



The Charter of Rights and Health Care Reform

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THE CHARTER OF RIGHTS AND HEALTH CARE REFORM

I. INTRODUCTION

The future of Canada's publicly funded and managed health care system is arguably the most pressing public policy issue in the country today. This is nowhere more evident than here in British Columbia where the government has embarked upon an ambitious program of reform aimed at restructuring the way in which health care services are delivered in the Province.

The prominence of the issue is also reflected in the numerous commissions and studies initiated across the country by various governments including:

- (a) The Federal Royal Commission on the Future of Health Care in Canada chaired by Roy Romanow;
- (b) The review being conducted by the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, entitled "The Health of Canadians-The Federal Role";
- (c) The Report of the Premier of Alberta's Advisory Council on Health, chaired by Don Mazankowski, entitled "A Framework for Reform" published in December 2001; and
- (d) The British Columbia Select Standing Committee on Health report entitled "Patients First: Renewal and Reform of British Columbia's Health Care System" published December 2001.

While these and other studies make it clear that the future and potential reform of Canada's health care system involves fundamental issues of public policy, it is also clear that the debate must inevitably be both informed and constrained by issues of law.

The notion that questions of law might arise in the context of an examination of the health care system is not new. For example, in 1994, the Canadian Bar Association published a comprehensive report entitled "What's Law Got To Do With It – Health Care Reform in Canada" that considered various legal principles relevant to health care reform.

One such issue is the role of the *Charter of Rights* and, in particular, the question of whether a rights analysis can be invoked to challenge the current model or system of health care delivery and thereby provoke reform. The role of the *Charter* in the health care debate has been considered by a number of commentators. Most recently, on May 14, 2002, the C.D. Howe Institute published a paper entitled "The *Charter* and Health Care – Guaranteeing Timely Access to Health Care for Canadians". The paper, written by Professor Patrick Monahan of Osgood Hall Law School and Stanley Hartt, a former Federal Deputy Minister of Finance, presents a credible argument that restrictions on patients' ability to purchase necessary medical services privately, when such services are not available in a timely manner within the public system, violates the guarantees of liberty and security of the person contained in Section 7 of the *Charter*. A similar argument is made by Andrea Karr in her two part paper "Section 7 of the *Charter*: Remedy for Canada's Health Care Crisis" published in The

Advocate (Volume 58, Part 3, p. 363 and Part 4, p. 531). (See as well the list of Selected Additional Readings attached to this paper).

This paper will examine the principles underlying this argument as well some of the key cases that support the *Charter* as a critical factor in the health care debate.

II. FRAMING THE ISSUE

At the outset, it should be stressed that arguments to the effect that the *Charter* guarantees a right to health care *per se* are unlikely to succeed. Indeed, as discussed below, the courts have generally been unreceptive to arguments that the *Charter* guarantees access to specific medical services. Rather, the issue is more narrow and arises as a result of the convergence of two primary factors:

1. The increasing inability of the public health care system to deliver medically necessary services in a timely and effective way; and
2. Provisions that exist in provincial legislation governing the various provincial medicare schemes that restrict the private purchase of health care services by patients.

With respect to this second factor, it is not necessary to describe in detail all of the relevant statutory provisions. Suffice it to say that in British Columbia, the primary governing statute, the *Medicare Protection Act*, effectively prohibits the provision of medically necessary services outside of the public system. The question therefore is whether this prohibition can withstand scrutiny under the *Charter*. (A very useful review of the legislation and its effects can be found in Karr, Part 1, *supra* at pp. 363-366).

