances, and the extent to which the challenged measures are proportionate to advancing the singular importance of the objectives they serve.

B. The Relevant Context for Interpreting and Applying the *Charter* to the Challenged Measures

11. Context is critical in *Charter* adjudication. This is true in interpreting the scope of constitutional rights, but also in determining the purposes of legislation, its impacts, and in any s. 1 analysis.[6] In this case, the broader context is distinctly different from leading s. 7 cases (*Bedford*,[7] *Carter*[8] and *Morgentaler*[9]), which arose in the criminal context where the state uses the blunt tool of the criminal law to punish individuals. The case at bar is different in at least two fundamental ways.

12. First, the challenged measures are not criminal prohibitions. Instead, they comprise the central tenets of a complex socio-economic benefit and protective regulatory scheme, which is the subject of significant federal and provincial funding. These protections operate individually and in tandem with the rest of the scheme to deliver BC's most comprehensive social benefit – a universal, publicly managed and fiscally sustainable health care system available to all British Columbians in which access to medically necessary medical care is based on need and not an individual's ability to pay.

13. On the record before this Court, as reviewed in the AGBC's overview of the BC health care system at s. 3.2 of its submissions, there can be no dispute that for most Canadians, including the most disadvantaged and vulnerable, access to necessary health care depends upon extensive

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[6] See e.g.: *R v Big M Drug Mart Ltd.*, [1985] 1 SCR 295, p 344; *Edmonton Journal v Alberta (Attorney General)*, [1989] 2 SCR 1326, pp 1355-56 (per Wilson J.); *Canadian Egg Marketing Agency v Richardson*, [1998] 3 SCR 157, ¶53; *R v Keegstra*, [1990] 3 SCR 697; *R v Lyons*, [1987] 2 SCR 309, ¶85; *R v Michaud*, 2015 ONCA 585 [***Michaud***], ¶85
[7] *Canada (Attorney General) v Bedford*, 2013 SCC 72 [***Bedford***]
[8] *Carter v Canada (Attorney General)*, 2015 SCC 5 [***Carter***]
[9] *R v Morgentaler*, [1988] 1 SCR 30 [***Morgentaler***]

governmental legislation, regulation and funding, all of which make up our medicare system and is necessary to protect their life and health. Indeed, the provisions of the legislation are consistent with the constitutional commitment, set out in s. 36 of the *Constitution Act, 1982,* to promoting equal opportunities for the well-being of Canadians, and providing essential public services of reasonable quality to all Canadians.[10]

14. This important social and economic context should inform this Court's approach to the s. 7 claim in this case. The challenged legislation protects the right to life and security of the person of all British Columbians, including the vulnerable and silent rights-holders whose equal access to quality health care depends on the challenged protections. As Justice Cory noted in *Wholesale Travel Group Inc.*:

> It would be unfortunate indeed if the *Charter* were used as a weapon to attack measures intended to protect the disadvantaged and comparatively powerless members of society. It is interesting to observe that in the United States, courts struck down important components of the program of regulatory legislation known as "the New Deal". This so-called "Lochner era" is now almost universally regarded by academic writers as a dark age in the history of the American Constitution.
>
> … The importance of the vulnerability concept as a component of the contextual approach to *Charter* interpretation... should apply whenever regulatory legislation is subject to *Charter* challenge.[11] [emphasis added]

Justice Cory's caution applies with full force in this case.

15. Second, and unlike *Bedford, Carter* and *Morgentaler*, the challenged measures in this case neither criminally nor absolutely prohibit anyone from accessing any medical care, or otherwise safeguarding their s. 7 rights. Instead, they are regulatory measures, intended to discourage the growth of a parallel private system which would threaten the equity, fiscal sustainability and viability of the publicly funded health care system. The challenged measures operate as follows:

a. Section 14 permits a physician who is enrolled with the Commission to "opt out" of the billing process, and bill beneficiaries directly. The beneficiaries must then claim reimbursement from the Commission for the amount billed.

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[10] *Constitution Act, 1982,* s. 36(1)

[11] *R v Wholesale Travel Group Inc.*, [1991] 3 SCR 154, pp 233-34; see also *Slaight Communications Inc. v Davidson*, [1989] 1 SCR 1038, p 1051; *Irwin Toy Ltd. v Quebec (Attorney General),* [1989] 1 SCR 927 [***Irwin Toy***], p 993; *R v Edwards Books and Art Ltd.*, [1986] 2 SCR 713, p 779

b. Section 17 prohibits the charging of beneficiaries for benefits. Section 17(2)(d) stipulates that this prohibition does not apply to services provided by physicians who have not enrolled with the Commission.

c. Section 18 prohibits non-enrolled physicians from charging beneficiaries more than the amount permitted by the fee schedule, for services provided in publicly funded hospitals or community care facilities. These same limits also apply to physicians who have opted out under s. 14, regardless of where they provide their services.

d. Section 45 prohibits contracts of insurance that would cover the cost of services that are already publicly funded, i.e. that are benefits when provided to beneficiaries.

16. However, nothing in the Act prohibits a non-enrolled physician, i.e. a physician who chooses not to participate in the public health care system, from providing services (or a patient from receiving services from such a physician), with only the price being regulated where the service is provided in a publicly funded facility. While a non-enrolled physician cannot also provide services as an enrolled physician within the publicly funded health care system, there is no prohibition on that physician offering medical services entirely on a private basis. This is unlike *Bedford* and *Carter*, where there was an absolute (and criminally enforced) prohibition on safeguarding the s. 7 rights at issue.

17. Third, the plaintiffs accept that there is no affirmative obligation of government to provide health care to the general public. Yet, they assert that government is obliged to establish a complicated regulatory regime for private medical insurance for their benefit, subsidize the corporate plaintiff's private enterprises with public funds, and permit physicians who benefit from the public system to bill in an entirely unregulated fashion outside the public system - all so the most advantaged residents have access to private health care and the physicians themselves personally benefit. However, if there is no obligation for the state to provide medical care to the general public, there cannot be an obligation on the state to assist in the creation of a private health care system which advantages only the most well-off British Columbians. For these reasons, government is not acting in an arbitrary or disproportionate fashion when it uses the regulatory levers available to it to discourage the creation of a parallel system where it has a reasoned apprehension that it will threaten the well-being of the public system designed to serve everyone.

18. There should be no mistaking the effects of this challenge if successful: it will privilege the interests of certain, already wealthy, physicians and allow queue jumping by our most financially well-off citizens all to the disadvantage of relatively less well-off and poorer patients, and all of those physicians who are committed to the public health care system. This would be a perverse application of our *Charter*.

C. Insufficient Causal Connection Between Challenged Measures and Alleged Harms

19. The context described above has important implications for the question of causation at this first stage of the s. 7 analysis. In *Bedford*, the Supreme Court of Canada held that the "sufficient causal connection" standard should prevail in *Charter* adjudication. The Court reasoned: "[t]his is a flexible standard, which allows the circumstances of each particular case to be taken into account", and requires "a real, as opposed to a speculative, link."[12]

20. On the issue of causation, the Coalition Intervenors adopt AGBC's submissions (s. 4.2.3.2 of their closing argument) and AGC's submissions (see ¶¶238-43) and, in addition, emphasize the following.

21. First, in considering whether there is sufficient causal connection between the challenged measures and the alleged interference with the s. 7 interests of the patient plaintiffs, the Coalition Intervenors submit that it is important to consider that, under the legislative scheme at issue in this case, the challenged measures do not constitute an absolute prohibition against access to private care, in the same manner as the absolute prohibitions in cases like *Bedford* and *Carter*. As can be seen when the challenged measures are considered carefully (see AGBC's submissions, s. 3.1.1), they do not impose a blanket prohibition.

22. Physicians, such as those operating at the corporate plaintiff's clinic, are free under the challenged measures to provide care outside the public system, so long as they do so outside of public facilities, and are not enrolled in or reimbursed by the public system. Thus, while the plaintiffs contend that the challenged measures cause the alleged interference with s. 7 interests by prohibiting access to private treatment options outside of the public system,[13] there is no such

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[12] *Bedford*, ¶¶75-76
[13] Plaintiffs' submissions, ¶¶50, 2785-86

absolute prohibition.

23. In this respect, Professor Marie-Claude Prémont, one of two expert witnesses called by the Coalition Intervenors, was qualified to give expert evidence, *inter alia*, in health care organization, delivery and financing in Canada, and the operation of private insurance and private insurers.[14] As Professor Prémont explained in her expert report:

> Provinces have never forced physicians to enroll into the public system. Physicians can decide not to enroll or be non-participants. As a corollary, Canadian provinces do not forbid physicians from engaging in a completely separate and private practice, so long as it is financed privately. Instead, what provinces do is ensure that the public funds cannot be directed to support a private healthcare system. In other words, provinces have used their regulatory powers in healthcare to minimize cross-subsidization from the public system to a private delivery of care set up to cater to customers or patients paying with private insurance or out-of-pocket money, be it to jump the queue or not. Thus, physicians are free to engage into a totally private practice (with some limitations, in particular regarding hospital care), but when doing so, they must assume all the risks of a private practice. They cannot count on public funding to round up their private revenues. This is achieved with the prohibition of co-mingling. Physicians cannot simultaneously be in the public system and out of it; they must choose.
>
> The third measure, the capping of un-enrolled physician fees at the level of the public tariffs, purports to limit deleterious competition from privately funded care…
>
> In a nutshell, the main objective of the three measures of provincial regulation is to minimize the overlapping of public and private insurance and delivery covering the same health services. The measures maintain private and public healthcare as two separate systems with no financial connection. It prevents unjust competition from private delivery of care that could attract health professionals with higher pay and better working conditions, because a duplicative private system has no duty to poorer and sicker populations.[15]

24. If the corporate and physician plaintiffs view the public system as deficient in terms of access to operating room time, or otherwise, they are permitted to engage in a private practice. It is not BC's most complex and comprehensive social benefit scheme, protecting the health and lives of all beneficiaries, that causes these physicians not to offer their services outside of that system, but rather the economic and business decisions of the corporate and physician plaintiffs, who choose to seek to take advantage of the benefits of the public system while also practicing outside of the public system.

