KEY FINDINGS IN JUSTICE STEEVES' DECISION

Summary of Bottom Line Findings

[15] The evidence demonstrates that there are multiple connections or rational connections between the purpose and effect of the impugned provisions of the MPA (paras. 2065-2670). These include rational bases for concluding that the introduction of duplicative private healthcare would increase demand for public care, reduce the capacity of the public system to offer medical care, increase the public system's costs, create perverse incentives for physicians, increase the risk of ethical lapses related to conflicts between the private and public practices of physicians, undermine political support for the public system, and exacerbate inequity in access to medically necessary care (paras. 2274-2670). Indeed, it would create a second tier of preferential healthcare where access is contingent on a person's ability to pay. As a result, the impugned provisions are not contrary to the principle against arbitrariness (paras. 2065-2670).

[2938] In conclusion, with respect to the plaintiffs' s. 7 claim, I have found that the impugned provisions do not deprive the right to life or liberty of the patient plaintiffs or similarly situated individuals. I have also found that the impugned provisions have the effect of limiting the right to security of the person of the patient plaintiffs Krystiana Corrado and Chris Chiavatti and similarly situated individuals who are suffering from degenerative/deteriorating conditions and waiting for elective surgery in the public system beyond their wait time benchmarks associated with their diagnostic priority codes, even though the patients are available for surgery. Specifically, some of these patients will experience prolonging and exacerbation of pain and diminished functionality as well as increased risk of not gaining full benefit from surgery.

[2939] However, I have found that the plaintiffs have not demonstrated that this limit on the right to security of the person of some patients is not in accordance with the principles of fundamental justice. Specifically, the impugned provisions are not arbitrary, overbroad or grossly disproportionate. There is a rational connection between the effects of the impugned provisions and the objectives of preserving and ensuring the sustainability of the universal public healthcare system and ensuring access to necessary medical services is based on need and not the ability to pay. The impugned provisions do not capture persons or activities that have no connection to these objectives. And, finally, the effects of the impugned provisions on the patients whose security of the person has been violated is not grossly disproportionate to the legislative purpose. The result is that the plaintiffs' s. 7 claim is dismissed.

[2940] With respect to the plaintiffs' s. 15 claim, I have found that in addition to fundamental threshold issues, the plaintiffs have not established that the impugned provisions confer a benefit or impose a burden in a manner that draws a distinction on the basis of an enumerated or analogous ground. The plaintiffs' claim under s. 15 is also dismissed.

Urgent and emergent care is provided in a timely manner

[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.

[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.

Restrictions on Duplicative Private Healthcare do not result in loss of life

[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."

[1751] This is also consistent with the evidence of patients. In Mandy Martens' case, once her cancer was diagnosed, she received timely surgery and appropriate follow-up. Likewise, Erma Krahn received timely surgical care when she required heart bypass surgery, abdominal surgery and surgery to deal with lung cancer. The only issue she complained about was the wait time for elective surgery on her knee. Barbara Collin testified that upon being diagnosed with breast cancer, she was able to access treatment "quite quickly". Other patients, such as Larry Cross, Kyle Doyle and Myrna Allison also stated in their affidavits that they received high quality and timely care when they had urgent needs.

[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.

[1760] … I conclude that the evidence does not establish that wait times for care in the public system put patients at greater risk of death. In other words, the evidence does not show wait times are clinically significant insofar as they put patients at risk of dying.

Restrictions on Duplicative Private Healthcare Do not Cause Wait times

[1340] Another limitation of the wait time data is that it does not tell us anything about what may have caused or contributed to the wait experienced by an individual patient. The evidence of patients and physicians demonstrates that lengthy wait times are caused by a variety of reasons, some of which relate to capacity in the public system, but others are associated with patient preferences as well as physicians' referral practices and how they manage their wait lists.

[1341] At times patients may elect to wait longer in order to see a specific specialist. For example Dr. Masri testified that at his clinic patients who are referred to a specific specialist with a long wait list are offered the choice of seeing another surgeon with a shorter Wait One time. However, some patients elect to wait for the surgeon with the longer wait time because of the latter's reputation:

> ... so some are given the choice to see another surgeon in our group. It's still -- the shortest time in our group is six months. So they're given the option of waiting six months, and many patients say, well, six months, 14 months, whatever; I want to wait for him because I want to see him because he operated on my friend/colleague/relative, what have you. And some say no, I want to see somebody else. So we do make an effort to allow patients to go to the next available surgeon.

[1342] Similarly, some patients are offered a surgical spot but decline to use it for various reasons. For example, Monique Forster was offered a surgical spot in October 2016 but declined to book the surgery due to a prior family commitment. Ms. Forster later decided, without first consulting her physician, that she did not need the surgery at all and asked to be removed from the wait list. A related matter is that Dr. Masri testified about patients being added to wait lists before they were willing, able and ready to undergo surgery only to then decline surgical spots for personal reasons.

[1343] Treating physicians, whether family physicians or specialists also contribute at times to lengthy wait times due to inappropriate referral practices and poor management of wait lists. For example, as discussed above, in Chris Chiavatti's case no attempts were made by the family physician to refer him to another specialist with a shorter wait time. Instead, the family physician advised him that there was no alternative to waiting for Dr. Reilly. Mr. Chiavatti testified that, had he known it was possible to be referred to another surgeon, he would have done so in order to have his surgery sooner.

[1344] Similarly, as discussed above regarding the evidence on the individual experiences of the patient plaintiffs and witnesses, no attempts were made by treating physicians to locate specialists with shorter wait times for Ms. Krahn, Ms. Forster, Ms.

Collin and Ms. Welch. And there is also evidence of physicians and specialists failing to promptly make referrals or send booking forms to the surgical booking office, thereby causing further delays. In the case of Ms. Tessier, it appears that her doctors added her to the wait list instead of referring her to another surgeon, knowing that they did not have capacity or sufficient operating room time to treat her. Likewise, as in the case of Mr. Pearson, the evidence suggests that certain specialists add patients to their wait lists before they are ready to undergo surgery, thereby artificially inflating their wait list and increasing overall wait times.

[1345] Other referral practices are more difficult to assess but nevertheless contribute to wait times. For instance, as I have discussed above, the increasing specialization of surgeons means family physicians refer patients to the specialist with a specific sub-area of expertise and, by definition, there are few specialists with that expertise. Additionally, family physicians also refer patients to the "best" surgeon based on reputation or complication rate, even though other competent surgeons may be available sooner.

[1346] Another cause for long wait times, according to the plaintiffs, is that operating room time in hospitals has been underused. There has been under-utilization of operating room time including, surprisingly, periodic closures of operating rooms during summer months and holidays. And the evidence is that most surgeons are under-utilized and could use more operating room time. The tail of this problem continues in some areas but there has been considerable improvement with, for example, increasing the hours of existing operating rooms and by innovative changes to medical practices. Dr. Masri agreed in his evidence that the days of extremely long wait times, in excess of one year, are over.

[1347] The plaintiffs say that the solution is to increase the number of surgeons and, if necessary, construct new operating rooms. Those, however, are obviously budgetary issues that I have no authority over. I do accept that many surgeons have unused surgical capacity but the plaintiffs exaggerate this factor. Beginning with the fact that only 30-40% of consultations with a surgeon proceed to surgery, they must be spending most of their time doing consultations. For obvious reasons no surgeon could work full-time in the operating room without running out of patients entirely.

[1348] It also has to be considered that surgeries take place in a complex environment. Dr. Dvorak, an orthopedic spinal surgeon at Vancouver General Hospital, testified that patients requiring emergent care (arriving by helicopter on very short notice, for example, from a motor vehicle accident) can cause cancellation of scheduled surgeries on a surgeon's daily surgical slate. The cancellations then must go back on a wait list to be rescheduled at a later time. The scheduling of surgeries is necessarily a dynamic and imperfect process and a plan put in place after a consultation may well have to change. As can perhaps be seen from both the lay and expert evidence in this trial, a further complication is that there is not always a direct correlation between increasing

operating rooms or surgeons and desirable outcomes such as decreasing wait times. As two examples, there can be pent-up demand or other aspects of the healthcare system that require increased resources. Dr. Reilly, for instance, testified that a shortage of spinal cord technicians hampered efforts to expand his surgical group's operating room time.

[1349] RebalanceMD and other parts of the system (the foot and ankle clinic in St. Paul's Hospital, as another example) are working on techniques to reduce wait times for accessing care, including waits for consultation and surgery. This involves applying resources and triaging as soon as possible after receipt of a consultation from a family physician in order to advance patients to services where they can be helped the most (and where they will probably be in any event if they have to wait for one year for consultation with a surgeon).

[1350] Stefan Fletcher, the CEO of RebalanceMD, testified (for the plaintiffs) that they had considerable success reducing Wait One times with their approach to servicing patients as soon as practicable after receipt of a consultation request from a family physician. RebalanceMD is a private facility owned by a number of doctors but it only works in the public healthcare system. It represents private sector innovation in healthcare (including sophisticated management) that partners with the public system in ways that are very much to the benefit of patients.

