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"The Last Line of Defence for Citizens": Litigating Private Health Insurance in Chaoulli v. Quebec

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"The Last Line of Defence for Citizens": Litigating Private Health Insurance in *Chaoulli v. Quebec*

Abstract

Litigating health care policy under the Canadian Charter of Rights and Freedoms has become an increasingly common phenomenon. The judicialization of health policy in this form raises important questions about the general phenomenon of legal mobilization. This article examines these questions in the context of *Chaoulli v. Quebec* (2005), in which the Supreme Court invalidated Quebec's prohibition against private insurance for medical services provided through the public health care system. Among the questions this article explores are: How do such cases get into the judicial system? Under what conditions are such claims likely to be successful? What is the impact of such litigation on the broader policy environment?

Keywords

Health policy; Judicial review; Quebec; Canada

“THE LAST LINE OF DEFENCE FOR CITIZENS”: LITIGATING PRIVATE HEALTH INSURANCE IN *CHAULLI V. QUEBEC*[©]

CHRISTOPHER P. MANFREDI & ANTONIA MAIONI*

Litigating health care policy under the *Canadian Charter of Rights and Freedoms* has become an increasingly common phenomenon. The judicialization of health policy in this form raises important questions about the general phenomenon of legal mobilization. This article examines these questions in the context of *Chaoulli v. Quebec* (2005), in which the Supreme Court invalidated Quebec's prohibition against private insurance for medical services provided through the public health care system. Among the questions this article explores are: How do such cases get into the judicial system? Under what conditions are such claims likely to be successful? What is the impact of such litigation on the broader policy environment?

Les litiges afférents aux soins de santé en vertu de la *Charte canadienne des droits et libertés* sont devenus un phénomène sans cesse croissant. La judicialisation sous cette forme des politiques en matière de santé soulève d'importantes questions au sujet de ce phénomène général de mobilisation juridique. Le présent article examine ces questions dans le contexte de la cause *Chaoulli c. Québec* (2005), dans laquelle la Cour suprême a invalidé l'interdiction du Québec en ce qui concerne l'assurance privée à l'égard des services médicaux dispensés par le biais du système public des soins de santé. Parmi les questions que le présent article aborde, citons : Comment de telles causes se sont-elles insinuées dans l'appareil judiciaire? En vertu de quelles conditions de telles demandes peuvent-elles obtenir gain de cause? Quelle est l'incidence d'un tel litige sur l'environnement plus vaste des politiques?

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I. INTRODUCTION

In November 2004, and again in June 2005, the Supreme Court of Canada delivered judgments in cases with potentially far-reaching implications for Canadian health care policy.¹ At issue in *Auton v. British Columbia* was whether provincial governments have a constitutional obligation to deliver an expensive form of autism treatment within their publicly funded health care regimes; at issue in *Chaoulli v. Quebec* was whether those same governments are constitutionally permitted to prohibit private insurance coverage for services provided through the public health care system. In contrast to previous health care cases decided by the Court, these cases involved basic issues of health policy rather than peripheral (even if important) questions of implementation. At stake in *Auton* was provincial policy discretion over the range of services provided through the public system, while *Chaoulli* represented a challenge to the very existence of publicly provided health care by attacking the effective provincial monopoly over the provision of core medical services.

Auton and *Chaoulli* are the most visible manifestations of an increasingly common phenomenon in Canada: the use of rights-based litigation as an instrument of health policy reform.² Among the key

¹ *Auton v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 [*Auton*]; *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 [*Chaoulli*].

² Martha Jackman, "The Regulation of Private Health Care Under the *Canada Health Act* and the Canadian Charter" (1995) 6:2 Const. Forum 54; Martha Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions Under Section 7 of the Canadian Charter" (1995/96) 4 Health L. Rev. 3; Canada, Commission on the Future of Health Care in Canada, *Health and the Distribution of Powers in Canada*, Discussion Paper No. 2 by André Braën (Ottawa: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy J. Romanow, Q.C.); Canada, Commission on the Future of Health Care in Canada, *The Implications of Section 7 of the Charter for Health Care Spending in Canada*, Discussion Paper No. 31 by Martha Jackman (Ottawa: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy J. Romanow, Q.C.) [Jackman, *Implications of Section 7*]; Canada, Commission on the Future of Health Care in Canada, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs*, Discussion Paper No. 20 by Donna Greschner (Ottawa: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy J. Romanow, Q.C.); and Christopher Manfredi & Antonia Maioni, "Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada" (2002) 27 J. Health Pol. 211.

issues litigated under the *Charter of Rights and Freedoms*³ are physician-supply management, medical practice regulation, hospital restructuring, and regulation and provision of specific treatment and services. Prior to 2004, the Court's contribution to this phenomenon included nullifying the federal abortion law,⁴ modifying professional advertising regulations,⁵ upholding the criminal prohibition against assisted suicide,⁶ and establishing a constitutional right to sign language interpretation in the provision of health care services.⁷

The judicialization of health policy in the form of constitutional rights claims highlights important questions about a cluster of related phenomena that falls under the rubric of "legal mobilization." These phenomena include the "process by which legal norms are invoked to regulate behavior";⁸ the translation of desires into demands through "an assertion of one's rights";⁹ and a "planned effort to influence the course of judicial policy development to achieve a particular policy goal."¹⁰ As a strategy for policy reform, legal mobilization ideally aims at establishing new legal rules that generate desirable policy consequences and strengthen the political position of the reform's advocates. Reality, however, is usually more complicated. Legal mobilization may fail to establish sought-after legal rule changes, yet desirable policy consequences may follow; desirable rules may emerge from litigation, but have no impact on policy or social conditions; unsuccessful legal mobilization may nevertheless strengthen a policy reform movement by energizing individuals around particular causes; by contrast, successful mobilization may enervate a movement or energize a counter-movement.

³ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

⁴ *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

⁵ *Rocket v. Royal College of Dental Surgeons of Ontario*, [1990] 2 S.C.R. 232.

⁶ *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

⁷ *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 [*Eldridge*].

⁸ Richard O. Lempert, "Mobilizing Private Law: An Introductory Essay" (1976) 11 *Law & Soc'y Rev.* 173.

⁹ Frances Kahn Zemans, "Legal Mobilization: The Neglected Role of the Law in the Political System" (1983) 77 *Am. Pol. Sci. Rev.* 690 at 700.

¹⁰ Susan E. Lawrence, *The Poor in Court: The Legal Services Program and Supreme Court Decision-Making* (Princeton: Princeton University Press, 1990) at 40.

Chaoulli and *Auton* are interesting examples of legal mobilization for several reasons. First, health care is arguably the single most important area of Canadian public policy: it consumes almost 10 per cent of GDP and is the largest single-expenditure item in provincial budgets. Second, the cases offer differing visions of the direction health policy should take—*Chaoulli* sought to expand private provision while *Auton* sought to expand public coverage. Finally, one case involved an individual lone crusader (*Chaoulli*), and the other a group with roots in an organized social movement (*Auton*). Consequently, both cases provide a good empirical base for exploring three key questions about legal mobilization: How do such cases get into the judicial system? Under what conditions are such claims likely to be successful? What is the impact of winning—or losing—on the broader policy environment?

In a previous article, we discussed these questions with respect to *Auton*.¹¹ In this paper, we turn to *Chaoulli*, whose legal history has at least two similarities to *Auton*. First, as in *Auton*, the Court reversed the unanimous judgments of lower appellate and trial courts. Second, again as in *Auton*, the Court reversed the judgments below not so much because of differences of legal interpretation (although this was important), but because of different interpretations of empirical evidence. In the pages that follow, we explore both of these characteristics in greater depth.

II. LITIGATING A PRIVATE ALTERNATIVE TO A PUBLIC MONOPOLY

Chaoulli entered the judicial process as a twin challenge to the effective public monopoly on the provision of basic medical services in Quebec. Part of the challenge came from George Zeliotis, who filed a constitutional complaint against Quebec's prohibition on the sale and purchase of private insurance for health services provided through the public system. The other part of the challenge came from Doctor Jacques Chaoulli, whose broader complaint included a right to liberty claim against legislative restrictions on the ability of physicians to practice simultaneously in the private and public health sectors. The basic litigation objective of both challenges was a remedy under section

¹¹ Christopher P. Manfredi & Antonia Maioni, "Reversal of Fortune: Litigating Health Care Reform in *Auton v. British Columbia*" (2005) 29 Sup. Ct. L. Rev. (2d) 111.

52 of the *Constitution Act, 1982*¹² invalidating the impugned legislative provisions.

In view of this objective, we adopt as a framework for analysis Philip Cooper's model of remedial decree litigation, which consists of trigger, liability, remedy, and post-decree phases.¹³ The trigger phase of remedial decree litigation includes both the general historical practices and the specific triggering events that lead to the initiation of a case. The liability and remedy phases, in which rights violations are determined and remedies formulated to correct the violations, constitute the central components of remedial decree litigation. These phases may occur simultaneously or be the subject of separate proceedings. The final step in remedial decree litigation is the post-decree phase, during which remedies are implemented, evaluated and refined. This phase is characterized by interaction between litigants and judges, with the degree of judicial involvement being related to the extent of the constitutional violation, the organizational capacity for change, and the surrounding political culture. With this model providing our framework, we explore three key questions: How did these issues get into the legal process? Why did the claims fail in the lower courts? Why did they succeed in the Supreme Court?

A. *Triggering Litigation*

In 1993, sixty-one year old George Zeliotis, a salesman for a chemical company, suffered several medical problems, including depression and a heart attack. In 1994, he began experiencing recurring hip problems, which led him to consult with a variety of medical practitioners. His general practitioner referred him to an orthopedic specialist in 1995, and he had surgery performed on his left hip. In 1997, after some delay, his right hip was operated on. During his year-long wait in 1996, Zeliotis investigated whether he could pay privately for surgery and discovered that the terms of Quebec's health care laws prohibited him from either obtaining private insurance or from paying directly for services provided by a physician in a public hospital. He

¹² *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

¹³ Phillip J. Cooper, *Hard Judicial Choices: Federal District Court Judges and State and Local Officials* (New York: Oxford University Press, 1988) at 16-24.

pleaded his case with administrators, politicians, and the local media without success.

Although it was Zeliotis's condition and waiting time for surgery that eventually led to litigation, the key protagonist in the judicial battle became Doctor Jacques Chaoulli, who one observer portrayed as "preparing and fighting this case almost single-handedly."¹⁴ Trained in France and Quebec, Chaoulli received his permit to practice medicine in Quebec in 1986. Then, as now, physicians were required to practice outside "over serviced" urban areas, such as greater Montreal, or receive lower reimbursement rates for their services. Chaoulli decided to return to Montreal after only two years. He soon became well-known in medical circles through his attempts to set up a home-based, 24-hour practice for doctors making house calls in Montreal's south shore region. After intense lobbying of government officials and the Regional Health Board's refusal to recognize his practice in 1996, Chaoulli began a hunger strike to draw attention to the situation. The strike lasted three weeks, and at that point Chaoulli decided to become a "non-participating" doctor in the Quebec health care system.¹⁵

In Quebec, as in all provinces, physicians may "opt out" of the public system and bill patients directly for services rendered. However, as Chaoulli soon discovered, the disincentives for opting out are very high. Under the terms of Quebec's health care laws, patients may not seek reimbursement from the public system if they consult non-participating doctors; in addition, these doctors may not provide private services in publicly-funded hospitals.¹⁶ From 1996 to 1998, Chaoulli attempted to gain permission, from both Quebec officials and the federal ministry of health, to create a private hospital. After this initiative failed, Chaoulli returned to the public system and worked as a general practitioner in a walk-in clinic.

