S.C.C. No. 29272

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR QUÉBEC)

B E T W E E N:

JACQUES CHAOULLI and GEORGE ZELIOTIS

Appellants

- and -

ATTORNEY GENERAL OF QUÉBEC and ATTORNEY GENERAL OF CANADA

Respondents

- and -

ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF NEW BRUNSWICK, ATTORNEY GENERAL OF SASKATCHEWAN, AUGUSTIN ROY, SENATOR MICHAEL KIRBY, SENATOR MARJORY LEBRETON, SENATOR CATHERINE CALLBECK, SENATOR JOAN COOK, SENATOR JANE CORDY, SENATOR JOYCE FAIRBAIRN, SENATOR WILBERT KEON, SENATOR LUCIE PÉPIN, SENATOR BRENDA ROBERTSON and SENATOR DOUGLAS ROCHE, CANADIAN MEDICAL ASSOCIATION and THE CANADIAN ORTHOPAEDIC ASSOCIATION, CANADIAN LABOUR CONGRESS, CHARTER COMMITTEE ON POVERTY ISSUES and THE CANADIAN HEALTH COALITION, CAMBIE SURGERIES CORPORATION, FALSE CREEK SURGICAL CENTRE INC., SPECIALTY MRI CLINICS INC., FRASER VALLEY MRI LTD., IMAGE ONE MRI CLINIC INC., MCCALLUM SURGICAL CENTRE LIMITED, 4111044 CANADA INC., SOUTH FRASER SURGICAL CENTRE INC., VICTORIA SURGERY LTD., KAMLOOPS SURGERY CENTRE LTD., VALLEY COSMETIC SURGERY ASSOCIATES INC., SURGICAL CENTRES INC., THE BRITISH COLUMBIA ORTHOPAEDIC ASSOCIATION and THE BRITISH COLUMBIA ANESTHESIOLOGISTS SOCIETY

Interveners

FACTUM OF THE INTERVENER THE CHARTER COMMITTEE ON POVERTY ISSUES and THE CANADIAN HEALTH COALITION

(Pursuant to Rules 37 of the *Rules of the Supreme Court of Canada*)

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PARTS I and II - STATEMENT OF FACTS AND QUESTIONS IN ISSUE

1. The Charter Committee on Poverty Issues (CCPI) and the Canadian Health Coalition (the Coalition) adopt the Statement of Facts and Questions in Issue in the Respondent's Factum.

PART III – ARGUMENT

What is at Stake in this Case?

2. This case raises the question of how sections 7 and 15 of the *Canadian Charter* should be applied to protect and guarantee the right to health care in Canada. The Court's decision will be of critical importance to Canadians generally, and to disadvantaged groups such as poor people in particular, who rely on access to publicly funded health care as an essential component of their rights to life, liberty, security of the person, and equality.

3. Since the Second World War, and with the advent of publicly funded health insurance across Canada in the late 1960s and early seventies, Canadians and their governments alike have come to perceive free and universal health care as a basic right of social citizenship. CCPI and the Coalition submit that the *Charter* must be interpreted in a way that gives clear constitutional expression to this "keystone tenet of governmental policy."[1] As the Romanow Commission on the Future of Health Care in Canada asserts in its *Final Report*: "Canadians consider equal and timely access to medically necessary services on the basis of need as a right of citizenship, not a privilege of status or wealth."[2]

4. Notwithstanding increasing pressures placed upon it, and unrelenting criticism from its opponents, Canadians have remained constant in their view that equality of access to health care must be preserved as a core and defining feature of our publicly funded health care system:

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[1] *Eldridge* v. *British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 at para. 50 [*Eldridge*].