III. SECTION 7 OF THE CHARTER

The starting point for the analysis is the proposition that the *Charter*, and in particular Section 7, guarantees certain rights in respect of health care. Section 7 states:

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

Various academic studies have examined the question of whether Section 7 guarantees an absolute right to health care and have concluded that it does not. (See for example, Canadian Bar Association Task Force on Health Care: *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association 1994) and Martha Jackman, "The Regulation of Private Health Care Under the Canada Health Act and the Canadian Charter" (1995) 6 Const. Forum 54). Moreover, attempts to invoke the *Charter* to compel the government to provide or fund a particular medical service have met with little success in the courts. For example:

- (a) In *Fernandes v. Director of Social Services (Winnipeg Central)* (1993), 7 Admin. L.R. (2d) 153 the Manitoba Court of Appeal held that the denial of funding for a home care attendant so as to enable the Plaintiff who suffered from a debilitating disease to live outside of a hospital setting did not violate the Plaintiff's rights under Sections 7 or 15 of the *Charter*;

- (b) In *Brown v. Minister of Health* (1990), 42 B.C.L.R. (2d) 294 the British Columbia Supreme Court held that the Province's failure to provide full funding of AZT treatment for AIDS patients was not discriminatory nor did it infringe the Plaintiff's Section 7 rights; and
- (c) In *Cameron v. Nova Scotia (Attorney General)* (Unreported: N.S.S.C. February 5th, 1999) the court held that Sections 7 and 15 could not be used to compel the government to provide full funding for in-vetro fertilization services.

In each of these cases, the applicants claimed a *Charter* right to receive a specific type of medical service within the publicly funded health care plan. The Courts' refusal to recognize any such right is rooted in part in the traditional reluctance of the Courts to interfere in government decisions relating to the distribution of scarce resources. This is clearly reflected in the words of Kennedy, C.J.S.C. in the *Cameron* case *supra*:

I agree with the Defendant's submission that finding the public funding of particular medical services to be considered an element of the right to life, liberty or security of person would expand the parameters of judicial review well beyond its present scope....

The courts should take care before interfering with an elected government's allocation of limited public funds for social programs or the medical profession's determination of health priorities.

(This last reference is to the fact that the list of insured or funded medical services was developed under an agreement between the province and the Nova Scotia Medical Society and that this process resulted in a specific exclusion of in-vetro fertilization from the approved tariff.)

The question of whether there is a guaranteed right to specific types of health care is different however from the issue under consideration here, namely whether the government can impede or deny access to essential medical services. Put another way, can the government effectively preclude a patient from seeking treatment in a private setting when that treatment is not readily available in the public system by reason of under-funding, significant wait lists or other such restrictions?

A strong argument may be advanced that laws or other government actions which impede the ability of individuals to make fundamental health care decisions, including decisions as to how, when and where they will obtain necessary medical treatment, violate the guaranteed right to life, liberty and security of the person under Section 7 of the *Charter* and as such are *prima facie* unconstitutional.

The common law has long recognized the concepts of personal autonomy and self-determination as they relate to medical treatment. As noted by Mr. Justice Cory of the Supreme Court of Canada in *Ciarlariello v. Schachter*, [1993] 2 S.C.R. 119, 135:

It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent.

This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient.

(See also *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.)).

Personal autonomy and self-determination also lie at the heart of the liberty and security of person rights guaranteed under Section 7 of the *Charter*. This was apparent in the Supreme Court of Canada's decision in *R. v. Morgentaler*, [1988] 1 S.C.R. 30 in which the Court struck down the *Criminal Code* provisions restricting access to abortion services. In that case, Mr. Justice Betz noted:

Generally speaking, the constitutional right to security of the person must include some protection from state interference when a person's life or health is in danger...If a rule of criminal law precludes a person from obtaining appropriate medical treatment when his or her life or health is in danger, then the state has intervened and this intervention constitutes a violation of that man's or woman's security of the person.

Similarly, in the same decision, Madam Justice Wilson said:

The idea of human dignity finds expression in almost every right and freedom guaranteed in the *Charter*. Individuals are afforded the right to choose their own religion and their philosophy of life, the right to choose with whom they will associate and how they will express themselves, the right to choose where they will live and what occupation they will pursue. These are all examples of the basic theory underlying the *Charter*, namely that the state will respect the choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to anyone conception of the good life.

Thus, an aspect of the respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty....

(See as well *Godbout v. Lonquenil (City)*, [1997] 3 S.C.R. 844 per La Forest J. at p. 893).

Building on these principles, it is arguable that while the government may not be obliged to fund every conceivable medical service, it cannot unduly restrict access to medical services considered by a patient to be essential. The importance of this concept of access has been underscored by subsequent authorities. For example in *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 Madam Justice Wilson said at page 544:

Simply put, government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any other member.

