No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO, WALID KHALFALLAH, by his litigation guardian DEBBIE WAITKUS and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH OF BRITISH COLUMBIA and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

(cont'd on following page)

OPENING STATEMENT OF THE COALITION INTERVENORS

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INTERVENORS

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A PARTY PURSUANT TO THE NOTICE OF CONSTITUTIONAL QUESTION

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OPENING STATEMENT OF THE COALITION INTERVENORS

1. This is the opening statement of the intervenors Dr. Duncan Etches, Dr. Robert Woollard, Glyn Townson, Thomas McGregor, the British Columbia Friends of Medicare Society, and Canadian Doctors for Medicare. We shall refer to this coalition of intervenors as the BC Physicians and Patients Coalition, or the Coalition Intervenors.

2. Over the next 30 minutes, I will describe:

   a. the individuals and organizations we represent;

   b. the evidence that we intend to contribute to this litigation and how that evidence fits into the larger case; and

   c. the important context or lens through which we ask this Court to consider and assess the evidence and arguments in this case.

A. WHO WE ARE

3. The intervenors we represent are four individuals – two patients and two physicians – and two organizations - the BC Friends of Medicare Society and Canadian Doctors for Medicare. Our clients include some of the most vulnerable beneficiaries of BC's universal public health care system, who stand to lose the most in this case, if the fundamental and core principle that every British Columbian should have equal access to physician and hospital services is undermined. Our clients also include physician providers of health care committed to the principles of universality and equal access, who would shoulder the damaging consequences if our publicly-funded single payor Medicare system is weakened.

4. Glyn Townson is the past Chair of the Positive Living Society of British Columbia, a collective of people living with AIDS and HIV. Mr. Townson has also himself been diagnosed with AIDS and has many concurrent health problems. Mr. Townson is a frequent user of the BC public health care system. With an annual income of $20,000, he is even more reliant than healthier individuals on the public health care system, to cover the cost of his essential and

critical medical needs (both primary care and specialist), and in order to receive equal access to quality health services.[1]

5. Thomas McGregor was the Co-Director of Advocacy for the BC Coalition of People with Disabilities until 2002 when he had to resign for health reasons. Mr. McGregor suffers from Limb-Girdle Muscular Dystrophy. As a result he uses the public health care system frequently and is more reliant than healthier individuals on the system to cover the cost of his medical needs. His approximate annual income is $15,000, primarily from Canada Disability Pension.[2] Mr. Townson and Mr. McGregor represent the *most vulnerable* beneficiaries of BC's health care system that the plaintiffs are asking this court to fundamentally change. Mr. Townson and Mr. McGregor would be disproportionately burdened by any weakening of the publicly funded health care system that would likely result from the development of a parallel private tier, since they are dependent upon the public system for their life and health. We do not expect the evidence to establish that people like Mr. Townson or Mr. McGregor - or for that matter the majority of ordinary British Columbians - would ever be able to afford the added burden of private insurance. Even if they could overcome these financial obstacles, their health status would likely be a barrier to any private insurance, as insurance providers – especially profit-driven insurers - will not insure individuals with disabilities or pre-existing conditions, or will exclude from coverage the very disabilities or pre-existing conditions most likely to require medical care. As a result, while they are not the main parties in this litigation, it is essential that their voices be heard.

6. We also represent two physicians. First, Dr. Duncan Etches, a practicing physician and Clinical Professor in the Department of Family Practice in the Faculty of Medicine at the University of British Columbia. Dr Etches is the medical director of South Granville Park Lodge, Dogwood Lodge and False Creek Residence, the chair of the board of Chalmers Lodge, and the District 3 representative for the College of Physicians and Surgeons. He is a former Director of the BC Women's Hospital Family Practice Centre, and former District 3 representative to the Board of the British Columbia Medical Association (now Doctors of BC) Second, the Coalition Intervenors include Dr. Robert Woollard, who has practised medicine in

[1] *Schooff v. Medical Services Commission*, 2009 BCSC 1596 [*Schooff*], paras. 159-61
[2] *Schooff*, para. 157

the province for over 40 years and has been actively involved in teaching medicine since 1974. Dr. Woollard has been a tenured, full professor at the Faculty of Medicine at the University of British Columbia since 1995, and served as the Royal Canadian Legion Professor and Head of the Department of Family Practice there from 1998 to 2008.[3]

7. Dr. Woollard is also the Vice-Chair of Canadian Doctors for Medicare ("CDM").[4] CDM is one of the organizations of this intervening coalition. CDM represents doctors across Canada committed to preserving, strengthening and improving Canada's universal and publicly-funded health care system for the benefit of *all* Canadians.[5] Its physician members collectively reflect the interests and concerns of physicians like Dr. Etches and Dr. Woollard.