25. Second, the causal relationship in this case is very different from and more attenuated than

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[14] Ruling of Qualifications of Marie-Claude Prémont on May 13, 2019 (Day 154), 3:17-3:37
[15] Prémont Report, Ex 158, pp 6-7 [emphasis added]

in cases like *Bedford* and *Carter*, including in the following respects:

a. unlike in *Bedford* and *Carter*, reducing the risk to any s. 7 harms arising from unreasonably long wait times involves very challenging and complex social and economic policy considerations. The BC government has been and continues to actively take measures to reduce those harms (see, for example, s. 3.2.7 to 3.2.12 of its closing submissions), and those measures are more likely to reduce any risk arising from wait times than permitting a parallel private health care system (see the expert evidence summarized in AGBC's submissions at s. 3.7.1);

b. in *Bedford* and *Carter*, removal of the criminal prohibitions would decrease the risk of harm for the claimants, but without increasing the risk of harm for others. In this case, removal of the challenged measures would not decrease the risk of harm for all those who depend on the publicly funded health care system, but instead would likely increase their risk of harm as wait times grew longer in the public system (see AGBC's submissions at s. 4.2.4.3, ¶¶1901-89);

c. the plaintiffs have not established that removal of the challenged measures would remedy unreasonably long wait times. Indeed, wait times exist in various health care systems in other countries regardless of the mix of private and public funding or insurance, including health care systems that permit, to varying degrees, some elements of private insurance, dual practice and extra-billing (see AGBC's submissions at ss. 3.2.10.5, 3.2.11, 3.7.3 and 3.8).

For these reasons, the plaintiffs have not met their burden of establishing a sufficiently close causal relationship between wait times and the challenged measures.

D. Principles of Fundamental Justice

26. Even if the plaintiffs were able to persuade this Court that the challenged measures have deprived them of their life, liberty or security of the person, they have not made out a breach of s. 7 because they have not established that such a deprivation was not in accordance with the principles of fundamental justice.

i. The Objectives of the Challenged Measures

27. The first step in assessing whether a law is arbitrary, overbroad or grossly disproportionate is to identify the objects of the challenged measures.[16] Only if the law has no connection to the legislative objectives can it be found to be arbitrary in all, or some, of its applications and hence overbroad. Similarly, any assessment of whether a law is grossly disproportionate to any of its legitimate objectives must first identify the objectives of the challenged law.

28. The objective is identified by an analysis of the provision in its full context. In general, the articulation of the objective should focus on the ends of the legislation rather than on its means, be at an appropriate level of generality and capture the main thrust of the law in precise and succinct terms.[17] Precision also requires that courts focus on the purpose of the particular statutory provision subject to constitutional challenge.[18] Courts should articulate the legislative objective in a way that is firmly anchored in the legislative text, considered in its full context, and avoid statements of purpose that effectively predetermine the outcome of the overbreadth analysis without actually engaging in it.[19] The appropriate level of generality, therefore, resides between the statement of an "animating social value" (such as protecting life in *Carter*[20] or enhancing confidence in the justice system in *Safarzadeh-Markhali*[21]) which is too general - and a narrow articulation, which can include a virtual repetition of the challenged provision, divorced from its context - which risks being too specific.[22]

29. Furthermore, for the purpose of determining whether a law is inconsistent with these principles of fundamental justice, the analysis does not question the importance or appropriateness of the objective. Rather, it takes as a given that the legislative objective is appropriate and lawful, and merely seeks to determine whether the challenged legislative provisions have any connection to the legislative objectives, and whether the effects of the law are grossly disproportionate to those

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[16] *Carter*, ¶73
[17] *R v Moriarity*, 2015 SCC 55 [***Moriarity***], ¶26, see also ¶¶27-28; *R v Safarzadeh-Markhali*, 2016 SCC 14 [***Safarzadeh-Markhali***], ¶¶26, 28
[18] *Safarzadeh-Markhali*, ¶28
[19] *Moriarity*, ¶32
[20] *Carter*, ¶76
[21] *Safarzadeh-Markhali*, ¶34
[22] *Moriarity*, ¶28; *Carter*, ¶77

same objectives.[23]

30. For their part, the plaintiffs misstate the scope of the legislative objective, seeking to limit the legislative objective of ensuring equitable access to health care to a concern over equitable access only within the publicly funded system.[24] However, attempting to restrict the legislative purpose to equitable access only within the publicly insured health care plan is an unduly and deliberately narrow conception of the legislative purpose. Moreover, as set out below it ignores the actual broader legislative objective of ensuring equitable access to medical care provided by enrolled physicians, whether or not services are provided in the public system or in any private clinics.

31. While the Court is not bound by a legislative articulation of purpose; the courts do look to the text, context and scheme of the *Act* in order to infer purpose.[25] Notably, in this case, the *MPA* contains a statement of the statutory objective: "The purpose of the Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay."[26] As is clear from the text, the legislative concern with access to necessary medical care is based on need and not ability to pay applies to all necessary medical services within the health care system as a whole.

32. This broader purpose is also supported by the preamble to the legislation, which includes affirming the belief that "medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations," confirms and entrenches "universality, comprehensiveness, accessibility, portability, public administration and sustainability as the guiding principles of the health care system of British Columbia," and which commits to "the preservation of these principles in perpetuity," to "developing an efficient, effective and integrated health care system aimed at promoting and improving the health of all citizens and providing high quality patient care that is medically appropriate and that ensures reasonable access to medically necessary services consistent with the *Canada Health Act*, to a fiscally sustainable health care

[23] *Moriarity*, ¶30; *Safarzadeh-Markhali*, ¶29
[24] Plaintiffs' submissions, ¶¶2721, 2864-73
[25] *Moriarity*, ¶31
[26] *MPA*, s. 2

system for future generations," and to "an individual's access to necessary medical care be[ing] solely based on need and not on the individual's ability to pay."

33. As can be seen, the legislative objective is firmly focused on access to necessary medical care based on the principles of the *Canada Health Act*, and need rather than ability to pay in the health care system as a whole.[27] Indeed, as set out in AGC's written submissions (see, for example, ¶¶3, 17, 102-05 and 109), this understanding of the legislative objective is entirely consistent with the historical record that the dominant concern of the federal government, including under the *Canada Health Act*, has been with ensuring that equity and fairness prevail in the provision of medically necessary insured health care services, wherever those services are provided.[28]

34. This understanding of the legislative objective is also firmly supported by the legislative history surrounding the enactment and extension of the challenged measures. For example, on June 22, 1992, in introducing the *Medical and Health Care Services Act*, Minister Perry stated that it "is essential now to preserve the key characteristics of medicare: equal access regardless of one's economic status; equal access, whether or not you are rich or poor, to good treatment;… not to be in the position where one must rely on being a charity case."[29]

35. On Second Reading of Bill-71, Minister Glen Clark stated that:

> … [t]he medicare system is under a great deal of pressure across the country, pressures to undermine the system. There are pressures to impose user-fess, pressures to de-insure services – in other words, not to provide universal access to the full range of services that we have today – and pressures to eliminate health care coverage for a whole range of services.

He added that Bill 7:

> … continues a tradition… of saving medicare, reforming medicare, retaining universal access to medical services and not having a two-tiered system, one for the rich and one for the poor.[30]

36. On that same day, Minister Clark stated that:

> In the last day or two, what the BCMA has said is the bottom line. Their bottom line is that they want user fees; they want the right to opt out; they want the right to extra-billing. They want to de-insure services from British Columbians, and they want more taxpayers' money put into their pockets. The inevitable result of what the BCMA has asked for is a two-tiered

[27] Prémont Report, Ex 158, at p 15
[28] see AGC's submissions, ¶¶70-91, 103-05, 295-96, 305-07
[29] Ex 584A, Tab 24, at p 2845 [emphasis added]
[30] Ex 584A, Tab 29, at p 3224 [emphasis added]

health care system: one for the rich, and one for the poor.[31]

… [t]his government is not backing down on user fees. It is not backing down on extra-billing for doctors. It is not going to allow opting out or the undermining of universal medicare in this province. We will do everything we can to ensure, protect and enhance our medicare system as we have come to know it over the last few years. Bill 71 is an improvement. It is a way in which we can deal with these financial crises together.[32]

37. In introducing the *Medicare Protection Act* in 1995, Minister Ramsey stated as follows::

This legislation is an essential step forward to protecting medicare for British Columbians. It protects patients from paying extra charges for medicare services in our province; it bans extra-billing for medicare services. It covers some 3,000 services paid for by medicare, covering the full health care spectrum, from simple blood tests to complex neurosurgery. This legislation says clearly and strongly that every British Columbian must have equal access to medicare services regardless of income. That means no tray fees, no more suture fees, no more facility fees, no extra charges at all for medicare services.