Similarly in upholding British Columbia's abortion facilities "bubble zone" legislation, Madam Justice Saunders of the B.C. Supreme Court said in *R. v. Lewis* (1996), 139 D.L.R. (4th) 480 at 509:

Health care has fundamental value in our society. A woman's right to access health care without unnecessary loss of privacy and dignity is no more than the right of every Canadian to access health care.

The notion that Section 7 of the *Charter* protects individuals from undue state interference with access to medical treatment has also been accepted by various academics. See for example Patrice Grant "*Fundamental Freedoms and Natural Justice*" in Beaudoin and Tarnapolsky (eds.) *The Canadian Charter of Rights and Freedoms: Commentary* (Toronto: Carswell 1982) 257 at 335 and Canadian Bar Association Task Force on Health Care, "*What's Law Go To Do With It?*" *Health Care Reform in Canada*", *supra* at pp. 48 - 50, 93 - 95.

Assuming that such a right exists, the question then arises as to whether legislation such as the British Columbia *Medicate Protection Act* so restricts access to medical care as to violate the right to liberty and/or security of the person. If such a violation can be shown, it must also be determined whether the violation contravenes the principles of fundamental justice which is the second element in the Section 7 analysis.

With respect to the denial of access, the analysis is again based on the premise that patients are effectively precluded from obtaining necessary medical services outside of the public system. Whether that constitutes an infringement of a patient's rights of liberty or security of the person will largely be a question of fact. Where the medical service in issue is relatively minor and the delay in accessing that service inconsequential then the values and principles reflected in Section 7 are likely not engaged. However, when a patient is denied timely access to a medical procedure with the result that the patient's life is threatened or the quality of her life significantly undermined, and that patient is prohibited from obtaining the necessary service privately, the infringement of the liberty and/or security of the person right seems clear.

The analysis then turns to the principles of fundamental justice in that only those deprivations of life, liberty or security of the person which also contravene those principles will be found to offend Section 7. The Court has not offered a definitive interpretation of what constitutes the principles of fundamental justice other than to say that they "are to be found in the basic tenets of the legal system". (See *Reference re Section 94(2) of Motor Vehicle Act*, [1985] 2 S.C.R. 486 at 503).

Mr. Justice Sopinka gave some further clarity to the concept in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 590 where he said:

A mere common law rule does not suffice to constitute a principle of fundamental justice, rather as the term implies, principles upon which there is some consensus that they are vital or fundamental to our societal notion of justice are required. Principles of fundamental justice must not, however, be so broad as to be no more than vague generalizations about what our society considers to be ethical or moral. They must be capable of being identified with some precision and applied to situations in a manner which yields an understandable result. They must also, in my view, be legal principles.

In *Rodriguez*, Mr. Justice Sopinka declined to recognize the concept of "respect for human dignity" as a distinct principle of fundamental justice given the breadth and vagueness of the notion. Rather, he viewed it as a concept underlying many of the principles of fundamental justice.

It is arguable that the principle of fundamental justice at issue here is the right to self-determination in making fundamental personal choices about medical care. This is a more concrete principle than the notion of respect for human dignity rejected by Mr. Justice Sopinka in that, as noted above, it translates into the legal doctrine of informed consent. In this sense, it is also a legal principle given that failure to adhere to it may give rise to legal rights and liabilities. (See for example *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.) where the Defendant physician was found liable for damages for giving a blood transfusion to the Plaintiff, a Jehovah's Witness, against her wishes.)

A law or government policy which unduly interferes with or restricts a patient's ability to pursue necessary medical treatment cannot accord with the principles of fundamental justice particularly if the basis for the restriction is arbitrary and without foundation. While I will return to this concept below, in the context of Section 1 of the *Charter*, it will be my contention that the prohibitions on private medicine and the strict adherence to the single-payer system reflect a political choice and are not based on any clear evidence demonstrating that the existing system is necessary for ensuring adequate health care for all citizens.