[2] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in

> The Canadian approach to the provision of health care services continues to receive strong and passionate support. The public does not want to see any significant changes which would alter the fundamental principles of our publicly administered health care system. They have an abiding sense of the values of fairness and equality and do not want to see a health system in which the rich are treated differently from the poor.[3]

5. Recognizing a positive obligation under the *Charter* to ensure equal access to health care is consistent not only with Canadians' understanding of health care as a basic right, but with governments' commitment under section 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." The National Forum on Health explains:

> Canadian underpinnings of the health care system include the premise that it ought to be government run and not for profit, that money is not the primary consideration and that all are entitled – as a matter of citizenship – to equal access to quality care. This typically Canadian approach is, for many people, emblematic of a commitment to compassion, to equality of opportunity, to a sense of community and to a common purpose.[4]

6. Giving *Charter* effect to this domestic conception of health care is also consistent with the evolving international recognition of health as a fundamental human right, reflected in the *Universal Declaration* and subsequent human rights treaties ratified by Canada.[5] As Justice Wilson expresses it: "government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."[6]

Canada, 2002) at xvi (Chair: Roy Romanow) [Romanow Commission].

[3]National Forum on Health, "Values Working Group Synthesis Report" in *Canada Health Action: Building on the Legacy, Volume II* (Ottawa: Minister of Public Works and Government Services, 1997) at 11 [National Forum on Health].

[4]*Ibid.*

[5]B. von Tigerstrom, "Human Rights and Health Care Reform: A Canadian Perspective" in T.A. Caulfield & B. von Tigerstrom, eds, *Health Care Reform and the Law in Canada – Meeting the Challenge* (Edmonton: University of Alberta Press, 2002)157 at 158-60.

7. Poverty is, beyond doubt, one of the most significant determinants of health in Canada.[7] While poor people's access to social welfare programs and services has been steadily eroded over the past decade,[8] publicly funded health care remains one social program to which they enjoy equal entitlement with other Canadians and for which the level of public support remains high. In *R.* v. *Edwards Books and Art Ltd.*, former Chief Justice Dickson warned that:

> In interpreting and applying the Charter ... the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the conditions of less advantaged persons.[9]

8. The Appellants have put forward an interpretation of the *Charter* that would subvert the equal enjoyment of the right to health for disadvantaged groups such as seniors, people with disabilities, women and the poor in order to entrench a right of more advantaged individuals to contract for private health insurance and private health care funding. As found by the Courts below, evidence from Canada and other countries is clear that granting the Appellants' *Charter* claim would lead to a two-tiered health care system which would deny disadvantaged Canadians an equal standard of care.[10]

9. The Appellants' argument, if upheld, would allow the *Charter* to become a vehicle for knocking down a critical pillar of legislative protection for social rights in Canada. CCPI and the

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[6]*Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 544.

[7]National Forum on Health, "Determinants of Health Working Group Synthesis Report" in National Forum on Health at 5-6; National Anti-Poverty Organization, *Government Expenditure Cuts and Other Changes to Health and Post-Secondary Education: Impacts on Low-Income Canadians* (Ottawa: National Anti-Poverty Organization, 1998) Chapter 3.

[8]B. Porter, "ReWriting the *Charter* at 20 or Reading it Right: The Challenge of Poverty and Homelessness in Canada" in W. Cragg & C. Koggel, eds, *Contemporary Moral Issues* (Toronto: McGraw-Hill Ryerson, 2004) at 374-86.

[9][1986] 2 S.C.R. 713 at 779.

[10]*Chaoulli* c. *Québec (Procureur général)*, [2000] J.Q. no. 479 (C.S.), Joint Appeal Docket, Vol.I pp.17-172 at para. 263 ["*Chaoulli* (C.S.)"].

Coalition submit that such an outcome would be profoundly at odds with international human rights law, domestic *Charter* principles, and deeply held Canadian values.

The Evidence in Relation to Public and Private Insurance Funding

10. Justice Piché found that the health and hospital insurance legislation provisions at issue[11] are a key element of the framework established by Québec, in accordance with the principles of the *Canada Health Act*, to ensure a single-payer, publicly funded health care system, accessible to all without barriers based on ability to pay.

