

No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

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

PLAINTIFFS

AND:

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

DEFENDANTS

AND:

**DR. DUNCAN ETCHE, DR. ROBERT WOOLLARD, GLYN TOWNSON,
THOMAS MCGREGOR, BRITISH COLUMBIA FRIENDS OF MEDICARE
SOCIETY, CANADIAN DOCTORS FOR MEDICARE, MARIËL SCHOOFF,
DAPHNE LANG, JOYCE HAMER, MYRNA ALLISON,
and the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY**

INTERVENORS

AND:

THE ATTORNEY GENERAL OF CANADA

PURSUANT TO THE *CONSTITUTIONAL QUESTION ACT*

OPENING STATEMENT OF THE PLAINTIFFS
September 6, 2016

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I. INTRODUCTION

1. Our case can be put very simply:
 - a) The B.C. Government does not provide timely medical services to all British Columbians;
 - b) The failure to provide timely medical services causes real and substantial harm to the physical and mental health of British Columbians;
 - c) The *Medicare Protection Act* (the “*Act*”) prohibits many, but not all, British Columbians from accessing private health care;
 - d) Because the public system has failed to protect the health of all British Columbians, the Government cannot constitutionally prohibit British Columbians from accessing private health care in the province;
 - e) This is a breach of section 7 of the *Canadian Charter of Rights and Freedoms* (“*Charter*”), which protects the rights to life, liberty and security of the person from arbitrary or unnecessary deprivation; and
 - f) The deprivation created by the *Act* is arbitrary and unnecessary because allowing British Columbians to access private health care will not undermine access to health care in the public system.
2. There is absolutely no doubt that the Government is unable to provide timely medical services to all British Columbians.
3. This is clear from the Government’s own data that shows a chronic failure to meet even the Government’s own definition of acceptable waiting times for medical services.
4. The statistics from the Vancouver Coastal Health Authority show, for example, that at Vancouver General Hospital, 44% of patients have to wait longer for surgeries than the recommended maximum waiting times set by the medical profession.
5. There is also absolutely no doubt that people in the province are being harmed every day by the inability of our public health care system to provide timely medical services to every British Columbian.

6. The Government concedes that it has to ration care to meet its budget for public health care.
7. This results in lengthy waiting lists which in turn cause British Columbians significant physical and psychological harms, as well as financial hardships.
8. The quality of life of many British Columbians is significantly and sometimes irreparably damaged because they cannot obtain timely care in the public health care system.
9. Take the example of the Plaintiff Walid Khalfallah, a young boy who required urgent surgery for his scoliosis/kyphosis.
10. Because he was not provided with timely surgery in our public system, he is now a paraplegic.
11. While this is an extreme case – it still happened. For individuals like Walid, this is their reality.
12. And it happened because we have a public health care system that could not provide timely medical care to Walid and other British Columbians.
13. There are many other British Columbians who have suffered, and continue to suffer, greatly because of the lengthy wait lists for treatment in our public health care system.
14. That is evidenced by the thousands of complaints the Government has received from British Columbians about being harmed by lengthy delays for medical services in the public system.
15. The other Plaintiffs in this case also faced lengthy wait times in the public system but were able to obtain timely private care from the Plaintiff Cambie Surgery Centre (“**Cambie**”)
16. This enabled them to avoid further harm from waiting for care in the public system.
17. Cambie and the other private surgical clinics in the province and the doctors working in them, along with the Plaintiff Specialist Referral Clinic (“**SRC**”), have been providing relief

to some British Columbians from the lengthy wait lists in the public system for the past 20 years.

18. This has not taken any diagnostic or surgical resources away from the public health care system.
19. It has simply provided a much needed safety valve for British Columbians who are, or would otherwise be, suffering physical and/or psychological harm by waiting for diagnosis and/or surgery in the public system.
20. The experience in other countries which have a mixed universal public health care system and a supplementary private health care system shows that British Columbians will be much better off, and certainly not worse off, by being able to access private medical care if the public health care system cannot adequately meet their health care needs in a timely way.
21. The problem is that Cambie and SRC and the other surgical clinics have been providing these services in contravention of the *Medicare Protection Act*.
22. The Act is designed in a way that effectively prohibits BC residents from accessing private health care in the province.
23. It does not achieve this result directly by making private clinics or accessing private care illegal.
24. Rather, it achieves the same objective indirectly, in two ways:
 - By effectively prohibiting doctors enrolled in the public system from providing medically necessary services in private clinics, and
 - By prohibiting BC residents from accessing private insurance to pay for the provision of medically necessary services in Canada.
25. Doctors must choose to either be ‘enrolled’ in the public system or not. They cannot be both.

26. Enrolled doctors can provide private surgeries.
27. But they can only charge a patient the doctor's fee payable under the public plan for the surgery.
28. The patient cannot be charged for the use of the private facility, nursing staff, equipment, medical supplies, or other associated costs.
29. This means that from a practical perspective, enrolled doctors cannot perform private surgeries, since the amount they are permitted to charge could never cover the true cost of the surgery.
30. Doctors who are not enrolled can charge patients more than the fee amount for the surgery under the public plan.
31. But most doctors want to remain in the public system.
32. They believe in public health care.
33. They do not want to have to leave the public health care system in order to provide private care.
34. But they also want to put their surgical skills to their full use for the benefit of patients, which they cannot do in the public health care system because of severe restrictions on diagnostics and operating room time.
35. Operating time restrictions have been put in place to save costs – surgeries have to be rationed in the public system to meet budgetary objectives.
36. Diagnostic procedures have also been rationed to meet budgetary objectives.
37. And then there is the prohibition of private insurance.
38. Most British Columbians cannot afford private diagnosis or surgeries.

39. So, without private insurance, private diagnostics and surgeries will remain inaccessible to a lot of British Columbians. Even de-enrolled physicians are effectively precluded from providing them.
40. Because they are prohibited from obtaining insurance, they are forced to languish on a waiting list, with the resulting physical, psychological, emotional and economic harm that this entails.
41. The combined effect of these two prohibitions in the *Act* is to prevent British Columbians from accessing private diagnosis or surgery in the province.
42. These two prohibitions are designed to prevent British Columbians from having any real access to private health care unless they are very wealthy and can afford to go outside the country for medical services, or come within one of the exemptions under the *Act*.
43. That is not an accidental byproduct of the *Act*. It is the intention of the *Act*.
44. The prohibitions on accessing private health care in the *Act* violate rights to life, liberty and security of British Columbians under s. 7 of the *Charter*.
45. It is now well established that under s. 7 of the *Charter*, Canadian citizens “are – and should be – free to make decisions about their bodily integrity” [*Carter* at para 67].¹
46. This is the fundamental constitutional right of Canadians, as defined by the Supreme Court of Canada.
47. The prohibitions in the *Act* prevent B.C. residents from freely making decisions about how best to protect their bodily integrity, by effectively preventing most of them from accessing private health care.

¹ *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

48. This case is about giving effect to the constitutional right of British Columbians to protect their own bodily integrity, by eliminating the legislative prohibitions on accessing private health care.
49. Eliminating these prohibitions on access to private health care will not harm the public system.
50. Indeed, in addition to better enabling British Columbians to meet their health care needs, it will also spur improvements in the public health care system, which have been difficult, if not impossible, to achieve because of the perceived need to preserve a public monopoly over core medical services.
51. Some people object to doctors and others being able to make money by providing private health care services.
52. But, when the public health care system is unable to provide timely medical services for everyone, it is necessary for the health of British Columbians that there be private financing and involvement generally in the provision of core health care services, just as is the case for other health services.
53. This is the approach adopted in other advanced nations where private insurance supplements a universal public health system, such as the United Kingdom, Sweden, Germany, France and many others, all of whom rate more highly than Canada in terms of quality, access and equality.
54. Some argue that the Government should raise taxes to the level required to provide the timely medical service every British Columbian needs to protect their bodily integrity.
55. But, after countless years of the Government being unable to provide sufficient funding for the public health care system to ensure that all British Columbians are receiving timely care – regardless of the party in power – we know that it is simply unrealistic to believe that this will ever happen.

56. The cost of providing medically necessary services is increasing very rapidly, and there are too many competing demands on the public purse.
57. When governments fail to protect the fundamental rights of Canadians, it falls to the Courts to enforce these rights.
58. In this case, vindicating these *Charter* rights would allow British Columbians to protect their own bodily integrity in the face of a public health care system that has proven to be unable to do that for them.
59. There are, of course, a few BC residents who are wealthy enough to afford to go outside of Canada for medically necessary health care, and some who can and do currently pay for treatment at private clinics in BC.
60. But the vast majority of British Columbians cannot afford to do so without the ability to obtain private insurance independently or, more likely, through their employer.
61. So the prohibitions on private health care have a disproportionate negative impact on the average British Columbian, because it prevents them from obtaining less costly private health care services in the province.
62. There are some other BC residents who are allowed to obtain timely medical services from enrolled doctors outside of the public system pursuant to exemptions in the *Act*.
63. The exemptions in the *Act* permit workers who suffer from workplace injuries to obtain expedited private surgeries through the Workers Compensation system so they can return to work more quickly, and endure less pain and suffering than other British Columbians.
64. And there other exemptions, for example, for patients from any other province in Canada or from other countries who can come to BC and obtain private medical services.
65. But the exemptions do not cover the vast majority of British Columbians, most of whom suffer non-occupational illnesses and injuries.

66. The result is that the vast majority of BC residents are harmed by the lengthy wait lists in the public health care system.
67. At the same time, the Government is effectively preventing individuals who do not come within an exemption from obtaining private medical care in the province to meet their medical needs in a timely manner.
68. As the Supreme Court of Canada has already found, it is a breach of s. 7 of the *Charter* for the Government to prohibit access to private medical care if the public system cannot provide timely medical care.
69. Also, the fact that only some BC residents and not others can lawfully obtain private health care in the province through one of the exemptions in the *Act* constitutes unequal treatment under the law, contrary to the *Charter*.
70. This is a separate *Charter* breach of s. 15, in addition to the s. 7 breach.
71. All British Columbians should have the same ability under the law to access private medical services to meet their health care needs in a timely way, as they themselves define it.
72. Dr. Day had a patient who highlights the arbitrariness and inequality of the prohibitions and exemptions in the *Act*.
73. The patient was a physical education teacher who injured one knee playing soccer with his students on the school playground, and the other knee playing soccer with his recreational team.
74. He should have been able to have the surgeries on both knees done in a timely manner in order to return to work as soon as possible. However, there are long waits for these surgeries in the public system. The wait times in the private system paid for by WorkSafeBC are much shorter.

75. He was able to have the knee that he injured on the job surgically repaired on a timely basis in a private clinic, by an enrolled doctor, through the Workers Compensation insurance scheme.
76. WorkSafeBC could do this with the knee injured at work because occupational injuries and illnesses are exempted under the *Act*.
77. He had to wait for a considerably longer period in the public system for the surgery on the knee he injured on the weekend, even though he had private disability insurance through his employer.
78. Waiting for this surgery also prevented him from performing his job.
79. But the private disability insurer could not pay for a private surgical clinic to repair the injury to his knee that he suffered while skiing so that he could return to work more quickly.
80. Thus, because medical services covered by private disability insurance are not exempt, the *Act* delayed his return to work, for no benefit to the public system, and caused him unnecessary pain and suffering as well as loss of income.
81. This is absurd.
82. These distinctions drawn in the *Act* advance no valid public interest.
83. This simple example highlights the arbitrariness and inequality of the law governing the public health care system, which causes unnecessary harm to British Columbians.
84. The Government's inability to provide timely medical care in the public system for all BC residents is not new.
85. This problem has existed for well over 30 years.
86. And the BC Government has been unable to fix it.

87. Given its inability to provide timely medical care to everyone in the public system, it is not surprising that the Government – both the Liberals and the NDP before them - knowingly permitted, for at least 10 years, Cambie and other private clinics to use enrolled physicians to provide private diagnoses and surgeries in breach of the Act.
88. The Government knew that it could not meet the diagnostic and surgical needs of all British Columbians in a timely manner.
89. It also knew that permitting enrolled surgeons to provide diagnoses and surgeries privately would help British Columbians meet their health care needs.
90. As then Premier Dosanjh said in a speech to the Hospital Employees Union in 2000 about the surgical clinics using enrolled doctors contrary to the Act:

One shouldn't underestimate how difficult it's going to be to deal with the issue It would do us no good to shut down [Dr. Brian] Day's clinic if we cannot provide those services elsewhere.²
91. The situation has not improved since then.
92. The Government is still unable to provide all British Columbians with timely surgeries.
93. Indeed, the situation is getting worse, not better.
94. What is surprising is that soon after the Supreme Court's decision in the *Chaoulli* case,³ in which the Supreme Court of Canada held that it was unconstitutional to deny Quebecers access to private health care when the Government could not provide timely health care to everyone in Quebec's public health care system, the BC Government commenced legal proceedings in 2008 to prevent the private surgical clinics from using enrolled doctors to provide much needed medical services to British Columbians.
95. The Government was prompted to take this action to stop the private clinics from using enrolled doctors to perform private surgeries by the Nurses Union and its surrogates, who

² CSC00017381 - Media Article, "Dosanjh not set to outlaw clinics" (November 17, 2000).

³ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 SCR 791, 2005 SCC 35 [*Chaoulli*].

had commenced their own legal proceedings to compel the Government to enforce the Act against Cambie and other surgical clinics.

96. Rather than amending the *Act* to allow the clinics to continue using enrolled doctors to perform private diagnoses and surgeries, the Government tried to stop them from doing so.
97. The Government did this even though it knew or ought to have known that allowing these clinics to continue to use enrolled doctors to provide private diagnosis and surgeries does not harm the public system by depriving it of medical resources - or in any other way.
98. To the contrary, the provision of private diagnoses and surgeries to some British Columbians has helped the public health care system by removing those patients from wait lists and allowing the public resources that would have been used to treat them to be used for other patients.
99. It also allows doctors to more fully utilize their skills to help patients, instead of sitting idle while they wait for their next brief allotment of public facilities.
100. In response to the Government's action to prevent them from continuing to use enrolled doctors to perform private diagnostics and surgeries, Cambie and SRC, along with the other Plaintiffs, brought this constitutional challenge to the *Act*'s prohibitions on private health care.
101. The Plaintiffs believe that British Columbians should not be denied their constitutional right to choose to protect their bodily integrity by obtaining timely private medical care, when they cannot receive it in the public system.
102. The Plaintiffs' constitutional challenge is both to the prohibition on doctors enrolled in the public system providing medically necessary services privately and to the prohibition on private insurance.
103. Cambie and SRC and the other surgical clinics rely on enrolled doctors.

104. If enrolled doctors cannot provide medical services privately, they will spend more time sitting idle, or will leave the province, while even more British Columbians remain in wait list queues in the public system, lengthening these wait lists and causing further harm to all patients.
105. Specialists are unable to obtain sufficient time and resources in the public system to adequately serve patients and maintain their own professional skills.
106. And, while the private clinics do provide medical services to WorkSafeBC, and indeed to the Health Authorities, which is a direct benefit to all British Columbians, the private clinics rely, for their economic viability, on the ability to provide private services to all British Columbians.
107. If they can no longer provide services to British Columbians on a private pay basis, then many, if not all, of the private surgical clinics in BC would have to close.
108. The closure of these clinics would mean that WorkSafeBC would no longer be able to access private health care for injured workers in order to return them back to work more quickly.
109. WorkSafeBC would then have to utilize public hospitals in order to provide needed surgeries to injured workers, with the result that current and future public patients on wait lists at public hospitals will be bumped or have their waits further extended.
110. Our Workers Compensation system cannot afford to have injured workers wait in line in the public system for these surgeries.
111. WorkSafeBC saves up to \$200 million a year in benefit payments by obtaining more timely surgeries.⁴
112. And it is of great benefit to injured workers, as well as to their employers and our economy generally, for them to return to work as quickly as possible.

⁴ Gord Van de Eeden, WCB Spokesperson, *Business in Vancouver Interview*, Issue 702 (April 2003).

113. The exemption enables WorkSafeBC to avoid the public system's lengthy waitlists by having surgeries done privately by enrolled doctors.
114. Being able to access private medical clinics reduces both the costs to the workers compensation insurance fund and the physical, mental and economic harms to workers.
115. That is why all workers compensation systems across Canada utilize private clinics.
116. Achieving these dual objectives depends on the existence of private clinics to provide more timely surgeries for injured workers.
117. But if the Government's enforcement of the *Act* results in private clinics no longer being able to provide private services to British Columbians through enrolled doctors, many of these clinics will be unable to remain viable.
118. The closure of these clinics will be a major health care loss to British Columbians who suffer workplace injuries and illnesses as well as a significant extra cost to the Workers Compensation System.
119. The closure of the surgical clinics will also be a loss generally to the public health care system.
120. Since 2002, the Health Authorities have been contracting with many of the private surgical clinics to perform some surgeries for the public health care system.
121. In a 2006 Government document prepared in response to the NDP questioning about enrolled doctors performing services in the private system, the Ministry of Health stated:

Medical services provided in private facilities under contract to health authorities can increase access to needed medical services for BC residents⁵
122. This could stop as well if the Government succeeds in preventing Cambie and the other surgical clinics from continuing to use enrolled doctors to perform private surgeries.

⁵ BC4339393 - Advice to Minister: BC Doctors working in public and private system (November 16, 2006).

123. Then, the closure or reduction of these clinics will have negative consequences on the health care of British Columbians beyond the fact they will no longer be able to obtain private surgeries outside of an exemption under the *Act*.
124. And for what benefit?
125. Absolutely none.
126. There is no valid health or other public policy reason to prevent enrolled doctors from performing medical services privately addition to their work in the public system.
127. The experience over the past 20 years has conclusively proven that the operation of the private surgical clinics has not taken any physician resources away from the public health system.
128. The surgeons working at Cambie and the other surgical clinics are the leading surgeons in the Province.
129. They believe in the public health care system, and wholeheartedly support it.
130. But, they are provided with very little surgical time in the public system – one or two days per week, at most.
131. These surgical quotas do not reflect, and are not based on, the medical needs of BC residents.
132. And they are certainly not based on the number of surgeries that these surgeons could perform in a week or month.
133. Rather, the surgical quotas are based on the Government's budgetary priorities and financial pressures.
134. The Government controls the amount it spends on health care by limiting the number of surgeries and other procedures that it will fund.

135. The problems this creates are highlighted by the following letter from a doctor in the Cowichan Valley to the President and CEO of the Vancouver Island Health Authority, with a copy sent to the Ministry of Health:

Dear Waldner:

The Orthopaedic Surgeons of the Cowichan Valley read with interest the above mentioned article in which you are quoted as saying, "I think it is huge that less than 10% of patients wait more than 26 weeks for hip and knee surgery." Unless the patients of the Cowichan Valley constitute the 10%, we adamantly deny the veracity of this statement.

There has been no significant increase in the number of arthroplasties performed at the Cowichan District Hospital over the past three years. In fact, despite an increasing wait list, there has not been any attempt to increase the amount of operating room time that would alleviate this orthopaedic problem.

The wait list for Orthopaedic surgery has actually increased over the last year in the Cowichan surgery, despite your claim that only 10% of patients are waiting more than 26 weeks. We have at least 257 people on our hip and knee surgery list. We are allowed to perform only 263 arthroplasties per year, even though we have the ability to perform a greater complement.

We feel that the statistics regarding the numbers of patients on the wait list are being manipulated to erroneously deceive patients to believe they will have their arthroplasties performed in three months.

This is not remotely possible under the current Operating Room time allocation. We have a much greater maximum surgical capability at Cowichan District Hospital. We could easily perform another 100 arthroplasties per year at CDH, significantly reducing our wait list, if we were to receive the necessary funding to do so.

We would also like to call you [sic] attention to the fact that the Orthopaedic Surgeons at Cowichan District Hospital are currently committed to a 1 in 3 call. This level of work has been the same for 18 years. We challenge you to find this exhausting call schedule in any other hospital in B.C. Since this pace is very difficult to sustain, we are trying to recruit an additional surgeon so that we can at least achieve 1 in 4 call. This would obviously necessitate an increase in O.R. time, so that the new surgeon can sustain a practice. Recently we presented a comprehensive proposal to our site Director, Lorna Jefferis, addressing this issue. Failure to promptly resolve this issue will likely result in gaps in Orthopaedic coverage at CDH.

We have been contacted by the local press, who have been pressured by patients for answers, by would prefer to consult with you first. The issues of patients being asked to go to Vancouver for surgery is one that will escalate hugely here. It is our view that in most cases, this is not a reasonably viable option. (To be dropped from the wait list because of a refusal to leave family to go to Vancouver for a surgery...IS THIS HAPPENING?)

We need more Orthopaedic Surgery funding at CDH – bottom line.⁶

136. So, we have surgeons who are willing and able to perform more surgical procedures in the public system and we have many British Columbians who are waiting long periods of time for surgeries, but we also have a Government that has arbitrarily limited the number of surgeries the surgeons can perform in order to reduce costs.
137. This is a terrible waste of surgical resources!
138. In a 2006 lecture, Senator Michael Kirby, the lead author of the 2002 Senate Report on health care in Canada, described this waste of human resources caused by the prohibition on dual practice as follows:

Let me give you two real-life examples, which illustrate why maintaining the ban on doctors taking both public and private pay patients is an inefficient use of health human resources.

In provinces that ration the supply of specialists' services by capping their income, it is common for a cardiologist to reach his or her income cap by working only three and a half days a week. I am personally aware of a specific case in which a cardiologist spends the other day and a half a week at home with his young family.

What a waste of highly trained, very expensive talent! Surely it would be better to allow — indeed encourage — this cardiologist to see patients that extra day and a half a week. If the province in question is unwilling to pay for his time, then it makes sense to remove the rationing constraint and let the cardiologist take private pay patients for the remaining day and a half a week.

The second example is an orthopedic surgeon in a province which rations the supply of health care by restricting the number of operating room hours available to the surgeon, thus rationing the number of procedures the surgeon can, do. Over the past decade or so, this surgeon has had his operating room hours reduced from approximately 22 hours per week to about 8 hours per week. Clearly wait times would improve if the rationing of this surgeon's services was eliminated by allowing him to take private pay patients once he had completed his maximum eight hours per week in the operating room treating publicly funded patients.

