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DECONTEXTUALIZED RIGHTS: CONCERNS REGARDING THE *BEDFORD* SECTION 7 FRAMEWORK IN THE HEALTH CARE CONTEXT OF THE CAMBIE SURGERY CENTER TRIAL

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INTRODUCTION

Cambie Surgery Centre, the Specialist Referral Clinic, and four individual patients [hereafter "Cambie et al."] are challenging the constitutionality of sections 14, 17, 18, and 45 of British Columbia's *Medicare Protection Act*.[1] This case went to trial in the BC Supreme Court on September 6, 2016, and the trial is ongoing at the time of publication.[2] Section 14 forces doctors to opt in or out of the public billing system, rather than allowing them to concurrently offer services both privately and in the public system. Sections 17 and 18 place limits on billing extra for services classified as a benefit under the BC Medical Services Plan, this limits the amount that enrolled doctors and clinics can charge for services. Section 45 voids private insurance contracts for services that are classified as benefits under the provincial medical services plan, making the cost of private health care an effective deterrent for most patients. Taken together, these provisions limit the ability of doctors to provide private health care for services that are considered medically necessary and included in the public health system, while limiting patients' ability to access those services. A concurrent private health care system is not prohibited, but it is made less viable by these provisions.

The plaintiffs' primary claim is made under section 7 of the *Canadian Charter of Rights and Freedoms* ("the *Charter*"). Section 7 protects the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.[3] The plaintiffs claim that the aforementioned provisions of the *Medicare Protection Act* infringe the section 7 *Charter* rights of patients by effectively forcing them to remain on long waiting lists for services in the public health care system and that the subsequent delay in receiving treatment causes them to endure physical and psychological suffering, at times increasing their risk of death.[4] This claim is grounded in the belief that if the provisions were not in place, these patients might have been able to obtain private health insurance and receive treatment much sooner at a private clinic such as the Cambie Surgery Centre. The present claim brought by Cambie et al. follows the 2005 *Chaoulli* decision, which also challenged provincial legislation that restricted the development of a concurrent privately-funded health sector.[5] The Supreme Court of Canada held that the legislation challenged in *Chaoulli* violated patients' rights. However, this decision was made under the *Quebec Charter* and thus, the decision was not binding outside of Quebec.[6] Cambie et al. now hopes to have this pronouncement extended to the rest of Canada through a decision made under the Canadian *Charter*.[7] If the plaintiffs in the present case are successful, the effects of the decision will have a more significant impact than *Chaouilli*, because it will be applicable across Canada.

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1 *Medicare Protection Act*, RSBC 1996, c. 286.

2 I will refer to the present case brought by Cambie et al. as *Cambie* for simplicity. An official case name was not released at the time of publication.

3 *Canadian Charter of Rights and Freedoms*, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c. 11, s. 7.

4 *Cambie Surgeries Corporation, et al. v The Medical Services Commission, et al.* Fourth Amended Notice of Civil Claim. No. S090663, Vancouver Registry, March 14, 2016, at para 92 [Notice of Claim], online: <https://d3n8a8pro7vhmx.cloudfront.net/bchealthcoalition/pages/234/attachments/original/1472934222/2016_03_14_Fourth_Amended_Notice_of_Civil_Claim.pdf?1472934222> archived at < https://perma.cc/G3FK-UKKT>.

5 *Chaoulli v Quebec (AG),* 2005 SCC 35, at para 18, 23 [*Chaoulli*].

6 *Ibid,* at para 101; *Charter of Human Rights and Freedoms*, CQLR c C-12, s.1.

7 *Cambie Surgeries Corporation, et al. v The Medical Services Commission, et al.* Opening Statement of the Plaintiffs. No. S090663, Vancouver Registry, September 6, 2016, online: <https://d3n8a8pro7vhmx.cloudfront.net/bchealthcoalition/pages/234/attachments/original/1473905437/2016_09_06-Opening-Statement-of-the-Plaintiffs.pdf?1473905437> archived at <https://perma.cc/7NN5-RTYY>.

Cambie et al.'s claim challenges the governing principles of Canada's health care system, questioning whether the principles that have guided the provision of Canadian health care for many years are even desirable. To describe this as an assault on Canadian Medicare is hardly an overstatement. *Charter* critic, Andrew Petter, warned that the *Chaoulli* decision "dealt a serious blow to the legitimacy of the single-payer model of health insurance, and the values of collective responsibility and social equality that it seeks to uphold."[8]

The defendants in *Cambie* are British Columbia's Medical Services Commission, Minister of Health, and Attorney General [hereafter "the provincial defendants"]. The provincial defendants' response to Cambie et al.'s claim displays a firm entrenched commitment to preserving the *Canada Health Act*: "the province is entitled … to protect the principle that care is allocated on the basis of need and not the ability to pay, and to further the *Canada Health Act* principles."[9] This position is supported by many intervenors including Doctors for Medicare, the BC Health Coalition, an independent patient group, and most recently the Attorney General of Canada.[10] As *Chaoulli* did before it, *Cambie* raises serious questions about the effectiveness of the current health care system and the extent to which individual rights may be infringed in order to protect it. The Court must determine the degree to which governments can constrain access to private health care in order to protect the public health care system, when that action forces people to remain suffering on waiting lists.

Cambie highlights the apparent tension between the values underlying the *Canada Health Act*, such as the protection of health care as a social benefit, and the interests of the individual entrenched in the *Charter*, which take precedence by reason of constitutional supremacy. Following *Chaoulli,* members of the academic community raised concerns that the Court did not properly consider the impact that decision would have on disadvantaged members of society.[11] This stems in part from the fact that the individual interests protected by the majority in *Chaoulli* were isolated and decontextualized. As relational theorist Jennifer Llewellyn states, "the Court's attention in *Chaoulli* was squarely on the extent to which individual freedom understood atomistically was limited by collective choices."[12] The Supreme Court of Canada's approach to individual rights in *Chaoulli* takes the individual out of his or her context, leading to the appearance that those individual interests are by necessity in conflict with the interests of the rest of

8 Andrew Petter, Wealthcare: the Politics of the Charter Revisited" in Colleen Flood, Kent Roach, and Lorne Sossin, eds, *Access to Care, Access to Justice: the Legal Debate Over Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) at 131 [Petter].

9 Cambie Surgeries Corporation, et al. v The Medical Services Commission, et al. Response to Fourth Amended Civil Claim. No. S090663, Vancouver Registry, 14 March 2016 [Provincial Response] Part 1 at para 13, online: <https://d3n8a8pro7vhmx.cloudfront.net/bchealthcoalition/pages/234/attachments/ original/1473048283/2016_03_14_MSC_Response_to_Fourth_Amended_Civil_Claim. pdf?1473048283> archived at <https://perma.cc/8AXA-5QWF>; Canada Health Act, R.S.C., 1985, c. C-6. The Canada Health Act principles include public administration, comprehensiveness, universality, portability, accessibility, and sustainability.

10 Cambie Surgeries Corporation, et al. v The Medical Services Commission, et al. Opening Statement of the Coalition Intervenors. No S090663, Vancouver Registry, 14 September 2016 [Statement of the Intervenors] at para 10, online: <https://d3n8a8pro7vhmx.cloudfront.net/bchealthcoalition/pages/20/attachments/original/1473869168/2016_09_14_Coalition_Intervenors'_Opening_Statement.pdf?1473869168> archived at <https://perma.cc/B4RE-8JJU>.