Chaoulli was never Zeliotis's physician, but the two plaintiffs effectively "teamed up" in their legal challenge of Quebec health and

¹⁴ Susan Pinker, "Why Does Such a Big Issue Rest on the Shoulders of Two Citizens? FP Asks After Losing Private Medicine Battle" (2000) 162 *Can. Med. Assoc. J.* 1348 [Pinker, "Private Medicine Battle"].

¹⁵ Barbara Sibbald, "In Your Face: A New Wave of Militant Doctors Lashes Out" (1998) 158 *Can. Med. Assoc. J.* 1505.

¹⁶ Colleen M. Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 *Can. Med. Assoc. J.* 825.

hospital insurance laws before the province's Superior Court. In 1997, they presented motions for a declaratory judgment that two articles of these laws were unconstitutional. First, they asked the court to invalidate Article 15 of the Quebec *Health Insurance Act*,¹⁷ which proscribes private insurers from covering publicly-funded services.¹⁸ Second, they asked the courts to invalidate Article 11 of the Quebec *Hospital Insurance Act*,¹⁹ which prevents non-participating physicians from contracting for services in publicly funded hospitals.²⁰

Chaoulli chose to represent himself in the initial trial, claiming that he had a "duty" to provide services, and he called upon several high-profile critics of public health care to testify on his behalf. Zeliotis, who stated that his personal goal was to ensure that any future surgery would not be "delayed again," retained the services of Philippe Trudel, of Trudel & Johnston.²¹ This Montreal law firm, which specializes in constitutional litigation, consumer protection, and health and medical liability, was also associated with a high-profile class action suit in the late 1990s against the tobacco industry on behalf of Quebec smokers and ex-smokers who became addicted to nicotine.²² Both Zeliotis and Chaoulli resorted to litigation because of dissatisfaction with the health policy status quo. In Zeliotis's case, this dissatisfaction appears to have been triggered by his specific negative experience of waiting for hip surgery. Chaoulli's dissatisfaction appears to have been the product of a long-standing normative objection to public management and control of health care delivery. In addition, the two cases emerged during a period of tremendous stress in the Quebec health care system, as the province

¹⁷ R.S.Q. c. A-29.

¹⁸ The relevant portion of Article 15 reads: "No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or temporary resident of Québec or to another person on his behalf."

¹⁹ R.S.Q. c. A-28.

²⁰ The relevant portion of Article 11(1) reads: "No one shall make or renew, or make a payment under a contract under which (a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services; [or] (b) payment is conditional upon the hospitalization of a resident."

²¹ Susan Pinker, "The Chaoulli Case: One-Tier Medicine Goes on Trial in Quebec" (1999) 161 *Can. Med. Assoc. J.* 1305-06.

²² Josée Hamelin, "L'industrie freine les recours collectifs québécois" *Info-Tabac* 46 (August 2003), online: [Info-tabac.ca <http://www.arrete.qc.ca/bull46/recours.htm>](http://www.arrete.qc.ca/bull46/recours.htm).

was implementing a major program of restructuring necessitated by significant fiscal pressures.

B. *Liability Proceedings: The Quebec Phase*

Trial proceedings in *Chaoulli c. Québec*²³ began in December 1997 and continued over four weeks before Justice Ginette Piché in the Superior Court of Quebec. At trial, the basic question was this: is the combination of waiting times for health care services in the public system and restrictions on private insurance for publicly provided services a violation of the right to life, liberty, and security of the person enshrined in section 7 the *Charter*?

The court heard testimony from both Chaoulli and Zeliotis, the physicians who had cared for Zeliotis, a former minister of health in Quebec, and several physicians and health policy specialists. The court also heard testimony from Barry Stein, a Montreal lawyer who had initiated successful proceedings against the Quebec government for reimbursement of cancer treatment he received in New York after having had his surgery cancelled at a Quebec hospital.

Chaoulli emphasized the mental anguish he experienced as a victim of an allegedly discriminatory law that prohibited him from practising his profession as a non-participating doctor outside the public system, and he portrayed Quebec's health care monopoly as infused with Marxist-Leninist theories of egalitarian ideology. His testimony was so dramatic and intense that the judge commented on his "tireless" efforts.²⁴ Zeliotis's counsel, meanwhile, focused on how Article 11 of the *Hospital Insurance Act* and Article 15 of the *Health Insurance Act* were contrary to the *Charter* under section 7 (life, liberty, and security of the person) and section 15 (equal treatment) because they did not allow non-participating Quebec doctors to use public hospital facilities or allow Quebec residents to use their own financial resources to insure themselves for private care.²⁵

The court heard the testimony of five medical specialists. Doctor Eric Lenczner and Doctor Côme Fortin expressed concern with the problems of access to timely care in orthopaedic surgery and cataract

²³ *Chaoulli c. Québec (Procureure générale)*, [2000] R.J.Q. 786 [*Chaoulli (2000)*].

²⁴ Pinker, "Private Medicine Battle," *supra* note 14.