11. Justice Piché further found that striking down the impugned provisions would have serious negative consequences for the public system, including decreased support from more affluent and thus politically influential groups; advantaging of those able to afford private insurance; diversion of financial and human resources away from, and lengthening of waiting lists in, the public system; increased administrative costs required to regulate private insurance; and increased overall spending with no clear improvement in health outcomes.[12]

12. This evidence of the regressive effects of allowing private insurance funding is reinforced by the conclusions of the Romanow Commission.[13] As health economist Robert Evans puts it: "The real motive underlying proposals for more private financing is very simple. The more private funding we have, the more those with high incomes can assure themselves of first class care without having to pay taxes to help support a similar standard of care for everyone else."[14]

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[11] *Health Insurance Act*, R.S.Q. c.A-29, s.15; *Hospital Insurance Act*, R.S.Q. c.A-28, s.11.

[12] *Chaoulli* (C.S.), *supra* at paras 91-93 (Dr. C. Wright); paras 103-115 (Dr. T. Marmor).

[13] Romanow Commission, *supra* at xx; National Coordinating Group on Health Care Reform and Women, *Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care in Canada for Women* (Winnipeg: Canadian Women's Health Network, 2003) at 9 [*Reading Romanow*].

[14] R. Evans, *Raising the Money: Options, Consequences, and Objectives for Financing*

13. In coming to her decision, Justice Piché recognized that all health care systems include some form of rationing:

> Le régime public de santé québécois ne bénéficie pas de ressources illimitées et inépuisables, tous les experts l'ont dit. Nous pouvons même en dire autant de tous les systèmes de santé existant dans le monde. Dans ce contexte, il est tout à fait justifiable qu'un gouvernement, ayant les meilleurs intérêts de sa population à coeur, adopte une solution en matière de santé qui vise à favoriser le plus grand nombre possible d'individus. Le gouvernement limite les droits de quelques-uns pour assurer que les droits de l'ensemble des citoyens de la société ne seront pas brimés.[15]

CCPI and the Coalition agree that the single-payer system, which creates some waiting period for all, is preferable to the multi-payer system advocated by the Appellants, in which large numbers of people (primarily the poor) never receive care at all. CCPI and the Coalition submit, as Justice Piché concluded, that the publicly funded system is to be preferred, not only as a matter of sound health policy, but of constitutional and international human rights law.

Health Care and the Section 7 Right to Life, Liberty and Security of the Person

14. CCPI and the Coalition submit that section 7 of the *Charter* guarantees a right to health, including to health care necessary for physical and mental well-being. In the most basic terms, a right to life, liberty, and security of the person is meaningless without access to health care and other services to protect health and treat illness. As Justice Piché held: "S'il n'y a pas accès possible au système de santé, c'est illusoire de croire que les droits à la vie et à la sécurité sont respectés."[16]

15. Access to health care is clearly necessary to maintain human life. It is directly connected to physical and psychological security and autonomy. As the Preamble to the *Canada Health*

Health Care in Canada (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 42 [Evans, "*Financing Health Care*"].

[15] *Chaoulli* (C.S.), *supra* at para. 262; para. 79 (Dr. F. Turcotte); para. 95 (Dr. J.L. Denis).

[16] *Chaoulli* (C.S.), *ibid.* at para. 223.

Act states: "continued access to quality health care without financial or other barriers [is] critical to maintaining and improving the health and well-being of Canadians."[17] In this sense access to health care "touch[es] the core of what it means to be an autonomous human being blessed with dignity and independence in 'matters that can properly be characterized as fundamentally or inherently personal'."[18] Access to health care necessary to maintain health and treat illness is essential to the exercise of other basic *Charter* rights, including expression, association, political and other rights that enable each individual to participate as full and equal members of Canadian society.[19]