[1351] I should add that I do not agree with the plaintiffs' submission that the significant reduction in Wait One times as a result of the techniques used by RebalanceMD and others provides no benefits to patients and does not serve any "conceivable healthcare purpose." Surely, it is desirable for patients to be seen by medical staff sooner rather than later and, indeed, long waits are the *bête noire* of the plaintiffs' constitutional claim. Overall, I find that innovative approaches that reduce the wait time for consulting a specialist are beneficial to patients and are to be encouraged, especially given the evidence of the experts and physicians that most patients who consult specialists do not require surgery but can be treated with non-surgical courses approaches.

[1352] There is also evidence about other systemic issues that cause delays in accessing surgical treatment. For example, hospitals cannot access patient information from each other and hospitals do not always use the same electronic programs for the same functions. These factors complicate treatment and add delays for patients who, for example, travel to another location and require care for a condition that arose in their home region.

[1353] According to the defendant, surgeons play a central role in terms of wait times because ultimately they manage their own wait lists. In its Response to Fifth Amended Civil Claim (filed October 26, 2018) the defendant says that "[p]physicians in British Columbia control their own wait lists, and determine which patients are seen and in what priority relative to each other." The Ministry of Health has no central list it

administers and health authorities "do not control the wait lists either, but do attempt to ensure that physicians are administering them appropriately" (at para. 49). Further, "... physicians have the ability, and are expected, to prioritize their patients on the basis of medical need, and not ability to pay" (at para. 50). And, "[f]amily physicians are expected to ensure their patients receive appropriate care within medically appropriate time lines" (at para. 56).

[1354] The evidence demonstrates that physicians and surgeons in particular do play a key role in managing wait lists. They decide who goes on the list and what priority is given to individual patients. They also decide when a patient should be re-prioritized because his or her medical condition has deteriorated. This is at the heart of the triaging function performed by surgeons and no one else can do it, including healthcare administrators and authorities (or judges).

[1355] So surgeons have significant responsibility and it is not respectful of the system as a whole or the care of patients for them to simply blame the government by saying that the solution is to allocate more operating room time. For sure, the defendant also has an important role in ensuring that overall conditions and infrastructure is in place to reduce wait times. Closing operating rooms for Christmas or summer holidays seems like an inefficient use of extremely valuable resources (this appears to be a past practice in most regions). There are limited resources but they have to be used effectively. What determines the length of wait times is more complicated than surgeons managing wait lists or government constructing more operating rooms. As can be seen above the causes are a complex mix of factors including the interplay between surgeons, nurses, technicians, administrative staff, cleaners, patients, hospitals, health authorities and the Ministry of Health.

Allowing duplicative private health care would not reduce waits in the public system

[2329] As above, there is clear evidence that wait times would not improve with the introduction of duplicative private healthcare in British Columbia. I turn here to discuss whether they could increase.

[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.

[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 Duckett, MABEL and Manitoba studies are all consistent in finding a strong correlation between duplicative private healthcare and increases in wait times in the public system. The evidence from the United Kingdom, Australia and New Zealand also demonstrate this connection. 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). The evidence relating to such diversion is discussed in the next section.

[2343] As noted by some experts, it is logical (and largely undisputed) that the introduction of private health insurance would increase demand in the public system. This would then put pressure on the resources available to the public system. Professor Hurley acknowledged that there was no empirical evidence that provides a "clean, unequivocal test" on this issue and "nor is such evidence likely to ever exist." He looked at a mixture of direct and indirect evidence. Similarly, as pointed out by Dr. Turnbull, the wide range of circumstances and medical conditions of patients on wait lists makes tracking them across the public and private sectors, or comparing those sectors, difficult. And Professor Hurley pointed out, it is not always possible to unambiguously classify patients since there are substantial and legitimate reasons for different judgements in the triaging process.

Duplicative Private Healthcare would benefit only the wealthy and healthy, but harm the less wealthy and less healthy by undermining the public health care system

[2301] Overall, there is wide consensus that those who benefit most from duplicative private health insurance and private delivery of healthcare, are primarily wealthier and healthier persons. The wealthier can afford to purchase private health insurance. The healthier would not be excluded because of pre-existing conditions (where risk selection is permitted). The business of insurance is to reduce risk so for example, pre-existing conditions are often excluded under private plans (but not under public plans). Those with the greatest medical needs, such as people with disabilities, the elderly, the mentally ill and individuals struggling with addiction would not be expected to participate or benefit from a duplicative private healthcare system because of pre-existing conditions and potential cost barriers.

[2348] There is evidence that wait times in the public healthcare system would actually increase with the introduction of duplicative private healthcare in British Columbia. This would be for a number of reasons including physicians preferring to work in the private system where they would be better paid…

[2389] I conclude that there is a rational connection between the effects of the impugned provisions and their purpose with respect to the potential diversion of resources. The suppression and discouragement of a private duplicative healthcare system prevents the drawing away of resources from the public system and reduction in capacity; this in turn preserves and ensures the sustainability of a universal publicly funded and managed healthcare system which guarantees that access to all necessary medical care is based on need and not the ability to pay. The introduction of private duplicative healthcare would make it difficult to operate the public system and maintain the same level of care, due to a diversion of resources.

[2428] To conclude I find that there is sufficient evidence to demonstrate that duplicative private healthcare would lead to competition between the private and public system over supply of healthcare professionals which in turn would put pressure on the public system to raise wages. This would raise the price of healthcare in the province and make it more difficult to ensure an adequate supply of healthcare professionals in the public system. Orthopedic surgeons may be an exception to this.

[2449] … in the event that duplicative private healthcare and insurance is permitted, there is the prospect of other regulatory and administrative processes to mitigate the problems of duplicative private healthcare and insurance. In my view the need for government regulation of private health insurance and healthcare would entail significant additional costs for the healthcare system as a whole, costs that are not incurred in the current system design.

[2450] Finally, there is the matter of the potential loss of federal funding under the *CHA* if the impugned provisions are struck. While this is not an additional cost associated with duplicative private healthcare generally, it is a significant cost consideration in the Canadian context of health transfer payments.

[2462] Under these circumstances, loss of federal funding would clearly result in a weakening of the public healthcare system. As above, I find that the risk of losing at least some of that funding is real and not "imagined" as claimed by the plaintiffs. It is therefore not irrational for the defendant to maintain provisions which ensure compliance with the *CHA* in order to remain eligible to receive the full CHT contributions. This promotes the purpose of preserving and ensuring the sustainability of the universal public healthcare system.

[2463] To conclude I find that the evidence shows that duplicative private healthcare would increase demand of healthcare overall, in both the public and private systems. This would lead to increased costs, stemming from three particular areas. First, the competition between the public and private healthcare systems over the same finite pool of human resources; second, the need to regulate the private healthcare system; and third, the potential loss of federal funding.

[2464] The evidence shows that this increase in healthcare costs would make it more difficult for the public system to maintain an adequate supply of healthcare professionals and current levels of care, especially if significant funding from the federal government would no longer be available. As discussed further below, it is individuals from lower socioeconomic status and with the greatest healthcare needs that would suffer the consequences of reduced capacity in the public system.

[2465] I conclude that there is a rational connection between the effects and purposes of the impugned provisions. The evidence shows that the introduction of duplicative private healthcare would lead to increased costs and diversion of human resources, which would be contrary to the purpose of the provisions to preserve and ensure the sustainability of the universal public healthcare system. Thus, suppressing and discouraging the emergence of such a system is directly in line with this purpose.

[2529] Accordingly, I find that there is a rational connection between supressing and discouraging the emergence of duplicative private healthcare in order to address the risk of erosion of public support in the public system and the purpose of preserving and ensuring the sustainability of the universal public healthcare system, which guarantees that access to all necessary medical care is based on need and not the ability to pay.

Duplicative Private Healthcare would result in perverse and unethical incentives for physicians

[2506] As above, the plaintiffs rely on the evidence from 20 years of private clinics in British Columbia as a strong indicator of what would happen in the event their claims are accepted. 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.

[2507] There are parallels between the problems identified here in British Columbia and similar problems identified in other jurisdictions where there is duplicative private healthcare.

[2508] Professor Hurley gave evidence regarding studies in the United Kingdom (which the plaintiffs propose as a comparator for the introduction of duplicative private healthcare in British Columbia) which found that some dual practice physicians engage in problematic and unethical behavior such as manipulating their wait lists in order to divert patients from the public system to their more lucrative private practices. Professor Oliver's evidence about dual practice in the United Kingdom was that there were concerns relating to conflicts of interest because physicians and hospitals were

responding to financial incentives by prioritizing private pay patients. This led the NHS to introduce more rigorous limits on dual practice.

[2509] Professor Marmor's evidence was that extra billing creates perverse incentives because patients with more resources can buy their way to the front of the line and physicians would have an incentive to allow their wait lists in the public system to grow in order to fuel demand for their private clinics. Further, he opined that the experiences of other countries show that it is extremely difficult to regulate or manage these types of conflicts.

[2510] Dr. J. Frank, an expert for Canada, also opined that dual practice creates conflicts of interest and that the experience in other jurisdictions which allow duplicative private healthcare suggests that physicians will manipulate wait lists in order to encourage patients to obtain private services. Professor Prémont gave evidence about concerns with physicians prioritizing private pay patients with respect to the experience with SMCs in Québec as discussed above.