IV. SECTION 15 OF THE CHARTER

A second provision of the *Charter* which is relevant to the issue of whether patients have enforceable rights in the context of access to health care is Section 15. Section 15(1) states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

As seen above in cases such as *Fernandes, Brown and Cameron*, Section 15 has not been successfully invoked to compel government to provide specific medical services. However, in the more recent Supreme Court of Canada decision in *Eldridge v. British Columbia (Attorney General)* (1998), 38 B.C.L.R. (3d) 1 the Court made it clear that in providing medical services the province must do so in a way which does not discriminate, or in the language of Section 15, does not deny certain persons "equal benefit of the law".

The case was originated by three hearing impaired patients who claimed that the failure to provide interpretation services violated their right to equal benefit of the law under Section 15 of the *Canadian Charter of Rights and Freedoms*. In particular, they contended that the absence of sign language interpreters impaired their ability to communicate with treating physicians and other health care providers thereby increasing the risk of misdiagnosis and ineffective treatment. The Plaintiffs argued that they received a lesser quality of medical service than hearing persons which infringed their Section 15 equality rights. Compelling evidence was led at trial by the Plaintiffs and by their physicians as to the difficulties encountered when clear communication between physician and patient was not possible.

At issue in the case was the *Medical and Health Care Services Act* (the predecessor to the *Medicare Protection Act*) which deals with medical services provided by physicians and the *Hospital Insurance Act* which allows for reimbursement to hospitals for medically necessary services provided to members of the public. Neither statute contains any special allowance for funding for sign language interpretation for the hearing impaired.

Both the British Columbia Supreme Court and the British Columbia Court of Appeal dismissed the Plaintiff's claim, essentially on the basis that while Section 15 of the *Charter* prohibits a Government from discriminating against disadvantaged people, the section cannot be invoked to compel the Government to institute programs to benefit the disabled. On further appeal to the Supreme Court of Canada, the appeal was allowed and a declaration granted that the failure to provide sign language interpretation services violates the Plaintiff's constitutional right to equality.

The Supreme Court's decision is significant in a number of respects. The first point of importance to note is that the *Charter* was found to apply at all, at least in respect to hospitals. As a constitutional document, the *Charter* is designed to regulate the conduct of "government" and in a previous series of decisions, (for example, *Stoffman, supra*), the Supreme Court had held that hospitals were essentially non-governmental private institutions which were not subject to scrutiny under the *Charter*. Accordingly, Section 15 could not be relied upon by physicians whose hospital privileges were mandatorily retired at age 65.

In *Eldridge* however, the Supreme Court held that while hospitals are not "government", in providing medically necessary services they are clearly carrying out a specific government objective and as such will be subject to review under the *Charter* in the provision of those services. Similarly, the Medical Services Commission acts in a governmental capacity in exercising its powers under the *Medicare Protection Act* to determine what services will constitute benefits for the purpose of that Act. Thus decisions which impact upon the delivery of health care services may attract *Charter* scrutiny.

The second significant aspect of the decision is the court's equality analysis. The circumstances of this case were different from many others in that the claim was not that the government acted in a way which is discriminatory, but rather, that it is the failure to act which gives rise to the discrimination. Both the *Medical and Health Care Services Act* and the *Hospital Insurance Act* are neutral on their face in that both simply provide for medically necessary services to all qualified beneficiaries. According to the Supreme Court however, this is not sufficient if the effect of the legislation is discriminatory which the Court found to be the case. In the Court's view, once the government made the decision to confer a benefit i.e. publicly funded medical services, it was obliged to do so in a non-discriminatory way. In the case of hearing impaired patients, this requires the assistance of sign language interpreters to ensure equality in the level and quality of medical care being provided.

The final aspect of the Supreme Court's decision which is of some importance is its consideration of Section 1 of the *Charter*. Under that provision, a government may seek to justify or maintain a law which otherwise violates a *Charter* right on the basis that the law is aimed at achieving a pressing and substantial public objective and is a reasonable and proportionate means of achieving that objective. In *Eldridge*, the government argued that given the limit amount of public money available for the health care system, difficult decisions must be made as to what services will be funded. Extension of funding to ancillary services like interpretation would, in the government's view, place severe strain on the fiscal sustainability of the overall health care system. Mr. Justice Lambert in concurring reasons in the British Columbia Court of Appeal expressly decided the case on this ground. In his view, while the absence of interpretation services was likely discriminatory, the Courts should not unduly interfere with governmental decisions about the allocation of scarce resources.