²⁵ *Chaoulli (2000)*, *supra* note 23 at 790.

surgery. Although waiting lists were not fatal, they claimed, they could seriously reduce the quality of life of patients in the interim. Doctor Abendour Nabid, meanwhile, argued that there could not be any reasonable delay for cancer patients. Although all of the physicians expressed frustration with the health care system in Quebec, there was no consensus that the system should be changed in the way in which the plaintiffs were demanding.²⁶ Barry Stein also testified about his problems with waiting for surgery, although the testimony was contradicted by his physician, Doctor André Roy, who told the court that the delay for the surgery had not been expected to be more than one week in duration.²⁷

The highest profile witness was undoubtedly Claude Castonguay, the provincial Minister of Health and Social Services during the early 1970s, considered the “father of medicare” in Quebec. He claimed that, while he still agreed with the objective of the 1970 law to ensure equal access to health care, the province’s strained financial situation and growing elderly population meant that new solutions and partnerships had to be created in the health care system. Nevertheless, he disagreed with the remedy suggested by the plaintiffs in the case.²⁸

The court also heard the opinions of several “experts” in the health care sector, who provided historical and comparative perspectives on the Quebec health care system. Doctor Fernand Turcotte, a professor of medicine at Laval University, testified about the historical impetus for public health care and the relationship between access to health care and socio-economic status.²⁹ Doctor Howard Bergman, director of geriatrics at the Jewish General Hospital in Montreal, agreed that patients were unsettled by the rapid changes in the health care system, but deplored privatization as a solution, suggesting that it would benefit only the “healthy” and the “wealthy.”³⁰ Doctor Charles Wright, a British Columbia surgeon, commented on the administrative efficacy of the single-payer system in Canada, while Jean-Louis Denis, a professor of health system organization at the University of Montreal, pointed out

²⁶ *Ibid.* at 791.

²⁷ *Ibid.*

²⁸ *Ibid.* at 791-92.

²⁹ *Ibid.* at 792.

³⁰ *Ibid.*

that rationing is necessary in every health care system, either through need, as in Quebec, or the ability to pay, as in the United States.³¹ Theodore Marmor, a professor of public policy at Yale University, was asked about the likely impact of a parallel private system in Canada, and his opinion was that the “undesirable side effects” would include decreased support in the public system and increased costs of care and administration.³² The last expert witness was Doctor Edwin Coffey, a retired obstetrician-gynecologist and research associate for the Montreal Economic Institute—a conservative think tank that advocates privatization of health care in Canada.³³ His lengthy testimony deplored the “ideological and politically driven myths” in health care.³⁴

Justice Piché delivered her judgment on 25 February 2000, and her treatment of the plaintiffs in *Chaoulli* was unsympathetic. She began her summary by remarking: “Let’s say it from the start: in light of Mr. Zeliotis’ testimony and an examination of his medical record, it is apparent that he did not really suffer all of the misfortune and delay that he claims in his deposition.”³⁵ As for Chaoulli, she questioned his motivation, pointed to contradictions in his testimony, and deplored his use of the court in a personal “crusade” against the Quebec health care system.³⁶ Although the Justice emphasized that the court had to take into account all sides of the expert testimony, she concluded that Coffey was very much a “lone ranger” in his heavy-handed criticism of the shortcomings of the Quebec health care system.³⁷

Justice Piché’s central legal analysis concerned the claims relating to the right to life, liberty, and security of the person under section 7 of the *Charter*.³⁸ She concluded that access to health care is indeed a right, since “without access to the health care system, it would

³¹ *Ibid.* at 792-93.

³² *Ibid.* at 793.

³³ Coffey and Chaoulli later co-authored a research paper on “universal private choice.” See Edwin Coffey & Jacques Chaoulli, “Universal Private Choice: Medicare Plus” 2d ed., (Montreal: Montreal Economic Institute, 2001).

³⁴ *Chaoulli* (2000), *supra* note 23 at 793-94 [translated by author].

³⁵ *Ibid.* at 791 [translated by author].

³⁶ *Ibid.*

³⁷ *Ibid.* at 793-94.

³⁸ For a review, see Martha Jackman, “Misdiagnosis or Cure? Charter Review of the Health Care System” in Colleen Flood, ed., *The Frontiers of Fairness: Who Decides What Is In and Out of Medicare* (Toronto: University of Toronto Press) [forthcoming in 2006].

be illusory to believe that the rights to life and security are respected,”³⁹ but she also pointed out that there exists no right to determine the “provenance” (or source) of that care.⁴⁰ On the question of whether the existing limits on private insurance coverage were in violation of these same rights, the Justice affirmed that these restrictions could limit an individual’s timely access to care, but that such limitations would only contravene life, liberty, and security of the person if the public system could not guarantee access to similar care. The Justice was careful to point out that even though these limitations existed and could be a “threat,” this was not in conflict with the principles of fundamental justice and therefore could not be considered to contravene section 7 of the *Charter*.⁴¹

The use of the principles of fundamental justice to defend the public health care system was a central feature of the legal analysis that portrayed limitations on any individual right to private insurance as necessary to protect the collective rights of the entire population.⁴² In effect, Justice Piché argued that although Quebec’s health care laws constrained economic rights, this prevention of “discrimination based on one’s ability to pay does not violate the values of the charter.”⁴³ Justice Piché referred at length to expert testimony that compared the efficiency and access to care offered by public and private health care systems, and cited at length Professor Marmor’s description of the negative impact of a parallel system of private insurance on the viability of the public system.⁴⁴

Justice Piché nevertheless concluded her analysis with a remarkable observation: she pointed out that while the health care system in Quebec was based on sound principles, there was evidently need for some change. However, she declared that this question was political, rather than legal. In effect, Justice Piché argued that health care reform was the responsibility of legislators, not judges: “[T]he Court notes that solutions to problems of the health care system are not

³⁹ *Chaoulli (2000)*, *supra* note 23 at 822 [translated by author].

