COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Cambie Surgeries Corporation v. British Columbia (Attorney General),* 2022 BCCA 245

Date: 20220715
Docket: CA47004

2022 BCCA 245 (CanLII)

Between:

Cambie Surgeries Corporation, Chris Chiavatti, Mandy Martens, Krystiana Corrado, Walid Khalfallah by his litigation guardian Debbie Waitkus, and Specialist Referral Clinic (Vancouver) Inc.

Appellants
(Plaintiffs)

And

Attorney General of British Columbia

Respondent
(Defendant)

And

The Attorney General of Canada

Respondent
Pursuant to the *Constitution Question Act*

And

Dr. Duncan Etches, Dr. Robert Woollard, Glyn Townson, Thomas McGregor, British Columbia Friends of Medicare Society, and Canadian Doctors for Medicare

Intervenors

And

Mariël Schooff, Joyce Hamer, Myrna Allison, and British Columbia Nurses' Union

Intervenors

And

Constandina Bezic, William Currie, Barry Goss, Joan Hama, Debby Harris, Jaspinder Johal, and Earl Vance

Intervenors

And

British Columbia Anesthesiologists' Society

Intervenor

FILE SEALED IN PART

Before: The Honourable Chief Justice Bauman
The Honourable Mr. Justice Harris
The Honourable Madam Justice Fenlon

On appeal from: An order of the Supreme Court of British Columbia, dated September 10, 2020 (*Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2020 BCSC 1310, Vancouver Registry Docket S090663).

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Place and Date of Hearing:	Vancouver, British Columbia June 14–18, 2021
Place and Date of Judgment:	Vancouver, British Columbia July 15, 2022

Written Reasons by:
The Honourable Chief Justice Bauman and the Honourable Mr. Justice Harris

Concurring reasons by: (p.125, para. 371)
The Honourable Madam Justice Fenlon

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Summary:

The appellants contend that certain provisions of the Medicare Protection Act, R.S.B.C. 1996, c. 286 [MPA] are unconstitutional because they effectively prevent patients in British Columbia from accessing private medical treatment that would otherwise be available to them when the public system cannot provide timely necessary care. They say the impugned provisions breach patients' rights to life, liberty, and security of the person under s. 7 of the Charter and are not saved by s. 1. The appellants allege multiple errors of fact and law in relation to both the s. 7 and s. 1 analysis.

Held: Appeal dismissed. Chief Justice Bauman and Justice Harris would do so on the basis that although the impugned provisions deprive some patients of their rights to life and security of the person, they do so in accordance with principles of fundamental justice. Although unnecessary to decide the case under s. 1, they agree with Justice Fenlon that, even if the provisions breach s. 7, they are saved by s. 1.

Justice Fenlon, in concurring reasons, would also dismiss the appeal. She would find that the provisions do deprive some patients of their rights to life and security of the person in a manner that is not in accordance with the principles of fundamental justice: the deprivations are grossly disproportionate. However, in her opinion, that s. 7 breach is justified under s. 1 of the Charter.

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Reasons for Judgment of the Honourable Chief Justice Bauman and the Honourable Mr. Justice Harris:

INTRODUCTION

[1] The appellants contend that certain provisions of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 [MPA] are unconstitutional because they effectively prevent patients in British Columbia from accessing private medical treatment that would otherwise be available to them when the public system cannot provide timely necessary care. They say the impugned provisions breach patients' rights to life, liberty, and security of the person under s. 7 of the *Charter*.

[2] Two of the impugned provisions, ss. 17 and 18, prevent medical practitioners enrolled in the Medical Services Plan ("MSP") from billing patients any amounts for their services beyond the rate paid by MSP (the ban on extra billing). The other impugned provision, s. 45, effectively prevents the sale of private insurance covering the same medical services as provided through MSP. The combined effect of these provisions is to suppress the development of a parallel private medical system that is duplicative of the public system for some surgeries and diagnostic tests.

[3] The trial judge dismissed the claim, rejecting arguments advanced under both ss. 7 and 15 of the *Charter*. The s. 15 claim is not at issue on this appeal.

[4] In brief, the judge accepted that the impugned provisions deprived some patients' right to security of the person by preventing them from accessing private care when the public system had failed to provide timely medical treatment. He concluded, however, that this deprivation accorded with the principles of fundamental justice. In his view, the impugned provisions were not arbitrary, overbroad, or grossly disproportionate when measured against their purpose. His articulation of the purpose of the MPA was important to his analysis. The judge defined that purpose as twofold: to preserve a publicly managed and fiscally sustainable healthcare system for British Columbia and to ensure that access to necessary medical care is based on need and not an individual's ability to pay. The

judge went on to find that, in any event, the impugned provisions were saved by s. 1 of the *Charter*.

[5] The appellants' position revolves around several principal themes. First, they say the judge erred in his s. 7 analysis in a number of critical respects: He failed to recognize that the rights to life and liberty of the person are engaged; he adopted too high a threshold for the constitutional engagement of s. 7 rights; and he misinterpreted and underestimated the data demonstrating the extent to which patients were waiting beyond the benchmark for treatment. As a result, the appellants say the judge operated with a diminished understanding of the nature and scope of the harm suffered by patients, as well as the numbers of people affected by lengthy wait times. This error fed into errors in his analysis of both the principles of fundamental justice and s. 1.

[6] Second, the appellants argue the judge inflated the true purpose of the statutory scheme so as to predetermine his analysis of the principles of fundamental justice. His articulation of the purpose of the MPA included an equitable principle that the delivery of all medically necessary care in the province be based solely on need and not the ability to pay. The appellants submit that when the proper purpose is correctly identified as the preservation of a publicly managed and fiscally sustainable healthcare system, the impugned provisions are not in accordance with the principles of fundamental justice. The prohibition on private insurance is arbitrary and does not advance the true purpose of the law; the provisions are overbroad; and the impugned provisions' effect on patients' constitutional rights is disproportionate to the proper purpose of the MPA.

[7] Third, the appellants contend that once the correct s. 7 analysis is undertaken, the impugned provisions are not demonstrably justifiable in a free and democratic society. The appellants rely on the proposition that once a s. 7 breach has been demonstrated, it will be only in exceptional circumstances that the law can be saved by s. 1. They contend that the provisions cannot be saved under s. 1

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because they are not minimally impairing and their harmful effects on patients are not proportional to their salutary effects.

[8] The core of the appellants' argument is that the effective prevention of a duplicative private system, when the public system is broken and has failed to deliver on its promise of timely quality care, unjustly prevents individuals from using their own resources to meet their healthcare needs. Individual rights are being sacrificed on the altar of collective aspiration. This is fundamentally at odds with the *Charter*, which has privileged individual rights over public imperatives. They contend, in any event, that permitting parallel private care would act as a safety valve, relieving the pressure on the public system without harming it.

[9] The respondents say the judge did not fall into any of the errors alleged. Importantly, they say the judge made a series of unassailable findings of fact that have not been properly challenged on appeal. They contend that this Court should defer to those findings. Principally, those findings concern the harmful consequences of permitting duplicative private healthcare both to the equitable principle of ensuring that necessary medical care is provided on the basis of need and not ability to pay, and also to the provision of necessary medical treatment within the public system. Both Canada and British Columbia argue that, even on the narrow statement of purpose adopted by the appellants, the judge's findings of fact compel the dismissal of the appeal.

[10] Before turning to address these questions, a few preliminary comments are in order. First, it is common ground that there is no freestanding constitutional right to healthcare. It follows that the engagement of constitutional rights in the delivery of healthcare flows from government action involving the public provision of healthcare.

[11] Second, we approach this case on the basis that it involves the constitutional rights of patients. The respondents advanced the view that the case was really about the financial interests and preferred business model of some physicians and private clinics. We found this submission unhelpful. We see no reason to doubt the sincerity of any of the appellants who believe that a parallel private healthcare system is

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compatible with, and perhaps even beneficial to, a high-quality public system while at the same time avoiding the breach of *Charter* rights.

[12] Third, we found the description of a possible duplicative private medical care system functionally reserved for the “healthy and wealthy” at the expense of ordinary British Columbians to be unhelpful. It is by no means clear that such a system would be inaccessible to a significant proportion of British Columbians given the costs of the types of procedures involved and the possibility of purchasing private insurance to pay for them.

[13] Fourth, it is important to say something about what this judgment is and what it is not. This is a review of a trial judgment to determine whether the judge made reversible errors in reaching his conclusions. Those errors may relate to findings of fact or questions of law. The question for us is not whether we agree with the facts found by the judge. It is whether those findings depend on a legal error. We defer to findings of fact if they were open to the judge on the evidence. In short, this judgment is a review of the trial judgment for error. This appeal is not a second trial.

[14] Due to the limited nature of our review, this judgment cannot be read as if it is the report of a royal commission into the merits of different ways to deliver healthcare. Nor was the trial judgment a royal commission. We are not examining what objectively would be the best, most efficient, or socially just means of delivering healthcare to British Columbians. That is beyond our mandate and our expertise and jurisdiction. What we say in this judgment does not address those questions. At most, we examine the findings of the judge and test those findings against the *Charter*. It is quite possible that public policy may be constitutionally compliant, yet also be flawed when analysed from other perspectives.

[15] It is also important to remember that we are reviewing a trial record that includes evidence relating to some aspects of healthcare policy and the workings of the medical system at a particular period of time. Even since the trial completed, much has changed. The facts as they stood at trial may well be significantly different now. We take judicial notice of the crisis caused by the COVID-19 pandemic,

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resulting in cancellation or postponement of elective surgeries and other procedures. We are also aware of the current shortage of family doctors, which limits readily accessible primary care. We point these issues out to highlight the continuously evolving challenges facing our medical system, although they do not factor into our analysis, which is limited to the record and issues before us.

[16] We turn now to the issues on appeal. We shall start by providing sufficient background to set the issues in context beginning with an outline of the statutory framework and the operation of the impugned provisions. We will then turn to an analysis of the trial judgment to provide focus to the errors the appellants allege. We cannot omit recognizing that the trial judge was faced with developing an immense record over an extraordinarily lengthy trial including innumerable evidentiary rulings. We are indebted to him for the diligence with which he developed a record capable of being reviewed. This was an enormous judicial task that he undertook with dispatch and care.

[17] For the reasons that follow, we would dismiss the appeal. We conclude that the judge's broad findings of fact about the harmful consequences of a parallel private medical system to the public system were open to him. Those findings go a long way to dispose of the constitutional issues raised at trial and on appeal. In our view, the judge erred in finding the impugned provisions did not deprive some patients of the right to life, and by underestimating the extent of the deprivation of the right to security of the person. However, we do not think he erred in concluding that any deprivations were in accordance with the principles of fundamental justice. Accordingly, we conclude that the judge did not err in finding that s. 7 of the *Charter* had not been breached. Even so, we approach the analysis of the principles of fundamental justice somewhat differently from that of the judge and our colleague, Justice Fenlon. In our view, it is not necessary to consider s. 1 of the *Charter*, but if it were, we agree with the reasoning of our colleague.

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BACKGROUND

The Parties

[18] Cambie Surgeries Corporation ("Cambie Surgeries") owns and operates Cambie Surgery Centre ("CSC"), a private surgical clinic located in Vancouver, British Columbia. Diagnoses and treatments (including operations) at CSC are performed by independent physicians, who are not employees of Cambie Surgeries. CSC's patients pay Cambie Surgeries, which then compensates the physicians.

[19] Special Referral Clinic (Vancouver) Inc. ("SRC") owns and operates a medical clinic in Vancouver that provides expedited medical assessments and consultations and arranges for diagnostic testing. SRC also refers patients to Cambie Surgeries for surgical procedures.

[20] Chris Chiavatti, Mandy Martens, Krystiana Corrado, and Walid Khalfallah (the "patient plaintiffs") are British Columbia residents who gave evidence at trial regarding their personal experiences in the public healthcare system.

[21] Throughout these reasons, Cambie Surgeries, CSC, SRC, and the patient plaintiffs are referred to collectively as "the appellants".

[22] The Attorney General of British Columbia ("AGBC") stands in place of the Medical Services Commission and the Minister of Health Services of British Columbia. The Attorney General of Canada ("AGC") was a party to the proceedings pursuant to s. 8 of the *Constitutional Question Act*, R.S.B.C. 1996, c. 68.

The Statutory Scheme for Public Healthcare in British Columbia

[23] The focus underlying the action was the provision of certain types of medically necessary care within the public system. The scope of the claim is a point of contention between the parties. The judge found the claim was limited to elective surgical and diagnostic procedures that are typically performed on a day-patient basis (the type of services provided by private clinics). The appellants say the claim was broader. We shall return to this issue later in the judgment.

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[24] For current purposes, it is sufficient to note that healthcare services are delivered through various institutions, both public and private. These include public hospitals and private facilities. Private facilities include doctors' offices and private clinics, such as Cambie Surgeries, which also provide publicly funded services in some contexts. Public funding is a mix of fee-for-service paid to physicians through MSP and grants to fund operating costs. Medical care in public hospitals is provided by a mix of physicians and salaried staff, such as nurses and other professionals. Almost all physicians are private actors who are reimbursed for providing necessary medical services. Many procedures, especially more complex procedures, are provided in publicly funded hospitals, even though physicians and surgeons are paid on a fee-for-service basis through MSP.

[25] It is important to appreciate that medically necessary care refers to procedures that are deemed to be medically necessary within the statutory insurance scheme (MSP), which classifies these services as "benefits". We may from time to time describe them as "insured services".

[26] The set of medical procedures covered by MSP as benefits is not universal, and does not purport to be. There are many procedures that might colloquially be thought of as medically necessary that are not covered. Indeed, much healthcare (including most pharmaceuticals, physiotherapy, certain diagnostic procedures, and dentistry) is not covered by MSP and must be privately funded, although some may be available through other government programs. Further, not all medical procedures classified by MSP as medically necessary are funded through MSP. For example, WorkSafe BC funds many such procedures, often through contracts with private clinics. Although this challenge was focused on some medically necessary procedures, it did not capture all of them. As mentioned, the judge found that the claim is limited to surgical and diagnostic services that are otherwise available in private clinics: at para. 89.

[27] It is also important to recognize that the services that can be provided in private facilities are influenced by professional regulatory bodies, including the

College of Physicians and Surgeons of British Columbia (the "College"). The College maintains a list of all procedures that can be performed at each private surgical clinic. As a result of the College's rules, many medically necessary services can only be provided in public hospitals. Private clinics generally only perform routine, elective surgeries on a day-patient basis.

[28] The point of these comments is to show that the claim focuses only on certain aspects of healthcare delivery in British Columbia. The healthcare system is extraordinarily complex, consisting of an interrelated web of public and private provision and funding. The judge's reasons contain a detailed account of this complexity, which figured importantly in his evaluation of the evidence.

[29] With that background in mind, the most important piece of provincial legislation engaged in this appeal is the MPA, under which MSP is administered. The purpose of the MPA, as set out in s. 2, is to "preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay". The proper interpretation of this purpose clause figures prominently in this appeal.

[30] As noted, MSP identifies medically required services (or benefits) and the MPA regulates payment for these services, the status of physicians, and the entitlement of British Columbia residents to enroll as beneficiaries under MSP. Physicians may enroll in MSP. Enrollment of beneficiaries and physicians in MSP is voluntary. Enrolled physicians are eligible to be paid by MSP for benefits provided to beneficiaries based on the rates set out in a schedule approved by the Medical Services Commission. In short, the scheme provides that beneficiaries may receive defined medically necessary services from enrolled medical practitioners without charge.

[31] Enrolled physicians are not permitted to engage in extra billing of any kind, pursuant to ss. 17 and 18 of the MPA. The prohibition against extra billing captures billing an amount greater than the schedule amount for a benefit and billing additional amounts associated with the provision of the service, such as a facility fee

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or charges for supplies. Services provided to non-beneficiaries, such as non-residents, are not subject to the schedule, and physicians can charge any amount for their provision, even if those services would be benefits if provided to a beneficiary.

[32] Although enrolled physicians can “opt-out” of being paid directly by MSP and instead receive payment from their patients, who are then reimbursed by MSP, very few do so. In addition, physicians are not required to enroll in MSP. However, beneficiaries cannot seek reimbursement from MSP for services provided by unenrolled physicians, even if those services would otherwise be covered by MSP. As a result, the vast majority of physicians in British Columbia are enrolled under the MPA. Subsections 18(1) and (2) of the MPA bar unenrolled physicians from billing beneficiaries more than the schedule amount for the provision of covered services if those services are provided at a publicly-funded facility. Unenrolled physicians are able to charge any amount for covered services provided at private facilities, unless the service was contracted for by the PHSA or a regional health authority.

[33] Sections 17 and 18 of the MPA control the amount enrolled physicians may charge for providing benefits under MSP. These are the means by which physician billing practices are regulated. This limits the supply of private services by making the delivery of medically necessary services in private facilities economically nonviable for enrolled physicians. Regulation also extends to the demand side. Section 45, effectively, prohibits the sale of private insurance for services that are benefits under MSP.

[34] These provisions, the ban on extra billing and the prohibition on the sale of private insurance, are the provisions the appellants say are unconstitutional. They do not explicitly prohibit private healthcare but effectively prevent the emergence of a duplicative private healthcare system in British Columbia by (1) making a private parallel market economically nonviable; (2) discouraging the emergence of a private market; and (3) making it more difficult to obtain necessary services privately: at paras. 2028, 2043.

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Wait Times and Priority Codes

[35] A key factual issue at the heart of this case is the extent to which patients are required to wait for certain scheduled surgeries and diagnostic procedures. This matters because it is the consequences (or risk thereof) of lengthy waits for medically necessary care that may engage the s. 7 interests.

[36] A key tool in British Columbia for recording wait times for scheduled surgeries is the Surgical Patient Registry (the "SPR").

[37] The Ministry of Health established the Provincial Surgical Advisory Council, which implemented the Patient Prioritization System for scheduled surgeries in 2010. The system involves the use of priority codes to provide timely care based on the severity of a patient's condition. In 2015, the system was reviewed. The judge described the objective of the review as follows:

> [1298] Participants were reminded that the purpose of this review was to establish the priority level and associated wait time target that is appropriate for each patient diagnosis/condition from the point of view of the patient. The target was described as the time beyond which patients presenting with particular diagnosis/condition could suffer negative consequences. The time frame associated with a diagnosis was described as the time within which most patients in that diagnosis group should have their surgery.
>
> [Emphasis added.]

[38] For non-emergent conditions, patients are typically referred to a specialist for consultation. The time from referral to consultation is known as "Wait One". Wait One times are only recorded for those patients who proceed to surgery. As only a minority of patients will proceed to surgery after consultation, the Wait One data is not an accurate measure of the actual Wait One times. Because of this limitation, the Wait One times in the SPR are not used to assess wait times in British Columbia.

[39] Decisions about whether to proceed to surgery are made by a surgeon in consultation with their patient. If a patient proceeds to surgery, they will also have a Wait Two time. Wait Two refers to the time between booking surgery and when surgery occurs. For each patient, the surgeon selects a diagnosis from a standardized list and assigns a priority code from 1–5. Each priority code has a

maximum acceptable Wait Two time, which is referred to as the "wait time benchmark". However, wait time benchmarks are not an absolute indicator of when a particular patient will suffer harm. Rather, benchmarks represent an estimate of when a patient presenting with that diagnosis may suffer negative consequences.

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[40] It is helpful to outline the adult priority codes in British Columbia:

a) priority code 1 requires treatment within two weeks, and is used for conditions that are acute or involve severe pain, have a risk of permanent functional impairment, feature cancer/high risk of malignancy, or are time sensitive;

b) priority code 2 requires treatment within four weeks, and is for conditions that involve severe pain or are severe/progressive, or feature cancer/suspected malignancy, or 'moderate symptoms';

c) priority code 3 requires treatment within six weeks, and is for conditions that are benign or include moderate pain, functional compromise, cancers that are slow growing or that are not malignant, or 'stable symptoms';

d) priority code 4 requires treatment within twelve weeks, and is for conditions with moderate pain or moderate/benign/stable conditions, and where malignancy/cancer is ruled out; and

e) priority code 5 requires treatment within 26 weeks, and is for non-time-sensitive conditions and conditions that are mild/stable, have a 'moderate' impact on lifestyle, or feature benign tumours/masses.

[41] Actual wait times can be compared to wait time benchmarks to assess the state of surgical wait times in British Columbia. In measuring compliance with the benchmark times, the Ministry of Health compares the 50th and 90th percentile wait times of completed surgeries against the benchmark for each priority code. For example, in 2017, the 50th percentile wait time for priority code 1 (a two-week benchmark) was 2.7 weeks and the 90th percentile was 10.1 weeks. However, it is

important to note that only limited inferences can be drawn from these statistics, as it does not capture the full distribution and raw SPR data is not in the record.

[42] There is no dispute that many patients in most surgical categories are waiting beyond the assigned benchmark. Some of those patients experience increased risk of deterioration and reduced surgical outcomes.

[43] This SPR data does not capture unscheduled surgeries including emergent procedures, but the evidence is clear that unscheduled urgent and emergent care is provided in a timely manner.

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THE TRIAL JUDGMENT

[44] At the outset, it is important to recognize the length and complexity of the trial. The trial lasted 194 days. The evidentiary record consists of tens of thousands of pages. The judge heard from multiple witnesses, including 17 patients, 36 physicians, 17 health authorities/ministerial agents, and 75 lay witnesses. The evidence of witnesses was both expert and lay. There are 590 exhibits and 40 expert reports. The evidence canvassed a wide variety of issues including the history of healthcare in British Columbia and Canada, the experience of other jurisdictions in dealing with public and private provision of healthcare, the existence, causes, and consequences of surgical wait times, the purpose and effects of the impugned provisions, the experiences of patients and professionals in British Columbia, and the potential consequences to the public healthcare system if the impugned provisions were struck down and a duplicative private system were permitted to exist. The judge had to make multiple evidentiary rulings dealing with, among other matters, the admissibility of expert evidence. This had a significant effect on shaping the evidentiary record. The judge had to evaluate and weigh the evidence, including determining the weight to attach to the opinions of different experts. He had to make findings of fact on myriad contentious issues. He had to grapple with a plaintiffs’ case that shifted during trial. He distilled all of his analysis into 880 pages of reasoning.

[45] Given that the appellants have not alleged error in relation to s. 15, our discussion is limited to the judge's ss. 7 and 1 analyses.

Deprivation of Section 7 Rights

[46] The judge applied the two-step analysis, asking whether the appellants had established a deprivation of s. 7 rights that was not in accordance with the principles of fundamental justice.

[47] The judge addressed whether the appellants had established the impugned provisions caused harm or risk of harm engaging the rights to life, liberty, or security of the person: at para. 1573. Life is engaged where waiting for care leads to death or increases the risk thereof; liberty is engaged by interference with patients' rights to make fundamental choices about their care; security of the person is engaged where waiting leads to serious physical or psychological harm (or increases the risk thereof): at para. 1633.

[48] The judge identified two evidentiary routes to showing a s. 7 deprivation: the impugned provisions caused harm or the risk thereof either to an individual claimant or to a class of persons that need not be before the court: at paras. 1636–1637. In either case, expert evidence is required to demonstrate that the provisions caused constitutionally significant harm. The judge found the threshold for engaging s. 7 rights was when the consequences of waiting become objectively serious or "clinically significant": at para. 1735, citing *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35. The appellants provided general evidence as to when wait times may become clinically significant: at para. 1639. There was no serious dispute that in most surgical categories some patients wait beyond the benchmarks: at para. 1654.

[49] It is important to keep in mind the potential deprivation of a s. 7 right is "caused by" the effect of depriving an individual of the opportunity to avoid the consequences of waiting for treatment by accessing private care. That deprivation is a consequence of the effects of the impugned provisions in inhibiting the development of a private option to those who could afford to take it. Waiting per se is not the deprivation. Rather, it is waiting beyond a certain point while being deprived

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of a private option as a result of the effects of the impugned provisions. Often in this judgment we will refer simply to wait times as a form of shorthand.

[50] In his assessment of whether the appellants established a s. 7 deprivation, the judge made findings of fact about the causes of wait times and the significance of wait time benchmarks, as summarized above. Numerous experts testified as to the effects of increased wait times on clinical outcomes. It is important to stress that the judge made findings of fact on the basis of what he had accepted as the admissible evidence before him, as well as in the face of contested evidence.

[51] One point of contention between the parties is about the scope of the claim. As this informs certain issues on appeal, particularly the s. 7 analysis in relation to the right to life, it is useful to note the judge concluded that:

> [89] … Applying the principle that pleadings ought to be interpreted generously, I nonetheless accept that the plaintiffs' claim is limited to surgical services and diagnostic services that are otherwise available in private surgical clinics.

The Right to Life

[52] While there was general evidence that waiting too long can lead to death, the judge found no evidence that waiting for care had led to the death of anyone, or had increased anyone's risk of death (some patients had died, but their deaths were unrelated to the wait time): at para. 1749. There was a consensus among the experts that urgent and emergency care was provided in a timely manner: at para. 1750.

[53] The judge concluded the evidence did not establish wait times increased patients' risk of dying: at para. 1760. He further reasoned that the right to life was not engaged because private clinics were not equipped or certified by the College to treat urgent patients: at para. 1761. The appellants challenge the finding that wait times do not increase the risk of death and, on appeal, contend that the judge erred in his conclusion that urgent cases are dealt with in a timely fashion.

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The Right to Liberty

[54] The judge found there was no evidence, nor allegation, that the impugned provisions interfered with patients' abilities to make fundamental choices about their health: at para. 1765. The MPA does not restrict a patient's choice of physician or treatment and enrollment in MSP is optional. Further, the impugned provisions do not prevent patients from purchasing private healthcare from unenrolled physicians or outside Canada. Accordingly, the impugned provisions did not engage liberty interests. The judge reiterated there was no freestanding constitutional right to healthcare (let alone private healthcare) or economic advantage: at para. 1766.

The Right to Security of the Person

[55] The appellants focused on elective and scheduled surgeries, alleging that lengthy wait times: (1) prolonged pain and suffering and the diminished quality of life associated with the underlying condition; (2) caused permanent harm that could have been avoided with timely care; and (3) caused psychological harm: at para. 1770. The judge found the appellants could establish deprivation if they proved the harm or increased risk thereof was caused by the wait or that the suffering caused by the underlying condition was prolonged or exacerbated by the wait: at para. 1779.

[56] The judge discussed several evidentiary issues regarding security of the person. He found he could not presume harm from SPR data alone, as it does not indicate the reason for delay or whether harm was suffered: at para. 1787. The judge found medical expert evidence, demonstrating that the wait times were clinically significant, was required to demonstrate harm or risk of harm (excluding psychological harm): at para. 1788. For psychological harm, he found the harm must be serious and not an ordinary annoyance, but that expert evidence was not required given its subjective nature: at para. 1804. The judge found there was no expert evidence to support claims that delayed treatment can lead to depression, addiction, violence, or self-harm: at para. 1677. However, he found that waiting

beyond a certain period of time for certain patients would put them at increased risk of physical harm: at para. 1707.

[57] The judge accepted that lengthy wait times engage the right to security of the person for some patients. He accepted that some patients suffering from non-urgent, deteriorating conditions waiting for elective surgeries do not receive care in a timely manner. Based on expert evidence and lay evidence he accepted that some patients waiting beyond their assigned benchmark for elective surgery faced increased risk of deterioration and reduced surgical outcomes: at paras. 1881–1884. He found this wait was clinically significant to their health and well-being.

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Causation

[58] The judge then turned to whether the impugned provisions denied those patients whose security interests were engaged the ability to access alternative measures in order to alleviate or avoid the risk associated with waiting beyond their wait time benchmarks in the public system. The judge found the provisions only implicitly denied patients access, distinguishing *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 [*Insite*], *Canada (Attorney General) v. Bedford*, 2013 SCC 72, and *Carter v. Canada (Attorney General)*, 2015 SCC 5, where the provisions explicitly prohibited certain activities: at para. 1903. The judge concluded ss. 17 and 18(3) limited access to private care by making it less lucrative for private clinics to provide services to MSP beneficiaries: at para. 1930. Section 45 likewise limited patients' access to timely care to which they would have had access if private insurance were available: at para. 1909. He concluded that the impugned provisions were sufficiently connected to the harmful consequences of waiting.

[59] In conclusion, the judge accepted that the impugned provisions deprived some patients of their right to security of the person by denying them the ability to access timely private medical services where the public system cannot meet the wait time benchmarks associated with the individual diagnoses assigned to them by their treating physicians: at para. 1943.

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The Principles of Fundamental Justice

[60] The judge then turned to whether this deprivation was contrary to the principles of fundamental justice because the impugned provisions are arbitrary, overbroad, and grossly disproportionate to their purpose.

[61] The judge emphasized the importance of properly articulating the purpose of the impugned provisions when assessing whether they accord with the principles of fundamental justice: at para. 1946. The major point of contention was the scope of s. 2 of the MPA, which reads:

> 2 The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay.