The Supreme Court rejected this argument. According to the Court, sign language interpretation is not an ancillary service for hearing impaired patients but rather is a central component of the

primary medical service being provided. Without that interpretation, hearing impaired patients are simply denied the same access to medical care as hearing patients. The Supreme Court was not persuaded by the fiscal sustainability argument given that, on the evidence the cost of providing the interpretation service amounted to no more than .0025% of the overall provincial health care budget.

Section 15 was also successfully invoked in the recent decision of the British Columbia Supreme Court in *Auton v. Attorney General of British Columbia*, 2000 BCSC 1142. There, certain parents of children with autism sought a declaration that the Province's failure to fund a particular autism treatment, the Lovaas Autism treatment, violated Sections 7 and 15 of the *Charter*. The Petitioners further sought an order of mandamus requiring the Crown to pay for the costs of the treatment already incurred and the future costs of that treatment.

The case was heard by Madam Justice Allan who considered it unnecessary to deal with the arguments under Section 7 and instead focussed her analysis on Section 15. Justice Allan canvassed numerous relevant authorities including *Eldridge* and concluded that the Petitioners' Section 15 rights were violated. She said:

In my opinion, there is no need to consider adverse effects discrimination. The petitioners are victims of the government's failure to accommodate them by failing to provide treatment to ameliorate their mental disability. That failure constitutes direct discrimination. Further, the petitioners' disadvantaged position stems from the government's failure to provide effective health treatment to them, not from the fact that their autistic condition is characterized, in part, by an inability to communicate effectively or at all.

* * *

Autism is the disorder or illness that requires treatment. It is of little assistance to reassure people suffering from debilitating illnesses that although the state will not provide treatment for that illness, should they break a leg or develop pneumonia, they will be treated for those conditions. While one of the effects of autism may be an inability to communicate and obtain government services which are universally available, the gravamen of the government's omission is its failure to provide treatment for the underlying disability, not its willingness to ensure access to other benefits.

Turning to Section 1, Madam Justice Allan addressed the primary justification advanced by the Crown, namely the need to ration scarce health care funding and resources. Madam Justice Allan did not find the Crown's argument compelling. She noted that similar arguments had not succeeded in *Eldridge*:

Those submissions were resoundingly rejected by the Court. As it turns out, accommodation for the deaf has been made without catastrophic results to the health care system. In *Eldridge*, as here, if there is a constitutional violation that must be redressed, a remedy can be fashioned without the wholesale destruction of the government's medicare system.

The exclusion of effective treatment for autistic children undermines the primary objective of the medicare legislation, which is to provide universal health care. The additional stated objection of the statute, to make “judicious use” of limited health care resources, does not justify a violation of the petitioners’ section 15 rights. Further, the state’s failure to accommodate the petitioners cannot be classified as a minimal impairment of their rights. It follows that the Crown’s submissions, which characterize the objective of the medicare legislation as funding core medical services that do not include ABA, cannot withstand the scrutiny of a proportionality analysis.

By agreement of the parties, the issue of remedies was left to be determined at a subsequent hearing. However, at the initial hearing, Madam Justice Allan had to determine the terms of the appropriate declaration, having found a violation of Section 15. Notwithstanding that the submissions of the Petitioners were largely concerned with the specific Lovaas therapy, Madam Justice Allan agreed with the Crown that it was beyond the jurisdiction of the Court to specifically order a particular treatment or to require that the Medical Services Commission list Lovaas behavioural therapists as service providers on the MSC tariff. The declaration was therefore framed in terms that the government’s failure to provide the infant Petitioners with “effective treatment for autism” violated their equality rights under Section 15.

The initial Reasons for Judgment of Madam Justice Allan were rendered on July 26, 2000. Her subsequent decision, dealing with the issue of remedies, was handed down on February 6, 2002. Between those dates, the Province had begun to implement a program of early intensive behavioural intervention treatment for children between the ages of two and six. In light of this program the Crown took the position that an order of mandamus was unnecessary.