⁴⁰ *Ibid.* at 823.

⁴¹ *Ibid.* at 832.

⁴² Greschner, *supra* note 2 at 11.

⁴³ Pinker, “Private Medicine Battle,” *supra* note 14 at 1348.

⁴⁴ Jackman, *Implications of Section 7*, *supra* note 2 at 6.

to be found on the legal side.”⁴⁵ Her decision was interpreted as a strong defence of the existing health care legislation’s restrictions on private insurance and private care. Although recognizing a right to receive health care, her decision did not recognize a right to receive privately contracted services.

Chaoulli and Zeliotis were convinced, however, that by losing the battle, they “had a chance to win the war,”⁴⁶ because Piché had agreed that the limitations on private insurance could constitute a violation of the *Charter* under section 7. They appealed to the Quebec Court of Appeal in November 2001. Chaoulli again represented himself, but changed his tactics slightly by arguing that the “excessive” limitations on private delivery and insurance in Quebec’s health care legislation could be remedied by allowing less restrictive regulations based on European examples. The strategy was to show that parallel private systems did not necessarily jeopardize the public system, as had been argued by experts in the trial proceedings on the basis of U.S. experience.

The appellate court delivered its judgment on 22 April 2002. The three justices, Delisle, Forget, and Brossard, again examined whether the impugned sections of Quebec’s health care laws (1) were *ultra vires* provincial jurisdiction, (2) violated section 15 equality rights under the *Charter*, and (3) violated section 7 rights to life, liberty, and security of the person. The three justices upheld Justice Piché’s decisions on each of these questions in their judgments. Justice Delisle made an important contribution by emphasizing the broadened definition of the right to access to care, and agreed with the Superior Court that although the health care legislation constituted a *prima facie* limitation of section 7 rights, this limitation was not inconsistent with the principles of fundamental justice. He also argued that while the right to enter into a private contract is prohibited by Quebec’s health care legislation, this remains an economic right, and is not “fundamental to the life of the person.” Furthermore, he declared that the violation of section 7 rights had to be immediate and real, which was not evident in the case at hand.⁴⁷ Justice Delisle also invoked an earlier Supreme Court

⁴⁵ *Chaoulli (2000)*, *supra* note 23 at 833.

⁴⁶ Pinker, “Private Medicine Battle,” *supra* note 14 at 1348.

⁴⁷ *Chaoulli c. Québec (Procureur général)*, [2002] R.J.Q. 1205 at 1211.

decision in reminding the appellants that the *Charter* was not an instrument to remedy “societal choices” in the public domain. In other words, as Justice Piché had argued, the courts cannot be expected to meddle too far in the realm of legislative responsibility. Justice Forget concurred with Justice Delisle on the basic principles of fundamental justice, while Justice Brossard agreed on the distinction between economic and fundamental rights in this case.

C. *Liability Proceedings: The Supreme Court Phase*

Zeliotis and Chaoulli persisted in their legal battle and applied for leave to appeal to the Supreme Court, which the Court granted in May 2003. By this time, the scope and stakes of the case had expanded significantly from a “lone crusade” to a fundamental question about the legality of restrictions on private health care in Canada. The *Chaoulli* case attracted interventions from several third parties, including: five other provinces (Ontario, Manitoba, British Columbia, New Brunswick, and Saskatchewan); interest groups committed to protecting the public health care system by maintaining restrictions on private insurance (*e.g.* the Canadian Labour Congress and the Canadian Health Coalition, representing labour groups, consumer groups, and segments of the community of health care professionals); organizations and businesses with a direct economic stake in the Court’s decision; and professional associations like the Canadian Medical Association, the Canadian Orthopaedic Association, and the British Columbia Anesthesiologists’ Society. In addition, *Chaoulli* attracted a highly unusual intervention from ex-Senators.

In 2002, two public reports presented the results of exhaustive studies of the state of health care in Canada. The Commission on the Future of Health Care in Canada (known as the Romanow Commission, after its director, former Saskatchewan social-democratic premier Roy Romanow) published a vigorous defence of public health care against privatization, and its recommendations had been widely acclaimed by public interest groups.⁴⁸ The Senate Standing Committee on Social Affairs, Science and Technology (known as the Kirby Committee, after

⁴⁸ Canada, Commission on the Future of Health Care in Canada, *Building on Values. The Future of Health Care in Canada: Final Report* (Ottawa: Commission on the Future of Health Care in Canada, 2002).

its chair, the Conservative Senator Michael Kirby) also produced a six-volume report that, while also a defence of the merits of the public health care system, suggested that there might be a better mix of public and private concerns in the delivery of health care.⁴⁹ Also relevant to the *Chaoulli* case, the Kirby Committee recommended a “Care Guarantee” to establish a maximum waiting time for each treatment or procedure, after which time the provincial government would have to make that service available by other means (such as funding treatment provided elsewhere).

The hearing in *Chaoulli* began with questions directed at Doctor Chaoulli by Justices Bastarache and Deschamps, who focused on the “socially undesirable” consequences of private services on access to health care as a whole.⁵⁰ Chaoulli, representing himself once more, framed his answer in terms of how the “deficiencies” of the health care system were leading to “discord” between federal and provincial governments. He referred to countries such as Australia and Sweden that he claimed allowed for parallel private health care. He also cited Friedrich Hayek in arguing that freedom of contract is a right protected by section 7 of the *Charter*.