[62] The judge found the MPA generally, and impugned provisions specifically, had two related purposes: (1) to preserve the public healthcare system for medically necessary care; and (2) to ensure that access to necessary care is based on need and not ability to pay: at para. 1972. He rejected the appellants' interpretation of s. 2 as only referring to services within the public system: at para. 1979. He found their proposed interpretation illogical, as it would mean that necessary medical care would only be delivered without regard to ability to pay for patients who could not afford private care: at para. 1996.

[63] The judge focused on ss. 17, 18(3), and 45, finding they served to restrict the ability of enrolled physicians to render benefits privately: at para. 2028. The judge found they were not blanket restrictions but rather suppression measures aimed at discouraging the emergence of a parallel private market: at para. 2038. They had the effect of: (1) making a private parallel market economically nonviable; (2) discouraging the emergence of a private market; and (3) making it significantly more difficult to obtain necessary services privately: at paras. 2042–2043.

[64] The bedrock of the judge's principles of fundamental justice analysis was his assessment of expert evidence about how the public system would be affected by the emergence of a duplicative private system.

[65] The judge noted the evidentiary challenges in assessing the likely effects of permitting a duplicative private system. He also acknowledged the difficulty in comparing healthcare systems in different jurisdictions. He noted that healthcare systems are extremely complicated, organized on different principles, and often reflect historical and institutional evolution within particular societies: at paras. 2091–2170.

[66] The judge's analysis rested on an exacting examination of the expert opinions presented to him and the weight he placed on them. As to the connections between the public and the private systems, the judge made findings of fact based on the AGBC's submissions:

> [2277] The defendant's rationales include the broad categories and sub-categories below, as summarized by me:
>
> a) The impugned provisions facilitate equity in terms of access to necessary medical services, by preventing the following effects of duplicative private healthcare:
>
> - Diversion of resources, especially healthcare personnel, from the public to the duplicative private system which reduces capacity in the public system;
> - Unavailability of physicians operating in the duplicative private system to consult and provide other necessary care in the public system;
> - Enhanced difficulty with ensuring an adequate supply of physicians in the public system;
> - Increased difficulty with improving quality of care, including timeliness, in the public system;
> - Increased inequity where persons with the greatest medical needs and from lower socioeconomic backgrounds would not be able to access private healthcare or private health insurance (due to lack of means or pre-existing conditions) while wealthier and healthier individuals will be able to purchase preferential treatment; and
> - A lack of reduction in wait lists and wait times in the public system and a potential increase in wait lists and wait times due to a reduction in supply of healthcare providers in the public system.

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b) The impugned provisions avoid the reduction in capacity in the public system, which would occur with the introduction of a duplicative system due to:

- Overall demand for healthcare in both the private and public systems increasing; and
- Overall healthcare costs rising across the board in both systems.

c) The impugned provisions prevent the rise of costs for maintaining the same level of services in the public system, which would rise with the introduction of a duplicative system due to:

- Competition between the public and duplicative private systems over healthcare professionals;
- The need for regulation of the duplicative private system and the fact that enforcement entails significant increases in administration costs;
- Loss of federal funding under the CHA due to mandatory and likely discretionary deductions for failure to comply with the CHA criteria; and
- The effects of duplicative private healthcare on the entire healthcare system, including its capacity to respond to urgent and emergent cases as well as administer preventative healthcare programs.

d) The impugned provisions prevent the introduction of perverse incentives for physicians to prefer private pay patients and manipulate wait lists in the public system.

e) The impugned provisions prevent the weakening in public support for the public system due to uptake of duplicative private health insurance by the wealthier and healthier segments of the population.

f) The impugned provisions prevent the lower quality of care that occurs in private for-profit medical facilities.

g) The impugned provisions prevent the emergence of a parallel duplicative private healthcare system, which is unethical.

[67] The judge made several key findings related to matters on which there was agreement between the experts:

a) all healthcare systems are complicated and not easily explained (at para. 2282);

b) introducing duplicative private healthcare increases the overall demand for health services (at para. 2283);

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c) introducing duplicative private healthcare increases the overall costs for health services (at para. 2287);

d) private healthcare has higher administrative costs than public healthcare (at para. 2293);

e) private healthcare is predominately purchased by wealthier, healthier, and better educated people (at para. 2295); and

f) people largely purchase private health insurance to get faster access to healthcare services (at para. 2302).

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[68] The judge also made several findings on issues where there was significant disagreement between the experts regarding the hypothetical introduction of duplicative private healthcare in British Columbia:

a) wait times would increase in the public system (at para. 2348);

b) physicians would prioritize patients in the private system over those in the public system (at para. 2385);

c) regulation would likely be difficult given the fee-for-service model (at para. 2386);

d) resources would be diverted from the public system to the private system (at para. 2389);

e) demand for all healthcare services would increase, worsening access in the public system (at para. 2398);

f) significant additional costs would be incurred (at para. 2449);

g) there would be a real risk of losing transfer funding (at para. 2462);

h) there would be a real risk of perverse incentives and unethical conduct (at para. 2506);

i) popular support for public healthcare could be eroded, including the willingness to fund the public system through taxation (at para. 2530);

j) there would be no change in the quality of medical services (at para. 2552); and

k) price effects and increased wages for physicians would increase the price of necessary medical services (at para. 2558).

[69] These findings were made in the context of his arbitrariness analysis but they apply to a variety of issues.

Arbitrariness

[70] The judge found multiple rational connections between the provisions' effects and the MPA's purposes and, accordingly, concluded the provisions were not arbitrary: at para. 2662.

[71] The appellants argued there was no rational connection because a parallel private system was compatible with a public system: at para. 2088. The judge rejected much of their expert evidence on this point: at paras. 2019–2116.

[72] The judge also summarized the expert evidence about other jurisdictions (United Kingdom, New Zealand, Ireland, Australia, and Québec) and their experience with wait times and parallel private provision of healthcare. The point of the analysis was to determine if the experiences of other jurisdictions could illustrate that there was no rational connection between the purposes and effects of the provisions: at para. 2258. The appellants placed great weight on the experience in the United Kingdom. The judge concluded the United Kingdom experience was of limited comparative value:

> [2267] The plaintiffs in this case rely primarily on the example of the United Kingdom. Indeed, the plaintiffs have emphasized that the system they envision in British Columbia is more along the United Kingdom approach where the private health insurance market is not subject to community rating regulations but is also not heavily subsidized by the public system.

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> [2268] In my view the plaintiffs fail to fully appreciate the differences between the healthcare systems in the United Kingdom and Canada. In the United Kingdom, the public NHS plan is comprehensive and covers most healthcare services, including pharmaceuticals and dental care which are not covered under MSP in British Columbia. For this reason, and others, very few NHS beneficiaries have either supplementary or duplicative private health insurance and, therefore, competition between the private healthcare system and the NHS is limited. In contrast, supplementary private insurance in Canada is significantly more prevalent given the narrow coverage under the public plan to only medically required services. Therefore, as explained by Professor Oliver, in Canada there is a greater risk of competition between the private and public systems and the potential scope of the private insurance market is greater.
>
> [2269] Further, in the United Kingdom both financing and delivery of healthcare are public. Physicians are either NHS employees or subject to government controls over their practices through the capitation system. The capitation payment system for family doctors requires the physicians to serve a certain number of patients in their designated geographic area. Moreover, specialists are NHS employees who are subject to contractual requirements, including how much time they must devote to the public system before serving private pay patients. As discussed previously, in British Columbia and the rest of Canada, necessary medical services are publicly funded but privately delivered. Physicians are not subject to any constraints in terms of how they manage their practices. In British Columbia it is significantly challenging to regulate how physicians spend their time including how they allocate their time between the public and private systems to address problems like wait lists in the public system. And, as will [be] seen below, there is some history of doctors challenging government regulation of their activities.

[73] The judge concluded a parallel private system in the United Kingdom had a limited effect in reducing wait times: at para. 2263. He found that physicians in Ireland had preferred their private patients to the point of breaching their obligations to public patients: at para. 2265. From the judge's perspective, the introduction of parallel private insurance in Australia illustrated the risk of public practitioners migrating from the public to the private system; thereby increasing wait times: at para. 2265. Overall, the judge concluded the appellants had not demonstrated there was no rational connection between the MPA's purposes and its effect:

> [2272] Overall, I conclude that the plaintiffs have not demonstrated that the experiences in the five jurisdictions presented here demonstrate that there is no connection or no rational connection between the purposes of the *MPA* and its effects. In fact, I find that there is evidence here that supports the defendant's position that the introduction of private healthcare would

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> detrimentally affect the public system in British Columbia as discussed in some detail below.

[74] Throughout much of his analysis, the judge grappled with the appellants' contention that there was no evidentiary foundation for concerns about duplicative private healthcare.

[75] We have already summarized the principal findings of fact above, but we highlight some key findings here. Specifically, with respect to equitable delivery, most of the experts agreed that private care primarily benefits the affluent and healthy and that duplicative systems would likely exacerbate health and wealth inequality: at paras. 2615, 2626. He accepted the evidence that socioeconomic status was a significant determinant of health and that poor health status disproportionately affects low-income individuals: at para. 2655. Further, even assuming those needing the most care could afford private care, the private system deprioritizes or refuses to treat the most complex cases, creating inequity by excluding those with the greatest need: at para. 2632. The judge also found the increased demand and costs of a duplicative system would undermine equitable financing of care: at para. 2639.

[76] In summary, the judge found multiple rational connections between the effects of the impugned provisions and the objective of ensuring medically necessary care was delivered, accessed, and financed based on need and not ability to pay: at para. 2661. Consequently, he concluded the deprivation of s. 7 rights was not arbitrary:

> [2662] As can be seen above, there are multiple rational connections between the effects of the impugned provisions and the interrelated purposes of the *MPA*. Those purposes are to preserve and ensure the sustainability of a universal publicly funded and managed healthcare system where access to medically necessary services is determined on the basis of need and not the ability to pay. As above, the combined effect of the impugned provisions is, as described by the defendant, one of supressing and discouraging the emergence of a parallel duplicative private healthcare system for the financing and provision of necessary medical services to MSP beneficiaries. Therefore, I conclude that the plaintiffs have not established that the effects of the impugned provisions bear no connection to their legislative purposes.

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[2663] In terms of equity, the evidence suggests that duplicative private healthcare would create or exacerbate inequity in terms of access, utilization and financing of necessary medical care. This is because duplicative private healthcare would create a second tier of preferential healthcare services on the basis of the ability to pay.

[2664] Further, the evidence also demonstrates that there are valid concerns that duplicative private healthcare would have the effect of increasing demand for healthcare as well as overall healthcare costs while reducing capacity in the public system (among other things, due to diversion of human resources to the private system). This in turn is likely to increase wait times in the public system. In this regard, patients with lower incomes and with greater healthcare needs who would depend on the public system would be worse off as a result.

[2665] I also find that the evidence supports the defendant's contention that there are real concerns that duplicative private healthcare would create perverse incentives for physicians to prioritize private pay patients to the detriment of patients in the public system. This is amply demonstrated by the experiences in other countries. Further, the evidence from British Columbia suggests that duplicative private healthcare raises the likelihood of unethical behavior by healthcare providers as well as situations of conflict between the best interests of patients and the economic interests of their treating physicians.

[2666] With respect to the rationale of preventing the erosion of public support in the public system, I have found that the evidence is less conclusive. However, there is some evidence to suggest that a potential long-term effect of duplicative private healthcare is to undermine the willingness of individuals who would benefit most from the private system to fund the public system through taxation. While the likelihood of this result is less certain, nonetheless, it cannot be said that there is no rational basis for the defendant's concern in this regard.

[2667] On the other hand, I have found that the evidence does not support the defendant's assertions regarding the risk of diminished quality of care if duplicative private healthcare is allowed in British Columbia. The evidence from the United States certainly demonstrates there is a concern with private care and quality of care. But the evidence from British Columbia demonstrates this concern has not arisen in this province.

[2668] For completeness, I point out that I doubt Professor Kessler's proposed "main effect" of private duplicative healthcare will free up resources in the public system because I have found support for all four of his hypotheses.

[2669] The result is that the deprivation of the right to security of the person of some patients waiting for elective surgical care in the public system beyond their priority code wait time benchmarks is not arbitrary. The plaintiffs have not been successful on this principle of fundamental justice under s. 7 of the *Charter*.

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Overbreadth

[77] The judge found the provisions were not overbroad, as it was rational to restrict private insurance and extra billing to preserve a public system based on need. The appellants had argued the impugned provisions were overbroad because they prohibited physician activities that bore no connection to preserving the public system: at para. 2673. Based on other jurisdictions' experiences, the judge rejected the argument that a private system can exist without interfering with the public system and found it was rational to suppress a private system: at para. 2680.

[78] The appellants had also argued the limitations on surgeon activities after they had fulfilled all of their allotted operating room time in the public system were overbroad: at para. 2681. The judge rejected this argument, finding it ignored the MPA's objective of preserving a system based on need: at para. 2687. The provisions had evolved over decades in response to physician billing practices and were not a blanket prohibition against speculative harms: at paras. 2689–2693. The judge found that there were issues in terms of operating room availability, but that performing surgery in public operating rooms was a minority of the services provided by surgeons (the most significant service being consultations): at para. 2703. The judge also found that restricting surgeon activities beyond their allotted operating room times was rationally connected to the preservation of the public system based on need: at para. 2708.

Gross Disproportionality

[79] The judge found the provisions were not grossly disproportionate to the objective of preserving a healthcare system based on need. There was no evidence the provisions had lethal outcomes or affected patients in need of urgent care. The evidence showed that urgent patients received timely care and that the wait time issues primarily concerned patients with non-life-threatening conditions: at para. 2757. The judge found that, while some private patients experienced symptoms that were causally connected to their excess wait times, the appellants had not established that those symptoms exceeded the ordinary pain, stress, and

inconvenience experienced by all people waiting for care: at para. 2772. He concluded the wait times were not disproportionate to the purpose of the impugned provisions.

Section 1

[80] The judge concluded that, even had there been a breach of s. 7, the impugned provisions are justified under s. 1 of the *Charter*: at para. 2877.

[81] The judge rejected the argument that the analyses under s. 7 and s. 1 were effectively the same, noting two important distinctions. First, the onus is on the claimant to establish a breach of s. 7 and on the government to establish that any breach is justified under s. 1. Second, the court weighs the societal benefits and broader effects of the law on society at large against the deprivation of the claimant's rights in the s. 1 analysis and does not do so under s. 7: at para: 2887–2888.

Pressing and Substantial Objective

[82] The judge found the MPA's objectives were pressing and substantial: para. 2902. He noted that preserving and ensuring the sustainability of the universal public healthcare system, as well as ensuring that all necessary medical care is funded and delivered based on need and not the ability to pay, were legitimate government interests as well as expressions of the foundational principles underlying universal healthcare in Canada: at para. 2902.

Rational Connection

[83] The judge found there was a rational connection between the impugned provisions and their legislative objectives. He found a real risk that a duplicative private system would result in reduced capacity and increased wait times in the public system, undermining the legislative objectives of sustaining the universal public system: at para. 2904.

[84] The judge found the impugned provisions furthered the objective of ensuring that access to necessary medical services is based on need and not ability to pay by discouraging the emergence of private healthcare where access to necessary

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services is based on the ability to pay (including the possibility of “queue jumping”). He also found there was a real risk that healthcare providers would prioritize private patients at the expense of public patients if the impugned provisions were struck down: at para. 2905.

[85] Bearing in mind the high degree of deference owed to government, the judge found it rational for the government to implement policies that sought to minimize the risk of diminishing public support for the public healthcare system in order to preserve the universal public system and ensure its sustainability. He found the impugned provisions were inherently prospective and based on a risk assessment that is the prerogative of government, not the courts: at para. 2907. The judge supported his conclusion on the virtually unanimous opinions of the experts (including those of the appellants’ experts) that the introduction of duplicative private healthcare would not decrease—but might actually increase—wait times in the public system: at para. 2908.

Minimal Impairment

[86] Bearing in mind the high degree of deference owed to government in regulating healthcare, the judge found the impugned provision interfered with s. 7 rights as little as possible: at para. 2922.

[87] The appellants had argued the impugned provisions were not the least-impairing means of maintaining a viable public healthcare system in which access to care is based on need and not ability to pay. The judge found the concerns of equitable access and perverse incentives with duplicative private healthcare were supported by the evidence: at para. 2913. He, therefore, rejected the appellants’ argument, due to the fact that the impugned provisions discouraged a private system, but did not act as a blanket ban on private healthcare: at para. 2911. The impugned provisions do not prohibit enrolled physicians from providing care in private facilities, as long as they do not charge more than the MSP tariffs. Nor do they prohibit unenrolled physicians from providing private care in private facilities and charging however much they see fit.

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[88] He rejected the appellants' alternative approach as being feasible in British Columbia—an approach akin to the United Kingdom's that requires doctors to provide a minimum number of hours in the public system before being able to provide private care—as British Columbia physicians are overwhelming not employed by the health authorities or Ministry of Health: at para. 2916. Further, the judge found the evidence from other jurisdictions (including Québec with post-*Chaoulli* reforms) showed a minimum-hours regulation has been ineffective and extremely challenging to enforce: at para. 2917.

[89] The judge also noted that, even if perfectly implemented, such a regulation would not address the impact on equitable access through the creation of a private healthcare system based on ability to pay or the impact on increased wait times in the public system: at para. 2918.

[90] The judge found the respondents had shown the Legislature chose a reasonable option to address a complex social issue: at para. 2919.

Proportionality

[91] The judge found the effects of the impugned provisions to be proportional to their societal benefits of preserving the universal public system and ensuring that access to care is based on need and not the ability to pay.

[92] The appellants had argued the physical and psychological suffering and risk of death outweighed whatever benefit the impugned provisions had for the healthcare system as whole. The judge rejected this argument, finding no evidence the impugned provisions caused serious psychological suffering: at para. 2924. While there was evidence of lengthy wait times, the judge found there was no evidence that a duplicative private healthcare system would shorten wait times: at para. 2927.

[93] The judge concluded the benefits were substantial and the provisions were essential to preserving the public healthcare system and ensuring that access to necessary care is based on need and not ability to pay. He found the Legislature

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was entitled to best determine how to balance the life and security interests of all patients who have competing need for limited healthcare resources: at para. 2931.

Conclusion

[94] As a result of the foregoing, the judge dismissed the claim.

ISSUES ON APPEAL

[95] The appellants allege multiple errors of fact and law in the judge's analysis. For the most part, they accept that the judge stated the tests and principles correctly, but say he erred in the application of those tests and principles. They contend:

1. The judge erred in his analysis of s. 7 deprivations concerning:

   (a) the right to life because he:

      (i) required evidence that delay caused the death of specific patients; and

      (ii) failed to appreciate that SPR data included procedures involving risk to life that could be performed in private clinics;

   (b) the right to liberty by finding that accessing timely necessary care did not engage this right;

   (c) the right to security of the person:

      (i) by determining that harm had to be clinically significant; and

      (ii) by failing to find that any wait beyond a benchmark caused harm.

2. The judge erred in his application of the principles of fundamental justice because he:

   (a) misinterpreted the legislative objective of the MPA;

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(b) considered irrelevant factors in relation to arbitrariness (ethical concerns, political factors, theoretical concerns);

(c) misdirected himself on overbreadth by:

(i) focusing on broad societal impacts rather than the patients who were deprived of their rights; and

(ii) failing to recognize that prohibiting patients from accessing surplus surgical capacity is not connected to protecting the public system;

(d) failed to find gross disproportionality by:

(i) understating the scope and scale of harms patients suffered while waiting;

(ii) assuming suffering is an inevitable feature of a public system; and

(iii) considering the societal interest in public healthcare, which is properly addressed as part of the s. 1 analysis;

3. The judge erred concluding the impugned provisions would have been justified under s. 1. Specifically, he erred:

(a) in law by deferring to prohibitory legislation that supresses otherwise lawful conduct (the MPA);

(b) in fact and law by finding that the impugned provisions minimally impaired patients' s. 7 rights;

(c) in fact by finding that private healthcare threatens the sustainability of public healthcare; and

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(d) in mixed fact and law by failing to find that the government's funding priorities deprive patients of their s. 7 rights without promoting an offsetting constitutional right or providing a benefit, other than the equal imposition of suffering on all patients.

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[96] Although we have listed the alleged errors, we have not found it convenient to analyse them seriatim. Rather, we have addressed the broad themes in issue in a manner that encompasses the specific points raised. We begin with a discussion of the scope of the claim and the standard of review. At the outset, we address the judge's findings of fact about the systemic consequences to the public system of allowing the emergence of a parallel private system. We have addressed the deference owed to those findings early in the analysis because they inform many of the more specific issues related to the principles of fundamental justice and s. 1.

[97] We then turn to deal with issues arising in connection with s. 7, beginning with the alleged errors in the judge's conclusions about the infringements of the rights to life, liberty, and security of the person. In this context, we address the errors alleged relating to the threshold for infringement and the evidence necessary to support an infringement. We conclude by addressing the errors alleged in relation to the principles of fundamental justice, in particular the errors alleged in relation to the definition of legislative objective, arbitrariness, overbreadth, and gross disproportionality.

[98] Having concluded the judge did not err in finding no breach of s. 7 of the *Charter*, we do not separately analyse s. 1, but adopt the reasoning of our colleague, Justice Fenlon.

THRESHOLD ISSUES

The Scope of the Claim

[99] The judge treated the appellants' claim as confined in scope to those procedures which the College had authorized to be performed in private clinics. Those procedures principally consist of routine elective and scheduled day

surgeries, including orthopedic procedures such as hip and knee replacements, cataract surgery, and certain diagnostic procedures, such as colonoscopies. Accordingly, the judge's assessment of the constitutional issues focused primarily on those types of procedures. He did not focus on more complicated, emergency, or urgent procedures that cannot currently be provided in the private system: at paras. 72–90.

[100] The judge's understanding was that over the course of trial, the scope of the claim was clarified and the factual foundation was reframed. The judge described this shift as follows:

> [77] An issue arises about the scope of the medical care that is described in the plaintiffs' claim. In their Fifth Amended Notice of Civil Claim, they challenge the constitutionality of the impugned provisions with respect to the private funding and the private delivery of all medical services insured under MSP. In setting out the legal basis for their claim, the plaintiffs' state that the impugned provisions constitute an unconstitutional deprivation of s. 7 because the public system cannot provide "reasonable health care within a reasonable time."

He observed that on the face of the pleadings the claim appeared to be directed at the provision of all medically necessary services covered under MSP.

[101] The judge then said:

> [80] On Day 169 of the trial, however, the plaintiffs presented a narrower version of their claim. On that day, the plaintiffs stated that their pleadings had always limited their claim to scheduled surgeries, primarily those day surgeries that can otherwise be provided in private clinics. They acknowledged that while their pleadings expressly referred to all healthcare services, it was clear from the context of their pleadings that scheduled surgeries were the "circumstances" where wait times were unreasonable and therefore, limits on the private funding and delivery of these medical services are unconstitutional.
>
> [81] I do not agree that the pleadings imply a focus on scheduled or day surgeries alone, as the plaintiffs suggest. Indeed, as noted above, the discussion of wait times in the pleadings refers generally to both diagnostic and surgical services. Contrary to the plaintiffs' suggestion, the "circumstances" referred to in the pleadings are not limited to elective surgeries performed in private clinics. Thus, in my view, on Day 169 of this trial, the plaintiffs effectively narrowed their claim to elective day surgeries performed at private clinics.

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> [82] Then, on Day 183, during closing submissions, the plaintiffs stated that their claim concerned diagnostic and surgical services (not just scheduled surgeries). This position appears to be more consistent with the framing of their claim in the wait time section of their pleadings. The plaintiffs went on to specify that, for instance, their claim does not concern services of family physicians. Despite that being narrower than in the pleadings, this expands the scope suggested on Day 169 because it challenges restrictions on the private delivery of all surgical services and not just scheduled day surgeries.
>
> [83] With respect to the reference to diagnostic services in the plaintiffs' pleadings, this must be interpreted in the context of the specific statutory provisions they challenge. The impugned provisions do not prohibit the private delivery of diagnostic imaging services provided in stand-alone diagnostic facilities, like MRIs. There is considerable evidence of the private and legal provision of diagnostic services. The plaintiffs' claim about diagnostic services is not clear. As I understand it, surgical services with a diagnostic function, like colonoscopies, are captured in the impugned provisions but diagnostic imaging is not (2018 BCSC 1141 at para. 50).
>
> …
>
> [88] The plaintiffs' current emphasis on the experiences of private clinics in British Columbia during the last 20 years appears to reframe the foundation of their claim as suggested by their pleadings, the evidentiary record they built at trial and the arguments they made earlier in their closing submissions.
>
> [89] The above changes or clarifications in the plaintiffs' position are noted (as is the fact that no application has been made to amend the plaintiffs' pleadings). However, I conclude that ultimately the plaintiffs are bound by their pleadings as reflected in the Fifth Amended Notice of Civil Claim, filed October 17, 2018. Applying the principle that pleadings ought to be interpreted generously, I nonetheless accept that the plaintiffs' claim is limited to surgical services and diagnostic services that are otherwise available in private surgical clinics.
>
> [Emphasis added.]

[102] With respect to the judge, we conclude that he narrowed the scope of the claim more than was justified in the circumstances. It is certainly true that the framing of the claim appears to have shifted throughout the trial. It is also true that the primary focus of the case and the bulk of the evidence was about the kinds of surgical and diagnostic services currently available at private clinics.

[103] On day 169 of trial, a discussion of the scope of relief sought arose because the AGBC contended that the line of questioning of a witness suggested a narrower claim than was pleaded. The point turned on whether the relief sought involved striking down the impugned provisions in their entirety or declaring them

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unconstitutional only to the extent that they interfered with the relevant *Charter* rights. The appellants asserted that the case was exclusively focused on scheduled surgeries across all priority codes, but did not relate to medically necessary services provided by general practitioners. They did not limit the case further. There is no limitation to certain procedures or the types of procedures currently able to be performed in private clinics.

[104] In this exchange, counsel did not clarify whether diagnostic services falling within the priority codes were within the scope of the claim. This issue resurfaced in final argument on day 183, when the scope of the claim was discussed in passing. The appellants made it clear that the claim involved diagnostic procedures falling within the scope of surgical services. We can see nothing in that discussion to suggest that the diagnostic services referred to were only those otherwise available in private surgical clinics.

[105] In our opinion, the judge erred in concluding that the appellants' claim was limited to surgical and diagnostic services that are otherwise available in private surgical clinics. While that may have been a primary focus of the claim, it was not so limited. The list of procedures that can be performed at private clinics as a practical matter is not static; it depends on many factors including College approval, financial viability, and operational capacity. Presumably, the list could expand if the impugned provisions are struck down.

[106] Accordingly, we conclude the claim relates to diagnostic services and scheduled surgeries across all priority codes. As a matter of scope, it is not restricted to only those procedures currently approved by the College to be performed in a private clinic. Having said that, we recognize that whether a procedure is of a type that could in principle be performed privately is a relevant evidentiary matter in proving deprivation and causation because the case turns on the proposition that the breach arises from the denial of the opportunity for some individuals to avail themselves of treatment that would otherwise be available, but for the effects of the impugned provisions.

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The Standard of Review

[107] Another threshold issue raised by the parties in this appeal is the applicable standard of review. The appellants submit the scope and application of the *Charter* provisions are questions of law, reviewable on the correctness standard. They also say many critical findings of fact stemmed from legal error and, accordingly, are not owed deference.

[108] It is well established that errors of law are reviewed on a standard of correctness, while errors of mixed fact and law or pure fact are subject to a standard of palpable and overriding error. Moreover, a judge's assessment and weighing of the evidence, including social science evidence, is a finding of fact entitled to deference on appeal: *Housen v. Nikolaisen*, 2002 SCC 33 at paras. 22–23; *Bedford* at paras. 48–49.

[109] The primary disagreements between the parties are, first, what is the proper standard of review for factual findings that can be "traced to a legal error" and, second, what is the standard of review to be applied to the "scope and application" of a *Charter* provision?

[110] The appellants say alleged factual errors can be traced to the judge's legal error in adopting "clinically significant" as the threshold for the deprivation of life and security of the person, and that error led the judge to overlook relevant evidence. As a result, they ask this Court to review that evidence and reach different conclusions to those of the judge.

[111] The appellants also say the judge misdirected himself in the application of the law, by misconstruing which findings of fact pertained to which legal issues. Specifically, they take issue with the judge's determination that detrimental effects to the public healthcare system only needed to be established as a theoretical concern to healthcare systems generally, rather than to British Columbia's public healthcare system specifically. Accordingly, they ask this Court to review those finding to determine whether the misapprehension caused the judge to ignore material evidence or rely on irrelevant evidence.

[112] Apart from the above explanation, the appellants do not specifically identify how each of their grounds of appeal should be characterized for review purposes.