[2511] In the result, looking at the limited history of private healthcare in British Columbia, there have been ethical problems in that history. I hasten to add that the evidence in this trial is that the care and triaging of the vast majority of patients every year is managed in compliance with the *MPA* and the College's practice standards. Indeed, it is done to very high quality standards throughout. The issue here is whether the business of practising medicine in a duplicative private healthcare context creates ethical issues. The expert evidence as well as the more anecdotal evidence from the limited experience of private healthcare in British Columbia demonstrates that it does.

[2512] I should add that I assume that some physicians in the public healthcare system also encounter ethical problems and these would continue whether duplicative private healthcare was introduced or not. However, when a surgeon is able to offer a patient a private surgical option paid for by the patient (or private insurance) to the surgeon, that creates a new problem that does not exist now, with the absence of duplicative private healthcare.

[2513] I conclude that there is a rational connection between the effects and purposes of the impugned provisions on the basis of ethical concerns that arise in the context of duplicative private healthcare. There is a rational connection between suppressing and discouraging the emergence of a duplicative private healthcare system and preserving and ensuring the sustainability of the universal public healthcare system that is based on need and not the ability to pay, as the impugned provisions function to prevent ethical concerns from emerging that create a real risk that the provision of healthcare on the basis of need would be undermined in British Columbia.

Duplicative Private Healthcare Would Undermine Equitable Access to health care

[2569] I conclude that equity is at the heart of a universally based system of healthcare and, as reflected in s. 2 of the *MPA*, it is a significant part of the purpose of the *MPA*. This is also consistent with the historical development of public healthcare in British Columbia and Canada as reflected in the above section on the history of the *MPA* and its predecessors. For example, previous governments have described the intent of the legislation as being to protect the rights of British Columbians to have access to medical services regardless of income or where they live.

[2580] The result is that duplicative private healthcare predominantly benefits the wealthy and healthy. Those who cannot afford private duplicative healthcare or who are not eligible for private health insurance due to pre-existing conditions cannot access the preferential care system and they remain in the public system. This is the idea of the two-tier system: the private tier provides preferential and timely care and the public tier treats everyone else. As can be seen above, the general purpose of the *MPA* (in s. 2) expressly states that medically necessary services are to be available on the basis of need and not the ability to pay. It is clear that a two-tier system of care is contrary to this purpose.

[2581] The plaintiffs' main response to this is that the principle of ensuring access to necessary medical services is based solely on need and not the ability to pay applies only to services provided within the public system. As above, I reject the plaintiffs' narrow articulation of the legislative purpose of s. 2 of the *MPA*. It is inconsistent with the words of the *MPA* and the legislative history and context. The legislative purpose is to ensure that all necessary medical services to MSP beneficiaries are funded and delivered on the basis of need and not the ability to pay.

[2585] As the plaintiffs' own witnesses and experts explained, the queue for care in the public system is nothing like a queue at a "movie theatre." It does not proceed in a linear fashion. Urgent and emergent patients literally jump the queue for valid reasons. Other patients may leave and re-enter the queue at different points in time. Dr. Vertesi, an expert witness for the plaintiffs, explained that wait lists do not operate as a regular queue. Patients drop off the wait list for a variety of reasons and there could also be changes to the prioritization of patients as their condition improves or deteriorates. This is the necessary and salutary result of the triaging process, and moving up or down the queue for valid medical reasons is a perfectly valid part of an equitable healthcare system. Patients with different needs are treated unequally but equitably.

[2586] Dr. Masri's evidence in fact contradicts the analogy to the line at a movie theatre using essentially the same analogy. His evidence was that waiting in line for healthcare is nothing like standing in line at "Starbucks" where "you expect that if you were in front

of the guy behind you you're going to get your cup in front of the guy behind you." He explained that waiting in line for healthcare is much more complex because the physician is prioritizing patients on the wait list based on medical need and not on the basis of first in/first out.

[2587] Moreover, as the plaintiffs acknowledged throughout this trial (with some modification in final argument), the individuals who would use private healthcare would not leave the public queue. They would remain in the public system and would continue to benefit from it in addition to the private system by, for example, having follow-up care in the public system. In this regard, they are not leaving the queue and freeing up space for those behind them in the queue as suggested by the plaintiffs. Rather, they are moving in and out of the public queue. Or, in other words, they are jumping the public queue

[2595] The evidence demonstrates that, in order to expand the reach of private healthcare to lower socioeconomic populations, government must substantively regulate and even fund the private healthcare system. As above, the experiences of other jurisdictions suggest that even when that is done there are significant issues in terms of equitable access to healthcare. On the other hand, the evidence shows that where a truly parallel private system is allowed (which is what the plaintiffs seek to achieve), it would serve the wealthy and healthy. As above, that would be contrary to the legislative purpose of the *MPA* because it would introduce preferential delivery of necessary medical services on the basis of the ability to pay.

[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.

[2661] In summary, there is a rational connection between the impugned provisions and the purposes of the *MPA* to ensure medically necessary care is financed and delivered based on need and not the ability to pay. The literature demonstrates that duplicative private healthcare creates or exacerbates inequity in terms of access, financing, and utilization of healthcare and for health outcomes. I conclude that the plaintiffs have not proven that there is no rational connection between the purposes and effects of the impugned provisions.

[2873] As addressed at the outset, the purpose of the *MPA* is ameliorative, since the province's goal is to ensure equitable access to quality healthcare for all, and especially vulnerable persons who lack economic means. This includes persons with disabilities and persons outside working age or with low incomes. As above, the evidence establishes that the impugned provisions are an essential element of ensuring that access to necessary medical care is based on need and not the ability to pay. In this regard, the impugned provisions have an ameliorative purpose and effect, of guaranteeing that socioeconomic and health status do not preclude persons with disabilities, the young and the elderly from gaining access to necessary medical services.

Expert Evidence from Other Countries is that Duplicative Private Health Care Would Adversely Affect Health Care Sustainability and Equity

[2257] As above, Professor Marmor provides a useful framework for conducting international comparisons of healthcare systems which requires defining the purpose of the comparison; selecting similar countries for comparison; and determining if there are common experiences across a wide range of countries/systems. Professor Marmor also cautions against reliance on anecdotal evidence.

[2258] The legal issue in this constitutional litigation is whether there is something in the experiences of the above jurisdictions that demonstrates that there is no connection or no rational connection between the purposes and the effects of the impugned provisions. The test is not, as the plaintiffs put it, whether the experiences of other jurisdictions such as the United Kingdom show that private healthcare is "perfectly compatible with a universal public health care plan."

[2259] As to what other jurisdictions are comparable to British Columbia, the parties have selected the healthcare systems in the United Kingdom, New Zealand, Ireland, Australia and Québec. Again, they are all versions of a universal public healthcare system but it is unclear what significance should be attached to that fact. As can be seen above, there are a number of differences between the design of the healthcare systems in these jurisdictions and in British Columbia (and between these different countries).

[2260] For example, with respect to ss. 17 and 18 and restrictions on dual practice, in the United Kingdom, Ireland and New Zealand, most specialists are employees of the public system and are subject to contractual obligations, including minimal time requirements spent in the public system. Subject to the limited example in Ireland that applies where a patient declares himself or herself to be a private patient after purchasing private health insurance, there is no evidence that there is extra billing by specialists who are employees.

[2261] In British Columbia, and the rest of Canada, virtually all physicians are paid on a fee-for-service basis. They are free to decide who they treat, where they treat, and how much they work. This is a fundamental feature of Canadian healthcare. In fact, as discussed above in the context of the history of Medicare in Canada, physicians have consistently and adamantly resisted government attempts to regulate or control their practices, even threatening to shut down the entire public system by going on strike. Physicians have charged user charges and engaged in extra billing and this has been significant enough in British Columbia to result in a penalty against the province's Canada Health Transfer.

[2262] All of the four international jurisdictions have wait time problems to a greater or lesser extent. If the plaintiffs' purpose of tendering evidence from the other jurisdictions is to demonstrate that private healthcare or a dual system of care would improve wait lists, that proposition has not been demonstrated by the above comparisons. In any event, the position of the plaintiffs is not that the introduction of duplicative private healthcare in British Columbia would decrease wait times in the public system.

[2263] The plaintiffs place particular reliance on the United Kingdom. If the point of the comparison with the United Kingdom is that a dual system by itself would decrease wait times in British Columbia, that lesson cannot be taken from the evidence. While private facilities (ISTCs) had a limited role in reducing wait times there, the aspect of their operation which was attributed to reduction of wait times was publicly funded and, in any event, there were more important factors within the NHS itself that led to a reduction in wait times (such as the star rating system). I cannot conclude that the introduction of a dual system as in the United Kingdom would somehow decrease wait times in British Columbia.

[2264] I add that I do not understand the plaintiffs to say that, for example, the healthcare system in British Columbia should be changed so it is the same as the United

Kingdom (or the other jurisdictions discussed above). Their objective is to have a dual system of healthcare in this province which would have its own unique characteristics. That result would be very different from the system in the United Kingdom, as one might expect. As an example of one important difference, surgeons would not be employees of the health authorities.