⁶ BC1028835 - Letter to Mr. Waldner re "VIHA Slices Wait Lists for Joint Surgery" (February 5, 2008).

To maintain the rationing constraint makes no sense! It is a colossal waste of human resources and exacerbates the waiting times for procedures such as hip and knee replacements.⁷

139. The enrolled physicians at Cambie and the other private clinics in the province want to use their unused capacity to benefit BC residents by providing medical services privately.
140. That is why a group of enrolled physicians decided in 1992 to start the Cambie Surgies Centre, which opened in 1996.
141. Faced with such limited surgical time in the public system, their only other option if they wanted to fully utilize their surgical skills would have been to leave the province.
142. That would not have been in the public interest.
143. These surgeons are needed in the public system.
144. And they want to continue working in the public system.
145. These are individuals who have spent 10 to 15 years training to become specialists in surgery, anesthesiology and other medical fields in order to apply their skills and to help people.
146. During that training in their residency, they frequently worked 100 hours each week in the public system, providing care to people who needed it, day and night.
147. The public system relies on their dedication and support.
148. And the physicians do not want to abandon it.
149. But even though there is no good or valid medical or public policy rationale for preventing Cambie and the other private clinics from continuing to use enrolled doctors to provide much needed medical services, that is what the Government is seeking to do in this case.

⁷ CSC00020411 - Michael Kirby, "The Only Two Options for Funding the Wait-Time Guarantee" *Policy Options* (July-August 2006) [Kirby, "Two Options"] at 72.

150. This makes no public policy or health care sense.
151. There is also no valid medical or public policy reason for preventing BC residents from using private insurance to pay for private surgeries or other medically necessary services provided by doctors in BC.
152. That is why the Plaintiffs are also challenging the prohibition on private insurance.
153. The prohibition on private insurance is a significant barrier preventing ordinary BC residents from accessing private health care to meet their medical needs in a timely way.
154. Eliminating the prohibition on private health care insurance for medically necessary services will make private health care more accessible for British Columbians, and will also reduce pressures on the public health care system.
155. The argument is made that removing the prohibition on private insurance will only benefit the wealthy.
156. But that is not so.
157. At the end of 2014, there were about 11 million Canadians covered by employer sponsored long term disability plans.
158. 25 million Canadians – workers and their dependents – were covered by employer sponsored extended health insurance.
159. This is two thirds of Canada's population.
160. There were also two-thirds of a million Canadians covered by employer-sponsored group critical illness policies and about 1.1 million Canadians who had individual critical illness insurance policies.
161. As can be seen, a significant number of Canadians already have private insurance that could be used to provide them with more timely private surgeries.

162. But the prohibition on private insurance prevents insurers from using the existing employer-provided disability coverage to obtain timely medical care privately to enable British Columbians to return to work more quickly.
163. The reason that the government has allowed WorkSafeBC to send workers with occupational illnesses and injuries to private clinics for medically necessary care is because it is far less costly –to employers, employees and the economy in general – to return employees to work as soon as possible rather than have them linger on a waiting list.
164. This rationale applies equally to workers who suffer non-occupational injuries and illnesses.
165. An injury is still an injury and deserving of equal care and attention regardless of where it occurs.
166. While the injuries may not have happened at work, they still often prevent people from working until they receive treatment.
167. They also prevent students from going to school, and others from carrying out their normal activities, including enjoying their leisure time, pain free.
168. In the Phys-Ed teacher example, he had disability insurance through his employer.
169. There was no good reason to legally prohibit his disability carrier from using this insurance to have the knee he injured on the weekend repaired at a private surgical clinic, in the same way that WorkSafeBC had his other knee – the one he injured at work - repaired at Cambie.
170. Denying private disability insurers the ability to use disability insurance to obtain more timely health care privately for non-occupational illnesses and injuries suffered by British Columbians imposes a significant cost on them, their families, and their employers.

171. Eliminating the prohibition on private insurance would enable insurance companies to provide employees with access to private medical care to meet their health care needs in a timely manner.
172. This will greatly benefit the employers, their employees and our economy generally.
173. And it would also reduce the costs of workplace private disability insurance, because injured workers would not remain as long off work and in receipt of disability benefits.
174. This would make disability insurance less costly and hence more readily available.
175. The longer a person remains off work on disability benefits, the greater the cost of this insurance.
176. Disability insurance costs are increasing rapidly.
177. The only way to control these costs, and therefore to make disability insurance more affordable and hence more available, is to get ill and injured workers back to work more quickly – in the same way as WorkSafeBC does – by using private clinics.
178. The prohibitions on private health care and private insurance have little detrimental effects on the very wealthy.
179. The United States is only a few hours away.
180. Wealthy Canadians can afford to pay for private care in the U.S and they can afford to buy private health insurance in the U.S.
181. Thus, eliminating the prohibition on private insurance would not primarily or substantially benefit the wealthy.
182. At a minimum, it would also benefit a great number of BC employees who already have employer-provided insurance that could be used by the insurance companies to return injured workers to work more quickly by accessing private health care.

183. Also, ICBC would be able to pay for surgeries in private clinics in order to reduce the costs of disability payments under the automobile insurance plan.
184. And, once the prohibition against private insurance is eliminated, insurance companies would then be able to provide private disability insurance to BC residents who do not have such insurance in their jobs.
185. For those who cannot afford private disability insurance or do not want it, they still have a universal public health care system, access to which can only be improved by having fewer patients to deal with.
186. They lose nothing by allowing BC residents to make a personal choice relating to their own health about whether to acquire private insurance.
187. Equity will be improved by allowing more British Columbians, instead of just the wealthy as is currently the case, to access private health care to meet their core health care needs.
188. Private health care insurance is not new in Canada.
189. BC residents already can and do obtain private insurance for their medical needs not covered by the public health care plan, either directly or through their employers to cover such health care items as pharmaceuticals, dentistry, psychological therapy and physiotherapy.
190. In its 2010 Economic Survey of Canada, the OECD described the private insurance and public financing situation in Canada as follows:

Overall, because of the relatively narrow scope of Medicare coverage, the share of private insurance is among the highest in the OECD, and the share of public financing is below the OECD average (70% versus 72%)⁸
191. Removing the ban on private insurance for health care services that are listed by the Government as being medically necessary, and hence covered by public funding through

⁸ CSC00019663 - Organization for Economic Co-operation and Development, *OECD Economic Surveys: Canada 2010*, Vol 2010/14 (September 2010) [OECD: Canada 2010] at 109.

the Medical Services Plan (“**MSP**”), would simply represent an extension of the scope of such insurance in the medical field in Canada.

192. And extending the range of private insurance to cover at least some hospital and physician services would allow more people to meet their health care needs.
193. This would make our health care system more, not less, equitable.
194. And again, the public health care system would not be harmed by allowing private health insurance as a complement to MSP coverage.
195. The Canadian Medical Association (“**CMA**”) shares this view, from a medical ethics perspective. The CMA’s policy paper “Managing the Public – Private Interface to Improve Access to Quality Health Care” states:

When access to timely care cannot be provided in the publicly funded system, Canadians should be able to use private health insurance to reimburse the cost of care obtained in the private sector.⁹

196. No one will be worse off by removing the prohibition on private insurance for medically necessary services.
197. That is proven by the experience in other countries which have universal public health care systems together with private health care covered by private insurance.
198. This includes countries like France, Germany, Sweden, the United Kingdom, Australia, New Zealand, Japan, and Netherlands.
199. Canada is the only country in the world in which private medical insurance is illegal.
200. The existence of private insurance along with universal public health insurance has not resulted in any harm to the public health care systems in other countries.

⁹ Canadian Medical Association, “Policy Summary: Managing the Public-Private Interface to Improve Access to Quality Health Care” (2007) at 2.

201. Rather, it has served to provide residents of these countries with better, more timely and more equitable health care at a lower per capita cost than in Canada.
202. One of the Plaintiffs' expert witnesses in this case is Professor Michael Bliss, who is Canada's pre-eminent historian.
203. He has studied, written about and taught classes on Canada's health care system for well over 30 years.
204. In a 2000 lecture entitled "The Case of the Melting Snowman: Integrative Thinking About Our Health Care," Professor Bliss described the situation confronting Canadian governments as follows:

I don't believe our current system is coping with our rising health-care expectations, nor that it can cope. While it's theoretically possible that a state monopoly on the funding of our health-care could continue, it seems to me almost certain that the tax system is not flexible enough to begin to raise the huge sums that will be required to meet our health-care expectations – quite apart from the managerial problems we have created and would sustain by continuing to try to plan health-care the way the Soviets tried to organize their tractor industry.¹⁰

205. From a financial perspective alone, there is an overwhelming need for private health care as a supplement to the public health care system.
206. This financial need is not going to disappear.
207. The cost pressures on the public system are going to be even greater in the future – which will mean even greater rationing of public health care services, not less.
208. And private health care is not a threat to high quality universal public care, as we know from the mixed systems of other countries.
209. The problem of lengthy wait lists in Canada is not new.

¹⁰ Michael Bliss, "The Case of the Melting Snowman: Integrative Thinking About Our Health Care" (Rotman Life-Long Learning Lecture) at 8.

210. Beginning almost immediately after the introduction of the public health care system in the late 1960's, British Columbia and other Canadian governments encountered difficulties in paying for the provision of timely medically necessary services for everyone.
211. In part, that is because the financial projections upon which the public health care system was premised turned out not to be accurate.
212. The financial problem is getting progressively worse because the cost of providing health care services has increased exponentially over the past four decades.
213. In its report entitled "Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer", the Society of Actuaries and the Canadian Institute of Actuaries concluded as follows:

The findings indicate that, without significant government intervention, the Canadian health care system in its current form is not sustainable. Key findings from the analysis show that:

- Assuming no governmental steps to curb health care expenditures, provincial/territorial spending on health care is estimated to increase at 5.1 percent real growth per year, increasing from 44 percent today to 103 percent of total provincial/territorial revenues by 2037.
- Even after assuming some governmental action (for the base scenario, see Appendix 4) to limit real growth rates to 3.5 percent—and thus to decrease 2037 health care expenditures by 30 percent—health care will still absorb 69 percent of total revenues available to provinces/territories by 2037 (86 percent of own-source revenues).
- The proposed changes to the CHT will impact total revenues available to provinces/territories, reducing the federal government's portion of provincial/territorial health care expenditures from the current 21.0 percent to 14.3 percent by 2037.
- The supply of physicians needs to increase by at least 46 percent over the next 25 years just to keep up with increased demand for services as a result of aging and population growth.

In summary, the research shows that in order to safeguard the sustainability of its health care system, Canada has to significantly limit health care cost increases, or

boost GDP growth, or raise taxes/fees, or substantially reduce or cut altogether other government programs/services, or implement some combination of these.¹¹

214. Former Bank of Canada Governor David Dodge and Economist Richard Dion put it this way in their 2011 C.D Howe Institute Commentary entitled “Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis”:

Even if we in Canada are incredibly successful in improving the productivity, efficiency and effectiveness of the healthcare system — our optimistic case — we face difficult but necessary choices as to how we finance the rising costs of healthcare and manage the rising share of additional income devoted to it.

In addition to increased spending by individuals — and employers — for services currently uninsured by provinces, some combination of the following actions will be necessary to manage the "spending disease":

- 1) a sharp reduction in public services, other than healthcare, provided by governments, especially provincial governments;
- 2) increased taxes to finance the public share of healthcare spending;
- 3) increased spending by individuals on healthcare services that are currently insured by provinces, through some form of co-payment or through delisting of services that are currently publicly financed;
- 4) a major degradation of publicly insured healthcare standards — longer queues, services of poorer quality — and the development of a privately funded system to provide better-quality care for those willing to pay for it, as in the UK and many European countries. This "two-tier" option would not have much effect on the rate of growth of total spending but, like option 3 above, would alter the public-private split and have distributional implications.

None of these options is appealing; there is no easy way to manage the chronic healthcare spending rise. In this paper we have attempted to provide a diagnostic of the spending disease and a prognosis of its evolution. The prognosis is not good, even if we are incredibly successful in improving the efficiency and effectiveness of healthcare delivery. But the spending disease must be managed. It is now up to Canadians to have an adult discussion about how to manage it.¹²

¹¹ Canadian Institute of Actuaries and Society of Actuaries, “Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer” (September 2013) at 1.

¹² David Dodge and Richard Dion, *Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis* (Toronto: CD Howe Institute, 2011) at 11.

215. There are a number of causes of the increased health care costs – including population growth, greater utilizations of service, new technological and scientific advances, and an aging population.
216. The meteoric rise in health care costs has left the Government in a very difficult, if not impossible, financial position regarding the provision of timely, high quality medical treatment in the public system.
217. The reality is that the public wants and expects more from the health care system.
218. And this demand for services within the public system will continue to increase as the population ages, and as advances in medical science and technology produce more effective and more expensive treatment options.
219. The BC Government cannot reduce demand *within* the public system without imposing user fees or other costs, in addition to MSP premiums, upon those accessing the public health system.
220. But that would be contrary to the *Canada Health Act*, because it would impede access to medical services in the public system.
221. The result is that there is no financial check on demand for medical services within the public system in Canada.
222. Providing all BC residents with timely treatment in the public system would necessitate a massive infusion of monies by the Government into the provision of health care beyond what the Government has been or will be able or willing to provide.
223. The experience over the past 25 years has proven that the tax system is not able to increase revenue to the extent necessary to meet the medical needs of all British Columbia residents, without extraordinary cuts to other important public spending priorities, such as social services and education.

224. Because the Government cannot afford to meet the health care needs of all British Columbians without massively increasing taxes or crowding out all other spending priorities, it has done the only other thing it can to do make the system sustainable: ration medically necessary services.
225. As the OECD has put it, the “solution” across Canada to the inevitable budgetary pressures created by the ever-rising costs in a closed system “has been to ration [health care] by means of long waits for treatment – widely regarded as the Achilles heel of the system – as budget considerations limit the possible increases in supply” [OECD: Canada 2010, at 106].
226. It is the ongoing rationing of physician and hospital care in a monopoly system that has led to this constitutional challenge.
227. The result of the rationing of medical services, through limiting operating room time and in other ways, is that the public health care system cannot meet the health care needs of all British Columbians in a timely manner.
228. This is admitted by the Government.
229. The Government has established wait times targets for at least some medically necessary services, in particular, certain surgical procedures.
230. However, the Government only measures and reports the wait times from the date of the request by a specialist to book the surgery to the date of the surgery.
231. This calculation ignores the amount of time that person has waited in the system before seeing and being diagnosed by a specialist, which can take months or even years.
232. And the wait times the Government considers acceptable are often longer than the wait times thought to be appropriate by physicians and experts and are always much longer than is medically or practically justified.

233. Significantly, the Government's objective is to provide medically necessary services within its wait time target to 90% of BC residents who need those services, not 100%.
234. This means that the Government accepts that at least 10% of B.C. residents will not receive surgeries within its own artificially acceptable waiting times.
235. The Government's wait times statistics also do not take into account the large number of people who give up waiting.
236. A study by one of the Plaintiffs' expert witnesses, Dr. Vertesi, shows that 17% of people dropped off waiting lists, and that 63% of them had been given a "high priority" for surgery, which means they had exceeded 112 days on the waiting list.
237. And in any event, the Government concedes that it has been unable to meet even its 90% goal for those remaining on the wait lists even under its own definition of an acceptable bench mark wait time.
238. In the mid 2000's, after *Chaoulli*, the Federal Government encouraged the provinces to establish wait time guarantees for its citizens, as had been recommended in the *Kirby* report on our health care system.
239. Only Quebec did so.
240. One of the reasons given by the British Columbia Ministry of Health for not implementing wait time guarantees was that:

The funding required to support wait time guarantees for special services will mean that there is less government funding for other health care needs (e.g. public health and prevention) as well as social services and other government priorities.¹³

241. Another stated reason for not doing so was:

A guarantee would increase the possibility of encouraging the establishment of private clinics for the sake of fulfilling guarantees. In a number of jurisdictions, there are currently private hospitals and clinics eager to take advantage of the opportunity

¹³ BC1035535 - Ministry of Health Information Briefing Document - Discussion with Minister Clement patient wait time guarantees (September 20, 2006).

to accommodate “surplus” patients (but only for uncomplicated ambulatory surgeries) – those that public hospitals would be unable to treat. In turn, private health care clinics and hospitals would alert health care human resources, exacerbating existing recruitment and retention challenges for P/T (Provincial/Territorial) governments.¹⁴

242. British Columbia already had surgical clinics that were providing private surgeries, with no evidence of any harm to the public system.
243. But from the Ministry of Health’s perspective, it was better financially to have “surplus patients” - that is patients who were not being provided with surgeries within the Ministry’s definition of an acceptable wait time - continue to wait for surgeries in the public system rather than have them obtain a timely surgery from a private surgical clinic.
244. In its 2014 report entitled “Setting Priorities for the B.C. Health System”, the Ministry of Health describes its inability to reduce wait times as follows:

Overall, Canadian elective waitlist reduction strategies have been expensive, narrow in focus and only partially successful. A negotiated 2003/04 Agreement (with the Federal Government) committed funding of \$5.5 billion over 10 years to the Wait Time Reduction Fund in order to reduce wait time for five procedures: cataract removal, hip and knee replacements, diagnostic imaging, cardiac bypass surgery and cancer radiation therapy. In 2011, the Canadian Institute for Health Information showed that these were reported improvements for three years, but also noted the very generous timelines being used by the health sector to measure the success of the strategy.

Despite the attention paid to surgical waitlists and increases in volumes of elective surgeries, B.C.’s wait times for many procedures have not declined and performance is either stagnant or slipping. For example, the average wait time for the top 20 surgical procedures declined slightly from 2009 to 2010, but has remained mostly the same since then. The percentage of non-emergency surgeries completed within the benchmark wait time in B.C. currently stands at 66 percent (Q2 2013/14), down from 82% in 2010/11. In 2002/03, 90 per cent of patients received their procedure within 23 weeks. Ten years later (2012/13), 90 per cent of patients received their procedures within 26 weeks. Over the same period, the number of procedures increased from 206,000 to 218,000 per year, pointing to increased use based on procedural improvements. Finally in the area of diagnostic imaging, and despite the needed debate on appropriateness, B.C. has one of the lowest rate of MRI and CT exams in

¹⁴ *Ibid.*

Canada and has only recently begun measuring wait times for diagnostic procedures.¹⁵

245. There has been no improvement, as the current statistics indicate.
246. The current situation is summarized by John McGurran in his Updated Expert Report as follows:

Taken together, the CIHI wait time data, the Wait Time Alliance reports and the Commonwealth Fund research clearly demonstrate that wait times have increased and often substantially in BC over the past few years and remain a serious problem from the physician and the patient points of view. The data clearly shows that the government of British Columbia and its health authorities have been unsuccessful in their attempts to sustain wait time reductions. Further, the significant variation in patient wait times across BC's five health authorities represents a serious challenge to the Health Ministry's role as steward of the public system. [at pp. 11]

247. The bottom line is that wait times are getting longer, not shorter, and the Government is doing worse in meeting its own targets, not better.
248. And most importantly, even if everyone could be treated within a generalized "reasonable" waiting period, this does not take into account individual circumstances which may make that waiting period too long for many people who are debilitated and suffering from pain.
249. They need the ability to go outside the public system to meet their own medical needs in order to protect their bodily integrity and psychological health.
250. Rationing care – through reduced spending, cutting operating room time, reductions in beds, de-listing services, and so on – may be a viable way to control health care costs.
251. But it has very significant real world consequences for those affected by it, in terms of ongoing pain and suffering, psychological and emotional harm, as well as personal, professional and economic harm.

¹⁵ BC2245063 - Ministry of Health, *Setting Priorities for the B.C. Health System* (February 2014) [**Ministry of Health, Setting Priorities**] at 26.

252. These consequences have been described by The Wait Time Alliance – a non-partisan association of medical practitioner associations – as follows:

Lengthy waits can have serious health consequences. We know that for some conditions, such as cancer, heart disease and mental health, the longer the wait for treatment, the worse the health outcome. Long waits for children to access necessary care can be particularly harmful. Given that physical development in children and youth occurs very quickly, especially in the earliest years, delaying surgery could have a lifelong impact on young patients and their families. There is also the mental anguish and uncertainty associated with waiting for necessary care.

The impact of long waits goes beyond the patient's health to include an economic cost to both the patient and society. For individuals and their families, a lengthy wait can mean a substantial loss of income, particularly if they do not have insurance to cover any period of economic Inactivity associated with the wait. A longer wait can also mean greater deterioration in the patient's health and a longer recovery time, potentially leading to a further loss of Income. We also know that low-income patients experience more problems accessing primary care and some types of specialty care than patients with higher incomes.

The substantive financial costs of lengthy waits for both patients and Canada's economy have been previously documented. A 2008 study prepared by The Centre for Spatial Economics for the Canadian Medical Association and the British Columbia Medical Association calculated the economic impact of excess wait times for five procedures (hip and knee replacement surgery, MRIs, CABG surgery and cataract surgery) in all 10 provinces. It found that, in addition to the obvious emotional, physical and financial toll endured by patients and their families, lengthy waits for these medical treatments cast Canada's economy an estimated \$14.8 billion overall in 2007 in reduced economic activity (\$16.9 billion in 2014 dollars). This took a \$4.4 billion chunk out of federal and provincial government revenues. Keep in mind that this study examined only a limited number of procedures and therefore underestimates the full cost of waiting that Canadians experience for a wider range of services.

Unnecessary waiting leads to substantive health and economic costs to patients and their families. Improving timely access to necessary care therefore has both health and economic benefits for all.¹⁶

253. It is unrealistic to think that the Government will be willing or able to fund the public health care system in the future to the extent necessary to provide timely medical

¹⁶ CSC00019446 - Wait Time Alliance, *Time to Close the Gap: Report Card on Wait Times in Canada* (June 2014) at 2.

services to every British Columbian, as this would necessarily mean cutting expenditures even more for other governmental services or raising taxes substantially.