11 Petter, *supra* note 8, at 131.

12 Jennifer Llewellyn, "A Healthy Conception of Rights? Thinking Relationally About Rights in a Health Care Context" in Jocelyn Downie and Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law Inc, 2007) at 79 [Llewellyn, "A Healthy Conception of Rights"].

society.[13] Further individualization of the section 7 analysis seen in *Bedford* and affirmed in *Carter* will only serve to exacerbate these concerns.[14]

The tension between individual and collective rights in *Chaoulli* and *Cambie* is troubling because it is in many ways an artificial construct created by section 7 jurisprudence. Relational rights theory, as articulated by Jennifer Llewellyn, asserts that individual rights cannot truly be understood apart from the context of their relation to other rights holders. Relational rights theory focuses on the way in which individuals relate to one another and aims to discover the relationships that are most healthy for both the individual and those who they relate to.[15] In this context, the term "relationships" refers to connections with and interdependency on others in society; not to personal or intimate relationships.[16] This theory can be a useful tool because it makes the interests of the vulnerable more visible. It is also important to note at this stage that relational theory does not aim to undermine the rights of the individual. Rather, it reveals the context within which those rights are exercised, with the aim of promoting rights in a way that strengthens the relationships necessary for individuals to flourish in society.[17]

Understanding rights relationally by necessity involves a balancing between the interests of an individual and the interests of the other individuals who make up Canadian society. This balance avoids the excessive focus on the individual, which Llewellyn terms the "rights as trumps approach,"[18] thereby providing a more nuanced perspective. The "rights as trumps" approach is derived from a more traditional liberal view that sees rights as a barrier or protection from others rather than a means of thriving in relationships with others.[19] The insight provided by relational rights theory is significant because failure to take the relational and contextual nature of all rights into account limits the Court's ability to come to a just resolution of the problem before it.[20] If *Cambie* advances to the Supreme Court of Canada, the Court may want to reconsider the guidelines set out in *Bedford* in order to determine whether the section 7 framework analysis needs to be adapted to better reflect the underlying purpose of that section. Otherwise, the Court risks decontextualizing Cambie et al.'s section 7 rights and turning the *Charter* into a tool that undermines the interests of vulnerable members of society while purporting to support the "basic values underpinning our constitutional order."[21]

This paper begins with a discussion of the Canadian Medicare system and Cambie et al.'s challenge to the *Medicare Protection Act*. I will then turn to a section 7 analysis and examine the claim's likelihood of success. This analysis will include a discussion of recent developments in section 7 jurisprudence through *Bedford* and will address why the regulatory context of health care legislation may complicate those developments. I

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13 *Ibid,* at 60.

14 *Bedford v Canada (AG)*, 2013 SCC 72 [*Bedford*]; *Carter v Canada (AG)*, 2015 SCC 5 [*Carter*]. *Bedford* involved a challenge to Criminal Code provisions relating to prostitution, while *Carter* challenged provisions criminalizing assisting or counselling death by suicide where it restricted physician-assisted death. Both of these cases held that the Court looks at whether even one individual has had their right to life, liberty, or security of the person infringed in a way that is not in accordance with the principles of fundamental justice when determining whether a section 7 right is infringed, and that societal interests are taken into account when considering justification under section 1.

15 Llewellyn, "A Healthy Conception of Rights," *supra* note 12, at 62.

16 Jennifer Llewellyn, "Restorative Justice: Thinking Relationally About Justice" in Jocelyn Downie and Jennifer Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012) at 103.

17 Llewellyn, "A Healthy Conception of Rights," *supra* note 12, at 62-63.

18 *Ibid*, at 63.

19 *Ibid,* at 60.

20 *Ibid*, at 57.

21 *Bedford, supra* note 14, at para 96.

will finish with a discussion of why cases such as *Cambie* and *Chaoulli* complicate the *Charter's* role in Canadian society. Such cases raise questions of what section 7 should protect, and highlight the consequences of an exclusively individualistic view of section 7 rights. Throughout the analysis, relational rights theory will be used as a tool to highlight the shortcomings in the current section 7 jurisprudential framework. In particular, this theoretical tool will highlight limitations that arise from the fact that this framework focuses on protecting the negative rights of an isolated individual to such an extent that the rights become decontextualized and lose their efficacious value.

I. CONTEXT

A. The Canadian Health Care Context

The *Canada Health Act* and the corresponding Canadian Medicare system have become defining features of Canadian identity such that "Canada's commitment to a universal public health care system is widely regarded by citizens as a core social value and a defining national achievement."[22] The idea of health care on the basis of need rather than wealth is rooted in the belief that the ability of society's vulnerable members to access health care should be protected. This organizing principle ensures a greater degree of equality in the delivery of health care services, as everyone in need of medically necessary services will receive roughly the same level of service regardless of their wealth. The *Canada Health Act* provides what is essentially a positive right to access health care, which necessarily involves state intervention in the provision of services. This can be contrasted with the *Charter*, which has been interpreted as protecting the autonomy and dignity of individuals through negative rights that prevent state interference.

The *Canada Health Act* is an aspirational document that defines the goals for the legislative scheme that regulates Canadian health care, but it cannot actualize those goals itself. As Justice Deschamps points out in *Chaoulli,* "the *Canada Health Act* does not … provide benchmarks for the length of waiting times that might be regarded as consistent with the principles it lays down, and in particular with the principle of real accessibility."[23] Though the *Canada Health Act* is the source of the principles that animate the Canadian health care system, it is limited in its practical ability to enforce the implementation of these principles as it is necessarily restricted to setting out certain factors that provinces must meet in order to receive federal funding rather than creating a fully-functioning system. When discussing the issues raised by Cambie et al., it is easy to be scornful of the seemingly elitist patients and doctors at private clinics who want to buy health care and who may undermine a cherished social benefits scheme, however the plaintiffs raise the legitimate concern that the goals of the *Canada Health Act* may not be realized within the current system.

Provincial legislatures work to incorporate requirements from the *Canada Health Act* into their own provincial systems through practical legislative frameworks such as British Columbia's *Medicare Protection Act*. It is this legislation that Cambie et al. are challenging. Flood and Choudhry suggested in 2004 that "governance in health care is in a state of paralysis, as both provincial and federal governments find it more politically expedient to blame each other for Canadians' concerns about Medicare than do something about it."[24] Since that time, benchmarks for certain categories of treatment

22 Petter, *supra* note 8, at 117.

23 *Chaoulli, supra* note 5, at para 16.

24 Colleen Flood and Sujit Choudhry, "Strengthening the Foundations: Modernizing the Canada Health Act" in Tom McIntosh, Pierre-Gerlier Forest, and Gregory P Marchildon, eds, *The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004) at 368 [Flood and Chowdry].

were set by the joint effort of federal and provincial governments.[25] There are mixed reports of whether these guarantees are actually helping and whether they actually reflect a reasonable degree of access. For example, ten years later, British Columbia received a failing grade in the Wait Time Alliance's annual report card in the category of knee replacements.[26] The Wait Time Alliance was formed by a group of doctors in 2004 to monitor government progress and provide benchmarks on medically acceptable wait times.[27] Though the values embraced in the Canadian legislative framework are laudable, reports such as those issued by the Wait Time Alliance indicate that there are less than trivial concerns arising from the lived experience of patients in the system. The severity of the current problems in the public health care system and the effect of changes to the *Medicare Protection Act,* such as decreasing limitations on concurrent private health care, are evidentiary issues that will need to be determined at trial. That being said it is important to recognize the current limitations of Canada's health system, which may be in need of reform to remain worthy of protection. As Flood and Choudhry note, "the [Canada Health Act] is a means, not an end in itself."[28]

B. The Litigation Context

Chaoulli challenged the prohibitions on concurrent private health insurance for items that are covered under public health insurance. That case marked a turning point in health care litigation by disrupting "the seamless co-existence of two national symbols cherished by Canadians: publicly funded health care and the *Charter*."[29] Though it was ultimately decided under the *Quebec Charter*, *Chaoulli* determined that Medicare was not off-limits for *Charter* litigation:

> "[W]here the government puts in place a scheme to provide health care, that scheme must comply with the *Charter* … By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the *Charter*."[30]

Chaoulli revealed a Court divided on what its role in this matter should be and on whether it had the ability to properly address the concerns raised by the plaintiff given the complexity inherent in the provision of public health care. A slim majority in *Chaoulli* concluded that "the courts have all the necessary tools to evaluate the government's measure".[31] Though the "necessary tools" includes the Court's ability to properly assess the evidence, equally important is the Court's ability to provide a remedy that properly accommodates the competing concerns and interests in this case. If the plaintiffs are successful in demonstrating that the current state of the Canadian health care system violates patients' section 7 rights, it does not necessarily follow that allowing

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25 Bacchus Barua, *Waiting Your Turn: Wait Times for Health Care in Canada* (Vancouver, Fraser Institute, 2015), [Fraser Report], online: <https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2015.pdf> archived at <https://perma.cc/7NAC-VQ5U> at 15.