8. Dr. Etches, Dr. Woollard and the physician members of CDM all support the preservation of a universal and single payor publicly funded health care system in Canada. They are critically concerned that if the protections the plaintiffs' challenge are struck down, the resulting for-profit and parallel private system of health care would severely impact the ability of members of the medical profession to provide the very best care to patients according to need, not ability to pay.[6]

9. The last Coalition Intervenor, the British Columbia Friends of Medicare Society, known as the BC Health Coalition ("BCHC") is a network of organizations and individuals from across British Columbia dedicated to the preservation and improvement of Medicare. The BCHC, which was founded in 1995, encompasses over 50 member organizations representing seniors, women, people with disabilities, anti-poverty activists, health care providers, patients, members of faith-based organizations and labour unions.[7] Many of their members would face insurmountable health and income barriers to accessing the kind of privately financed health care system the plaintiffs seek to impose. They are very concerned that the shift to a parallel for-profit private system would reduce resources and capacity in the public health care system to provide for patients, would establish harmful incentives for longer wait times in the public system, and would make it even more difficult to implement the necessary reforms we need to

[3] *Schooff*, para. 162
[4] *Schooff*, para. 163
[5] *Schooff*, para. 163
[6] *Schooff*, paras. 164-65
[7] *Schooff*, paras. 170

improve the public system. Despite the plaintiffs' claims to the contrary, we expect that you will hear considerable evidence to support the validity and strength of these concerns.

10. In short, the Coalition Intervenors are here to advocate for all of those British Columbians who rely on the public system, and whose right to *equitable* access to health care without regard to financial means or ability to pay - the very object of the legislation being attacked – would be undermined if the plaintiffs were to succeed. Indeed, one of the most important considerations we will be urging your Lordship to maintain top of mind throughout these proceedings is the adverse impact on the s. 7 and s. 15 interests of ordinary British Columbians whose health depends on retaining the longstanding protections that the plaintiffs seek to eliminate.

B. OUR EVIDENCE

11. Pursuant to the Order of this Court dated May 21, 2014, the Coalition Intervenors have tendered the evidence of two experts in this proceeding – Professor Marie-Claude Prémont, and Dr. David Himmelstein – each of whom has prepared an expert report that will be tendered at this trial. Briefly, their evidence will be the following.

12. Professor Prémont is a professor at the Ecole nationale d'administration publique in Montreal, before which she was a member of the Faculty of Law of McGill University. Her expertise in health law focuses on healthcare organization, delivery and financing. She has published extensively on the implications of the *Chaoulli* decision in Quebec.[8]

13. In her evidence, Professor Prémont explains how the protections being challenged in this case represent the three core regulatory measures used by provinces to achieve the objectives underlying the *Canada Health Act*[9] – these measures are (i) the prohibition of duplicative private insurance, (ii) the prohibition of dual practice or co-mingling of physicians in the public and private spheres, and (iii) the capping of private medical fees to the level of public fees. Each of these measures forms part of a regulatory framework designed to enhance the sustainability of public healthcare and ensure that *public* financing of healthcare is directed to the *equitable*

[8] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*]
[9] *Canada Health Act*, R.S.C. 1985, c. C-6

delivery of care. The policy objectives of these measures include preventing the diversion of *public* healthcare resources to a private market catering to a privileged niche, and which would in turn pose various threats to sustainability of the public system, and to the health and well-being of all who depend on it.

14. Of course, as Professor Prémont will note, the *Chaoulli* case was narrower, in that it challenged only one of the three core regulatory measures used by provinces – the prohibition on duplicative insurance. This case challenges all three, and if successful, would mean that none of the core protections necessary to preserve and strengthen our public health care system would continue or be constitutionally permitted.

15. The second expert witness tendered by the Coalition Intervenors is Dr. David Himmelstein, a professor of health policy and management at the City University of New York School of Public health and a lecturer in medicine at Harvard Medical School. Dr. Himmelstein has published extensive empirical research in highly respected peer reviewed journals on health care policy and finance, with a particular focus on comparative analyses of the U.S. and Canadian health care systems.