254. The Government has made it clear that it is not going to raise taxes to provide more funds for the public health care system.
255. As stated in the 2002 Report of the Select Standing Committee on Health of the B.C. Legislature:

New Taxes: While we believe more new money is needed for health care, it cannot be raised by further taxation of already burdened Canadians. Whether a special designated health tax, increased GST percentage points or outright or hidden ways of obtaining more money from Canadians, your Committee feels Canadians are not prepared to pay more for health in this way.¹⁷

256. The Government is focused on making health care funding sustainable, as can be seen by the 2008 amendment to the Act to make sustainability a principle of the public health care system.
257. The Government has maintained its position of not increasing taxes to pay for the increased costs of providing public health care, and pursuing the objective of sustainability, even though it has had increasing difficulty in providing timely medical services in the public health care system to British Columbians.
258. The challenge this has posed to delivery of public health care is described as follows by the Government in its 2014 report entitled “Setting Priorities for the BC Health System”:

Government is challenged on how to meet the increasing costs of the health care system without raising taxes and cutting programs. This is further complicated by the belief of many Canadians that their public health care system should deliver more without requiring them to pay for it. [Ministry of Health, *Setting Priorities*, at 13]

259. The inevitable result of arbitrarily limiting the amount of public money that is allocated to our public health care system is the further rationing of medical services.

¹⁷ BC2246033 - Legislative Assembly of British Columbia, Select Standing Committee on Health, *Patients First 2002: The Path to Reform*, Report for the 3rd Sess, 37th Parl (Victoria, BC: 2002) [**BC, Patients First 2002**] at 66.

260. To meet their budgets set and enforced by the Government, the Health Authorities frequently have to stop providing surgeries altogether for a period of time.
261. For example, in a July 15, 2009 “Positioning Note”, the Vancouver Island Health Authority stated:

Issue: VIHA Elective Surgery Reductions

Background: As part of its budget mitigation plan, VIHA will be reducing elective (non-urgent) surgery slates through deeper closures of slates at Christmas and Spring Break...¹⁸

262. The need to stay within the assigned budget for health care services was emphasized by Premier Clark in her June 10, 2013 letter to the Honourable Terry Lake, congratulating him on his appointment as Minister of Health:

British Columbians have asked us to build a strong economy, a secure tomorrow and a lasting legacy for generations to come. Now it's time to deliver. We must be alive to the challenges of a fragile global economy. We have a duty to be disciplined for taxpayers today, and a responsibility to be fair to future generations. (...)

Protecting British Columbia for us and our children means making tough choices now to combat spending and balance the budget. By charting a course for a debt-free B.C., our children can be free to make their own choices when it's their turn to lead.

To grow our economy and create high-paying jobs for British Columbians, I am asking you to keep your Ministry focused on the BC Jobs Plan.

The Minister of Health is responsible [sic] protecting and enhancing the health care system in British Columbia while ensuring the best possible value for taxpayers. Currently, British Columbia has the best outcomes for patients in Canada while having the second best (lowest) spending on a per capita basis. I expect this to continue, despite significant demand pressures from a growing and aging population.

Your job will be to live within the funding envelope provided by the Minister of Finance while at the same time continuing to innovate and improve patient services. (...)

In your role as Minister of Health I expect that the following initiatives are completed by you and your Ministry over the coming year:

¹⁸ BC5013828 - Issues Note: VIHA Elective Surgery Reductions (February 5, 2010).

- Balance your ministerial budget to control spending and ensure an overall balancing budget for the province of British Columbia.
 - Ensure services are delivered within health authority budget targets. (...) ¹⁹
263. The Government has capped increases in health care spending to meet its budgetary objectives, even though it is clear that the capped spending increases will not meet the health care needs of all British Columbians.
264. The cap has been set at a maximum of 2.6% increase per annum in health care spending.
265. Previously, the annual increases were higher:
- 07/08 6.6%
 - 08/09 3.0%
 - 09/10 5.7%
 - 10/11 4.9%
 - 11/12 6.3%
 - 12/13 2.8%
266. Since 2012/14, the increases have been:
- 13/14 2.3%
 - 14/15 2.4%
 - 15/16 2.7%
267. A 2.6% maximum increase in health care spending is not based on an assessment of the population's need for medically necessary services, but entirely based on what the Government thinks it can afford, or what it is willing to spend in order to balance the provincial budget.
268. As the Conference Board of Canada has observed in a recent report, the Government's planned 2.6% increase is not sufficient to maintain even the *current* provision of health care for B.C. residents, inadequate as those are, let alone to improve the provision of care:

¹⁹ Ministry of Health, *Setting Priorities*, Appendix A, at 40-42.

As noted in the February budget, spending on health care is set to rise by an annual average rate of 2.6 per cent over the 2014-15 to 2016 -17 period. While constraining health care spending growth is necessary to maintain balanced budgets without drastic cuts in other program areas, the province will face a difficult task in capping spending at an average of 2.6 per cent over the next three fiscal years....Our projection for health care spending in B.C. suggests that health care will grow at an average page of 4.3 per cent per year over the next three fiscal years just to keep pace with inflation and demographic change....it is evidence that health care will require significant efficiency gains or reforms to maintain services levels without substantial increases in spending.²⁰

269. A Government document entitled “Creating a Sustainable Health Care System for BC” stated:

Over the past several decades the publicly funded health system in British Columbia has faced a number of influences including changing population needs and the development of new technologies. Current projections are that unless we change how we meet the health care needs of citizens, spending pressure on the British Columbia health system will increase at about six percent annually. This rate of growth is substantially higher than the rate of growth of the economy. Therefore the key issue facing the publicly funded health system is its ability to meet the increasing demands and needs of an aging population for quality health services while ensuring the sustainability into the future for all British Columbians.²¹

270. The Government did not do any analysis to see whether the 2.6% maximum cap on health care expenditures would be sufficient to maintain, let alone improve, the timely access to medical care for British Columbians.
271. This was conceded by Gordon Cross, the Executive Director, Regional Grants and Decision Support at the Ministry of Health, in his examination for discovery:

Q: ...Has the Ministry done an analysis of whether a 2.6 percent increase is sufficient to maintain current levels of service?

A: I can't really answer that question in that way. We receive a funding allocation from the Ministry of Finance according to the budget and fiscal plan, and that budget is the amount of funding that we have to work with. And so my job is to work within that -- within that position of funding.

²⁰ CSC00020250 - Conference Board of Canada, “British Columbia Fiscal Snapshot: Back on Solid Ground” (2014) at 6-7.

²¹ BC5036034 - Ministry of Health Services, “Creating a Sustainable Health Care System for BC” at 1.

Q ...are you involved in determining what is necessary -- from a health care perspective, what is necessary in terms of funding increases to maintain current levels of service?

A No

...

Q Is there somebody else in the Ministry who does that?

A As I said, my involvement is to take the funding allocation that the Ministry gets from the Ministry of Finance, as part of the budget and fiscal plan, and then to work within that allocation of funding. I can't speak to the deliberations that may occur at the senior level of government about setting what that funding allocation is.

Q Is there somebody in the Ministry of Health that prepares an analysis of: How much does the health care system need by way of an increase to maintain current levels of service?

A I don't know of -- I don't know of a particular person that does that.²²

272. In other words, the Ministry of Finance sets the allocation for health care expenditures based on the government's budgetary objectives and the Ministry of Health then has to do the best it can with the amount of money it has been allocated to provide public health care to the residents of British Columbia.
273. It is clear that the Government's decision to cap health care expenditures to a maximum increase of 2.6% was based solely on the cost pressures of health care on the Provincial budget, and not on the health care needs of British Columbians.
274. At least in theory the Government could have massively increased health care spending so that all British Columbians could receive timely medical service.
275. But that would have required drastic cuts in other essential government services such as education and social assistance; a significant increase in taxes; a massive government deficit; or some combination of these.

²² Examination for Discovery of Gordon Cross (August 8, 2014) at Q 37.

276. None of these measures was acceptable to the Government.
277. So the Government has had to ration health care services even further.
278. And even after capping health care expenditures, there are still complaints that there is insufficient public money for other necessary public services such as education.
279. As financially necessary as this may be, choosing to ration health care has very significant harmful impacts on the lives of those affected by long wait times.
280. And the situation is made much worse by the Government legislatively preventing British Columbians from accessing private medical treatment.
281. By leaving people stranded on wait lists, thereby jeopardizing their life and security of person while effectively prohibiting any meaningful alternative, the Government is violating the constitutional rights of BC residents.
282. The *Chaoulli* decision put Canadian governments on notice that they had to allow their residents access to private health care if they continued to be unable to provide everyone with timely medical care in the public system.
283. Senator Michael Kirby, the lead author of the 2002 Senate Report on health care in Canada, entitled “The Health of Canadians”, put it this way in a 2006 lecture at the University of Alberta:

Long waiting lists are a result of the rationing of services that every provincial government must address. As it is currently constituted, our system allows governments and providers to shift the consequences of excessive waiting times onto the backs of patients and their families. This gives them a “cost-free” way to control costs. Patients suffer; governments do not – at least not immediately.

While Canadians understand that they have to wait for certain services and treatments, they are willing to endure only so much. At the same time, a major impetus for change has come from the fact that we have a Charter of Rights and Freedoms that guarantees Canadians the right to life, liberty and security of the person.

The *Chaoulli* decision by the Supreme Court in June 2005 drew these threads together. The decision obligates governments to provide timely service for medically

necessary treatment or if they are not willing – or able – to provide timely service, then the Court said governments must stand aside and not prevent individuals from paying personally for service.

Although, strictly speaking, the *Chaoulli* decision is directed only at the province of Quebec, in my view it would be politically impossible for other provincial governments to ignore the requirement for timely service imposed by the Court. To try to do so would leave us with an extreme form of what has frequently been called a two-tier system. In this version of a two-tier system, Quebecers would have the right to timely service while this same right was denied to all other Canadians.

(...)

Here again, it is vitally important to understand the implications of the *Chaoulli* decision. We cannot continue as before. It is no longer permissible simply to muddle through, and to allow some people to wait, and wait, and wait, for service. Pre-*Chaoulli* that was possible, although it was never right. Post-*Chaoulli* there is no longer any choice. People must be given timely service within the publicly funded system, or they must be allowed to purchase it for themselves. [Kirby, “Two Options”, at 66-67, 73]

284. Quebec responded to the *Chaoulli* decision by allowing greater access to private care in the province.
285. British Columbia did not follow suit, even though the then Premier of the Province, Gordon Campbell, said that “[w]e don’t want two-tier health care in Canada – one tier in Quebec and another tier for the rest of the Country.”
286. But that is exactly what has happened.
287. Quebecers have the right to access private health care when the government is unable to provide timely public health care to everyone, but British Columbians do not.
288. This is despite the undeniable fact that 11 years after *Chaoulli*, British Columbia is still unable to provide timely medically necessary services in the public health care system to all British Columbians.
289. And rather than following the direction of the Supreme Court of Canada in *Chaoulli*, that it must allow British Columbians to access private health care, the BC Government is going in the opposite direction – by seeking to prevent British Columbians from continuing to

obtain private surgeries from Cambie and the other surgical clinics in the province as they have been doing over the past 20 or so years.

290. It is argued by some that the harmful consequences of lengthy waits for medical treatment for some Canadians are an acceptable price to pay to protect the public system.
291. With respect, this argument denies the true nature and extent of the harms suffered by waiting for medically necessary health care services, is based on an incorrect factual premise, and reflects a perverse conception of equity.
292. Delay caused by the deliberate rationing of services in the public system creates risk to the life, health and well-being of the sick and injured; it creates anxiety and fear; it forces people to suffer physically, psychologically and emotionally; and it creates broader social costs.
293. Those on wait lists will often be unable to work, and even may be forced to rely on social assistance, while being unproductive and creating problems for themselves, their families, their employers, and our economy.
294. In addition to the suffering while waiting, for some the treatment will come too late.
295. They will die before receiving the treatment, or will never be restored to full health because of the irreparable deterioration caused by delay.
296. That was the case with Walid.
297. There is also no legitimate need to harm BC residents by denying them access to private medical care in order to protect and preserve the public health care system.
298. If required, controls can be put in place to ensure that the public system has the physicians and resources it requires without preventing access to private health care.
299. Publicly-funded health care will still be available to those who want and need it.

300. No one's access to the public system will be impaired, and access should even be improved, if more people make use of private health care while still paying taxes to support the public system.
301. And the overall health care system will experience an injection of new funding, primarily through disability and critical health insurance funding.
302. Canadians spend an incredible amount of money outside of Canada on medical treatment.
303. A 2011 Ministry of Health Briefing Note describes the situation as follows:

Canadians continue to seek out-of-country medical services. A 2008 report of international consultants McKinsey & Co. found that 7 percent of medical tourists are Canadians, potentially spending \$5 billion a year for out-of-country health care. These patients seek the most advanced technologies (40%), better quality care, (32%), greater access to medical care (15%), and only 9% driven by cost. The majority of Canadian medical tourists are most likely go to the United States (U.S.) for treatment although there is no tracking system to fully assess the volume and type of interventions received. U.S. data suggests that patients seek care in several key specialties, particular cardiology, orthopaedics and general surgery.²³

304. If this money, or even some of it, were spent in Canada by private individuals and insurers, this would improve both the quality of care as well as timely access to care in Canada.
305. It would also contribute to the local economy.
306. In other words, we could improve our health care system without the expenditure of more public monies, by allowing private health care as a complement to our universal public health care system.
307. The claim will be made in this case by the Government and the Intervenors that this will lead to inequity and unfairness.

²³ BC2086628 - Ministry of Health Briefing Note - Out-of-Country and In-Province Medical Tourism (April 21, 2011).

308. But, preventing BC residents from meeting their medical needs outside of the public system if they are not being met in the public system is not fair or equitable.
309. Nor is it constitutional.
310. British Columbians are already going outside the country to obtain more timely medical service.
311. And the exemptions in the *Act* allow many individuals to obtain expedited services in BC.
312. So, the alleged inequality already exists and will continue to exist, unless the Government eliminates all the exemptions and prohibits British Columbians from leaving the country for medical care – something that will not and could not happen.
313. Allowing more British Columbians to access private health care to meet their medical needs will reduce this inequality, not make it worse.
314. And, the fact that currently some individuals in British Columbia are allowed under the exemptions to the *Act* to obtain private health care services, while others are not, is itself inequitable and unfair.
315. A monopoly public health care system that is unable to meet the needs of every British Columbian does not promote equity; it only causes unnecessary harm contrary to the *Charter of Rights and Freedom*.
316. It is also not what was intended when universal health care was introduced in Canada.
317. The public health care system was created to ensure that all Canadians had access to publicly provided health care.
318. It was not enacted to prohibit Canadians from obtaining private health care to meet their medical needs if these needs could not be met in the public system.
319. But that is what the *Act* does, in the same way as the public health care legislation in Quebec did prior to the Supreme Court of Canada's decision in *Chaoulli*.

320. Quebec, like British Columbia, had effectively prohibited its residents from having their medical needs met outside of the public system, even though they could not be met in a timely way in Quebec's public health care system.
321. Under the Quebec *Health Insurance Act*, Quebec prohibited its residents from contracting for private insurance for a service that was available through the public health care system and prohibited anyone from paying for services that were insured hospital services.
322. The Supreme Court of Canada in *Chaoulli* held that it was neither legally acceptable nor necessary for Quebec to prohibit people from accessing private health care to meet their medical needs in a timely manner when, as proven by the Plaintiffs in that case, the public system was unable to do so.
323. As Chief Justice McLachlin and Justice Major in *Chaoulli* observed, "access to a waiting list is not access to healthcare" [*Chaoulli* at para 123].
324. The Court held in *Chaoulli* that Quebec Government could not legally have it both ways: it could not deny access to private health care if it was unable or unwilling to provide timely care in the public system.
325. That is the bottom line constitutionally.
326. This is not because there is a positive "right" in the constitution to a certain standard of health care paid for through tax revenues.
327. That is not the constitutional principle or right that was upheld in *Chaoulli*.
328. And that is not what the Plaintiffs are asserting in the case at hand.
329. Rather, the constitutional principle is that the Government cannot prohibit people from privately meeting their own health care needs if they are not being met in the public system.
330. It is that simple and straightforward from a constitutional perspective.

331. The former Dean of Osgoode Hall Law School, Patrick Monahan, has said that the *Chaoulli* decision adds public accountability as a ‘sixth’ principle to our public health care system in keeping with the demand of the public.²⁴
332. In another lecture in 2000, Professor Bliss predicted that Canadians would increasingly demand accountability from Government in the provision of health care. He put it this way:

Our governments do not yet realize how very quickly Canadians will insist on real, rather than phoney accountability. By real accountability, I mean the accountability that physicians have always been held to for their acts of malpractice, accountability in law. Angry Canadian health-care consumers are increasingly talking about legal challenges to the *Canada Health Act* and its supporting legislation. We will see much more of this. We will see much more Canadian talk of the idea of patient rights. Why should Canadians not have enforceable rights of reasonable access to the health-care system, just as they have legally enforceable recourse when the state fails to provide educational facilities for their children? In an election campaign watch for more talk about health-care rights, more pressure on politicians to guarantee rights of access, more talk about health-care bills of rights.

Putting the emphasis on patient rights, on consumer sovereignty, has the effect of undercutting our sometimes sterile one-tier, two-tier health-care debate. As a patient what I want is accessibility to the system, and I don’t particularly care how it is financed. The key is to force the politicians to truly be accountable for their commitments on health care. When governments have to deliver the goods, they’ll work out themselves the best mix of delivery systems. I have little doubt that they will gradually realize that they will have to expand the private sector, have to allow for more pluralism and private money in the system, have to keep ahead of the game by stopping footing the bill for Conrad Black’s health care, and so on.²⁵

333. The use of lengthy wait lists to ration health care – without any assurances or legal obligations to provide timely care – does not meet the accountability principle.
334. While the BC Government amended the *Act* in 2008 to include “accountability”, it has not actually provided any mechanisms for patients to hold the Government accountable.

²⁴ Patrick J. Monahan, “*Chaoulli v. Quebec* and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act” *C.D. Howe Institute, Benefactors Lecture, 2006* (Toronto, November 29, 2006) [Monahan, “*Chaoulli v. Quebec*”].

²⁵ CSC00024185 - Michael Bliss, “Health Care in the Era of Patient Sovereignty”, address to a seminar hosted by the Ontario Medical Association (October 19, 2000) at 7-8.

335. And at the same time, in 2008, the Government added sustainability as a principle, which has become the touchstone for the BC Government in its provision of funding for the public health care system.
336. As a result, the funding levels for the public health care system are far less than what is required to meet the health care needs of all BC residents in a timely way.
337. And there is no accountability in the public health care system.
338. I will now outline the constitutional argument.
339. As stated above, preventing persons from taking steps to protect and secure their own health and well-being infringes upon the life, liberty and security of person interests in section 7 of the *Charter*.
340. That was the conclusion of the majority of the Supreme Court of Canada in *Chaoulli*.
341. This principle was recently affirmed by a unanimous Supreme Court of Canada in the *Carter* decision, where the Court emphasized the “tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity” [*Carter* at para 67].
342. The Court in *Carter* found that the “right to ‘decide one’s own fate’” and the freedom to “direct the course of their own medical care” are protected by s. 7’s guarantees of liberty and security of the person [*Carter* at para 67].
343. The prohibitions in the Act on accessing private medical care prevent people from deciding their own fate, from directing the course of their own medical care, and from making fundamental decisions about their bodily integrity.
344. That infringes the rights to liberty and security of person.
345. The Court in *Carter* further observed that where “state action imposes death or an increased risk of death on a person, either directly or indirectly”, it will infringe upon the right to life [*Carter* at para 62].

346. That is exactly what the *Act* does in this case.
347. Indeed, all of the judges in *Chaoulli* – including the minority who voted to uphold the restrictions on access to private care – acknowledged that such restrictions can, in some situations, “[put] at risk [the rights to] life or security of the person”.²⁶
348. Similarly, in the *PHS* case, which involved the need for exemptions from the criminal law to permit safe-injection sites, the Court held that preventing persons from accessing “lifesaving and health-protecting services” infringes upon security of the person.²⁷
349. The unanimous Court in that case found that “(w)here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out... Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer” [*PHS* at para 93; emphasis added].
350. This describes the deprivation in the case at bar.
351. Where a law deprives persons of their right to life, liberty and security of person, as the *Act* does, it will violate s. 7 if that deprivation is not in accordance with the principles of fundamental justice.
352. In particular, a law that infringes section 7 rights cannot be arbitrary, overbroad, or grossly disproportionate to the objective of the law.
353. The restrictions on access to private treatment are arbitrary, because they are unnecessary to achieve and inconsistent with the objective of the law.
354. As the experience of every other developing country shows, these drastic restrictions are not required to ensure a viable and universal public health care system.

²⁶ *Chaoulli* at para 119, *per* Binnie & Lebel JJ. See also at paras 40, 45, *per* Deschamps J., and at paras 110-125, *per* McLachlin CJ & Major J..

²⁷ *Canada (AG) v. PHS Community Services Society*, 2011 SCC 44 (“**PHS Community Services**”) at para 92.

355. And indeed, imposing these restrictions serves to undermine the objectives of the *Act*, by preventing private sector treatment from taking some of the pressure off the public system, which could then provide more treatments to other patients.
356. The restrictions in the *Act* are also overbroad, because they capture more conduct than is necessary to achieve their objective.
357. For instance, even if the restrictions had some benefit in general terms, they prevent physicians from providing medically necessary treatment in the private system, even where there is excess time and capacity that is not being used in the public system.
358. Where health care resources – like operating rooms, facilities, surgeons and other health care professionals – are not being fully utilized by the public system due to a lack of funding, prohibiting the use of those resources in the private system bears no relation to the objective of protecting the public health care system.
359. The restrictions are therefore overbroad, in addition to being arbitrary.
360. Finally, the restrictions are grossly disproportionate, because the constitutional harm imposed by these laws is too severe in relation to the harm sought to be avoided.
361. Causing wide-spread and unnecessary pain and suffering, and even death, is grossly disproportionate to the objective of preserving a public monopoly on the provision of health care.
362. Importantly, the Supreme Court of Canada recently confirmed in *Bedford* that if the impact of the law is arbitrary, overbroad, or grossly disproportionate with respect to even a single person, it will violate section 7.²⁸
363. Therefore, the Government cannot avoid the conclusion that the prohibitions in the *Act* on private health care are a violation of section 7 by saying that *most* people receive

²⁸ *Canada (AG) v. Bedford*, 2013 SCC 72 (“**Bedford**”) at paras 122-123.

adequate treatment in the public system, and that it is only *a few* people falling through the cracks.