... With this legislation, British Columbia becomes the first province in Canada to entrench the founding principles of medicare in law: universality, comprehensiveness, accessibility, portability and public administration.[33]

38. On second reading, on July 10, 1995, Minister Ramsey stated:

This legislation, which bans extra-billing of patients in British Columbia, is part of an ongoing commitment to protect medicare for all British Columbians and their children. This legislation shows British Columbians that they can depend on this government to make sure that health care is available to all of us on the basis of need, not on the size of someone's wallet.[34]

The legislation will, for the first time in any Canadian province, entrench in provincial law the five founding principles of Canadian medicare: universality, comprehensiveness, accessibility, portability and public administration.[35]

39. During that same day of debate at second reading, Minister Ramsey observed that:

Finally, we are working with [the BCMA] on how we deal with the threat of two-tier medicine. We have had extensive negotiations with the BCMA…. This initiative is no surprise; I and the Premier of this province have been talking since January about the necessity of making sure that one-tier, Canadian-style medicare is the reality for this generation of British Columbians and for future generations.[36]

40. The Minister also alluded to "two-tier" health care systems in the UK and New Zealand:

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[31] Ex 584A, Tab 29, at p 3225 [emphasis added]
[32] *Ibid*
[33] Ex 584B, Tab 38, at p 16405 [emphasis added]
[34] Ex 584B, Tab 39, at p 16750 [emphasis added]
[35] Ex 584B, Tab 39, at p 16751
[36] Ex 584B, Tab 39, at p 16775 [emphasis added]

> I keep hearing again and again in various versions: "Look at Great Britain; look at New Zealand." Let's look at them. What has two-tier medicine done for them? Has it increased or decreased wait-lists in the public health sector. It has increased them. Has it "taken the pressure off" the public health system? No, it has not. Instead, it has drained resources from the public health system and made it worse for person after person in New Zealand and Great Britain.[37]

41. In Committee, discussing the preamble of the *MPA* bill, which cites the principles of universality and accessibility, Minister Ramsey said:

> Let's just say that I and, I think, all members of the Legislature believe that medicare is one of our defining features as a nation. It is widely recognized that access to medicare without financial barriers is one of the hallmarks of our system, and I think that it is broadly acknowledged that there are growing threats to that access without financial barriers. The provisions of this act lower and remove those financial barriers. I think the preamble reflects the intent of the act.[38]

42. Furthermore, in 1997, the *MPA* was amended to further address extra-billing. Minister MacPhail referred to the legislation as ensuring universality and accessibility in this way:

> This legislation ensures the protection of medicare services in British Columbia and builds on the Medicare Protection Act. Universal access to medical services is a defining principle of health care in Canada. The amendments to the Medicare Protection Act will protect the rights of British Columbians to equal access to medical services regardless of income or where they live. This government is ensuring that medicare coverage is truly universal and that all British Columbians register with the Medical Services Plan and have the opportunity to receive health care benefits. We are strengthening provisions that prohibit the extra-billing of patients by physicians. We will ensure that there are no loopholes that would allow even a small minority of practitioners to extra-bill.[39]

43. As is abundantly evident, one of the specific objectives of the challenged measures was to discourage the development of a two-tiered health care system, precisely because of the effect this would have on equitable access to physician services. While the plaintiffs may wish the critical equity objectives of the legislation were more limited in scope, they must take the objectives as they actually exist, in meeting their onus of establishing inconsistency with principles of fundamental justice. In the intervenors' submission, it is clear that the objective of equal treatment applies to all British Columbians in need of medical care and to the health care system as a whole, and that this necessarily includes discouraging the existence of a two-tier system. Far from being

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[37] Ex 584B, Tab 39, at p 16776
[38] Ex 584B, Tab 40, at pp 16983-84
[39] Ex 584B, Tab 43 at p 3269 [emphasis added]

merely an "animating social value," as the plaintiffs contend,[40] this is one of the primary and core objectives of the challenged measures.

44. Furthermore, in their articulation of the legislative purpose, the plaintiffs assert that the "the purpose of the challenged measures is to protect the accessibility and viability of the public system, **by** ensuring that patients can receive treatment in the public system without financial barriers, and that sufficient physicians are available to provide treatment in the public system [emphasis added]."[41] However, apart from unduly narrowing the actual objective of the legislative provisions, this also ignores the injunction not to focus unduly on the *means* by which the challenged measures achieve their purpose, wrongly equating the means by which the legislative operates to the level of objective. When, as here, *how* the *Act* achieves its purpose is described, the argument has shifted to describing *means* not objective.[42]

45. The plaintiffs argue that, because some patients can seek medical care outside of the country or when injured at work or in car accidents, the core equity objective of the legislation is therefore somehow restricted to physician services provided only within the public system, and does not apply to the services that they wish to provide through a parallel private insurance market.[43] However, the fact that the legislation, and its objective, does not extend to physician services outside of BC, or to injured worker or automobile insurance claims,[44] amounts at the very most to an argument of under-inclusiveness.[45] However, it does not support the plaintiffs' contention that the legislative equity objective should be artificially narrowed. In short, and contrary to the plaintiffs' contention, the legislative objective is not indifferent to whether there is a parallel

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[40] Plaintiffs' submissions, ¶2866
[41] Plaintiffs' submissions, ¶2864
[42] Apart from misstating the legislative objective, the plaintiffs also misstate the legislative means by which that objective is achieved, which includes the challenged measures. See also *Ward v Canada (Attorney General)*, 2002 SCC 17, ¶19
[43] Plaintiffs' submissions, ¶¶2881-84
[44] For which there is a cogent explanation, as set out in AGBC's submissions, ss. 3.2.2 and 3.3, and AGC's submissions, ¶¶38, 55-57, 329-32
[45] Moreover, when it comes to the s. 7 principles of fundamental justice analysis, under-inclusiveness is not a relevant factor. Rather, in order to establish that legislation is arbitrary, it is necessary to show no connection between the measure and the objective, not that the measure does not go far enough. Indeed, so long as there is some connection, the extent to which the measure furthers the objective e is a matter for the legislature and not the courts. As the Court recently stated in *Ewert v Canada*, 2018 SCC 30, ¶73: "[t]he fact that a government practice is in some way unsound or that it fails to further the government objective as effectively as a different course of action would is not sufficient to establish that the government practice is arbitrary."

private health care system in which access to physician services is based not on need but ability to pay. Indeed, the plaintiffs know that, once it is recognized that the legislative objective includes preventing a two-tiered system from being established, they cannot possibly succeed in their claim that the challenged measures are arbitrary, overbroad or grossly disproportionate, since they seek to strike down the specific provisions aimed at promoting that very objective.[46]

46. Based on the above, the Coalition Intervenors submit that the legislation, including the challenged measures, serve at least three inter-related objectives, as follows:

a. ensuring access to medically necessary medical services based on need and not an individual's ability to pay;

b. preserving publicly managed health care system; and

c. preserving a fiscally sustainable health care system.

ii. The Challenged Measures are Neither Arbitrary nor Overbroad

47. A law is arbitrary when the limits it imposes on s. 7 interests has *no connection* to its objectives. This standard is not easily met.[47] The overbreadth inquiry asks whether a law that has some connection to its objectives nonetheless goes too far by imposing limits on s. 7 interest on some individuals in a way that bears no relation to its objectives. The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means affecting those individuals s. 7 interests in a way that has *no connection* with the mischief contemplated by the legislature.[48]

48. The challenged measures are specific means designed to achieve the multiple objectives of the *MPA*. They do so by attempting to limit but not absolutely prohibit the private market for health care. As Justice Binnie observed for three of the six judges who reached the *Charter* issue in *Chaoulli*:

> Not all Canadian provinces prohibit private health insurance, but all of them (with the arguable exception of Newfoundland) take steps to protect the public health system by

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[46] The Alberta Court of Appeal has recognized this same core equity objective of health care legislation in Alberta and across Canada: *Allen v Alberta*, 2015 ABCA 277, ¶¶16, 37, 50, also observing that a legislative policy objective is not arbitrary simply because some may disagree with it (¶¶40, 47-48, 51, 56-57, 61).
[47] *Bedford*, ¶¶111, 118-19
[48] *Carter*, ¶85; *Bedford*, ¶¶101, 112-13

> discouraging the private sector, whether by prohibiting private insurance… or by prohibiting doctors who opt out of the public sector, from billing their private patients more than the public sector tariff, thereby dulling the incentive to opt out… or eliminating any form of cross-subsidy from the public to the private sector… The mixture of deterrents differs from province to province, but the underlying policies flow from the Canada Health Act and are the same: i.e., as a matter of principle, health care should be based on need, not wealth, and as a matter of practicality the provinces judge that growth of the private sector will undermine the strength of the public sector and its ability to achieve the objectives of the *Canada Health Act*.[49]

(a) Connection of Challenged measures to the Objective of Ensuring Access to Medically Necessary Medical Care is Based on Need and Not an Individual's Ability to Pay

49. The objective of the legislation at issue is to implement a public health care system which provides access to medical and hospital care based on patient need, rather than ability to pay. In the Coalition Intervenors' submission, it is clear that the assertion of a right to purchase medical services through private insurance at whatever price the market will bear threatens to undermine the objective of ensuring access to care based on need. This is because only those individuals with sufficient economic means are able to assert (i.e. purchase) the right, and because the right asserted is to jump the queue and obtain preferential access to health services based not upon need but upon economic capacity or status (i.e. ability to pay).

50. Given that the BC Legislature has determined that a fundamental objective of the legislation it has enacted to regulate and govern the health care system must provide for equal access for all Canadians to needed health care services, it can hardly be arbitrary or overbroad or grossly disproportionate that the legislation includes measures to promote the legislative goal that physician services must be universally available on an equitable basis to all British Columbians, and not just to those who are privileged by wealth.

Sections 14, 17 and 18

51. Sections 14, 17 and 18 affect this objective in relatively obvious ways, individually and collectively ensuring that patients cannot be required, directly or indirectly, to pay out of pocket in order to access medically necessary physician services, wherever those services are provided by enrolled physicians or in public facilities. Indeed, as is clear from the record, when these provisions

[49] *Chaoulli*, ¶174

are circumvented, a patient's ability to pay can determine their access to medical care.

52. This is confirmed by the specific evidence of physicians who work in the public and private systems in BC, who testified that they offer patients the option of paying for private treatment precisely so they can avoid the public waitlist and access *treatment* more quickly.