Philippe Trudel again represented Zeliotis, and asked the Justices whether the state could prohibit Canadians from using their own resources to buy care that they need when the public system is unable to provide it in a timely fashion because of inadequate resources. He was quizzed by Justice Binnie as to whether the existing means being employed to protect public health care were “grossly disproportionate” to that aim, but stood firm on the point that the Court’s responsibility was to focus on the rights of the individual at hand rather than the integrity of the public system. Bruce Johnston, also representing Zeliotis, argued that more money was needed in the health care system,

⁴⁹ Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians — The Federal Role: Final Report*, vol. 6 (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2002).

⁵⁰ Sources for this testimony include the author’s notes from the Supreme Court of Canada proceedings on 8 June 2004; *CTV News*, transcript (8 June 2004); Dennis Bueckert, “Private health-care system would undermine quality of medicare: lawyer” *Canadian Press* (8 June 2004) (eC); and Matt Borsellino, “Future of health care at stake in Chaoulli-Zeliotis legal case” (2004) 40:25 *The Medical Post* 2. Two Justices, Louise Arbour and Frank Iacobucci, had announced their intention to leave the Court and therefore did not participate in the deliberations.

and that individuals should be allowed to inject that money even if governments were unwilling to do so.

Zeliotis's case was supported by submissions on behalf of Cambie Surgeries, whose counsel claimed that the health care system was in "desperate" shape but that the waiting list problem could be easily solved by a readily available, parallel system of access to private care. With somewhat more nuance, Earl Cherniak, representing the Kirby Committee, agreed that the health care system was in dire straits, but also insisted that there was a constitutional obligation for governments to deliver necessary services to their residents, preferably through a "health care guarantee" enforced by the federal government.

The Canadian Medical Association (CMA), vigorously reminding the Court of the physicians' obligation to "advocate for life, all life," supported this view on timely care, and reiterated that governments must provide a timeliness guarantee or stop promising that they can deliver such care. Guy Pratte, the CMA's counsel, urged an *Eldridge*-type remedy in this case, in which the Court should mandate provincial governments to remedy their health care legislation to conform to care guarantees, but suspend any declaration of unconstitutionality to allow the governments to explore alternative means of meeting this obligation.

The Justices were persistent in their questioning, but understood the broad implications of the case. Four of the justices were particularly sharp in questioning representatives of the governments in the courtroom, all of whom cautioned the Court not to get involved in the policy issues at hand. Justices Bastarache and LeBel seemed unconvinced by Quebec's assertion that Zeliotis's experience was an isolated incident and that the delays in care are often due to patient decisions rather than system failures. Justice Major grilled Jean-Marc Aubry on the federal government's insistence that private services would have harmful effects on the public system, while Justice Binnie expressed exasperation at the Ontario government's conclusion that services must be rationed in order to control costs, and that a two-tiered health care system would not solve the waiting list problem. In her argument on behalf of the Canadian Health Coalition, Martha Jackman, a legal scholar widely known for her analyses of health care and the *Charter*, reminded the Court of the distinction between private care (which is available) and private insurance (which is prohibited by Quebec and other provincial legislation).

It took exactly one year—until 9 June 2005—for the Court to deliver its judgment in *Chaoulli*. As in *Auton*, it reversed the lower court

decisions, but this time with very different consequences. The Court was also more divided than in *Auton*, with seven justices rendering three separate judgments. Like Justice Piché in the trial court, Justices Binnie and LeBel, writing in dissent with Justice Fish, argued that the question at issue in *Chaoulli* was not one that could “be resolved as a matter of law by judges.”⁵¹ In their view, there is no “constitutionally manageable standard” for determining what constitutes “reasonable” access to health care services.⁵² Moreover, even if such a standard did exist, the dissenting justices saw no reason, either as a matter of fact or law, to reverse the lower court decisions. On the factual question, they accepted the lower court finding that “a two-tier health care system would likely have a negative impact on the integrity, functioning and viability of the public system.”⁵³ On the legal issue, although recognizing that the meaning of section 7 of the Canadian *Charter* has been expanded, they noted that this challenge did not “arise out of an adjudicative context or one involving the administration of justice.”⁵⁴ Consequently, it did not engage even a broad interpretation of section 7.

Despite this strong dissent, a majority of the Court reversed the lower court judgments and found in favour of Zeliotis and Chaoulli. According to Justice Deschamps, the existence of lengthy waiting lists for certain surgical procedures affected the rights to life and personal inviolability protected under section 1 of the Quebec *Charter of Human Rights and Freedoms* (which has quasi-constitutional status) in a way that could not be justified under section 9.1 of the same document.⁵⁵ Justice Deschamps rejected both the alleged micro- and macro-level consequences of eliminating the public monopoly on health care provision. She indicated that “no study ... produced or discussed” at trial supported the conclusion that the availability of private insurance would have perverse consequences on individual behaviour in the

⁵¹ *Chaoulli*, *supra* note 1 at 861.

⁵² *Ibid.*

⁵³ *Ibid.* at 871.

⁵⁴ *Ibid.* at 877.

⁵⁵ *Charter of Human Rights and Freedoms*, R.S.Q. c. C-12 [Quebec *Charter*]. Section 1 of the Quebec *Charter* provides that: “Every human being has a right to life, and to personal security, inviolability and freedom. He also possesses juridical personality.” Section 9.1 provides that: “In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Quebec. In this respect, the scope of the rights and freedoms, and limits to their exercise, may be fixed by law.”

system,⁵⁶ nor did she find adequate evidence that private insurance would lead to increased costs or a general deterioration of the public system.⁵⁷ To the contrary, she cited the experience of other OECD countries as evidence that “a number of measures are available ... to protect the integrity of Quebec’s health care plan” even with private insurance.⁵⁸

In choosing to base her decision on the Quebec *Charter* rather than the Canadian *Charter*, Justice Deschamps departed significantly from the issues that engaged the attention of the judges below her as well as the parties before the Court. None of the lower court judgments had discussed the Quebec *Charter*, none of the twelve constitutional questions formulated by Justice Major for the Court on 15 August 2003 dealt with the Quebec *Charter*, and, contrary to the impression given by Justice Deschamps,⁵⁹ only four brief paragraphs of the Zeliotis factum raised arguments based on the Quebec *Charter*.