364. When falling through the cracks involves an infringement of even a single person's liberty, security of person, and even their life, it is violation of the constitution.
365. And the reality is, as the evidence in this case will show, individuals suffering unnecessarily on waitlists is not an exceptional occurrence.
366. It is widespread. This is the unavoidable and expected result of rationing medically necessary services, while preventing any alternative means of accessing care outside of the public system.
367. Further, we will show that the harm to the health of citizens caused by the impugned provisions is not necessary for the achievement of – or even rationally connected to – the Government's important purpose of maintaining a high quality and universal public health care system available to all regardless of their ability to pay.
368. As the experience in every other OECD country shows, there are better ways of achieving a strong and equitable public health care system, without violating constitutional rights.
369. Indeed, permitting individuals to obtain insurance to access care outside of the public system and allowing doctors to work in both the public and private health care systems will improve the treatment available to all.
370. In sum, the prohibitions on access to private medical care therefore infringe the s. 7 *Charter* rights of British Columbians and are not justified under s. 1 of the *Charter*.
371. However, that is not the only *Charter* right infringed by the prohibitions on private health care in the *Act*.
372. British Columbians, like all Canadians, have the right to be equal before and under the law, and the right to the equal benefit and protection of the law without discrimination.

373. The prohibitions on access to private health care are not applied equally to all British Columbians.
374. Some BC residents are already allowed access to medically necessary private health care in the province, which makes the application of the prohibitions on private health care a breach of s. 15 of the *Charter* as well as s. 7.
375. For example, as stated before, British Columbians who become injured or ill in the course of their employment are able under the Workers Compensation system to obtain timely medical services outside of the public health care system from enrolled doctors.
376. However, if they become injured or ill outside of the workplace, they are not able to pay privately for the same services, nor are they able to purchase private insurance or use disability insurance provided by their employers to obtain timely medical services outside of the public system even if provided by unenrolled doctors.
377. There is no health care or other valid public policy reason to draw a distinction between the location at which or manner in which an illness or injury occurs, for the purposes of access to treatment.
378. The Government has provided timely access to necessary medical care to some, while at the same time depriving many others of the same rights.
379. Because the right to access necessary medical treatment, and to decide the course of one's own health care, is so fundamentally important, this unequal treatment violates the s. 15 right of all persons to be treated equally before and under the law, and to receive the equal protection and benefit of the law.
380. Moreover, the legislation in question is discriminatory in that it imposes a disproportionate burden on individuals in a manner linked to protected grounds of discrimination, specifically age and disability.

381. Again, the restrictions in the *Act* are not imposed upon those who seek treatment for an injury or illness sustained in the workplace. But not everyone is able to work, and not everyone's injury or illness stems from work-related factors.
382. BC residents who are below working age, or are of pensionable age, will be less likely to be in the workforce, and therefore less likely to benefit from the exemptions in the *Act*.
383. Similarly, if a person is unable to work because of his or her disability they will not ever be entitled to the exemptions in the *Act*, and therefore will be unable to access private care that is available to individuals able to participate in the workforce.
384. And if a person suffers from a disability caused by a workplace injury or illness, they will have greater access to timely and necessary medical treatment than a person whose disability stems from a genetic predisposition or a non-workplace injury.
385. The discriminatory impact of the *Act*, as it operates in reality, is imposed unequally on the basis of age and disability, and therefore violates section 15.
386. In short, under section 7 of the *Charter*, the Government cannot constitutionally justify the severe mental and physical harm caused by failing to adequately provide timely medical services, while at the same time preventing those persons from caring for their health in other ways.
387. Nor can the Government justify distributing access to necessary medical treatment differently, depending on a person's employment status, or where they were injured, or the cause of their injury or disability. That is a breach of the equality rights in section 15.
388. The Government says that despite the Court's ruling in *Chaoulli* and subsequent decisions that have confirmed the right of Canadian citizens to not be denied the ability to protect their own health, the prohibitions on access to private health care in the *Act* are necessary to protect the public system, and therefore justified under section 1 of the *Charter*.
389. But there is no evidence to support this contention.

390. All other OECD countries, most of which have more effective and equitable universal public health care systems than Canada, permit a private care option for their residents.
391. As proven by the experience in these other advanced countries which have mixed private and public health care systems, allowing BC residents to access private health care to meet their medical needs will not diminish access to a high quality public health care system, or otherwise harm the public system.
392. This was the conclusion of the majority of the Court in *Chaoulli*, where it stated:

The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care. [*Chaoulli* at para 140]

393. After reviewing the evidence from other jurisdictions, the majority concluded:

In summary, the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care. [*Chaoulli* at para 149]
394. The evidence in this case shows the same thing.
395. Canada is the only advanced country that has a monopoly public health care system.
396. With the exception of the United States, all other advanced countries have a universal public health care system available to all.
397. And all of them permit private health care options to coexist with the public system.
398. In international comparisons of health care systems in advanced countries, Canada consistently ranks behind countries with mixed systems on most dimensions of health care.
399. One of the most prominent and reputable of the comparative studies is conducted by the Commonwealth Fund.

400. The Commonwealth Fund is a “private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.”
401. In its annual survey of health care in advanced countries, the Commonwealth Fund considers various health care indicia in its annual survey: quality of care, which includes consideration of effective care, safe care, coordinated care, and patient-centered care; access to health care, which includes consideration of cost-related problems and timeliness of care; efficiency; equity; healthy lives; and health care expenditures per capita.
402. All of the countries surveyed except Canada and the United States have a mixture of universal public health insurance coverage and private insurance coverage.
403. Canada ranked poorly in most of these categories, and was last in terms of timeliness of the provision of health care services.
404. Overall, Canada has consistently ranked second from the bottom in the Commonwealth Fund’s annual surveys, above only the United States [Canada was ranked 10th out of the 11 countries surveyed in the 2014 annual study], even though it spends more per capita on health care services than most of the countries with which it is being compared (those that spend more per capita cover a greater range of health care services in their public system).²⁹
405. The Commonwealth Fund’s comparative study also shows that prohibiting access to private medical care to everyone but the wealthy, as is the case under the *Act*, does not result in a more equitable health care system.

²⁹ CSC00019587 - Commonwealth Fund, “Mirror, Mirror on the Wall - How the Performance of the U.S. Health Care System Compares Internationally” (2014) at 11.

406. The Commonwealth Fund uses the following Institute of Medicine definition of health care equity: “providing care that does not vary in quality because of personal characteristic such as gender, ethnicity, geographic location, and socioeconomic status.”
407. According to the latest Commonwealth Fund report, Canada ranked 9th out of the 11 advanced countries with respect to equity.³⁰
408. The Commonwealth Fund study shows that mixed public and private health care systems provide both more timely and more equitable access to health care than Canada’s monopoly public health care system.
409. And these other countries are able to do this at a lower per capita cost for health care.
410. In his 2006 lecture, Senator Kirby put it this way:

However, the overall evidence is clear. All the other OECD countries except Canada and the US have found ways, imperfect no doubt, of making private insurance systems coexist with universal coverage. Moreover, in comparable rankings among countries, the Canadian health care system ranks well below that of many other OECD countries, each of which includes some form of private insurance system alongside a publicly funded universal system. [Kirby, “Two Options”, at 71]

411. The Government knows that BC’s public health care system is failing to meet the needs of British Columbians. As the Government states in its 2013 paper “Health Sector Budget Management Strategies and Implications”:

Canada’s health system fares poorly in international comparisons of value for money and quality. B.C. has made some steps regarding quality but the pace is relatively slow to have any significant system impact level.³¹

412. The Government also knows from its 2006 “Fact Finding Mission” to Europe to examine the mixed public and private systems in Sweden, Norway, France and the United Kingdom, that a mix of public and private providers of health care services and health care

³⁰ *Ibid.*

³¹ BC2158602 - Health Sector Budget Management Strategies and Implications.

facilities is an accepted reality in those countries, all of which provide high quality and timely care to their residents.

413. Governments across Canada know that the Canadian model, which frequently prohibits private treatment, is more expensive and less effective than other models, which permit patients to access private care.
414. In a speech just a few weeks ago, the Federal Minister of Health Jane Philpott conceded this point, pointing to the UK and Australia as systems to emulate:

Other nations, as I've said, provide us with inspiration and with lessons from which to learn about how to expand our understanding of what's possible.

I've been looking at the National Health Service in Britain, which now ranks at the top of most international health care surveys. For those who spent time in that system, perhaps in the seventies or the eighties, it would have been unfathomable to see how it looks today. So too, Australia has been a poor performer in the past and now outranks most comparable countries on health systems. These nations, Australia and Great Britain, spend less than Canada does on health care, both per capita and as a percent of GDP, and yet they outperform us in terms of what they provide to patients. And these are not stories about the infusion of cash; these are stories about countries deciding to do things differently.³²

415. And earlier this year, BC Minister of Health Terry Lake was quoted in the Ottawa Citizen as admitting that these other health care systems do a better job than Canada's:

Lake said medicare isn't performing as well as health systems in places such as Europe, Australia and New Zealand. He predicted there will be a heightened interest in reform as the Canadian population ages and baby boomers discover they can't get the medical services they need.

"I don't think we should hide ourselves in the sand and keep telling ourselves we have a great system when we know we could do better".³³

416. And yet, that is exactly what the BC Government has been doing for years, and exactly why this Constitutional challenge is necessary.

³² Government of Canada, *Remarks from the Honourable Jane Philpott, Minister of Health, to the Canadian Medical Association Annual General Meeting* (Vancouver, BC: August 23, 2016) (emphasis added).

³³ Mark Kennedy, "Provinces eager to work out health-care prescription with federal government" *Ottawa Citizen* (January 16, 2016).

417. Interestingly, one of the conclusions of the Province's Fact Finding Mission was that patient choice is integral to health care delivery in the European countries and that "[p]atients can generally choose whether to receive health care services from a public or private provider, including which hospital they wish to use and are insured in either venue for medically necessary services".³⁴
418. Nevertheless, the Government, even in the face of worsening waiting lists for surgeries has not moved to eliminate the legislative barriers to permit a supplementary private health care system, despite the direction from the Supreme Court of Canada in *Chaoulli*.
419. As the Majority in *Chaoulli* held, prohibitions on access to private health care are unnecessary to protect access to the public system and, therefore, from a legal perspective are arbitrary:

When we look to the evidence rather than to assumptions, the connection between prohibiting private insurance and maintaining quality public health care vanishes. The evidence before us establishes that where the public system fails to deliver adequate care, the denial of private insurance subjects people to long waiting lists and negatively affects their health and security of the person. The government contends that this is necessary in order to preserve the public health system. The evidence, however, belies that contention.

We conclude that on the evidence adduced in this case, the appellants have established that in the face of delays in treatment that cause psychological and physical suffering, the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice. [*Chaoulli* at paras 152-3; emphasis added]

420. One of the Government's experts, Professor Marmor, has confirmed the accuracy of the Court's analysis in *Chaoulli*. He has stated that, "(i)n fact, no scholar I know of would claim that rational health financing is incompatible with supplementary private health insurance."³⁵

³⁴ BC1003895 - Report on the European Fact Finding Mission (February 28 to March 6, 2006).

³⁵ BC1003103 - Theodore R. Marmor, "Canada's Supreme Court and Its National Health Insurance Program: Evaluating the Landmark *Chaoulli* Decision from a Comparative Perspective" (2006) 44 Osgoode Hall LJ 311 [Marmor, "*Chaoulli*"] at 317.

421. However, he goes on to contend that a society should be able "...to decide democratically what health care its citizens should be entitled to in health care and how scarcity should be apportioned" [Marmor, "*Chaoulli*", at 320].
422. However, as the evidence in this case shows, the scarcity is not in the supply of surgeons and other specialists in BC.
423. Rather, the scarcity in the public system is caused by Government's rationing of surgical and diagnostic services to contain health care costs.
424. That frames the issue in this case: can the Government legally prevent its citizens from accessing private health care when it has chosen not to provide timely medical services to all British Columbians within the public system?
425. The Plaintiffs say that the answer is no.
426. The Government does not have to violate the constitutional rights of BC residents in order to provide universal and accessible public health care to all. Our public health care system will not be harmed by allowing BC residents to be able to obtain private health care if they believe their health care needs are not being met in the public system.
427. This has become increasingly recognized in Canada after *Chaoulli*.
428. For example, in 2007, the Quebec Government established a committee to review the provision of health care in that province.
429. The 2007 Committee was chaired by Claude Castonguay.
430. Mr. Castonguay had previously chaired a Quebec Royal Commission in the 1960s on health care reform which recommended that Quebec adopt a government administered health care system, covering all citizens through tax levies. This recommendation was adopted.

431. Mr. Castonguay is called the “father of the Quebec Medicare”. He is so closely identified with public health care in Quebec that many people refer to the Quebec Health Care Card as a “Castonquette”.

432. In 2007, Mr. Castonguay was asked to review the health care system he designed.

433. In May 2007, Mr. Castonguay described the health care situation in Quebec as follows:

During the past four years, annual expenditures in the health sector have increased from 19 to 23.6 billion which represents an increase of 24% in four years. Relative to 2003, this is 4.5 billion more each year. Despite this massive injection of public funds, an obvious corresponding improvement in the quantity and quality of the care and services provided has not taken place. Such growth in expenditures, which detracts from other government objectives, and which will only accelerate with an aging population, is clearly not sustainable in light of such limited results. It is necessary to accept the evidence which shows that, in its current state, our health care system is unable to respond to the demands which it is now facing. An increasing number of Quebecers of all ages suffer the consequences on a daily basis. Hardly a week passes without the media drawing attention to this unacceptable situation. The conclusion seems obvious to me. We have to move beyond patchwork solutions and filling the gaps in order to respond to problems which continue to arise.

For far too long, the corrections that have been made have aimed to plug the holes in the system at a cost of billions of dollars. Fundamental changes are essential. In my view, health care is the most important issue; it is our greatest asset that must be protected and valued. As I see things, the question of health care is so essential that it is really one that is above political allegiance. Understandably, I am deeply disturbed by the current situation. What is important to me is to show that it is possible to bring about changes to the health care system which are capable of re-establishing a balance. Let us look what happens elsewhere. The first thing that is critical to note is that all advanced countries are faced with the same pressures.

With the exception of the United States, all of them have public health systems whose objectives is to ensure universal access to health services. These systems seek to respond to the pressure for the demand for services, which can only increase with the aging of the population, while at the same time keeping the growth of public expenditures in check. Change in the health sector is inevitable and in no way results from left or right ideological considerations.³⁶

434. The same situation exists in British Columbia.

³⁶ Claude Castonguay, “The Health Care System: Towards Significant Changes” (Montreal: May 16, 2007) [Castonguay, “**Significant Changes**”] at 1.

435. As in Quebec, despite a substantial injection of money into the public health care system in BC – which mainly went to the service providers over the last fifteen years – there has been no significant improvement in access to care in British Columbia.
436. Wait lists for surgeries in British Columbia are getting longer, not shorter.
437. Almost weekly, there are media reports of the harms being suffered by British Columbians because of a failure of the public health care system to meet their health care needs in a timely manner.
438. This is not the fault of the doctors. They are doing the best they can within the fiscal restraints of the public system and the restrictions on their services that have been imposed to save costs.
439. Nor can the problem be cured by wringing more efficiencies out of the public health care system, because the demands on the public system are increasing beyond the limits of financial sustainability.

440. As Jeffrey Simpson put it in his book *Chronic Condition*:

...Efficiency gains from a massive public system of any kind defy the way those systems are organized and the nature of incentives within them. The lure of efficiency is enticing, and the need for greater efficiency is urgent, but efficiency alone will not allow us to improve the chronic condition of medicare.³⁷

441. Mr. Castonguay and an increasing number of others who have studied health care in Canada have come to recognize that fundamental change is required for Canadians to have access to the timely and equitable medical care that they need and are entitled to under the *Charter*.
442. An essential part of that fundamental change is the elimination of the prohibitions in the Act on private insurance and blended practice, so that, like residents in other advanced

³⁷ J. Simpson, *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century* (Toronto: Penguin, 2010) [Simpson, *Chronic Condition*] at 12.

countries, BC residents can have access to private health care as a complement to the universal public health care system to meet their health care needs.

443. Mr. Castonguay emphasized in his May 2007 paper with respect to Quebec that eliminating the prohibitions that effectively prevent access to private health care will increase access to health care for patients, not decrease it:

Quebec is one of the only jurisdictions where the role of private health insurance is limited to providing coverage for services not covered by the public sector. Yet in countries where private insurance plays a large role in the financing of health services, it is interesting to note that there is nothing to suggest that access to health care is inequitable towards the poorest. In the majority of countries, the health systems are universal or quasi-universal and the goal of universality of access is generally to guarantee equitable access to all. According to the OECD, private health insurance is one of the numerous tools which can contribute to improve the reactivity of health care programs, to facilitate the realization of public health care objectives, and to respond to the needs of consumers and of society.

In Quebec, private health insurance would offer an interesting potential to increase health care funding and to reduce the pressures on the public system. It gives citizens a fundamental freedom of choice. (...)

Our system of hospital and medical care is a monopoly. It has all the attributes of a monopoly as part of its own culture. To break this monopoly, it is necessary to impose change that is capable of engendering a new model. Presently, with the exception of radiology, doctors must either participate in the public system or be excluded. This impenetrable divide must disappear or else the monopoly which exists in our system will remain intact. But is it possible without the private system cannibalizing the public one? The co-existence of public and private systems in the OECD countries show that it is possible to establish a healthy equilibrium between the two by means of an appropriate framework. In these systems, generally, the doctors must fulfill well-defined responsibilities within the framework of the public system as a prerequisite to permitting them to provide private services. These conditions can take the form of a limit on the amount of revenue in the private sector. Numerous examples show that it is possible to establish efficient control while at the same time avoiding the introduction of heavy bureaucratic controls. Obviously, ethical standard would be necessary to avoid possible conflict of interest and to ensure equitable treatment for all. Such standards are within the jurisdiction of the College of Physicians. [Castonguay, "Significant Changes", at 5; emphasis added]

444. In his 2006 lecture, Senator Kirby made the same point about the ability of governments to require specialists to meet their allocated quotas in the public system before being allowed to provide private services for a fee:

Currently, the income of specialists is capped in most provinces. Sometimes it is capped by an absolute maximum amount a specialist can earn. This is the case in some of the Atlantic provinces, and it was the case in Ontario until the most recent contract negotiated with the Ontario Medical Association. In other provinces, specialists' income is capped by restricting their access to equipment or operating room time.

Capping specialists' income in these ways has been used across the country as a means of controlling health care expenditures. The practical impact of this capping has been to ration the supply of services – the number of procedures a specialist can perform. This, in turn, has increased wait time. The wait-time problem cannot be solved unless specialists are paid to do substantially more procedures than they do now.

Under the system I have described, however, doctors could take private pay patients once they had worked up to their cap in the public system. In this way, they could see more patients and do more procedures. This would, in turn, lead to shorter wait times in the publicly funded system because patients treated privately would no longer remain on the publicly funded wait list.

Since all specialists would be required to work up to their capped income in the publicly funded system, there would be no reduction in the supply of services to the publicly funded system. The new procedures would be over and above what doctors are currently permitted to perform, while not costing the public system anything. As well, should a wait-time guarantee be in place, patients who relied on the public system would be assured of receiving timely care.

Such a system would closely resemble the British and Australian health care systems. In Britain, for example, a doctor must first fulfill his contract with the National Health Service before taking private pay patients. In many cases, this means that the doctor treats private pay patients only on the weekends. [Kirby, "Two Options", at 71-72]

445. If necessary, the same sort of protections proposed by Mr. Castonguay and Mr. Kirby could be put in place in British Columbia with respect to dual practice, to protect the public system, while at the same time allowing British Columbians to protect their bodily integrity outside of the public system.
446. However, in practical terms the concerns about taking specialists away from the public system are, at least at this point in time, of little relevance in British Columbia, because

there are many specialists who are effectively unemployed or underemployed due to limitations on their access to hospital facilities.

447. Thus an expanded complementary hybrid system would add to the physician capacity of our health care system.
448. Similarly, a study done at McMaster University revealed that while 79% of new nurse graduates sought full time work, 56.4% of the graduands were actively seeking employment, as they could not get full time work they wanted.³⁸ This is an indication that added capacity would also benefit nurses and help improve overall capacity and access.
449. The opponents of private health care have attempted to frighten Canadians into believing that removing the prohibitions on access to private health care would pitch British Columbians into an American-style health care system.
450. That is simply not the case.
451. As the BC Government itself previously asked, in its 2006 speech from the Throne, “Why are we so quick to condemn any consideration of other systems as a slippery slope to an American-style system that none of us wants?”
452. Canadians fear of becoming “Americanized” cannot be allowed to prevent us from seeing that most other countries are providing more timely, better quality, and more equitable health care services than Canada through a combination of universal public health care and private care.
453. If opponents of private health care were being honest with the public they should threaten Canadians with a Swedish, French or German health care system and see if that engenders any fear.
454. The Canadian approach of limiting the scope of public health care to hospital and physician services providing what our government considers to be “medically necessary

³⁸ Kristin Cleverley et al, “Educated and Underemployed: The Paradox for Nursing Graduands” (December 2004) *Nursing Health Services Research Unit, McMaster University*, at 12.

services” and excluding private care from this realm has led to worse, not better, access to quality health care than is the case in all advanced countries other than the United States.