16. While this Court has yet to consider the full scope of health related *Charter* rights, it has underscored the importance of health and health care decision-making to life, liberty and security of the person.[20] In *Rodriguez* v. *British Columbia (Attorney General)*, Justice Sopinka recognized that "security of the person is intrinsically concerned with the well-being of the living person."[21] In *Singh* v. *Canada*, Justice Wilson cited the Law Reform Commission of Canada's conclusion that: "the right to security of the person means not only protection of one's physical integrity, but the provision of necessaries for its support."[22]

17. In *Irwin Toy* v. *Québec (Attorney General)*, this Court drew a distinction between social

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[17] *Canada Health Act*, R.S.C. 1985 c. C-6, Preamble.

[18] *R.* v. *Clay*, 2003 SCC 75 at para. 31.

[19] Committee on Economic, Social and Cultural Rights, *General Comment No.14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4 (11 August 2000) para 3 [*General Comment No.14*].

[20] *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at paras 83, 217.

[21] [1993] 3 S.C.R. 519 at 585 ["*Rodriguez*"].

[22] [1985] 1 S.C.R. 177 at 206-07, citing Law Reform Commission of Canada, *Medical Treatment and the Criminal Law – Working Paper No. 26* (Ottawa: Supply and Services Canada, 1980) at 6.

and economic rights "included in various international covenants", which may be "fundamental to human life or survival" and "corporate-commercial economic rights" which were intentionally excluded from section 7.[23] In *Gosselin* v. *Québec (Attorney General)*, a majority of the Court again held that "one day s. 7 may be interpreted to include ... a positive obligation to sustain life, liberty or security of the person"[24], while Justice Arbour found that positive rights "intimately intertwined with considerations related to one's basic health (and hence security of the person) – and ... one's survival (and hence "life") ... can readily be accommodated under the s. 7 right..."[25]

18. Consistent with the reasoning in *Irwin Toy*, the right to health as it is guaranteed under section 7 and international human rights law must be distinguished from the right to contract for private health insurance being claimed by the Appellants in this case.[26]

19. Similarly, the right to liberty advanced by the Appellants and supporting Interveners, should be rejected as inimical to the particular significance Canadians attach to the idea of autonomy and choice in the health care context – that is – the capacity to choose and receive medically necessary care without barriers based on individual ability to pay. As Marie-Claude Prémont explains: "it is considered unacceptable for one segment of society to be able to profit from the suffering of others, especially when misfortune confronts a person with a terrible choice such as paying for medical treatment or the family's food and clothing."[27]

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[23][1989] 1 S.C.R. 927 at 1003-04 [*Irwin Toy*].

[24]*Gosselin* v. *Québec (Attorney General)*, 2002 SCC 204 at paras 82-83, McLachlin C.J.; at para. 414, LeBel, J.

[25]*Ibid.* at para. 311, Arbour J.

[26]*Irwin Toy*, *supra* at 1004; *Chaoulli* c. *Québec (Procureur général)*, [2002] J.Q. no. 759 (C.A.), Joint Appeal Docket, Vol. I pp. 175-89 at para. 25, Delisle J.; at para. 66, Brossard J. [*Chaoulli* (C.A.)].

[27]M.-C. Prémont, *The Canada Health Act and the Future of Health Care Systems in Canada* (Saskatoon: The Canada Health Act and the Future of Health Care in Canada, 2002) at 6; National Forum on Health, *supra* at 5-7; *Chaoulli* (C.A.), *ibid.* at para. 25, Delisle J.