Chief Justice McLachlin, with Justices Major and Bastarache, agreed with Justice Deschamps on the Quebec *Charter* issue, but went further in declaring that the prohibition was also invalid under section 7 of the Canadian *Charter*. According to the Chief Justice, “access to a waiting list is not access to health care,” so that

prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person as protected by s. 7 of the Charter.⁶⁰

D. *Remedy and Post-Decree Phases*

The result of these judgments was that Quebec’s ban on private insurance for publicly provided services was invalidated by a 4-3 margin. Since a majority of the Court did not reach this decision on *Charter* grounds, the decision did not have immediate legal impact outside of Quebec. In the absence of any significant discussion of potential

⁵⁶ *Chaoulli*, *supra* note 1 at 829.

⁵⁷ *Ibid.* at 828.

⁵⁸ *Ibid.* at 836.

⁵⁹ *Ibid.* at 809.

⁶⁰ *Ibid.* at 850.

remedies in written submissions or oral arguments before the Court, the majority simply exercised its authority under section 52 of the *Constitution Act, 1982*⁶¹ to declare the impugned provision “of no force or effect.” This placed the Quebec government in a difficult situation, and it filed a motion with the Court on 28 June 2005 asking for the judgment to be suspended for a period of eighteen months so the government could analyze its impact and design measures to respond appropriately.

In seeking to have the judgment suspended, Quebec raised several issues that it had neglected to discuss during the Court proceedings themselves. These included the real concern of citizens and social groups about the future of the public system, and the way in which the rising costs of care and difficult choices are associated with the organization and administration of the health care system on the ground. In addition, Quebec’s motion alluded to the potential consequences that opening up private markets might have for trade relations, and particularly for Canada’s relations under NAFTA, where a grandfather clause applies only to existing social legislation. Ironically, given the heated federal-provincial disputes over health care and the fact that the Supreme Court decision constitutes a bold move by a national political institution into the realm of provincial jurisdiction, the Quebec government pointed out that operationalizing the *Chaoulli* decision required careful examination of how it could be managed within the parameters of the *Canada Health Act*.⁶² These arguments proved partially persuasive, and on 4 August 2005, the Court granted the province’s motion for a partial rehearing and suspended its judgment for twelve months (retroactive to 9 June 2005).

However, even as the immediate legal impact of *Chaoulli* was suspended, the post-decree political manoeuvring accelerated. The signals from Quebec Premier Jean Charest made it unlikely that his government would invoke the notwithstanding clause in this case. In September 2005 the Quebec Minister of Health and Social Services, Philippe Couillard, pointed out that Quebec could draw lessons from the private-public mix in European countries such as France and the U.K. Although the government was expected to present a white paper,

⁶¹ *Supra* note 12.

⁶² R.S.C. 1985, c. C-6.

or preliminary bill, by December 2005, in order to allow sufficient time for legislative hearings and public consultations, this schedule was pushed back due to the start of the general election, since health care reform would be an obvious electoral issue. Nevertheless, it is widely assumed that the bill will allow Quebeckers to purchase private insurance for core services now covered under the public health care regime. The conundrum for the Quebec government is how to implement this major change while ensuring that the public system remains viable. It must consider such operational issues as allowing doctors to provide both publicly and privately insured services, and imposing quotas to ensure that health care professionals provide a certain minimum amount of service in the public system.

Regardless of how the Court ultimately resolves the remedial issues in *Chaoulli*, the decision has acquired a separate political life.⁶³ The implications of *Chaoulli* for the health care system in Canada are potentially important in that the ban on private insurance has been the essential brake to the development of a parallel private delivery system: without insurance, few individuals would be able to pay for such services, and few health care professionals would be attracted to provide them. But the effective impact of the decision will not be felt until the Quebec government implements its policy changes, and until we can see whether and how similar cases make their way through other provincial courts.

III. ANALYSIS

The *Chaoulli* litigation represents a classic instance of policy-oriented legal mobilization. Dissatisfaction with the policy status quo manifested itself as a specific constitutional rights claim in favour of a single alternative policy: access to private health insurance. This challenge then raised complex empirical questions about the future impact of the desired policy change, which involved the link between waiting lists and a public health care monopoly, and the long-term impact of a parallel private health care system on the viability of a

⁶³ See Peter H. Russell, "Chaoulli: The Political versus the Legal Life of a Judicial Decision" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 5.

universal and comprehensive public system. One advantage of examining questions like these through litigation is that concrete cases may identify operational flaws in legislation. However, in this instance neither Chaoulli's nor Zeliotis's complaints provided a particularly good foundation for challenging the status quo. There was no evidence that Zeliotis himself would have been better off without the prohibition, or even that he had failed to receive "health care services" that were "reasonable as to both quality and timeliness."⁶⁴ Chaoulli's complaint was not even really about waiting lists, but about his philosophical opposition to state interference with his freedom to practice medicine as he wished. Consequently, although Zeliotis presented a plausible and sympathetic section 7 claim, his case lacked evidence of actual harm. Similarly, although Chaoulli could demonstrate real harm by virtue of his having received administrative penalties for violating regulations, his case presented an unpalatable section 7 claim premised principally on freedom of contract. It is therefore unsurprising that the case failed in the lower courts.