53. For example, Dr. Kevin Parkinson, an ophthalmologist, deposed that he offered his public system patients the option of paying for private surgery if they expressed concerns about his public system wait times for surgery.[50]

54. Dr. Mark Adrian, a physiatrist, acknowledged that, if a patient he sees in consultation in the public system expresses an interest in having him perform the recommended procedure in a private clinic so it can be performed faster, he directs the patient to contact the private clinics where he works.[51]

55. Dr. Amin Javer, a sinus surgeon, deposed that, for patients he saw through the public system who needed surgery: "I advised patients of the wait time at SPH [Saint Paul's Hospital] and also advised them of the private option."[52] Dr. Javer also acknowledged that patients who are able to pay for a *consultation* in a private clinic can book surgery faster, and thus get faster treatment.[53]

56. Dr. Parkinson, an ophthalmologist who has worked in the public system and a private clinic, deposed that it was his "ethical obligation to advise patients of all their options for obtaining treatment."[54] Accordingly, when patients expressed concern about his public system wait time for eye surgery, he discussed the option of private surgery with them.[55] However, he testified that it was *not* his practice to refer these patients to other colleagues who had a shorter waitlist, even though he knew that the waitlists of some of his colleagues were shorter, stating that "I never believed that it was my duty ethically or otherwise to refer them off elsewhere."[56]

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[50] Affidavit #1 of Dr. Kevin Parkinson, made August 17, 2018, Ex 387 ("**Parkinson #1**"), ¶¶1, 38, 58-59; see also Cross-examination of Kevin Parkinson on October 3, 2018 (Day 120) ("**Parkinson Cross**"), 33:36-33:42, 42:39-43:6
[51] Cross-examination of Mark Adrian on October 5, 2018 (Day 122) ("**Adrian Cross**"), 2:36-2:28, 10:4-10:39
[52] Affidavit #1 of Dr. Amin Javer, made February 16, 2018, Ex 299, ¶¶1, 113
[53] Cross-examination of Dr. Amin Javer on July 3, 2018 (Day 105) ("**Javer Cross**"), 37:26-37:42
[54] Parkinson #1, Ex 387, ¶58
[55] Parkinson #1, Ex 387, ¶¶58-59; Parkinson Cross (Day 120), 33:36-33:42
[56] Parkinson Cross (Day 120), 12:43-12:45, 61:24-61:35

57. Dr. Fadi Tarazi, an orthopedic surgeon who works in the public system and a private clinic,[57] testified that patients who can pay to have *diagnostic imaging* done privately, can gain access to medical care more quickly because it takes much longer to get an MRI in the public system than privately. If a patient has an MRI done privately, they can bypass six months of waiting in the public system, and have a consultation and surgery with Dr. Tarazi in the public system much more quickly.[58]

58. Further, Dr. Tarazi testified that sometimes patients come to him for a consultation at a private clinic and then decide to have the surgery done in the public system. In those circumstances, he generally refers the patient back to their family physician to be referred to a different surgeon. *However*, for higher risk patients who cannot have surgery at a private clinic, he will treat them in the public hospital. These patients can get surgery faster than if they had had a consultation in the public system, and they effectively jump the queue for consultation.[59]

Section 45

59. Section 45 also protects patients from having their ability to pay (in this instance for private insurance), as opposed to their need, determine their access to medical and hospital care. Section 45 also discourages the creation of a two-tiered publicly and privately paid market for physician services, and therefore furthers the objective of ensuring that access to physician services is equitably based on need and not ability The availability of private insurance would undermine this legislative objective since, as the evidence shows, it is primarily wealthier people who can access private insurance and, conversely, individuals without means or with pre-existing or complex health conditions will not be able to access private insurance.

60. Dr. Adam Oliver, who was qualified as an expert in health care economics and policy,[60] noted that the demand for private health care insurance is significantly correlated with socioeconomic class and better health, due to the fact that those with better health and higher-paying jobs find private insurance more affordable, and the fact that higher paying jobs were more likely to offer

[57] Direct of Dr. Fadi Tarazi on October 11, 2016 (Day 20) ("**Tarazi Direct**"), 1:33-2:43
[58] Tarazi Direct (Day 20), 16:21-17:34
[59] Tarazi Direct (Day 20), 38:36-39:31
[60] Ruling re Qualifications of Dr. Adam Oliver on June 4, 2019 (Day 160), 13:23-13:25

employment "perks" like private health insurance.[61] The plaintiffs' witness Professor Alistair McGuire, who was qualified as an expert in health economics, agreed that private health insurance is more likely to be purchased by wealthy people than by poor people.[62]

61. Mr. Gary Walters, a plaintiff expert, was qualified as an expert in group insurance and reinsurance, including the purpose of insurance, insurance markets, insurance types and the insurance industry and, in particular, the current role, use and availability of private health insurance in Canada.[63] He acknowledged that private insurance in Canada could be used to purchase shorter wait times.[64] In cross-examination he testified that private insurance is not accessible and affordable to everyone.[65] In part it would be inaccessible due to risk selection.[66] Risk selection occurs when insurance companies increase premiums or exclude or limit coverage for individuals with pre-existing conditions and individuals who are very likely to make a claim due, for example, to medical- or family history.[67] Insurance companies use risk selection to manage premiums and increase profits.[68] Mr. Walters explained that, if insurance for private medical procedures were permitted, risk selection would be used for insurance purchased by individuals.[69] While risk selection is generally not an issue for individuals covered by group insurance – meaning coverage purchased by an employer for an employee and his or her spouse and dependents[70] – Mr. Walters acknowledged that people who are retired, unemployed or unemployable are not usually covered by such insurance.[71]

62. Professor Hurley, was qualified to give expert evidence on health economics, health care financing and funding, equity in health systems and assessment of health system performance.[72] He testified that according to dozens of studies and in every jurisdiction he had seen, it was the

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[61] Expert Report of Dr. Adam Oliver, dated February 27, 2014, Ex 490, p 5
[62] Cross-examination of Professor Alistair McGuire on January 26, 2017 (Day 59) ("**McGuire Cross**"), 37:42-37:45
[63] Ruling re Qualifications of Gary Walters on April 17, 2018 (Day 89), 1:35-1:45
[64] Cross-examination of Gary Walters on April 17, 2018 (Day 89) ("**Walters Cross**"), 29:17-29:22
[65] Walters Cross (Day 89), 39:5-39:28
[66] Expert Report of Gary Walters dated September 20, 2016, Ex 268 (**"Walters Report"**), p 11; Walters Cross (Day 89), 39:5-39:24
[67] Walters Report, Ex 268, p 7
[68] Walters Cross (Day 89), 19:11-20:15, Walters Report, Ex 268, p 7
[69] Walters Report, Ex 268, p 11; Walters Cross (Day 89), 20:16-20:21
[70] Walters Report, Ex 268, pp 6-7
[71] Walters Cross (Day 89), 39:12-39:34
[72] Ruling re Qualifications of Professor Jeremiah Hurley on June 20, 2019 (Day 169), 15:17-15:29

socio-economically advantaged who were the purchasers of private health insurance.[73] He also noted that purchasers tended to be comparatively better educated, male, living in urban centres, and more likely to have secure housing tenure and work in professional, non-manual labour jobs.[74] In his expert report, Professor Hurley stated that duplicative private insurance concentrates coverage primarily, and in most jurisdictions, exclusively, on a small set of acute-care services used to treat relatively uncomplicated elective procedures, and generally excludes complicated, catastrophic care.[75] He also noted that, absent regulations prohibiting such exclusions, duplicative private insurance policies exclude coverage for pre-existing conditions, and also generally exclude coverage for chronic conditions.[76]

63. Professor Hsiao was qualified as an expert in actuarial science and health care economics and the application of those files to the design and reform of health care systems.[77] In his expert report, he stated that, even in the case of employer-provided health coverage, the socio-economically advantaged, such as executives and higher paid employees were more likely to have coverage.[78] Professor Hsiao, in his expert report, described risk selection as "a major problem" for any nation that permits voluntary health insurance, and noted that "regulating risk selection to ensure that the elderly and less healthy people can buy private insurance has been extremely difficult."[79]

64. Professor McGuire acknowledged that people will not want to buy private health insurance unless it provides them faster access to health care than they would receive through the public system.[80] Professor McGuire acknowledged that in several OECD countries, private insurance had only increased choice for a limited segment of the population, in part because some people are uninsurable. In his view, this issue could be addressed through regulation, although he acknowledged this would imply regulatory costs (which undermines a different objective discussed below).[81]

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[73] Cross-examination of Professor Jeremiah Hurley on June 20, 2019 (Day 169), 54:22-54:26
[74] Expert Report of Professor Jeremiah Hurley, dated September 17, 2013, Ex 121 ("**Hurley Report**"), pp 5-8
[75] Hurley Report, Ex 121, p 16
[76] Hurley Report, Ex 121, pp 13-16
[77] Ruling on Qualifications of Dr. William Hsiao on May 8, 2019 (Day 151), 9:45-10:3
[78] Expert Report of Dr. William Hsiao, dated March 30, 2017, Ex 465 ("**Hsiao Report**") p 9
[79] Hsiao Report, Ex 465, p 11
[80] McGuire Cross (Day 59), 38:40-38:47
[81] McGuire Cross (Day 59), 43:38-44:11

65. The evidence from other jurisdictions also shows that private insurance allows wealthier patients to access care before poorer patients. Dr. Law, an expert called by the AGC, was qualified as an expert in health policy and private health benefit plans.[82] He testified that there is evidence from Europe that patients in those jurisdictions who hold private insurance get surgeries faster than those who do not.[83] Dr. Jacqueline Cumming was qualified as an expert in health economics and public policy, including comparative health policy with an emphasis on New Zealand.[84] In her responsive report to Mr. Davidson, she wrote that in New Zealand, "those who hold private health insurance tend to be wealthier and healthier on average, and can use their private insurance to access private specialist care and get specialist care more quickly than through the public system, as well as receive elective operations more quickly, and in private facilities, even where they are eligible for publicly financed services."[85]

66. The evidence shows that permitting a two-tier health care system diminishes equity. Professor Yanick Labrie was qualified as an expert in economics and health care policy, including health care policies and reforms in Canada and selected OECD countries.[86] He acknowledged that an OECD report referenced by Professor Prémont identified problems with private health insurance that are related to access and equity.[87] He also acknowledged that disparities in access to health care persist in countries that have private health insurance.[88] His evidence also supports the conclusion that Canada has a relatively equitable health care system. While Professor Labrie asserted in his report that Canada fares poorly in international rankings with respect to the probability of consulting a doctor for low-income people,[89] when he was confronted with the source he cited for this assertion on cross-examination, he ultimately acknowledged that Canada actually ranks favourably.[90]