[113] The respondents submit that the appellants attempt to greatly oversimplify the standard of review analysis by advocating for correctness review of all alleged errors. The respondents contend that only two of the alleged errors of statutory interpretation are errors of law reviewable for their correctness: whether the judge (1) misinterpreted the legislative purpose of the MPA and; (2) erroneously read an objective of equitable access to all healthcare into the statutory scheme. The respondents submit that the remainder of the alleged errors are questions of mixed fact and law attracting a deferential standard of review, as the appellants allege that the application of a legal test should have resulted in a different outcome.

[114] The respondents also submit that it is not the case that findings of fact "stemming" from legal error are reviewed on the correctness standard. They say the appellants' position relies on a misinterpretation of *Housen*, which finds no support in the jurisprudence. The appellants seek to employ a subtle principle recognized in *Housen* as a sword to strike down factual findings without first having established palpable and overriding error. The respondents argue that *Housen* is clear that the application of a legal standard to a set of facts is a question of mixed fact and law warranting deference. Accordingly, the appellants' contention that both the scope and application of a *Charter* provision attract correctness review is unfounded.

[115] We acknowledge that in *Housen*, the majority stated that less deference is required where an erroneous factual finding of a trial judge may be traced to an error in the judge's characterization of the legal standard: at para. 33. But the scope of this principle is narrow. It applies where a factual conclusion is drawn on the basis of a mischaracterization of the proper legal test to be satisfied. In that case, the factual conclusion (that the individual in question was part of the "directing mind" of a company) was readily traceable to an error of law (what was required for an individual to be properly identified as a "directing mind"), which was distinct from the mixed question of law and fact (whether the facts satisfied the legal standard). The

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applicable standard of review with respect to the conclusion about being a directing mind was correctness because that ultimate factual conclusion was clearly tainted by the mischaracterization of the legal standard to be applied: *Housen* at paras. 34–36.

[116] Thus, correctness review applies where an error of fact can be clearly attributed to the application of an incorrect legal standard, the failure to consider a required element of a legal test, or some other error in principle. However, appellate courts must be careful in applying this principle, as it is often difficult to extricate the legal principle from the facts in evaluating the application of a legal standard: *Housen* at para. 36.

[117] Accordingly, if the trial judge is found to have mischaracterized the legal standard to be applied, failed to consider a required element of that standard, or committed some other clear error in principle, factual conclusions which can be clearly traced to that error may be reviewed on a correctness standard, if the legal error can readily be extricated from the application of the law to the facts. Otherwise, conclusions of mixed fact and law are subject to the more deferential standard of review. We approach our task with this framework in mind.

[118] During the course of his analysis, the judge made many findings of fact about the operation of the public healthcare system, the effects on patients of waiting for procedures, the causes of wait times, and, importantly, the likely effects of allowing a duplicative private system on the public healthcare system and the delivery of medically necessary care on the basis of need and not the ability to pay. In our view, for the most part, the judge's findings are free standing and not contaminated by legal error. They are reviewable on a palpable and overriding standard.

<u>Appellate Interference with the Judge's Findings of Fact</u>

[119] The judge made multiple findings of fact about the connections between the public provision of necessary medical care and the consequences of allowing a private healthcare option for elective day surgeries. Those findings are of critical importance to the judge's analysis of the principles of fundamental justice and

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whether the impugned provisions can be justified under s. 1. We have summarized those findings above.

[120] Consequently, we think it useful, before turning to the analysis of the remaining issues on appeal, to address whether these findings are vulnerable to appellate interference. In approaching this question, we must be mindful of the deference owed a trial judge's findings of fact.

[121] In this case, the appellants attempt to avoid many of the findings of fact about the connections between a public and private system. In some instances, they suggest the facts are contaminated by an underlying legal error. In others, they suggest that the findings are irrelevant to the true legal question. In yet other cases, they argue that the findings are plainly wrong and contrary to the evidence or that there was no proper evidentiary foundation for the conclusions reached.

[122] It is impossible to detail the specifics of these allegations here. To do so would be to lose the forest for the trees. But, in broad response to these arguments, we are persuaded that the judge's findings of fact were open to him on the record. This is particularly so in relation to the deleterious consequences for the public system and the objective of providing necessary medical care on the basis of need and not the ability to pay of permitting the development of a parallel duplicative private system. In general terms, we are not persuaded that the judge made the systematic errors alleged. In this sense, we are of the view that much of the thrust of the appellants' case amounted to rearguing the case at trial.

[123] We must not lose sight of the context in which the judge had to reach his conclusions of fact. He was faced with an extraordinary amount of expert and lay evidence. He had to determine the admissibility of expert opinion. He had to weigh, evaluate, and assess the opinions before him. He was invited to engage in a comparative analysis of a significant number of other healthcare systems in order to draw conclusions about the likely effects on the healthcare system in British Columbia of allowing a private option.

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[124] The judge's analysis is canvassed over hundreds of pages and displays meticulous attention to detail. Most importantly in our view, the judge made findings about the weight he could place on certain experts' opinions and made findings in relation to contested issues that were responsive to the issues presented by the parties. In particular, the judge broadly accepted expert evidence that the development of private healthcare would be detrimental to the provision of the same procedures within the public system, as well as on the provision of necessary medical care on the basis of need and not the ability to pay.

[125] The judge's conclusions also rested on the rejection of the opinion evidence provided by the appellants' principal expert (Professor Kessler) on these issues. The appellants argue that the judge erred in his rejection of that evidence. But the fact is that the judge gave detailed reasons for his rejection. The appellants have not made a concerted effort to demonstrate that those conclusions rest in some way on legal error. Rather, they suggest that the judge was wrong to exclude certain expert and other evidence or to give it little weight. This amounts to rearguing the case at trial. It is not our task to reweigh the evidence or revisit the judge's rulings on the admissibility of certain evidence in the absence of a clear allegation of error.

[126] Moreover, in our view, as a general proposition, the findings of fact about the connections between a public and private system and the possible effects of permitting a duplicative private system are not dependent on, or contaminated by, legal principle. They are freestanding findings about purely factual questions that can be applied to resolve the legal issues. As a result, the question to be addressed in this section is whether the critical findings rest on palpable and overriding error. We shall address the question whether the findings were properly applied to the relevant legal question later.

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Effects of a Duplicative Private System on Public Healthcare

[127] A useful summary of the judge's critical findings regarding the potential effects of a parallel private system is found in his discussion of arbitrariness:

> [2663] In terms of equity, the evidence suggests that duplicative private healthcare would create or exacerbate inequity in terms of access, utilization and financing of necessary medical care. This is because duplicative private healthcare would create a second tier of preferential healthcare services on the basis of the ability to pay.
>
> [2664] Further, the evidence also demonstrates that there are valid concerns that duplicative private healthcare would have the effect of increasing demand for healthcare as well as overall healthcare costs while reducing capacity in the public system (among other things, due to diversion of human resources to the private system). This in turn is likely to increase wait times in the public system. In this regard, patients with lower incomes and with greater healthcare needs who would depend on the public system would be worse off as a result.
>
> [2665] I also find that the evidence supports the defendant's contention that there are real concerns that duplicative private healthcare would create perverse incentives for physicians to prioritize private pay patients to the detriment of patients in the public system. This is amply demonstrated by the experiences in other countries. Further, the evidence from British Columbia suggests that duplicative private healthcare raises the likelihood of unethical behavior by healthcare providers as well as situations of conflict between the best interests of patients and the economic interests of their treating physicians.
>
> [2666] With respect to the rationale of preventing the erosion of public support in the public system, I have found that the evidence is less conclusive. However, there is some evidence to suggest that a potential long-term effect of duplicative private healthcare is to undermine the willingness of individuals who would benefit most from the private system to fund the public system through taxation. While the likelihood of this result is less certain, nonetheless, it cannot be said that there is no rational basis for the defendant's concern in this regard.
>
> [2667] On the other hand, I have found that the evidence does not support the defendant's assertions regarding the risk of diminished quality of care if duplicative private healthcare is allowed in British Columbia. The evidence from the United States certainly demonstrates there is a concern with private care and quality of care. But the evidence from British Columbia demonstrates this concern has not arisen in this province.

[128] In our view, all of these findings were open to the judge on the evidence. All of the AGBC's experts and a number of the appellants' experts (Professor McGurran, Professor Blomqvist, and Nadeem Esmail) agreed that the introduction of private finance would not reduce public system wait times. A more contentious

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question was whether a private option would increase wait times in the public system.

[129] The judge found that the preponderance of evidence suggested a link between duplicative private healthcare and increased wait times in the public system. This conclusion was based on the judge's review of the evidence of several experts: Professor Hurley, Professor Gillespie, Dr. McMurtry, and Dr. Turnbull. Their evidence was supported by literature and empirical studies (many of which were peer reviewed), and it was subject to extensive cross-examination at trial. He accepted that the evidence did not go so far as to establish causation, but in his view causation, in the sense of conclusive proof, was not the standard:

> [2330] As a starting point there is considerable evidence and literature that, where there is duplicative private healthcare, physicians reduce their time and efforts in the public system. This in turn leads to increases in wait times for care in the public system. I note that the experts for the defendant (Dr. Hurley, for example) acknowledged that the empirical evidence on this point does not establish a causal connection between duplicative private healthcare and an increase in wait times in the public system. However, causation is not the standard and, in my view, the preponderance of the evidence demonstrates a strong link between the two.
>
> [2331] Professor Hurley opined that duplicative private healthcare insurance, especially when dual practice is allowed, would likely cause a reduction of capacity in the public system (due to diversion of human resources to the private sector) which in turn would likely increase wait times in the public system. Dr. McMurtry opined that while the evidence on the effects of parallel private healthcare does not establish a casual link with increased wait times in the public system, the evidence does show a strong correlation between duplicative private healthcare and increases in wait times in the public system.

[130] In our view, the judge's conclusions were open to him on the evidence. The fact that there was not conclusive proof of causation does not undermine the judge's assessment of the likely consequences of permitting duplicative private healthcare. As the judge observed, there are "no definitives in health policy": at para. 2282. It is the nature of the subject matter that there will not be clean and unequivocal methods of measuring and predicting causes and effects within the healthcare system: at para. 2322.

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[131] At the heart of the judge's conclusion that permitting duplicative private care would have detrimental consequences for the public healthcare system, is his rejection of the opinion evidence of Professor Kessler. Professor Kessler had opined that a duplicative private system was compatible with the public system, would not be harmful to it, and indeed the "main effect" of introducing private insurance would be to "free up" resources in the public system unless certain hypotheses were true:

> [2319] Professor Kessler opined that the introduction of duplicative private healthcare in British Columbia will "free up" resources in the public system and that would be the "main effect" of introducing private health insurance in British Columbia. In his report of March 15, 2014, Professor Kessler approached the issue this way (responding to a question from counsel for the plaintiffs):
>
>> Question 2: What would be the likely consequences of allowing private financing and dual practice [footnote omitted] in BC on the well-being of those who continue to receive publicly-financed care?
>>
>> In my expert opinion, the likely effect of allowing private financing and dual practice in BC would be to improve the well-being of those who continue to receive publicly-financed care. *The main effect of allowing private financing and dual practice would be to free up resources in the public system.* As long as some privately-financed patients would have been treated in the public system in the absence of private finance, *private financing will expand the amount of care that can [be] provided to the patients who remain.*
>>
>> In order for this to be incorrect, at least one of the following hypotheses must be true:
>>
>> - Allowing private financing will stimulate demand for publicly-financed care so much that it outweighs the main effect;
>> - The effort of physicians or other clinicians in the publicly-financed system will be reduced by private financing or dual practice so much that it outweighs the main effect;
>> - Increases in the availability of privately-financed care will change voters' political preferences for taxation and thereby reduce willingness to pay for publicly-financed care; or
>> - There is some other mechanism through which private financing, dual practice, or some combination will reduce the availability of publicly-financed care.
>>
>> There is no persuasive empirical support for any of these hypotheses. Evidence that is claimed to support them is at best equivocal, and in general flawed, irrelevant, or actually supportive of the opposite hypothesis. I discuss each of these hypotheses in turn.
>
> [Underlining in Professor Kessler's report; italics added by the trial judge.]

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[132] The judge, however, determined that he could give Professor Kessler's opinions no significant weight because there was evidence in support of each of the four hypotheses. The judge concluded that Professor Kessler assumed the truth of his main effect and then relied on the suggestion that there was no, or not sufficient, evidence to rebut it. The judge then gave further explanation of why he could not give any significant weight to Professor Kessler's evidence. It is worth setting that out here because the appellants rely heavily on Professor Kessler's evidence, suggesting that it deserves more weight:

> [2327] There are other problems with Professor Kessler's evidence I will address briefly here (some of these are discussed by the other experts, Professor Hurley in particular):
>
> a) I assume Professor Kessler applied his expertise in choosing the four hypotheses he poses but he did not explain how they were chosen. We do not know, for example, why the other issues discussed below are not among his hypotheses.
>
> b) Professor Kessler discussed his four hypotheses as individual factors, and there is no consideration of their combined effect. Professor Hurley pointed out that even modest effects across the four hypotheses can have a cumulative and detrimental effect that could offset the main effect.
>
> c) Professor Kessler assumed in his report and evidence that the four impugned provisions were absolute prohibitions on duplicative private healthcare, but that is not the case. Specifically, ss. 17 and 18(3) do not constitute absolute prohibitions of dual practice. Rather, they restrict enrolled physicians from imposing fees in excess of the MSP rates. Further, the *MPA* does not prevent unenrolled physicians from providing private surgical care in private clinics at whatever rate they deem appropriate.
>
> d) Some of the studies cited by Professor Kessler find that his hypotheses are in fact supported by empirical evidence. And it is not clear why these studies do not rise to the level of either being "persuasive empirical evidence" or outweighing the main effect. In cross-examination, Professor Kessler accepted that there were negative effects of duplicative private healthcare and he clarified his position to say that the evidence does not establish a clear causal connection between duplicative private healthcare and his hypotheses. However, this qualification of his opinion is absent from his report.
>
> e) We do not know the particulars of the resources that would be freed up in the public system in Professor Kessler's construct. Presumably it would be of a type and quantity that would increase the number of surgeries able to be performed in the public system. As discussed elsewhere, the resourcing of healthcare is a

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complex (and imperfect) mix of human, capital and administrative resources. For example, as above, we know that the introduction of duplicative private healthcare would increase demand for public care as well as increase its costs. It is unclear from Professor Kessler's evidence at what point the increase in demand and costs would outweigh the assumed main effect.

f) Professor Kessler appears to only have considered elective surgeries in the public system and assumed that there is a direct link between the numbers of surgeries that are performed in the public system and those that can be performed in the private system. However, he failed to consider the effects of duplicative private healthcare on the public healthcare system as a whole, including the effects on surgical emergencies and non-surgical care.

g) With respect to equity, Professor Kessler opined that introduction of duplicative private healthcare will not undermine equitable access to healthcare as long as private pay patients would have otherwise been able to obtain that care in the public system. However, that seems to me to be beside the point because those who can afford private healthcare would be able to obtain faster care in the private system, thus creating inequity in access to medically necessary care. Presumably, those with less need would be able to be treated in the private system faster than those with greater need who would be treated in the public system.

h) Finally, as above, Professor Kessler's conclusion that the introduction of duplicative private healthcare would free up resources in the public system and reduce wait times stands alone. At least with respect to whether wait times would decrease, even the plaintiffs' other experts disagree with Professor Kessler.

[133] The appellants also go beyond suggesting that Professor Kessler's opinions should have been given more weight. They argue there was no empirical evidence that duplicative private care would reduce physician supply and increase wait times in the public system and that the judge, in accepting Professor Hurley's evidence on this point, misconstrued and ignored key elements of Professor Hurley's evidence. They cite the following passage of Professor Hurley's expert report:

> I am unaware of any empirical evidence regarding the magnitude of the potential effects of expanded private-sector practice opportunities on the supply of active physicians in Canada (or elsewhere)….
>
> Therefore, the predicted impact of expanded private-sector practice opportunities associated with duplicative private insurance on total physician labour supply is ambiguous.

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[134] The appellants omit that Professor Hurley was referring to total supply (public and private physician hours) when he said the relationship was ambiguous. Professor Hurley went on to say:

> Three unambiguous predictions, however, are that compared to the current situation with limited opportunities for private practice, expanded private sector opportunities following the introduction of duplicative private insurance will:
>
> - Cause the hours devoted to direct patient care in the private practice to increase;
> - Cause the hours of direct patient care in the public sector to decrease;
> - Cause the hours devoted to non-patient care professional activities to decrease.
>
> [Emphasis added.]

[135] Later, Professor Hurley noted that "these studies support the conclusion that dual practice and higher-earnings potential in the private sector would lead to a reduction in hours of practice in the public sector by dual-practice physicians and at best a small increase in total hours of work". He agreed that correlations as proof of causation must be viewed skeptically, but went on to cite a study that found a causal (not merely correlative) relationship. Professor Hurley further noted that Professor Kessler had failed to cite key studies, and Professor Hurley concluded that "the underlying concern that the introduction of duplicate [private health insurance] may increase public-sector wait times is a valid concern." The appellants' criticisms are unfounded.

[136] Another key conclusion, challenged on appeal, is that striking down the impugned provisions would increase healthcare costs in the public system. The judge explicitly found:

> [2402] As can be seen above, there is little disagreement that the overall demand for healthcare, public and private, and the overall costs of healthcare, public and private, would increase with the introduction of duplicative private healthcare.
>
> …
>
> [2404] Further, given my findings that duplicative private healthcare would increase demand for healthcare, it is not surprising then that duplicative private healthcare also leads to increased costs overall. Indeed, as noted

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> above, there is relative consensus among the experts that duplicative private healthcare increases overall costs. I discussed above the evidence of Professors Kessler, McGuire, Blomqvist, Dr. Hsiao and Mr. Esmail in this regard. Dr. Hsiao referred to a number of studies which conclusively show that private health insurance leads to increases in administrative costs. Likewise, Dr. Turnbull cited several studies which show that private healthcare is associated with significantly higher administrative costs.

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[137] The judge's conclusion that costs would increase depended on his assessment of a variety of factors. These included increased demand for unnecessary healthcare services, increased competition between the public and private sectors for a limited supply of specialized healthcare professionals, increased administrative and regulatory costs, and the potential loss of federal funding: at paras. 2402–2465.

[138] The judge also concluded that a material increase in healthcare costs to sustain the public system could lead to service cuts in the public system. It would be difficult to predict how those cuts might be implemented and what services might be affected. Nonetheless, this conclusion illustrates potential consequences for the public system if a duplicative private system were permitted. The findings of fact underlying these conclusions were available to the judge on the evidence before him and we see no basis to intervene.

[139] The judge also identified that striking down the impugned provisions created a risk of perverse incentives and unethical conduct that could induce physicians to direct patients away from the public into the private system. He found:

> [2506] … I find that the evidence relating to the practices of the private clinics and some enrolled physicians over the last 20 years suggests that the risk of perverse incentives and unethical conduct is real and significant. Moreover, the fact that the legislative restrictions did not stop some physicians from engaging in unlawful provision of necessary medical services further underlies how difficult it would be to implement and enforce regulations against this kind of behavior in the event that duplicative private healthcare is allowed.

[140] The appellants dispute this conclusion, suggesting that it is unsupported by the evidence and is unfair. They suggest practitioners can be relied on to act ethically, putting the patients' interests first.

[141] The appellants also criticize the judge's conclusion that striking down the impugned provisions could have the effect of undermining political support for the public system. They say that conclusion is speculative and not properly supported by the evidence. The judge explained his reasoning as follows:

> [2517] The reasoning behind this rationale is that the sustainability of the public healthcare system depends on the pooling of resources from the wealthy and healthy as well as the poor and ill in the same system. If large numbers of the wealthy and healthy, those who make less claims, take up private health insurance or seek private healthcare then their willingness to fund a public system that does not benefit them to the same extent would diminish. Eventually they may wish to reduce their contributions to the public system, which would lead to a weakening of the public system.

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[142] The judge's conclusion was rooted in expert evidence and studies testing the proposition that political support for public care might be affected if more affluent citizens could avail themselves of private care. The judge assessed those studies and opinions and reached a conclusion that was open to him on the evidence. We note that this is yet another issue where the judge was asked to reach conclusions about the potential consequences of striking down the impugned provisions. This is an inherently difficult exercise since it involves weighing a complex constellation of factors to reach an informed judgment rooted in the best evidence available. Reaching these conclusions is the responsibility of a trial judge. The nature of the challenge is formidable. But it cannot be said the judge's conclusion was speculative or unsupported by the evidence. For example, the judge observed:

> [2524] The unique features of the Canadian healthcare system make it difficult to infer directly from the experiences of other jurisdictions regarding what would be the degree of erosion of public support for the public system as a result of the introduction of duplicative private health insurance. Nonetheless, Professor Marmor opined that a parallel private system in Canada, given its current arrangements, can be expected to lead to erosion of support, not strengthening of it. Professor Marmor did not argue that such a result is demonstrated by the experience of other nations. Rather, he argued that such an expectation is reasonable on the basis of obvious financial incentives and the struggles other nations have faced in restraining privileged access to medical care for patients with private insurance.
>
> [2525] Professor Oliver's evidence is consistent with Professor Marmor's evidence in this regard. He opined that in the United Kingdom, wide spread erosion of public support for the public system has not been observed. However, he noted that this is likely because of the very limited scope of

> private healthcare and the very expansive coverage of the NHS. He added that if the parallel private system was more expansive the risk of erosion of public support in the public system would likely be greater.

[143] It is possible that another finder of fact would not have reached the same conclusions on the same body of evidence. However, we are not persuaded that the overall conclusion that the existence of a private system would create risks of perverse incentives rises to the level of a palpable and overriding error. In our view, this does not amount to an overriding error because, in the scheme of his analysis overall, it is a relatively minor factor. The judge's ultimate conclusions about the detrimental impact of permitting duplicative private care would be unaffected by removing this portion of the analysis in its entirety.

[144] We have set out this factual analysis at some length because it demonstrates the care with which the judge assessed the evidence. We can see no proper basis to interfere with these conclusions. In our view, the appellants have not offered any basis on which appellate interference could be justified.

Effects of a Duplicative Private System on Meeting Medical Need

[145] Most of the factual findings we have discussed to this point relate to the impact of striking down the impugned provisions on the public healthcare system itself. The findings are relevant to the evaluation of the impugned provisions in relation to the narrower purpose of the MPA advocated by the appellants. However, the judge also made important findings of fact about the effect of the duplicative private system on the provision of necessary medical care on the basis of need and not the ability to pay.

[146] In making findings of fact on this question, the judge adopted the language of the "healthy and wealthy" which we do not find particularly helpful. Nonetheless, the findings made by the judge are important and, in our view, were open to him on the evidence. Broadly speaking, the appellants' criticism of the judge's findings on this point (apart from their argument that these equitable concerns do not form part of the purpose of the MPA) is that scheduled surgical procedures would be more

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affordable and available to a much greater proportion of the population than the judge acknowledged.

[147] The judge made an evidence-based conclusion that those who are relatively wealthier, healthier, and more educated are more likely to purchase private insurance: at paras. 2295–2301, 2578. He also found that purchasing private care tended to provide shorter wait times and higher quality care. He had a considerable body of social science evidence before him that supported his conclusion that a parallel private system would reduce equity. He said the following:

> [2656] To conclude, I find that there is a rationally based risk that the introduction of duplicative private healthcare in British Columbia would have a direct negative impact on equitable access to necessary medical services. This includes equity in access, equity in utilization, equity in finance and equity in health and socioeconomic outcomes. The introduction of duplicative private healthcare would create a two-tier healthcare system where preferential treatment can be purchased either directly or through private insurance. That would discriminate against the poor and the ill. There is evidence that health outcomes are associated with income and permitting duplicative private healthcare would only exacerbate existing health inequities.
>
> [2657] I also reject the plaintiffs' propositions that these harms could be significantly mitigated by regulating duplicative private healthcare. I find that it is highly questionable whether such regulations are effective, as demonstrated by the experiences in other countries. And, in any event there are significant cost consequences to such regulations which would only create new problems of equitable access to healthcare, and preserving and ensuring the sustainability of the universal public system.
>
> …
>
> [2660] The expert evidence, including the evidence about other countries, is that access to preferential timely medical services would be based on the ability to pay rather than need. There is also good reason to be concerned about other consequences such as increased demand and costs in the public system, reduced capacity and an increase in wait times in the public system, that may further the inequitable divide between the public and private systems. Also, because private medical facilities treat the less complex medical conditions, patients with the greatest medical needs, including urgent and emergent cases, would be worse off as a result of the reduced capacity in the public system.

Pent-Up Demand

[148] As part of their effort to displace the judge's findings of fact, the appellants contend the expert consensus was, all else being equal, that private care would free

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up resources in the public system. In other words, permitting a parallel private system and dual practice would benefit the public system. For example, this would increase effective demand by allowing “pent-up demand” to be expressed—people who otherwise would have been dissuaded from seeking care because of long wait times would seek care in the public system in response to the private system siphoning off some patients. They argue that this effect reflects excessive wait times in the public system; accordingly, the appellants submit it is irrational for the government to restrict private care on this basis that allowing private care would increase overall demand for healthcare.

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[149]   There are a number of weaknesses in this position. First, the judge found that a parallel private system would not have the effect of freeing up public resources because “all else” is not equal. The evidence, save that of Professor Kessler, was that public resources would not be freed up if duplicative private care was introduced: at para. 2346. The judge’s rejection of Professor Kessler’s evidence is detailed above and need not be repeated. The judge concluded:

> [2342] From the above evidence, I conclude that there is a strong connection between duplicative private healthcare and increases in wait times in the public system… The leading explanation for this is that the increase in wait times is the result of duplicative private healthcare increasing demand, while at the same time reducing capacity in the public system (by diverting human resources to the private system among other things).

[150]   Second, the appellants’ position also relies on physicians having excess capacity that they do not have the opportunity to use in the public system. This argument was rejected by the judge. Theoretically, if surgeons had excess capacity, then private surgical care could be increased without a corresponding decrease in the services provided by physicians in the public system. As the judge rejected the theory that surgeons have excess capacity (based on his finding that most of their time is spent on consultation), we see no basis to interfere with the judge’s findings regarding a lack of excess physician capacity.

[151]   The judge undertook a detailed analysis of the evidence to explore whether the public system would benefit if dual practice were to be permitted. That analysis

involved assessing a number of studies and the evidence of experts. Part of that analysis is found at paras. 2346–89. We can see no proper basis to interfere with the conclusions the judge reached.

Complementary Services

[152] Complementary services include follow ups and post-surgical therapy. The appellants contend that increased demand for complementary services in the public system is not a rational basis on which to prohibit private insurance. They argue this “complementary demand” is not a consequence of a private system, as the service would have had to have been met if the surgery had been done in the public system. They say a duplicative private system would simply advance the timing of demand for that care. They argue there was no evidence that existing resources could not accommodate an increase in complementary care such that the timeliness or quality of public care would be impaired.

[153] In our opinion, this argument reworks the position rejected by the judge that excess surgeon capacity could be more fully utilized if the restrictions of private care were eliminated. As with the submissions on pent-up demand above, the argument that there was no evidence that increased demand for complementary services would increase wait times relies on physicians having unused surgical capacity. As we see no basis to interfere with the judge’s finding regarding excess capacity, we, accordingly, see no basis to find that a lack of evidence regarding the system’s inability to accommodate increased complementary demand affects the judge’s conclusions regarding the likely effect of introducing duplicative private care.

Summary

[154] The judge was required to make far-reaching findings about how a parallel private system for scheduled surgeries would affect the public healthcare system. Those findings underpinned and were foundational pillars of his constitutional analysis. We do not think that the appellants have demonstrated a basis for us to interfere with those findings. They were open to the judge, despite the fact that another judge might have drawn different inferences and reached different

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conclusions. Being persuaded that these findings are not based on reversible error, we must accept and apply them in our analysis of whether the judge committed any error of law in his constitutional analysis. We now turn to that task.

SECTION 7: LIFE, LIBERTY, AND SECURITY OF THE PERSON

Introduction

[155] As is apparent, this case is inspired by the Supreme Court of Canada decision in *Chaoulli*. In that case, the Supreme Court struck down a prohibition in Québec on private healthcare insurance for medically necessary services. Three judges found the prohibition breached s. 7 and could not be saved by s. 1. Three judges found the prohibition did not breach s. 7. The deciding judge analysed the case under the Québec Charter. It is common ground that the decision does not have a binding effect with respect to the issues in this case, in part because it has no majority decision in respect of s. 7, and the evidentiary record in this case is different. It is also clear that the s. 7 test relied on by those judges who found a breach of s. 7 has since evolved in more recent cases. This is particularly so in relation to the arbitrariness analysis.

[156] Section 7 provides:

> Everyone has 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.

[157] Demonstrating a violation of s. 7 is a two-step process. First, the claimant must show "that the law interferes with, or deprives them of, their life, liberty or security of the person": *Carter* at para. 55. The jurisprudence treats life, liberty, and security of the person as three distinct sets of rights, although in some cases it may be appropriate to consider liberty and security of the person together: *Carter* at para. 64.