The Petitioners did not support the Province’s program, in part because it did not include the Lovaas treatment and because it was, in their view, too restrictive.

Faced with this stark disagreement on the question of what constitutes proper and effective treatment, Madam Justice Allan commented on the role of the Courts and their ability to provide appropriate remedies:

This case raises significant public policy issues as to the respective roles of the judiciary and the legislature. The issues raised by the petitioners underscore the difficulties inherent in a process where the Court’s finding of unconstitutionality is designed to change governmental behaviour. The effective treatment of autistic children must be delivered within a framework that is necessarily constrained by the resources available and the need to allocate those resources equitably in response to competing demands. As the Court stated in *Schachter v. Canada*, [1991] 2 S.C.R. 679 at 709, although budgetary considerations “cannot be used to justify a violation under s. 1” of the *Charter*, they are “clearly relevant once a violation which does not survive s. 1 has been established.

While the Government’s programmes and policies are subject to review by the Courts to ensure constitutional compliance, the judiciary cannot dictate what treatment programmes should or should not be implemented, nor can it

dictate how limited financial resources should be allocated. It is not the role of the Courts to undertake the nature and degree of supervision of the delivery of Early IBI treatment suggested by the petitioners. An overly robust judicial approach may interfere with legitimate policy making choices.

In light of those restrictions and given the movement of the Province to implement a program of treatment, Madam Justice Allan declined the order of mandamus. However, she maintained a limited supervisory role and granted the Petitioners to renew their application in the event that the Province did not in fact move forward in a timely way to implement an affective program of treatment.

(Madam Justice Allan did award each of the adult Petitioners the sum of \$20,000.00 as a symbolic award to reflect the financial and emotional burden they had shouldered in pursuing the litigation on behalf of, and for the benefit of, a wider community. Madam Justice Alan's conclusions on this point followed an extensive review of the law relating to *Charter* damages that is beyond the scope of this paper.)

V. SECTION 1 OF THE *CHARTER*

If a violation of either Section 7 or Section 15 can be established, then it is open to the government to attempt to justify the offending provisions under Section 1 which provides:

The Canadian *Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

It is difficult at this time to canvass thoroughly how the Section 1 analysis might proceed given that it is very dependent upon the evidence adduced by the government to support the offending law. However, some general observations can be made.

The test for determining whether an impugned law or measure may be saved under Section 1 is well established and involves the following elements:

1. Is the objective which the impugned measure is designed to address of sufficient importance to warrant overriding a constitutionally protected right or freedom, i.e. is there a pressing and substantial objective?
2. Are the means chosen proportional to the intended objectives? This proportionality test has three subcomponents:
 - (a) Are the means chosen rationally connected to the intended objective?
 - (b) Do the means chosen impair the affected rights as little as possible? and
 - (c) Does the measure have a disproportionately severe effect on the persons to whom it applies i.e. do the deleterious impacts outweigh the salutary effects of the measure?

(See *R. v. Oakes*, [1986] 1 S.C.R. 103).

In applying this test the Courts have often distinguished between cases in which the legislation in issue is of a socio-economic nature requiring the legislature to balance competing interests and instances in which the state is characterized as the “singular antagonist” of the individual (i.e. criminal proceedings). In the former cases a more flexible approach to justification is often adopted with greater deference to the legislative choice whereas a more rigid approach may apply in the latter instances.

Notwithstanding the flexibility and deference which may apply to legislation like the *Medical Protection Act* which falls within the socio-economic realm, the Supreme Court of Canada has confirmed that such deference only goes so far and that the Courts cannot abdicate their responsibility to carefully scrutinize impugned laws:

The bottom line is this. While remaining sensitive to the social and political context of the impugned law and allowing for difficulties of proof inherent in that context, the Courts must nevertheless insist that before the state can override constitutional rights, there a reasoned demonstration of the good which the law may achieve in relation to the seriousness of the infringement. It is the task of the Courts to maintain this bottom line if the rights conferred by our Constitution are to have force and meaning. The task is not easily discharged, and may require the Courts to confront the tide of popular public opinion. But that has always been the price of maintaining constitutional rights. No matter how important Parliament’s goal may seem, if the state has not demonstrated that the means by which it seeks to achieve its goal are reasonable and proportionate to the infringement of rights, then the law must perform fail.