16. Dr. Himmelstein explains the fundamental flaws in the Plaintiffs' suggestion that striking down the protections of the *Medicare Protection Act* would open the way to a healthcare system similar to those operating in several European countries, where public and private payment systems operate in parallel. For a number of economic and historical reasons that Dr. Himmelstein explains, striking down these protections would be more likely to result in a U.S.-like healthcare system, with large public insurance programs (Medicare and Medicaid) covering the portion of the population that is unprofitable or ineligible for private insurance, and private insurers selling to more profitable portions. Dr. Himmelstein surveys the various systemic problems in the U.S.-style multi-payer system, that are largely avoided as a result of the challenged protections - and to which British Columbia would become exposed should the impugned provisions be struck down, especially given the implications, which the Court will hear about, of Canada's trade agreement, including the North American Free Trade Agreement ("NAFTA").

17. Dr. Himmelstein's evidence is that if the plaintiffs were successful, this would result in (i) greatly amplified inequalities in access to care, (ii) an acceleration of health care cost increases, (iii) a very great increase in health care administrative costs, and (iv) compromised quality of care overall.

C. CONTEXT FOR EVIDENCE

18. It is axiomatic that context is critical in *Charter* adjudication.[10] This is true in interpreting the scope of constitutional rights at issue, but also in determining the purposes of legislation, its impact, and in any s. 1 analysis.

19. The broader context of this case is distinctly different from most leading cases decided under s. 7 – for example, *Bedford*,[11] *Carter*,[12] and *Morgentaler*[13] – which arose in the criminal context where the state uses the blunt tool of the criminal law to punish individuals with criminal sanctions as a result of prohibited conduct.

20. In the case at bar, by contrast, the challenged protections comprise the central tenets of a complex socio-economic benefit and protective regulatory scheme. These protections operate individually and in tandem with the rest of the scheme to deliver British Columbia's most comprehensive social benefit – a universal, sustainable and publicly funded health care system available to all British Columbians on *equal* terms and conditions. This legislation is intended to protect the right to life and security of the person of all British Columbians, including the vulnerable and silent rights-holders whose equal access to quality health care depends upon the challenged protections.

21. As Justice Cory noted in *Wholesale Travel Group Inc*.:

> This Court has on several occasions observed that the *Charter* is not an instrument to be used by the well positioned to roll back legislative protections enacted on behalf of the vulnerable.

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[10] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*]
[11] *Canada (Attorney General) v. Bedford*, 2013 SCC 72 [*Bedford*]
[12] *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter*]
[13] *R. v. Morgentaler*, [1988] 1 S.C.R. 30 [*Morgentaler*]

> It would be unfortunate indeed if the *Charter* were used as a weapon to attack measures intended to protect the disadvantaged and comparatively powerless members of society....
>
> The importance of the vulnerability concept as a component of the contextual approach... should apply whenever regulatory legislation is subject to *Charter* challenge.[14]

22. Justice Cory's caution applies with full force to this case.

23. As you know from last week's opening statement from the plaintiffs, they assert that the plaintiffs' s. 7 rights were infringed as a result of the restriction of the ability of enrolled physicians to operate simultaneously in the public system and outside of it, and restrictions on the right of physicians to bill patients or private insurance companies in excess of the amounts paid by the public system for any work they perform.

24. However, the plaintiffs' argument ignores the extent to which the restrictions the plaintiffs' challenge have as their objective to protect equitable access to health care and to prevent harm to the public system by limiting the extent of a private market. As Justice Binnie observed for three of the six judges who reached the *Charter* issue in *Chaoulli*:

> [174] Not all Canadian provinces prohibit private health insurance, but all of them (with the arguable exception of Newfoundland) take steps to protect the public health system by discouraging the private sector, whether by prohibiting private insurance… or by prohibiting doctors who opt out of the public sector, from billing their private patients more than the public sector tariff, thereby dulling the incentive to opt out… or eliminating any form of cross-subsidy from the public to the private sector… The mixture of deterrents differs from province to province, but the underlying policies flow from the *Canada Health Act* and are the same: i.e., as a matter of principle, health care should be based on need, not wealth, and as a matter of practicality the provinces judge that growth of the private sector will undermine the strength of the public sector and its ability to achieve the objectives of the *Canada Health Act*.[15]

25. From the perspective of the Coalition Intervenors, what the plaintiffs seek flies in the face of what have been the historic and underlying objectives and rationale of the British Columbia and other Canadian medicare health insurance programs since their very outset, namely, access

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[14] *R. v. Wholesale Travel Group Inc.*, [1991] 3 S.C.R. 154, pp. 233-34; *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038, p. 1051; *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927, p. 993

[15] *Chaoulli*, para. 174

to medical care for *all* based on the same uniform financial terms and conditions, that is, regardless of ability or willingness to pay.