[158] If successful at the first stage, the claimant must then show that the deprivation is not in accordance with the principles of fundamental justice, including that the law it not arbitrary, overbroad, or grossly disproportionate. Principles of

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fundamental justice are legal principles for which there exists sufficient consensus that the principle is fundamental to our societal notion of justice, and that are capable of being identified with precision and applied in a manner that yields predictable results: *R. v. Malmo-Levine*, 2003 SCC 74 at para. 114.

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[159] The judge concluded that the impugned provisions did not deprive patients of the right to life or liberty, although they did deprive certain individuals of the right to security of the person: at paras. 2790–2795.

[160] We think the judge erred in some aspects of his s. 7 analysis. First, the judge made a legal error in his conclusion about the evidence necessary to establish a deprivation of the right to life. Second, the judge underestimated the number of patients who were deprived of security of the person by operation of the impugned provisions. Third, while the judge misstated the threshold for deprivation of a s. 7 right, that error had no material impact on his conclusion. We do not think he made the other errors alleged by the appellants.

[161] We begin our analysis with the right to life. Certain of our commentary about the evidentiary basis for finding a deprivation of the right to life is applicable also to the judge's analysis of the right to security of the person. We attempt to point out where that is so.

The Right to Life

[162] The appellants contend the judge erred in concluding the impugned provisions did not deprive patients of the right to life. They say that conclusion rested on a series of errors. First, the judge erred in finding that a risk of death must be "clinically significant" to engage s. 7. Second, he made a palpable and overriding error in finding that the public system provided timely care in urgent and emergent situations, which were scheduled but nonetheless life threatening. As a result, they say he failed to give effect to his own finding that waiting too long can lead to death. Third, the judge erred in requiring proof that the risk of death was increased for particular patients. Finally, the judge erred in rejecting expert evidence establishing that the risk of death is increased by waiting.

[163] The judge correctly identified the test for a deprivation of the right to life. The judge acknowledged that the right to life was engaged "where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly": *Carter* at para. 62. Moreover, the right may be engaged currently or prospectively. Further, although related to the nature of causal connection, the following is important:

> [1630] One distinguishing feature of the subject claim, compared to *Morgentaler,* is that the plaintiffs here are not alleging that the impugned provisions of the *MPA* cause wait times and they are, therefore, the source of the alleged harm. Instead, they rely on the framework in *Insite*, *Bedford* and *Carter* to argue that the impugned provisions deny patients access to treatment outside the public system which would otherwise alleviate or prevent the harm of lengthy waits. In this regard, the plaintiffs' claim here is different from the one in *Morgentaler*. However, as discussed below, I find that this difference is only relevant in determining whether there is a sufficient causal connection between the physical and psychological harm from waiting for care and the impugned provisions in this case. The fact that the impugned provisions do not cause wait times is irrelevant at the first stage of the deprivation test.
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> …
>
> [1634] If the evidence establishes that unreasonable wait times for necessary medical care in the public system cause harms or risk of harms that engage life, liberty or security of the person, then the plaintiffs still have to demonstrate a sufficient causal connection between these harms and the impugned provisions of the *MPA*. In other words, as discussed in *Bedford*, the evidence must show that the impugned provisions sufficiently cause the unavailability of more timely, private alternatives for care outside the public system to patients as a means of avoiding the harm of unreasonable wait times.
>
> [Emphasis added.]

[164] Before turning in more detail to the alleged errors, it is helpful to set out what the judge had to say about the two routes for proving deprivation. As we noted above, the judge identified the two routes to prove deprivation of a s. 7 right. The judge explained:

> [1636] Ultimately, as the cases discussed above illustrate, there are two potential evidentiary paths to making a successful s. 7 claim. The first is on the basis of evidence relating to the individual claimant (as in *Carter* and *Blencoe*). Where claimants frame their case in this way they need to prove the alleged harm (including questions of causation) through admissible evidence that specifically concerns their individual circumstances. Where the alleged harm involves a medical condition, such as whether waiting caused

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> physical harm like a reduced surgical outcome, then expert medical evidence will be required about causation in the individual case.
>
> [1637] The second evidentiary path is to establish that a class of persons, even if not personally before the court, are at risk of suffering harm as a result of the challenged law or state action (as in *Morgentaler* and *Chaoulli*). In cases involving medical issues, such as the subject claim, expert evidence is required on the question of when waiting becomes clinically significant and creates a risk of suffering harm for some groups of patients. The assertion of harm by a patient is not sufficient since it is not clinically based. Here we have the considerable, generalized evidence about wait times and expert evidence explaining when clinically significant harm arises. The evidence of individual patients is also relevant on this second path. Together, this evidence demonstrates that a class of patients is likely at risk of suffering harm from waiting. For the individual plaintiffs the question is whether their individual circumstances make them a member of this class.
>
> [1638] Both these options are equally valid and, more importantly, they are not mutually exclusive. Indeed, in *Carter* there was evidence relating to the individual claimants, namely Ms. Taylor and Ms. Carter, but also generalized scientific evidence that enabled the court to infer that other unidentified persons with grievous and irremediable medical conditions were also suffering or were at risk of suffering physical and serious psychological harm due to the prohibition on assisted suicide.

[165] The judge's ultimate conclusion that the appellants had not established a deprivation of the right to life rests on a number of different strands of reasoning to which we will return. At this stage, it is worth noting that these reasons include conclusions about the need for expert evidence about the consequences of waiting (both individually and statistically), findings about the public system response to emergent and urgent care, the scope of the claim, and whether private alternatives would otherwise exist in the absence of the impugned provisions.

[166] The judge required either: (1) expert evidence showing a causal link between delay and harm for a specific patient; or (2) generalized evidence that there is a class of patients subjected to excessive wait times and expert evidence that those wait times can lead to constitutionally significant harm for a class of patients.

[167] The appellants argue that specific claimants are not required to prove their individual rights were engaged after it has been established that at least some patients (even if not before the court) are suffering harm from excess wait times.

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[168] We agree that it is not necessary for a claimant to prove that a particular identifiable individual with an excessive wait time caused by the impugned provisions experienced an increased risk of death. We agree that the existence of admissible expert evidence identifying a class of persons for whom the excessive wait times caused increased risk of death is sufficient to make out deprivation.

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[169] The judge did not err in his articulation of this requirement. Although the judge accepted that statistical evidence could not identify particular individuals, he also clearly rejected the argument that the claim had to be proven in respect of specific individuals before the court: at para. 1603. However, we agree with the appellants that there is some ambiguity in the judge's analysis, particularly in respect of whether he required identification of an individual patient whose right to life was engaged: see e.g., at para. 1745. We do not think the judge required that such an individual be before the court (as the appellants suggest) either as a claimant or as a patient witness. It is less clear whether he thought that some individual evidence was necessary.

[170] The judge concluded that an individual whose rights were breached did not need to be before the court through a discussion of the jurisprudence, including *Chaoulli*, *Insite*, and *Bedford* (at paras. 1581–1586, 1591–1592). He summarized the law as follows:

> [1602] As will be seen, I have found that the right to security of the person under s. 7 of the *Charter* for two of the patient plaintiffs has been engaged. This is on the basis of their individual circumstances, generalized evidence of wait times and expert evidence about the clinical significance to patients of waiting beyond the time that corresponds with their priority codes/benchmarks. Those findings address the defendant's submission that the court must find at least one of the plaintiffs suffered harm from the effects of the impugned provisions of the *MPA*.
>
> [1603] I add that it seems to me that the defendant's submission on this point is not consistent with the authorities. As I read them (in particular, *Morgentaler*, *Insite*, *Heywood* and *Bedford*) a deprivation of the s. 7 interests of persons not before the court may be inferred from generalized evidence.
>
> [1604] The cases include a number of examples of this. In *Morgentaler* the Supreme Court of Canada referenced "thousands of Canadian women who have made the difficult decision that they do not wish to continue with a pregnancy" (at p. 56). There is also a comment that the challenged provision

> of the *Criminal Code* "threaten[s] women" and "interferes with a woman's bodily integrity" (at p. 56) And the court concluded that the appellants had standing to challenge an unconstitutional law "if they are liable to conviction for an offence under that law even though the unconstitutional effects are not directed at the appellants per se ..." (at pp. 56, 57 and 63). The dissent in *Morgentaler* (McIntyre, La Forest JJ.) pointed out that physicians were not directly involved with the challenged provision. Therefore, "[t]here [was] no female person involved in the case who [had] been denied a therapeutic abortion". This made the claim a "hypothetical" one in the sense that there was no claimant before the court who had established that she had suffered physical or serious psychological harms (at pp. 133, 150).
>
> [1605] In *Insite* the Supreme Court of Canada asked whether the challenged legislation "engages or limits the s. 7 rights of *Insite* staff and/or clients" (at paras. 86, 94). In *Bedford* the court referenced harm to "prostitutes", "street prostitutes" and "people engaged in a risky -- but legal - activity", not merely the activities of the applicants (at paras. 60, 65-67, 71-73). And in *Carter* the court referenced the rights of one of the applicants "and of persons in her position" (at para. 56) as well as "others suffering from grievous and irremediable medical conditions" (at para. 70).
>
> [1606] Finally, in *Chaoulli* the claimant, Mr. Zeliotis, could not prove that he suffered any harm as a result of waiting (and there were serious problems with the reliability of the evidence of the other plaintiff). Nonetheless, it was accepted that the plaintiffs in that case had "a sufficient interest" in the constitutional issues in the case (at paras. 186-188). Similarly, the minority judges stated that "[s]ome individuals that meet this test [for psychological harm] are to be found entangled in the Quebec health system. The fact that such individuals do not include the appellants personally is not fatal to their challenge" (at para. 204). I accept that those statements are of limited application because, unlike the plaintiffs in the subject claim, the plaintiff in *Chaoulli* had public interest standing.
>
> [1607] Overall, as can be seen from cases such as *Bedford* and *Insite* the approach in s. 7 cases seems to be to consider the impact of harms beyond the actual claimants. I am proceeding on the basis that the plaintiffs can rely on evidence of the experiences of others in the public healthcare system as part of their claim. Ultimately, where a party with sufficient interest challenges the constitutionality of a law, the question is whether the evidence as a whole demonstrates that the impugned provisions deprive at least one patient of their right to life, liberty or security of the person.

[171] The judge said this about the deprivation of security of the person, which bears also on the right to life analysis):

> [1798] With respect to the wait time data and general expert evidence on the effects of wait times, I conclude that when combined with evidence of individual circumstances this evidence can establish a deprivation of s. 7 rights. This expert evidence about the effect of wait times need not relate specifically to any of the individual patients who gave evidence at trial. <u>If the wait time data, along with the expert evidence on the general harms of wait</u>

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> times, enables the court to conclude that some patients wait a clinically significant time, such that their wait increases the risk of physical or serious psychological harms, then a deprivation of security of the person may be established.
>
> [Emphasis added.]

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[172] Thus, to prove a claim using the second evidentiary path, the judge concluded that expert evidence must establish what would constitute clinically significant harm to enable the court to infer the existence of a class of persons whose rights are engaged (who need not be before the court).

[173] After setting out this evidentiary threshold, the judge concluded the appellants had not provided relevant admissible expert evidence of an increased risk of death in relation to the plaintiffs or the patient witnesses: at para. 1749. Accordingly, they failed to prove their case through the first path.

[174] As to the second path, the appellants attempted to prove that the right to life was engaged by excessive wait times caused by the impugned provisions, principally through the opinion of Professor Kessler. On appeal, they contend that the judge erred in rejecting Professor Kessler's evidence, along with the evidence of a number of other witnesses and experts which they say established that lengthy wait times increase the risk of death. They say that some of the witnesses were appropriately qualified to provide the relevant opinion evidence and that, in any event, lay evidence was sufficient.

[175] The judge ruled that Professor Kessler was not qualified to give the opinions offered in his report and gave it no weight: at para. 1082. Similarly, he excluded portions of the report of Alistair McGuire. The appellants tendered the report of Dr. Matheson to replace Professor Kessler's evidence. The judge gave it no weight: at para. 1147. He gave detailed reasons for doing so, including that Dr. Matheson did not have the relevant expertise and had failed to refer to studies that contradicted his conclusions: at paras. 1147, 1667. The judge preferred the evidence of the government's expert, Dr. Guyatt, on this point.

[176] He also concluded the appellants had not proven a deprivation of the right to life in the aggregate by means of admissible expert evidence: at para. 1756. The judge provided an extensive analysis of the evidence, setting out which evidence was admissible, the weight assigned to each piece of evidence, and his findings of fact. We do not think it is appropriate to revisit these evidentiary rulings on appeal. To do so would require us to reweigh the evidence. We owe deference to the judge's findings of fact and are not persuaded that his evaluation of admissible evidence constituted a palpable and overriding error.

[177] However, we do think the judge erred in law in his evaluation of the evidence. In our view, he did not give effect to his own findings of fact, particularly in relation to the significance of the wait times for scheduled surgeries for patients assigned priority codes 1 and 2.

[178] As we have noted, those codes are assigned to time-sensitive cases and where patients present with life-threatening conditions. The risk of death and the potential increased risk of death resulting from waiting beyond the benchmark is inherent in the assignment. When combined with the judge's conclusion that the impugned provisions have the effect of inhibiting the development of a duplicative private system that would otherwise be available, it seems to us that it follows that the increased risk associated with waiting and the elimination of the option to avoid that risk entails an infringement of the right to life, based on an increased risk of death.

[179] In our opinion, the judge erred in not giving effect to a compelling inference that at least one patient faced an increased risk of death as a result of waiting beyond the applicable benchmark. The judge made a legal error in requiring further expert evidence to demonstrate that patients assigned to priority codes 1 and 2 faced an increased risk of death by reason of waiting beyond the benchmark. This extra step in the evidentiary chain is legally unnecessary given the findings the judge had already made about the consequences of waiting beyond the applicable

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benchmark. In our view, the appellants had discharged their burden to demonstrate an infringement.

[180] A deprivation of a s. 7 right can be made out in respect of only one person, who need not be before the court. Thus, if a compelling inference is that wait times beyond the benchmark increases the risk of death for some patients assigned priority codes 1 and 2, the question is whether we can conclude that, on the judge's findings of fact, no one faced an increased risk of death, despite being assigned to these priority codes (in other words, whether the class of patients has been reduced to zero). As we shall see, we do not think the judge's reasons and findings support his conclusion that no patient experienced an increased risk of death.

[181] Here we examine the conclusions the judge reached about the significance of wait times. The judge broadly accepted the evidence of Dr. Masri about the purpose of the priority codes. In creating those codes:

> [1323] … the provincial government and health authorities expressly intended to design a system that would be used by physicians in the diagnostic process of their individual patients. Dr. Masri explained this in his evidence:
>
> > ... we were instructed to come up with prioritization codes for a bunch of diagnoses for all of surgery ... and the benchmark to our mind was the maximum acceptable wait time for those patients. In other words, patients should not wait beyond X, and that was the benchmark ...
> >
> > ...
> >
> > So the maximum acceptable wait time is the time beyond which patients are potentially harmed, physically, psychologically, medically, whatever.
>
> [1324] He explained that the objective was to make the benchmarks "patient centric as opposed to physician-centric" and the groups had to think of it from the point of view of patients. Indeed the evidence is that the priority codes and corresponding wait time benchmarks were established as a way of assessing what wait time is "appropriate for each patient diagnosis/condition from the point of view of the patient". The discussion did not settle on a specific number but the idea was that about 95% should have their surgery done within the specified time as part of the clinical judgment about the status of a patient.
>
> [1325] Dr. Masri explained that the benchmarks were based on the best scientific evidence available at that point in time regarding when waiting increases the risk of deterioration and reduced surgical outcomes.

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[182] While the judge identified limitations on the inferences that could be drawn from the fact that some patients wait beyond the benchmark wait time, nonetheless, he concluded that:

> [1334] On the other hand, I find that, in the absence of clear wait time guarantees, the British Columbia prioritization codes and corresponding wait time benchmarks reflect what can be considered a "reasonable time" in any given case. I reach this conclusion because unlike the pan-Canadian benchmarks, the priority codes and corresponding wait time benchmarks are integrated in the individualized diagnostic process of each patient. These benchmarks are patient centric and represent the qualified treating physician's individual assessment of each patient based not only on the patient's general diagnosis group but also on the totality of their medical history, their mental and emotional state and their social and personal circumstances. In other words, these wait time benchmarks are an integral part of how physicians triage patients in British Columbia.
>
> …
>
> [1364] In summary, it can be taken from the defendant's SPR wait time data that significant numbers of patients waiting for a number of different procedures are waiting beyond the established provincial wait time benchmarks that correspond to their diagnostic priority code…
>
> …
>
> [1367] These explanations for delays in surgery are real and noteworthy. However, as I explain below, there is no dispute that at least some patients who are willing, able and ready to undergo surgery have to wait beyond the established wait time benchmarks that correspond to their diagnostic priority code assigned by their treating physician. Indeed, the defendant acknowledged that despite the best efforts of government and the health authorities to reduce wait times, some patients wait beyond what they should for surgery due to excess demand on the public healthcare system. As discussed in my analysis of the first stage of the plaintiffs' s. 7 claim, this situation has affected some of the individual plaintiffs.
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> ...
>
> [1650] The British Columbia priority codes and corresponding benchmarks are both a diagnostic and administrative tool. Physicians use the priority codes and corresponding benchmarks in order to reflect the level of urgency of a particular patient's condition. The priority code assigns to each patient the appropriate timeframe within which his or her surgery ought to be completed in order to avoid an increased risk of deterioration or long-term harms. This is an important part of the triaging process and, in many cases, the end of that process (but subject to being changed if necessary).

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[183] As a general proposition, the judge accepted that waiting beyond benchmarks can have adverse consequences for patients:

> [1610] The harm alleged by the plaintiffs here is not speculative. As will be seen, there is strong statistical generalized evidence that large numbers of patients are not provided with medically necessary services in the time periods mandated by their diagnoses. Further, there is expert evidence that shows that for some types of medical conditions waiting beyond these benchmarks is associated with increased risk of physical harm, including reduced surgical outcomes. At a very general level the plaintiffs must be correct that some patients have experienced (and others will in the future experience) harms due to waiting for medically necessary services.
>
> …
>
> [1707] By way of a summary of the expert evidence with respect to wait times, I conclude that in some cases waiting for surgery beyond the assigned priority code benchmark prolongs pain and suffering, reduces mobility, functionality and quality of life and increases the risk of reduced surgical outcomes.

[184] However, this conclusion does not encompass increased risk of death. It is useful then to turn to certain types of scheduled surgeries or diagnostic procedures which, in our view, respond to inherently life-threatening conditions.

[185] The judge discussed the evidence about wait times for various procedures and the fact that many patients are waiting beyond the benchmarks assigned by their treating physicians.

> [1358] As of the first quarter of 2018, 85,468 British Columbians were waiting for medically necessary or publicly funded surgeries. Of these, 35,335 patients, or 41.3%, had already waited longer than the applicable priority code.

[186] We begin with his general analysis focused principally on priority codes 3–5 which we acknowledge do not involve life-threatening conditions. We do so as a prelude to examining those pertinent to the right to life, but also to give some indication of the extent to which the judge has potentially reduced the size of the class of persons for whom waiting may infringe their s. 7 rights.

[187] The judge presented some specifics about the distribution of these wait times, focusing on orthopedic procedures: at paras. 1657–1658. For knee replacement, the

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90th percentile wait time was 61.3 weeks in 2009 and 2010; 42.2 weeks as of 2014. For anterior cruciate ligament (ACL) repairs, the 90th percentile wait time was 60.9 weeks in 2009 and 2010; 42.6 weeks as of July 2014. For a meniscus repair, the 90th percentile wait time was 46.1 weeks in 2009 and 2010; 36.3 weeks in 2013 and 2014. For the diagnosis “Knee – Ligament Dysfunction - Severe Constant Pain Or Constant Functional Deficit, Imminent Threat To Role Or Independence,” with a maximum acceptable wait time of six weeks, the 90th percentile wait time in 2017 was 23.7 weeks. In 2017, only 46.3% of patients with that categorization received their surgeries within the six-week maximum. For a more severe diagnosis, “Knee – Ligament Dysfunction – Severe Pain And/Or Urgent Impairment/Disability, Immediate Threat To Role Or Independence – E.G. Collapse Femoral Head, Avn,” with a maximum acceptable wait time of four weeks, the 90th percentile wait time in 2017 was 16.2 weeks and only 44% of patients received their surgeries within the four-week maximum.

[188] We acknowledge that these statistics relate to conditions that are not obviously life threatening, but a similar story can be told about patients falling within priority code 1 where conditions are more obviously life threatening. Stepping back for a view of the higher-level statistics: in the first quarter of 2015, 72.1% of patients who had been assigned priority code 1 were waiting beyond the maximum acceptable wait time of two weeks: at para. 1360.

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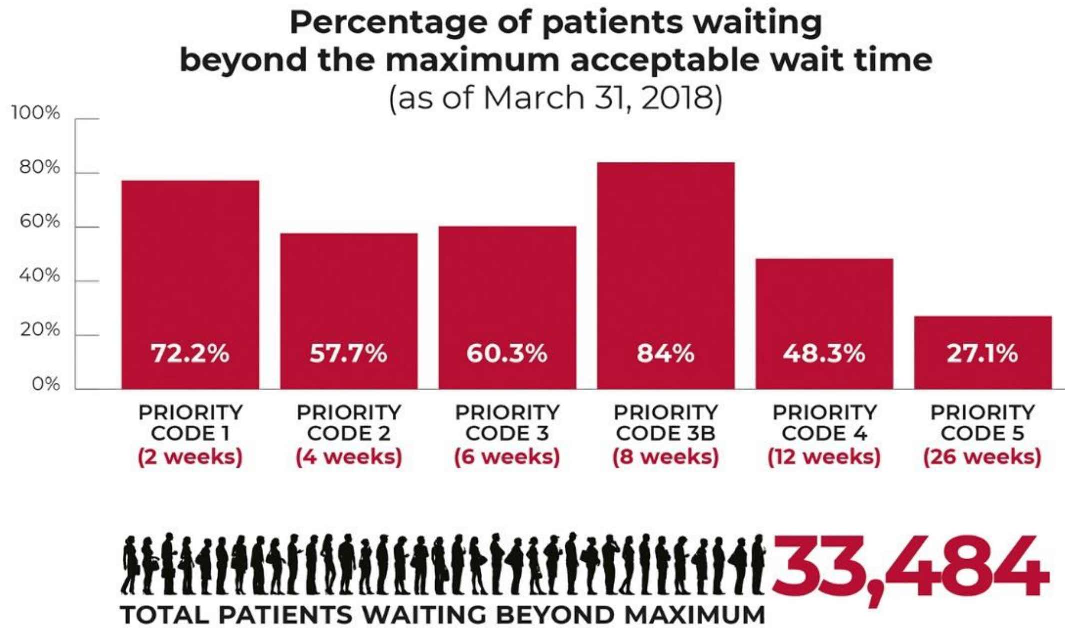
[189] As of March 2018, 33,484 adult patients were waiting for necessary medical care beyond the maximum wait time for their particular priority code. This is graphically illustrated by this figure drawn from the appellants' factum:



[190] We reiterate the seriousness of the medical conditions included in at least priority codes 1 and 2:

- priority code 1: patients have severe pain or acute conditions, risk of permanent functional impairment, tumour/carcinoma/cancer/high risk of malignancy, or time sensitivity; and
- priority code 2: patients have severe pain or severe/progressive condition, tumour/carcinoma/cancer/suspected malignancy, or "moderate symptoms".

[191] We acknowledge that the figures contained in the table may not be completely accurate, but they are illustrative of the extent of the wait time problem in general and for potentially life-threatening conditions in particular.

[192] Generally, the judge concluded that the SPR data are a reliable indicator of the typical wait time for each priority code: at para. 1664.

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[193] It is clear from the priority code 1 and 2 data that many patients are waiting beyond the applicable benchmarks for diagnostic or surgical procedures that are necessary to respond to life-threatening conditions. Given the underpinnings of priority code 1, it is inescapable that, all other things equal, waiting beyond the benchmark increases the risk of death for those patients. The same could be said for at least some patients assigned priority code 2. Yet, the judge did not draw this inference. He provided a battery of reasons why this conclusion did not follow.

[194] In our view, the inference can only be avoided if waiting beyond the benchmark does not increase the risk of death for any patient. For the reasons that follow, we conclude that factors identified by the judge may reduce the number of persons whose right to life is engaged, but they do not reduce the number to zero.

[195] The judge also recognized the existence of at least some general evidence that waiting too long can lead to death:

> [1749] There is generalized expert evidence that waiting too long can lead to death, as one might expect at a very general level. However, there are no examples in the evidence where waiting was clinically significant such that it led to the death of anyone or increased the risk of death…

[196] This generalized evidence, so far as we can determine, appears to have been provided by Dr. Guyatt in cross-examination when he acknowledged generally that waiting for certain kinds of care may increase the risk of death. He referred specifically to the treatment of leaking aortic aneurysms and some cancers, where delaying treatment would be dangerous. While the former would presumably require emergent, unscheduled surgery, the latter class of cases would include some scheduled procedures falling within the claim. This lends some further support to the conclusion that the impugned provisions deprive some patients of the right to life.

[197] The critical paragraph in the judge's reasoning on the right to life is:

> [1756] Here there is no expert medical evidence that a particular patient's condition may develop into an urgent or emergent condition <u>or</u> expert evidence that patients at a critical priority level are suffering wait times that place their lives at risk. Indeed, as above, the evidence is the opposite. Therefore, it is simply not possible to accept the plaintiffs' speculation that perhaps some patients whose wait times are recorded in the SPR data might

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> deteriorate to a state where they may die. As I have previously discussed, the statistical wait time data does not and cannot indicate whether a particular patient's life has or will be put at risk.
>
> [Emphasis added.]

[198] In our view, the judge's errors can be identified in this paragraph. We accept the points made in the first sentence; namely, that there was no expert medical evidence about particular patients or statistical evidence of the kind described. However, the judge erred in treating the possibility of deterioration increasing the risk of death as merely speculative. That conclusion is a compelling inference, rooted in the facts the judge had found. Moreover, given those inferences, it is not necessary to identify any particular patient whose life has been or will be put at risk. The judge recognized this elsewhere in his analysis. All that is necessary is that at least one patient's risk of dying increased.

[199] Respectfully, in our view, the judge made a legal error in requiring expert evidence in addition to the SPR data. That data is based on a clinical diagnosis and assessment of the appropriate length of time a patient should wait for a procedure. Thus, embedded in the statistics are necessary medical judgments about the point beyond which patients may deteriorate. For patients with inherently life-threatening conditions, this includes the point beyond which the risk of death will increase.

[200] As we read the judge's reasons, there are essentially five considerations underpinning his conclusion that the right to life was not engaged. We would summarize them as follows:

a) *Scope of the claim*: The primary focus of the claim—elective surgeries—do not address life-threatening conditions;

b) *Clinical significance*: There was no evidence that waiting was so clinically significant that it led to the death of anyone or increased the risk of death. Any deaths that occurred were unrelated to wait times;

c) *Urgent and emergent care*: Urgent and emergent care is timely and excellent in British Columbia;

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d) *Triaging*: There was no expert evidence that a non-urgent condition may develop into an urgent or emergent one; and

e) *Unavailability of private alternatives*: Private clinics are not equipped to treat urgent or emergent conditions, so these patients fall outside the scope of the claim.

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[201] In our view, none of these considerations ultimately support the judge's conclusion. As we have already observed, expert evidence that wait times place lives at risk for patients assigned priority codes 1 and 2 was unnecessary given the judge's findings of fact.

[202] Additionally, the judge had concluded that there was a lack of expert evidence that non-urgent conditions may develop into urgent or emergent ones. In our view, this is insufficient to show that the class of patients is reduced to zero. The life-threatening nature of at least some of the conditions identified in priority codes 1 and 2 is such that waiting inherently carries the risk of death. The judge's conclusion that wait time benchmarks are a useful proxy for the threshold at which waiting is clinically significant, coupled with his conclusion about the implications of waiting beyond the relevant benchmark, compels the inference that waiting too long increases the risk of death. Moreover, the absence of expert evidence that waiting led to the death of any particular patient does not address the question whether those waits increased any patient's risk of death. The risk of death can, as we have noted, be inferred from the wait time data alone.

[203] We now turn to deal with certain of the other considerations referred to by the judge.

Scope of the Claim

[204] We have already expressed our disagreement with the judge's view that the claim was limited to elective surgeries of the kind that could otherwise be performed in a private clinic. It may be true that the claim was primarily focused on procedures of that kind, typically orthopaedic procedures, but the claim is not limited to that

focus. It includes diagnostic and surgical procedures that are capable of being scheduled and which fall within every priority code.

[205] It may be the case that most procedures for which patients wait beyond the applicable benchmark are not life threatening and, therefore, the patient's right to life is not engaged. But some procedures which fall within the claim do involve life-threatening conditions.