26 *Eliminating Code Gridlock in Canada's Health Care System: 2015 Wait Time Alliance Report Card* (Ottawa: Wait Time Alliance), online <http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card_REV.pdf> archived at <https://perma.cc/H5KN-LGSU>. The 2015 report cited in this paper was the last report issued by the Alliance.

27 Wait Time Alliance, "About Us", (2014), online: <http://www.waittimealliance.ca/about-us/> archived at <https://perma.cc/D3JT-Y63D>.

28 Flood and Choudhry, *supra* note 24, at 382.

29 Christopher P. Manfredi and Antonia Maioni "Judicializing Health Policy: Unexpected Lessons and an Inconvenient Truth" in James Kelly and Christopher P. Manfredi, eds, *Contested Constitutionalism: Reflections on the Canadian Charter of Rights and Freedoms* (Vancouver: UBC Press, 2009) at 138 [Manfredi and Maioni].

30 *Chaoulli, supra* note 5, at paras 104-105.

31 *Ibid*, at para 96.

concurrent private health care is an equitable solution to this problem. As Manfredi and Maioni suggest, the adversarial context of *Charter* litigation has disadvantages, as "the articulation of policy demands in the form of constitutional rights can exclude alternative choices from consideration."[32] *Charter* challenges brought under section 7 have a tendency to place the individual in opposition to society, creating a context in which one side wins and the other loses. As long as this opposition remains central to such litigation, the courtroom may not be the best context in which to assess the issues raised in *Cambie*. More specifically, the Court may be unable to find a solution to current limitations on access to health care that does not exacerbate existing relationships of inequality within Canadian society.

C. The Present Case

Four years after they intervened in *Chaoulli*, Cambie et al. launched the present case claiming that the restrictions on concurrent private health care violate patients' section 7 rights, which they say "include the right to access necessary and appropriate health care within a reasonable time."[33] The problem identified in both *Cambie* and *Chaoulli* is that in order to preserve a health care system based on equality of access, legislators are willing to allow the possibility that some patients will suffer more than they otherwise would. As the provincial respondents argue, "a functional health care system must prioritize differently for elective conditions than for urgent, emergency, or high priority conditions. The prioritization process takes into account the fact that no risk of death arises with respect to elective surgery."[34] Section 7 of the *Charter* does not, however, only protect against threats to patients' life—it is also engaged by threats to patients' security of the person. The Court makes this clear in *Chaoulli,* stating that "clearly not everyone on a waiting list is in danger of dying before being treated … [yet] many patients on non-urgent waiting lists for orthopaedic surgery are in pain and cannot walk or enjoy any real quality of life."[35] Cambie et al.'s claim raises the important question of the degree to which an individual's autonomy and choice can be interfered with in order to preserve social benefit legislation. As a constitutional principle, human dignity "shapes the interpretation of all rights guarantees … the state must treat each person as an end in herself, rather than a means to the well-being or advantage of others—regardless of wealth or power."[36] Though the principles of human dignity and autonomy shape this case, and section 7 rights more broadly, these principles are not absolute.[37] *Cambie* seeks to determine the limits of those principles in the context of health care legislation.

As in *Chaoulli,* the plaintiffs in *Cambie* argue that though private provision of medically necessary health care services is not prohibited, it is out of the reach for most Canadians due to the restrictions in the *Medicare Protection Act*. They argue that patients are effectively denied health care, as most patients cannot afford to pay the cost of the treatment without insurance and physicians cannot afford to provide the service for the amount stipulated in the medical services plan. Unlike *Chaoulli,* which focused primarily on the restrictions on private health insurance, *Cambie* is challenging the provisions that prohibit extra billing and that force physicians to opt in or out of the public system.[38] They argue that even if private insurance was available, it is not a commercially viable option for doctors to offer private health services as long as the other restrictions are in

32 Manfredi and Maioni, *supra* note 29, at 142.

33 Notice of Claim, *supra* note 4, at para 105.

34 Provincial Response, *supra* note 9, Part 1 at para 48.

35 *Chaoulli, supra* note 5, at para 42.

36 Lorraine Weinrib, "Charter Perspectives on *Chaoulli:* The Body and the Body Politic" in Colleen Flood, Kent Roach, and Lorne Sossin, eds, *Access to Care, Access to Justice: the Legal Debate Over Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) at 58 [Weinrib].

37 *Rodriguez v BC (AG)* [1993] 3 S.C.R. 519, at para 30 [*Rodriguez*].

38 Notice of Claim, *supra* note 4, at para 115.

place due to facility costs.[39] The plaintiffs' argument assumes that patients will receive better access if the restrictions are lifted, yet there is a secondary issue of how many patients will qualify for private health insurance.

This case is complicated by the fact that success for Cambie et al. would at most assist only those patients who can access private health care. It is to be hoped that if the Court finds a *Charter* violation, the remedy will involve some balancing that reduces harm to the vulnerable. Regardless, a favourable ruling will provide no benefit to those who cannot afford or qualify for private health insurance. This problem has prompted Martha Jackman to suggest that finding provisions such as those challenged in the present case to be unconstitutional would "represent a serious perversion of a right to health."[40] The dilemma of negative vs. positive rights lies beneath everything argued in this case. As Emmett MacFarlane notes, "when cases develop a right of access … that is rooted in the logic of negative rights, the result ultimately fails to produce consistent rights protection and coherence from a policy perspective."[41] The decision in *Chaoulli* to protect patients' security of the person by allowing them access to private health care does not fully take context into account and so does not address the inequality it would create within the Canadian health care system. Chief Justice McLachlin and Justice Major write that "the *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[42] Within the context of the *Chaoulli* decision, this means that access to concurrent private health insurance should be allowed as the appellants in that case requested. Some argue, however, that what should actually be provided is *Charter*-compliant health care within the public scheme itself.[43] When cases such as *Chaoulli* and *Cambie* are viewed in their relational context, it is more apparent which members of society would actually be able to exercise the choice to utilize a concurrent private health care system if the restrictions in the *Medicare Protection Act* were lifted.

Cambie et al. are challenging the provisions restricting private health care, not the management of the public health care system. It has been suggested that *Chaoulli* could be the precursor to positive rights claims, yet the claims that have followed, including the present case, are negative rights claims that seek to expand upon the remedy granted in *Chaoulli*.[44] A weakness of the adversarial process in handling complex social problems, however, is that the cases that are brought determine which problems the Court rules on. Though the focus is on the suffering sustained by individual patients, both *Cambie* and *Chaoulli* were brought by doctors who have a financial interest in access to care outside of the public health care system.[45] The development of negative rights claims without a corresponding development of positive rights has a serious impact on contexts that relate to social benefits such as health care because applying the *Charter* in such a manner exacerbates existing relationships of inequality in Canadian society.[46]

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39 *Ibid*, at paras 112, 114.

40 Martha Jackman, "Misdiagnosis or Cure? Charter Review of the Health Care System" in Colleen Flood ed, *Just Medicare: What's In, What's Out, How We Decide,* (Toronto: University of Toronto Press, 2006) at 72.

41 Emmett MacFarlane, "The Dilemma of Positive Rights: Access to Health Care and the Charter" (2014) 48:3 Journal of Canadian Studies 49, at 51.

42 *Chaoulli, supra* note 5, at para 104.

43 Weinrib, *supra* note 36, at 68.

44 Flood, Colleen and Michelle Zimmerman, "Judicious Choices: Health Care Resource Decisions and the Supreme Court" in Jocelyn Downie and Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law Inc, 2007) at 43.

45 *Chaoulli, supra* note 5, at para 181.

46 See Lorne Sossin "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Colleen Flood, Kent Roach, and Lorne Sossin, eds, *Access to Care, Access to Justice: the Legal Debate Over Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) at 162.