20. The effect of the Appellants' claim would be to define the section 7 right to health as under-inclusive, protecting those able to pay for private insurance while excluding poor people from access to necessary services. This Court has recognized that the poor are "one of the most disadvantaged groups in society"[28] and that when it comes to poverty-related barriers to equal enjoyment of *Charter* rights the poor ought not, in the Chief Justice's words, to be treated as "constitutional castaways."[29]

21. CCPI and the Coalition submit that section 7 should be interpreted consistently with international human rights law and *Charter* values, to ensure that the right to health is guaranteed for all. On the facts of this case, section 7 must therefore be applied in a way that maintains the integrity of the public health care system and the principles of the *Canada Health Act*.[30] It also means that the right to health under section 7 includes more than access to acute care services, and extends to preventive and proactive measures, including to address poverty, environmental degradation and social exclusion, which cause or contribute directly to ill-health.[31]

22. The right to health under section 7 must be an inclusive right, ensuring its full and equal enjoyment by disadvantaged groups. The impugned provisions protect the integrity of the public health care system by preventing the development of a parallel privately funded system for those who are more economically advantaged.[32] Thus, the impugned provisions do not violate but

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[28] *R.* v. *Prosper*, [1994] 3 S.C.R. 236 at 288, l'Heureux-Dubé, J.

[29] *Ibid.* at 302, McLachlin J.

[30] *Supra*, Preamble, ss. 3, 4, 7-13, 18-20.

[31] M. Townson, *Health and Wealth – How Social and Economic Factors Affect our Well Being* (Ottawa: Canadian Centre for Policy Alternatives, 1999) at 21-33 [Townson, *Health and Wealth*]; D. Raphael, "From Increasing Poverty to Societal Disintegration: The Effects of Economic Inequality on the Health of Individuals and Communities" in H. Armstrong, P. Armstrong & D. Coburn, eds, *Unhealthy Times: The Political Economy of Health Care in Canada* (Toronto: Oxford University Press, 2001) at 223-246; *Reading Romanow*, *supra* at 33.

[32] *Chaoulli* (C.S.), *supra* at para. 263.

rather are a positive measure required by section 7, in conformity with the principles of fundamental justice.

Section 7 Principles of Fundamental Justice in the Health Care Context

23. In its recent decision in *R.* v *Malmo-Levine*; *R.* v. *Caine*, this Court emphasizes that the principles of fundamental justice are those "about which there is significant societal consensus" that they are "fundamental to the way in which the legal system ought fairly to operate". In particular, it found that decisions that are "arbitrary or irrational" violate fundamental justice.[33]

24. In *Rodriguez*, Justice Sopinka underscored the societal consensus in Canada that human life must be respected.[34] By ensuring that access to health care services is not conditional upon ability to pay, the impugned legislative provisions, and the *Canada Health Act* principles which they implement, reflect and promote the fundamental *Charter* value of respect for human life.

25. At an individual level, the impugned provisions accord with the principles of fundamental justice because they ensure that health care and medical treatment decisions are made based on need, rather than on the arbitrary and irrational criteria of ability to pay.

26. At a societal level, as Justice Piché found, the impugned provisions accord with fundamental justice by ensuring that broader health policy and resource allocation decisions are equitable and effective, rather than dictated by market pressures which have been shown to generate not only inequitable, but inefficient and irrational health care choices.[35] As Justice Piché concluded:

> La seule façon de garantir que toutes les ressources en matière de santé

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[33] *R.* v *Malmo-Levine*; *R.* v. *Caine*, 2003 SCC 74 at paras 115, 135.

[34] *Rodriguez*, *supra* at 608.

[35] *Chaoulli* (C.S.), *supra* at para. 66, 75 (Dr. F. Turcotte); World Health Organization, *World Health Report – 1999* (Geneva: WHO, 1999) cited in *Chaoulli* (C.S.) *ibid.* at para. 66.