67. Finally, Dr. Himmelstein, the other expert witness called by the Coalition Intervenors (and

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[82] Ruling re Qualifications of Dr. Michael Law on April 29, 2019 (Day 146), 14:30-14:44
[83] Cross-examination of Dr. Michael Law on April 29, 2019 (Day 146), 76:29-76:36
[84] Ruling re Qualifications of Professor Jacqueline Cumming on June 6, 2019 (Day 162), 7:17-7:14
[85] Responding Report of Professor Jacqueline Cumming, dated April 27, 2015, Ex 499, p 5
[86] Ruling re Qualifications of Professor Yanick Labrie on December 5, 2016 (Day 45), 16:20-16:24
[87] Cross-examination of Professor Yanick Labrie on December 5, 2016 (Day 45) ("**Labrie Cross**"), 35:38-36:44, 38:44-39:1
[88] Labrie Cross (Day 45), 42:45-43:1
[89] Expert Report of Professor Yanick Labrie dated July 31, 2014, Ex 155, p 7
[90] Labrie Cross (Day 45), 57:14-58:45

who was qualified to give expert evidence about foreign and international health care policy and finance, including the operation of private insurance and private insurers, cost of care, access to care and quality of care, with particular expertise in the relationship and links between and comparative analysis of, the US and Canadian health care systems)[91] testified that:

> … there is every reason to believe that striking down the key provisions of the [BC] Medicare Protection Act… would result not in a European-style hybrid system, but in a U.S.-like health care system, with large public insurance programs… covering the portion of the population that is unprofitable, and private insurers selling to profitable portions…. [and] bringing with them the profit-first ethic that has severely compromised care in the U.S. … The net result would likely be greatly amplified inequalities in access to care, an acceleration of health care cost increases, a very great increase in health care administrative costs, and severely compromised quality of care.[92]

68. In summary, there can be no doubt that without the restrictions on extra-billing and dual practice, there would be a second tier of parallel private payment, completely inconsistent with and undermining the legislative objective of providing for access to health care services based on need and not ability to pay.[93] Moreover, the evidence before this Court demonstrates that people with limited economic means cannot afford private health care insurance, that private health care allows wealthier patients to get treatment faster than poorer patients, and that it allows wealthier patients to jump the queue in the public system, pushing poorer patients behind them. By restricting extra-billing, dual practice and access to private insurance, the challenged measures are clearly connected to the objective of access to health care services based on need, rather than economic means, and are neither arbitrary nor overbroad. Indeed, by putting in place measures which discourage a private market but still permitting physicians to entirely opt out of the system if they so choose, the Legislature has acted in a measured manner to protect the underlying objectives of the legislation in a manner which is neither disproportionate or overbroad.[94]

(b) Connection to Preserving Publicly Managed Health Care System

69. The challenged measures are also connected to the objective of preserving a publicly managed health care system, including by limiting the diversion of limited resources from the public system.

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[91] Ruling on Qualifications of Dr. David Himmelstein on June 21, 2019 (Day 170), 2:13-2:29
[92] Himmelstein Report, Ex 199, pp 2-3
[93] see also AGC's submissions, ¶¶87-91, 93, 103-04, 127-28, 130
[94] See Prémont Report, Ex 158, pp 6-7, 14, 22. See also AGC's submissions at ¶¶92-109 specifically focussing on the objectives served by restricting dual practice.

70. Indeed, if the challenged measures were struck down, the evidence establishes that there is a very real risk that critical human health care and other resources will be diverted from the public health care system to the private market. The public health care system is not only comprised of surgeons, but also includes anesthesiologists, anesthesia assistants, physician surgical assistants, nurses, medical imaging and lab technologists, respiratory therapists, health care aides, administrators, and many others. All of these individuals are needed to run a quality public health care system – and at least some of them would be incentivized by removal of the restrictions on extra-billing, dual practice and private insurance to work in a more lucrative private market for health care instead of in the public system.

71. Historic evidence supports the concern that expanding access to private health care will sap resources from the public health care system. Professor Bliss testified that the original medicare system in Canada permitted extra-billing and opting out to a significant extent, and that many physicians had joined the private sector by the 1970s.[95] As a result, "you were starting to find large areas of the country where you couldn't find a doctor who hadn't opted to join the private system."[96] Professor Bliss testified that, in the 1980s, this situation led the government to suggest that constraints on the private sector needed to be tightened to protect public health care.[97] Professor Bliss further testified: "It was done in the name of accessibility. You can't have a private system taking so much away from the public system that Canadians don't have access anymore to their public health care."[98]

72. Dr. Roland Orfaly, an anesthesiologist and Chief Executive Officer of the British Columbia Anesthesiologists' Society acknowledged that the BC Ministry of Health in 2004 raised the concern that the participation by anesthesiologists in providing private surgical facilities negatively affected their availability to public hospitals.[99] Janine Johns, the Network Director of Surgical Services for the Interior Health Authority ("**IHA**") testified that there is an insufficient number of anesthesiologists in the IHA, and that the shortage of anesthesiologists has played a considerable role in IHA's inability to meet waitlist targets.[100] The Fraser Health Authority ("**FHA**") is also

[95] Direct of Professor Michael Bliss on September 19, 2016 (Day 10) ("**Bliss Direct**"), 63:23-63:38
[96] Bliss Direct (Day 10), 63:31-63:37
[97] Bliss Direct (Day 10), 63:39-63:42
[98] Bliss Direct (Day 10), 64:8-64:12
[99] Cross-examination of Dr. Roland Orfaly on May 6, 2019 (Day 149), 87:40-88:15
[100] Cross-examination of Janine Johns on February 12, 2019 (Day 132), 30:16-30:24, 37:8-37:15

struggling with a shortage of anesthesiologists. Laurie Leith, VP Regional Hospitals and Communities of FHA, testified that, for fiscal year 2018/2019, 52 operating room days (which corresponds to roughly 402 operating hours) within FHA were lost during fiscal period 9 due to a shortage of anesthesiologists. She testified that the loss would be 13 times as high in a year (because there are 13 fiscal periods in a year). She also testified that, for the first 9 fiscal periods of 2018/2019, 318 surgical days were lost due to anesthesia shortages, which corresponds to more than 2,000 operating hours. Ms. Leith testified the shortage of anesthesiologists was the most significant issue FHA was dealing with in terms of reducing wait times, and that the loss of operating time due to this shortage was staggering.[101] Similarly, Ms. Munjeet Bhalla, director of surgical services in the Ministry of Health,[102] agreed that lack of anesthesiologists is one of the causes of delays in performing surgery.[103] Ms. Leith testified that, when FHA contracts out public surgeries to private clinics, the private clinic arranges for an anesthesiologist to be booked, and she was not aware of cases where a private clinic had struggled to provide an anesthesiologist.[104] AGBC has detailed evidence that some BC anesthesiologists have been traveling to other provinces to provide services because of a perception they can make more money there, and that the volume of procedures undertaken by private clinics has a substantial bearing on the availability of anesthesiology services in public hospitals.[105]

73. Dr. Marcel Dvorak, an orthopedic surgeon who has worked in the public system and private clinics, testified that there has been a nursing shortage at the Vancouver General Hospital (**"VGH"**) which has contributed to a decrease in the number of funded and operational rooms at VGH. He testified that this has reduced the OR allocation for the Spine Clinic Group at VGH.[106] Dr. Masri testified that nursing shortages at VGH were preventing the hospital operating rooms from running at full capacity.[107] Ms. Joanne MacLaren, Executive Director of the Nursing Policy Secretariat in the Ministry of Health testified that the Ministry has faced challenges with retaining

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[101] Cross-examination of Laurie Leith on February 13, 2019 (Day 133) ("**Leith Cross**"), 22:47-28:1; "Room Closure Summary", Ex 409. These statistics included not only cases where no anesthesiologist could be booked, but also cases where one had been booked but failed to attend for some reason: Leith Cross (Day 133), 43:9-43:24
[102] Discovery Evidence of Munjeet Bhallla read in on October 18, 2016 (Day 25) ("**Bhalla Read In**"), 46:35-46:37
[103] Bhalla Read In (Day 25), 83:30-83:38
[104] Leith Cross (Day 133), 40:44-44:44
[105] AGBC's submissions, ¶¶734-35
[106] Direct of Dr. Marcel Dvorak on November 15, 2016 (Day 26), 17:41-18:46
[107] Direct of Dr. Bassam Masri on April 13, 2018 (Day 87), 2:1-2:3. 39:3-39:26

specialty nurses who are trained in areas that the Ministry has identified as "highest need", including perioperative and operating room registered nurses.[108] BC, in its Provincial Health Workforce Strategy for 2018/2019-2020/2021, identified that gaps in the supply of registered nurses who work in operating rooms have resulted in the temporary closure of some operating rooms in the province.[109]

74. Dr. Kevin Wade, an ophthalmologist practicing in Vancouver,[110] testified that eye surgeries are contracted out to the Ambulatory Surgical Centre (a private clinic) because of a shortage of nurses at VGH. However, there *are* nurses at the Ambulatory Surgical Centre.[111]

75. The evidence also shows that private clinics siphon off expertise developed in the public sector. For example, Dr. Ross Outerbridge, an orthopedic surgeon, testified that Kamloops Surgical Clinic (a private clinic) does not have a residency or an official practicum for nurses. While he was the medical director of this clinic, all of the nurses they hired already had their operating room certificate or training.[112]

76. The evidence shows that where specialists may have maximized their operating times in the public system, they may choose to prioritize private sector activities at the expense of public sector consultation activities. For instance, Dr. Turnbull testified that in the context of cataract surgeons, if they were to maximize their consultation activities they would not have time for private sector surgeries.[113] Dr. McMurtry, who was qualified as an expert in health care policy and system administration,[114] testified that surgical time was usually the "bottleneck" in the public system, but that a bottleneck could also occur in relation to waiting for consultations. He stated that to the extent that physicians were engaged in surgeries in the private sector they would be unavailable for consultation in the public sector.[115] Delay in getting a specialist consultation because specialists are working privately does not just cause additional delay for patients to receive surgery. It can

[108] Direct Examination of Joanne Maclaren on July 16, 2019 (Day 176), 15:10-15:45
[109] Ex 565, p 270
[110] Direct of Dr. Kevin Wade on November 14, 2016 (Day 35) ("**Wade Direct**"), 1:45-1:47
[111] Wade Direct (Day 35), 28:5-29:16; Cross-examination of Dr. Kevin Wade on November 14, 2016 (Day 35), 69:33-70:6
[112] Cross-examination of Dr. Ross Outerbridge on July 4, 2018 (Day 106), 3:9-3:11, 12:1-12:39
[113] Re-direct of Dr. Jeffrey Turnbull on July 10, 2019 (Day 172) ("**Turnbull Re-Direct**"), 92:13-92:19
[114] Ruling on Qualifications of Dr. Robert McMurtry on May 29, 2019 (Day 159), 6:3-6:4
[115] Re-Direct of Robert McMurtry on May 29, 2019 (Day 159), 112:17-112:47

delay a patient getting an accurate diagnosis and/or being referred for what is often more appropriate, non-surgical treatment.