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Clinical Significance

[206] The appellants argue that the judge imposed too high a threshold for determining whether a s. 7 deprivation was established. The judge relied on a "clinically significant" threshold, based on his conclusion that this threshold was endorsed in *Chaoulli* where it is said:

> 123 Not every difficulty rises to the level of adverse impact on security of the person under s. 7. The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged. Access to a waiting list is not access to health care. As we noted above, there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care. Where lack of timely health care can result in death, s. 7 protection of life itself is engaged. The evidence here demonstrates that the prohibition on health insurance results in physical and psychological suffering that meets this threshold requirement of seriousness.
>
> [Emphasis added.]

[207] Before us, the appellants submit that it was an error to interpret "clinically significant" as the threshold for the invocation of s. 7 rights. The appellants are correct that the judge read this paragraph of *Chaoulli* incorrectly. The threshold set in this analysis is "seriousness". In the healthcare context, this means a serious impact on "a condition that is clinically significant to their current and future health". That is not to say that the judge's analysis here is totally undermined. It is not. The appellants must still demonstrate a serious physical or psychological impact to engage the rights to life and security of the person.

[208] In the context of a systemic claim of constitutional invalidity of the impugned provisions, the provisions fall only if they cause or increase the risk of serious harm to persons in British Columbia in respect of their asserted s. 7 rights (and further, only if contrary to the principles of fundamental justice). In the context of that question, it does not appear critical or even necessary to define with precision the actual point in fact when a serious impact occurs.

[209] However, it is not apparent that the judge's misreading of the threshold from *Chaoulli* has a material impact on the constitutional analysis. It is not clear whether there is any real difference between "clinical significance" and "seriousness". As we read *Chaoulli*, "clinical significance" is a measure that can assist courts in identifying serious impacts. If there is a difference, it is far from obvious how to articulate it and any consequences it might have on the subsequent constitutional analysis. At most, if "clinically significant" sets a higher threshold, it may reduce the size of the class of patients experiencing an increased risk to life or other deprivations. But, with the record available to us, it is difficult if not impossible to evaluate the extent of significance of that consequence. As a result, we conclude that this error is of little consequence to the ultimate outcome of the case and has relatively little impact on the important aspects of the analysis.

[210] We note further that the judge accepted that provincial wait time benchmarks are a useful proxy for the threshold to be used for determining "seriousness", because they are premised on an individualized clinical assessment of each patient's condition: at para. 1736. Since our analysis is predicated on the judge failing to draw the necessary inferences from waiting beyond the applicable benchmark, this ground of appeal is of no material significance.

Urgent and Emergent Care

[211] This brings us to the judge's reasoning that the right to life was not engaged because of the timeliness and quality of urgent and emergent care: at para. 1752. Here, although we do not agree with the appellants that the judge materially misapprehended the evidence, his findings do not address the circumstances of

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persons whose medical conditions are not immediately life threatening (in the sense that they require unscheduled emergency care) but who suffer nevertheless from life-threatening conditions that require scheduled treatment. In this analysis, the right to life is not only implicated where the risk of death is immediate and high. It is also implicated when the risk exists but is more remote. As a result, the judge's reasoning does not lead to a result that empties the class of persons falling within the claim to zero.

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[212] The appellants submit the judge made a palpable and overriding error when he found that the public system provided timely care for emergent and urgent care, noting the judge extensively cited this finding in his reasons to justify his conclusion that the right to life was not engaged. They argue the judge conflated emergency and urgent procedures when concluding both are unscheduled procedures. However, the appellants submit that urgent cases involve life-threatening conditions with a non-immediate threat to life for which surgery can be scheduled and recorded in the SPR data. They submit priority code 1 cases include urgent conditions, citing the definition of priority code 1 as involving "time-sensitive" conditions. With this conflation, the judge wrongly concluded that patients who are at risk of dying do not wait beyond the maximum acceptable time, when in fact the majority of priority code 1 patients wait beyond the benchmark time.

[213] In order to set this issue in context it is necessary to examine how the judge treated urgent and emergent care. He said:

> [1186] In prioritizing patient care, medical needs are roughly classified under three categories: urgent, emergent and elective. Urgent and emergent refer to situations that pose threat to life or limb if not treated within a matter of hours or days. Some physicians use urgent and emergent to mean different situations and some use the terms synonymously. These patients are not included in the SPR data, discussed above and below. Elective surgeries are still medically necessary, but can be performed weeks or months without imminent jeopardy to life or limb. These surgeries are recorded in the SPR data.

[214] Here it seems to us the judge is drawing a distinction between unscheduled cases (urgent or emergent) and those cases that can be scheduled (whatever their

priority code). As discussed, the claim is limited to scheduled procedures. The judge then went on to evaluate evidence related to urgent and emergent cases:

> [1187] There is broad consensus amongst the experts that patients with urgent and emergent needs are provided timely care in British Columbia.
>
> [1188] For example, Professor McGurran, who gave evidence on behalf of the plaintiffs, stated in his expert report that if a patient's condition "becomes an emergency, it will be treated accordingly, without delay". He confirmed in his *viva voce* testimony that "on the acute care side of things when you've got an urgent case it's dealt with really well, really effectively."
>
> [1189] Dr. Lauzon, one of the plaintiffs' physician witnesses testified that in his experience physicians are "able to do a good job accommodating the urgent cases". He described "urgent" cases as those where there is a significant chance that the patient's health will seriously deteriorate in the short term. Likewise, Dr. Dvorak, another witness for the plaintiffs, testified that "I think we do a good job caring for the urgent and emergent patients in my practice." Further, "we take great care of the emergent/urgent patients, best anywhere in the world, no question in my mind, and I've travelled the world and I know."
>
> [1190] Dr. Penner likewise testified that if a patient has an urgent problem, the patient is treated immediately. Dr. Smith stated in his expert report that "individuals who are critically ill, both medically and psychiatrically, usually receive excellent and timely healthcare". He also testified that, with respect to his own practice, he can treat urgent patients without delay.
>
> [1191] Experts for the defendant also agreed that urgent needs are properly addressed in the public system. Dr. McMurtry testified that "the studies that I'm familiar with across Canada show that generally speaking that the response to emergencies and emergency surgery is good in Canada."
>
> [1192] The experiences of individual patients who gave evidence at trial also demonstrate that urgent and emergent cases are treated in a timely fashion.
>
> …
>
> [1196] The result is that the plaintiffs' allegation of untimely medical care cannot be sustained against patients in British Columbia who require urgent or emergent care in British Columbia.

[215] Thus, the judge treated patients with a serious risk of deterioration in the short term as urgent or emergent. He does not use this terminology when discussing scheduled surgeries that are otherwise included in the SPR data.

[216] These findings of fact, insofar as they are relevant, were open to the judge. Further, he did not fail to recognize the nature of cases assigned priority code 1 or 2 or fail to recognize that they are urgent or time sensitive even though they can be

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scheduled. What he says later must be read in this light. When dealing with this issue in the right to life section, the judge reasoned:

> [1748] As above, the right to life is engaged when a law or state action imposes death or the threat of death, directly or indirectly. The evidence is that medical conditions which entail a risk to life or limb are classified as urgent or emergent. Elective or scheduled surgeries (the primary focus of this claim) for conditions like joint replacement or cataracts are distressing for patients but they are not urgent or emergent and, as Dr. Masri pointed out, they are not life-threatening.
>
> …
>
> [1750] I have set out above the evidence about urgent and emergent care in British Columbia. There is a strong consensus amongst the physicians and experts who gave evidence in this case that urgent and emergent medical needs, where there is risk to life or limb, are treated in a timely manner. This includes the experts of the plaintiffs: Professor John McGurran and Dr. Derryck Smith. Dr. Smith, a psychiatrist, testified that "individuals who are critically ill, both medically and psychiatrically, usually receive excellent and timely healthcare". The lay evidence from physicians testifying for the plaintiffs was the same: Drs. Jean Lauzon, Marcel Dvorak and Murray Penner. For the defendant Dr. Robert McMurtry testified "urgent" cases, where there is a significant chance that the patient's health will seriously deteriorate in the short term, are addressed within hours or days at the most. He also testified that "the response to emergencies and emergency surgery is good in Canada."
>
> …
>
> [1752] Overall, the evidence demonstrates that when patients face risk to life or limb they are provided with timely and high quality care in British Columbia. This may be the reason that there is no evidence that wait times were clinically significant in the death of patients in British Columbia.
>
> [1753] Nonetheless, the plaintiffs claim that the SPR wait time data reveals that even patients with urgent needs are experiencing lengthy and unreasonable wait times for surgical services. They refer to wait time data which shows that some patients with conditions that may develop into emergent or urgent situations, such as cardio-vascular disease or cancer patients, wait beyond their wait time benchmarks. In my view, this is a misinterpretation of the evidence.
>
> [1754] First of all, the SPR wait time data does not include urgent and emergent cases because these surgeries are not scheduled as in cases of elective surgery. They are performed as in-patient procedures at publicly funded hospitals. As such, no conclusions can be drawn from the SPR data with respect to wait times for urgent and emergent surgeries.
>
> [1755] In addition, as discussed above, the SPR wait time data does not provide any information about the causes of wait times. For example, it is not known whether any particular cancer patient is waiting because of lack of capacity in the system or because of co-morbidities. And there are some

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> procedures related to cancer treatment that are not urgent or emergent with the result that there can be a medical justification for waiting for treatment.
>
> [1756] Here there is no expert medical evidence that a particular patient's condition may develop into an urgent or emergent condition or expert evidence that patients at a critical priority level are suffering wait times that place their lives at risk. Indeed, as above, the evidence is the opposite. Therefore, it is simply not possible to accept the plaintiffs' speculation that perhaps some patients whose wait times are recorded in the SPR data might deteriorate to a state where they may die. As I have previously discussed, the statistical wait time data does not and cannot indicate whether a particular patient's life has or will be put at risk.

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[217] The judge was aware of the appellants' claim that the risk of death was increased for some patients assigned priority codes 1 and 2. He rejected that argument, however, by noting that urgent and emergent cases are not scheduled, and, therefore, are not captured by SPR data: at para. 1754. Insofar as this finding relates to patients facing an immediate risk to life (e.g., urgent or emergent as the judge uses the terms), this is not in error.

[218] In our view, the judge failed to recognize that some procedures for life-threatening conditions are scheduled and assigned priority codes 1 and 2. If these procedures are not performed in a timely manner, the patients will experience an increased risk of death.

[219] There are a number of problems with these conclusions, but they do not stem from the error the appellants allege. The judge recognized the distinction between priority codes 1 and 2 and scheduled procedures and does not conflate them with urgent and emergent conditions. He did not err in concluding that non-scheduled, emergent cases do not establish the appellants' case because they are addressed in an efficient and timely fashion, provided those cases are not the result of deterioration in the condition of patients assigned to priority code 1 or 2. The judge found no expert evidence of patients progressing to urgent or emergent while waiting for care (at para. 1756) and there is no basis for this Court to interfere with that result.

[220] However, we think the judge erred in his analysis as it applied to patients assigned priority codes 1 and 2. The claim is not limited to only non-life-threatening

elective surgical procedures. The inference that waiting for care for life-threatening conditions increases the risk of death is clear from the wait time data. The fact that some waiting results from unknown causes such as co-morbidities and could be beneficial does not mean that all are. Indeed, the fact that a patient has been assigned a priority code, on the judge's findings, suggests that they are ready for and should undergo the scheduled procedure within the applicable benchmark time. As we shall see, some life-threatening conditions are treatable in private clinics. Others are only available in the public system because the impugned provisions inhibit physicians from offering them in a parallel private system.

[221] In our view, although the judge's analysis of urgent and emergent care does not fall for the alleged errors, it is insufficient to displace the conclusion that there are urgent, scheduled cases where long waits increase the risk of death.

[222] With respect to patients assigned priority codes 3–5, the judge concluded that the appellants had not proven deprivation of the right to life for a number of reasons: at paras. 1748–1761. First, any unscheduled surgeries are performed as in-patient procedures at public hospitals, so the provisions are not the cause of any harm. Second, wait time data does not explain the cause of delay. For example, some cancer patients wait while their co-morbidities are addressed. Hence no conclusions can be drawn from the wait time alone. Finally, the judge found the suggestion that waiting causes an increased risk of death was speculative, due to the absence of relevant expert evidence for these priority codes. We would not interfere with his conclusion with respect to these patients because the record does not allow us to conclude that they experienced an increased risk of death.

Triaging

[223] A critical finding of the judge was that doctors triage their patients and, as a result, reallocate them to different priority codes depending on any changing medical needs: e.g., at para. 1759. This, as the judge understood it, mitigates the risk of patients developing life-threatening complications while waiting for care. While no doubt an important consideration, the judge did not make findings that would allow

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us to say that every patient whose wait time had the potential to increase their risk was reallocated to an appropriate priority code to avoid that risk. The appellants had discharged a burden to show that some patients faced an increased risk of death, and the findings about triaging do not rebut that conclusion entirely.

[224] Again, these findings allow us to conclude the number of patients who experienced an increased risk of death was reduced but not eliminated.

Unavailability of Private Alternatives

[225] The judge reasoned that there was no deprivation of the right to life because there were no private alternatives for addressing life-threatening conditions, as these procedures must be performed in public facilities. The judge stated:

> [1761] I also note that, even if this was not the case, these types of medical conditions cannot be treated at private surgical clinics but only at publicly funded hospitals. Private clinics are not suited to treat these situations nor are they certified by the College of Physicians and Surgeons to perform these kinds of surgeries. Put another way, regardless of the effects of the impugned provisions of the *MPA*, physicians would not be able to offer urgent or emergent surgical services privately. Thus, it cannot be said that there is a sufficient causal connection between the impugned provisions and the unavailability of urgent or emergent surgical services outside the public system.

[226] We make two points here. First, there was indeed evidence that some conditions for which delayed treatment or diagnosis would engage the right to life can be dealt with at private clinics. The judge listed the types of diagnostic and surgical services performed at Cambie Surgeries (at para. 370):

> a) Pediatric dental surgery: extractions and restorations.
>
> b) General surgery: diagnostic colonoscopy (for cancer); procedural colonoscopy for polyp removal, excision of skin lesions/soft tissue lesions and lumps; diagnostic gastroscopy; laparoscopic surgery such as cholecystectomy; hernia repair, breast surgery, including mastectomy for cancer.
>
> c) Gynecological surgery: cystocoele and rectocele repair, laparoscopic procedures including ovarian cystectomy (removal of cysts from ovaries).
>
> d) Interventional pain: nerve blocks (for serious, debilitating pain).
>
> e) Neurosurgery: lumbar discectomy, laminectomy, anterior cervical discectomy with fusion (all spine surgery).

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f) Ophthalmology: cataract extractions.

g) Orthopedic surgeries: arthroscopy for hip, knee, shoulder, elbow, wrist, and finger; small joint replacement; including ankle joint replacement and hemiarthroplasty (partial knee replacement); rotator cuff repair; fracture and dislocation repair; tendon repair; excision of bone or soft tissue tumors; nerve transposition (to alleviate nerve compression); and ACL reconstructions.

h) Plastic surgery: excision of lesions, including cancerous lesions; tendon grafting; and amputation of fingers.

[227] Many of these services do not address life-threatening conditions or engage a risk of death, but some do. For example, timely access to diagnostic colonoscopies, prophylactic mastectomies, and cholecystectomies (gallbladder removal), as well as certain cancer treatments assigned priority codes 1 and 2 can currently be performed privately. Arguably too, cataract extraction may reduce the risk of death at least for those elderly persons with a tendency to fall as a result of poor vision. Thus, a breach is made.

[228] Second, whether existing private clinics can currently perform these procedures is not a full answer to the argument. The claim advanced by the appellants attacks the impugned provisions because they inhibit the development of parallel private care. The judge accepted that the impugned provisions were effective in preventing the development of such a system: at para. 14. It may be that a full private parallel system would not emerge if the provisions were struck down, but on the judge's findings some greater range of private provision than currently exists would likely emerge. The judge's findings do not foreclose the possibility that some procedures to address life-threatening conditions could be available in private clinics if the impugned provisions were struck down and they were approved by the College. Moreover, the current list of approved procedures should not be taken as static and it is not speculative to conclude that the list of approved procedures would expand if the impugned provisions were struck down or modified.

[229] In the result, the judge's findings do not support his conclusion that no patient facing a life-threatening condition is subjected to an increased risk of death. When that conclusion is coupled with the recognition that the impugned provisions prevent

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such persons obtaining private care that would otherwise be available, a deprivation of the right to life is made out.

Summary

[230] We conclude that the judge erred in his analysis of the right to life. That error is rooted in the judge's failure to draw the inferences compelled by his findings about the significance of waiting beyond applicable benchmarks for patients assigned priority codes 1 and 2. Insofar as the impugned provisions caused these patients to wait beyond their benchmark and foreclosed the possibility of obtaining private care, they deprive some patients of their s. 7 right to life.

[231] The judge's findings justify the conclusion that this class of patients was reduced, but not that it was entirely emptied. Accordingly, the inescapable inference is that some patients face an increased risk of dying as a result of the impugned provisions.

[232] It may well be impossible to identify particular individuals whose risk of dying increased because the impugned provisions prevented them from paying for private care. Moreover, the evidence does not permit a quantification of the number of persons whose risk was increased nor the materiality of that increase. It is also unclear exactly what types of procedures and, therefore, medical conditions are captured by this analysis, except to the extent that they include those procedures addressing life-threatening conditions captured by priority codes 1 and 2 which are currently available in private clinics and which it is reasonably likely would become available if the impugned provisions are eliminated. Despite these limitations, given the applicable jurisprudence, enough is established to conclude that the appellants succeeded in proving a deprivation of the right to life.

The Right to Liberty

[233] The judge addressed the s. 7 right to liberty at paras. 1764–1768 of his reasons. We agree with his conclusions on this point.

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[234]   The right to liberty is a right to make fundamental personal decisions without interference from the state. In the medical context, this has been interpreted as limited to the right to consent to or withhold consent from certain medical interventions: see e.g., *Carter* at para. 67; *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para. 100.

[235]   Importantly, the Supreme Court of Canada has said, "[t]he right to life, liberty and security of the person encompasses fundamental life choices, not pure economic interests": *Siemens v. Manitoba (Attorney General)*, 2003 SCC 3 at para. 45 (emphasis added).

[236]   The appellants submit the judge erred in holding the liberty right only protects the choice to proceed with treatment. They submit he erred in concluding that the impugned provisions do not engage the liberty interest because they do not deny patients the freedom to refuse treatment or limit their ability to choose their treating physician. They argue this finding ignores the reality that patients have no timely care to accept or refuse.

[237]   The appellants argue the provisions restrain patient choice as in *Chaoulli*, where they say four justices found the barrier to timely healthcare violated the right to liberty. They argue the provisions are akin to the prohibitions in *R. v. Smith*, 2015 SCC 34, where the Court recognized that liberty is engaged where the government forces a person to choose between a legal but inadequate treatment and an illegal but more effective treatment: at para. 18.

[238]   Finally, the appellants submit the judge erred by considering the social benefits of the provisions in deciding they did not deprive patients of the right to liberty. He noted the funding and provision of necessary care based on need was a "significant benefit" of the MPA: at para. 1765.

[239]   The respondents argue the judge correctly identified the legal test for engagement of the liberty interest as government interference with a person's ability

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to make fundamental personal choices. They submit the appellants' reliance on *Chaoulli* is misplaced.

[240] We would not accede to the appellants' arguments on this point; the judge did not err in concluding the liberty interest was not engaged. The liberty right is a right to make fundamental personal choices on the basis of autonomy and human dignity: *Carter* at para. 64; *R. v. Clay*, 2003 SCC 75 at para. 31. Unlike in *Carter*, where the provision served to restrict access to an entire class of treatment, the provisions at hand restrain patients from choosing the means by which the (identical) treatment is received, with the only distinctions being the financing and potential wait. We think it stretches the definition of "liberty" too far to suggest the choice of private or public medical care is a fundamental choice related to autonomy and human dignity. As such, we would distinguish *Smith*, in which the Court struck down the restriction of a different (and more effective) treatment. The provisions at hand only restrict the access to timely treatment for those who could afford a private alternative.

[241] In our view, the Court in *Chaoulli* did not recognize a right to liberty engaged by the prohibition on the private provision of healthcare. Both sets of reasons based on the Canadian *Charter* conclude that the rights to life and security were engaged but do not discuss liberty: at paras. 45, 124. The passages the appellants identify as finding a deprivation of liberty all use the combined "life, liberty, and security of the person" to mean a deprivation of s. 7 generally: *Chaoulli* at paras. 34, 102, 153, 158. It was not an error for the judge to refuse to follow jurisprudence that does not exist.

[242] We do not accept the appellants' submission that the judge considered the societal benefits of the MPA at the deprivation stage of the liberty interest. In context, the judge is only noting that the MPA, far from prohibiting medical treatment for patients with the threat of criminal prosecution, provides patients with a publicly funded medical system: at para. 1765.

[243] In our view, it would be an expansion of the current conception of the liberty right to recognize a deprivation in this case. The gravamen of the plaintiff's complaint is not the lack of choice, but rather, the consequences of that lack of choice on the

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life and security of the person in light of the long waiting times. The complaint is properly dealt with under those components of s. 7.

The Right to Security of the Person

[244] The appellants say the impugned provisions interfere with the right to security of the person. At trial, they focused on elective and scheduled surgeries, alleging that excess wait times: (1) prolonged the pain, suffering, and diminished quality of life associated with the underlying condition; (2) caused permanent harm that could have been avoided with timely care; and (3) caused psychological harm: at para. 1770. The judge concluded the appellants could establish deprivation if they proved the harm was causally related to the wait itself or if the wait prolonged or exacerbated suffering caused by the underlying condition: at paras. 1778–1779.

[245] As noted above, the judge discussed several evidentiary issues regarding security of the person. He found he could not presume harm from SPR data alone, as it does not establish that harm was suffered or explain the reason for delay: at para. 1787. The judge concluded that expert medical evidence that the wait times were clinically significant was required to demonstrate harm or risk of physical harm: at para. 1788. For psychological harm, he concluded the harm must be serious and not an ordinary annoyance, but that expert evidence was not required: at para. 1804.

[246] The judge accepted that some patients were deprived of the right to security of the person:

> [1884] When taken as a whole, the specific evidence of Mr. Chiavatti, Ms. Corrado, Ms. Tessier and the generalized wait time and expert evidence demonstrates that some patients with degenerative conditions who are otherwise available for surgery are nonetheless waiting beyond their priority code benchmarks. The evidence is that waiting beyond this benchmark may cause prolonging of pain and suffering and deterioration of their underlying condition which also increases the risk of reduced surgical outcomes. On this basis I find that for patients in these circumstances, waiting for surgical services infringes the right to security of the person.

[247] It is helpful at this stage to note that much of the right to life analysis also applies to the analysis of the right to security of the person, particularly in relation to

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the inferences to be drawn from the wait time data. We included information about wait times for non-life-threatening scheduled surgeries in the right to life section.

[248] The appellants argue the judge misinterpreted the scope of the right to security of the person. They argue it is engaged by government action that has the likely effect of seriously impairing a person's physical or psychological health. Accordingly, they argue security of the person is engaged as soon as a patient learns that timely treatment is unavailable in the public system.

[249] They appellants complain about the judge's use of the clinically significant threshold. According to the appellants, *Chaoulli* establishes that the combination of excessive wait times and an effective prohibition on private care amounts to a deprivation of security of the person. They submit the evidence clearly shows there are many patients—in many cases the majority of patients—who wait beyond the benchmark times.

[250] We have already commented on the judge's use of the "clinically significant" threshold and concluded that the difference between it and a "seriousness" threshold is of no great moment. The judge was correct, however, that the threshold for engagement of the right to security of the person is more than mere desire or a "patient choice" to purchase private healthcare. Recognizing that this right is engaged only when there is a serious impact on the patient avoids conflating liberty and security of the person. There is little value in identifying a more precise threshold, given the context of the claims and evidence in this litigation.

[251] We disagree with the appellants' suggestion that the right to security of the person is engaged as soon as a patient learns that treatment within the benchmark is unavailable in the public system and the state has effectively prevented treatment being obtained at the patient's cost. In our view, it is necessary that a complainant establish a proper evidentiary foundation for the claim by showing constitutionally significant ("serious") consequences of being required to wait beyond the benchmark. In our view, the judge was correct in noting that in cases such as *R. v. Morgentaler*, [1988] 1 S.C.R. 30, *Bedford*, and *Carter*, the claimants adduced

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concrete evidence to establish a connection between the impugned provisions and the harms they allegedly caused: at paras. 1730–1731. The judge was not wrong to require objective medical evidence to substantiate that waiting for certain types of treatment causes, contributes to, or increases the risk of serious harm to at least some patients.

[252] We have also indicated our view of the inferences that flow from the finding that patients are waiting beyond the benchmarks for their medical conditions. While we agree that harm cannot always be presumed from a patient waiting beyond a benchmark, for the reasons we have already explained, this inference can and must be made even for some patients assigned priority codes 3–5, not to mention for those assigned priority codes 1 and 2.

[253] One final issue in relation to security of the person has to do with the judge's conclusion that there was no evidence that delayed treatment of psychological illness can lead to depression, addiction, violence against others, or self-harm: at para. 1677.

[254] It appears that the only expert testimony on psychological harm was from Dr. Smith. The judge found significant problems with Dr. Smith's evidence, saying:

> [1675] Dr. Smith is the only mental health expert that gave evidence in this trial. He opined on the psychiatric effects of wait times for surgical care. There are problems with his evidence, similar to the issues I have identified above with respect to Drs. Wing and Chambers [evasive testimony, no discernable methodology, exclusion of relevant evidence, pecuniary interest in litigation]. Overall, Dr. Smith's reports contain no analysis or any discussion of the literature about psychological harms from waiting for treatment in the public system or generally. The only study he cites in this regard does not in fact support the proposition that waiting for treatment in the public system leads to psychological harm …

[255] Dr. Smith's expert report only asserts that physical illness can lead to mental stress and psychological conditions. In his lay affidavit, he testified that untreated mental illness and chronic pain can lead to depression and addiction issues due to ongoing use of narcotics or self-medication with illegal drugs or alcohol. Dr. Smith's report and affidavit were determined to be unreliable and given little weight. Given

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the judge's role in assessing and weighing evidence, we see no basis to set aside his findings regarding Dr. Smith's report. In our view, a single, unexplored reference is not sufficient to prove psychological harm. We would not displace the judge's conclusions on this point.

[256] The judge gave no weight to the evidence of Professors Kessler and McGuire related to the harms of waiting for care. The appellants have not provided these reports on appeal, nor have they established a reviewable error with respect to the judge's weighing of the evidence. Accordingly, we would not interfere with the judge's weighing of the evidence.

[257] Finally, another example referring to narcotic use was the lay testimony of Dr. Nacht, where he stated:

> … in waiting for these consultations with us and the treatment these patients have suffered substantial amounts of pain in certain circumstances and they sometimes get started on narcotics by a well-meaning physician who is listening to the patient and hearing these cries for help. And when we see them, some of these patients having been waiting—having waited so long to see us and then to see the surgeon are often narcotic addicted.

[258] The judge cautioned Dr. Nacht not to opine on the impact of a wait on patient health. Dr. Nacht went on to state that approximately 10% of his patients were using narcotics chronically. Given that Dr. Nacht was not qualified as an expert, the judge did not err in concluding there was no expert evidence to support a causal link between wait times and addiction.

[259] We are of the opinion that the appellants have not identified any reviewable errors so as to permit appellate intervention.

[260] In summary, we have accepted the judge made some errors in his security of the person analysis. These are similar to the errors made in his right to life analysis, flowing from the failure to draw the inferences compelled by his own findings of fact about priority codes. However, since the judge accepted that the impugned provisions deprived patients of the right to security of the person (on a narrower basis), the effect of these errors is only to expand the class of persons deprived of

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the right to security of the person. As a result, the deleterious effects of the impugned provisions may be more serious than the judge acknowledged. This has consequences for the weighing and balancing of competing rights and interests later in the constitutional analysis.

Causation

[261] The appellants attempted to demonstrate that the judge set too high a standard of proof by requiring the appellants to show a causal link between the impugned provisions and the alleged deprivations of s. 7 rights. They submit the judge erred in identifying the standard of proof required to show clinically significant harm.

[262] We have addressed these questions in our review of the "clinically significant" threshold and our interpretation of what the judge accepted as an evidentiary foundation to make out a deprivation.

[263] The judge based his conclusion that harm cannot be presumed from excess wait times alone on numerous findings of fact regarding the nature of the SPR:

> [1787] I have already addressed the limitations of generalized wait time data above and due to these limitations, I find that it cannot prove a deprivation of s. 7 on its own. This kind of data does not indicate the reasons for any delays in treatment. Nor can it provide any information on whether a particular patient in fact suffered actual harm as a result of the delay. Overall, I cannot simply presume that actual harm to an individual patient has occurred simply on the basis of unparticularized statistical data. The SPR wait time data is based on median calculations and we do not know whether an individual is at the median, below it or above it. The court cannot assume harm from the SPR wait time data alone. Moreover, as I have discussed above, the fact that a patient exceeds a benchmark does not in itself prove she or he suffered actual physical or serious psychological harm. More is required.