26. Indeed, as Justice Slatter more recently recognized in the Alberta Court of Appeal's 2015 decision in *Allen v. Alberta*:

> [16] A key aspect of the Canadian health care system is its universality, which has two main components:
>
> a) Economic Universality. Because basic health care is publicly funded, all Canadians have equal access to it. There are no distinctions to access based on means, wealth or social status.
>
> b) Risk Universality. All Canadians are entitled to access the public health system without proving "insurability". Even those who are frail, elderly, or sick, or who have genetic or other vulnerabilities to particular illnesses, are covered. No Canadian is denied coverage, or expected to contribute more to health care costs, based on his or her medical profile.[16]

27. As you will hear as the evidence unfolds, departure from these objectives would undermine the equality of British Columbia residents, undermine the efficiency, accessibility and affordability of the public health care system and weaken the public health care system that remains. If the plaintiffs are successful, the very people the Legislature seeks to protect with the *Medicare Protection Act*[17] – those who either would not qualify for or who could not afford to avail themselves of "private options" – would be harmed. They are the people who will be most at risk if the public system is weakened as a result of doctors and other health care providers leaving for a more profitable private market tier.

28. The plaintiffs say that they will establish on the evidence that the public system is not operating at full capacity when it comes to certain surgical procedures, that the provincial government is not prepared to provide the funding needed to operate at full capacity, and therefore that there will be no harm to the public system if Dr. Day and his associates were permitted to engage in dual practice and be paid more through private insurance. Apparently, they have envisaged a scheme in which a mechanism is developed which would ensure that physicians work outside the public system only where there is no work for them to do in the

[16] *Allen v. Alberta*, 2015 ABCA 277 [*Allen*], para. 16
[17] *Medicare Protection Act*, R.S.B.C. 1996, c. 286

public system. Apart from the dubious and unlikely workability and capacity to monitor and enforce such a commitment, what the plaintiffs fail to recognize, is that, whether or not there is unused surgical capacity in the public system, the harms that the restrictions on dual practice, private insurance and extra-billing are aimed at will still occur. As we expect the evidence will show, these restrictions protect patients, and the public health care system, in at least nine ways:

a. They protect patients from having their ability to pay determine their access to medical and hospital care (including in some cases the risk of financial ruin and bankruptcy), since this would undermine the core public policy and legislative objective of equal access, and the basic principle that the costs of medically necessary health care should be borne by society at large, rather than by relying on or permitting individuals to pay out of pocket directly or through private insurance. In this respect, Senator Kirby, in the same 2006 article on which the plaintiffs rely in their opening statement, acknowledges this as a valid criticism of permitting a parallel private health insurance system, noting that there is "one criticism made of the private option that is widely shared by most Canadians, including members of the Senate committee. This is that it is unfair to allow people to buy their way to the head of the queue for medically necessary services. I agree that this is a valid criticism of the system."

b. They protect patients from the additional risk that they will not be eligible to be insured privately on the same terms as others because of their pre-existing adverse health status. For example, private insurers are generally unwilling to cover pre-existing medical conditions. They also protect employers from having to bear the cost of private health insurance for their employees, which makes them more competitive in the global marketplace, and protect workers from the job lock they would experience if they needed to remain with an employer because they were afraid to lose private health insurance.

c. They protect patients from the risk of self-interest or greed among those in the medical profession who are not satisfied with the reasonable compensation

provided under the *Medicare Protection Act*, and so would charge patients extra for receiving medical care if they were allowed to do so.

d. More generally, as the evidence will show, the measures protect *all* patients from the risk that if private insurance, extra-billing and dual practice were allowed, the public system would be worse off. Despite the plaintiffs' claim to the contrary, the very real risk of sapping critical health care human and other resources from the public health care system – a public health care system which is not only comprised of surgeons, but which also includes anesthesiologists, anesthesia assistants, physician surgical assistants, nurses, medical imaging and lab technologists, respiratory therapists, health care aides, administrators and many others. All of these people are needed to run a quality public health care system – and at least some of them would be incentivized to work in a more lucrative private market for health care instead of in the public system.