[2265] With respect to Ireland, it represents another example of physicians preferring their private patients even to the point of breaching contractual provisions aimed at mitigating against preference of private pay patients. Put another way, regulating the time physicians spend in the public system may not always be effective. In New Zealand there has been a reduction in wait times but that may have been achieved by patients being taken off a surgical list and referred back to their family physicians. And Australia at least raises the question as to whether the introduction of private health insurance actually increases wait times in the public system.

[2266] Moreover, as the comparisons above illustrate, even in the context of duplicative private healthcare, there are different approaches. In the United Kingdom the private health insurance market is minimally regulated. Insurers are free to engage in risk selection, which in turn reduces the risks of public subsidization of private healthcare. On the other hand, in Ireland, New Zealand and Australia, there are more restrictions against risk selection, and in turn also extensive public subsidies of private healthcare. Each of these different approaches raises a myriad of issues.

[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.

[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 seen below, there is some history of doctors challenging government regulation of their activities.

[2270] It is also significant that, despite the different and more regulated physician market in the United Kingdom, (as well as New Zealand, Ireland and Australia) there are serious questions as to whether these regulations are effective. And the experience of New Zealand and Ireland also demonstrates that private duplicative healthcare creates risks in terms of equitable access as well as risks to the preservation and sustainability of the universal public healthcare system.

[2271] With respect to Québec, I agree with the defendant that the events in Québec after the *Chaoulli* decision reflect the difficulties with regulating the private provision of healthcare. As well, the absence of a significant private health insurance sector in Québec, despite the elimination of the equivalent of s. 45 of the *MPA,* demonstrates that the market is not necessarily responsive to changes in legislation that only go to permitting private health insurance. According to the plaintiffs the reason for this is that the result in *Chaoulli* does not go far enough. Their position is consistent with the evidence of Professor Prémont that a duplicative private healthcare system can emerge only if both private health insurance and dual practice are allowed. Indeed, in this constitutional challenge the plaintiffs challenge both the restriction on private health insurance and the restrictions on extra billing and user charges, which create a disincentive for engaging in dual practice.

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

Restrictions on Duplicative Private Health Care Do Not violate section 7 of the Charter, because they are not arbitrary, overbroad or grossly disproportionate

[2662] …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 suppressing 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.

[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.

Restrictions on Duplicative Private Healthcare are Not Arbitrary

[2797] The test of arbitrariness (from Bedford) is whether there is a connection or a rational connection between the purpose of a law and its effects. The evidence establishes that there are multiple rational connections between the effects of the impugned provisions and their legislative purpose. I do not agree with the plaintiffs that the defendant's "concerns" with respect to the effects of duplicative private healthcare on the preservation of and sustainability of the universal public system and equitable access to necessary medical care are "imagined." To the contrary, I find that the evidence demonstrates that the risks the defendant has identified with duplicative private healthcare are very real and well founded.

[2798] I have concluded that the evidence suggests there is a rational basis for concluding that the introduction duplicative private healthcare in British Columbia would have a serious detrimental impact on equitable access to necessary medical services. It would introduce a second tier of preferential healthcare on the basis of one's ability to pay and not medical need. Further, the evidence suggests that duplicative private healthcare would increase demand and costs overall while also reducing capacity in the public healthcare system. There is a genuine risk that both the sustainability of the universal public system and equitable access to healthcare would be undermined.

[2799] In addition, I find that there is evidence to support the defendant's concern that duplicative private healthcare would encourage perverse incentives and unethical behavior by healthcare providers in order to divert certain patients from the public to the more lucrative private system. Due to the change a duplicative private healthcare system would have on the incentive mechanisms underlying the healthcare system in this province, including the financial allure of the private provision of care, there is a real and substantive risk that the public system and its patients would be worse off as a result of allowing duplicative private healthcare.

[2800] Therefore, I find that the plaintiffs have not established that the effects of the impugned provisions bear no connection to their legislative purpose. The plaintiffs have not proven that their deprivation of the right to security of the person under s. 7 of the Charter is arbitrary.

Restrictions on Duplicative Private Healthcare are not Overbroad

[2687] Significantly, in their submissions on overbreadth, the plaintiffs ignore a second and important part of the *MPA*'s purpose: ensuring that access to necessary medical care for MSP beneficiaries in British Columbia is based on need and not the ability to pay. There cannot be any dispute that this part of the purpose of the *MPA* must be considered as part of the overbreadth analysis. That is, s. 2 in its entirety must be considered and it cannot be read down as the plaintiffs have done. I add that I do not think that s. 2 of the *MPA* can be read as two distinct purposes requiring different overbreadth analyses. The clear objective is to include three features in one system: public management, financial sustainability and access based on need, not the ability to pay.

[2688] The legislative history of the *MPA* is of assistance in understanding the context of the overbreadth submission of the plaintiffs here and, in particular the development of the issue of access based on need. The history is set out in some detail above and I repeat some parts of that history that are relevant to the overbreadth analysis.

[2689] Overall, the history of the impugned provisions is that they developed organically over time because it became increasingly evident that private insurance and extra billing were an obstacle to equitable access to healthcare based on need. The provisions were not introduced as blanket prohibitions aimed at preventing speculative future harms, but they evolved as responses to concrete financial impediments to access.

[2690] Access based on need rather than income or socioeconomic status was first addressed in British Columbia through legislation in 1965, which introduced British Columbia's universal provincial health plan. The 1965 plan included a government-funded public insurer that covered high-risk patients and expanded delivery of care through the public system. Those efforts did not address the issues with extra billing and despite the government-funded public insurer, insufficient coverage by private insurers persisted.

[2691] Legislation was introduced in 1967 which essentially eliminated private insurance for medically necessary services in the province by imposing uniform rates and terms of coverage. Within a few years there were no private insurers in British Columbia offering coverage for services covered under MSP. However, even these reforms did not resolve the problems associated with financial obstacles to accessing healthcare. In the late 1960s and early 1970s there were still complaints regarding extra billing by physicians for services covered under MSP.

[2692] This led to legislation introduced in the 1970s which imposed restrictions on extra billing. Issues with healthcare providers circumventing these regulations and

engaging in extra billing and user charges continued. In response, British Columbia introduced tighter restrictions on extra billing and user charges, including a permanent ban on extra billing enacted in 1981. Subsequently, in 1992, the predecessor of the *MPA* was introduced (the *Medical and Health Care Services Act*). The impugned provisions, including the restrictions on extra billing and user charges, were included in substantively the same format as found in ss. 17 and 18 of the current *MPA* and are the subject of the plaintiffs' constitutional challenge here.

[2693] I take from this history that the impugned provisions are actually a regulatory scheme that has developed along with, and as a response to, extra billing by enrolled physicians. Extra billing has been seen as an impediment to equitable access to healthcare, ultimately resulting in its prohibition. The Legislature has tried a variety of less severe restrictions, none of which were successful. Extra billing remains an issue, as demonstrated by the recent and substantial deductions from the Canada Health Transfer from Canada to British Columbia as discussed above (extra billing by the plaintiff Cambie Surgeries is a significant component of that deduction).

[2694] It seems to me that the Legislature has consistently attempted over the last 60 years to prevent precisely the situation the plaintiffs are seeking through their claim here. If their claim is successful, physicians would be able to decide when they will charge only according to the MSP tariffs and when they will charge in excess of those tariffs. This would effectively overturn the history of attempts by government to restrict extra billing. The plaintiffs are certainly entitled to challenge the legislative results of this history but, as a matter of overbreadth, the above history demonstrates strong connections between the purpose and effects of the *MPA*, and in particular the impugned provisions. That is, the impugned provisions were tailored over time to address real problems and inequities in accessing healthcare in British Columbia.

[2711] Given the above I conclude that the impugned provisions are not overbroad. The plaintiffs have not demonstrated that they capture persons or activities that are not related to their purpose. As discussed above in the context of the principle against arbitrariness, it is rational to restrict private financing, extra billing and user charges in order to preserve and ensure the sustainability of the universal public healthcare system and ensure that access to necessary medical care is based on need and not the ability to pay. The impugned provisions do not deny s. 7 rights any further than necessary in achieving their purpose.

[2801] I have… concluded that the plaintiffs' overbreadth claim must be rejected. To the extent the plaintiffs raise a separate argument from their arbitrariness claim, they have not established that the impugned provisions capture persons or activities that are not connected to the legislative purpose. Specifically, the plaintiffs claim that the impugned provisions go too far. This is because they restrict enrolled specialists from providing necessary medical care privately when they have fulfilled their obligations in the public system (such as using all of their operating room time available). However, according to

the defendant, whose view I accept, this ignores the actual nature and full range of services provided by specialists. I have decided that this submission also does not address the concerns associated with duplicative private healthcare in a meaningful way.

Restrictions on Duplicative Private Healthcare are Not Grossly Disproportionate

[2774] It is also important to keep in mind that the plaintiffs do not say that wait times for medical care in the public system would improve in the event their claim is successful. Instead they seek the choice to obtain private care rather than waiting in the public system. As discussed above, this position is consistent with the near unanimous expert evidence (including all but one of the plaintiffs' experts) that the introduction of duplicative private healthcare in British Columbia would not improve wait times in the public system. There is also significant expert evidence that wait times would actually get worse in the public system with the introduction of duplicative private healthcare in British Columbia (because of competition for resources, among other reasons).