77. Evidence from other jurisdictions demonstrates that allowing a parallel private health care system to exist may negatively affect the public system.

78. Professor McGuire agreed that there are studies showing that wait times for elective surgeries in Australia are longest in areas where private provision is high. Even Professor Kessler testified that there is theoretical evidence that dual practice can cause harm to patients in the public health care system.[116] He testified that dual practice could raise the possibility of harm to the public system by diverting the doctors away from it, although whether that occurred would depend on different factors.[117] He also testified that Ireland, which has a dual practice system, has experienced difficulties due to private patients using public hospitals.[118] Professor Gillespie was qualified as an expert in public health policy in Australia.[119] He noted that in instances of dual practice, where there is a limited supply of specialists working across public and private sectors, any increase in demand in private hospitals may lead to a decline of services and increased waiting lists in public hospitals. In addition, he found that where there were shortages of specialists, they were more likely to be working in the private sector.[120]

79. Similarly, Professor Normand, who was qualified as an expert in health care economics, policy and financing,[121] identified that in Ireland, the loss from the public sector of skilled staff who may be attracted to better paying positions in the private sector was an additional impact of the existence of a parallel market. He noted that this was of concern particularly with regards to the skill-based areas of surgery, anesthetics and specialized medical services.[122]

80. Professor Hurley, in his expert report, stated that evidence from the UK shows that a large number physicians in dual practice failed to fulfil contractual obligations to the public sector in

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[116] Cross-examination of Professor Daniel Kessler on December 12, 2016 (Day 50) (**"Kessler Cross"**), 68:47-69:9
[117] Cross-examination of Professor Daniel Kessler on December 13, 2016 (Day 51) (**"Kessler Cross Cont'd"**), 8:31-9:6; 35:16-35:27
[118] Kessler Cross (Day 50), 89:47-90:26
[119] Ruling on Qualification of Professor James Gillespie on June 11, 2019 (Day 164), 12:36-12:43
[120] Expert Report of Professor James Gillespie, dated July 2014 and updated June 2016, Ex 504, p 9
[121] Ruling re Qualifications of Professor Charles Normand on June 10, 2019 (Day 163), 20:21-20:22
[122] Expert Report of Professor Charles Normand dated October 16, 2013, Ex 501, p 13

order to devote a greater amount of time to private-sector activity.[123] He added that "the more general lesson from the UK and other countries with dual practice is the difficulty of trying to regulate the allocation of physician time across sectors to prevent abuses that advantage physicians and disadvantage the public system."[124]

81. To summarize, while the plaintiffs argue that the existence of a private market for medical services would merely relieve pressures on the public system, and therefore bears no connection to the objective of preserving the publicly funded system, and is overbroad in its effects, the evidence summarized above, as well as the evidence summarized in AGBC's submissions (see ss. 3.7.1 and 4.2.3) establishes more than sufficient basis for there being a connection, and indeed a strong connection, between the legislative objective and the challenged measures. Moreover, given that the public system is constrained by shortages of personnel, it cannot be that increased private financing would relieve this pressure. Furthermore, a "parallel" private system risks drawing personnel away from the public system by offering higher incomes, paid for from higher prices charged private patients, and reducing the capacity of the public system. As a result, the challenged measures cannot be said to be overbroad in their effects.

(c) Connection to Preserving a Fiscally Sustainable Health Care System

82. The challenged measures also advance the objective of preserving a fiscally sustainable health care system by limiting human resource and administrative costs, and seeking to efficiently and effectively deploy overall health care spending in an integrated manner within a publicly funded system. These objectives are, of course, inter-related with the objective of preserving a publicly managed health care system.

Sections 14, 17 and 18 – Limiting Human Resource Costs

83. Absent the challenged measures, the evidence supports the concern that medical professionals will charge patients above and beyond what they are paid in the public system. This would both increase overall expenditures in the health care system as a whole, shifting cost to patients, and increase the cost in the public system as it has to compete with a private sector

[123] Hurley Report, Ex 121, p 35. Notably, while physicians in the UK are employed, Canadian physicians are generally independent contractors, making regulation of their activities even more challenging.
[124] Hurley Report, Ex 121, p 36

charging higher amounts and therefore being able to pay higher rates, . Professor Bliss testified that the original medicare system in Canada "had allowed for lots of extra billing, had allowed for physician opting out."[125] He explained that, by the 1970s, many physicians were opting to join the private system.[126] He testified that increased extra billing occurred in the 1970s and early 1980s.[127] Professor Bliss agreed that the *Canada Health Act* would not have been necessary but for this increase in privatization.[128] He also agreed that physicians were not immune to economic incentives.[129] Dr. Turnbull, former chief of staff of the Ottawa Hospital and past-President of the Canadian Medical Association, said that during his time as president of the CMA, he heard from physicians who feared that "many doctors… only support causes that line their pocketbooks."[130]

84. For his part, Dr. Day testified that Cambie has never had any difficulty recruiting all of the OR nurses it requires, beginning by paying them significantly higher wages than nurses in the public system and offering them greater flexibility.[131] There is evidence as well that allied health professionals such as physiotherapists are already being attracted to the private sector.[132]

85. Dr. Javer acknowledged that he charges roughly three to four times more for a unilateral intranasal ethmoidectomy at the False Creek Surgical Centre (a private clinic) than what MSP would pay for the procedure.[133] Dr. Adrian agreed that he makes more per hour for his work in private clinics than in the pubic system.[134] On average per year, he makes four times as much money from his work at Cambie Surgeries and the Specialist Referral Clinic ("**SRC**") than from his public billings.[135] In fiscal year 2016/2017, he received approximately $965,826 from Cambie and SRC combined.[136] Dr. Day testified that surgeons at Cambie Surgeries are paid more per

[125] Bliss Direct (Day 10), 63:23-63:25
[126] Bliss Direct (Day 10), 63:23-63:38
[127] Cross-examination of Professor Michael Bliss on September 20, 2016 (Day 11) ("**Bliss Cross**"), 25:11-25:15
[128] Bliss Cross (Day 11), 26:3-26:9
[129] Bliss Cross (Day 11), 49:36-49:43
[130] Turnbull Re-Direct (Day 172), 89:20-89:31
[131] Cross-examination of Dr. Brian Day on September 17, 2018, 29:24-30:21; Affidavit #9 of Dr. Brian Day, made January 26, 2018, Ex 346A, p 19, ¶¶96-101
[132] Ex 565, "British Columbia Provincial Health Workforce Strategy 2018/2019 – 2020/2021", p 233 at p 284 [*Prima Facie* Truth]
[133] Javer Cross (Day 105), 37:43-39:39
[134] Adrian Cross (Day 122), 22:36-23:24
[135] Adrian Cross (Day 122), 22:27-22:30
[136] Adrian Cross (Day 122), 21:18-21:22

surgery than they would be paid by MSP. For example, for an arthroscopic hip surgery, MSP would pay the surgeon $648.67, whereas Cambie Surgeries would typically pay the surgeon $2,880.[137] Dr. Tarazi testified that private insurance companies and out-of-province patients at False Creek Surgical Centre pay roughly two or three times more than MSP for the same procedure.[138]

86. Dr. Leslie Samaroo, a retired family physician who was involved in developing a specialist referral clinic within the WCB,[139] testified that the WCB Visiting Specialist Clinic ("**VSC**") recruited top-notch specialists who were willing to attend at the clinic because they were paid an attractive wage and a premium (above what MSP would pay) to see patients in an expedited manner.[140] Andrew Montgomerie, director of financial services and health care programs for the WCB testified that there was generally a lot of interest from surgeons and specialists for the positions at VSC, and that VSC does not generally have to seek out physicians when hiring – rather, those physicians generally approach the VSC.[141] As discussed above, the evidence shows that private clinics will provide better compensation than MSP.[142]

Sections 14, 17, 18 and 45 – Promoting Efficiency and Limiting Administrative Costs

87. The evidence establishes that increasing access to private health care will likely increase the complexity and costs of associated regulatory efforts, and as a result increase costs to the system as a whole . Many of the plaintiffs' experts testified or gave expert opinion that the extent of potential harmful effects of increased access to private health care would depend upon or could be mitigated through regulation. The plaintiffs' expert, Professor McGuire also acknowledged that regulating private health insurance would likely be time consuming and expensive.[143] Indeed, this is why the province regulates by imposing constraints on the billing practices of enrolled physicians.