II. CHARTER ANALYSIS

A. Section 7 and the *Bedford* Framework

At the first stage of a section 7 analysis, Cambie et al. must show that a patient's life, liberty, or security of the person interests are engaged by the impugned provisions. At the second stage, the plaintiffs must establish that any infringement under the first stage is not in accordance with the principles of fundamental justice.[47] If a section 7 violation is established, the provincial respondents must then show that the violation is justified under section 1.[48] In the timespan between the *Chaoulli* decision in 2005, and the time when *Cambie* began to be heard in the BC Supreme Court in September 2016, the Supreme Court of Canada ruled on *Bedford* and *Carter.* In those decisions, the Court clarified the principles of arbitrariness, overbreadth, and gross disproportionality and held that "in determining whether the deprivation of life, liberty and security of the person is in accordance with the principles of fundamental justice under s. 7, courts are not concerned with competing social interests or public benefits conferred by the impugned law."[49]

This statement in *Bedford* made a significant impact on section 7 jurisprudence by shifting the point at which courts consider the public good in a section 7 challenge. As the Court put it in *Bedford*, "the question of justification on the basis of an overarching public goal is at the heart of section 1 but plays no part in the section 7 analysis, which is concerned with the narrower question of whether the impugned law infringes individual rights."[50] This raises two potential causes of concern. First, the principles of fundamental justice may lose their ability to protect section 7 rights as violations may be more easily justified under section 1.[51] Second, concerns for the public good may be pushed out of the Court's conception of what justice means in Canadian society. This risk is seen in *Bedford* and *Carter,* where the impugned provisions, which are arguably an attempt by the legislature to protect broader social interests, are deemed by the Court to be "inherently bad" and "fundamentally flawed" before the Court has even considered the social interests that might be engaged by the legislation.[52] By dividing social interests from the determination of fundamental justice, the Court places individual and societal interests in an increasingly antagonistic relationship to one another. Such division may not be sustainable. As Mark Carter suggests, "societal interests are inextricable from the objects or purposes of the laws."[53] Cambie et al.'s claim challenges a legislative scheme that is directly concerned with the societal interest in accessing health care, so the BC courts will need to determine what the Supreme Court of Canada meant by its statements on the place of the public good or social interest in the analysis of a section 7 claim. Because the *Bedford* decision had such a serious impact on the structure of courts' analyses of claims made under section 7, I will refer to the current framework of section 7 analysis as the *Bedford* framework. Despite the flaws inherent in the *Bedford* framework's division between individual and social interests, this paper will analyze Cambie et al.'s claims in the context of this framework because it is the current state of the law.

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47 *Bedford, supra* note 14, at para 58.

48 *Ibid,* at para 161.

49 *Carter*, *supra* note 14, at para 79; See also Hamish Stewart, "Bedford and the Structure of Section 7" (2015) 60:3 McGill LJ at 593-594 [Stewart].

50 *Bedford, supra* note 14, at para 125.

51 Stewart, *supra* note 49, at 594.

52 *Bedford, supra* note 14, at para 96; *Carter, supra* note 14, at para 82.

53 Mark Carter, "*Carter v Canada:* "Societal Interests Under Sections 7 and 1" (2015) 78 Sask L Rev 209, at 210.

B. Engaging Life and Security of the Person Interests

Though the impact on patients' life and security of the person from sitting on a waitlist is generally negative, evidence of this infringement and a causal connection to the provisions in question must still be proven.[54] This should not be too difficult because as the recent Fraser Report indicates, "wait times are not benign inconveniences. Wait times can, and do, have serious consequences such as increased pain, suffering, and mental anguish. In certain instances they can result in poorer medical outcomes."[55] What complicates Cambie et al.'s task is the need to link the protected interest to the impugned sections of the *Medicare Protection Act*. Cambie et al. and the Fraser Institute clearly think this connection exists, but that point must still be determined by the BC Supreme Court. *Allen,* a similar case challenging legislation prohibiting concurrent private health insurance in Alberta, was unsuccessful because the plaintiff attempted to advance *Chaoulli* as a factual determination that prohibitions of private health insurance infringe patient's security of the person without advancing any additional evidence at this initial stage of the section 7 analysis.[56] Though people suffer while waiting for surgery, it is the underlying injury that causes the pain. Therefore, if the patient would not have experienced less suffering without the restrictions imposed by the *Medicare Protection Act*, there is no case for challenging the restrictions under section 7. In order to engage life and security of the person interests, public wait times must cause the patient to suffer more than they would with the injury alone and more than if they received treatment in the private health care system.

The above analysis has looked at the combined effect of the provisions. On the evidence presented, the Court may find that not all of these provisions engage section 7 rights. *Cambie* is complicated by the complex nature of the legislation involved. All of the impugned provisions acting together deter private health care and protect the public health system. When taken together they effectively prevent all but the wealthiest patients from exiting the system to obtain their treatment quicker. However, as seen in the divided court in *Chaoulli* and the commentary that followed, it is difficult to measure the effects of just one piece in a legislative scheme. It remains to be seen which, if any, of the provisions will be found to engage section 7 interests in the way claimed by Cambie et al.

Though Cambie et al.'s claim focuses primarily on the infringement of the right to security of the person, rather than their right to liberty, the plaintiffs argue that security of the person includes a patient's right to exercise control over their own health by choosing to step outside of a public health care system that does not adequately meet their needs. This link between choice and security of the person is not new. In *Chaoulli*, the Court relied on *Morgentaler* and *Rodriguez* in finding that security of the person encompasses:

> "[A] notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress … [T]he prohibition against private insurance in this case results in psychological and emotional stress and a loss of control by an individual over her own health."[57]

In *Carter,* liberty and security of the person interests were considered together because "underlying both of these rights is a concern for the protection of individual autonomy

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54 *Allen v Alberta,* 2014 ABQB 184, at paras 39-41 [*Allen*].

55 *Fraser Report*, *supra* note 25, at iii.

56 *Allen, supra* note 54, at paras 39-41.

57 *Chaoulli, supra* note 5, at para 122; *R v Morgentaler* [1988] 1 S.C.R. 30; *Rodriguez*, *supra* note 37, at para 21.

and dignity."[58] It is noteworthy that the plaintiffs are not asking for wait times to be decreased within the public system, which would likely involve a positive right to a certain quality of health care. Rather, they seek the right to choose from a wider range of health care options when they believe the public health care system is not meeting their needs.

The provincial defendant's response attempts to separate any suffering that patients might experience from the restrictions in the *Medicare Protection Act*, arguing that, "to the extent that the Patient Plaintiffs, or any of them, experienced unnecessary or unreasonable pain or suffering … that pain or suffering was not caused by the Impugned Provisions, but by decisions made by, and actions taken by, their treating physicians."[59] The provincial defendants argue that this is not a constitutional matter because the legislation or government action does not itself cause the delays responsible for the patients' increased suffering. It is unlikely that the Court will accept the defendants' argument, given the Court's discussion of causation in *Bedford*: "the causal question is whether the impugned laws make this lawful activity more dangerous."[60] It is clear in the present case that the patients' suffering is caused primarily by injury and illness, secondarily from being forced to wait for treatment, and finally from being denied the ability to receive treatment sooner. However, "a sufficient causal connection standard does not require that the impugned government action nor law be the only or the dominant cause."[61] The *Medicare Protection Act*'s effect of forcing patients to remain in the public health care system puts at least some patients at an increased risk of suffering and lasting damage. It is highly likely that the Court will find that this first step of the section 7 analysis is met.