[2775] Logically, this must mean that the wait time problems relied on by the plaintiffs ("severe and prolonged suffering" and the "lethal impact" of the impugned provisions) for their argument about gross disproportionality would continue or even get worse in the public healthcare system if their claim is successful. Those that could afford private healthcare would get faster care in a private system and those with pre-existing conditions, co-morbidities or insufficient funds would continue to wait for care in the public system, perhaps wait even longer than they are currently waiting. As discussed above this is contrary to care based on need and not the ability to pay and it would create an inequitable healthcare system.

[2776] Finally, as a matter of the proportionality between purpose and harm (or effect), it is important to acknowledge the importance of the purpose of the MPA. It is the foundation of our public healthcare and it creates an equitable (although imperfect) system of care based on need rather than on ability to pay. The evidence is that those with the greatest and most urgent medical needs, such as people with disabilities, the elderly, and people struggling with mental illness and substance abuse issues, are highly unlikely to benefit from a duplicative private healthcare system.

[2777] This is the equity issue discussed above and it arises because these groups of people would not be eligible for private insurance and possibly could not afford private care. Further, those without the most urgent medical needs, but of lower incomes, would not be able to afford private insurance or care. All of these populations would be dependent on a public system struggling with reduced capacity due to competition with a parallel private system over the same pool of healthcare professionals. They would not

have the same choices as those who could afford private care and those that did not have pre-existing conditions or co-morbidities.

[2778] In this context, I agree with the submission of the Coalition Intervenors that the patients on whose behalf the plaintiffs have brought this claim are also beneficiaries of the same provisions they challenge in this case and they do not seek to relinquish these benefits. To the contrary, the plaintiffs have repeatedly stated that they wish to stay part of the public system. This at least demonstrates the importance of the government objectives being advanced by the provisions, and the complex ways in which the MPA furthers those objectives.

[2779] The underlying support for the purpose of the impugned provisions is set out in some detail in the above section on arbitrariness. The evidence (in particular, the expert evidence and the literature discussed above in the arbitrariness section) demonstrates that the impugned provisions are essential in order to suppress and discourage a duplicative private healthcare system from emerging and competing with the public system to the latter's detriment. This is not a matter of unfair competition by a monopolistic and inefficient public healthcare system, but a legislative technique to avoid the increased taxes that would be necessary for the public system to compete with the private system. Again, the impugned provisions do permit some private healthcare and they are not a blanket prohibition as asserted by the plaintiffs.

[2802] … I also find that the plaintiffs' gross disproportionality claim must fail. While I recognize that for some patients, excessive wait times for elective surgery will cause some harm, the evidence does not demonstrate that the effects of the impugned provisions are extreme or totally out of sync with their legislative purpose.

Section 1 Justification: Restrictions on Duplicative Healthcare Serve Pressing and Substantial Objectives

[2902] For my part, I have no difficulty in also finding that the objectives of the *MPA*, including that of the impugned provisions, are pressing and substantial. Preserving and ensuring the sustainability of the universal public healthcare system and ensuring that all necessary medical care (to MSP beneficiaries) is funded and delivered based on need and not the ability to pay, are more than just legitimate government interests. These objectives are expressions of the foundational principles which underlie universal healthcare in this country.

Section 1 Justification: Restrictions on Duplicative Health Care Are Rationally Connected to Sustaining the Public Health Care System and Maintaining Equitable Access

[2904] Given my conclusions above under arbitrariness, I find that the defendant has established a rational connection between the impugned provisions and their legislative purpose. The impugned provisions preserve and ensure the sustainability of the universal public healthcare system by suppressing and discouraging the emergence of a duplicative private healthcare system for necessary medical services that would compete with the public system over the same pool of healthcare professionals and increase the demand and price of healthcare overall. This would make it more difficult for the public system to maintain its current level of care. The evidence suggests that there is a real risk that a duplicative private system would result in reduced capacity and an increase in wait times in the public system, undermining the legislative purpose of preserving and ensuring the sustainability of the universal public system.

[2905] In this regard, the impugned provisions also further the objective of ensuring that access to necessary medical services is based on need and not the ability to pay. They do so by discouraging the emergence of a second tier of private healthcare where access to preferential provision of necessary medical services is based on the ability to pay (including by way of jumping the queue in the public system). Further, the evidence suggests that there is a rational basis for concerns that duplicative private healthcare of the kind the plaintiffs seek would create perverse incentives for healthcare providers. For example, there is a real risk that they will prioritize private pay patients at the expense of patients in the public system. This is another way in which duplicative private healthcare may undermine the purpose of ensuring that patients are prioritized according to medical needs.

[2906] The defendant also suggests that it is rational to supress a duplicative private healthcare system for necessary medical care in order to ensure continued public support for the public healthcare system. There are some studies and economic modeling that suggest that a competitive duplicative private healthcare system would, in the long term, undermine the willingness of higher income individuals (who would opt for private care) to support the public system through their taxes. On the other hand, other studies find no direct connection between the two.

Section 1 Justification: Restrictions on Duplicative Private Healthcare Are Reasonably Necessary to Achieve the Government's Health Care Sustainability and Equity Objectives

[2913] Moreover, the evidence in this case shows that the defendant's concerns with duplicative private healthcare are real and not "hypothetical" or "speculative" as claimed by the plaintiffs. The plaintiffs' own experts confirmed that duplicative private healthcare raises issues in terms of equitable access to healthcare and the sustainability of the public system. Professors McGuire and Blomqvist confirmed that duplicative private healthcare leads to increases in demand and costs overall. There is also evidence from Professor McGuire that duplicative private healthcare leads to the potential diversion of healthcare resources from the public to the private system. All of the plaintiffs' experts who provided evidence on this point also agreed that duplicative private health insurance would primarily benefit higher income individuals. Professor McGuire's evidence was that perverse incentives for healthcare providers to prioritize private pay patients over patients in the public system is a real concern that would require effective regulations.

[2914] The result is that the plaintiffs' contention that duplicative private healthcare in British Columbia will not require substantial regulation is inconsistent with the expert evidence in this case. The plaintiffs' own experts agreed that if duplicative private healthcare is introduced in British Columbia then certain regulations would have to be implemented in order to mitigate these threats to the public system.

[2915] The only alternative regulatory approach that the plaintiffs suggest would be less impairing than the impugned provisions is that "the Government could put in place measures which required that all doctors must provide treatment in the public system, before providing services outside of that system." The plaintiffs propose something akin to the approach in the United Kingdom, as discussed above, whereby enrolled doctors would be required to provide a minimum number of hours in the public system before they can provide private care.

[2916] This submission fails to appreciate that, unlike the United Kingdom, in British Columbia physicians generally are not employees of the health authorities or the Ministry of Health. Under the current design of the healthcare system in British Columbia the government would have considerable difficulty imposing something like the United Kingdom model on physicians. Physician autonomy and control over their practices, including how many hours they work, where, and what patients they treat, is a fundamental feature of Canadian healthcare. As discussed above, past attempts by governments in Canada (including in British Columbia) to limit physicians' autonomy and impose certain conditions on how physicians practise have been met with fierce opposition from physicians as well as legal challenges. I do not take the plaintiffs to speak for the medical profession in British Columbia. I cannot accept their assertion that

imposing limits on how many hours enrolled physicians must work in the public system before working in the private system is a feasible alternative in British Columbia.

[2917] More importantly, even if the defendant could impose certain limits on physicians who wish to practise in a parallel private system, the evidence demonstrates that this type of regulation has not been effective in other jurisdictions. As discussed above, the evidence is that in the United Kingdom, New Zealand, Ireland and Australia it has been extremely challenging to enforce these restrictions. In all these jurisdictions there is evidence that physicians, especially specialists providing elective surgical services, are not meeting their obligations in the public system before working in the private system. Even after the implementation of legislative changes in response to the *Chaoulli* decision in Québec, there are problems in Québec regulating the work of physicians so they continue to contribute fully to the public healthcare system.

[2918] In any event, such restrictions would only partially address the wide range of issues associated with duplicative private healthcare. Specifically the restrictions would not address the direct impact on equitable access through the creation of a second tier of preferential healthcare based on the ability to pay. Restrictions also do not address the issues associated with increased demand and costs and how that would impact wait times in the public system.

[2921] Indeed, the historic evolution of the MPA discussed above illustrates that the impugned provisions developed with time in order to address extra billing and user charges which undermined equitable access to necessary medical care. From the late 1960s until the late 1980s several attempts were made by way of less impairing regulations with respect to private insurance, extra billing and user charges. Ultimately, these measures were unsuccessful. Extra billing and user charges continued despite these regulatory measures and proved to be an obstacle in terms of ensuring equitable access to necessary medical care. As the above discussion of the Canada Health Transfer from Canada to British Columbia demonstrates, extra billing in this province has very recently resulted in a substantial reduction of the Canada Health Transfer. I conclude that the impugned provisions are a measured approach to issues that persisted throughout the history of public healthcare in this province.