455. And it bears repeating: the Government says it is doing this to preserve equality within the health care system, but as the evidence in this case shows, the present system does not even achieve this objective.
456. Despite being the only country surveyed to effectively ban private care for medically necessary services, Canada is ranked 9th out of 11 developed countries in terms of equity in health care.
457. With the removal of the prohibitions on private insurance and blended practice, British Columbians will move forward into a European-style system of health care, where they will have access to both public and private health care to meet their needs.
458. In other words, BC residents will have the best of both health care worlds, as is the case in most other advanced countries which provide more equitable and accessible health care through mixed private and public health care systems than does Canada.
459. Removing the prohibitions on private health care will not detrimentally affect the public health care system or the principles that underlie it.
460. Rather, this will simply allow all BC residents to exercise their constitutional right to take the steps necessary to maintain and enhance their health, which is being endangered by long wait lists.
461. If the Plaintiffs succeed in this case, British Columbians’ access to a universal and equally accessible public health care system will remain intact, with no user fees or extra billing.
462. The result will be that all residents of British Columbia will have greater access to public and private medical services to meet their individual needs, consistent with their constitutional rights.

463. This is a benefit to all British Columbians.
464. And most importantly, from a constitutional perspective, it upholds and protects their constitutional rights to take the necessary steps to protect their health.
465. While Canadians pride ourselves on our ability to provide for those in need, the evidence in this case will show that an effective prohibition on private care does not contribute to a just health care policy.
466. We are increasingly being left behind by our peer nations, who are able to provide high quality public health services without restricting access to private health care.
467. One Canadian health researcher recounted the following view of British health policy planners about Canadian efforts at improving health care performance:
- The worst possible outcome, they concluded, would be to increase spending... and end up looking like Canada. By this they meant that it would be a travesty to spend so much and achieve so little.³⁹
468. In light of the international experience with mixed health care systems, and the current unsustainability of the health care system here, British Columbians have nothing to fear and everything to gain in terms of access to health care services by eliminating the prohibitions on private health care and adopting, like most other advanced countries, a mixed private and public health care system.
469. Indeed, British Columbians should fear the consequences of the Plaintiffs not succeeding.
470. This would mean taking away the *de facto* option British Columbians have had over the past 20 years of obtaining timely surgeries from enrolled surgeons at Cambie and other surgical clinics in the province. It may also mean the complete loss of many of these private clinics, with resulting loss of expedited services for WCB claimants and vastly increased wait lists in public hospitals.

³⁹ Expert Report of John McGurran, dated July 18, 2014, at 21.

471. If the Plaintiffs are successful, more British Columbians will be able to benefit from the private system when the public system is not meeting their health care needs, because at a minimum they will be able to use their existing disability insurance for non-occupation injuries and illness to access private health care to be able to return to work more quickly.
472. This option of private health care will no longer be reserved for the very wealthy, or those who have become so desperate that they have no other option but to make significant financial sacrifices.
473. We have a two-tier system of health care now – those who can afford it can go to the U.S. or elsewhere for medical treatment, and those who are lucky enough to suffer their injury at work or are a member of another advantaged group can obtain expedited service paid for by an insurance plan.
474. By removing the prohibitions in the Act on access to private health care, average British Columbians will have a similar ability to access private health care to meet their medical needs.
475. As noted earlier, about 30% of aggregate Canadian health care spending is already privately paid for, which is at or near the OECD average for the countries that are part of this organization.⁴⁰
476. However, unlike other countries, Canadian governments limit public coverage for health care items such as outpatient drugs, long-term care, and dental and vision care.
477. But also unlike other countries, Canadian governments pay for almost all physician services for medically necessary services and acute-care hospital costs.
478. Jeffrey Simpson described the situation this way in his book on the Canada's public health care system, *Chronic Condition*:

... In other words, the Canadian system fulfills its secularly sacred mission of equity through public payment when you are in the hands of a doctor and/or in a hospital,

⁴⁰ OECD Health Statistics: 2014 .

but on either side of those parts along the continuation of care, the mission falls apart. Similarly, if the definition of health care is broadened to include dental and eye care and pharmaceuticals, the Canadian public system offers nothing or a patchwork, far short of what public systems supply in Europe.

That is why – to the surprise of most Canadians who do not know the facts – Canada uses tax money for a smaller share of its total health budget than almost every country with a public health system. As noted previously, 70 percent of health care spending in Canada is public, but 30 percent comes from private sources. Only Switzerland, the Netherlands and Australia, countries with essentially public systems, spend more health-care money privately.

The Scandinavian countries (minus Finland), Japan, New Zealand, France and Germany among others, spend less private money. This seventy-thirty distribution makes Canada an outlier in the world of public health care systems: almost complete public coverage for what we have come to define as “essential” medical needs, – doctors and hospitals – but a patchwork of non-existent public coverage for other health-care needs, even though as medicare has evolved these have become “essential”. Deep, narrow and expensive, as opposed to the systems elsewhere that are somewhat shallower, wide and cheaper. This unique shape of the Canadian system is what history has handed down, even though it no longer fits the health-care needs of a somewhat older population and taking into consideration the changes to medicare. (...)

... Governments understand that the shape of health care has somehow got to change so more care is provided across the entire continuum of care, but they are so stretched financially that expanding public care is proving difficult. [Simpson, *Chronic Condition*, at 235-237]

479. If there was no effective prohibition on private health care for medically necessary services, Canadian governments would be able to re-balance their health care spending, by potentially reducing expenditures on hospital and physician services and paying for a larger share of drugs, dentistry, and long-term care.
480. Also, as Dr. Vertesi will testify, the presence of a supplementary private care system will provide a basis for measuring the performance of the public system, and thereby provide insight into, and hence spur, necessary improvements in the public delivery of health care.
481. The Government might contend that the *Canada Health Act* prevents the Provincial Government from eliminating these prohibitions. However, that is not so.

482. The *Canada Health Act* does not require the provinces to limit or prevent access to private health care, by prohibiting private insurance and blended practice or in any other way.
483. It provides for the transfer of federal monies to the provinces for health care, on certain conditions.
484. Prohibitions on access to private health care are not required under the *Canada Health Act* to obtain federal transfer payments to assist in covering health care spending.
485. To be eligible for these federal health care monies, the Province must provide universal public health care to its residents that does not require patients to pay doctors for medically necessary services.
486. As long as BC residents have access to medically necessary services within the public health care system, without being required to make extra payments or users fees for individual services, the provinces are entitled to their share of the Federal health care transfer fund.
487. This is proven by the fact that a number of provinces do not prohibit their residents from obtaining insurance for private health care, and some other provinces allow blended practice, without any resulting reduction in health transfer payments, or harm to their public health care systems.
488. But even if the Province's federal transfer payments would be at risk (which they would not) that would not make unconstitutional legislation constitutional, as the Court's decision in *Chaoulli* makes clear.
489. The potential loss of some transfer payments is not a defence to the breach of the fundamental right of Canadians under the *Charter* to be able, without impediment by the Government, to take their own steps to obtain medical care outside the public system to meet their individual needs.
490. Even if the Government was correct, it cannot justify a breach of *Charter* rights by saying "Canada is paying us to do it".

491. It might be thought that faced with a worsening public health care situation, the Government would make the necessary legislative changes without the need for a Court to tell it that this is constitutionally required.

492. However, as the interventions in this case show, the political reality is that this is a public policy matter that is so politically charged that governments are politically afraid of doing what they know is necessary.

493. As Jeffrey Simpson stated in the introduction to *Chronic Condition*:

Medicare is the third rail of Canadian politics. Touch it and you die. Every politician knows this truth. Yes, politicians talk about health care, usually to promise more of it. Such talk is not part of a reasoned debate but essentially a bidding war. Many of them understand that a health care system that costs about \$200 billion a year in public and private money cannot continue as it is, that the system is inadequately structured for an aging population and has costs that grow faster than government revenues. Discussing these realities, however, risks shortening political careers. [Simpson, *Chronic Condition*, at 1]

494. Political road blocks required the intervention of the Constitution to protect the s.7 *Charter* rights of citizens in other cases such as *Carter*, *Insight*, and *Bedford*.

495. In a 2002 report, the BC Government acknowledged the difficulty in implementing change in the health care field:

In Part Three, we discuss how Canadians seem to have no difficulty pointing out the problems of our health care system and recommending various actions to improve the situation. The difficulty, instead, is in being able to implement the necessary changes, dealing with the fear and overwhelming resistance to change and devising an effective complementation strategy that achieves the desired results. Resistance to change is such a common problem that no less than six papers about managing change were commissioned from academics by the Romanow Commission in an attempt to find ways to allow health care reform to successfully proceed. The papers, along with the lessons gleamed from the Health Fund research, all concluded that change is difficult and must be effectively managed by common strategies such as leadership, shared visions, time to plan and commitment to public consultation and communication. [BC, *Patients First 2002*, at 7]

496. Fourteen years later, the public health care system is still not able to provide timely medically necessary services to all British Columbians.

497. In a July 2013 report entitled “Health Sector Budget Management Strategies and Implementation” the Government described the problem this way:

However...

- The first and important lesson about managing the health care system is that any simple solutions to such a complicated problem are invariably wrong or deeply suspect.
- A health care system encumbered by so much national emotion and featuring huge bureaucracies, large institutions, formidable professional associations and unions, high paid and well educated administrators is notoriously difficult for governments to manage and fairly intractable to change.
- There is strong consensus that the health system cannot continue as delivered, administered and financed.⁴¹

498. British Columbia residents shouldn’t be prevented any longer from being able to access private health care to protect their bodily integrity and security, as guaranteed under s. 7 of the *Charter*.

499. It is necessary therefore for the Courts to break this political log jam by stepping in to protect citizens from being the captives of a monopoly public health care system that cannot meet their medical needs in a timely manner.

500. In *Chaoulli*, Justice Deschamps described the need for judicial intervention to protect Canadians from being harmed by a monopoly public health care system as follows:

The instant case is a good example of a case in which the courts have all the necessary tools to evaluate the government’s measure. Ample evidence was presented. The government had plenty of time to act. Numerous commissions have been established [citations omitted]. Governments have promised on numerous occasions to find a solution to problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens.

For many years, the government has failed to act; the situation continues to deteriorate. This is not a case in which missing scientific data would allow for a more informed decision to be made. The principle of prudence that is so popular in matters relating to the environment and to medical research cannot be transposed to this case. Under the Quebec plan, the government can control its human resources in

⁴¹ BC2158602 - Health Sector Budget Management Strategies and Implications, at 6.

various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services (s. 30 HEIA) or by implementing less restrictive measure, like those adopted in the four Canadian Provinces that do not prohibit private insurance or in the other OECD countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebecers' right to security. The government has not given reasons for its failure to act. Inertia cannot be used as an argument to justify deference. [Chaoulli at paras 96-97; emphasis added]

501. Clearly, it is necessary for the Courts to step in to protect B.C residents from the harm they are suffering from a monopoly health care system, as they did in *Chaoulli*.
502. *Chaoulli* was a start in protecting the constitutional rights of Canadians to be free from Government restrictions on their ability to take the steps they feel are necessary to protect their bodily integrity.
503. But it requires a further Court decision in this province for British Columbians to have access to private health care to meet their medical needs in a timely manner.
504. I emphasize that the Plaintiffs are not saying that the Courts should design a new health care system for British Columbia.
505. That is for the legislature to do.
506. As Senator Kirby stated in his 2006 lecture:

The Supreme Court has clearly ruled [in *Chaoulli*] that excessive wait times are unacceptable but it did not prescribe a specific policy solution to the wait-time issue. Nor should it have. The role of the Court is to describe the standard that the public policy must meet, not the means required to get there [Kirby, "Two Options", at 70]

507. But the Courts need to be the catalyst for change to our public health care system in British Columbia, by ruling that the current situation is unconstitutional.
508. Specifically, it is necessary for the Court to "kick start" the process of change by eliminating the barriers to private health care.

509. It would then be up to the Province to build in protections, if necessary, for the public health care system as well as improvements to that system, but in a way which allows British Columbians to protect their own bodily integrity and security from being harmed by lengthy wait lists in the public system and no other viable options.
510. The Plaintiffs do not seek to harm or diminish the public system.
511. They believe fully in a universal health care system and want to work to support it.
512. But, the current monopoly system is not meeting the health care needs of British Columbians.
513. A British Columbian who experienced a lengthy delay for surgery and then opted for a private surgery described the public system as broken in a 2014 letter he wrote to the Government:

I can appreciate what people that have been waiting for surgery since November 2013 are going through as I've been waiting longer, I've been waiting since April 2013.

In regards to the private consultation that I paid for perhaps you did not understand my question. If the doctor that I paid a private consultation to was available to so do why can he not see more patients whose visits are paid for by the medical system. Are doctors limited as to how many consultations the medical system pays for and then they make themselves available for private consults or can they do unlimited consults paid for by the system but chose to not do so and run private pay for consults on some days?

In regards to the consult, I have experience pain on a daily basis since last November and was told this past June that my consultation wait would be over a year without the surgeon knowing my level of pain of [sic] the severity of my condition. Once again I appreciate that serious conditions should be handled in a priority but without a timely consult how can the pecking order be assessed and determined properly?

In all fairness if an individual pays for private consult or surgery to avoid living in pain for over a year the medical system should reimburse that person the amount that the system would have paid for that service, the excess should be borne by the patient. That individual by paying for the service has shortened the list for others that chose not to pay and live with the wait time. I also realize that this issue has been debated previously and the government does not have to so what is fair or morally correct but your system is badly broken.

I would venture to bet that no MLA would ever be expected to endure the same wait times as his or her constituents.

Thanks for the reply, predictable as it was I'm at 20 months from the time I was referred by my family physician and counting.⁴²

514. A monopoly public health care system falls apart if it cannot provide timely care.
515. And the Government has proven it cannot provide timely care for everyone in the public health care system.
516. Therefore, the courts are constitutionally required to end the monopoly, and permit private health care.
517. As Dean Monahan put it, in response to critics of the *Chaoulli* decision:

Largely overlooked in this academic debate was whether anyone had an answer to the fundamental question of principle that had moved the Court to intervene in the first place. This question was simply whether it was legally and morally justifiable for the state, on the one hand, to require individuals to access healthcare services only through a universal, single-payer system and then, on the other, to deny them access to needed service when they were sick or dying. In such circumstances, which the Court found to prevail in Canada today, was it legitimate for the state to prohibit individuals from using their own resources to access the care they needed? Could the sick be legally compelled to wait indefinitely for care without legal consequences of any kind, even if it resulted in a serious deterioration of their health or even their death? (...)

In these circumstances, the state is essentially forcing individuals to endure pain and even death in aid of the efficient operation of a social program. This offends the basic liberal principle that all persons should be treated "as equals"; that is, as entitled to equal concern and respect. No one citizen may be treated as a mere instrument to improve the welfare of another. Government fails to observe this bedrock moral principle when it imposes a "sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning his sense of his equal worth" (Dworkin 1985, 204). By way of illustration, as a democratic society we believe it would be wrong and immoral to put an innocent person to death, even if by so doing we might increase the health or welfare of others in society. The fundamental defect in such a proposal is that it treats the person to be sacrificed as a mere means to increase the welfare of others in society, rather than as an equal person entitled to the same concern and respect as those who stand to benefit from his or her death.

⁴² BC 225 0202 - Ministry of Health Response – 1015605.

Nor is this merely a moral principle. The Supreme Court of Canada has indicated that the “ultimate standard” for justifying limits on rights must be the values of a free and democratic society, which values include respect for the “inherent dignity of the human person” (*R. v Oakes*, 136). It is for this reason that any healthcare system which deliberately and systematically imposes pain or even death on innocent individuals in the name of improving healthcare provided to others cannot be justified either morally or legally, since it fails to treat all individuals as equally deserving of concern and respect. Nor could such a system be regarded as being in accordance with the “principles of fundamental justice” enshrined in section 7 of the Canadian *Charter*, since any legal regime which treated one person as a mere instrument for the satisfaction of the needs of another must be regarded as odious and fundamentally unjust. It is for this reason that the Supreme Court’s conclusion in *Chaoulli* was correct, both legally and morally. [Monahan, “*Chaoulli*”, at 3-5]

518. Professor Bliss makes the same point very simply and eloquently at the end of his expert report:

[A] country that as a matter of public policy bars treatment to the sick in the hour of their need and pain has lost its moorings and drifted into the unnecessary acceptance of a bizarre form of social cruelty.⁴³

519. This sentence from Professor Bliss’ expert report captures the essence of the constitutional violation in this case.
520. In light of the Government’s inability to address the harms caused by excessive waiting times, the courts must take the necessary and appropriate steps to protect the constitutional rights of BC residents.
521. The Courts cannot wait any longer for the Legislature to remedy the situation.
522. With that by way of introduction to my opening remarks, I now want to provide an outline of the relevant background information about the public health care system and the *Act*, to put our constitutional argument in its appropriate context.
523. After I do that, I will outline our evidence in this case and provide an elaboration of our legal argument.

⁴³ Response Report of Michael Bliss, dated July 31, 2014, at para 28.

II. A BRIEF HISTORY OF THE PUBLIC HEALTH CARE SYSTEM

524. At the present time, the Government is not only failing to adequately meet the medical needs of BC residents in the public care system, but it is prohibiting them from responding to that failure by accessing adequate treatment elsewhere.
525. It is worth taking some time to describe how we arrived at this point.
526. The provision of health services care comes within the jurisdiction of the provinces under the *Constitution Act, 1867* under s. 92(7) (covering the establishment, maintenance and management of hospitals) and s. 92(13) (property and civil rights), and s. 92(16) (local or private matters).
527. However, the Federal Government has intervened in the provincial health care field by using its so-called “spending power”, which is a power inferred from sections 91(1A), 91(3) and 106 of the *Constitution Act, 1867*.
528. The Federal Government began using its spending power in the 1950s, when it agreed to provide financial assistance to provinces to help them establish health insurance programs.
529. In 1957, the Federal Government enacted the *Hospital Insurance and Diagnostic Services Act* to cover some of the costs of hospital and diagnostic services in provincial insurance programs.
530. The *Hospital Insurance and Diagnostic Services Act* was implemented in 1958. At this time, Newfoundland, Saskatchewan, Alberta, British Columbia, and Manitoba had hospital insurance plans.⁴⁴

⁴⁴ Health Canada, “Canada’s Health Care System” online:< <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php> >.

531. By 1961, all of the provinces were participating in the Federal Government's health insurance program and had public insurance plans that provided universal access to hospital services.
532. Also in 1961, the Federal Government established a commission on health services chaired by Justice Emmett Hall.
533. The Hall Commission issued its report in 1964.⁴⁵
534. It recommended the creation of a new public insurance program that would ensure that all Canadians had access to medically necessary care, which went beyond hospital and doctors' services and included prescription drugs, eye glasses, dental services, and long term/home care.⁴⁶
535. In 1966, the Federal Government enacted the *Medical Care Act* to provide for Federal transfer payments for hospital and physician services, which was a much narrower public health care system than the Hall Commission had recommended.
536. That is the case to this day. The public health care system in Canada provides a much narrower range of coverage than the public health care systems of most other countries.
537. Under the *Medical Care Act*, the Federal Government offered to provide 50% of the costs of any provincial health insurance program that met the criteria of universality, comprehensiveness, portability, and public administration.
538. The Federal Government's Medical Care Program was implemented on July 1, 1968.
539. By 1972, all provincial insurance plans had been extended to include physician services pursuant to the Federal Government's Medical Care Program.

⁴⁵ Emmett Hall, Chair, *Report of the Royal Commission on Health Services*. (Ottawa: Queen's Printer, 1964) [Hall Report].

⁴⁶ Hall Report, at 17-92 ("Recommendations").

540. Under the Canadian public health care system, as originally conceived and implemented, there was no prohibition of a private health care system. As explained by Professor Bliss in his C.D. Howe Lecture:

Individual reliance on Canadian medicare was not compulsory. Citizens would have to pay a share of the costs of health insurance either in taxes or, in provinces that levied them, healthcare premiums, or both. But they could opt not to take any benefits and arrange to get their healthcare privately, just as they could educate their children privately while also paying school taxes or decline to cash baby bonus or old age pension cheques. Similarly, physicians, whose associations had lobbied strenuously to maintain professional independence from government and who had fought the government of Saskatchewan to a draw in a bitter doctors' strike, could choose to practice outside the system, billing patients at whatever rates they thought the market would bear...⁴⁷

541. Even with its comparatively limited scope, the costs to Canadian governments of providing public health care were much greater than anticipated, rising much faster than national income.

542. This is described as follows by Jeffrey Simpson in his book *Chronic Condition*:

With the best will in the world, and the most excellent forecasting models, intelligent people peer through a glass darkly in predicting in the future. So it was for Hall's commission's financial projections. They were accurate for the early decades of medicare but grew increasingly useless because they hugely underestimated the costs of the commission's proposals. Canada's population reached about 35 million in 2012, for example whereas the commission had predicted that level in 1991. Hall and his colleagues had not foreseen the decline in the fertility rate, and that miscalculation threw off the commissions' cost projections.

When the commission reported in 1964, Canada was spending 5.4 percent of its gross domestic product on health care. Without any change to the basic system, the commission thought the share of GDP would nudge up to only 5.5 percent in 1971. The implementation of its proposals, the commission forecast, would push health care to 6.4 percent of GDP in 1971 and 7.4 percent in 1991. Additional revenues would come from higher personal incomes taxes, premiums, sale taxes or whatever revenue-raising methods provinces chose. Such an increase, Hall asserted, could be accommodated "without affecting detrimentally the requirement of the Canadian people for other goods and services." Instead, health-care costs blew past what Hall

⁴⁷ CSC00024094 - Michael Bliss, "Critical Condition: A Historian's Prognosis on Canada's Aging Healthcare System" *C.D. Howe Institute Benefactors Lecture* (2010) [Bliss, "A Historian's Prognosis"].

had predicted, and other “goods and services” desired by Canadians did suffer as health care squeezed the budgets for other programs.

Hall’s predictions were wobbly from the start. In 1971, health care took 7 percent of GDP, not 6.4 percent; by 1991 it consumed 9 percent of GDP, not 7.4 percent. Two decades later, it used 11.7 percent of GDP, an increase of about 70 percent in the share of GDP since medicare began. Remember that the commission proposed a considerably wider public health-care model than the one that governments subsequently negotiated. Even the narrow system that emerged from federal-provincial negotiations soon outstripped the costs of the wider one that the commission had recommended. Higher costs than anticipated, plus an aversion to higher taxes, shattered any hopes that the commission’s more comprehensive model might have been implemented.