88. In his expert report, Professor Hsiao noted that:

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[137] Cross-examination of Dr. Brian Day on September 17, 2018 (Day 116) ("**Day Cross**"), 45:36-46:34
[138] Tarazi Direct (Day 20), 35:27-35:33, 36:36-36:40
[139] Direct of Dr. Leslie Samaroo on November 7, 2016 (Day 34) (**"Samaroo Direct"**), 17:44-19:43
[140] Samaroo Direct (Day 34), 23:24-23:37, 24:25-24:42
[141] Direct of Andrew Montgomerie on July 9, 2019 (Day 171), 11:46-12:20
[142] J Javer Cross (Day 105), 37:43-39:39; Adrian Cross (Day 122), 22:27-22:30, 22:36-23:24; Day Cross (Day 116), 45:36-46:34; Tarazi Direct (Day 20), 35:27-35:33, 36:36-36:40
[143] McGuire Cross (Day 59), 50:23-50:46

> If British Columbia allows duplicate insurance, the government would have to consider many regulations for private health insurance. These include regulating risk selection, insurance premium rates (e.g., imposing community rating), claim loss ratios, administrative expenses, dual practice, and setting fees for providers, among other issues. To monitor private insurance operations for compliance, the regulatory agency has to impose regulations on data collection and submission, then analyze the data. The enforcement of these regulations often involves setting up a new regulatory agency or expansions of current regulatory agencies. This regulatory process can be very expensive to the government and private insurers.[144]

89. Professor Hurley testified the process of regulating the behavior of dual practitioners is challenging in the UK (where he described doctors as essentially hospital employees), and would be more challenging in the Canadian system (in which most specialist practitioners operate on a fee-for-service basis), where there are "fewer levers" available to regulate doctor behavior than in the UK.[145]

90. Doctor Turnbull, in his expert report, stated that while advocates of private health care argue that increased regulation will allow for fair co-existence between firms (whether insurers or care delivery organizations) and public or non–profit entities "even if such regulation is possible, it is almost certain that it will increase total expenditure."[146]

91. Professor Hurley found that the introduction of duplicative insurance and the associated expansion of the private sector would create new demand for services of health care providers, which would exert upwards pressure on prices for these services and reduce the purchasing power of public health care sector.[147]

92. Dr. Himmelstein opined that striking down the challenged measures would likely result in an acceleration of health care cost increases and a very great increase in health care administrative costs.[148] This excess spending would likely impact not only private expenditures but public ones as well, as it does in the US.[149] Dr. Himmelstein noted that US physicians spend almost twice as much as Canadian doctors do on billing and paperwork, and that US hospital administration costs

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[144] Hsiao Report, Ex 465, p 10
[145] Question by the Court of Professor Jeremiah Hurley on June 20, 2019 (Day 169), 101:22-101:34
[146] Expert Report of Dr. Jeffrey Turnbull dated March 7, 2014, Ex 548A, p 5
[147] Hurley Report, Ex 121, pp 37-38
[148] Himmelstein Report, Ex 199, pp 3, 9
[149] Himmelstein Report, Ex 199, pp 9-10

were double that in single-payer system nations such as Canada, and attributed both of these differences to the higher complexity and regulation required under a hybrid public/private system with multiple payers.[150]

93. This evidence is corroborated by that of Dr. Hendry whose affidavit was tendered in evidence without cross-examination. Dr. Hendry deposed to the considerable time she had to devote to administrative tasks when she practiced in the US, as compared to in BC,[151] and to the lower insurance premiums she must pay in BC as compared to the US.[152]

94. Professor Kessler also testified to the possibility that private financing for physician and hospital services and dual practice could increase costs for the public system.[153] Professor McGuire agreed that, generally speaking, the use of parallel private health insurance tends to increase public health care financing. [154] Professor McGuire also agreed that, to make private health insurance more attractive in Australia, "there are considerable tax subsidies, which would imply that if left on its own it would not provide value for money."[155] Professor Labrie acknowledged that, in Ireland, any savings to government provided by private insurance is diminished by the fact that the government subsidizes private health insurance.[156]

95. Professor Kessler testified he was aware of studies that highlight that private insurance entails higher administrative costs.[157] He also testified that having multiple payers (which occurs when there is duplicate public and private insurance, or many private insurance options) results in increased administration costs, as is apparent in the US and the Netherlands. He testified: "I would by no means endorse the situation that has come to pass in the United States, which… involves very significant inefficiency in administration."[158]

96. Thus, at the very least, the evidence establishes a sufficient relationship between the objective of preserving a health care system that is fiscally sustainable for both governments and individuals,

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[150] Himmelstein Report, Ex 199, pp 9-10
[151] Affidavit #1 of Dr. Khati Hendry, made April 14, 2014 ("**Hendry #1**"), Ex 485, ¶¶4-6
[152] Hendry #1, Ex 485, ¶7
[153] Kessler Cross Cont'd (Day 51), 29:34-31:3
[154] McGuire Cross (Day 59), 11:6-11:35
[155] McGuire Cross (Day 59), 71:21-71:25
[156] Labrie Cross (Day 45), 23:42-24:46
[157] Kessler Cross (Day 50), 76:17-76:44
[158] Kessler Cross (Day 50), 79:18-81:8

and the limits on private insurance, extra-billing and dual practice contained in the challenged measures, which is neither arbitrary nor overbroad.

iii. The Challenged Measures are Not Grossly Disproportionate

97. The inquiry into gross disproportionality asks whether the impact of restrictions that law places on an individual's life, liberty, or security of the person is *totally out of sync* with any legitimate legislative objective.[159] This is a very exacting standard that only applies in "extreme cases."[160]

98. The importance of preserving a publicly managed, and fiscally sustainable, health care system for BC, in which access to medically necessary medical care is based on need and not an individual's ability to pay, cannot be overstated.

99. As a result, even if the plaintiffs can satisfy this Court that the challenged measures have caused some of the effects they complain of, those effects are not *grossly disproportionate* to the importance of the legislative objectives. This is not a case like *Bedford* where Parliament attempted to protect the streets from nuisance and in so doing, jeopardized the lives and health of its citizens. Here, the legislative objective is integrally connected with preserving and sustaining an equitable health care system necessary to promote the health of all British Columbians.

100. In assessing the proportionality of the effect on the plaintiffs as against the legislative objective, it is also noteworthy that the plaintiffs are beneficiaries of the public health care system, and do not propose to give up its benefits. Rather, they seek to continue to take advantage of all of the benefits of the publicly funded health care system, including the access to primary, elective and emergency physician services, but with a super-added right to obtain preferential access to health care at their own option, and contrary to the legislative objective of preservation of a health care system in which patients do not obtain preferential access based on ability to pay. The plaintiffs are not seeking to "opt out" of the public system in its entirety; even in the private market they wish to establish, they would continue to benefit from society's investment in health care professionals and public funding of the entire health care infrastructure, while seeking to avoid the

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[159] *Carter*, ¶89; *Bedford*, ¶120
[160] *Bedford*, ¶120

single-tier foundation of the system, of which the challenged measures are an essential component.

E. Section 1 Justification

101. If this Court concludes that any of the challenged measures interfere with s. 7 protected interests in a manner is inconsistent with the principles of fundamental justice, any such infringement is justified under s. 1.

102. In approaching s. 1 justification, the court must take care not to collapse the s. 7 and s. 1 inquiries.[161] It cannot simply transplant the s. 7 analysis into the s. 1 analysis, nor can it treat the unconstitutionality of the challenged measures as a foregone conclusion.[162] The s. 1 analysis is analytically distinct from the s. 7 analysis.[163] There are "crucial differences" between the two sections.[164] They "ask different questions"[165] and "work in different ways."[166] As the Court explained in *Bedford*, the societal and collective goal of the challenged provision takes on particular significance in the s. 1 analysis. In this respect, the question of justification on the basis of considerations relating to overarching public objectives is at the heart of s. 1 and, in particular, balancing these larger societal interests against any infringement of s. 7, but this balancing exercise plays no part in the s. 7 analysis.[167]As the Court noted in *Smith*, "the s. 1 analysis focuses on the furtherance of the public interest and thus differs from the s. 7 analysis, which is focused on the infringement of the individual rights."[168]

103. In the specific context of this case, to the extent that the court holds that the challenged measures are arbitrary, overbroad or grossly disproportionate, as applied to those relatively limited number of individuals who would potentially benefit from a private health care system, the s. 1 justification exercise requires the court to consider the broader collective societal interests in an equitable health care system based on need and not ability to pay, and in a publicly managed and fiscally sustainable health care system. This is recognized even by the plaintiffs, when they accept in paragraph 2843 of their submissions that "competing claims and broad society benefits are

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[161] *R v Malmo-Levine; R v Caine*, 2003 SCC 74, ¶¶96-97
[162] See Hamish Stewart, "Bedford and the Structure of Section 7" *McGill LJ* (2015), 60(3):575-94, at pp 589, 592
[163] *Bedford*, ¶128; see also *R v Mills*, [1999] 3 SCR 668, ¶¶66-67
[164] *Bedford*, ¶124
[165] *Bedford*, ¶125
[166] *Bedford*, ¶126
[167] *Bedford*, ¶125
[168] *R v Smith*, 2015 SCC 34, ¶29

relevant to section 1."

104. The Supreme Court of Canada has emphasized that while the public interest is not considered under s. 7, it is essential to the section justificatory inquiry. Thus, for example, in *Carter*, the Court noted that "in some situations the state may be able to show that the public good - a matter not considered under s. 7, which looks only at the impact on the rights claimants - justifies depriving an individual of life, liberty or security of the person under s. 1 of the *Charter*."[169] Similarly, *Bedford* suggests that a s. 7 violation may be justified in cases where the legislative objective has great importance.[170] In this connection, assuming that the principle that a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7[171] (regardless of the extent to which the law benefits others or advances the public interest) applies not only in the criminal context but also to social and economic regulatory legislation, and assuming the principles of fundamental justice extend beyond the criminal law/administration of justice context,[172] the Coalition Intervenors submit that this makes it all the more critical that the courts ensure that broader public interest factors are given due weight and consideration in the application of s. 1 of the *Charter* in the social and economic legislative context.

105. Turning to the pressing and substantial objective inquiry, there can be no doubt that the objectives of the challenged measures are pressing and substantial. Indeed, this is not seriously contested by the plaintiffs. Preserving a publicly managed and fiscally sustainable health care system for BC in which access to medically necessary medical care is based on need and not an individual's ability to pay is among the greatest public goods.