e. As well, this Court will hear evidence that the measures protect patients from the perverse and destructive incentive for doctors to keep waits in the public system longer, an incentive that would exist if dual practice, extra-billing and private insurance were permitted. This is because under the system the plaintiffs propose, physicians could earn more income by siphoning patients into their private practices – in other words, no matter what the capacity of the public system, they would have an incentive to create a greater demand for private care, including by keeping their public waits longer.

f. The restrictions at issue also protect patients from physical harm. This Court will hear evidence that when surgical care is provided by private for-profit clinics, medical decision-making - especially for elective surgery - can, as a result of the conflict of interest arising from being paid more in the private system than in the public system, lead to inappropriate surgical intervention, i.e. surgeries that do not provide a health benefit to the patient, that are risky or that result in deterioration in a patient's health status.

g. They also protect the public health care system from a phenomenon this Court will hear about which is known as “cream-skimming”, where physicians in a private health care system prefer healthier patients and simpler, lower cost surgeries in order to increase their profit margin. This in turn risks undermining the public system as the efficiencies and cost savings that derive from simpler, more predictable surgeries become profits for private clinics rather than savings captured and used by the public system to mitigate the costs of more expensive and complex patient care. Again, this harm arises regardless of whether or not there is unused capacity in the public system.

h. The legislative protections are also intended to advance the objective of most effectively and efficiently deploying overall health care spending, thus protecting society from waste of scarce resources. This Court will hear evidence that marshaling the resources devoted to medical and hospital services through the public system is intended to avoid the substantially higher administrative costs and profit margins inherent in a market for private health care insurance.

i. Finally, the measures protect the public system from falling into disrepair as a result of the loss of social solidarity if a portion of the population who can afford to do so were permitted to exit the system. The measures ensure that those individuals who could otherwise opt out of the public system (because they could afford private health care) have the same stake as everyone else in supporting sufficient funding for and ongoing improvements in the public health care system.

29. It is true, as the plaintiffs have pointed out, that the legislation permits doctors to un-enroll altogether from the public system and to operate entirely outside of the public system. This right to disengage entirely has been a feature of our health care system since the birth of medicare in Saskatchewan. But under our health care system, this is only permitted if physicians and their patients are not using or being subsidized by public resources, including public payment for physician services, and use and reliance on public hospitals, publicly funded diagnostics and public community care facilities. In other words, the legislation permits a limited right for physicians to un-enroll, but stops at the point of permitting the public

subsidization of inequitable access to care, and increasing the risk of resulting harm to the public system.

30. Notably, early on in the first day of their opening last week, the plaintiffs recognized that a deliberate objective of the legislative protections under challenge is as the Coalition Intervenors contend: namely, to prevent the emergence of a private market in health care. As plaintiffs' counsel put it in his opening submissions at paragraph 43, "that is not an accidental byproduct of the Act," but rather "it is the intention of the Act." We agree. For the reasons we have discussed, and on the basis of the historical record and evidence this Court will hear, the objective of the challenged protections – the prohibitions against extra-billing, against dual practice, and against duplicative private health insurance – include at their core discouraging and preventing the growth of a market in private health insurance and private health care, and therefore the proliferation of private, for-profit health care.

31. The plaintiffs may not agree that the objectives underlying the legislative protections they challenge - including protecting equal access to physician and hospital care on uniform terms and conditions, and preventing the emergence and subsidization of a private health care market – are appropriate. However, as Justice Slatter recognized in *Allen*: "A legislative policy is not 'arbitrary' just because we may disagree with it."[18] Indeed, as the Supreme Court of Canada has held in *Bedford*, for purposes of the s. 7 fundamental justice inquiry, it is not for the plaintiffs, or for that matter the court, to question the government's objectives; rather, the objectives must be accepted at face value, as the starting point for the fundamental justice inquiry.[19]

32. And in that respect, given the complex public benefit and regulatory context in which this case arises, the Coalition Intervenors expect that the evidence will show that the challenged protections and prohibitions – far from being arbitrary, overbroad, or grossly disproportionate – are directly related to advancing the multiple and complementary objectives that underlie their enactment. As detailed by one of the Coalition Intervenors' two experts, Professor Prémont, the protections at stake are each important mechanisms by which to ensure that all Canadians have universal access to health care services irrespective of their ability or willingness to pay, and to ensure that overall societal resources are expended without the harm that would result from an

[18] *Allen*, para. 40
[19] *Bedford*, para. 125

expanded and subsidized market for private health care. As explained by the Coalition Intervenors' other expert, Dr. Himmelstein, the effect of removal of these kinds of protections would be to amplify inequalities in access to care based on ability to pay, and to accelerate overall health costs, not to mention, compromise overall quality of care.