In fairness, how could the Hall commission have predicted the OPEC crisis of the early 1970s that dramatically slowed economic growth and caused soaring inflation and high unemployment? How could it have known that the future would mock its optimistic projection of only 4 percent unemployment and strong productivity growth? How could it have predicted, decades ahead, the surges in expensive medical technology and drug costs, the feminization of medical schools, the ever-increasing demand for health-care services with little concern for their “wise use,” the confrontations between unionized employees within the health-care sector and provincial governments, the aggressive pursuit of self-interest by doctors’ organizations in fee bargaining, the massive health-care bureaucracies, the radically changed demography of Canada and a host of other changes?

When Canadians embraced Hall’s dream, they wedded themselves with such passion to its nobility of purpose, its humanitarian and nation-building impulses and its egalitarian values that no politician of any stripe dared to tear the marriage asunder. Hall’s dream prevails today, Emmett Hall deserves to be called the “father of medicare.” He, arguably more than any other Canadian with the exception of Tommy Douglas, laid the foundation and built the intellectual superstructure for Canada’s unique system. Within a few short years of its start, however, medicare began to be rocked by events far from home that produced renewed domestic battles over health care. [Simpson, *Chronic Condition*, at 109-111.]

543. Professor Bliss has also commented on the financial challenge faced by Canadian governments in paying for the public health care system:

With payment systems socialized on a national basis, Canadian healthcare was increasingly seen or conceptualized as a “system”. Instead of being driven by a diversity of signals, forces, initiatives, and incentives, in a complex of decentralized markets, healthcare would now be “managed” by those responsible for funding it. The fact that funding responsibility was divided between Ottawa and the provinces would always muddy this situation, generating frequent frictions and confusing voters and politicians alike. It was not always clear which governments were in charge of

Canadian healthcare, but there was no doubt that the genus, government, had stepped in to make fundamental decisions.

Total healthcare costs, however, rose relentlessly –and faster than national income – from less than 6 percent of gross domestic product (GDP) in the 1960’s to more than 10 percent today [2010](figure 1). Canadians liked their healthcare, and now that cost hindrance had been removed at the point of service for basic healthcare, they wanted more of it, and they also had the resources vastly to increase their spending on uninsured forms of care. Very quickly after medicare’s introduction, all Canadian governments began to be concerned about the affordability of the commitments they had made. As usage and public costs soared (see figure 2), and critics began to wring their hands about the unlimited propensity to consume a free service, alarmist projections issued about the capacity of healthcare to take over practically the whole tent of government spending (Gray 1991). If the central problem before medicare had been to make modern healthcare accessible to all Canadians, the central problem after the introduction of medicare was how to pay for it. It has continued, into the present, to be a central problem. [Bliss, “A Historian’s Prognosis”, at 7-8]

544. Faced with these cost pressures, Canadian governments sought ways to limit spending.
545. In 1977, the Federal Government replaced its open-ended 50% cost sharing commitment with what is called block funding.
546. Under the Federal Government’s new funding program, about half of the former cost-sharing, which had been fully in cash, was replaced by the permanent transfer of federal “tax points” (i.e. the federal government reduced taxes permitting provincial governments to increase them by an equivalent amount).
547. The remaining cash portion was no longer based on actual health spending but on population plus an inflation adjustment.
548. The provinces tightened their controls on fees paid to doctors and grants to hospitals. Most provinces froze or reduced reimbursement rates to doctors.
549. In response, some doctors engaged in “extra-billing,” that is, charging patients an additional fee on top of what was paid to them by the government for their services to patients.
550. Some provincial governments, including British Columbia, imposed user fees for publicly provided health care.

551. By 1980, user fees and extra billing had become a part of the public health care system in most provinces [Simpson, *Chronic Condition*, at 136].
552. In the meantime, the Federal deficit had increased from \$2 billion in 1972 to \$30 billion in 1982. This was an increase from 1.7% of GDP to 7.6%.
553. Health care budgets were increasing by 16% a year up to 1980, and from 1981 to 1984 they rose by 9-10% per year. In dollar terms, the cost of the public health care system rose from \$12 billion in 1975 to \$27 billion in 1984.
554. Health care costs were rising much faster than government revenues [Simpson, *Chronic Condition*, at 131].
555. Beginning in 1982, the Federal Government began reducing its transfer payments under the *Established Program Financing Act*.
556. The result was to increase the cost pressures on the provincial governments for health care funding.
557. Although the Federal Government was reducing the amount it paid into the system, it also became concerned that user fees and extra billing were making the public health care system inaccessible to some members of the public.
558. This led the Federal Government to enact the *Canada Health Act* in 1984, which introduced a new “accessibility” principle as a condition for receipt of federal transfer payments.
559. The accessibility principle was enforced in the *Canada Health Act* by a deduction from the federal transfer payments of the amount of any user fees or extra billing allowed by the provinces to be charged for obtaining medically necessary services under the provinces’ public health care system.
560. Canadians could still obtain private health care outside of the public health care systems without any reduction in federal transfer payments to the provinces.

561. Specifically, as will be discussed in more detail in the section on the *Canada Health Act*, it is not necessary for the provinces to prohibit private insurance for medically necessary health care or to prohibit blended practice by physicians in order to meet the “accessibility” requirements of the *Canada Health Act*.
562. But that is what the BC government did in the *Medicare Protection Act*. It effectively precluded most BC residents from accessing private medical care in the province even though this was not required under the *Canada Health Act*.
563. I will now review the applicable federal and provincial legislation, beginning with the *Canada Health Act*.

III. FEDERAL AND PROVINCIAL LEGISLATION

A. The Canada Health Act

564. As just described, the federal government transfers some monies to the provinces for health care spending.
565. This is governed by the *Canada Health Act*.⁴⁸
566. The policy objective of the *Canada Health Act* is to “facilitate reasonable access to health services without financial or other barriers”.
567. As stated in the preamble and section 3 of the *Canada Health Act*:

Preamble

Whereas the Parliament of Canada recognizes:

[...]

- that the continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.

[...]

Primary objective of Canadian Health Care Policy

⁴⁸ *Canada Health Act*, R.S.C. , 1985, c. C-6 [*Canada Health Act*].

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.
568. The provinces have jurisdiction over the provision of health care.
569. The federal government cannot compel the provinces to provide universal, or any, health care to their residents.
570. But it can offer financial inducements to the provinces to provide universal public health care, through the transfer of money to the provinces to cover some of their health care spending.
571. That is accomplished under the *Canada Health Act* by making the federal government's contribution to provincial health care costs conditional upon the provinces meeting certain requirements.
572. The requirements in the *Canada Health Act* for the transfer of money are not legally binding on the provincial governments, and are likely unenforceable even against the federal government, except in exceptional circumstances.⁴⁹
573. As described by Gerard Boychuk in his research paper for the University of Calgary School of Policy Studies, the *Canada Health Act* is not justiciable:

... the Legislation [*Canada Health Act*] is not justiciable – it is neither agreed to by both parties, legally binding on either party, nor does it create a set of citizen entitlements which may be claimed through the courts.

...

... The *CHA* is not legally enforceable, it is not a contract between two parties, and it does not confer rights on citizens which can be invoked to force provinces to provide health services in any particular way. The critical point is that *CHA* enforcement is primarily a political – not legal – issue.⁵⁰

⁴⁹ See generally Sujit Choudhry, "The Enforcement of the *Canada Health Act*" (1996) 41 McGill LJ 461.

⁵⁰ CSC00020406 - G. Boychuk, "The Regulation of Private Health Funding and Insurance under the Canada Health Act: A Comparative Cross-Provincial Perspective" *SPS Research Papers: The Health Series*, Vol. 1, Iss. 1 (December 2008) [Boychuk, "**Regulation of Private Health Funding**"].

574. The federal government can change the legislation at any time, and the provinces are not in breach of the *Canada Health Act* if they do not comply with these requirements.
575. But, if the provinces do not comply with the requirements in the *Canada Health Act* for the transfer of money to them for health care, the money can be withheld.
576. There are nine requirements in the *Canada Health Act*.
577. These requirements are broken down into five criteria, two conditions, and two specific provisions dealing with mandatory deductions from the federal contribution to the provinces.
578. The five criteria are:
- (i) *Public administration* (s. 8) – the public health care program of a province must be administered on a non-profit basis by a public authority responsible to the provincial government. (Note that this does not preclude the private delivery of health care under the public administration).
 - (ii) *Comprehensiveness* (s. 9) – the health care insurance programs of the provinces must insure all hospital services, medically required services rendered by physicians, and surgical-dental services.
 - (iii) *Universality* (s. 10) – all residents of a province must have access to public health care insurance and insured services on uniform terms and conditions.
 - (iv) *Portability* (s. 11) – this criterion requires the provinces to cover insured health services provided to their residents while they are temporarily absent from their province or from Canada.
 - (v) *Accessibility* (s. 12) – insured persons must have reasonable and uniform access to publicly insured health services, free of financial or other barriers.
579. These five criteria contemplate a universal public health care system.
580. But they do not require the elimination of a private health care option.
581. Therefore, these five criteria do not preclude the provinces from allowing a supplementary private health care system covering medically necessary health care services to co-exist with a universal public health care system.

582. There are two conditions set out in s. 13 of the *Canada Health Act*.

583. The provincial government must:

- (i) provide information to the federal Minister of Health “of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act”; and
- (ii) recognize the Canada Health Transfer [the federal contribution] in any public documents, or in any advertising or promotional material, relating to insured health services in the province.

584. Again, these two conditions do not preclude the provinces from allowing for the provision of private health care as a supplement to universal public health care.

585. Under sections 14 to 17 of the *Canada Health Act*, the Federal Minister of Health has the discretionary power to withhold Canada Health Transfer (federal contributions) from a province that fails to meet any of the five criteria or the two conditions.

586. There are two sections of the *Act* that require mandatory deductions from the Federal transfer of monies to the Provinces for health care spending:

587. They are sections 18 and 19.

588. These are the user fee and extra billing provisions.

589. Sections 18 and 19 read as follows:

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the provinces for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

19. **(1)** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province. [emphasis added]

590. User charges and extra billing are defined in the *Canada Health Act* as follows:

User charge means any charge for an insured health service that is authorized or permitted by a provincial health care plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra billing.

Extra billing means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an accident in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.

591. Under s. 18, a province will not qualify for a full transfer of monies if, in respect of insured health services, there has been extra billing by medical practitioners – that is charges to the patient in addition to what is paid by the public plan for the medical service in question.
592. Under s. 19, a province will not qualify for the full transfer of health care money if user fees are charged to a patient for services provided under the public plan – that is, charges in addition to what is paid for by the public plan for the services.
593. The result of these two sections is that if there is a payment under the provincial health care plan for a portion of a medically necessary service, any further charge by a physician or a private clinic for the same service may constitute extra billing and/or a user fee under the *Canada Health Act*.
594. Therefore, as long as no part of the medical service is paid under the public plan, a private clinic can charge the patient for the medically necessary service without this constituting extra billing or a user charge under the *Canada Health Act*.
595. That is the case regardless of whether the private medical service is provided by an enrolled doctor and/or is paid for through private insurance.
596. If a province permits the imposition of user fees or allows extra billing as described in ss. 18 and 19 of the *Canada Health Act*, the mandatory deduction from the federal government's financial contribution to a province is the amount of the extra billing and user charges (s. 20).

597. In 1995, the Federal Minister of Health, the Honourable Diane Marlowe, advised her provincial counterparts that the Federal Government considered the charging of facility fees by private clinics to patients constituted a “user charge” in circumstances where the province paid for part of the private service, such as the surgeon’s fee.
598. This is discussed as follows in the 1995 letter sent by the Federal Health Minister to Provincial Health Ministers, which is considered an interpretative aid to the *Canada Health Act*:

While there is no definition of facility fee in federal or most provincial legislation, the term, generally speaking refers to amounts charged for non-physician (or “hospital”) services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act [*Canada Health Act*].

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. The subsidization of two-tier health care is unacceptable.⁵¹

599. As can be seen, what the Federal Government was objecting to was charging patients a facility fee for medical services that were paid for by the public system.
600. There can be no deduction if the provinces allow their residents to pay for the full amount of private health care services, both the surgical fee and the facility fee. It does not matter whether the private medical services are provided by enrolled doctors and/or are paid for through private insurance.
601. It follows therefore that the provinces do not have to limit or restrict access to private health care – by prohibiting either or both blended practice and private insurance – in order to receive their full portion of federal health care payments under the *Canada Health Act*.

⁵¹ BC1003094 - Canada Health Act Interpretation - Letters from the Honourable Jake Epp and the Honourable Diane Marleau at 7.

602. That was made clear by Justice Deschamps in the *Chaoulli* case:

The Canada Health Act does not prohibit private health care (...)

The Canada Health Act is therefore only a general framework that leaves considerable latitude to the provinces (...) [*Chaoulli* at paras 16-17]

603. Indeed, five provinces, namely Saskatchewan, New Brunswick, Nova Scotia, Newfoundland, and, after *Chaoulli*, Quebec, do not prohibit private insurance.

604. And three provinces do not prohibit dual practice by doctors: Newfoundland, Prince Edward Island, and New Brunswick.

605. In his research paper, Mr. Boychuk commented on the different approaches taken by the provinces regarding dual practice and private insurance, as follows:

Firstly, the *CHA* regulations focus on the status of services and not on the status of service providers. Secondly, provinces vary significantly in how they regulate the mixing of public and private income streams for publicly-insured services. Thirdly, provinces also vary significantly in their regulation of private insurance – regulation that is neither specified in or required by the *CHA*. [Boychuk, “Regulation of Private Health Funding”, at 16-17]

606. In summary, to qualify for federal transfer monies for health care under the *Canada Health Act*, the provinces simply have to ensure that the public health care system is accessible to everyone without the payment of any extra charges.

607. And in any event, the *Canada Health Act* transfers are irrelevant to the constitutional analysis required in this case.

608. It is not a defence to a breach of the *Charter* to say “but the federal government bribed us to do it”.

609. From a *Charter* perspective, the federal government could not induce the provinces, by withholding federal transfer monies, to breach the *Charter* rights of Canadian residents by prohibiting access to private health care if the public system is unable to provide timely treatment – even if the *Canada Health Act* did require that, which it does not.

B. Provincial Legislation

610. As described in the Supreme Court of Canada's decision in *Eldridge*,⁵² there are two statutes governing the public health care system in British Columbia, the *Hospital Insurance Act*⁵³ and the *Medicare Protection Act*:

Medical care in British Columbia is delivered through two primary mechanisms. Hospital services are funded by the government through the *Hospital Insurance Act*, R.S.B.C. 1979, c. 180 (now R.S.B.C. 1996, c. 204), which reimburses hospitals for the medically required services they provide to the public. Funding for medically required services delivered by doctors and other health care practitioners is provided by the province's Medical Services Plan, which is established and regulated by the *Medical and Health Care Services Act*, S.B.C. 1992, c. 76 (now known as the *Medicare Protection Act*, R.S.B.C. 1996, c. 286). [*Eldridge*, at para 2]

C. The Hospital Insurance Act

611. Section 5(1) of the *Hospital Insurance Act* describes the "general hospital services" that are to be provided by acute care hospitals as follows (similar provisions list services for extended care and out-patient facilities):

5.(1) Except as provided in subsection (2), the general hospital services provided under this Act are

(a) for beneficiaries requiring treatment for acute illness or injury, the public ward accommodation, necessary operating and case room facilities, diagnostic or therapeutic X-ray procedures, anesthetics, prescriptions, drugs, dressings, cast materials and other services prescribed by regulation;

[...]

(2) General hospital services under this Act do not include the following:

(a) transportation to or from hospital;

(b) services or treatment that the minister, or a person designated by the minister, determines, on a review of the medical evidence, the beneficiary does not require;

⁵² *Eldridge v. British Columbia (Attorney General)*, [1997] 3 SCR 624 [*Eldridge*].

⁵³ *Hospital Insurance Act*, RSBC 1996, c 204 [*Hospital Insurance Act* or *HIA*].

(c) services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council.

(d) laboratory services that are benefits within the meaning of the Laboratory Services Act. [Emphasis added.]

612. The *Regulation to the Hospital Insurance Act* states that the hospital services to be provided shall include “such of the following services as are recommended by the attending physician and as are available in or through the hospital to which the person is admitted”.⁵⁴
613. The funding of hospitals is provided for in s. 9(1) of the *Hospital Insurance Act*. It provides that there “must be paid annually” to each Health Authority:

for the hospitals it funds an amount determined by the minister to cover all or part of the cost to the regional health board, the Nisga'a Nation or the PHSA for the provision to beneficiaries of those general hospital services authorized by this Act that the hospitals are required by the minister to provide for beneficiaries admitted for treatment, excluding those amounts payable for those hospitals under section 5 (7) and section 14.

614. The Government generally gives the Health Authorities an annual lump sum to pay for hospital services. The Health Authorities have discretion regarding the spending of their allotted money.

D. The Medicare Protection Act – Prohibitions on Private Care

615. The *Medicare Protection Act*⁵⁵ (“MPA” or the “Act”) provides for the provision of medical services by physicians.
616. The Act is administered by the Medical Services Commission (the “Commission”).

⁵⁴ *Hospital Insurance Act Regulations*, BC Reg 25/61, s. 5.1.

⁵⁵ *Medicare Protection Act*, R.S.B.C. 1996, c. 286 [the *Act* or the *MPA*].

617. The objective of the *Act*, as set out in the preamble and section 2, is to provide a public health care system that meets the health care needs of British Columbia residents regardless of their ability to pay:

Preamble

WHEREAS the people and government of British Columbia believe that medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations;

WHEREAS the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability, public administration and sustainability as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity;

WHEREAS the people and government of British Columbia are committed to building a public health care system that is founded on the values of individual choice, personal responsibility, innovation, transparency and accountability;

WHEREAS the people and government of British Columbia are committed to developing an efficient, effective and integrated health care system aimed at promoting and improving the health of all citizens and providing high quality patient care that is medically appropriate and that ensures reasonable access to medically necessary services consistent with the Canada Health Act;

WHEREAS the people and government of British Columbia wish to ensure that all publicly funded health care services are responsive to patients' needs and designed to foster improvements in individual and public health outcomes and ongoing value-for-money for all taxpayers;

WHEREAS the people and government of British Columbia recognize a responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system for future generations;

AND WHEREAS the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay.

[...]

Purpose

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

618. As I will discuss in more detail later on, the principle of “fiscal sustainability” was added to the “Purpose” clause in 2008, when it became clear to the Government that the increases in health care spending were, in its view, not sustainable.

619. This led to the cap on health care spending increases.

620. As we have seen, the *Canada Health Act* does not require as a condition of federal funding that the BC government prevent British Columbians from accessing private health care in the province to meet their medical needs.

621. But that is what the Government did in 1992, when it introduced the prohibitions on private insurance and on so-called dual or blended practice (i.e., enrolled doctors providing private medical services).

(i) *The Prohibition of Private Insurance*

622. Section 45(1) of the *Act* prohibits the provision of private insurance for medically required services:

Private Insurers

45(1) a person must not provide, offer or enter into a contract of insurance with a resident for the payment, reimbursement or indemnification of all or part of the cost of services that would be benefits if performed by a practitioner.

623. This prohibition on private insurance does not apply to insurance for private health care services provided outside of Canada.

624. Insurance obtained to cover health services outside of Canada is specifically excluded from the prohibition, by s. 45(2)(b) of the *Act*.

625. This exemption enables those with the financial means to travel for health care to obtain private insurance and private treatment for health care in another country.

626. But those who cannot afford to do so are unable to practically access private insurance, because they are prohibited from obtaining private insurance for health care coverage in BC or elsewhere in Canada.

627. This prevents, for example, insurance companies providing disability insurance from paying for private surgeries in BC to enable workers to return to work more quickly, as WorkSafeBC does.

(ii) *The Prohibition of Blended or Dual Practice*

628. The Act effectively prohibits doctors enrolled in the Medical Services Plan (“MSP”) from providing medically necessary services in a private clinic.

629. The prohibition is set out in s. 17 of the Act.

630. Section 17(1) states:

17(1) Except as specified in this Act or regulations or by the commission under this Act, a **person** must not charge a beneficiary

(a) for a benefit, or

(b) for materials, consultation, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit. [emphasis added]

631. This section, standing alone, would prohibit the provision of any medically required services (a “benefit”) in a private clinic, because no patient can be charged for a medically required service or any facility fees related to that service.

632. However, there is an exception in 17(2)(d), which provides that the prohibition does not apply

(d) if the service was rendered by a medical practitioner who is not enrolled.

633. The fees that unenrolled doctors can charge are not capped at the fee amount for the service paid by MSP, as long as the medical services are provided in a private clinic and not in a hospital or community care facility.

634. There is no restriction on the fees charged by private clinics, provided that all of the required medical services are performed by unenrolled doctors

635. Therefore, unenrolled doctors, and the private clinics in which they perform services, can charge patients for medically required services beyond the prescribed fee schedule.
636. The situation is, however, very different if the medically required services are provided by a doctor who also wishes to treat patients in the public system. A doctor who treats even one patient in the public system must be enrolled.
637. Section 13 of the *Act* provides for the enrollment of medical practitioners and health care practitioners.
638. Practitioner is defined as follows:

“practitioner” means

- (a) A medical practitioner, or
- (b) A health care practitioner

Who is enrolled under s. 13

639. It is possible for enrolled doctors to elect to have their fees for medically necessary services under the *Act* paid directly by a patient, if the doctor elects to be paid in this manner instead of by MSP.
640. This is provided for in s. 14 (1) of the *Act*:

14 (1) A practitioner may elect to be paid for benefits directly from a beneficiary.
641. So enrolled doctors can bill patients directly if they elect to do so. However, if they make this election, they must bill all of their patients directly.
642. Enrolled doctors who do this are said to have “opted-out” of the public system.
643. They are still technically enrolled in the public health care system, but are not directly paid by that system.

644. Opted out doctors are paid directly by the patients, who are then reimbursed by the public system [see section 20 (1) of the *Act*].
645. Enrolled doctors who have not “opted-out” cannot bill their patients directly.
646. But, enrolled doctors who have opted out cannot charge their patients more than the prescribed fee paid by MSP for the service.
647. This is set out in s. 18(3):

Limits on Direct or extra billing by a medical practitioner

18(3) If a medical practitioner described in Section 17(2)(c) [opted out doctor] renders a benefit to a beneficiary, a person must not charge the beneficiary for, or in relation to, the service an amount that, in total, is greater than

- (a) The amount that would be payable under the *Act*, by the Commission, for the service, or
- (b) If a payment schedule or regulation permits or requires an additional charge, the total of the amount referred to in paragraph (a) and the additional charge.