[264] We agree that constitutionally relevant harm cannot universally be presumed solely from patients exceeding wait times. But as we have discussed above, wait time benchmarks reflect the consensus view of when treatment should occur to avoid adverse clinical outcomes: at para. 1298. The assignment of patients to a priority code rests on diagnostic judgments, as we have explained. They cannot (and should not) be used as a proxy for when delays give rise to psychological and

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physical suffering in all cases. We would not interfere with the judge's finding that not every patient who exceeds the benchmark will suffer decreased outcomes: at paras. 1738–1739. We would also not disturb his reasoning that, presumably, harm may occur before the benchmarks are exceeded (although, the appellants provided no example of this occurring, and did not plead this fact).

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[265] In addition, presuming serious harm every time a patient exceeds benchmark would cede the constitutional analysis to medical guidelines that were created as a compromise amongst many factors: at para. 1326. Hence, while the benchmarks are probative of whether constitutionally relevant harm has occurred, they are not always determinative. For the reasons we explained in the right to life section, we conclude, however, that at least some persons who wait beyond the benchmark will have been deprived of their s. 7 rights to life or security of the person.

The Principles of Fundamental Justice

[266] The deprivations of the rights to life and security of the person that we have identified are only a breach of s. 7 if they are not in accordance with the principles of fundamental justice. Section 7 does not entail that the state will never interfere with a person's life, liberty, or security of the person. There are many valid laws that do just that. Rather, s. 7 requires that the state will not to do so in a way that violates the principles of fundamental justice.

[267] The parties agree that the relevant principles of fundamental justice in this case are arbitrariness, overbreadth, and gross disproportionality. These principles are directed at two different evils. The norms against arbitrariness and overbreadth target the absence of rational connection between the law's purpose and effects (the deprivations). The norm against gross disproportionality targets a law that is connected to its purpose but has an impact on s. 7 rights so severe that it violates our fundamental norms: *Bedford* at paras. 108, 109, 111.

[268] Because this analysis measures the law against its purpose, the articulation of the purpose is foundational. An unduly broad statement of purpose will almost always lead to a finding that the provision is not arbitrary or overbroad; an unduly

narrow statement of purpose will almost always lead to a finding of overbreadth: *R. v. Moriarity*, 2015 SCC 55 at para. 28.

[269] We begin, then, with the legislative objective of the impugned provisions.

Legislative Objective(s)

[270] The appellants contend the judge erred in his identification of the objective of the impugned provisions. They say he inflated the objective, which had the effect of predetermining the principles of fundamental justice analysis.

[271] We accept that it is necessary to correctly identify the law's purpose since doing so lies at the heart of the principles of fundamental justice analysis. As the Supreme Court described in *Bedford*:

> [108] The case law on arbitrariness, overbreadth and gross disproportionality is directed against two different evils. The first evil is the absence of a connection between the infringement of rights and what the law seeks to achieve — the situation where the law's deprivation of an individual's life, liberty, or security of the person is not connected to the purpose of the law. The first evil is addressed by the norms against arbitrariness and overbreadth, which target the absence of connection between the law's purpose and the s. 7 deprivation.
>
> [109] The second evil lies in depriving a person of life, liberty or security of the person in a manner that is grossly disproportionate to the law's objective. The law's impact on the s. 7 interest is connected to the purpose, but the impact is so severe that it violates our fundamental norms.
>
> [Emphasis added.]

[272] In *Moriarity*, the Supreme Court provided guidance on how to determine the objective of a challenged provision: at paras. 24–33. A legislative objective is identified by looking at the provision in its full context, including: (1) explicit statements of purpose contained in the legislation; (2) the text, context, and scheme of the legislation; and (3) extrinsic evidence such as legislative history and evolution: *Moriarity* at para. 31.

[273] The appropriate level of generality in construing the objective is critically important. The purpose must not be interpreted too generally, as an unduly broad statement of purpose will almost always lead to a finding that the provision is not

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overbroad. Neither can a purpose be cast too specifically, as an unduly narrow statement of purpose will almost always lead to a finding of overbreadth: *Moriarity* at para. 28. The Court in *Moriarity* provided four examples of statements of purpose that were appropriately precise and succinct:

> [29] … So, for example, in *R. v. Heywood*, the law's purpose was to protect children from becoming victims of sexual offences. In *R. v. Khawaja*, the purpose of the scheme was to prosecute and prevent terrorism. In *Bedford*, the purpose of the living on the avails of prostitution offence was to target pimps and the parasitic, exploitative conduct in which they engage. In *Carter*, the objective of the ban on assisted suicide was to prevent vulnerable persons from being induced to commit suicide at a time of weakness.
>
> [Citations omitted.]

[274] Finally, in interpreting a legislative objective, courts should not conflate a law's purpose with the means chosen to achieve that purpose: *Moriarity* at para. 27. A law's means may be helpful in determining its objective, but the two should be treated separately, to the extent possible.

[275] Section 2 of the MPA provides:

> The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay.

As discussed above, the judge concluded the purpose of the MPA and the impugned provisions is twofold: at para. 1972. The first objective is to preserve the publicly funded and managed universal healthcare system for medically necessary services (sustainability). The second objective is to ensure that access to necessary medical care is based on patient need and not ability to pay (universal, equitable access). The judge also accepted that the second objective is intended to ensure consistency with the principles of accessibility and universality under the *Canada Health Act*, R.S.C. 1985, c. C-6 [CHA]: at paras. 1973–1974.

[276] The critical question at trial, and again on appeal, was whether the proper legislative purpose was limited to the first objective: the preservation of a publicly funded healthcare system. The judge reasoned that s. 2 appears to apply generally

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to the provision of all medically necessary services in the province. He rejected the appellants' submission that the second part of the clause ("in which access to necessary medical care is based on need and not on an individual's ability to pay") only applies to services delivered within the public system: at paras. 1978–1981. More specifically, he rejected the appellants' argument that the objective does not apply to medically necessary services for insured residents that are privately funded. Further, he rejected the argument that the preservation of an equitable healthcare system in which access is governed by need rather than ability to pay is merely an "animating social value": at para. 1990.

[277] On appeal, the appellants once again contend that the purpose of the MPA is to preserve a publicly managed and fiscally sustainable <u>public</u> healthcare system, and that the requirement that access to necessary care be based on need only applies to care provided within the public system.

[278] If the plain language of the section were the sole basis on which to interpret its meaning, the appellants' position might be arguable. However, there is more to the identification of legislative purpose than just plain language. To properly identify the legislative objective, we must examine the text of the statute, the context and scheme of the legislation, and relevant extrinsic evidence. The judge undertook this analysis in some detail. Overall, the language of s. 2 may be interpreted in various ways, but when a full, contextual analysis is undertaken, we conclude that the judge's analysis was correct.

[279] Before turning to broader issues of legislative history and context, we point out what we see as a fundamental error in the appellants' approach, based on the broad legislative scheme. They argue that "neither the provisions, nor the MPA seek to regulate access to or delivery of healthcare services provided outside of the public healthcare system". According to the appellants, the provision of necessary medical care by an enrolled physician to a beneficiary is outside the scope of the public healthcare system if the beneficiary does not seek reimbursement from MSP and the physician does not bill MSP.

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[280] In our view, this is a mischaracterization of the scope of the public healthcare system and its boundary with the private system. First, the impugned provisions do not apply to patients. They apply to enrolled physicians, healthcare facilities, and the funders of healthcare: at para. 2037. Second, the impugned provisions apply to medical practitioners who have enrolled in MSP, prohibiting them from billing beneficiaries except in accordance with MSP. In short, they are aimed at regulating dual practice. These physicians, by virtue of enrolling in MSP, <u>are</u> part of the public healthcare system even when they are not providing medically necessary services to MSP patients. In contrast, the provisions do not apply to unenrolled physicians providing services to unenrolled patients in a private facility.

[281] A second difficulty with the appellants' argument is that they say the publicly managed and fiscally sustainable healthcare system is the subject of the purpose clause. If that is so, what do the words "for British Columbia" mean? Obviously, the words signify more than just some abstract, constitutional or juridical entity. In our view, the words must refer to the residents of the province. At a minimum, the public healthcare system includes those residents who are enrolled as MSP beneficiaries. This suggests that s. 2 might be read as preserving a publicly managed and sustainable healthcare system for insured residents of British Columbia in which necessary medical care is based on need and not the ability to pay. Read in this way, the public healthcare system encompasses both enrolled medical practitioners and insured beneficiaries. The suggestion that the MPA has a dual purpose creates a false issue. When the scope of the public system is properly understood, there is really one purpose that governs the provision of necessary medical care to all enrolled British Columbians.

[282] Hence, even if the appellants are right to suggest that the objective of the MPA is to preserve a <u>public</u> healthcare system delivering necessary medical care on the basis of need and not the ability to pay, at least ss. 17 and 18(3) must be seen as regulation of that system. We agree with the AGC that these provisions are aimed at furthering the objective of equitable access to medically necessary services within

the publicly funded system, and that physicians who are enrolled in MSP are part of that system.

[283]   We now turn to consider the legislative purpose in its wider, historical context, as the judge did. The judge undertook a detailed analysis of the development of public healthcare in Canada and British Columbia, with a view to understanding the policy objectives underlying the evolution of the system: at paras. 160–401, 1982–1996. He concluded that for decades healthcare policy has been driven by the objective of ensuring that medically necessary healthcare is provided to Canadians (including British Columbians) on the basis of need and not the ability to pay. The following summary is primarily based on the judge's factual findings.

[284]   The judge began by reviewing the postwar initiatives of Saskatchewan, which first introduced a universal hospital care plan in 1946. In 1957, the federal government passed the *Hospital Insurance and Diagnostic Services Act*, S.C. 1957, c. 28, to assist the financing of specified hospital and diagnostic services for all residents on "uniform terms and conditions".

[285]   Saskatchewan was the first province to introduce universal health insurance for medical services to all residents in 1961, through the *Saskatchewan Medical Care Insurance Act, 1961*, S.S. 1961, c. 1. Shortly thereafter, the federal government established the "Royal Commission on Health Services" chaired by Justice Hall, with a broad mandate to recommend measures to ensure that "the best possible healthcare is available to all Canadians".

[286]   The Hall Report recommended a single payer, universal scheme for medical services as the most administratively viable and cost-effective way to ensure comprehensive coverage. The judge noted:

> [178]   The Hall Report led to the introduction of the federal *Medical Care Act*, S.C. 1966-67, c. 64. When he introduced the Bill in the House of Commons on July 12, 1966 Allan J. MacEachen, Minister of National Health and Welfare, said:
>
> > ... The government of Canada believes that all Canadians should be able to obtain health services of high quality according to their need for such services and irrespective of their ability to pay. And we

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> believe that the only practical and effective way of doing this is through a universal, prepaid, government-sponsored scheme.
>
> [179] The *Medical Care Act* offered to reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside of hospitals. Federal funding was conditional on meeting four criteria: comprehensiveness, portability, public administration and universal coverage, such that all residents would have access on uniform terms and conditions. Within five years, all the provinces and territories had universal physician services insurance plans.

[287] British Columbia introduced its own universal health plan in 1965.

> [181] …Significantly, coverage under the plan was provided through a roster of "certified" non-profit private insurance carriers and a public insurer that covered high-risk patients. In response to pressure from the BCMA, the plan did not limit extra billing, nor did it prohibit doctors from working outside the plan. The 1965 plan also did not prohibit non-certified private insurance carriers from offering plans on terms and conditions different from those offered by a certified carrier. However, three years later, the 1965 plan was reformed in order to conform to federal requirements for funding under the *Medical Care Act*. The result of the reform was the British Columbia *Medical Services Act*, S.B.C. 1967, c. 24, passed into law in 1968.

[288] The plan was reformed in 1968. Under this legislation, the province began to regulate the terms on which private insurance could be offered, effectively limiting its availability. The legislation also introduced restrictions on extra billing. The new universal scheme continued to allow private care within the framework of worker's compensation schemes.

[289] In the 1970s, further changes were made to the regulatory framework. The multi-payer approach to health insurance came to an end and the administration of MSP was consolidated in the Ministry of Health. Further restrictions on extra billing were introduced, ultimately leading to a permanent ban on extra billing in 1981.

[290] The judge also described the introduction of a category of unenrolled physicians. Initially unenrollment was a penalty and for cause. Unenrolled physicians were required to inform patients in advance that their services were not insured under MSP. In 1986, the province began allowing physicians to voluntarily unenroll from MSP.

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[291] Partly as a result of continued concerns that extra billing would interfere with the accessibility of medical care, the Minister of Health and Welfare asked Justice Hall to examine the extent to which policies and legislation introduced since 1964 had met the goals of Justice Hall's initial recommendations. The judge commented:

> [193] …In his report, he described extra billing by doctors and hospital user charges as creating a two-tiered healthcare system. He concluded that:
>
> > These then are the two cornerstones upon which my conclusions on this issue are based:
> >
> > 1. That physicians are entitled as a right to adequate compensation for services rendered.
> > 2. That if extra billing is permitted as a right and practised by physicians in their sole discretion it will over the years destroy the program creating in that downward path the two-tier system incompatible with the societal level which Canadians have attained.
>
> [194] Following the 1980 Hall Report, the *Canada Health Act*, R.S.C. 1985, c. C-6 ("*CHA*") was introduced in 1984. The *CHA* reaffirms the four key principles enunciated by the first Hall Report which are: comprehensiveness, universality, portability, and public administration. A fifth principle, accessibility, was also added.
>
> [195] Pursuant to the *CHA*, each province must ensure that its health plan meets these five criteria in order to be eligible for federal funding. However, under the *CHA*, it is left for the provinces to choose how to structure their healthcare systems to meet the five program criteria.

[292] The judge then turned to the origins and development of the MPA. He began by referring to the Royal Commission on Health Care and Costs, chaired by Justice Peter Seaton. The Seaton Commission issued its comprehensive three volume report entitled "Closer to Home" in November 1991. As the judge said:

> [200] In its recommendations, the Seaton Commission endorsed the four principles from the 1964 Hall Report and the additional principle of accessibility, which was added to the *CHA*. In its conclusions, the Commission advised strongly against allowing any private financing of healthcare that is covered by the public plan. The Seaton Commission was concerned about the risk of creating a two-tier system through private financing of healthcare which would undermine the objective of having a universal and accessible system. The defendant and Canada both voice these same concerns in this litigation.
>
> [201] One year later, in 1992, the impugned provisions that are the subject of this litigation were enacted, drawing from the recommendations of the Seaton Commission. They were first introduced under the *Medical and Health Care Services Act*, S.B.C. 1992, c. 76 (the "1992 Act"), which repealed and

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> replaced the 1967 Act (*Medical Services Act*, S.B.C. 1967, c. 24) and the 1981 Act (*Medical Services Plan Act*, 1981, S.B.C. 1981, c 18.). The 1992 Act was renamed the *Medicare Protection Act* in 1996. In the next section, I discuss the *MPA* in greater detail as well as the structure of the healthcare system in British Columbia. Here, however, I will briefly note the key legislative changes introduced in the 1990s.
>
> [202] The 1992 Act was not a radical break from the province's earlier legislation, but an evolution. MSP remained the province's universal health plan and the MSC continued its administration of the plan. Although not recommended by the Seaton Commission, s. 39 of the 1992 Act introduced a prohibition on selling private health insurance for services insured under MSP. This section was amended and renumbered as s. 45 of the *MPA* (one of the impugned provisions in this trial). Section 39 strengthened the earlier restrictions on private health insurance, since the previous restriction prohibited "non-licensed" private insurance carriers.
>
> [203] The 1992 Act included new provisions on extra billing by enrolled practitioners. As was the case before the 1981 Act (the 1981 Act introduced a permanent ban on extra billing), physicians who "opted-out" could generally extra bill a patient for services rendered, provided the patient was informed beforehand regarding the extra amount and agreed to pay it. However, "opted-in" physicians (i.e., those who billed MSP directly) were still prohibited from extra billing under the 1992 Act. Unenrolled physicians, as under the previous legislation, were permitted to charge insured patients whatever amount they pleased, provided they notified patients in advance of providing a service that they were not enrolled and their services were not covered by MSP. There is no specific evidence of the numbers of unenrolled physicians in British Columbia today, but all parties indicated it is very small.

[293] Concerns about extra billing persisted as physicians opted out or unenrolled and began extra billing. In 1995, legislation was introduced in British Columbia to prohibit extra billing by physicians who had "opted-out" of billing MSP directly, in line with the 1981 Act. The 1995 Act also prohibited all unenrolled physicians from extra billing if their services were rendered in a hospital or community care facility.

[294] These continued concerns about extra billing and private payment for necessary medical care are reflected in two subsequent parliamentary studies of Canada's healthcare system. Both studies reaffirmed the need to ensure that access to medically necessary services is equitable. In 2002, the Kirby Report reiterated the centrality of equity and noted that allowing some individuals to pay to jump the queue was an inequitable approach to addressing wait time problems. Also in 2002, the Romanow Report concluded that the prohibitions on extra billing and user charges in the CHA were necessary to ensure equity in healthcare delivery.

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[295] Currently, the CHA establishes the criteria and conditions for provinces to receive for federal funding under the Canada Health Transfer. These criteria are: (1) public administration; (2) comprehensiveness; (3) universality; (4) portability; and (5) accessibility. The CHA also directs that provinces must not permit extra billing or user charges for insured health services, because of the barrier these out-of-pocket charges create. To meet these criteria, provinces typically prohibit the sale and purchase of duplicative private health insurance and discourage physicians from dual practice in the public and private systems: at para. 197.

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[296] With respect to the interaction of the MPA and CHA, the judge said:

> [1973] I agree with the defendant and Canada that the second purpose of ensuring access based on need, is meant to, among other things, ensure consistency with the principles of accessibility and universality under the *CHA*. In other words, the latter part of s. 2 reflects the manner in which the British Columbia Legislature has decided to articulate and enshrine the principles of universality and accessibility of healthcare services established in the *CHA*.
>
> …
>
> [1985] While introducing the MPA in 1995 and referring specifically to ss. 17 and 18, the then Minister of Health stated:
>
>> This legislation is an essential step forward to protecting medicare for British Columbians. It protects patients from paying extra charges for medicare services in our province; it bans extra-billing for medicare services. It covers some 3,000 services paid for by medicare, covering the full health care spectrum, from simple blood tests to complex neurosurgery. This legislation says clearly and strongly that every British Columbian must have equal access to medicare services regardless of income. That means no tray fees, no more suture fees, no more facility fees, no extra charges at all for medicare services.
>>
>> ...
>>
>> ... With this legislation, British Columbia becomes the first province in Canada to entrench the founding principles of medicare in law: universality, comprehensiveness, accessibility, portability and public administration...
>
> [1986] I note in these latter remarks that the Minister specifically connects the impugned provisions of the *MPA* and the five criteria from the *CHA*, universality, comprehensiveness, accessibility, portability and public administration. This further supports the defendant's and Canada's submissions regarding the interrelations between the two statutes. More importantly, it demonstrates that the provisions restricting extra billing and

> user charges in the *MPA* were specifically intended to incorporate the *CHA* principles into the *MPA*, namely universality and accessibility.
>
> [Emphasis omitted.]

[297] The preamble of the MPA expressly incorporates the five criteria of the CHA and adopts a principle of equitable access. It reads: “the people and government of British Columbia believe it to be fundamental that an individual’s access to necessary medical care be solely based on need and not on the individual’s ability to pay”. This lends support to the conclusion that accessibility is integral to the MPA and its objectives.

[298] The judge also correctly considered various policy interpretation letters issued by federal Ministers of Health, intended to assist the provinces in understanding the conditions to receive for federal funding. These letters expressed concern about extra billing, private clinics, dual practice, and patients using private services, such as diagnostic services, to jump the queue that had developed in some provinces.

[299] We can see no reversible error in the judge’s assessment of this historical and legislative context. To the extent the analysis represents findings of mixed fact and law, his findings are owed deference. In any event, in our view, the judge was correct to interpret the purpose of the MPA and the impugned provisions in the context of the framework established by the CHA. We also agree with his conclusion that the provision of medically necessary care is premised on the principle of equity such that patients are prioritized based on medical need and not ability to pay: at para. 1974.

[300] Overall, we conclude that the fundamental purpose of the MPA is to ensure that access to necessary medical care for all insured beneficiaries is based on need and not on an individual’s ability to pay. We do not think that this purpose can be limited only to services provided within the public system as that system has been restrictively defined by the appellants. The objective is to ensure that all residents have access to necessary medical care based on need and not the ability to pay. The first part of the purpose clause is intended to ensure that 100% of insured

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persons are entitled to publicly funded healthcare on uniform terms and conditions, and the second part of the purpose clause is intended to ensure that access is unimpeded (directly or indirectly) by extra billing, user charges, or other issues unconnected with medical need. This purpose is realized through the preservation of a publicly managed and fiscally sustainable healthcare system.

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[301] This statement of purpose is consistent with the historical context and the underlying policy objectives identified by various commissions who have warned against allowing the development of a private healthcare system accessible only to those who can afford to pay. It is also consistent with the evolution of the statutory scheme, which reflects the legislative response to those commissions and to problems that have arisen in achieving these objectives. This conclusion is further bolstered by the statements of Ministers when introducing legislation in response to the recommendations of those commissions. Finally, federal and provincial governments appear aligned on this point—there is considerable overlap and no apparent inconsistencies between the objectives of the MPA and CHA.

[302] Although the judge characterized s. 2 of the MPA as disclosing two interconnected purposes, we see it as one central and underlying purpose: the provision of necessary medical care based on need and not the ability to pay. Despite this difference in framing, it follows from our conclusion that we reject the appellants' limited articulation of the purpose of the MPA. In our view, the judge did not inflate the objective of the MPA.

[303] In this case, we do not think the ultimate outcome of the s. 7 analysis depends upon which of the competing views on the scope of the purpose is correct. Even on the articulation of the purpose put forward by the appellants, the judge made sufficient findings of fact about the detrimental effects of duplicative private care on the preservation of a publicly funded healthcare system to compel our conclusion that any s. 7 deprivation is in accordance with the principles of fundamental justice. Having said that, we are of the view that the judge correctly

identified the purpose of the legislation, even though we disagree with some aspects of his analysis.

[304] With the purpose of the MPA settled, we return to the second stage of the s. 7 inquiry: whether the deprivations of s. 7 rights are in accordance with the principles of fundamental justice.

Arbitrariness

[305] A law is arbitrary when there is no connection between its effects and objects: *Bedford* at para. 98. The question on the arbitrariness analysis is whether the law's purpose is rationally connected to its object. The efficacy of the legislation in achieving that purpose is not considered and the court does not second-guess the means chosen by the legislature: *Bedford* at paras. 125, 127. It takes the law's purpose at face value and considers whether it is at least conceivable that the law could achieve that purpose: *Bedford* at para. 90.

[306] The appellants do not argue that ss. 17 and 18 are arbitrary. They accept that preventing enrolled doctors from working in a private system is rationally connected to preserving the publicly funded system. They submit, however, that the s. 45 prohibition on private insurance <u>is</u> arbitrary, and has no connection to the preservation of public healthcare for two reasons. The first is the appellants' narrow view of the purpose of the MPA—i.e., that it is concerns only equitable delivery of care <u>within</u> the public system, an interpretation we have rejected. The second argument rests on the appellants' view that private insurance to cover procedures in a private system would have no effect on the delivery of public healthcare and would in fact ease the burden on the public system. This argument amounts to a challenge to the judge's factual findings that a duplicative system would negatively affect the public system in the ways identified above (at para. 68). We have concluded that these findings were open to the judge, supported as they were by accepted expert evidence. We owe them deference.

[307] When the broader framing of the purpose of the provisions and the findings regarding negative effects of private care on the public system are considered, it is

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evident that s. 45 is rationally connected to the purpose of the MPA. Allowing private insurance for necessary services would increase demand by making it possible for more people to pay for private care: at paras. 2283–2286. Conversely, prohibiting private insurance suppresses demand because only patients who can afford to pay out-of-pocket can access private care. Lower demand decreases the incentive for physicians to unenroll—if there are fewer patients seeking out private care, it is less likely that an unenrolled practice would be financially sustainable.

[308] We accept the judge's conclusion that increased demand on the private side would have deleterious consequences for the public system, primarily by creating competing demand for the limited pool of physicians and other healthcare providers who would prefer to work in a higher-paying private system. Suppressing that demand by prohibiting private insurance is thus rationally connected to preserving the public system and is not arbitrary.

[309] Prohibiting private insurance is also rationally connected to the second part of the objective: ensuring care is delivered equitably based on need. The judge found that not all residents would be able to obtain private insurance: it would not be available to those who cannot afford it, nor to the elderly or those with complex pre-existing conditions who could not qualify for it: at paras. 2295–2301. Thus, we conclude that the appellants have not established that s. 45 is arbitrary.

Overbreadth

[310] A law is overbroad if it "goes too far and interferes with some conduct that bears no connection to its objective": *Bedford* at para. 101. In other words, the law is arbitrary in part: *Bedford* at para. 112. The appellants contend the judge made two errors in assessing whether the impugned provisions were overbroad. First, they say that by focusing on whether it was <u>rational</u> to suppress a private system through banning private insurance and extra billing, the judge simply repeated the arbitrariness analysis. Instead, they argue he should have asked whether the impugned provisions <u>go too far</u> by denying access to timely private care to everyone, including patients who are required to wait in the public system beyond their

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assigned benchmarks for procedures that can be performed in private clinics. Second, they say the judge erred by failing to consider whether the provisions are overbroad because they bar all enrolled physicians from any private billing, even those who have excess capacity that cannot be used in the public system.

[311] Unlike the question of arbitrariness, the appellants do not limit their challenge to the prohibition on private insurance. Thus, we will consider all three of the impugned provisions.

Limiting Access to Private Care for Patients Waiting Past Benchmarks

[312] As to the first error, the appellants say the judge failed to consider the minimal impact the provision of private healthcare in limited circumstances would have on the public system. Specifically, they say the province should allow physicians to provide private care to patients who have waited beyond the benchmark. They point to the experience of British Columbia over the last 20 years, during which non-exempt patients have paid for private diagnostic and surgical services performed by enrolled physicians at private clinics, as well as private care provided through disability insurance, automobile insurance, and the Worker's Compensation Board. The appellants contend this is the best evidence that private insurance and dual practice on a limited scale do not harm the public system and, therefore, limiting them is not necessary to achieve the objectives of the impugned provisions.

[313] The judge addressed this argument, albeit under his arbitrariness analysis, and concluded he could not draw the inference proposed by the appellants: at paras. 2129–2130. First, he found the past 20 years of illegal private healthcare in British Columbia was of limited use in understanding what would happen if the impugned provisions were struck down: at para. 2130. If the provisions are struck, or materially read down, there would be nothing or little to prevent enrolled physicians and private insurance companies from developing an expansive duplicative private healthcare market: at para. 2133. Further, enrolled physicians who felt constrained to comply with the ban on private billing might begin to bill privately in far greater

numbers if it were legal to do so: at para. 2133. Second, the expert evidence accepted by the judge does not support the inference the appellants ask us to make. The experts testified that any duplicative system would harm the public system: at para. 2663–2666. Third, as the judge noted, there is no way to empirically test the assertion that the past 20 years of limited unlawful private care has had no impact on the public system: at paras. 2135, 2142. Fourth, as the judge stated, allowing patients waiting beyond a benchmark to access private care would create perverse incentives for physicians to prioritize private work: at para. 2665. Finally, the judge accepted evidence that suggests that when doctors limit their operating time in the public system, wait times there would grow, more patients would exceed the benchmarks, and more patients would be eligible for private care: at paras. 2330–2334.

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[314] In short, the appellants have not established that the provisions are arbitrary in respect of these patients.

Limiting Delivery of Private Care by Physicians with Excess Capacity

[315] We turn now to the argument that the prohibitions are overbroad because they prevent doctors from offering private care with their excess capacity that cannot be used in the public system. The appellants say that once doctors have used all of their public system operating time, procedures performed privately would have no impact on the public system, therefore, it is not rational to prohibit such care.

[316] The judge acknowledged that some surgeons have excess capacity, but specifically rejected the assertion that it is sustainable unused capacity: at para. 2703. He observed that the work of surgeons in the public system is mostly done outside the operating room—only 20–40% of patients referred for consultation will proceed to surgery: at para. 2702. If surgeons spent significantly more time in the operating room, "over the medium or long term they would simply run out of patients": at para. 2703. Further, the patients who do not need surgery are often referred to alternative treatments, some of which can only be obtained after

consultation with a specialist: at para. 2702. Thus, consultations form a significant part of a specialist's role, as do research, teaching, and administrative responsibilities: at para. 2703.

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[317] In addition, focusing on the excess capacity of some specialists, such as orthopedic surgeons, ignores the interconnectedness of the healthcare system. Surgeons operating in private clinics require anesthesiologists and specially trained nurses: at paras. 967–975. The evidence established there is a significant shortage of both, resulting in unused public system operating time. That evidence supports the judge's conclusion that even smaller scale "incursions" into private care can affect the public system. As a result, the provisions do not prohibit conduct that bears no connection to their objective.