> bénéficient à tous les Québecois, et ce sans discrimination, est d'empêcher l'établissement d'un système de soins privés parallèles. Voilà précisément ce que font les dispositions attaquées en l'espèce ... Par conséquent, l'atteinte au droit à la vie, à la liberté et à la securité de la personne, en l'espèce, est faite en conformité avec les principes de justice fondamentale.[36]

The Right to Equal Protection and Benefit of Health Care Under Section 15

27. The impugned legislative provisions must, as was held by the Courts below, be understood in their broad social context and in light of the substantive equality rights of disadvantaged groups which section 15 is meant to protect. In the words of Justice Piché:

> Les dispositions attaquées visent à garantir un accès aux soins de santé qui est égal et adéquat pour tous les Québécois. L'adoption des articles 15 LAM et 11 LAH a été motivée par des considérations d'égalité et de dignité humaine et, de ce fait, il est clair qu'il n'y a pas de conflit avec les valeurs générales véhiculées par la Charte canadienne ou de la Charte québécoise des droits et libertés.[37]

28. The impugned provisions and the *Canada Health Act* principles they reflect represent positive measures to respect, protect and fulfill the right to health for vulnerable groups, as mandated by section 15. The Romanow Commission describes the equality-based premise of the public system, of which the impugned provisions are an integral part, in the following terms: "our tax-funded, universal health care system provides a kind of "double solidarity." It provides equity of funding between the "haves" and "have-notes" in our society and it also provides equity between the healthy and the sick."[38]

29. Governments' failure to ensure equal enjoyment of the right to health by preventing the development of two tiered care would have a discriminatory effect on the dignity and security of disadvantaged groups protected under section 15, including poor people, women, seniors and those with disabilities, for whom access to publicly funded health care is crucial. As Donna

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[36] *Chaoulli* (C.S.), *ibid.* at paras 264, 267; *Chaoulli* (C.A.), *supra* at paras 60-63.

[37] *Chaoulli* (C.S.), *ibid.* at para. 260; *Chaoulli* (C.A.), *ibid.* at para. 38.

[38] Romanow Commission, *supra* at 31.

Greschner explains:

> Several fundamental values, such as equality and non-discrimination, animate the existing Medicare system. The principles of the *Canada Health Act* fulfill Canada's international obligations with respect to health services, and go a long way toward satisfying the requirements of sections 7 and 15.[39]

30. Justice LaForest outlined the positive obligations imposed by section 15 in the context of health care services for the Deaf in *Eldridge* v. *British Columbia (Attorney General)*:

> If we accept the concept of adverse effect discrimination, it seems inevitable, at least at the s. 15(1) stage of analysis, that the government will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services.[40]

It is therefore not the impugned provisions, but rather an absence of legislative measures to ensure equal access to health care which, CCPI and the Coalition submit, would raise *Charter* equality rights concerns.

The Right to Health in the International Human Rights Context

31. An interpretation of sections 7 and 15 that recognizes the right to health, including access to health care without financial barriers, is consistent with and dictated by Canada's international human rights obligations.

32. Article 3 of the *Universal Declaration of Human Rights*[41] provides that "Everyone has the right to life, liberty and security of person." Article 25(1) provides that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including ... medical care." Article 12(1) of the *International Covenant on Economic, Social and Cultural*

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[39]D. Greschner, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Cares Costs?* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 21.

[40]*Eldridge*, *supra* at para. 77.

[41]*Universal Declaration of Human Rights*, GA Res. 217A (III), UN Doc. A/810 (1948).

Rights (*ICESCR*),[42] ratified by Canada after lengthy discussion and with the assent of the provinces, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 12(2)(d) sets out Canada and other State parties' obligations to take all steps necessary for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

33. In its *General Comment* on Article 12 of the *ICESCR*, the U.N. Committee on Economic, Social and Cultural Rights (CESCR) has outlined a number of critical components of the right to health under international law. First, the right to health extends beyond access to acute health care services, and includes obligations with respect to underlying determinants of health, such as access to nutrition, housing, healthy occupational and environmental conditions, as well as participation in health related decision making at the local and national levels.[43]

34. Second, the right to health under international law requires that: "functioning **public** health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level."[44]

35. Third, governments must ensure that the right to health is enjoyed without discrimination, and in particular, without discrimination based on "social origin, property, birth or other status."[45] In the words of the CESCR: "Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."[46]

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[42] *International Covenant on Economic, Social and Cultural Rights*, (1966) 993 U.N.T.S. 3, Can. T.S. 1976 No. 46 [*ICESCR*].