648. The combined effect of these sections of the *Act* is that enrolled doctors, who have not opted out, cannot charge their patients any fees at all for medically required services, and enrolled doctors, who have opted out, cannot charge their patients fees that are higher than the prescribed MSP fee for the doctor’s services.
649. These restrictions do not only affect the doctor's fees.
650. Section 17(1) of the *Act* applies to any "person", which includes a private clinic or surgical facility.
651. In this way, the fee restrictions applicable to all enrolled doctor also apply to the private clinic or surgical facility in which the enrolled doctor performs the medical services.
652. If a required medical service is provided by an enrolled doctor in a private facility, neither the doctor nor the private facility can charge the patient more than the prescribed doctor’s fee under MSP for the required medical service.

653. This means that the enrolled doctor and the private facility, which provides the operating room, nursing and other staff, equipment and medical supplies, can collectively charge only the fee that the doctor alone would be paid for providing the service in the public system.
654. The facility cannot charge an extra fee for the use of the surgical facility, nurses, staff, equipment and/or medical supplies.
655. To do so would constitute extra-billing in contravention of ss. 17(1)(b) and 18(3).
656. These restriction in the *Act* make it economically impossible for an enrolled doctor to perform any medically required services in a private facility, and also economically impossible for the private clinic to allow the doctor to do so.
657. So, while the *Act* technically permits enrolled doctors to perform private surgeries for the fee paid under MSP, the *Act* prohibits the private facility from charging the patient any additional amount for all of the services it provides.
658. Therefore, it is not financially feasible or practicable for a private clinic to operate using enrolled doctors under the *Act*.
659. Without payment of the facility cost by the patient or a private insurer, enrolled doctors, regardless of whether they opt to charge the patient directly, are effectively prohibited under the *Act* from providing private surgeries even if their fees for the actual medical service are no more than the fees paid by MSP for that service.
660. The result is that under the *Act*, the excess available surgical time that enrolled doctors possess, beyond what they are able to utilized in the public system, cannot be used to provide medically necessary services to BC residents, even though this would not result in any loss of their services to the public system or any harm to the public system.

(iii) Exemptions under the Act

661. As stated before, the prohibitions on dual practice and private insurance do not apply in all circumstances.

662. There are exemptions under the *Act*, that are provided for under the definition of benefits in the *Act*.

663. “Benefits” is defined as follows in s. 1 of the *Act*:

“**benefits**” means

(a) medically required services rendered by a medical practitioner who is enrolled under section 13, unless the services are determined under section 5 by the commission not to be benefits.

664. The prohibitions on private care only apply to benefits as determined under the *Act*.

665. Under s. 5 of the *Act*, the Commission has the power to “(j) determine whether a service is a benefit or whether any matter is related to the rendering of a benefit”.

666. The Commission, pursuant to these powers, passed Minute 97-068, which states as follows under the heading “Excluded Medical and Diagnostic Services”:

Excluded medical services

1. Benefits under the *Act* do not include services rendered by an enrolled medical practitioner, or performed in an approved diagnostic facility, that a person is entitled to and eligible for under:

- (a) the *Aeronautics Act* (Canada);
- (b) the *Civilian War Pensions and Allowances Act* (Canada);
- (c) the *Government Employees Compensation Act* (Canada);
- (d) the *Merchant Seaman Compensation Act* (Canada);
- (e) the *National Defence Act* (Canada);
- (f) the *Penitentiary Act* (Canada);
- (g) the *Pension Act* (Canada);
- (h) the *Royal Canadian Mounted Police Act* (Canada);
- (i) the *Royal Canadian Mounted Police Pension Continuation Act* (Canada);
- (j) the *Royal Canadian Mounted Police Superannuation Act* (Canada);
- (k) the *Veteran Rehabilitation Act* (Canada);
- (l) the *Workers Compensation Act*; and
- (m) the *Hospital Insurance Act*.

667. Some of these exceptions are also provided for in the *Canada Health Act*, which defines insured health services as meaning:

(...) hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers or workmen's compensation

668. The most prominent exemption, in terms of numbers of individuals it applies to, is the one covering injured or ill employees under the *Workers Compensation Act*.
669. Beginning in the 1990's, WorkSafeBC has been obtaining core health care services outside of the public health care system.
670. The reasons for this are explained as follows in an article by a research team led by McMaster University Dean of Social Sciences Jeremiah Hurley, entitled "Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers":

During the 1990s the combination of three new factors — service delays in the provincial systems, new evidence of the link between workplace absence and long-term disability, and unfunded disability costs — pushed WCBs to develop new arrangements to expedite care for workers.

Service delays in the provincial systems grew in the mid-1990s as the Canadian healthcare system underwent retrenchment and upheaval: real per-capita public healthcare spending fell for the first time since data had been collected (Canadian Institute for Health Information 2005), cuts to hospital budgets reduced access relative to demand for many services and the physician shortage worsened (Chan 2002). Wait times for care mushroomed, especially in areas vital to WCBs such as orthopedic surgery and diagnostic imaging. These delays imposed large financial costs on WCBs because every day of delayed care was another day that a WCB had to pay a worker wage replacement.

During this time, new research evidence demonstrated that the full costs to WCBs of such delays were potentially far greater than had been recognized. Research showed that, other things equal, the longer a worker was off work, the greater the chance that he or she would never return to work (Brooker et al. 2001; Hogg-Johnson and Cole 2003; Loisel et al. 2002). The implication for WCBs was clear: by stressing early return to work and maintaining a worker's link to his or her workplace during an episode of disability, the WCB could reduce the likelihood that a short-term disability would turn into a chronic disability and a lifetime WCB pension.

Finally, WCBs were facing increasing pressures related to disability benefit costs. WCBs in a number of provinces held large unfunded liabilities, and they had to act to restore financial sustainability.⁵⁶

671. This has resulted in considerable savings for WorkSafeBC:

The initiatives to expedite care save substantial costs for a WCB. The WCB in British Columbia, for instance, estimated that the combination of its specialist visiting clinic program for assessments and contracts with private clinics for surgery reduced the treatment time from six to nine months through the provincial plan to less than six weeks, saving the WCB an estimated \$50,000 per client in wage-replacement costs alone. [Hurley et al, at 11]

672. Among the group of people who are waiting in the public system for surgeries are workers injured off the job, even though they may be covered by disability insurance often provided by their employers.
673. Disability insurers have the same financial incentive as WorkSafeBC to get insured workers back to work as soon as possible.
674. The insured workers, who only received about 66% of their salary as disability benefits, also want to return to work as quickly as possible.
675. There are significant economic cost to employees, employers and our economy of employees being off work for lengthy periods of time.
676. Studies show that 44% of injured workers are unemployed by the time they make it to surgery, and once they have lost their jobs, only 62% of these regain employment.
677. This is in addition to the physical and psychological harm to workers by delays in receiving medical treatment so they can resume their former lives.
678. While waiting for medical treatment, the patients endure pain, and must utilize various treatments, including physiotherapy, drug therapy and, in some case, psychological therapies, in order to deal with the pain.

⁵⁶ Jeremiah Hurley et al, "Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers" *HealthcarePapers*, Vol. 8 No. 3 (2008) [Hurley et al] at 9.

679. Therefore, there are sound policy reasons beyond the financial cost to employees, employers and our economy generally, of getting workers back to work as soon as possible through the use of private surgeries if timely surgeries cannot be provided in the public system.
680. But these policy reasons apply regardless of whether the injury has been suffered on or off the job.
681. It is both arbitrary and unfair to provide access to more timely care in private clinics only to workers who are injured on the job.
682. *Where* an injury is suffered is irrelevant to the treatment. The fact that a worker was injured off the job is not a valid reason for denying access to private surgeries to enable a quicker return to work.
683. Anyone suffering an accident, regardless of their job or occupational status, should be able to obtain timely medical treatment for their injuries.
684. As stated in the Hurley et al article:

Finally, policy makers should recognize that WCBs are the proverbial canaries in the coal mine. The public system is not currently meeting the expectations of many Canadians (e.g., Blendon et al. 2003). WCBs have acted because they bear the substantial financial costs associated with waiting, costs borne by patients in the provincial plans. WCBs' incentives therefore closely match the incentives of an ill individual in provincial plans. Time off work is costly, and quicker access is most valuable to high-income individuals — those for whom the personal cost of delayed access is highest and the burden of any payment for quicker access lowest. WCB expedited-care strategies typify the actions to be expected of any parallel payer, including private individuals and private insurers (who are less inclined than WCBs have been to work co-operatively with provincial plans). Like that of the WCBs, total private demand will be small relative to the public plans but will concentrate in selected areas where its effects will be disproportionately large. Closer examination of the impacts of WCB expedited-care initiatives can provide valuable insight into what Canada can expect should it both fail to address current problems of health system performance and expand opportunities for parallel private finance for publicly insured services. [Hurley et al, at 13]

685. In New Zealand, persons who suffer an injury due to an accident are entitled to expedited treatment through the Accident Compensation Corporation (formerly the Accident Compensation Commission).
686. The Accident Compensation Corporation is explained by Dr. Ross Davidson in his expert report in this case:

[I]n New Zealand there is also a funding mechanism called Accident Compensation Commission (ACC), which was introduced in 1977 to the public system. What this did was to introduce a no-fault system of insurance for all accidental injury in New Zealand, whether this occurred at work or play. That system is not funded by taxation as such, but rather is funded by fees and levies on income, payroll, fuel, and vehicle licensing. The presence of ACC in New Zealand can be equated to a system similar to the Worker's Compensation System in Canada, but rather than being just for injuries sustained at work, it is for everybody and for all injuries. [...]

It is interesting to note that ACC, the funder of services required as a result of an accident, will fund procedures in public hospitals for the first two weeks but after two weeks, if the patient requires treatment and is not able to get treatment in the public hospital for whatever reasons, ACC will then fund the treatment in a private hospital. In other words, ACC is totally focused on rapid access to treatment, and restoration of the patient to their pre-accident status or as close to that as possible. They make no distinction between public and private facilities, but rather select wherever the patient can receive treatment in a timely manner.⁵⁷

687. It should be the health care goal in British Columbia as well to ensure that a patient can receive treatment for injuries in a timely manner regardless of where or how the injury is sustained, and whether the treatment is provided in a public hospital or private clinic.
688. And if the public system cannot provide timely medical services to everyone, then British Columbians must be allowed to obtain medical services privately either by paying for these services themselves or through insurers.

⁵⁷ Expert Report of Dr. Ross Davidson, July 14, 2014.

(iv) Medical Services Paid For In The Public Health Care System under the Medicare Protection Act

689. Under the *Canada Health Act*, the provinces must publicly insure all services that are “medically necessary” in order to meet the comprehensiveness criterion for the purposes of receiving Federal transfer-money.

690. However, the *Canada Health Act* does not define what a “medically necessary service” is.

691. That is left to the individual provinces to determine, which results in differences in the scope of public health care coverage between provinces.

692. This is explained as follows in a 2005 Parliament of Canada paper entitled “The Canada Health Act: Overview and Options”:

Under the criterion of comprehensiveness stipulated in [the Canada Health Act], the health care insurance plan of a province must insure all services that are “medically necessary.” The criterion of comprehensiveness refers in a way to a minimum basket of services, because the Act neither mentions the quantity of services to be provided nor gives a detailed list of what services will be insured; provincial governments can define these. Thus, the range of insured services may vary among provinces and from one year to the next.[...]

The Act makes a distinction between “insured health services” (i.e., those that have been deemed “medically necessary”) and “extended health care services.” So-called medically necessary services are defined only in the broad sense of the term in the Act. Section 2 states that insured health services – which must be fully insured by provincial health care insurance plans – comprise:

- hospital services that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, including accommodation and meals, physician and nursing services, drugs and all medical and surgical equipment and supplies;
- any medically required services rendered by medical practitioners; and
- any medically or dentally required surgical-dental procedures which can only be properly carried out in a hospital.⁵⁸

⁵⁸ Parliamentary Information and Research Services, “The *Canada Health Act: Overview and Options*” *Current Issue Review* (94-4E) (May 16, 2005) [Parliament, “**Canada Health Act Overview**”] at 7-8.

693. In 1985, the then Federal Minister of Health, the Honourable Jake Epp, wrote a policy letter to the Provinces indicating that the Provinces had leeway in determining what is medically necessary or required:

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provincial of health services. [...]

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plan. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services. [...]

Within [certain] broad parameters [set out in the letter], provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.⁵⁹

694. Significantly, Minister Epp also stated as follows in his 1985 letter to the Provincial and Territorial Health Ministers:

I might also say that the Canada Health Act does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care alternatives.⁶⁰

695. This shows that even in 1985, right after the prohibition on extra billing and user fees were added to the *Canada Health Act*, that the Federal Government recognized that new approaches within the framework of a universal health care system would need to be taken to meet the health care needs of Canadians in the future.

696. In British Columbia, the public health care system pays for “benefits” as set out in the *Medicare Protection Act*.

⁵⁹ BC1003094 - Canada Health Act Interpretation - Letters from the Honourable Jake Epp and the Honourable Diane Marleau at 2.

⁶⁰ *Ibid.*

697. “Benefits” is defined as follows in the *Act*:

- (a) medically required services rendered by a medical practitioner who is enrolled under section 13, unless the services are determined under section 5 by the commission not to be benefits,
- (b) required services prescribed as benefits under section 51 and rendered by a health care practitioner who is enrolled under section 13, or
- (c) unless determined by the commission under section 5 not to be benefits, medically required services performed
 - (i) in an approved diagnostic facility, and
 - (ii) by or under the supervision of an enrolled medical practitioner who is acting
 - (A) on request of a person in a prescribed category of persons, or
 - (B) in accordance with protocols approved by the commission;

698. Under s. 5(1) of the *Act*, the Medical Services Commission has the power to

- (c) determine the services rendered by an enrolled medical practitioner, or performed in an approved diagnostic facility, that are not benefits under this *Act*;

[...]

- (j) determine whether a service is a benefit or whether any matter is related to the rendering of a benefit;

699. Section 51(1)a of the *Act* gives Cabinet the power to make regulations “specifying the services rendered by an enrolled health care practitioner that are benefits under this *Act*.”

700. “Health care practitioner” is defined in the *Act* as meaning:

- (...) a person entitled to practise as
 - (a) a chiropractor, a dentist, an optometrist or a podiatrist in British Columbia under an enactment, or
 - (b) a member of a health care profession or occupation that may be prescribed;

701. So, under the *Act*, the Government (either directly or through the Commission) has the power to determine what medical and other health care services are covered under the MSP.
702. There are differences between provinces regarding what is covered under their public health care program.
703. The 2005 Parliament of Canada paper describes the situation as follows:

Likewise, some people believe the criterion of comprehensiveness is not being observed in practice, because provinces do not necessarily cover the same basket of insured health services or medically required services. They also believe that cutting government expenditures could compromise this principle even further and that the process of de-insuring begun in recent years could lead to the balkanization of provincial health care insurance plans. Federal legislation defines only the major outline of insured services and leaves each province complete freedom to determine what services its public plan will provide. However, de-insurance emphasizes the gaps between provinces in their coverage of health services; these discrepancies are likely to become increasingly difficult to justify. Moreover, de-insurance with the sole purpose of reducing public health expenditures could ultimately undermine the criterion of free access, inasmuch as it has not been proved which services are or are not medically necessary. This raises the thorny problem of how to determine when a service is medically necessary. It could prove difficult to determine the limits of any list of medically necessary health services. Furthermore, it is hard to know how far the federal government can intervene in defining insured services, without encroaching on provincial jurisdiction. [Parliament, "Canada Health Act Overview", at 12]

704. The BC Government has used its "leeway" in delivering benefits to exclude what could be considered medically necessary services in order to save costs.
705. In addition to long wait lists for services that are covered by the public health care plan, the delisting or not listing of medical services as benefits under the *Act* is another way the Government rations public health care.

706. An example of how medical services are rationed by not including them under the public health care plan can be seen in the Pacific Centre for Reproductive Medicare (“PCRM”) case.⁶¹
707. As part of its medical series for women with high risk pregnancies, PCRM used specially trained Maternal Fetal Medicine doctors to perform diagnostic obstetrical ultrasound testing.
708. PCRM sought a license from the Commission in order to bill the cost of these ultrasounds to the Medical Services Plan.
709. The ultrasounds were clearly medically necessary for women with high risk pregnancies.
710. However, the Commission had restricted the granting of ultrasound licenses to accredited radiologists working in a facility that already is licensed, even though radiologists are not trained to perform and analyze ultrasounds for high risk pregnant women.
711. PCRM applied for judicial review of the Commission’s decision not to grant the license needed to permit PCRM to bill the MSP for this service, so as to enable high risk pregnant women to access this service in the public system.
712. The Court held that the application for judicial review was premature because the Commission offered to reconsider its decision not to give PCRM an ultrasound license.
713. As the Commission did not subsequently change its mind about denying the licence, the judicial review application is in the process of being rescheduled.
714. In the course of its reasons on the first judicial review application, the Court stated as follows:

The legislature has created an expert Commission to administer a complex scheme for the management of pre-paid medical insurance on which entitled “beneficiaries” rely. This is a significant part of the delivery of healthcare services in this Province. The Commission must not only attempt to meet the reasonable medical needs of beneficiaries, it must also ensure that the MSP is financially sustainable,

⁶¹ *Pacific Centre for Reproductive Medicine v. Medical Services Commission*, 2015 BCSC 53 [PCRM].

notwithstanding the multiple demands it faces on its resources. The Commission is an expert tribunal performing tasks assigned to it by the legislature on issues in which this Court is not expert. Nor does this Court have expertise or even evidence of the financial constraints to which the Commission is obliged by its governing statute to have regard... [PCRM at para 29]

715. Cost is obviously the major consideration. The ultrasound services was needed, but the Government wanted to restrict the amount of money it spends on ultrasounds in the public system, even though this was a much needed medical service.
716. Another example of rationing of medical services is eye exams.
717. Prior to November 2001, MSP covered one routine eye exam every two years.
718. In 2002, the routine eye exam was delisted as a benefit, which enabled the government to “save” \$6 million/year.⁶²
719. As a further example, in 2002, chiropractic and community-based physiotherapy were delisted in BC (for all but the poorest 20% of residents).
720. The Canadian Physiotherapy Association says delisting resulted in increased waiting times for other medical services.⁶³
721. A consulting report commissioned by the Canadian Chiropractic Association says that a similar delisting of chiropractic services in Ontario would result in a 7-14% increase in the number of patients visiting emergency departments and 1.3-2.6% increase in visits to family physicians in Ontario.⁶⁴
722. In other words, delisting services can lead to increased wait-times and cost pressures elsewhere in the system, because people go to the emergency rooms or family physicians

⁶² CSC00024745 - MSCommuniqué CMQ02-001.

⁶³ Deloitte Consulting Services, “Impact of delisting chiropractic services: Final report” (2004); Jennifer Dales, “Ontario Chiropractic Association, Delisting chiropractic and physiotherapy: False saving?” (January 18, 2005) CMAJ, Vol 172(2), at 166.

⁶⁴ *Ibid.*

for treatments they would have received through the delisted services, or suffer other effects of the condition.

723. Other examples of medical services that are not listed as benefits include dentistry, optometry, physiotherapy, and psychological assessment and therapy services, as well as out-of-hospital pharmaceutical drugs, despite all of these services being significant contributors to an individual's overall health and quality of life and often an integral part of the necessary treatment for a medical problem.
724. Also, the Province has for many years severely limited the number of MRIs available to the public through the public health care system.
725. In his examination for discovery, Tom Vincent, the Chair of the Medical Services Commission, was asked whether, in the opinion of the Commission, a beneficiary can pay to obtain an MRI from a private facility without the Act being breached, after a consultation with an enrolled specialist.
726. In response to this question, the Government advised as follows:

MRIs are not considered "benefits" under the Medicare Protection Act, and have not been since 17 October 1989, when the Commission made that determination by way of Minute 89-921, a copy of which is attached. MRIs are only funded publicly, pursuant to the global funding provided to health authorities, if they are delivered in a hospital. See s. 5.23 of Hospital Insurance Act Regulation, BC Reg 25/61.⁶⁵

727. Ms. Braidwood-Looney, a representative of the Ministry of Health and the Director of Diagnostic Services Strategy, was also asked about MRIs in her examination for discovery in this case.
728. She described how, unlike other diagnostic imaging or services, medically necessary MRIs are only paid for by the Government when they are provided in a hospital. If a patient chooses to obtain a medically necessary MRI outside of the hospital, because the wait list is too long, the patient is able (and indeed required) to pay for this. This is not a breach

⁶⁵ Letter from the Defendants - Responses to the requests made of Tom Vincent during his examination for discovery (August 13, 2014).

of the Act, even though this will lead to a faster diagnosis than is available to others who wait for MRIs in the public system.

729. Ms. Braidwood-Looney stated:

And for MRI and CT and PET, the funding model is – the funding is embedded in the health authority budgets because they're high-cost services and the others are quite relatively low-cost services. And that's -- that's the primary distinction for why...why it was set up in this way.⁶⁶

730. She further explained this as follows:

Q. Is there some funding rationale for that or is there some other rationale, or is it just some historical anomaly? Do you know?

A I think it's -- well, when MRI was invented, I wasn't -- I wasn't working on this file. My understanding is that embedding the advanced imaging services, PET, MRI and mostly CT, into the hospital sector only was because those were high-cost services that required greater oversight to make sure that the levels stayed sustainable.

Q. As compared to the lab services, blood work, sorts of diagnostic –

A. For lab and for ultrasound. I mean, it's fee-for-service and there is no cap on the available amount. And so there's no controls over volumes.

Q. Right. So part of the rationale was, this would be a way to control the volume, as you called it, the service, by not making it a fee-for-service funding model? And I'm talking about MRIs and CTs.