C. The Principles of Fundamental Justice

Even if Cambie et al. successfully show an adverse impact on patients' life and security of the person interests, they still must prove that the infringement is not in accordance with the principles of fundamental justice. The plaintiff's notice of claim primarily focuses on principles against arbitrariness, overbreadth, and gross disproportionality.[62] In order to evaluate whether the provisions infringe section 7 rights in a manner that is arbitrary, overly broad, or grossly disproportionate, it is first necessary to determine what the purpose or object of the law is. The purpose stated in the *Medicare Protection 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 the individual's ability to pay."[63] Though relevant, the Act's purpose statement is not determinative. The Court will consider other factors including the words of the challenged provision and the broader legislative context.[64]

In *Chaoulli,* Chief Justice McLachlin and Justice Major found that the objective of the *Canada Health Act* is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[65] Justice Deschamps went further to suggest that quality of care and equality of access are inseparable even where "the quality objective is not

58 *Carter, supra* note 14, at para 64.
59 Provincial Response, *supra* note 9, at part 1, para 32.
60 *Bedford, supra* note 14, at paras 87, 89.
61 *Ibid*, at para 76.
62 Notice of Claim, *supra* note 4, at paras 118-139.
63 *Medicare Protection Act, supra* note 1, s. 2; Provincial Response, *supra* note 9, at para 11.
64 *R v Appulonappa*, 2015 SCC 59, at para 34.
65 *Chaoulli, supra* note 5, at para 105 [emphasis omitted]; see *Canada Health Act, supra* note 9, s. 3.

formally stated."[66] The purpose of the legislation challenged in *Chaoulli* is similar to that challenged in *Cambie*. Though it is difficult to speculate on how the purpose of the law will be framed by the courts, it is likely that they will consider the purposes stated in both the *Medicare Protection Act* and the *Canada Health Act* as part of the larger legislative context. The purpose of each act will likely be determined to include at a minimum both the preservation of the public system and reasonable access to health care without financial or other barriers.[67]

i. Principle Against Arbitrariness

A provision is considered arbitrary where there is no connection between the provision and its purpose, or where the provision contradicts the purpose of the legislation.[68] In *Chaoulli*, the Court was split on whether provisions prohibiting private health insurance were rationally connected to the purpose of preserving the public health care system. Chief Justice McLachlin and Justice Major looked at whether a limit on life and security of the person is necessary to further the state objective, broadening the scope of the principle against arbitrariness. The Court returned to a narrower understanding of arbitrariness in later cases as an adverse effect on section 7 interests with no rational connection to the provision's purpose (rather than an adverse effect that is merely *not necessary* for the fulfillment of the provisions' purpose).[69] Ultimately, "the applicability of *Chaoulli* must be assessed in light of subsequent judicial decisions … [and] any connection to the stated policy objectives negates arbitrariness."[70]

Given *Bedford*'s statement that arbitrariness, overbreadth, and gross disproportionality are all applied by assessing the effects on a single individual, the distinction between the arbitrariness and overbreadth analysis is unclear. *Carter* holds that "an arbitrary law is one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law."[71] On the other hand, an overly broad law is rational in some cases, just not in connection to the individual claimant. As Hamish Stewart notes, "it is unclear how a court is supposed to decide that a law has no rational connection to its objective without considering how well it achieves that objective."[72]

Cambie et al. argue that the Court should determine arbitrariness for the same reasons endorsed by Chief Justice McLachlin and Justice Major in *Chaoulli*: "[b]ased on comparison with other health systems in Canada and internationally, permitting and facilitating access to a private health care system does not jeopardize the existence of a strong public health care system."[73] The *Chaoulli* decision has received much criticism on this point. Colleen Flood writes that the majority looked only to the fact that public and private insurance exist alongside one another in some jurisdictions without analyzing the complexity of those systems and other differences that might exist between each jurisdiction.[74] As Lorraine Weinrib suggests, "the expert and comparative evidence before the Court, as well as expert predictions of what would follow from invalidating the insurance ban, demonstrate complexity that the majority either ignored or dismissed too

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66 Ibid, at para 50.

67 See *Medicare Protection Act, supra* note 1, s. 2; *Canada Health Act, supra* note 9, s. 3

68 *Bedford, supra* note 14, at paras 98-99.

69 *Ibid*, at para 111; *Carter, supra* note 14, at para 83.

70 *Allen, supra* note 54, at para 45.

71 *Bedford, supra* note 14, at para 117; *Carter*, *supra* note 14, at para 83.

72 Stewart, *supra* note 49, at 587.

73 Notice of Claim, *supra* note 4, at para 120; *Chaoulli, supra* note 6 at paras, 140-149.

74 Colleen Flood, "Chaoulli's Legacy for the Future of Canadian Health Care Policy" (2006) 44 Osgoode Hall LJ 273, at 276-277.

easily."[75] The concern articulated by both Flood and Weinrib led the BC Health Coalition and Doctors for Medicare to intervene in *Cambie* in order to ensure that evidence of a connection between the purpose and effects of the provisions is presented.[76] The fact that the plaintiffs are challenging all provisions that restrict the growth of a concurrent private health system rather than merely the restrictions on private health insurance may contribute to a different ruling than in *Chaoulli*. Whether or not these provisions are the only way or the best way to protect the public health care system, they are certainly a way to protect it. The courts will likely not find the provisions to be arbitrary for the same reason stated in *Carter*: "a total ban … clearly helps achieve this object."[77]

ii. Principle Against Overbreadth

There have been significant developments to the principle of overbreadth since the *Chaoulli* decision. Unlike arbitrariness, which asks whether there is any connection between the effects and the purpose, "the overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law goes too far by denying the rights of some individuals in a way that bears no relation to the object."[78] It is likely that the plaintiffs will be able to meet this test. If the purpose of the provisions is to grant reasonable access to health care without financial or other barriers, provisions which prevent access do not further that object and in fact contradict it. The plaintiffs stress that "preferred beneficiaries" are already permitted to receive treatment outside of the regular public system by physicians who have not been forced to opt out of the public system.[79] Though the provincial respondents stress differences in funding in such cases, they do not address the fact that such patients are not placed in the same waitlists as those within the public health system.[80] Such exceptions complicate the simple binary that the provincial respondents seek to maintain between need and wealth as organizing principles in the delivery of health care.

The provincial respondents argue that if the plaintiffs' treating physicians had acted properly, the plaintiffs "could have been treated appropriately in the public system."[81] It is clear, however, that at least some patients are not receiving appropriate access to health services within the public system, as "access to a waiting list is not access to health care."[82] It is likely that even if the provisions are not arbitrary because they are for the most part rationally connected to their object, they may still be caught by overbreadth. As *Bedford* states, "where a law is drawn broadly and targets some conduct that bears no relation to its purpose in order to make enforcement more practical, there is still no connection between the purpose of the law and its effect on the specific individual." The Court does not take "enforcement practicality" into account until the justification stage of section 1.[83] This complicates the overbreadth analysis for certain types of laws that by their nature target more people than necessary. As the Ontario Court of Appeal notes in

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75 Weinrib, *supra* note 36, at 67.

76 Statement of the Intervenors, *supra* note 10, at paras 34-35.

77 *Carter, supra* note 14, at para 84.

78 *Ibid*, at para 85.

79 Notice of Claim, *supra* note 4, at para 126a. The preferred beneficiaries include WCB claimants (whose coverage is funded through an entirely different system that predated the *Medicare Protection Act*) as well as the RCMP, people serving in the military, and prison inmates who according to the defendants cannot constitutionally be restricted as they fall under federal jurisdiction.

80 Provincial Response, *supra* note 9, at Part 3, paras 24-30.

81 *Ibid*, at paras 33, 57.

82 *Chaoulli, supra* note 5, at para 123.

83 *Bedford, supra* note 14, at para 113. In *Bedford*, the Attorney General argued that the broader provision was necessary to capture exploitative relationships. The Court held that it was better addressed under s.1 (para 143).

Michaud, "the singular focus of s. 7 means that it is not possible to dismiss this prospect as a *de minimis* consequence of a beneficial safety regulation."[84] This complication is clear in the context of safety regulations, but I would assert that it is applicable to the statutory scheme regulating health care as well.