See *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at 329.

In the same case Madam Justice McLachlin discussed the nature of the Section 1 analysis and the degree of proof required to meet the test. She said:

The Section 1 inquiry is by its very nature a fact-specific inquiry. In determining whether the objective of the law is sufficiently important to be capable of overriding a guaranteed right, the Court must examine the actual objective of the law. In determining proportionality, it must determine the actual connection between the objective and what the law will in fact achieve; the actual degree to which it impairs the right; and whether the actual benefit which the law is calculated to achieve outweighs the actual seriousness of the limitation of the right. In short, Section 1 is an exercise based on the facts of the law at issue and the proof offered of its justification, not on abstractions.

In applying the Section 1 test to the restrictions on private health care contained in the *Medicare Protection Act* and similar legislation, it can be anticipated that the government will argue that the objective underlying the restrictions is the need to protect the integrity of the health care system and ensure fair access to all citizens regardless of ability to pay. Indeed, this objective is identified in the preamble to the *Medicare Protection Act* which states:

The purpose of this 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 on an individual's ability to pay.

Assuming that this is a valid objective, which few people would quarrel with, the real issue is whether restrictions on private health care represent a reasonable and proportionate means of achieving that objective. Fundamentally, this requires an examination of whether the current single-payer model in fact continues to be an effective model for ensuring the delivery of adequate health care given the demands being placed on the system and current fiscal realities. It also requires consideration of the impacts associated with permitting private health care. Would a parallel private system relieve some of the stress on the public system thereby enhancing that system or would it, as some would have it, drain resources away from the public system to the prejudice of poor and disadvantaged patients?

To my knowledge, no comprehensive study of these issues has been undertaken in Canada yet the answers to these questions are critical to the Section 1 analysis and indeed to any rational discussion of the future of health care in Canada. In the specific context of the legal issues, as Madam Justice McLachlin noted above in *RJR-MacDonald*, the Section 1 analysis requires that the government demonstrate how an offending measure can be justified. Accordingly, it is not sufficient for government to simply say that the current model is necessary; it must be prepared to adduce evidence to demonstrate this as a matter of fact.

At a general level, it is difficult to conceive how restrictions on a person's ability to pursue necessary medical services could be justified when these services are not readily available through the public system. Certainly, the Courts in cases like *Eldridge* and *Auton* have given short shift to the Section 1 arguments advanced by the Crown

VI. WHERE TO FROM HERE

Based on the above, a compelling case can be made that the current model of delivering essential medical services in Canada, which combines a cash-strapped and overburdened public system with prohibitions against the purchase of private health care, is vulnerable to scrutiny under the *Charter*. However, this by no means ensures that opponents of the health care *status quo* can successfully invoke the *Charter* to bring down that *status quo*. A number of questions and issues remain outstanding, two of which are worth noting here:

1. As discussed by Monahan and Hartt in their C.D. Howe paper *supra*, the cost and logistics of mounting a *Charter* challenge can be overwhelming, particularly for an individual already faced with poor health and the need to find appropriate medical care. Given that standing to mount a constitutional challenge would likely be restricted to such an individual, this presents a significant challenge. In order to overcome that challenge, Monahan and Hartt suggest options such as the Court granting discretionary public interest standing to a representative public interest Plaintiff or for an institution with adequate resources to promote and fund litigation brought by ordinary Canadian patients; and
2. As illustrated by the *Auton* case, the question of remedies remains very much in issue. While the Courts have not been willing to entertain arguments based upon available resources and

administrative efficiencies under Section 1, those factors may still influence the types of remedies that the Courts are prepared to fashion.

Notwithstanding these outstanding questions, it is apparent that the *Charter of Rights* may be a powerful tool in bringing about much needed health care reform. What is also apparent, is that if the politicians continue to offer only cosmetic changes to the current system and to ignore fundamental structural problems, the impetus for change may come from individual litigants and the Courts with the aid of the *Charter*.

Selected Additional Readings

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