Benefits of Restrictions on Duplicative Private Healthcare Are Substantial and Outweigh Any Adverse Effects

[2927] While I accept that the ability of physicians to control the wait times experienced by their patients is limited due to shortage of surgical capacity in the public system, the evidence does not suggest that allowing a duplicative private healthcare system would solve the problem. In fact, the evidence suggests that duplicative private healthcare would likely reduce capacity in the public system and could even lead to an

increase in wait times in the public system, especially for patients with greater medical needs.

[2928] Overall, the evidence shows that the benefits of the impugned provisions are substantial. The impugned provisions are essential to preserving and ensuring the sustainability of the universal public healthcare system and ensuring that access to necessary medical care is based on medical need and not the ability to pay. I also agree with the defendant that:

> In considering whether the effect of the Impugned Provisions on the Patient Plaintiffs is disproportionate, however, it is necessary and appropriate to consider the fact that enabling a group of privileged patients to access medical services more quickly will have a deleterious impact on the ability of *less* privileged patients with even greater needs to access such services in a timely manner.

[2929] I must consider not only the effects of the impugned provisions on access to elective surgical services, but their effects on the entire healthcare system. As discussed above, surgical care is only one aspect of the public healthcare system. This means that in deciding this claim I must weigh in the balance the effect of striking the impugned provisions on the majority of patients who rely on the public healthcare system to provide other essential services, including:

a) Primary care;
b) Pharmacare;
c) Emergent public health crises;
d) Residential care for the senior population;
e) Treatment for mental health and substance use;
f) Non-surgical cancer treatments; and
g) Disease prevention and health promotion.

[2930] Further, the evidence in this case shows that a significant percentage of the costs of the healthcare system are for services for the most vulnerable segments of society who would not benefit from a parallel private system. These include the senior population living in residential care; patients with complex chronic conditions; and patients with severe mental illnesses or substance use issues. These patients would likely be affected if the public healthcare system was burdened with additional costs associated with the operation and regulation of a duplicative private healthcare system.

[2932] … [I]n the context of the provision of necessary medical care, however the government designs the regulatory scheme, it will inevitably be to someone's detriment. This is because decisions need to be made as to how to allocate resources. It is for government and not the court to determine how to design an equitable system

that achieves maximum benefit to society at large and fairly balances overall demand for necessary medical services. In this context it cannot be said that the effects of the impugned provisions on the patient plaintiffs and similarly situated individuals is disproportionate to their societal benefits in terms of preserving and ensuring the sustainability of the universal public system and ensuring that access to care is based on need and not the ability to pay.

Inadequacy of Fraser Institute Wait Time Data and Reports

[1254] As might be expected, doctors in British Columbia have views about wait times. They are certainly well-placed to observe the time their patients wait and the effects of waiting.

[1255] As might also be expected views among doctors about wait times are complicated and varied. For example, the plaintiffs presented evidence from doctors who believe that private healthcare is a valid and ready solution to wait time problems in the public system (although the plaintiffs in their pleadings and argument accept that the introduction of private healthcare would not necessarily reduce wait times in the public system). On the other hand, the Coalition Intervenors in this trial include doctors who speak out strongly for public healthcare. They accept there are problems in the public system, including wait times, but they say private healthcare is not the answer and it will weaken public healthcare. There are also differing views about how long a patient can wait for a medical procedure before harm may result from the wait.

[1256] With respect to measuring and assessing doctors' views about wait times the evidence included a report and testimony from Nadeem Esmail. He was certified as an expert for the plaintiffs on healthcare systems, policies and economics of Canada and other developed countries that maintain universal access to healthcare, including assessing the success of these systems in providing timely, high quality healthcare to patients.

[1257] Mr. Esmail's expert report is dated "March 2014." It relies on work he and others did for the Fraser Institute. For example there is the October 2013 report "Waiting your turn: Wait times for health care in Canada, 2013 Report", co-authored by Bacchus Barua and Mr. Esmail.[19]

[1258] Mr. Esmail discusses a number of issues including the length of wait times in British Columbia and other issues such as whether access to private medical care would improve the length of wait times in British Columbia (as below, his evidence is that it would not). I am addressing here only the data used by Mr. Esmail in his discussion of wait times. I permitted Mr. Esmail to provide a second, addendum expert report under Rule 11-7(6) of the *Rules* to present and testify about new information, including a 2016

report from the Fraser Institute (2017 BCSC 559). It is instructive to review here how those reports were prepared.

[1259] Mr. Esmail works as a senior fellow for the Fraser Institute, an organization he described as a "free market think tank". Except for four papers, he has published reports and commentaries for the Fraser Institute only. He has no peer reviewed academic publications. Most of his research articles were published in the *Fraser Forum* which is now a blog for the Fraser Institute. He also currently owns and operates a manufacturing business and his economic research has primarily been with the Fraser Institute.

[1260] In general his publications have not been exposed to the rigour of independent and established peer review procedures (including the reports he relies on for his opinions in court) and his research has to be considered within the context of the free-market advocacy perspective of the Fraser Institute.

[1261] Mr. Esmail's *curriculum vitae* describes previous expert testimony before the Alberta Health Services Preferential Access Inquiry in 2012 and the Pennsylvania House Policy Committee in 2009. In cross-examination he agreed that the latter was before the Republican Policy Committee in Pennsylvania. The Alberta inquiry work involved submitting written responses to questions. There was no oral testimony under oath, there was no cross-examination and Mr. Esmail's contribution was not credited in the final report. He has no academic training in health policy and no affiliation with any university.

[1262] While Mr. Esmail's qualifications were not disputed by the defendant, the defendant urges me to give no or very little weight to his report given his lack of expertise. More importantly, the court retains a general superintending responsibility for assessing expert evidence and as the trial judge I also have an important gatekeeper role to ensure that only truly necessary and reliable expert opinion is relied upon (*R v. Abbey*, 2009 ONCA 624 at paras. 62, 63, 71, 76, 79; also *White Burgess Langille Inman v. Abbott and Haliburton Co.,* 2015 SCC 23 at paras. 16, 22, 54).

[1263] I conclude that Mr. Esmail is minimally qualified as an expert in the area of health policy. His research and publications suggest a very narrow philosophical interest. He has made the most of his qualifications but this has, unfortunately, included embellishments of his experience. For example, despite the reference in his *curriculum vitae* that he has previously been an expert witness, his evidence demonstrates that he has not worked in that role in any sense comparable to being an expert in court. In addition, his work in Pennsylvania is presented in his qualifications as independent and non-partisan work for the legislature there, apparently involving all political parties. However, in cross-examination it became clear that his work in Pennsylvania was in fact partisan and internal to one political party.

[1264] More importantly, the methodology used in his 2013 and 2016 reports is problematic. In the case of the 2013 report 10,155 survey questionnaires were sent to doctors in 12 specialities across Canada. Someone else chose the 12 specialities; Mr. Esmail did not know why they were chosen and he agreed they did not coincide with the list of specialities used by the Canadian Institute for Health Information ("CIHI") in its reporting on the numbers of physicians in Canada. In 2013 there were 38,282 doctors in Canada and so the sample chosen by the Fraser Institute of 10,155 doctors was 26% of the total number of doctors in Canada. Mr. Esmail could not explain why that rate was chosen or why it is statistically significant.

[1265] Further, there were only 2,160 responses nationally (from 10,155 questionnaires sent out) for a response rate of 21%. Mr. Esmail testified that the Fraser Institute set a target response of 25 to 30% for the surveys and, if the response rate for a specialty is less than 25%, a fax is sent out to generate more responses. I take from this that, based on the Fraser Institute's own methodology, there are problems with the reliability of the 2013 report which had a national response rate of only 21%. Other experts have described physicians as having something of a reputation for not responding to surveys.

[1266] Looking at one province, questionnaires were mailed to 1,213 specialists in British Columbia; the largest number were sent to internal medicine specialists (225) and the lowest number (30) sent to neurosurgeons. There were 167 questionnaires sent to orthopedic surgeons. It is unknown whether these numbers correlate in any way to the numbers of specialists in each practice area. Thus, once again, it is impossible to determine if there is any statistical significance to the design of the survey.

[1267] The total number of responses from British Columbia was 326 or 27%; the range was 43% for neurosurgery and 5% for radiation oncology. The highest response rate across Canada was from Prince Edward Island at 49% although two specialties in that province (plastic surgery and cardiovascular surgery) had zero responses. The lowest response rates were 15% in Québec and 20% in Ontario (according to tables 1a, 1b and 1c of the 2013 report). Once again, Mr. Esmail could provide no meaningful explanation of the statistical significance of these diverse response rates. This is especially important given the different population sizes in each of these provinces.

[1268] It is unclear whether any general conclusions can be drawn from the Fraser Institute surveys, even if these surveys could generally be relied upon as providing reliable data (a proposition I seriously question). For example, it is unclear how one could draw an inference regarding physicians' views on wait times in a practice area where there were no or minimal responses from doctors, simply based on responses from doctors in other practice areas. Once again the reports fail to address these fundamental statistical issues.