[43] *General Comment No. 14*, *supra* at para. 11.

[44] *Ibid.* at para. 12(a).

[45] *ICESCR*, *supra* Art. 2.

[46] *General Comment No. 14*, *supra* at para. 12(b).

36. Governments, such as Canada, which have ratified the *ICESCR*, are required to "respect", "protect" and "fulfill" the right to health under Article 12. The CESCR describes the obligation to protect the right to health in the following terms:

> Obligations to protect include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties [and] to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services ...[47]

37. Periodic reviews by the CESCR of State party compliance with Article 12 emphasize the obligation to ensure that the poor and other disadvantaged groups are assured equal access to health care. The CESCR has noted "with satisfaction that Canadians as a whole enjoy a high standard of health care, with a health care system which is based on universality and accessibility."[48]

38. In the course of its most recent periodic review of Canada's performance under the *ICESCR*, the CESCR asked about limits on access to health care facing poor people in Canada.[49] In its response to this question, the Canadian government noted that:

> Canada has a publicly financed health care system that is best described as an interlocking set of ten provincial and two territorial health insurance plans, better known as "medicare" ...Under this universal system, rationing of health care services occurs on the basis of need, not financial means. As a result, waiting periods do exist for certain health care services. However ... waiting periods are fairly stable and not increasing. Rural residents do not wait longer for services than urban residents, women do not wait longer than men, and wealthy residents

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[47] *Ibid.* at para. 35.

[48] United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on Canada*, E/C 12/1993 (10 June 1993) at para. 9 [CESCR, *Concluding Observations on Canada*, 1993].

[49] Government of Canada, *Responses to the Supplementary Questions to Canada's Third Report on the International Covenant on Economic, Social and Cultural Rights,* HR/CESCR/NONE/98/8 (October, 1998) at 33 (Question 54).

are not "bumped up" ahead of middle-or low income patients.[50]

39. Having ratified the *ICESCR* and other human rights instruments recognizing the right to health, Canada with the agreement of Québec, has recognized access to health care as a fundamental human right and not simply a governmental "policy objective". [51] Notwithstanding their pleadings in this case, Canada and Québec are obligated under the *ICESCR* to promote an interpretation of domestic law which ensures appropriate remedies for violations of the right to health.[52]

40. The impugned legislative provisions are thus a critical component of Canada and Québec's joint obligations under the *ICESCR* to ensure the equal enjoyment of the right to health without discrimination, and to adopt necessary legislative measures to guard against threats to equality of access posed by privatization, such as the introduction of private health insurance called for by the Appellants and supporting Interveners in the present case.

41. An interpretation of the right to life, liberty and security of the person, and of the right to equality for disadvantaged groups, which includes the right to adequate health care based on need, not on ability to pay, is consistent with emerging jurisprudence in other constitutional democracies. As the Constitutional Court of Korea recently observed in dismissing a challenge to legislation preventing hospitals from opting out of the public insurance system in that country: "it is one of the constitutional duties required of the state to provide citizens with medical insurance in order to achieve human dignity and guarantee a humane livelihood ..."[53]

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[50]*Ibid.*

[51]CESCR, *Concluding Observations on Canada, 1993*, *supra*, at para. 21; United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on Canada*, E/C.12/1/Add.31 (10 December 1998) at para. 14-15.

[52]United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 9: The Domestic Implementation of the Covenant*, E/C.12/1998/24 (3 December, 1998) at paras 10, 15.