33. The following passage from the Alberta Court of Appeal's reasons in *Allen* is particularly apposite:

> [50] ….. Permitting private health care insurance is incompatible with fundamental values underlying the Canadian system, notably economic universality and risk universality, but also public administration, and accessibility. It must be obvious that private health care insurance is only available to the wealthy and the healthy. The result in *Chaoulli* is arguably inconsistent with these core Canadian values which, to use the words of Prof. Hogg, are "…. other values respected in Canadian society". It is arguably constitutionally "justifiable" for the Canadian governments to craft a system in a Canadian context, as they have done, that is consistent with those values as expressed in the *Canada Health Act*, notwithstanding the policy choices that have been made by other democratic societies which reflect their different social circumstances.[20] [emphasis added]

34. The plaintiffs' arguments simply fail to accept that, in delivering health care to its citizens, Canada and British Columbia deliberately chose to place the principle of *substantive equality* at the centre of their health care system. That principle ensures equal access to care for all citizens based on uniform terms and conditions, without individual patients and their families facing the risk of being required to pay in excess of what is paid to physicians by the public system. In other health care systems where some element of extra-billing, or dual practice, or user fees, or parallel private insurance is permitted, governments may develop different regulatory schemes in order to provide health care in an attempt to mitigate or reduce the negative effects – but the principle of equity – which our Legislature placed at the very heart of our system – is compromised.

35. This is not to claim that there is not room for improvement in the organization and delivery of our health care system. But this Court will also hear evidence that Canada is by no means the only country to experience issues with wait lists, that no health care system is perfect or cannot be improved, and there are also waiting lists in the countries that the plaintiffs' claim Canada should emulate. This Court will also hear evidence about the difficulties of

[20] *Allen*, para. 50

cross-jurisdictional comparison in complex disparate regimes and why it is not analytically sound to focus on one or two particular features in such a scheme to the exclusion of the entire context. The health care systems in each of these jurisdictions is unique in its specific history and values, and in the various measures in place which are aimed at protecting the public health care system from being eroded by a parallel private system.

36. This in turn raises the significant question, reflected in this Court's exchange with Mr. Gall at the end of his opening, of whether the plaintiffs will be able to establish the necessary degree of causal relationship between the measures they challenge and the existence of wait lists in the public system. Once all the evidence is presented, we expect that it will show that the relief the plaintiffs seek would not reduce wait lists in the public system, and moreover, that there are other and better solutions that are more consistent with the objectives of the *Medicare Protection Act* – solutions which would not diminish the overall accessibility and quality and efficiency of our public health care system. Indeed, a misplaced focus on the measures the plaintiffs invoke - private insurance and dual practice and extra-billing – only serves to divert valuable time, energy and resources away from evidence-based strategies, about which this Court will hear, to improve use of existing surgical capacity and to improve operating room and other efficiencies in the public system.

37. At the end of the day, it is our submission that there is no constitutional right to a health care system where physicians can claim entitlement to compensation from the public system while also participating in a private system in which they are incentivized to provide preferential access to care to those who can afford to pay more for it, nor do the principles of fundamental justice require such a health care system. There is no constitutional right to a health care system in which the Legislature is prevented from enacting safeguards to protect its fundamental objective of ensuring that individuals receive access to care without fear of having to pay for that care, or that prevents the enactment of social policy that declines preferential access to those who can afford to pay extra for their care over those who might need the care more, nor do the principles of fundamental justice prevent the Legislature from enacting such safeguards. And there is no constitutional right to compel the government to subsidize a private health care system, nor do the principles of fundamental justice require it. Not only would dual practice, extra-billing and duplicative private health insurance be inconsistent with the objectives of the

legislation establishing the public health care system, but allowing such practices would also cause harm to the majority of patients served by the public health care system and to their s. 7 rights and interests.

All of which is respectfully submitted this 14th day of September, 2016.

Alison M. Latimer,
Counsel for the Coalition Intervenors