Michaud provides a useful analysis of how clarifications to the principles of fundamental justice in the *Bedford* framework play out in the context of a complex regulatory scheme, specifically with regard to the principle against overbreadth. Michaud was a case involving mandatory speed limiters for truck drivers. A speed limiter prevents a vehicle from accelerating past a set speed. Michaud argued that his section 7 right to security of the person was violated because he could not accelerate to avoid danger.[85] The Court identified various features that differentiate safety regulations from other types of legislation typically encountered in section 7 litigation such as the *Criminal Code* provisions challenged in *Bedford* and *Carter*.[86] First the uncertainty inherent in safety regulations complicates a legislature's decision of how best to control the risk they seek to prevent. Second, regulatory schemes are often orientated in a prospective or precautionary way that aims to prevent the harm in the first place rather than, or in addition to, penalizing harmful behaviour after the fact.[87] Third, there is a tendency for safety regulations to consist of "bright line" rules that are certain and knowable but over inclusive to some degree.[88] Finally, safety regulations are often a delicate balancing act as competing purposes and policies are reconciled.[89]

These features laid out in *Michaud* are also seen in the legislative scheme challenged by *Cambie et al*.. First, as seen through the Court's division in *Chaoulli*, it is not certain how increased access to private health care would impact the public health care system. Secondly, the restrictions in the *Medicare Protection Act* attempt to pre-emptively restrict harmful effects to the system by discouraging the creation of concurrent private health care in addition to penalizing prohibited behaviour after the fact. Third, as in safety regulations, the legislature has drawn a line delineating which health care services will be allowed to take place outside of the public system. Lastly and perhaps most importantly, finding a balance between conflicting interests and policies is essential in the context of health care legislation. As suggested previously, the purpose of the *Medicare Protection Act* includes reasonable access to health care and the preservation of the public health care system. These two purposes are for the most part compatible but become complicated when the means of preserving the system undermines peoples' access, or when access undermines the preservation of the system. This balancing is recognized by the dissent in *Chaoulli*: "the issue here, as it is so often in social policy debates, is where to draw the line. One can rarely say in such matters that one side of a line is "right" and the other side of a line is "wrong."[90] As *Michaud* recognizes, the principle against overbreadth has a tendency to be engaged by such laws because it is their nature to be over or under inclusive.[91] It is highly likely that the impugned provisions in the present case will be captured by overbreadth, but by doing so the principle of overbreadth may itself be overbroad, catching that which does not actually implicate "the basic values underpinning our constitutional order."[92]

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84 *R v Michaud,* 2015 ONCA 585, at para 74 [Michaud].
85 *Ibid,* at paras 1-2
86 *Ibid*, at paras 86-113.
87 *Ibid*, at paras 100-102.
88 *Ibid*, at paras 88-89.
89 *Ibid*, at para 91.
90 *Chaoulli, supra* note 5, at para 170.
91 *Michaud, supra* note 84, at para 89.
92 *Bedford, supra* note 14, at para 96.

iii. Principle Against Disproportionality

Gross disproportionality occurs "in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure … the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society."[93] This is a high threshold that will arguably be difficult for the plaintiffs to meet. As mentioned earlier, the individual plaintiffs' suffering is caused by their illness or injury and then worsened by not being able to receive a specific health care service. The plaintiffs must prove that not being able to access medical care outside of the public system increased their suffering or the threat to their life to such a degree that it is "totally out of sync" with the purpose of the provisions.[94]

As with arbitrariness and overbreadth, a law is in breach of section 7 if it impacts even one person in a manner grossly disproportionate to its purpose. Though it is easy to generalize all patients on waitlists as suffering to some degree, some wait times may be more unreasonable than others as, for example, more serious injuries or illnesses may result in greater suffering. The plaintiffs in *Cambie* include a number of patients who believe their section 7 rights were infringed due to wait times for surgery or diagnostics. It may be that waiting for diagnostic services for a serious condition such as cancer causes a grossly disproportionate degree of psychological suffering and risk to life.[95] A disproportionate amount of suffering may also arguably occur where delays significantly increase the risk of an adverse outcome.[96] Waiting for an elective orthopaedic surgery, on the other hand, would involve some physical and psychological suffering but may be more proportionate in its effects as the condition is not life threatening.[97]

The Court emphasizes in *Bedford* that "gross disproportionality under s. 7 does not consider the beneficial effects of the law for society. It balances the negative effect on the individual against the purpose of the law, *not* against societal benefit that might flow from the law."[98] It is hard to imagine how the Court might accomplish this task in this case: the societal benefit that flows from the law is intimately connected to the value of the purpose of protecting the public health care system. As Hamish Stewart writes, "a non-trivial impact on, for example, even one person's security of the person is always disproportionate to the complete achievement of a relatively unimportant objective, even if that objective is completely achieved."[99] It is unclear how the Court is supposed to measure the importance of an objective without considering the social benefits that flow from that objective.

It is at this stage of the analysis that a consideration of the relational context can truly underline the impact of the Court's focus on negative rights in past jurisprudence. If the Court finds that the suffering and risk that a patient can sustain on a public waiting list

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93 *Ibid*, at para 120.

94 *Ibid*.

95 Notice of Claim, *supra* note 4, at paras 29-38: Individual plaintiff Ms. Martens had suspected colon cancer but required a biopsy to confirm this diagnosis. According to the Notice of Claim, survival rates for early detection is approximately five times higher than late-stage cancer detection. Cambie et al. do not specify whether waiting six months for the colonoscopy as scheduled in the public system would have crossed the line between early and late detection.

96 *Ibid*, at paras 50-64. Due to complications in surgery, individual plaintiff Mr. Khalfallah was left a paraplegic, paralysed below the navel. Cambie et al. claim that there would have been far less likelihood of this adverse consequence if he had received treatment for his kyphosis sooner.

97 *Ibid,* at para 39-48. Individual plaintiff Ms. Corrado suffered pain and was unable to play soccer while waiting for knee surgery, but her condition was not life-threatening and there were no lasting effects.

98 *Bedford, supra* note 14, at para 121 [emphasis in original].

99 Stewart, *supra* note 4, at 586.

while being denied access to private health care is so grossly disproportionate as to be out of sync with our societal norms, then the Court must also acknowledge that there are others suffering the same fate who could not afford to access private health care even if they were allowed to. By looking at the context within which the present case is situated, one can see that if gross disproportionality is found, there are serious questions regarding whether the remedy requested by Cambie et al. properly addresses the problems revealed through the section 7 analysis.

iv. Vagueness

The plaintiffs also argue that the provisions are unconstitutionally vague.[100] It is highly unlikely that the vagueness claim would be successful given the test laid out by the Supreme Court of Canada in *Canadian Foundation for Children*.[101] Though the definition of "medically necessary" may be open to interpretation, the overall provisions challenged by the plaintiffs are clearly intelligible and it is reasonable to assume that the corporate plaintiffs are well aware of what actions are contravene the law.

D. Section 1: Justifying an Infringement

If the Court does find that some or all of the impugned provisions of the *Medicare Protection Act* infringe section 7, any infringement may be justified under section 1. At this point in the analysis, the burden shifts to the provincial respondents who must show that:

> "[T]he law has a pressing and substantial objective and that the means are proportional to that object. A law is proportionate if (1) the means adopted are rationally connected to that objective; (2) it is minimally impairing of the right in question; and (3) there is proportionality between the deleterious and salutary effects of the law."[102]

Though the Supreme Court of Canada has not yet found a section 7 violation justified under section 1, "the highly individualistic focus of the section 7 analysis is complemented by an apparent willingness to consider societal interests at the section 1 stage, thus opening up the possibility of justifying a violation of a principle of fundamental justice."[103] As stated in *Carter,* though it will be difficult, "in some situations the state may be able to show that the public good—a matter not considered under s. 7, which looks only at the impact on the rights claimants—justifies depriving an individual of life, liberty, or security of the person."[104] The *Medicare Protection Act* is concerned at the very least with preserving the public health care system because of the societal good that results from having a health care system in which access to care is on the basis of need. This is a pressing and substantial objective. Thus, what the Court must determine whether its adopted means are also proportionate.

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100 Notice of Claim, *supra* note 4, at para 140.

101 *Canadian Foundation for Children, Youth and the Law v Canada (AG)* 2004 SCC 4, [2004] 1 S.C.R. 76, at para 15. This case holds that "a law is unconstitutionally vague if it does not provide an adequate basis for legal debate and analysis, does not sufficiently delineate any area of risk, or is not intelligible."