[53]*Compulsory Designation of Medical Care Institutions* (2002), 14-2 Korean Constitutional Court Reports 410 (Date of Decision: 31 October 2002); summarized in Constitutional Court of Korea, *Decisions of the Korean Constitutional Court* (Seoul:

42. The right to health is now widely recognized and applied by courts around the world, both as a free-standing right and as an implicit component of rights such as the right to life or the right to equality. For example, in *Consumer Education and Research Centre and Others v. Union of India and Others*, the Indian Supreme Court held that: "The right to health for workers is an integral facet of meaningful right to life..." [54] In its 2002 decision in *Minister of Health and Others* v. *Treatment Action Campaign and Others*, the South African Constitutional Court required the provision of antiretroviral drugs to HIV-positive pregnant women throughout the country as a requirement of the right to health.[55] In *Cruz Bermudez et al* v. *Ministerio de Sanidad y Asistencia Social*, the Supreme Court of Venezuela held that the right to life and the right to health are closely linked, and on that basis ordered the provision of antiretrovirals and other medications, as well as the design and funding of programs necessary for affected patients' treatment and assistance.[56] In these and similar cases, judicial intervention to protect the right to health of vulnerable groups has saved thousands of lives.

The Appropriate Remedy in this Case

43. The Appellants and supporting Interveners argue that the impugned provisions violate Canadians' *Charter* right to health because lack of financial and human resources in the public system has resulted in unacceptable waiting times for treatment. The remedy, they suggest, is to permit private health care funding which, they contend, will benefit not only those with the means to avail themselves of privately funded care, but also those who remain in the public system, as demand for public services will be reduced.

Constitutional Court of the Republic of Korea, 2003) at (summary) 151-154.

[54](1995) AIR Indian Supreme Court 922 at paras 24-30 (Date of Decision: 27 January 1995); see also *Paschim Banga Khet Mazdoor Samity and Others* v. *State of West Bengal and Another* (1996), AIR Indian Supreme Court 2426.

[55]2002, (5) South African Law Reports 721 (CC) (Date of Decision : 5 July 2002).

[56]Decision No. 916 of the Administrative Law Court of the Supreme Court of Justice of Venezuela, Case No. 15.789 (Date of Decision: 15 July 1999).

44. The evidence, as Justice Piché found, fails to support these claims. Rationing is common to all health care systems; in Canada, it occurs based on need rather than ability to pay. Waiting periods in Canada are no worse, and may in fact be better than in countries where parallel private funding is allowed.[57] Most significantly, private health insurance funding has been shown to have profound deleterious effects for the public health care system as a whole, and for access to health care by disadvantaged groups in particular.[58]

45. Senator Kirby and the other Senators supporting the argument that the impugned provisions should be struck down, assert that "Health Care Guarantees" would be sufficient to preserve the main features of the current system. This claim runs counter to the clear evidence at trial that the impugned provisions are necessary to maintain the integrity of the publicly funded system. It is also belied by the Romanow Commission's conclusion that public funding is what ensures not only the most equitable, but the most rational and efficient health care for all Canadians.[59]

46. The Respondent and Intervener governments have insisted that health care decision-making is "rooted in choices the appropriateness of which it is not for a court to debate."[60] Similar arguments were made and rejected by this Court in *Gosselin*.[61] This Court is not only competent, but constitutionally mandated to remedy *Charter* violations in health care as in any

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[57] C.H. Tuohy, C.M. Flood & M. Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations" (2004) 29:3 *Journal of Health Politics Policy and Law* (forthcoming) at 40 [Tuohy, "Private Finance"].

[58] R.B. Deber, "Getting What We Pay For: Myths and Realities About Financing Canada's Health Care System" (2000) 21 *Health Law in Canada* 9 at 32-39; Evans, *supra*.

[59] Romanow Commission, *supra* at xx; Tuohy, "Private Finance", *supra* at 40-43; Evans, "Financing Health Care", *supra*; *Reading Romanow*, *supra* at 33.

[60] *Factum of the Respondent (Mis-en-cause) Attorney General of Canada* at para. 50; *Factum of the Respondent Attorney General of Québec* at paras 80, 104; *Factum of the Intervener Attorney General of Ontario* at para. 30.

[61] *Supra*.