[318] Finally, the appellants claim of overbreadth focuses on only one part of the purpose of the MPA—the need for the preservation and sustainability of a publicly funded and managed system. They do not address the objective of ensuring that access to medically necessary care is based on need and not ability to pay. Suppressing <u>all</u> private care is necessary to meet that objective. The introduction of even small scale duplicative private healthcare would create a second tier of preferential healthcare for those with the means to either acquire private insurance or pay out-of-pocket once their benchmark was exceeded.

[319] In summary, we agree with the judge's conclusion that the impugned provisions are not overbroad. They are necessary to preserve a publicly funded system delivering necessary services based on need and not ability to pay, and do not prohibit conduct that bears no connection to that objective.

Gross Disproportionality

[320] A legislative measure is grossly disproportionate where the seriousness of its impact on s. 7 interests "is totally out of sync with the objective of the measure": *Bedford* at para. 120. As we shall see, the test is formulated in a variety of other

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ways that help bring the issue into focus. As Professor Hamish Stewart observes in "Bedford and the Structure of Section 7" (2015) 60:3 McGill LJ 575 at 585:

> … A grossly disproportionate law is not necessarily arbitrary: whatever its other defects, it may well be rationally connected to its purpose. Nor is it necessarily overbroad: it may affect only those people whom it needs to affect to achieve its purpose. But its impact on the life, liberty, or security of the person of those people "is so severe that it violates our fundamental norms." <u>A grossly disproportionate law is one which, even if it achieves its purposes completely, does so at too high a cost to the life, liberty, and security of individual persons</u>.
>
> [Emphasis added.]

[321] The standard of gross disproportionality is not easily met; the law's effects can be incommensurate with its object without being grossly disproportionate: *Carter* at para. 89, citing *Bedford* and *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1.

[322] In *Bedford*, the Supreme Court clarified that when assessing the principles of fundamental justice, the question is whether <u>anyone's</u> life, liberty, or security of the person has been denied by a law that is inherently bad—be it grossly disproportionate, arbitrary, or overbroad: *Bedford* at para. 123. In other words, the effect on one person is sufficient to establish a breach of s. 7.

[323] In determining whether the deprivation of a s. 7 right is in accordance with the principles of fundamental justice, courts have generally not been concerned with competing moral claims or the societal benefits conferred by the impugned law; these have typically been considered at the justification stage under s. 1.

[324] The relationship between ss. 7 and 1 was explained in *Bedford* as follows:

> [125] Section 7 and s. 1 ask different questions. The question under s. 7 is whether the law's negative effect on life, liberty, or security of the person is in accordance with the principles of fundamental justice. <u>With respect to the principles of arbitrariness, overbreadth, and gross disproportionality, the specific questions are whether the law's purpose, taken at face value, is connected to its effects and whether the negative effect is grossly disproportionate to the law's purpose</u>. Under s. 1, the question is different — whether the negative impact of a law on the rights of individuals is proportionate to the pressing and substantial goal of the law in furthering the public interest. <u>The question of justification on the basis of an overarching</u>

> public goal is at the heart of s. 1, but it plays no part in the s. 7 analysis, which is concerned with the narrower question of whether the impugned law infringes individual rights.
>
> [126] … Under s. 1, the government bears the burden of showing that a law that breaches an individual's rights can be justified having regard to the government's goal. Because the question is whether the broader public interest justifies the infringement of individual rights, the law's goal must be pressing and substantial. … At the final stage of the s. 1 analysis, the court is required to weigh the negative impact of the law on people's rights against the beneficial impact of the law in terms of achieving its goal for the greater public good. The impacts are judged both qualitatively and quantitatively. …
>
> [127] By contrast, under s. 7, the claimant bears the burden of establishing that the law deprives her of life, liberty or security of the person, in a manner that is not connected to the law's object or in a manner that is grossly disproportionate to the law's object. The inquiry into the purpose of the law focuses on the nature of the object, not on its efficacy. The inquiry into the impact on life, liberty or security of the person is not quantitative — for example, how many people are negatively impacted — but qualitative. An arbitrary, overbroad, or grossly disproportionate impact on one person suffices to establish a breach of s. 7. To require s. 7 claimants to establish the efficacy of the law versus its deleterious consequences on members of society as a whole, would impose the government's s. 1 burden on claimants under s. 7. That cannot be right.
>
> [Emphasis added.]

[325] In *Carter,* the Court expanded on this position with the following comments:

> [79] Before turning to the principles of fundamental justice at play, a general comment is in order. 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. These competing moral claims and broad societal benefits are more appropriately considered at the stage of justification under s. 1 of the *Charter*…
>
> [80] … A claimant under s. 7 must show that the state has deprived them of their life, liberty or security of the person and that the deprivation is not in accordance with the principles of fundamental justice. They should not be tasked with also showing that these principles are "not overridden by a valid state or communal interest in these circumstances"…
>
> …
>
> [89] … As with overbreadth, the focus is not on the impact of the measure on society or the public, which are matters for s. 1, but on its impact on the rights of the claimant. The inquiry into gross disproportionality compares the law's purpose, "taken at face value", with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law …
>
> …

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> [95] … However, in some situations the state may be able to show that the public good — a matter not considered under s. 7, which looks only at the impact on the rights claimants — justifies depriving an individual of life, liberty or security of the person under s. 1 of the *Charter.* More particularly, <u>in cases such as this where the competing societal interests are themselves protected under the *Charter*, a restriction on s. 7 rights may in the end be found to be proportionate to its objective</u>.
>
> [Emphasis added, citations omitted.]

[326] Central to the disproportionality analysis is a <u>qualitative</u> (rather than quantitative) comparison between the importance of the law's object and the magnitude of its impact on an individual whose *Charter* rights are engaged—the more trifling the object or the more severe the impact, the more likely a finding of gross disproportionality. Thus, a law that seeks to keep the streets clean by imposing a sentence of life imprisonment for spitting is grossly disproportionate, as is a law that seeks to reduce neighbourhood disruption and nuisance by making it a crime to operate a public bawdy house, increasing the risk of harm to sex workers who are then less able to protect themselves from violent attacks and homicide: *Bedford* at para. 134.

[327] However, it appears there has been a subtle shift in the Supreme Court's views on this matter. In *R. v. Brown*, 2022 SCC 18, the Court appears to accept that where conflicting *Charter* rights are each directly implicated by state action, then recognition of that conflict may be relevant to the analysis of the principles of fundamental justice. As we shall explain below, we think the issue before us does engage conflicting *Charter* rights directly implicated by state action.

[328] Subject, however, to the implications of *Brown*, the Supreme Court instructs us to undertake a qualitative assessment and focus relentlessly on the rights of the individual claimant, to accept that the effect on the rights of even one person can be inconsistent with the principles of fundamental justice, and not to balance competing moral claims or broad societal benefits at this stage of the analysis.

[329] At the same time, the Court has been clear that "[t]he rule against gross disproportionality only applies in <u>extreme</u> cases where the seriousness of the

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deprivation is totally out of sync with the objective of the measure": *Bedford* at para. 120 (emphasis added). This is not an easy standard to meet. As noted in *Insite*, the effects of the state action or law must be "so extreme as to be disproportionate to any legitimate government interest": at para. 133. And the law's impact and its object may be incommensurate without reaching the standard of gross disproportionality; *Carter* at para. 89. In short, before a law can reach the standard, the relationship between the deprivation, even of one person, and its objects, must violate our sense of the fundamental norms acceptable in our society. As the Court said in *Bedford*, "[t]he connection between the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society": at para. 120 (emphasis added).

[330] This analysis calls for a deeper assessment of the purpose of the impugned provisions. It involves a qualitative assessment of the significance of that purpose when measured against the effect on *Charter* rights.

[331] We say this, in part, because this case is unlike those cases in which the Supreme Court has articulated the governing principles and found gross disproportionality. This case does not deal with a law with a purpose of promoting public benefits or the public interest in a generic and amorphous way. Furthermore, this case is not one in which the law (that is, the impugned provisions) itself immediately and inevitably gives rise to the deprivation of s. 7 rights. In past cases, state-imposed prohibitions have directly put individuals in danger, often with the other option being the threat of criminal sanction for the claimant or someone attempting to keep them safe (see e.g., *Carter* and *Bedford*). In this case, the deprivation does not arise in such an immediate and direct way nor are its adverse impacts felt by a clearly defined and discrete group of persons subject to the law.

[332] The existence of lengthy waits for healthcare in the public system is not a direct, inevitable, or even probable effect of the impugned provisions. Waiting arises from capacity constraints in the system and the lack of resources available to meet wait time benchmarks in the face of budget constraints and competing priorities. The

effect of the impugned provisions is to discourage the development of a parallel private system. It is not inevitable that this would cause the current wait time problem. This has some importance to assessing the connection of the law's objective to its adverse consequences.

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[333] It is our view the rights of different patients are in conflict and are directly implicated by state action. On our analysis, the s. 7 right to life and security of the person is deprived by the effect of the impugned provisions for some patients who could avoid the serious harm of waiting beyond the benchmark by making private provision that would otherwise be available. The judge, however, made a number of findings of fact about the consequences of the state permitting the development of a duplicative private system in the absence of the impugned provisions. In short, a burden would fall on those without resources who were dependent on the public system and could not avail themselves of a private alternative. Those individuals would, on the judge's findings, among other matters, suffer the consequences of reduced capacity in the public system, reduced quality of care, including increased wait times, and a tendency for physicians to prioritize private patients at the expense of public patients.

[334] The judge identified many deleterious consequences of permitting a duplicative private system. Some of these are general in nature, such as increased cost. But many demonstrate the impact on patients who cannot afford a private alternative. Those effects, in our view, engage the s. 7 rights of those who would be affected by the removal of the impugned provisions. In a world of scarcity, part of the objective of the scheme and the means adopted is to protect those s. 7 interests. It is in, at least, this sense that we think that on the judge's findings of fact the s. 7 rights of both those who can afford a private alternative and those who cannot are directly implicated by the state's action in the existence or otherwise of the impugned provisions. A balancing of *Charter* rights is engaged on the facts of this case.

[335] Our colleague makes a number of criticisms of our analysis. In her view, these include an assertion of a free-standing right to healthcare and a mistaken

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analysis about whether s. 7 rights are in conflict. As a result, we think it helpful to comment on those criticisms, in order to assist in appreciating the difference in our views. While we respectfully do not agree with her other criticisms, we think it more appropriate to leave it to others to evaluate the merits of our disagreements on these limited number of issues.

[336] We do not think that we are asserting a free-standing constitutional right to healthcare and agree that no such right has been accepted. In our view, our analysis proceeds from the fact that the state has undertaken both to provide and regulate the provision of healthcare. Our s. 7 analysis turns on the fact the state is engaged in the provision of healthcare according to certain principles and the implications of that action for individual rights.

[337] The reason we think that s. 7 rights are in conflict is rooted in the judge's findings outlined above, coupled with the articulation of the objective of the legislature as we have analysed it. Hence, the objective of providing necessary medical care according to need and not the ability to pay engages a distributional principle that conflicts are to be settled by prioritizing need over ability to pay. If the province were to organize its delivery of healthcare so that those who could pay for private healthcare were allowed to do so to avoid unreasonable wait times, this would engage potentially conflicting s. 7 rights: individuals without means to pay would end up waiting longer in a public system with worse access than otherwise would have been the case.

[338] The state has mandated an objective that, on the judge's findings of fact, would be not be achieved if a private parallel system (to protect the s. 7 rights of those deprived of private care) were allowed to emerge. The price paid to avoid depriving some of their s. 7 rights is to condemn others to the deprivation of theirs. Although there may be, when viewed in a certain way, a positive right aspect to this deprivation, it arises from the legislative objective and the state action in furtherance of that objective. We endorse the proposition, accepted by the judge, that when the province assumes a monopoly power over the provision of medical services it is

under a constitutional duty to ensure that the service is provided in a timely fashion: at para. 1330, citing Peter W. Hogg, *Constitutional Law of Canada*, 5th ed. (Toronto: Thomson Reuters Canada Limited, 2007) (loose-leaf updated 2019), c. 32.6 at 32–13, citing *Morgentaler*, *Chaoulli* and *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27 [*Health Services*]. Here, in our view, the province has asserted a monopoly regulatory power over the provision of medical services in a way that inherently creates the potential conflict of rights we describe. We will develop these considerations more fully below.

[339] We turn now, more specifically to what the Court had to say about balancing *Charter* rights within s. 7 in *Brown*:

> [67] As a preliminary matter, the Court must first decide whether the rights of victims of intoxicated violence, in particular the rights of women and children under ss. 7 and 15 of the *Charter* and alluded to in the preamble to Bill C-72, should inform the analysis of a possible breach of the accused's rights under s. 7, or whether it is appropriate to consider these interests specifically at the justification stage under s. 1.
>
> [68] The intervener Women's Legal Education and Action Fund Inc. (LEAF) invites this Court to balance the rights of the accused against the rights of women and children in the s. 7 analysis. It says that, in *Daviault*, there was no consideration of competing rights at that stage, unlike the clear engagement with equality, security and dignity interests in Bill C-72. These rights are not simply other social interests that should be "relegated" to the s. 1 justification. Where courts fail to undertake balancing under s. 7 — as the majority of the Court of Appeal did not do in *Sullivan*, for example — the effect is that, wittingly or unwittingly, they favour individual rights over those of vulnerable groups who disproportionately bear the risk of intoxicated violence. Others, including the Crown and the Canadian Civil Liberties Association, depart from this view and submit that the interests of women and children are properly considered under s. 1 following *Canada (Attorney General) v. Bedford*, and *Carter v. Canada (Attorney General)*.
>
> [69] LEAF invokes *Dagenais v. Canadian Broadcasting Corp.*, and *R. v. Mills*, in which this Court balanced competing *Charter* rights under the breach analysis. These cases involved situations where state action directly implicated multiple sets of *Charter* rights. In both, the procedural rights of the accused brought the *Charter* rights of another party into conflict and created the risk that both sets of rights would be undermined.
>
> [70] In my view, the *Dagenais* and *Mills* mode of analysis does not apply and does not support the argument that balancing between the rights and interests of alleged perpetrators and victims of crime should take place under s. 7 in this circumstance. *Dagenais* and *Mills* apply when the *Charter* rights of two or more parties are in conflict and both are directly implicated by state action, which is not the case here. Section 33.1 affects the substantive rights

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of the accused subject to prosecution by the state. The equality and dignity interests of women and children are certainly engaged as potential victims of crime — but in this context, by virtue of the accused's actions, not of some state action against them. This is qualitatively different from the balancing undertaken for example in *Mills*, where it was state action — through the application of an evidentiary rule for the production of records to the accused relating to the complainant — that directly affected both the accused and the complainant. Section 33.1 operates to constrain the ability of an accused to rely on the defence of automatism but nothing in the provision limits, by the state's action, the rights of victims including the ss. 7, 15 and 28 *Charter* rights of women and children. These interests are appropriately understood as justification for the infringement by the state. As the preamble of Bill C-72 makes plain, the equality, dignity and security interests of vulnerable groups informed the overarching social policy goals of Parliament; they are best considered under s. 1.

[71] Considering these as societal concerns under s. 1 does not "relegate" the equality, security and dignity interests of women and children to second order importance. LEAF is correct to say that these rights are intensely important and must be given full consideration in the *Charter* analysis. Indeed, it has been usefully argued that the opportunity to consider the competing interests of vulnerable groups in the present context should find its fullest expression when a court considers the proportionality of deleterious and salutary effects of legislation under s. 1. Commenting on the justification for the breach by the majority of the Court of Appeal in *Sullivan*, Professor S. Coughlan writes that s. 1, as opposed to s. 7, gives a proper opportunity to "shift from an individual focus to a comparative focus", which is methodologically more suited to balancing under s. 1 than s. 7 in this context. Counsel for LEAF at the Sullivan and Chan appeals rightly urged that, as an alternative to her preferred s. 7 balancing, s. 1 should be seized upon by this Court to reinforce the accountability and protective objectives of s. 33.1 from the perspective of the particular vulnerability of women and children to the intoxicated violence. I agree.

[72] Finally, and with due respect for other views, the basic values against arbitrariness, overbreadth and gross disproportionality are unrelated to the analysis of the *Charter* rights engaged in this appeal and the *Sullivan* and *Chan* appeals. The principles in *Bedford* speak to "failures of instrumental rationality" that reflect a legislative provision that is unconnected from or grossly disproportionate with its purpose (para. 107). By contrast, the principles of fundamental justice in this case relate to substantive and procedural standards for criminal liability that ensure the fair operation of the legal system and which are "found in the basic tenets of our legal system" (*Motor Vehicle Reference*, at p. 503). I agree on this point with Paciocco J.A. in *Sullivan* (para. 61) that the challenge here pertains to s. 7 principles of the voluntariness and *mens rea* required to justify punishment and not those matters of arbitrariness and proportionality at issue in *Bedford*. A court's s. 7 analysis should start by asking whether a statutory provision fails to meet the requirements of the specific principle raised by the claimant before turning to the more general matter as to whether the law is arbitrary or disproportionate

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> in light of its purpose in the Bedford sense (R*. v. Malmo-Levine* at paras. 129 and 135–45).
>
> [Citations omitted.]

[340] Thus, taking account of competing *Charter* rights within the s. 7 analysis may be appropriate where state action directly brings competing *Charter* rights into conflict. It is not appropriate in circumstances where the rights of others are threatened not by state action but by the action of private individuals. Equally, it is not appropriate where the balance is between established *Charter* rights and matters of the general public interest of budgetary concerns. In those cases, competing rights and the public interest are considered as part of the proportionality of deleterious and salutary effects of legislation under s. 1. In this case, the gross disproportionality analysis, in our opinion, unavoidably engages the effects on competing *Charter* rights given the objective of the law and the role state action plays in putting those rights at risk.

[341] We turn now to address what we see as the critical issue on this aspect of the appeal. In order to assess whether the impugned provisions fail the gross disproportionality test because the draconian effect of the law is entirely outside our societal norms, it is necessary to explore some relevant context more explicitly.

[342] We begin by observing that we would agree with the judge that if the only s. 7 deprivation involved the security of the person rights of patients, then the impugned provisions are not grossly disproportionate. We do not think this is a quantitative analysis, but it is measuring the effect of the provisions against the importance of their purpose. The real issue arises because, as we have found, some patients' lengthy wait for certain procedures increases their risk of dying and the impugned provisions prevent them accessing private care to alleviate that risk. It is also relevant that we have concluded the number of patients whose s. 7 rights were deprived is materially greater than acknowledged by the judge.

[343] As we have discussed, it is sufficient that this circumstance is made out in respect of at least one individual to establish the deprivation at the first stage of the

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s. 7 analysis. However, we think that more needs to be said to assess the extent of the deprivation in a complex scheme intended to provide and regulate medical care at the second stage of the analysis.

[344] First, it should be recalled that the claim engages the effects of the impugned provisions on a complex system including scheduled diagnostic and surgical procedures. Many of these procedures do not involve life-threatening conditions. Indeed, the primary (although not exclusive) focus of the claim is orthopaedic procedures which are not generally life-threatening: at para. 1772. Accordingly, conclusions about whether the deprivations of s. 7 rights are not in accordance with principles of fundamental justice must be analysed in relation to the class of patients whose risk of death was increased by the impugned provisions and who were deprived of the opportunity to alleviate that risk.

[345] Second, the judge found as a fact that the plaintiffs had not proven that any individual had in fact died because of the impugned provisions while waiting care. Further, the judge also found that it had not been demonstrated that the medical condition of individuals had deteriorated while waiting so as to increase their risk of death.

[346] We also defer to the judge's conclusion that the appellants did not prove a deprivation of the right to life of any individual plaintiff of patient witness. At best, the plaintiffs had standing to advance a claim in respect of a class of unknown individuals whose s. 7 interests are engaged by the impugned provisions.

[347] Other findings also remain pertinent. Care for emergent, unscheduled surgical procedures was excellent and timely. This may explain, on the evidence, the judge's finding of the absence of death attributable to wait times. He also concluded that surgeons actively triage patients and alter their priority code to respond to any changing risks. Furthermore, some wait times are not sufficiently connected to the impugned provisions, including those caused or increased by decisions made by patients and surgeons. It also would capture wait times for procedures that are unavailable privately for some reason other than the impugned provisions (for

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example, those that are too complex, or not permitted by the College to be performed privately).

[348] What we are left with then is this: the risk of death has increased for an unknown number of individuals suffering from life-threatening conditions who wait beyond the benchmark for certain procedures and who, but for the impugned provisions, would otherwise have been able to access private care and mitigate the wait. We cannot say how many individuals fall within this class. We cannot quantify the increase in the risk of death. There is no evidentiary basis to do so. We do not have the benefit of a study such as that in *R. v. Michaud*, 2015 ONCA 585 that estimated a 2% increased risk of death in accidents caused by the use of speed-limiters in trucks. We are left with an unquantifiable, unknowable risk, affecting an unknown number of persons waiting for a limited number of diagnostic or surgical procedures among a large array of procedures affected by the impugned provisions.

[349] We wish to emphasize that we do not minimize the seriousness of these deprivations. Although much is unknown, we are discussing avoidable risks faced by real people. These people are not merely statistics. They are British Columbians who are effectively deprived of the opportunity to pay out-of-pocket to alleviate the risk that they might die as a result of being required to wait longer than the benchmark for diagnosis or treatment.

[350] Hence, although the deprivation of one person's rights may be sufficient to constitute a deprivation that is not in accordance with the principles of fundamental justice, we think the analysis of the deprivation has to be informed by the context we have explained.

[351] It is now necessary to assess the reality of that deprivation against the purpose of the law. In approaching this task, we recognize, as we have emphasized, the seriousness of the interference with the rights of those individuals who are prevented from paying for early access to a diagnostic or surgical procedure thereby reducing their risk of death.

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[352] Accordingly, the question to ask is whether the fact that some unknown individuals who have the capacity to pay for medical care are deprived of the opportunity to do so at an increased risk of death by being forced to wait beyond the benchmark for medical care is:

a) an extreme case where the seriousness of the deprivation is totally out of sync with the objective of the measure; or

b) a rare case in which the law's effects on an individual is grossly out of sync with its purpose; or

c) one in which the deprivation caused by the law is so extreme as to be disproportionate to any legitimate government interest; or

d) a law in which the relationship between its effects, even on one person, and its objects must violate our sense of the fundamental norms acceptable in our society; or

e) one in which the connection between the draconian impact of the law and its object is entirely outside the norms accepted in our free and democratic society.

[353] In our view, even giving full weight to the seriousness of the deprivation, the test is not met in light of the nature of the objective or the impugned provisions.

[354] We have accepted that the objective is to ensure that the provision of medically necessary care is premised on the principle of fairness in which patients are prioritized based on their medical needs and not their ability to pay. There are two dimensions to this objective. First, meeting the medical needs of individuals. Second, doing so in accordance with an equitable principle.

[355] The point of providing access to medical care based on need is to ensure that medical care is provided to each member of our community to mitigate risks of morbidity and death. More concretely, it is to save lives and alleviate pain and suffering. These are, of course, the very same s. 7 interests engaged by the

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impugned provisions. The same interests that would be threatened by the striking down or repeal of those provisions. Viewed from one point of view, the objective of the law is to ensure that each individual's claim to medically necessary care is protected. Implicit in that objective is recognition that distribution of medical care based on the ability to pay may frustrate that objective and the objective includes obviating that risk. In our view, using the language of the Supreme Court, the issue is whether the adverse consequences of inhibiting the development of a parallel private system (with consequences for individuals who would be able to access it) are so extreme as to be disproportionate to <u>any legitimate government interest</u>.

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[356] We are reminded that in analysing the balance between the seriousness of the deprivation and the objective of the law, we are not to look at its efficacy. This complicates the analysis, because the real source of the burden on rights is not, as we have indicated, an inevitable consequence of the operation of the law. Presumably, if unlimited resources were available to be devoted to this one particular aspect of public policy (or were made available at the expense of other health, educational, and social priorities) no one would have to wait beyond the benchmark for a necessary procedure and there would be no need for anyone to resort to private care.

[357] Hence, we must engage in the gross disproportionality analysis acknowledging the reality of finite public resources and recognizing that the allocation of resources among competing priorities reflects public policy and political choices that are, for the most part, mediated through democratic processes. In short, state action, through the policy choices and priorities of government, implicates potentially conflicting *Charter* rights. Courts cannot substitute their view of policy priorities for those of democratic institutions.

[358] As we have said, we accept the personal interest British Columbians have in avoiding a lengthy wait when they have resources to avail themselves of private care to avoid an increased risk of death. We do not minimize the seriousness of that issue. But, we also recognize that the objective of the MPA includes ensuring that

individuals without the ability to pay are not thereby deprived of medically necessary care. We repeat the judge's findings of fact that, in the absence of the impugned provisions, individuals in the public system may wait longer and may not receive the medical care they need: e.g., at paras. 2343, 2387.

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[359] If we were to conclude that some individuals who can afford to pay are the victims of a law that deprived them of their rights in a manner that is not in accordance with the principles of fundamental justice, the court would grant a veto over public health policy to a single individual, at the expense of other individuals who were deprived of their s. 7 rights. It may be that this veto should be dealt with and dissolved under s. 1, but that would not address the underlying issue. Patients who face increased risk of death because they wait beyond the benchmark but who lack the ability to pay for private care surely also have a s. 7 claim that their rights are engaged by state action that has failed to ensure that benchmark wait times are met or who face longer wait times because a private system has been permitted to emerge. To repeat, the judge concluded that if a parallel private system were allowed to emerge, individuals without means would wait longer for medically necessary or may not receive it at all.

[360] It seems to us that in considering the balancing exercise we are describing, the issue is not weighing *Charter* rights against a general public interest or benefit. Rights belong to individuals. At issue here are rights and claims distributed across a population as a whole, in circumstances where it is not possible to identify particular patients who have suffered a deprivation. Inherently, what is at issue here is the differential, distributional impact of policy on s. 7 rights protections and deprivations within a population. In our view, this distributional reality is material to the assessment of gross disproportionality.

[361] The norms we are interested in reflect foundational principles of fairness and the criteria on which fundamental human needs are met. We cannot ignore the fact that no system is perfect. In the face of competing priorities and competing demands on public resources, it is likely that some shortfall of desired outcomes will occur.

The question can be framed as follows: does the failure fully to achieve the MPA's objective of guaranteeing timely care according to need and not the ability to pay make the impugned provisions totally out of sync with their objective, such that they fall entirely outside the society's accepted norms?

[362] On the record, an unknown number of individuals face an increased risk of dying if they cannot get timely access to certain medical procedures. The materiality of that risk and its quantum is unknown. It will likely be related in part to the resources available to deliver certain medical procedures. The system, however, has sufficient resources that in cases of emergent need or where patients may deteriorate and face seriously increasing risk of death, it is capable of responding and providing timely and effective care. In other words, to a significant degree the system protects against the materialization of the risk of death.

[363] Within the population we have individuals with varying amounts of wealth. Some could afford private care to varying degrees, if is available. Some may have access to the needed resources through other means. Some may not have any means of accessing private care. But individuals who face lengthy waits as a result of the impugned provisions fall into all categories. It will be recalled that the judge found that lower income British Columbians tend to be less healthy. It is a reasonable inference, based on the judge's findings, that these individuals are probably disproportionality overrepresented in the category of people who need care because their lives are at risk.

[364] We now must ask what fundamental norm related to the distribution of medical resources would be acceptable within our society? There are a range of possibilities. We could pose the question this way: Would it be entirely outside an acceptable norm to reason as follows? Of course, if one knew that one would be sufficiently wealthy to control resources to make private provision it would be in one's interest to do so. But, to address the question as a matter of fundamental justice, for society as a whole, one should do so on the basis that no one knows whether they will be among those with sufficient resources. It may be that one will

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fall into the group without those resources. If everyone had to chose a distributional principle, but did not know if they would turn out to be able to make private provision or not, it is plausible that many or most would opt for a system the protects distribution according to need, rather than ability to pay. That result may reflect hypothetical preferences rooted in self-interest in the face of uncertainly or, more directly, a sense of fairness. It is, we note, a conclusion that is consistent with the principles underlying the many commission reports into the delivery of healthcare in Canada and in British Columbia.

[365] Of course, the choice might be easy if one could anticipate that all medical needs would be satisfied. But the hypothetical choice here builds in three critical assumptions. First, that not all need can be met in a timely fashion. Second, that the price of prioritizing need is prohibiting private provision that could otherwise be available. Third, some unknown individuals are deprived of the chance to access private care resulting in an increased risk of death. It is, we think, in keeping with our society's foundational norms to prioritize fairness and chose a needs-based model. This is not to say that this principle is the only possible choice that accords with fundamental norms. It is, however, the choice the legislature has selected. What matters is that this choice cannot be said to fall entirely outside acceptable norms.