[1269] The conclusions in the 2013 Fraser Institute report taken from these questionnaires included that there was a weighted median wait time of 18.2 weeks nationally from the time of referral by the family physician to treatment. In British

Columbia it was 19.9 weeks. The highest was 40.1 weeks in Prince Edward Island and the lowest was 13.7 weeks in Ontario (table 2). Other tables broke down the numbers for the median time to see a specialist after referral from a family physician (8.6 weeks nationally and 9.5 weeks in British Columbia) and median time from appointment with specialist to treatment (9.6 weeks nationally and 10.4 weeks in British Columbia) (tables, 3, 4). There are other breakdowns of median times by specialty and province.

[1270] There is reason to question the reliability of the sample used in the Fraser Institute reports and the conclusions based on that sample. For example, as above, presenting the views of 10,155 doctors as representative of 38,282 doctors is obviously problematic. Mr. Esmail explained this in his evidence by saying the Fraser Institute takes the largest available sample. It simply cannot go higher "as an independent organization" because it does not have the power of the medical association or government to compel physicians and so they take the largest sample possible. I accept that explanation but it does not address the sample size problem or explain why the number 10,155 was chosen. And, while it is true that the reports do not "conceal" the low sample, as Mr. Esmail put it in his evidence, nor is there a caution in the reports about the limitations of such a small sample.

[1271] Another problem with the Fraser Institute reports is that it is unclear whether doctors responding to the questionnaires were in fact using the same terminology. As discussed elsewhere in this judgment, different doctors employ different referral and triaging practices. For example, as previously noted, wait times are measured differently in different provinces and benchmarks are set differently in each province. In other words, it is unclear whether how a doctor in Ontario measures wait times is equivalent to how a doctor in British Columbia measures wait times. I add that it is also unclear whether even two doctors in the same province measure wait times in the same manner.

[1272] Further, there is no way of testing whether doctors' responses are in fact supported by their patients' medical records. As we have seen throughout this trial, doctors' assessments of their own wait times are often inaccurate. The manner in which the Fraser Institute surveys were conducted lacks any assurances that doctors' responses were based on medical records and not their subjective or generalized and unsubstantiated assessments of wait times.

[1273] Overall, I conclude that Mr. Esmail's evidence demonstrates that the tracking of wait times by the Ministry of Health, which includes data from hospitals and health authorities with reference to all doctors and for all surgical procedures in the province, is the best evidence available on actual wait times. As can be seen in other parts of this judgment, this macro approach to wait times is not perfect and it is certainly the object of criticism. However, the OECD has described it as the "best method for accurately measuring waiting times," preferring it to questionnaire data.[20] Mr. Esmail indeed acknowledged that government data is "preferred".

[1274] The information collected by the Ministry is in a very different form so comparisons with the Fraser Institute are tenuous. However, in the 2013/2014 year the Ministry recorded 215,347 for "all" scheduled surgical procedures in British Columbia and had very different median wait times than the numbers found in the Fraser reports. Of all surgeries performed in 2013/14 the 50th percentile of patients had their surgery within 5.6 weeks and the 90th percentile had surgery within 27.1 weeks. The figures for 2012/2013 were similar.

[1275] One of the questions sent to doctors by the Fraser Institute was to ask what was a "clinically reasonable" wait time for a specific procedure and Mr. Esmail testified that some doctors responded by saying zero wait time. Median figures were used to adjust for these kind of figures but, as will be seen, a zero wait time is contrary to the plaintiffs' own expert evidence. An answer of zero from doctors also suggests that some doctors did not take the survey or the issue of wait times seriously.

[1276] The 2013 report states in a section titled "Method" that it "is designed to estimate the wait for elective treatment" and "[w]aiting time is calculated as the median of physician responses". There is no discussion about the size of the sample or what weight should be given to the report's underlying data in light of the problems with the sample size. The report simply presents data from an unreliable sample without any critical analysis.

[1277] Finally, I take from Mr. Esmail's evidence that these problems are known to the Fraser Institute. He explained that the largest source of complaints about the Fraser Institute reports is that their surveys of doctors are not "sufficient" to measure wait times.

[1278] In summary, there is information from doctors about their opinions on the length of wait times for medical care in British Columbia. The low response rate from doctors suggests that, as a group, they are not motivated to participate in these surveys. That some of them think a clinically reasonable wait time is zero suggests a lack of understanding of the importance and complexity of wait times. The evidence suggests that, even accounting for the methodological problems in the Fraser Institute reports, we do not have a reliable presentation of the views of doctors. Whether a more reliable method could be employed to obtain the opinions of doctors is an interesting question but it is not part of the evidence before this court. An organization called the Wait Time Alliance reportedly also uses surveys of doctors to measure wait times. However, it has similar low response rates and, in any event, it is not in evidence.

Findings on Brian Day's Improper Communications with Plaintiff's Experts

[1115] Dr. Brian Day apparently had a prior relationship with Drs. Albert Schumacher, Hollinshead, and Davidson, and Mr. Labrie. They were first approached by Dr. Day to be experts for the plaintiffs, not by counsel for the plaintiffs. What follows here is a cautionary tale about the value of counsel having control over the development of expert evidence.

[1116] The *Rules* are very clear about the duty of experts in court. Rule 11-2(1) states that an expert "has a duty to assist the court and is not to be an advocate for any party" and Rule 11-2(2) states that an expert must certify in any report that he or she is aware of that duty, made his or her report in conformity with that duty and will provide oral testimony in conformity with that duty. The four expert reports included essentially the same statement in compliance with this Rule; in the case of Dr. Schumacher his report stated:

> I am aware that [sic] of my duty and obligation as an expert witness to assist the court and not to be an advocate for any party. I certify that if I am called upon to give further testimony it will also be in conformity with that duty.

[1117] A serious problem arises here because these four witnesses were retained by Dr. Day in circumstances that are the opposite of this important duty.

[1118] When approaching each of these individuals, Dr. Day sent them a 31-page document setting out his views on the case and his views about the "ineffective and harmful" rule that experts must maintain neutrality and impartiality when giving expert evidence. He also provided comments on the expert reports of the defendant's witnesses, which these four individuals were asked to respond to.

[1119] I include here the introduction of the communication that Dr. Day sent to Dr. Schumacher as an attachment to an email dated June 30, 2014. The email described the attachment as "my (confidential) notes that comment on the government reports":

> *"When I refuse to obey an unjust law, I do not contest the right of the majority to command, but I simply appeal from the sovereignty of the people to the sovereignty of mankind."*
>
> Alexis de Tocqueville, Democracy in America
>
> **An Expert**
>
> In BC, Supreme Court rule 11-2 (1) potentially eliminates valuable sources of evidence that might help a Court determine the correct decision. The issue is not the principle that expert witnesses have a duty to assist the

court, but the requirement to declare they are not advocates for any party *or any position* of any party. Their "neutrality" must be certified in any report they prepare.

While I can appreciate the difficulty that judges may experience in balancing the evidence of opposing experts, I would argue that is what their role should be. The imposition of the current rule generates obviously false claims of neutrality.

In practical terms, many experts must be in an advocacy role. A physician has an ethical duty to advocate for her or his patient if their health is at stake. If Buddha were to give evidence supporting the Buddhist religion, under this rule he would not be an eligible expert. The Pope would be rejected as an expert on Roman Catholicism, and the Archbishop of Canterbury would similarly be excluded as an expert in Anglican doctrine. Gandhi could not be sworn in to testify as an expert on poverty, nor Einstein on the theory of relativity, since each would clearly advocate for their position on those issues.

It is time to modify this ineffective and harmful rule. Any knowledgeable judge can detect bias and partisanship in a witness. It is their job to judge the credibility and discern the degree of weight that is put on evidence provided by an expert "advocate". The current rule is not achieving its goal (see Appendix 2). It would be far more helpful to the Court if the expert declared his or her allegiance, which could then be weighted appropriately in the judicial decision making process. A false statement of neutrality is not helpful. Experts will tend to support whoever is funding them. "He who pays the piper calls the tune".

Peer Review and Significance

Many of the reports that are submitted by government experts rely on hearsay, unverified opinions and sometimes publications that are, when subjected to analysis, not valid. Peer reviewed publications, for example, are often wrong. If Columbus's discovery of America and Darwin's theory of evolution had been subjected to peer review they would likely have been rejected as pure fantasy. Even at the highest levels of scientific research, historical evaluation methods are being challenged:

http://www.economist.com/_news/briefing/21588057-scientists-think-science-self-correcting-alarmingdegree-it-not-trouble

...

[Emphasis in original.]

[1120] Dr. Day sent essentially the same communication to Drs. Hollinshead and Davidson, and Mr. Labrie.

[1121] It is plain enough from this communication that Dr. Day was requesting that the four recipients of his email be experts in court while at the same time counselling them to ignore, if not violate, their primary duty to the court. However, a person cannot do both since the clear intention of the *Rules* is that a person cannot be an expert in court unless he or she complies with this duty. If it needs to be said, the requirement for experts to be independent is necessary in order to assist the court in understanding specialized evidence. It does not impose "false claims of neutrality" on experts. In the circumstances here, any falsity is the retaining of experts by telling them they are advocates and then tendering their reports with statements asserting that they are not advocates.