106. The commitment to a single payer publicly funded health care system, as reflected in the BC legislation, is also a quintessential reflection of those core *Charter* values essential to a free and democratic society which this Court has, since its seminal decision in *R v Oakes*, [1986] 1 SCR 103, recognized as a foundation of the s. 1 analysis. The BC medicare system is premised on a concern for the inherent dignity of the human person, a commitment to social justice and equality

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[169] *Carter*, ¶95; *Safarzadeh-Markhali*, ¶57
[170] *Bedford*, ¶129
[171] *Bedford*, ¶¶122-23
[172] *Association of Justice Counsel v Canada (Attorney General)*, 2017 SCC 55, ¶49

and a desire to enhance the ability of individuals to participate in society (particularly since health is a precondition to any such participation). Medicare is also the product of a democratic consensus within our social and political institutions. These considerations form the overall context in which s. 1 should be applied in this case, and provide strong support for the finding that the legislative objectives underlying the challenged measures are pressing and substantial.

107. Turning to the s. 1 proportionality analysis, in assessing the proportionality of the challenged measures, significant deference to the legislative choice as to which measures are appropriate is warranted.[173] In all cases, "[p]roportionality does not require perfection"[174] and s. 1 "does not demand that the limit on the right be perfectly calibrated, judged in hindsight, but only that it be 'reasonable' and 'demonstrably justified'."[175] However, even greater deference to legislative choice is warranted, for the following reasons.

108. First, the challenged measures are part of a "complex regulatory response to a social ill" rather than "a penal statute directly threatening the liberty of the accused."[176] Increased deference under s. 1 is warranted when the challenged legislation concerns public welfare.[177]

109. Second, the challenged legislation is designed to address competing interests and protect the vulnerable, as opposed to cases where the government is "the singular antagonist of the individuals whose rights have been infringed."[178] As the Court explained in *Irwin Toy*:

> When striking a balance between the claims of competing groups, the choice of means, like the choice of ends, frequently will require an assessment of conflicting scientific evidence and differing justified demands on scarce resources. Democratic institutions are meant to let us all share in the responsibility for these difficult choices. Thus, as courts review the results of the legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of the legislature's representative function.[179]

110. This case certainly requires balancing of competing rights. The legislative and policy scheme governing the overall design of the health care system, including the determination of the

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[173] *Carter*, ¶97; *Saskatchewan (Human Rights Commission) v Whatcott*, 2013 SCC 11 [***Whatcott***], ¶78; *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 [***Hutterian Brethren***], ¶37
[174] *Carter*, ¶97
[175] *Hutterian Brethren*, ¶37
[176] *Hutterian Brethren*, ¶37; *Carter*, ¶97; *Michaud*, ¶¶127-29
[177] *Michaud*, ¶106
[178] *Irwin Toy*, pp 993-94
[179] *Irwin Toy*, p 993

appropriate role for and mix of private and public funding and delivery, requires the legislature to strike a balance between the claims of many different competing groups and interests. As the record demonstrates, the health care systems of other free and democratic countries differ markedly in their design and structure, in terms of a myriad of features, including how services are delivered, choice of health care provider, method of provider payment, scope of publicly insured services, scope of services which can be privately insured or purchased, supply and distribution of health care providers, taxation measures, and the like. Some features promote greater efficiency, while others promote equity, quality, accessibility, provider autonomy and so forth. Each health care system is comprised of a delicate mix and balance of these different and competing features, none of which exist in isolation. Altering one feature will impact on all the others, sometimes with predictable consequences, other times with unintended consequences. These involve choices among competing values and policy objectives, and form part of the delicate and complex balance inherent in the design of a health care system.

111. This case also requires that special consideration be given to the rights of two of the Coalition Intervenors – and many other British Columbians like them – who are vulnerable beneficiaries of BC's universal public health care system, and who stand to lose the most in this case if the fundamental principle that every British Columbian should have equal access to physician and hospital services is undermined. One of the core objectives of the challenged measures is to promote and protect the interests of the disadvantaged and vulnerable in equal access to essential health care, and to ensure that the health care system fairly, equitably and efficiently allocates resources based on medical need and not ability to pay. Thus, to the extent the legislation is specifically aimed at protecting disadvantaged and vulnerable groups, a considerable degree of deference is owing.

112. The Intervenor Glyn Townson is the past Chair of the Positive Living Society of British Columbia, a collective of people living with AIDS and HIV. Mr. Townson has also been diagnosed with AIDS and has many concurrent health problems. Mr. Townson is a frequent user of the BC public health care system. With an annual income of $20,000, he is even more reliant than healthier individuals on the public health care system to cover the cost of his essential and critical medical needs (both primary care and specialist), and in order to receive equal access to quality health

services.[180]

113. The Intervenor Thomas McGregor was the Co-Director of Advocacy for the BC Coalition of People with Disabilities until 2002, when he had to resign for health reasons. Mr. McGregor suffers from Limb-Girdle Muscular Dystrophy. As a result, he uses the public health care system frequently and is more reliant than healthier individuals on the system to cover the cost of his medical needs. His approximate annual income is $15,000, primarily from the Canada Disability Pension.[181]

114. Individuals such as Mr. Townson or Mr. McGregor – and many other ordinary British Columbians – would not be able to afford the added burden of private insurance. Even if they could overcome these financial obstacles, the evidence shows that their health status would likely be a barrier to any private insurance, as insurance providers will not insure individuals with disabilities or pre-existing conditions, or will exclude from coverage the very disabilities or pre-existing conditions most likely to require medical care.

115. Third, in *Bedford*, the Court determined that the nature of the s. 7 violation is relevant in assessing whether it is justified.[182] The nature of the s. 7 violation in this case differs from many landmark s. 7 cases. Here, the state is not positioned as a singular antagonist relative to the individuals whose rights were infringed, where the blunt tool of the criminal law is brandished against individuals. Rather, it is endeavoring to balance competing moral claims and to protect the life and health of Canadians by expending significant public funding and resources in order to provide health care to all.

116. Fourth, "[e]nforcement practicality may be a justification for an overbroad law, to be analyzed under s. 1 of the *Charter*."[183] Even if the challenged measures were overbroad, the practicality of enforcing limitations on a parallel private tier of health care justifies this overbreadth (see, for example, the expert evidence summarized in s. 3.7.1 of AGBC's submissions).

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[180] *Schooff v Medical Services Commission*, 2009 BCSC 1596 [***Schooff***], ¶¶159-61
[181] *Schooff*, ¶157
[182] *Bedford*, ¶129
[183] *Bedford*, ¶113

117. Fifth, as the Supreme Court held in *Carter*, "where the competing societal interests are themselves protected under the *Charter*, a restriction on s. 7 rights may in the end be found to be proportionate to its objective."[184] The competing interests protected by the challenged legislation – access to quality health care for *all* British Columbians, including the poor and the sick on equal terms – engage ss. 7 and 15 of the *Charter* and are precisely the type of competing social objectives which warrant a finding that measures are proportionate to the objectives. Notably, the plaintiffs themselves submit that there is a fundamental *Charter* interest in "equal access to timely and necessary health care."[185]

118. Sixth, the issue of whether the Legislature's decision to remedy the undesirable consequences of a private market for essential health services can be justified necessarily requires the Court to assess the validity of health and social science evidence. As it turns out, the evidence overwhelmingly supports the validity of the legislative objective and the proportionality of the legislative remedy. However, even if there had been a real conflict on the evidence, that in itself would attract judicial deference. In any event, this is a case where the Court is being asked to redesign fundamental elements of the health care system, a task which falls outside the Court's institutional expertise.[186]

119. Seventh, the interests restricted by the challenged measures, even if falling within s. 7, have a large economic component and, in substance involve the assertion of a right to charge for and purchase health services based on ability to pay rather than need. In this respect, the plaintiffs are asserting a right to jump the queue and obtain preferential access to health care. Even if this interest was constitutionally protected, it is not of greater value than the rights of others who would be significantly disadvantaged by the creation of a private health care market.

120. Both the AGC and the AGBC have extensively outlined the extent to which the evidence supports the conclusion that the challenged provisions are rationally connected to the legislative objectives, and the extent to which the legislative objectives would not be met if the challenged provisions were not in effect (see ¶¶2117-58 of AGBC's submissions, and ¶¶293-326 of AGC's submissions).

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[184] *Carter*, ¶95; *Safarzadeh-Markhali*, ¶57
[185] Plaintiffs' submissions, ¶2984
[186] *Hutterian Brethren*; see also *Whatcott*, ¶134

121. In the Coalition Intervenors' submission, patients like the Coalition Intervenors, and all other members of the public reliant on the publicly health care system, will be substantially worse off if the challenged measures are struck down. They will be worse off, *inter alia*, because without the challenged measures, public system wait times will likely increase (AGBC's submissions, ¶¶1840-41, 1941 and s. 3.7); many patients – including the neediest – will not be able to access a private system (AGBC's submissions, ¶¶1843, 1934, 2141, 2146 and s. 3.7.1); physicians and other health professionals will leave the public system (¶¶1911-16) and/or be unavailable for consulting in the public system (¶¶1922-26), it will be more difficult to ensure an adequate supply of physicians for the public system (¶¶1928-29 and s. 3.2.14), and improving the public system would become more difficult (¶¶1931-33 and s. 3.2.10).

122. Finally, with respect to the third stage of the proportionality analysis, there can be no question that the challenged measures have the very salutary and actual effects of ensuring that all individuals have equal access to health care based on medical need and regardless of their income, and preserving a publicly managed, and fiscally sustainable, health care system. Certainly, it was reasonable for the Legislature to determine that those salutary effects outweigh the detrimental effects on those relatively small number of mostly hypothetical individuals who experience wait times in any harmful or disproportionate way. It has been said that "the perfect is the enemy of the good." No health care system can ever be perfect. Waiting lists will arise in any system, and will not be eliminated and indeed will likely be exacerbated by the creation of a parallel private market for physician services. It is for the democratic process to which ongoing reforms to the public health care system must be left, and there is ample evidence that the government continues to make best efforts to improve the health care system for the good of all rather than a privileged few.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 1st day of November, 2019.

Joseph J. Arvay, O.C., Q.C.
and Alison M. Latimer
Counsel for the Coalition Intervenors

List of Authorities

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