[366] We recognize the instruction that s. 7 focuses relentlessly on the individual claimant. But we do not think that can mean that foundational norms structuring the basic distributional principles ordering our society can be held hostage to the veto of any one individual who bears adverse consequences. The analysis we offer does focus on individual claims. It focuses on the effect that a complex social policy which necessarily engages the principles of fair distribution has on individual rights. It also focuses on the kinds of choices British Columbians make when faced with the most fundamental questions about what kind of society they would chose to live in and how to breathe life into the fundamental norms defining that society.

[367] In the result, we conclude that the impugned provisions are not grossly disproportionate.

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[368] The s. 7 deprivations are in accordance with the principles of fundamental justice.

SECTION 1

[369] In light of our conclusion that the appellants have not made out their s. 7 claim, the appeal must be dismissed. It is unnecessary to go on to address s. 1. If we are wrong about s. 7 and the impugned provisions deprive patients of their s. 7 rights not in accordance with the principles of fundamental justice, we would adopt the reasoning of our colleague, Justice Fenlon with respect to s. 1.

DISPOSITION

[370] We would dismiss the appeal. In light of the public interest at stake in this appeal, we would not award costs of the appeal to any party or intervenor.

"The Honourable Chief Justice Bauman"

"The Honourable Mr. Justice Harris"

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<u>Reasons for judgment of the Honourable Madam Justice Fenlon</u>

[371] I agree with my colleagues on the disposition of this appeal and on all points of the analysis save whether the effects of the impugned provisions are grossly disproportionate to their object. In my respectful view, they are.

[372] First, I accept that *R. v. Brown*, 2022 SCC 18, may signal a shift in the s. 7 analysis where conflicting *Charter* rights are directly implicated by the same state action, but, in my view, this case does not involve conflicting *Charter* rights.

[373] My colleagues state that patients who face increased risk of death because they wait beyond benchmarks, but who lack the ability to pay for private care "surely also have a s. 7 claim that their rights are engaged by state action that has failed to ensure that benchmark wait times are met or who face longer wait times because a private system has been permitted to emerge". However, it is common ground in this case that there is no *Charter* right to healthcare. The state is not under a legal or constitutional obligation to provide healthcare to its citizens—indeed, government provision of healthcare is a relatively new development, emerging in the 1960s.

[374] The appellants do not assert such a right; they do not claim that a public system that causes them to wait past the benchmarks infringes their right to life, liberty, and security of the person. Rather, it is the government's act of legislating to suppress the private healthcare that would otherwise be available to them that is said to infringe their right to life and security of the person.

[375] The appellants' framing of the *Charter* breach in this way is consistent with the nature of the right granted by s. 7. Section 7 does not impose on the government a positive duty to implement social programs so as to ensure to everyone life, liberty, and security of the person. Rather, s. 7 gives everyone the right <u>not to be deprived</u> of those rights by reason of state action. Thus, a legislative program that provided social assistance at a level inadequate to meet basic needs was held not to breach

s. 7: *Gosselin v. Québec (Attorney General)*, 2002 SCC 82 at paras. 47–84. The majority in *Gosselin* observed:

> 81 Even if s. 7 could be read to encompass economic rights, a further hurdle emerges. Section 7 speaks of the right not to be deprived of life, liberty and security of the person, except in accordance with the principles of fundamental justice. Nothing in the jurisprudence thus far suggests that s. 7 places a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person. Rather, s. 7 has been interpreted as restricting the state's ability to deprive people of these. Such a deprivation does not exist in the case at bar.
>
> [Emphasis in original.]

[376] *Gosselin* did not rule out the possibility that s. 7 might one day be interpreted as creating positive rights, but we are not there yet. In *Victoria (City) v. Adams*, 2009 BCCA 563, the issue was raised again but this Court found it unnecessary to address it given that the bylaw in issue involved a deprivation of the right to life and security by prohibiting homeless people from erecting overhead protection overnight, such as tents and tarps. Section 7 was not relied on to impose a positive duty upon the city to provide shelter to its residents (at paras. 90–95).

[377] Nor is it clear that s. 7 would be engaged if the government for policy reasons decided to stop suppressing private healthcare. If a private system were permitted to function alongside the public one, any disparity in access to private care would be due arguably to economic imbalances in society and not government action. Economic inequality exists throughout society in areas like healthcare and shelter that fundamentally affect people's lives and basic needs, without engaging *Charter* rights.

[378] Those who could not afford private care have a compelling interest in obtaining timely care in the public system and in suppressing a private system that could negatively affect that system, but an interest is not a *Charter* right.

[379] In summary on this first point, there is a compelling public interest in providing healthcare to all on the basis of need that engages the interests of those patients who could not pay for private care if it were available, who would be dependent on

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the state for healthcare, and whose wait times might be even longer if private care were to emerge. Those are undoubtedly important conflicting interests that must be weighed in this case under s. 1, but, in my view, they cannot be described as conflicting *Charter* rights.

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[380] Second, I do not agree that balancing of competing interests under s. 7 is required in order to avoid society being held hostage by “the veto of any one individual who bears adverse consequences” as my colleagues suggest. A claimant’s burden of establishing a *Charter* breach of s. 7 is only one part of the analysis. The needs of others, and the foundational norms of society, are squarely considered under s. 1. It is, ultimately, the importance of the public interests that justify the s. 7 breach. There is thus no realistic prospect of a single *Charter* claimant having a veto over the competing interests of others.

[381] Third, *Bedford* directs that s. 7 involves a <u>qualitative</u> analysis with a relentless focus on the individual. To balance the interests of those who could not afford private care against those who could, would be to conduct a <u>quantitative</u> analysis. Further, this case demonstrates the difficulty of undertaking a quantitative analysis at the s. 7 stage. The record establishes that thousands of patients are waiting too long for care, but we do not know how many of that number would be able to access private care and how many would not be able to do so. How, then, is disproportionality to be assessed? If we knew, for example, that 20 patients would be able to obtain timely treatment in the private system, but the corresponding effect would be that 100 patients would wait even longer for care in the public system than they do now, the balancing would be relatively straightforward. But we do not have precise evidence; there are only general opinions expressing the view that delays would increase to some extent in the public system.

[382] My colleagues deal with this difficulty by noting that many of the procedures patients are waiting for do not involve life-threatening conditions, that the focus of the claim was orthopedic procedures which are not generally life-threatening; that the appellants had not proven that any individual had in fact died because of the

impugned provisions while waiting; and that the system deals well with acute emergencies. With great respect, that is to minimize the infringements we have recognized. As we have found, those infringements are real, significant, and affect thousands. Orthopedic problems may not cause death, but the judge accepted that they cause real and debilitating suffering, affecting people's ability to function and work. Although specific patients were a small part of the case, the data accepted by the judge represents real people, with real pain, real setbacks, and real risk of dying prematurely.

[383] It seems to me that it will be a rare case indeed in which a court will have reliable quantitative evidence sufficient to balance competing interests at the s. 7 stage of the *Charter* analysis. Without that evidence, the court would have to look to the broad social benefits of any government initiative, as the judge did in this case, considering the general salutary effect of suppressing private healthcare, and the negative impact on others should the provisions be struck down: at paras. 2773–2779.

[384] The balancing of competing social interests in assessing the gross disproportionality blurs the distinction between ss. 1 and 7. Much of my colleagues' assessment in the s. 7 balancing includes consideration of limited government resources as well as foundational principles of fairness and the criteria on which fundamental human needs are met. Indeed, the very question to be answered shifts from "is the law's object totally out of sync with its impact <u>on the individual</u>" to: "<u>does the failure fully to achieve the MPA's objective</u> of guaranteeing timely care according to need and not ability to pay make the impugned provisions totally out of sync with their objective such that they fall entirely outside the society's accepted norms."

[385] Finally, balancing competing interests at this stage of the s. 7 analysis would place an enormous burden on *Charter* claimants who, as in this case, are often private citizens asserting *Charter* rights against government—often two levels of government—who have all the resources of the state behind them. The appellants in this case would be required to establish, across the entire spectrum of medical

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services, that allowing private care to exist would not negatively affect public healthcare. As the Supreme Court of Canada observed in *R. v. Mills*, [1999] 3 S.C.R. 668, 180 D.L.R. (4th) 1, there are important differences in the balancing exercises that occur under ss. 7 and 1:

> 66 However, there are several important differences between the balancing exercises under ss. 1 and 7. The most important difference is that the issue under s. 7 is the delineation of the boundaries of the rights in question whereas under s. 1 the question is whether the violation of these boundaries may be justified. The different role played by ss. 1 and 7 also has important implications regarding which party bears the burden of proof. If interests are balanced under s. 7 then it is the rights claimant who bears the burden of proving that the balance struck by the impugned legislation violates s. 7. If interests are balanced under s. 1 then it is the state that bears the burden of justifying the infringement of the *Charter* rights.

[386] More recently in *Carter v. Canada (Attorney General)*, 2015 SCC 5, the Court said:

> [80] … A claimant under s. 7 must show that the state has deprived them of their life, liberty or security of the person and that the deprivation is not in accordance with the principles of fundamental justice. They should not be tasked with also showing that these principles are "not overridden by a valid state or communal interest in these circumstances" …

[387] I conclude that, in keeping with *Bedford* and *Carter*, the court is to conduct a qualitative comparison between the importance of the law's object and the scale of the s. 7 deprivations on the individual claimants. Competing societal interests are to be considered under s. 1. Since the focus of s. 7 is "relentlessly on the individual" (*R. v. Michaud*, 2015 ONCA 585, leave to appeal refused [2015] S.C.C.A. No. 450 at para. 79 [*Michaud*]), one must compare the impact of the provisions on individuals—the potential for impaired outcomes, prolonged significant suffering, and an increased risk of death—and ask whether those infringements are totally out of sync with the objective of preserving a public healthcare system that delivers care based on need and not ability to pay.

[388] *Charter* rights must be assessed contextually. Taking the object of the provisions at face value as we must—preservation of a publicly managed and fiscally sustainable healthcare system that provides care based on need—we

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nonetheless cannot ignore the distinction between a system and the delivery of medical care. A system that provides care three years after it is needed could not, except by the most strained definition, be described as a system that provides access to medical care. Healthcare includes a temporal dimension. As McLachlin C.J. and Major J. said in *Chaoulli*, “[a]ccess to a waiting list is not access to health care”: at para. 123. Nor does waiting beyond benchmarks alongside everyone else amount to receiving care based on need. The *Canada Health Act* at s. 3 states that “the primary objective of Canadian health care policy 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.” (Emphasis added.)

[389] As the judge observed, “when the province assumes a monopoly power over the provision of medical services it is under a constitutional duty to ensure that the service is provided in a timely fashion”: at para. 1330, citing Peter W. Hogg, *Constitutional Law of Canada*, 5th ed. (Toronto: Thomson Reuters Canada Limited, 2007) (loose-leaf updated 2019), c. 32.6 at 32-13, citing *Morgentaler*, *Chaoulli* and *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27 [*Health Services*]. Thus, governments are, in some circumstances, “constitutionally obliged to provide public health care of a reasonable standard within a reasonable time”: *Health Services* at para. 144. In *Chaoulli*, the minority judgment criticized this description of a constitutional obligation given the uncertainty inherent in phrases such as “reasonable” and “timely”: at para. 163. Those comments were made in 2005 when there were no established standards, benchmarks, or priority codes in place in Québec or British Columbia: at para. 1332. The judge acknowledged, however, that in British Columbia there is now a comprehensive and sophisticated diagnostic prioritization mechanism in the form of British Columbia’s prioritization codes and corresponding wait time benchmarks which were developed by physicians, healthcare administrators, and healthcare policy experts: at para. 1332. He concluded that the wait time benchmarks reflect what can be considered a “reasonable time” in any given case, as the wait time benchmark assigned to an individual patient reflects what their treating physician

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has concluded is “the maximum acceptable wait time … beyond which patients are potentially harmed”: at paras. 1334, 1336.

[390] As I have noted, at this stage of the analysis we are not to consider the societal benefits of the current system, or the costs of a different or better system. But we can recognize, based on the record below, that wait times in considerable measure flow from government rationing of healthcare—fiscal decisions about how much should be spent on the healthcare system over which they have a monopoly. The respondents acknowledge that the system does not have the resources or capacity to meet current demand: at para. 1367. It is preservation of that system that is the object of the impugned provisions. In this context, it seems to me that asking patients to wait beyond a medically determined benchmark and thereby to incur an increased risk to life and limb is grossly disproportionate to the object. In other words, it is more than incommensurate to ask patients to risk irremediable harm and increased risk of death in order to preserve a public healthcare system that is intentionally under-designed in order to achieve fiscal sustainability. In the words of McLachlin J., the law asks patients waiting beyond their benchmarks to “serve as a scapegoat”: *Carter* at para. 81 quoting *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 621, 107 D.L.R. (4th) 342.

[391] As the Supreme Court observed in *Bedford*, there is significant overlap between the three principles of fundamental justice, and one law may properly be characterized by more than one of them: at para. 107. Arguably, a law that causes patients to wait beyond a medically determined benchmark and thereby to incur an increased risk to life and limb in order to preserve a system intended to provide timely necessary care based on need is a law whose effects are inconsistent with its purpose and is, therefore, arbitrary in respect of those patients.

[392] In summary on this issue, I conclude that when the full scope of the s. 7 deprivations on individuals is compared to the object of the provisions through a qualitative lens, the impacts are totally out of sync and are, therefore, not in accordance with the principles of fundamental justice. The provisions’ effect of

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eliminating the availability of timely private care comes at too high a cost to the life and security of those individuals who cannot access timely care in the public system, but who would be able to access private care.

SECTION 1

[393] Given my conclusion above, the critical question becomes whether the s. 7 infringements of security and life interests are a reasonable limit that is demonstrably justified in a free and democratic society under s. 1 of the *Charter*.

[394] In early *Charter* jurisprudence, it was generally accepted that it would be a rare case indeed in which a law that violated the principles of fundamental justice would be saved by s. 1. In *Re B.C. Motor Vehicle Reference*, [1985] 2 S.C.R. 486, 24 D.L.R. (4th) 536 [*BC Motor Vehicle Reference*], Lamer J. opined that such could occur "only in cases arising out of exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like": at 518.

[395] That view seems to have shifted in the intervening years. In *Bedford*, the Court observed that the concepts under s. 7 and s. 1 are rooted in similar concerns, but are analytically distinct: at para. 128. Although the significance of the fundamental rights protected by s. 7 makes it unlikely that a law that violates s. 7 will be justified under s. 1, the jurisprudence since *BC Motor Vehicle Reference* recognizes that there may be some cases in which s. 1 has a role to play depending on the importance of the legislative goal and the nature of the infringement: *R. v. Safarzadeh-Markhali*, 2016 SCC 14 at para. 57; *Carter* at para. 95; *Bedford* at para. 129; *Michaud* at para. 157. As the Court put it in *Carter*:

> [82] … In some cases the government, for practical reasons, may only be able to meet an important objective by means of a law that has some fundamental flaw. ...

[396] *Michaud* was such a case. The main issue was the validity of a regulation made under Ontario's *Highway Traffic Act*, R.S.O 1990, c. H.8, that required commercial trucks to be equipped with speed limiters set to 105 km/h. Mr. Michaud was a commercial truck driver who had equipped his truck with a speed limiter set at

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109.4 km/h. After being charged with a breach of the regulation, he challenged the constitutionality of the statute and the regulation under s. 7 of the *Charter*. The Court of Appeal for Ontario accepted expert evidence that in about two percent of traffic conflicts it was necessary for a truck driver to accelerate beyond 105 km/h in order to avoid a collision. It followed that the regulation put truck drivers at a risk of physical harm by making it impossible to avoid collisions in some circumstances. This constituted a deprivation of Mr. Michaud's right to security of the person in breach of a principle of fundamental justice, here overbreadth. The regulation was nonetheless justified under s. 1 because the purpose of improving highway safety by reducing truck-related traffic accidents overall was sufficiently important to justify a limit on the *Charter* right. As the Court of Appeal for Ontario recognized in *Michaud*, *Bedford's* relentless focus on the individual under s. 7 may make s. 7 breaches easier to establish but also easier to justify in s. 1's distinct analytical space where broader social interests can be considered: at paras. 79, 83. In my view, the present case is cut from similar cloth.

[397] As set out in *R. v. Oakes,* [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200, four criteria must be established by the respondents in order to justify the s. 7 infringements under s. 1:

1. the law must pursue an object that is sufficiently important to justify limiting a *Charter* right;

2. the law must be rationally connected to the objective;

3. the law must impair the right no more than is necessary to accomplish the objective; and

4. the law must not have a disproportionately severe effect on the persons to whom it applies.

[398] The appellants accept (and I agree) that the first two criteria have been met: there is both a sufficiently important objective and a rational connection between the impugned provisions and the objective of preserving a public healthcare system that

provides care on the basis of need. The appellants argue that the judge erred, however, in finding the impugned provisions to be minimally impairing and proportionate in their effect—the third and fourth criteria to which I now turn.

Minimum Impairment

[399] Under this criterion, the court considers whether the law impairs the right no more than is necessary to accomplish the desired objective. Put another way, the court asks whether the government has established that the legislation has used the least drastic means of achieving its object: *Carter* at para. 102.

[400] The appellants submit that the judge erred in finding the provisions minimally impaired s. 7 rights, contending he showed far too much deference to the legislature. They also submit the provisions are not minimally impairing because they serve as blanket prohibitions and are not a tailored regulatory response.

[401] We begin by recognizing that under the minimum-impairment analysis, the court must be aware of the limits of its institutional competence. The role of the court is not to second-guess the legislature and simply identify a less restrictive or less impairing way to carry out the objects of the impugned legislation. As Hogg notes at §38:21:

> It is rarely self-evident that a law limiting a Charter right does so by the least drastic means. Indeed, "a judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation, and thereby enable himself to vote to strike legislation down". This is especially so if judges are unaware of the practicalities of designing and administering a regulatory regime, and are indifferent to considerations of cost. If s. 1 is to offer any real prospect of justification, the judges have to pay some degree of deference to legislative choices.

[402] The appellants acknowledge that deference is appropriate in some cases, but they say this is not a case like *Michaud* where the government, recognizing that there is a debate about countervailing risks in a situation of uncertainty, makes a decision within a margin of appreciation. They submit, rather, that the experience of parallel systems in other countries like the United Kingdom and New Zealand demonstrates that the prohibitions are not necessary to protect a private system.

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The appellants contend the impugned provisions reflect the government's decision to protect a rationed public healthcare system that fails to meet the goal of providing timely care.

[403] These submissions are effectively a challenge to the judge's findings on the complexity of the public healthcare system, the limited usefulness of international comparisons, and the negative effect of operating a parallel private system on public care and the provision of equitable access. We have already addressed these arguments and concluded that those findings were open to the judge on the record before him. The impact of allowing duplicative private care in British Columbia cannot be determined by looking to other jurisdictions. An expert for the appellants acknowledged that it has been challenging for the United Kingdom to effectively prevent physicians from prioritizing private patients at the expense of public ones through regulation: at para. 2178; see also at para. 2916–2917. That is so despite the fact that physicians in the United Kingdom are almost entirely public employees of a national health service, whereas in British Columbia most physicians are private actors: at para. 2916.

[404] The judge was also alive to the regulatory difficulties inherent in limiting the prohibitions on private insurance and extra billing to those patients waiting within the benchmarks: see e.g., 2269–2270, 2700. We see no error in the judge's analysis on this issue.

[405] In my view the judge did not err by extending the notion of deference too far under this stage of the *Oakes* test. The provisions in issue invoke all of the considerations identified by the jurisprudence in support of a high degree of deference to the legislative choice:

1. the law is premised on complex social science evidence;
2. it deals with a complex social issue;
3. it reconciles the interests of competing groups;

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4. it allocates scarce resources; and

5. it deals with a vulnerable group.

Hogg §38:21.

[406] As the judge said, "[t]here is no question that the British Columbia healthcare system is among the largest, most complex and most expensive social programs administered by the provincial government": at para. 247. In addition to the MPA, British Columbia's healthcare system is governed by numerous other statutes, including: the *Hospital Act*, R.S.B.C. 1996, c. 200; the *Hospital Insurance Act*, R.S.B.C. 1996, c. 204; the *Laboratory Services Act*, S.B.C. 2014, c. 8; the *Health Authorities Act*, R.S.B.C. 1996, c. 180; and the *Health Professions Act*, R.S.B.C. 1996, c. 183. We agree with the respondents that the provision of public health services in the province is the archetype of a complex regulatory regime. Propounding a different approach to delivery of even one part of the system—such as the provision of surgical services—"risks trivializing the challenges of fairly balancing competing claims over healthcare resources" in a system that must address acute care, residential care, mental health, and other health needs: at para. 2900.

[407] Furthermore, as the judge noted, greater deference will be afforded to the government with respect to legislation that concerns "the reconciliation of claims of competing individuals or groups or the distribution of scarce government resources": at para. 2060, quoting *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927 at 994, 58 D.L.R. (4th) 577. That is so not only in recognition of the difficulty of the choice that has to be made in striking the balance among competing needs, but also because "there are inherent advantages in a democratic society of having representative institutions deal with matters such as the division of scarce social resources between competing groups": *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 527, 76 D.L.R. (4th) 700 [*Stoffman*]. Regulation of a public healthcare system is a far different context than cases challenging criminal

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prohibitions in which the state is the singular antagonist of the person whose rights have been violated: *Stoffman* at 521.

[408] Nor do I agree with the appellants that the impugned provisions constitute an untailored and unsophisticated response to the government's objectives. The MPA has evolved incrementally over the past 50 years to address inequities arising from private billing by enrolled physicians: see e.g., paras. 199–207; see also paras. 2689–2694. Although s. 45 prohibits all private insurance, ss. 17 and 18 do not categorically block the delivery of private care by physicians. The appellants seek to remove the prohibitions so that doctors would be entitled to provide medically necessary services on a private pay basis without relinquishing their status as enrolled physicians able to bill the public healthcare insurance plan. They are not seeking the option of billing entirely privately as unenrolled physicians—that option has been and remains open to them.

[409] Enrolled physicians may provide care in private facilities as long as they do not charge more than MSP rates, and unenrolled physicians may provide private care in private facilities and charge whatever they see fit. While it is true that the provisions are effective in meeting their object of suppressing a private system—most physicians are enrolled in the public system—the option to provide exclusively private care remains open to them. Admittedly, s. 45, which prevents private insurance, means that all necessary services provided by unenrolled doctors must be paid for by patients out-of-pocket. The appellants provided little evidence about the feasibility of maintaining an unenrolled private practice, however, as the judge repeatedly observed, the provisions discourage, rather than prohibit the delivery of private care: see e.g., para. 2028.

[410] We are of course constrained by the record before the trial court which predated and, therefore, did not address any lack of capacity in the public system exposed by the COVID-19 pandemic. The day may come when a greater number of patients would be willing to spend $2,000 to $10,000 to obtain the medical help they need and have not been able to obtain in the public system. If that point is reached it

may be fiscally sustainable for more physicians to unenroll and work entirely for private-pay patients. At that critical mass, suppression measures will fail, with a corresponding negative impact on the resources available to the public system. There thus remains a strong incentive for the government to reduce wait times to avoid surging demand for private unenrolled care. If there is to be improvement in the delivery of timely care in the public system, the pressure of voter dissatisfaction with the current system and the sheer number of those who cannot obtain timely care will be catalysts for change.

[411] In conclusion on this ground of appeal, I agree with the margin of appreciation afforded by the judge to the legislative choice to suppress the emergence of a private healthcare system.

Proportionate Effect

[412] To meet this part of the *Oakes* test, the respondents must establish that the law does not have a disproportionately severe effect on the persons to whom it applies. Whereas the minimum impact criterion looks at the means used, the proportionate-effect criterion is concerned with the actual effects of the legislation. Here, the court must ask whether the *Charter* infringement is too high a price to pay for the benefit of the law.

[413] The concern addressed in the gross disproportionality analysis under s. 7 is reconsidered here, but in a much more expansive context. Rather than the narrow qualitative assessment of s. 7, with its focus on individuals whose rights might be infringed, the s. 1 assessment is both qualitative and quantitative, and the full weight of the societal benefits of the law comes into play: *Bedford* at paras. 126–127. Under s. 1, the numbers matter, both the number of those whose rights are infringed by the law and the number whose interests are protected by it.

[414] We have found that the judge understated the scale and impact of the *Charter* infringements on thousands of patients who are waiting beyond benchmarks for required care, many of whom would have the option of seeking timely private care but for the impugned provisions. But it must be remembered that not all patients

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would be able to access private care, even if private insurance were available. A remedial order striking down ss. 17, 18, and 45 to open the door to private care would not provide better access to healthcare for those too poor to afford insurance or those with complex pre-existing medical conditions who would not be eligible for private insurance, including the elderly. To the contrary, striking down the provisions could decrease access and increase wait times in the public system. The benefit to these patients of a public system based on need, and the effect striking the provisions would have on those patients, must be considered. The impugned provisions affect them as well as those who could otherwise obtain private care. As the judge noted, a significant proportion of services in the public system are provided to vulnerable people—the mentally ill, the elderly, and those suffering from chronic conditions: at paras. 2301, 2873.

[415] The record and findings of the judge amply support his conclusion that a duplicative system would result in longer wait times and, therefore, even poorer care for those who would have no option but the public system. We do not find that the judge overstated the societal benefits of the suppression of private care or the negative effects of striking the provisions on the sustainability and effectiveness of the public system.

[416] As the judge noted, although the claim focused on the impact of the impugned provisions on surgical care, they apply more broadly to the entire public health system, including primary care, emergency care, non-surgical cancer treatments, public health, residential care, mental health, and substance use: at para. 2929. He accepted that the benefits of the provisions—preserving the public system based on need—were substantial, based on his findings of the risks posed to the entire public system by duplicative care: at paras. 2664–2666.

[417] I recognize the legal dissonance in finding that a law that does not accord with the principles of fundamental justice is nonetheless constitutional. But I conclude that this is one of those rare cases that compels such a result. Section 1 is intended to ensure that laws that infringe individual rights may, if they meet certain

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criteria, nonetheless be upheld when the needs of others—the common good—compels such a result. I find that the common good in the context of this case justifies infringements of a kind I acknowledge are, from the perspective of the individual, grossly disproportionate: prolonged suffering, irremediable physical harm, and even increased risk to life. That is so because the negative consequences of striking the impugned provisions and allowing private care would cause those who could not avail themselves of private care—the most vulnerable in society—to wait even longer for care, thereby potentially increasing their risk of harm—beyond that we have found to exist under the current regime. Consideration of the interests of those patients who could not afford private care accords with the Supreme Court's guidance in *R. v. Edwards Books and Art Ltd.,* [1986] 2 S.C.R. 713 at 779, 35 D.L.R. (4th) 1:

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

[418] In assessing the impact of allowing a duplicative private healthcare system, the judge necessarily relied on imprecise social science evidence. For example, although the evidence demonstrated correlations between private care and negative effects on public systems, it did not establish clear causation. Nor can we know precisely how much longer patients reliant on the public system would wait for care if a duplicative private system emerged. Better and more precise data might illustrate that there would be a minor increase in wait times for public patients and an associated drastic decrease in wait times for private patients, which might be constitutionally justifiable under s. 1. However, the studies, data, and expert opinions do not provide that level of certainty. The weighing of societal benefits and disadvantages does not conduce to precise measurements and comparisons. It is for that reason the legislature is afforded a margin of appreciation in crafting complex regulatory schemes. Put another way, the court must be aware of its institutional role and limits.

[419] The court cannot act as a royal commission. Earlier in the judgment we allude to comprehensive reviews by such commissions that have studied the unified delivery of healthcare in Canada. All of them have concluded one public system should be continued despite the imperfections of this model. That is not to say that the court can never address *Charter* arguments and challenges to rights infringed in the context of healthcare, but the intractability of problems within the healthcare system despite the concerted efforts of experts and royal commissions should inspire some degree of judicial humility when considering whether a regulatory scheme developed by the legislature over the course of 50 years cannot be justified under s. 1.

[420] For a court accustomed to protecting *Charter* rights of the parties who come before it, the conclusion we are compelled to reach is far from a satisfactory one. The record establishes that thousands of patients every year are waiting beyond medically acceptable wait times for care. Those thousands include many, perhaps even a majority, who could afford private insurance and private care if the impugned provisions did not effectively prevent a private system from emerging. Even without private insurance, many could and would choose to pay for basic surgeries for cataracts, hips, knee replacements, and for diagnostic tests. It is this broad range of British Columbians of relatively ordinary means who are being denied a remedy by the application of s. 1—the truly wealthy will simply cross the border to avail themselves of the private care available in the United States.

[421] We reach the decision we do in this case, constrained by the record, and recognizing that the impugned provisions are upheld at the cost of real hardship and suffering to many for whom the public system is failing to provide timely necessary care.

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DISPOSITION

[422] I would dismiss the appeal and also, in light of the public interest at stake in this appeal, not award costs of the appeal to any party or intervenor.

"The Honourable Madam Justice Fenlon"