102 *Carter, supra* note 14, at para 94; *R v Oakes* [1986] 1 S.C.R. 103.

103 Stewart, *supra* note 49, at 589.

104 *Carter, supra* note 14, at para 95.

i. Rational Connection

It is highly unlikely that an arbitrary provision will be justified under section 1. In fact, the Court in *Chaoulli* questioned whether that would ever be possible.[105] On the other hand, a law that is not arbitrary will almost certainly be rational. Under the *Bedford* framework, courts considering the principle of arbitrariness under section 7 must focus on the individual, but when they consider rationality under section 1 they may expand their analysis to include broader societal effects. It is unclear whether the results of these analyses would ever differ, however, since both focus on a complete lack of rational connection between the effects and the objectives of the provisions. Because the Court will likely not find the impugned provisions of the *Medicare Protection Act* to be arbitrary under section 7, it is equally likely that the Court will find the provisions are rationally connected to their object in the section 1 analysis.

ii. Minimal Impairment

At the minimal impairment stage, "the burden is on the government to show the absence of less drastic means of achieving the objective in a real and substantial manner."[106] This stage will likely see more novel analysis than the rational connection stage as a result of the changes in *Bedford*, which found that enforcement practicality—meaning where a law is drawn broadly in order to make enforcement more practicable—is to be considered during the minimal impairment analysis rather than at the overbreadth stage in section 7.[107] Though the Supreme Court of Canada has not yet justified a section 7 infringement, the Ontario Court of Appeal in *Michaud* has shown how an overly broad law, specifically a regulatory statute, could be considered minimally impairing.[108] The Supreme Court of Canada has also affirmed that it is willing to give deference to the legislature under section 1 where a law violating section 7 involves a "complex regulatory response" to a social problem."[109] The Court in *Michaud* acknowledged that although *Carter* held that an absolute prohibition could not be described as a "complex regulatory response," this does not necessarily mean that Courts should never show deference when a prohibition is challenged.[110] The Ontario Court of Appeal further developed this point, noting that sometimes the concept of "prohibition" may not always be useful because "picking out one feature from a very complex regulatory response is too granular an approach," and a seemingly cut-and-dry prohibition may actually be an indivisible component of a complex regulatory response.[111] *Cambie* involves prohibitions on extra billing and concurrent private health insurance, but these prohibitions may be an inseparable part of a complex network of health care legislation.

In addition, *Irwin Toy* suggests that courts should use increased deference when the government is balancing the interests of competing groups, especially when vulnerable groups are involved, in contrast to cases where the government is a "singular agonist."[112] Though there are strong arguments in the present case for justification under section 1 if the Court finds the law to be overly broad, it is uncertain how much weight the Court will give these elements. In *Carter* and *Bedford*, which also included a concern for the protection of vulnerable people from exploitation, the Court did not find that the impugned provisions were justified. *Carter* states that "a theoretical or speculative fear

105 *Chaoulli, supra* note 5, at para 155.
106 *Carter, supra* note 14, at para 102.
107 *Bedford, supra* note 14, at para 113.
108 *Michaud, supra* note 84, at paras 130-131.
109 *R v Safarzadeh-Markhali,* 2016 SCC 14, at para 57.
110 *Carter, supra* note 14, at para 98; *Michaud, supra* note 85, at paras 129-130.
111 *Ibid*.
112 *Irwin Toy Ltd v Quebec (AG)* [1989] 1 S.S.R. 927, [1989] S.C.J. No 36, at paras 80-81.

cannot justify an absolute prohibition, nor can the government meet its burden simply by asserting an adverse impact on the public."[113] Though enforcement practicality and protection of the vulnerable may be important factors, the Court may choose to take a strict view of whether there is a less impairing option when considering whether to justify an overbroad law at this stage of the analysis.

iii. Proportionality

The provincial respondents may be able to justify overbreadth at the final stage of section 1, which focuses on proportionality and balancing the positive and negative effects of the challenged provisions. Hamish Stewart cautions that though "it should not be assumed that the law would automatically fail … it is hard to imagine that a court would accept that a law could be justified by its social benefits if its impact, even on only one particular individual, was so draconian as to fall entirely outside the norms of Canadian legal and political culture."[114] That being said, it may be at this proportionality stage that the Court is able to give the most thought to the effects that repealing the law would have on Canada's current social inequalities, since only those who can afford and qualify for private insurance would be able to take advantage of concurrent private health care if it were to be established. The Court will likely be extremely cautious in justifying a grossly disproportionate provision, however, because such a decision would seriously impact the significance of finding a law grossly disproportionate in the first place. If a law is held to be grossly disproportionate and then is easily justified under section 1, it raises the question of whether the law was actually "entirely outside the norms" of Canadian society in the first place.[115]

The provisions in *Michaud* were justified under the proportionality stage because their overly broad effect only infringed the security of the person interests of two percent of individuals captured by the law.[116] Thus, even though the law in that case infringed the plaintiff's section 7 rights in a manner that was overbroad, the infringement was held to be justifiable when balanced against the safety interests of the other ninety-eight percent of drivers. If more than two percent of patients in need of treatment have their interests negatively impacted by the impugned provisions in *Cambie* in a manner that is overly broad, it may be more difficult to justify that overbreadth at the proportionality stage.

Conclusion of Charter Analysis

The Court is in a difficult position in this case. If it declares the provisions invalid, it will be accused of rolling back legislation that is in place for the benefit of those who would be severely disadvantaged by a private system. Yet a decision that upholds the provisions leaves the system in its current state with little incentive for provincial governments to undertake costly improvements. The *Canada Health Act* and the legislative schemes that surround it are a powerfully symbolic testament to the need to protect the social good of health care that all can access on the basis of need rather than ability to pay. Yet long waitlists persist and people suffer physically and psychologically as they wait for treatment. In some cases, longer wait times before treatment result in greater risk of adverse outcomes.

If the Court finds a section 7 violation that is not justified under section 1, it will need to decide what relief to grant. The Court's conclusion in *Cambie* would likely be similar to *Chaoulli*, in which "the prohibition on private health insurance [was] not constitutional where the public system fail[ed] to deliver reasonable services."[117] Such a

113 *Carter, supra* note 14, at para 119.
114 Stewart, *supra* note 49, at 592-593.
115 *Ibid.*
116 *Michaud, supra* note 84, at para 139
117 *Chaoulli, supra* note 5, at para 158.

ruling is complicated by the lack of consensus between governments and physicians as to what constitutes a reasonable length of time.[118] Cambie et al. argue for access to private health care generally, but it is likely that only restrictions in certain areas of health care could actually be found to infringe patients' section 7 rights. All the examples raised by Cambie et al. involved elective surgery or diagnostics. Though allowing access to private health care in these areas would still have an impact on the public health care system, that impact may be less severe than a general right to access private health care. The Court cannot set out comprehensive guidelines as to what the legislature must do in such situations, however it may be able to provide guidance on how the *Medicare Protection Act* could be maintained in a way that does not unjustifiably infringe on section 7 rights.

III. ISOLATING THE INDIVIDUAL: FURTHER REFLECTIONS ON THE *BEDFORD* FRAMEWORK

The Canadian government's decision to entrench the rights contained in the *Charter* created a powerful tool for checking government power and abuse of authority. In order to give effect to this protection, it is important that statutes such as the *Canada Health Act* are not insulated from *Charter* protection merely because of the important place such statutes have in society. As Loraine Weinrib states, "legislatures cannot be the final arbiter of their own fidelity to [principles of human dignity]. Independent review is necessary."[119] That being said, such a powerful tool must be treated with care so that it does not undermine the values upon which it is based. As the Supreme Court of Canada suggested in 1986, "the courts must be cautious to ensure that [the *Charter*] does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons."[120] Relational theorist Jennifer Llewellyn argues that rights cannot properly be understood outside of the context of human relationships. She suggests that "a relational conception of rights is particularly helpful in understanding and responding to rights claims in a health care context because it can properly conceive of the complex nature of the relationships and claims at issue in this context."[121] Acknowledging the potential impact on vulnerable members of society does not need to result in excessive deference that insulates government actions from review, but such considerations may help the Court to ensure that the *Charter's* mission is accomplished in a way that brings some measure of balance rather than increasing the current inequalities in society.