Why, then, did it succeed in the Supreme Court? Perhaps the most important factor was a flurry of activity in the health policy field in 2002. In May 2002 the C.D. Howe Institute published a report by Stanley Hartt and Patrick Monahan entitled "The Charter and Health Care."⁶⁵ According to Hartt and Monahan, existing section 7 jurisprudence meant that "[g]overnments cannot tell Canadians that they are required to obtain medically necessary services exclusively through the public health care system and then deny them access to those services on a timely basis when they are ill."⁶⁶ Under conditions of delayed access to public health care, they continued, "provincial prohibitions that suppress private medical services are legally unenforceable."⁶⁷ Although none of the *Chaoulli* judgments referred specifically to this report, in many ways it provided the legal argument that would ultimately prevail in the case. In fact, Monahan served as co-counsel for the intervening Senators.

⁶⁴ *Chaoulli*, *supra* note 1 at 860.

⁶⁵ Stanley H. Hartt & Patrick J. Monahan, "The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians" (2002) 164 C.D. Howe Institute Commentary.

⁶⁶ *Ibid.* at i.

⁶⁷ *Ibid.*

The year 2002 also saw the publication of two different reports on the state of public health care in Canada: the Romanow and Kirby reports. Indeed, in an important sense *Chaoulli* can be characterized as a judicial referendum on the content of these two reports rather than as a contest between two private individuals and a provincial government. Forty-four separate paragraphs of the 278-paragraph judgment contain references to these two reports. More importantly, the distribution of these references between the majority and dissenting judgments is highly suggestive of the reports' influence. References to the Kirby report outnumber references to the Romanow report by thirteen to three in the two majority judgments; by contrast, twelve paragraphs of the dissenting judgment contain references to the Romanow report, and its sixteen references to the Kirby report are there only to refute the majority's interpretation of the Senate Committee's findings.

Consider, for example, Chief Justice McLachlin's use of the Kirby report to compensate for the absence of concrete evidence from the actual dispute about the relationship between waiting lists and private insurance in Quebec.⁶⁸ In her words, the existence of waiting lists indicated that Quebec was "failing to provide public health care of a reasonable standard within a reasonable time," thereby "creat[ing] circumstances that trigger the application of s. 7."⁶⁹ Under these circumstances, a measure that "subjects people to long waiting lists"⁷⁰ by limiting access to "alternative medical care"⁷¹ is unconstitutional. Therefore, the prohibition against private health insurance infringes section 7. According to the Chief Justice, removing this prohibition would improve individual health care outcomes without adversely affecting collective access to public health care. Similarly, Justice Deschamps relied on the Kirby report in a key paragraph of her judgment, explaining why the Court needed to act in this area. "Courts," she argued, "have all the necessary tools ... to find a solution to the problem of waiting lists" and respond to "the urgency of taking concrete action" in the face of a "situation that continues to deteriorate."

⁶⁸ *Chaoulli*, *supra* note 1 at 854-57.

⁶⁹ *Ibid.* at 844.

⁷⁰ *Ibid.* at 858.

⁷¹ *Ibid.* at 854.

Governments “cannot choose to do nothing,” and when they do, “courts are the last line of defence for citizens.”⁷²

The different fortunes experienced by the Kirby and Romanow reports in the Court are in contrast to their fortunes in the policy realm. Indeed, the Romanow report has been clearly favoured by the federal government, and several recommendations from it are in the process of being implemented (*e.g.* multi-year funding to the provinces and creation of the Health Council). Moreover, despite making “wait lists” a major issue in the 2004 election campaign, the Liberal party did not embrace the solutions contained in the Kirby report. In effect, *Chaoulli* breathed new life into the Kirby report, which was adopted almost in its entirety by the Conservative party as the centrepiece of its health care policy for the 2005-06 election campaign.

IV. CONCLUSION

By the time *Chaoulli* reached the Supreme Court, it was no longer about Zeliotis, Chaoulli, and Quebec, but about Romanow and Kirby. The majority’s decision to intervene in the debate between these two different health care visions is well summed up in Justice Deschamps’s bold *cri de coeur* that “courts are the last line of defence for citizens.” In this sense, the majority’s judgment represents a paradigmatic case of judicial policy making: it identified a policy problem (waiting lists), took jurisdiction over the problem through a broad interpretation of section 7, and then specified a solution through its remedial power to invalidate the impugned provision.⁷³

Perhaps the most problematic aspect of the judgment is the majority’s decision to use the Kirby report—rather than the evidence presented at trial—as the empirical basis for its diagnosis of the state of health care policy. Without passing judgment on the report’s quality, there was no opportunity to subject it to the disciplined evaluation that can take place in the adversarial process. The only opportunity for external assessment of the report came during a one-day hearing.⁷⁴

⁷² *Ibid.* at 840.

⁷³ Malcolm M. Feeley & Edward J. Rubin, *Judicial Policy Making and the Modern State: How the Courts Reformed America’s Prisons* (Cambridge: Cambridge University Press, 1998) at 148.

⁷⁴ The Supreme Court of Canada’s hearing of oral arguments on 8 June 2004 in *Chaoulli*, *supra* note 1.

Legal mobilization for private health care did momentarily lead to a change in legal rules—at least in Quebec—that may persist when the Court's suspension of its remedy ends in June 2006. Whether this legal change—if it persists—will produce the desired policy change by reducing waiting times for certain medical procedures is an open question. However, it is probably the case that *Chaoulli* has energized proponents of a greater role for the private health care sector while putting advocates of the pre-*Chaoulli* status quo on the defensive.