[1122] The other parts of Dr. Day's 31-page document to the experts are equally if not more concerning. Dr. Day provides his personal criticisms of the individuals retained as experts by the other parties. By personal, I mean comments by Dr. Day that another expert makes "an academic career out of studying wait lists", the person's "literature review is clearly selective" and the person "appears to have little understanding of statistics and their uses and limitations." Another person has "a long-standing ideological aversion to non-government delivered or funded care" and raises "distorted" questions. Another "ignores patient care issues" and has a "failure to pay attention to detail." This continues at some length with opinions about the work and reputation of more than 20 people who were considered at the time to be experts in this trial (a number of reports by some of these experts were ultimately not tendered by the defendant).

[1123] This information was clearly intended to inform and influence the four experts and yet it was not included as factual assumptions in the four expert reports, as described in Rule 11-6(1)(f)(i). The obvious explanation is that the information was intended as a "confidential" briefing for the experts, as Dr. Day made clear in his cover email.

[1124] Apart from the partisan and personal nature of Dr. Day's comments, he also provided his opinions about the issues on which the plaintiffs were seeking independent opinions from the four experts. In doing so Dr. Day made numerous unsupported assertions of fact, that were later adopted by the experts in their reports, including those relating to the design and operation of healthcare systems in other countries. There is no indication the experts independently verified these assertions.

[1125] Moreover, Dr. Day's email suggests that it was intended to inform and influence the experts' opinions and reports precisely because he could not give his own expert evidence in this case. On p. 15 of the 31-page document attached to the email sent to Dr. Schumacher, Dr. Day writes:

> **Bias in reports of [name of expert for defendant] and others:**

> I am an advocate for the 5 patient plaintiffs in our constitutional challenge, and understand (see introduction) that this precludes my being an "expert" witness in this constitutional challenge. I will briefly outline just a few examples -- ignored by advocates for our current system -- that counter the bias that I have observed in the [expert for the defendant's] report. I do not claim that the following are comprehensive, nor do they necessarily refute all of the claims made by [the expert for the defendant]. I merely point to the fact that these examples demonstrate partisanship and selectivity by [expert for the defendant] and the other 27 government experts ...

[1126] Dr. Day then goes on to set out 10 points which he claims were omitted from the other experts' reports. Some of these points are then reproduced almost identically in the reports of the four experts who received his email correspondence.

[1127] In cross-examination Dr. Day explained that he sent his commentary to the experts because he did not want them to "write a partisan report" and he "didn't believe that experts should be advocates for one side or the other." However, this explanation is directly contradicted by what Dr. Day actually wrote to the experts. For example, he clearly expressed his view that all experts are and must be "advocates" for one side or another. Overall, under the circumstances, there is reason to question Dr. Day's explanation at trial about his purpose in writing his email to the four experts. Further, his explanation does not address the main issue which is his clear attempt to influence and inform the reports of the experts he wrote to.

[1128] I also note that Dr. Day's email correspondence includes many inappropriate personal attacks against some of the defendant's experts. While his personal attacks did not make their way into the experts' reports, it is hard to say they did not influence the manner in which the plaintiffs' experts read the defendant's expert reports that they were responding to. Some of the four experts did say in their evidence that they were not influenced by Dr. Day's communication. However, I find that the opposite was the intention of the communications and, again, it is difficult to see how that intention could have been separated from the work that resulted.

[1129] Besides the content and manner of the communication between Dr. Day and Drs. Schumacher, Hollinshead, and Davidson, and Mr. Labrie, there are other indicators that they approached their roles as experts in this litigation in a manner that is inconsistent with their duties to assist the court and to maintain independence and impartiality.

[1130] Dr. Hollinshead has a direct economic interest in the outcome of this litigation given the fact that he has elected to work exclusively in private clinics. His evidence was that he bills patients $500-$600 for a surgical consultation whereas the MSP rate for a surgical consultation is $120-$140. If the plaintiffs are successful in this litigation Dr.

Hollinshead, as well as other similarly situated specialists, will likely benefit from a much expanded private healthcare market, thereby significantly increasing their client base and earnings.

[1131] More concerning perhaps is that, during his oral testimony, Dr. Hollinshead confirmed that he is a "passionate advocate" for private medical care and has been involved in an advocacy group which has publicly supported the corporate plaintiffs. Dr. Hollinshead acknowledged that in his report he cited only articles that supported his views despite being aware that there were studies and reports which contradicted his opinions. Finally, Dr. Hollinshead incorporated at least six of the opinions expressed by Dr. Day in his email, at times using nearly identical terminology.

[1132] There are also indicators of lack of independence as well as partisanship with respect to Dr. Schumacher's evidence. After receiving Dr. Day's email correspondence, Dr. Schumacher was asked to respond to five of the defendant's expert reports. He was provided 450 pages of materials on July 9, 2014, and provided his response only four days later, on July 13, 2014. In cross-examination it became apparent that Dr. Schumacher did not conduct his own independent research in preparing his expert report. He could not recall whether he even completed a review of the materials that were provided to him by plaintiffs' counsel. In fact, there are very few references to scientific literature, or any evidence for that matter, to support the opinions expressed by Dr. Schumacher in his report. Like Dr. Hollinshead, some of the opinions expressed in Dr. Day's email were also incorporated in Dr. Schumacher's report without any indication that he made any attempts to independently verify them.

[1133] It is also significant and concerning that plaintiffs' counsel made substantive changes to Dr. Schumacher's expert report. These included adding a newspaper article from the *Calgary Herald* that had been provided by Dr. Hollinshead; changing the wording of one of his sentences to say that arguments made in a paper that reached conclusions contrary to the plaintiffs' claim were "surprising and contrary to health care policy," and adding a sentence to Dr. Schumacher's report to the effect that better treatment and monitoring of chronic conditions is both beneficial to patients and more cost effective in terms of overall healthcare costs. Dr. Schumacher's file contains no documentation to suggest that he had reviewed and approved these changes and he could not recall having done so. As discussed below, there are also other instances of counsel for the plaintiffs making substantive changes to the contents of expert reports.

[1134] With respect to Mr. Labrie, in addition to the email correspondence from Dr. Day excerpted above, on April 15, 2014, Dr. Day wrote in his email to Mr. Labrie as follows:

> We have received them [the defendant's expert reports] and I have been sequestered for the past several days going through a filling cabinet full of 28 government expert reports, some of which are more than a hundred pages long. I have done this to add my commentary, although I

> do not believe it can be used in court because I am an advocate (see introduction of my attached review).
>
> I wonder if you could glance over the comments and let me know, based on my critique, which expert reports you think would be most appropriate for you to consider responding to?

[1135] Once again, this email makes it abundantly clear that Dr. Day's "commentary" was meant to inform and influence the experts and the manner in which they approached their task of responding to the defendant's expert reports. At least in the case of Mr. Labrie, there is good reason to think that he was intended to be a proxy for Dr. Day.

[1136] As with the previous three experts, Dr. Davidson's report also incorporated aspects of Dr. Day's email correspondence with respect to his response to a report from an expert for the defendant (which the defendant ultimately did not rely on). For example, during cross-examination Dr. Davidson confirmed that he had no previous knowledge of the history, regulatory context and design of the Accident Compensation Commission ("ACC") system in New Zealand. Instead, he based his opinions on the information contained in Dr. Day's email correspondence as well as Wikipedia and he did not conduct any independent research beyond those sources. As previously noted, Dr. Davidson is also one of the initial investors and doctors who operated at Cambie Surgeries.

[1137] In final reply submissions, counsel for the plaintiffs acknowledged some of the concerns raised by Dr. Day's email correspondence and its influence on these four experts. However, the submission was that ultimately it did not matter:

> The defendant also wants to make a great deal out of the email that Dr. Day sent to some experts. First it was only sent to four experts: Dr. Schumacher, Davidson, Hollinshead and also to Professor Labrie, and very little use had been made of the evidence of these experts. So the plaintiffs emphatically dispute [counsel for the defendant's] claim that the [defendant's] experts were superior to the plaintiffs' experts with regard to impartiality and that Your Lordship can feel comfortable relying on their opinions rather than the plaintiffs. (Transcript Day 194, p. 49)

[1138] It is true that the evidence of Dr. Schumacher is not referenced at all in the plaintiffs' closing submissions. The reports of Drs. Davidson and Hollinshead and Mr. Labrie are each referenced only twice and that is with respect to very general and uncontentious issues. Thus, the plaintiffs are correct in stating they do not rely on the evidence of these experts. But the above problems were manifest from the beginning and it is not at all clear why the reports were tendered to begin with. Having tendered them, the problems must now be dealt with. I add that the qualitative comparison

raised by the plaintiffs is simply not responsive to this situation. Overall, the plaintiffs' reply does not address the issues here.

[1139] I can only conclude that no weight can be given to the expert reports and evidence of Drs. Schumacher, Davidson and Hollinshead and Mr. Labrie. The communications from Dr. Day to these individuals has so tainted their evidence that I cannot be confident in their independence. In addition, to the extent that the four witnesses responded to the defendant's experts, their responsive evidence has no weight and cannot be preferred over the expert evidence of the defendant on the applicable issues.