In *Chaoulli*, this balance is arguably lacking. Justice Deschamps seems disdainful of the emotional reaction of those who "characterize the debate as pitting rich against poor when the case is really about determining whether a specific measure is justified under either the *Quebec Charter* or the *Canadian Charter.*"[122] Such a mechanistic view of the Court's role is particularly troublesome given how much the Court's own decisions have contributed to the development of the *Charter* rights that they apply. The dissent written by Justices Binnie and Lebel in that case is equally flawed due to a singular focus on the social benefits provided by the *Canada Health Act*. As Weinrib writes, "the dissent's delineation of the appropriate tests and its examination of the argumentation and supporting evidence focused less on the Court's special obligation to protect constitutional rights than on the legitimacy and desirability of a public health care system, whatever its operative performance."[123] In both *Chaoulii* and *Cambie*, we see concerns for the public good placed

118 Notice of Claim, *supra* note 4, at paras 91, 95.

119 Weinrib, *supra* note 36, at 59.

120 *R v Edward Books,* (aka *R v Videoflicks*) [1986] 2 SCR 713, at para 141 [*Edwards Books*].

121 Llewellyn, "A Healthy Conception of Rights," *supra* note 12, at 63.

122 *Chaoulli, supra* note 5, at para 16.

123 Weinrib, *supra* note 36, at 58.

in opposition to individual interests and autonomy. Insufficient consideration of the impact of finding the impugned provisions void could lead to unanticipated societal side effects. Excessive deference, however, can lead to stasis and can fail to provide protection if the legislature steps too far. Using the *Bedford* framework with its almost exclusive focus on the individual may make it difficult to avoid slipping into either of these two pitfalls.

The *Bedford* framework attempts to isolate the individual from their societal context, as the Court determines whether the law impacts a single person in a way that is arbitrary, overbroad, or grossly disproportionate. The law is then declared "inherently flawed" even if societal interests and effects are important enough to justify the infringement on the individual's interests.[124] Such an analysis sees the social and the individual as two distinct considerations that are in opposition to one another. However as Llewellyn suggests, "the rights as trumps approach that emerges simply cannot produce the sort of complex responses to rights claims required in the health care context."[125] In addition to being inadequate for producing a complex response, the "rights as trumps approach" is not needed to accomplish the goal of protecting the rights of the individual.

In *Mills*, the SCC considered section 7 in the criminal trial context.[126] Though that case involved a very different context than *Bedford* or *Cambie*, it may provide a useful contrast to the extremes noted above in the *Chaoulli* judgments. Though not explicitly addressed, *Mills* showed how courts can take relational contexts into account in a way that works within the existing constitutional structure provided by section 7. *Mills* affirmed the Court's statement in *Seaboyer,* that "the principles of fundamental justice reflect a spectrum of interests, from the rights of the accused to broader societal concerns."[127] In *Mills,* the Court was evidently aware of the need to balance these competing interests and "[interpret] rights in a contextual manner—not because they are of intermittent importance but because they often inform, and are informed by, other similarly deserving rights or values at play in particular circumstances."[128] The individual's right to make a full answer and defence was of great importance in that case, but could not be defined in isolation. *Mills* was decided in the context of sexual violence. Throughout the case, the Court considered both the interests of the accused, whose rights were clearly at stake in the trial, but also the interests of the complainant, who was part of a vulnerable and historically underprotected group, and the interests of society at large.

Unlike *Bedford,* which held that the interests of the individual must be isolated from the interests of society in order to be protected, *Mills* found that the interests of the individual, and the principles of fundamental justice, can only be defined within their context.[129] As mentioned previously in the overbreadth analysis, the principles defined in *Bedford* may lead to incongruous results, such as a finding that nearly all safety regulations are inherently flawed. The Court's attempt to clarify the principles of fundamental justice in *Bedford* risks isolating the principles from their context and thereby giving them less meaning. As stated in *Seaboyer* and affirmed in *Mills*, "the ultimate question is whether the legislation, viewed in a purposive way, conforms to the fundamental precepts which underlie our system of justice."[130] I am not convinced that the Court can properly answer this question using the *Bedford* framework.

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124 *Carter, supra* note 14, at para 95.

125 Llewellyn, "A Healthy Conception of Rights," *supra* note 12, at 63.

126 *R v Mills* [1999] 3 S.C.R. 668, 1999 CarswellAlta 1055 [*Mills*]. In the context of a charge of sexual assault, the accused challenged the restrictions on access to the complainant's private records contained in Bill C-46 arguing that it infringed his right to bring full answer and defence.

127 *R v Seaboyer* [1991] 2 S.C.R. 577, [1991] S.C.J. No. 14, at para 24 [*Seabouyer*].

128 *Mills, supra* note 126, at para 61.

129 *Ibid*, at para 63.

130 *Seaboyer, supra* note 127, at para 24; see also *Mills, supra* note 126, at para 72.

Cambie et al.'s claim could potentially undermine the life and security of the person interests of those who must remain in the public health system. It must be noted that in *Mills*, the Court was concerned with balancing two sets of *Charter* rights. Because those who stand to be most negatively impacted by a concurrent private health care system have no positive right to health care, their interests are not constitutionally protected. These interests are still part of the context of this case, however, and must be considered for the Court to fully understand what is at stake. If the Court decides it simply cannot consider these interests within the section 7 analysis, then it should hold off judgment on whether a provision is "inherently flawed" until the impugned provision has been assessed in its entire context. As Llewellyn suggests, section 1 "seeks to protect *Charter* rights while creating space to balance these rights where they might conflict with democratically determined values and objectives."[131]

CONCLUSION

Cambie raises serious concerns regarding how the Court should balance the interests of the individual *Charter* litigant with the interests of the rest of society. Though this case will likely not follow *Chaoulli* in finding that the provisions are arbitrary, it is very possible that the provisions will be captured by the principles against overbreadth and gross disproportionality. If that occurs, the Court will have to determine whether such violations of section 7 are justified under section 1 of the *Charter*. In doing so, the Court must determine the degree of deference it is willing to give the legislature's choices in the complex regulatory context of health care legislation. *Cambie* highlights the possibility that courts will "roll back legislation which has as its object the improvement of the condition of less advantaged persons."[132] As section 7 interests and the principles of fundamental justice continue to develop, the Court must remain aware of the degree to which such developments actually bring justice to Canadian society. The further individualization of the principles of fundamental justice seen in the *Bedford* decision may be seen as a positive step because it may provide protection in situations where the public goals are seen as oppressive to minority interests. It is also worth noting that a decision made using the *Bedford* framework will not always undermine a relational theory of justice. It is arguable that the *Bedford* decision drew attention to the way in which the challenged prostitution laws were creating oppressive or unhealthy relationships in society. The weakness of the *Bedford* framework, however, is that it is susceptible to misuse. Those in power may use this framework to further their own interests in a way that subsequently undermines the interests of the vulnerable. Further, there are situations in which the *Bedford* framework is inappropriate, particularly in complex regulatory contexts that involve a balancing of interests.

As demonstrated in this paper, the focus of relational rights theory on an individual's context may help the Court to avoid some of the pitfalls that arise from a decontextualized analysis of the individual claimant's interests. Taking an individual's relational context into account will not solve the tensions that underlie this health law context; the tension between the individual and society will always exist because neither interest can be absolute. Taking the full context into account, however, allows the Court to embrace this complexity and balance these interests in order to seek justice. As seen in *Mills*, this does not negate or diminish the rights protected within the *Charter*. Rather, a contextual analysis provides the means by which those rights can be understood and realized as fully as is possible within the judicial context.

131 Llewellyn, "A Healthy Conception of Rights," *supra* note 12, at 64.

132 *Edward Books, supra* note 120, at para 141.