A. M'mm-hmm. I believe so.⁶⁷

731. The Government's documents confirm Ms. Braidwood's understanding that limiting the amount of MRIs in the public system is a way to control usage and hence costs.⁶⁸

732. In a 2000 policy paper on "Establishing Medically Required and Core Services" covered by the BC public health care plan, the BC Medical Association stated as follows:

Assessment/Implications

⁶⁶ Examination for Discovery of Tricia Braidwood-Looney (May 5, 2016).

⁶⁷ *Ibid.*

⁶⁸ BC4265205 - Ministry of Health Briefing Note, at 1; BC4413949 - Current State of MRI Services in BC and Recommendations for Change, at 4; BC5117895 - Information Request.

The debate over determining which services are medically necessary must be refocussed. The view of the National Forum is correct; creating a prioritized list of insured services on the basis of what is medically necessary is not feasible. On the other hand, the WHO assessment of “some for all, rather than all for some” represents today’s reality.

Defining core services must be approached from the perspective of providing universally accessible services, but not necessarily comprehensive services, within a limited amount of funding. In the fact of economic constraints, the public program should assess the benefit of treatments against the cost to Medicare. An explicit and transparent rationing approach must be developed.

There are numerous methodologies for defining and implementing core services:

1. Condition – by general diagnosis or treatment group
2. Service – by specific service to a particular person
3. Volume – limiting the number of procedure performed over a specific period of time to meet specific budgetary targets.
4. Utility – based on urgency/degree of dysfunction vs. potential benefit from treatment
5. Service provider – insure only those services delivered by specific health care provider

Each approach raises a different set of issues and difficulties and there is no simple solution. Ultimately, the choice of rationing methods must be determined by the public.⁶⁹

733. What is clear from this discussion is that there is no clear or evident rationale for which health care services are included as “benefits” under the Act, and thus covered by MSP, and which are not.
734. In most cases, the decision appears to be based not on whether the service in question is truly “medically necessary”, but simply whether the government is prepared to pay for it.

⁶⁹ CSC00024183 - British Columbia Medical Association, “Establishing ‘Medically Required’ and Core Services” (April 2000).

(v) Payment from the Public Plan for Medical Services Outside of the Province

735. Section 29 of the Act provides for the payment from the Province's public health care plan for medical services outside of the country, upon application by a beneficiary covered under the plan.
736. Minute of the Commission 11-011, regarding the Medical Services Commission Guidelines for payments for out of country, non-emergency elective surgeries states that:

The existence of a wait-list in BC or elsewhere in Canada will not be accepted as evidence that care is not available in BC or elsewhere in Canada. The existence of a wait-list will only be taken into account in considering whether delay in the provision of medical care available in BC or elsewhere in Canada can be shown to be immediately life-threatening or result in medically significant irreversible tissue damage.⁷⁰

737. A government document disclosed to the Plaintiffs in this case discusses the application of a British Columbia woman to have the plan pay for breast reconstruction outside of Canada.⁷¹
738. She had been waiting for over four years for this surgery in British Columbia.

739. The document states that:

[Patient Name] advised the [sic] her general practitioner told her that MSP will only pay for one breast reconstructions surgery per month, per plastic surgeon and this is why the wait time in BC is so long. It goes on to say that her plastic surgeon in BC had 219 patients waiting for breast reconstruction surgery and averaged 2-3 days of surgery per month.

740. The response to the application stated that:

- [the patient] should work with [her plastic surgeon's] office in regard to surgical priority
- Additionally [the patient] should work with her family physician to find a plastic surgeon in BC that can do the breast reconstruction surgery in a timely manner [...]

⁷⁰ BC2187197 - Medical Services Commission, "Minute of the Commission 11-011 - Revised Out of Province and Out of Country Medical Care Guidelines".

⁷¹ BC1022641 - MLA Ralph Sultan / [patient name] - Breast Reconstruction Surgery - Bullets required (Cliff 867898 x ref 867630, 866549 & 866552/MLA Log #23).

- In determining whether funding is appropriate for out of country medical care, MSP may consider whether treatment is recommended by the medical profession and Canada, and whether all avenues for treatment within the Canadian health care system have been exhausted. [...]
741. The document does not state when or even whether the patient received breast reconstruction surgery either in BC or elsewhere.
742. Another Ministry of Health Information Document prepared for the then Minister of Health George Abbott in 2005 states that:
- BC has the lowest reimbursement rates across Canada for out-of-country emergency in-patient hospital care and does not provide reimbursement of costs for outpatient services.⁷²
743. That 2005 Information Document also states that:
- Increasing reimbursement rates may result in fewer people buying private insurance, or reduce insurance company costs, thereby shifting cost to government...⁷³
744. In so far as emergency medical services for out-of-country medical services is concerned, this document indicates that the Government seems to favour private insurance over public coverage.

IV. THE CAUSES OF RATIONING IN THE PUBLIC HEALTH CARE SECTOR: EXPONENTIAL COST INCREASES AND UNSUSTAINABLE SPENDING

A. Overview

745. As discussed, the prohibitions in the *Act* are designed to ensure that anyone needing medically necessary services can only obtain those services through the public health care system, unless they have the wealth to avoid the restrictions by going outside the country for medical services.

⁷² BC2104205 - Ministry Of Health Information Briefing Document - Reimbursement of Out-of-Country Medical Expenses for British Columbia Residents, at 3-4.

⁷³ *Ibid.*

746. This is the case whether or not the public health care system can provide those medically necessary services in a timely manner, without subjecting those on waiting lists to undue pain, suffering, personal and financial consequences, and the risk of deteriorating health and loss of life.
747. In other words, outside of the statutory exemptions, it is an all or nothing proposition for most British Columbians: if you cannot get timely access to medically necessary services in the public system, there is no other option.
748. The problem for British Columbians is that the Government is simply unable to provide medically necessary treatment in a timely manner to those who need it through the public system.
749. The reasons for that inability are clear:
- A. Because the *Medicare Protection Act* is designed to ensure that the vast majority of medically necessary health spending is borne by the public health care system, any increases in the cost of providing medically necessary services must be paid for by the Government;
 - B. As a result of rising costs – due to demographic pressures, improvements in medical technology, and so on – the overall cost of providing medically necessary health care to everyone who needs it has been and will continue to increase exponentially;
 - C. In light of this increasing cost, the only way to avoid either a huge increase in taxation and/or having health care spending continue to crowd out all other necessary public services, is to reduce or cap public sector health care spending;
 - D. Therefore, the Government has put artificial and arbitrary caps on public health care spending, which do not reflect – and are not based on – the health

care needs of British Columbians or the actual cost of meeting those needs; and

- E. The only way to stay within these caps on public sector health care spending, in a manner consistent with the *Medicare Protection Act* and the *Canada Health Act*, is to ration medically necessary services.
750. It is this rationing of health care services in the public sector which has led to lengthy wait times, and the resulting serious negative health consequences for British Columbians, who are unable to access private health care treatment.
751. Or, to put it in simpler terms:
- By prohibiting private care, the Government has ensured that *all* demand for medically necessary procedures is channeled into the public health care system.
 - But the public system was not designed to, and cannot, handle all of the demand for medically necessary services across the entire population.
 - As such, the Government has been forced to control costs the only way possible: by rationing the supply of medically necessary services.
 - This has led to serious harm to many British Columbians, which are exacerbated by the restrictions on access to private health care.
 - The result is a denial of the constitutional right of British Columbians to decide for themselves how to best protect their bodily integrity.
752. I will address each of these points in turn.

B. Medicare Protection Act Funnels All Spending into the Public System

753. As just discussed in some detail, the public health care system in British Columbia is a closed system.

754. Access to medically necessary care outside that system is effectively prohibited, for all but the very wealthy, or for those in the privileged classes exempt from the restrictions.
755. As a result, almost all demand for medically necessary health services as defined by the Government is funneled into the public system, to be paid for exclusively by government revenues.
756. What this means is that whenever there is an increase in either the demand for, or the cost of, providing medically necessary health care, the *Medicare Protection Act* is designed to ensure that that entire increase is borne solely by the public purse.

C. **Health Care Costs Are Increasing Exponentially**

757. Funneling all increases in health care spending into this closed public system has led to large increases in government spending on health care over the past four decades, as mentioned above.⁷⁴
758. The drivers of these ever-increasing health care costs – in BC and everywhere else – are many and varied.
759. In particular, an aging population, high pharmaceutical costs, and more scientifically and technologically advanced medical treatment, have all proven incredibly and increasingly expensive.⁷⁵
760. At first, the Government’s response to these increased costs was to spend more money. Over the past two decades, it has devoted an ever-greater share of revenues to health care spending.

⁷⁴ BC2248954 - Actuals GRE Health function from requests for information following Examination for discovery of Gordon Cross; BC2248953 - GRE v. GDP from Gordon Cross.

⁷⁵ BC20110058 - FHA Memorandum discussing increasing demand within limited financial capability; BC2092712 - Ministry briefing note listing overview of challenges faces the ministry re ability to fund healthcare in the future.

761. Some indicators of these huge increases in health care spending – in both relative and absolute terms - over the past few decades are as follows:

- A. Overall health care spending in British Columbia has risen from \$994 million in 1975 to \$18.8 billion in 2012;⁷⁶
- B. Government spending on health care increased from \$8.8 billion in 2000 to \$15.1 billion in 2010;⁷⁷
- C. Recent spending increases have well outstripped inflation, at 6.4% in 2007/08, 3.0% in 2008/09, 5.7% in 2009/10, 4.9% in 2010/11, 6.3% in 2011/12;⁷⁸
- D. In 2001/02, about 33% of the budget was made up by health care costs. In 2013/14, that amount had increased to almost 42%;⁷⁹
- E. Spending by the Ministry of Health as a percentage of total consolidated government revenues has increased from 42.1% in 2008/09 to a projected 47.1% in 2015/16.⁸⁰
- F. According to the Ministry of Health, the amount actually spent in 2012/13 was \$16.2 billion, and is projected to rise to \$17.9 billion for 2016/2017.⁸¹

762. The reason health care spending has increased so much, as a proportion of government revenue, is that expenditures for the public health care system are greater than the growth in BC's economy.

763. This was expressly recognized in the Ministry of Health's 2012/13 Annual Service Plan Report:

Spending on health has steadily increased from 9.7 billion in 2001/02 to 15.9 billion in 2012/13, and is expected to keep growing. In fact, health spending is growing faster

⁷⁶ BC2043259 - Presentation re Budget Management, at 18; BC2138984 - Chart re Increasing Utilization Rates; BC2158602 - Presentation re Budget Management, at 99.6-8.n.

⁷⁷ BC5057125 - BCMA Report, "Charting the Course" (February 2, 2012) [BCMA, "**Charting the Course**"] at 4. BC2248954: Actuals GRE Health function from requests for information following Examination for discovery of Gordon Cross; BC2248953 GRE v. GDP from Gordon Cross.

⁷⁸ BC2245063 - Ministry of Health, *Setting Priorities for the B.C. Health System* (February 2014) [**Ministry of Health, Setting Priorities**] at 14.

⁷⁹ Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2015—Data Tables F.1.1.5" (Ottawa, ON: CIHI, 2015).

⁸⁰ Ministry of Health, *Setting Priorities*, at 14.

⁸¹ Ministry of Health Prima Facie Facts Document, at 53/379.

than the economy, and continued growth at this rate could affect funding for other important government services.⁸²

764. Despite these large increases in health care spending over the years, the BC Ministry of Health acknowledged in 2014 that while the number of patients on the BC surgical wait list has remained stable in recent years, the *amount of time* patients are waiting has increased significantly.⁸³
765. The Government has not been able to keep up with the rising costs to the extent necessary to ensure everyone in BC has access to medically necessary treatment within clinically appropriate times, as will be discussed in the next section.
766. It is important to emphasize that the cost pressures leading to the huge increases in the cost of providing medically necessary health care are getting worse in British Columbia, not better.
767. The costs of funding medically necessary health care will continue to increase, particularly in response to population trends.
768. It is well established that the vast majority of health care expenditures occur later in life.
769. Statistics from 2008 show that persons over 60, while making up less than 20% of the population, account for nearly half of all total health care expenditures.
770. The average cost per person aged 70 to 79 is \$7,950 per year, more than double that across the population. The average cost per person over age 80 was \$15,137, over five times the average cost across the population.⁸⁴
771. And these costs are set to skyrocket, because BC's population is aging rapidly.

⁸² CSC00019619 - BC Ministry of Health, "2012/13 Annual Service Plan Report" (June 2013) at 10.

⁸³ BC5110322 - "BC Perioperative Excellence, An Analysis of Surgical Volumes and Physical Operating room Inventory in BC" (Doc:) at 7/89.

⁸⁴ BCMA, "Charting the Course", at 4-5.

772. According to statistics from the BC Medical Association, BC's population is expected to grow at 1.2% a year, while its 80+ population is the single fastest growing segment of BC's population, increasing at 3.5% a year.
773. By 2036, people over age 65 will increase from 15% to 24% of total population, people over 80 will increase from 4.2% to 7.4% of the population, and the proportion of people between 18-64 will drop from 66% to 59% of the population.⁸⁵
774. Referring again to the 2010 OECD study of the provision of health care in Canada, the authors of that report observed:

As in other OECD countries, constraints [in Canada] are set to tighten further, both in the medium term, as an aging population requires substantially more services, while growth in the tax base to fund them slows, and technology goes on expanding possibilities for life extension and life quality....⁸⁶

775. Thus, the need for health care services is ever increasing, and so are the costs of providing these services.
776. As the Conference Board of Canada has found, the Government's planned 2.6% increase is not sufficient to maintain even *current* levels of health care for B.C. residents, let alone to improve the level of care to a constitutionally-acceptable level.
777. The Conference Board states as follows in its 2014 Report:

The Conference Board has developed demographically driven models for health care and education spending by province. For health care expenditures, a constant level of service is maintained in our projections. Thus, the model assesses future demand for health care by projecting real spending across age and gender cohorts. This allows not only for population growth, but also changes in demographic composition. We then combine these estimates with our projections for health inflation. Our projection for health care spending in B.C. suggests that health care will grow at an average pace of 4.3 per cent per year over the next three fiscal years just to keep pace with inflation and demographic change (see Chart 3). Additionally, if you add in another 0.5 per cent growth per year to account for new services or products, new drugs or innovations, or increased utilization – all factors that have driven growth over the last

⁸⁵ BCMA, "Charting the Course", at 2

⁸⁶ CSC00019663 - Organization for Economic Co-operation and Development, *OECD Economic Surveys: Canada 2010*, Vol 2010/14 (September 2010) [**OECD: Canada 2010**] at 106.

30 years – it is evident that health care will require significant efficiency gains or reforms to maintain service levels without substantial increases in spending.⁸⁷

778. And in its most recent report in March 2016, the Conference Board revised the data as follows:

The latest provincial budget indicates that the government plans to keep growth in health care expenditures below that of inflation and demographic pressures, which could be difficult. Health care spending will continue to compose the lion's share of total expenditures over the forecast period, and any spending overruns would hurt the province's bottom line. (...)

Overall, total program spending is set to rise by a tight 2 percent over the next three fiscal years...Achieving the targeted growth rate in expenditures will require significant cost-containment measures in all spending areas – particularly in health care, education, and social services. (...)

As noted in the February budget, spending on health care is set to rise by an annual average rate of 2.8 per cent over the next three fiscal years. The province will face a difficult task of capping spending at this rate given our projections for growing demand in health care. (...)

Our projection for health care spending in B.C. suggests that funding will need to grow at an average rate of 4 per cent per year over the next three fiscal years just to keep pace with inflation and demographic change. Additionally, if you add another 0.5 per cent growth per year to account for new services or products, new drugs or innovations, or increased utilization—all factors that have driven growth over the last 30 years—spending would need to grow by about 4.5 per cent per year to meet demand. With the budget projecting much slower growth in health spending, health care will be an area that will need efficiency gains or reforms to maintain service levels if spending growth is in line with budget estimates.⁸⁸

779. The Government is therefore in the position where current funding amounts are insufficient to meet health care needs, health care costs are increasing, demand for newer and more expensive procedures and treatments are increasing, the population is aging, and there is not enough room in the budget to meet everyone's medical needs in a timely manner.

⁸⁷ Conference Board of Canada, "British Columbia's Budget Back on Solid Ground if Cost Growth can be Contained" (August 6, 2014).

⁸⁸ Conference Board of Canada, "British Columbia Fiscal Snapshot March 2016" (March 2016) at 3, 7-8 (emphasis added).

780. All of this has created something of a perfect storm, with the costs of providing medically necessary services in the public system far outstripping the fiscal capability of the Government to provide those services in a timely way to all BC residents.

781. Jeffrey Simpson described the public health care situation across Canada as follows in his book *Chronic Condition*:

Health-care budgets have been rising, and will continue to rise, faster than the rate of inflation adjusted for population growth, faster than provincial government revenues or spending on any other program, faster than nominal economic growth (growth plus inflation). Since government revenues generally grow in tandem with nominal economic growth, if health care grows faster than nominal economic growth, government budgets will be pinched. Health care today consumes 42 to 45 percent of provincial program spending. If no change is made to the spending trajectory of health care, in two decades the share will be 55 to 65 percent. The wealthier a country becomes, the more its citizens want to spend money, either directly or through the state, on health care. Fine, except that in Canada we restrict severely what people can spend on themselves for essential medical care, and we are reluctant to pay more tax. We have boxed ourselves in. [Simpson, *Chronic Condition*, at 3-4]

782. These challenges to funding the public system are real, they are structural, and they are not going away.

783. The 2014 C.D. Howe Institute publication on Health Care and an Aging Population describes the situation facing British Columbia as follows:

British Columbia's Outlook: Trends and Implicit Liability

Our projections show British Columbia's health care spending rising from 7.6 percent of provincial GDP this year to 11 percent in 2035 and 15.7 percent in 2064. (...)

Most public discussion of health care and other programs emphasizes maintaining them – perhaps enhancing, but certainly not cutting – and does not contemplate higher taxes to pay for them. These political understandings create an implicit liability on the government's balance sheet, because meeting the commitment will require the government to tax a higher share of provincial income. (...)

In other worlds, to cover the additional 50-year cost of these programs, the province would need about \$400 billion in assets yielding income at the same rate as its long-term bonds. This figure is almost double provincial GDP, or about \$87,000 per British Columbian. (...)

Such an enormous funding gap, and its implication of a massive increase in provincial taxation, strengthens the case for continuing changes to the BC health care system.⁸⁹

784. While the Government has attempted to reform the system, it has been unable to do so.
785. This is admitted in a 2013 report by the Health Sector Planning and Innovation Division of the BC Ministry of Health as follows:

The health system is expensive, and it does not produce good outcomes. We cannot continue in this manner, and addressing it through separate initiatives does not produce system-wide success. In fact in BC it is the foundational components of the system that need to be addressed. Without fixing those, it is like moving deck chairs on the Titanic. You can put more money into the chairs, you can rebuild them, you can paint them, and you can add more. However, the ship will still sink. The health system's focus and legislative foundation have not changed to keep up with the changes in society and demand. Overall, we do not get good value for the care that is provided.⁹⁰

D. Reducing Health Care Spending

(i) Arbitrary Limits and Budgetary Caps

786. These exponential increases in health care costs – and as a result, public sector health care spending – have left the Government with difficult choices to make.
787. Because the *Act* effectively prohibits an infusion of private funds, it leaves the Government with three options, all of them poor.
788. First, it could increase revenue through more taxation. However, the huge increases in taxation necessary to keep pace with the exponential growth in health care costs would have a serious impact on the economy and on investment, and would be politically unpopular.
789. So the Government has not increased taxation to match the increase in necessary health care costs, but even if it tried, it could not continue to do so indefinitely, given that the

⁸⁹ CSC00023498 - W. Robson, C. Busby, & A. Jacobs, "Managing Healthcare for an Aging Population: Managing Slow-Growing Revenues and Rising Health Spending in British Columbia" (December 2014) at 5-6.

⁹⁰ BC5112656 - Health Sector Planning and Innovation Division of the BC Ministry of Health, "Report: Health System Governance and Issues in BC" (November 16, 2013).

cost of health care spending consistently continues to outpace inflation, GDP growth, and population growth.

790. Second, the Government could continue to cut the proportion of spending devoted to other important areas, such as education, the environment, infrastructure, and social services. In effect, it could let health care spending take up a larger and larger share of government revenues, and continue to crowd-out all other important government programs as a proportion of the budget. It has not done this, either.
791. Instead, the Government has chosen the third option; which is to cap or reduce the increases in health care *spending*, notwithstanding the fact that the *cost* of providing medically necessary health care services to British Columbians continues to grow.
792. In short, because the Government has not, and will not, dedicate the resources necessary to ensure that all medical needs are met (through increased taxation or increased crowding out), the Government has chosen the only other option available in a closed system with ever-increasing demand and ever-increasing costs: it has simply turned off the taps.
793. To this end, as stated before, the *Medicare Protection Act* was amended in 2008 to add a new Guiding Principle: “Sustainability”.
794. The new section 5.7 reads as follows:

Sustainability

5.7 The plan is administered in a manner that is sustainable over the long term, providing for the health needs of the residents of British Columbia and assuring that annual health expenditures are within taxpayers' ability to pay without compromising the ability of the government to meet the health needs and other needs of current and future generations.

795. This provision expressly recognizes and acknowledges the financial constraints on the ability of the public health care system to meet the medically necessary needs of BC residents.

796. As the then Finance Minister, Colin Hansen stated in the 2010 budget fiscal plan:

If health care continues to grow at the current pace, it will increasingly crowd out expenditures in other areas.⁹¹

797. The Government has made sustainability a top priority moving forward, both generally and with respect to health spending particularly.

798. For example, in her 2013 letter to the Honourable Terry Lake, congratulating him on his appointment as Health Minister, the Premier talked about “charting a course for a debt-free B.C”, and stressed the importance to grow “our economy and create high paying jobs for British Columbians”.⁹²

799. In particular, the Premier asked the Minister “to keep your ministry focused on the *BC Jobs Plan*” – a strange focus for the Minister of Health.

800. In order to achieve the objective of budgetary sustainability, the Ministry of Finance allocates the Ministry of Health a global budget amount, as set out in the following graph.



⁹¹ Ministry of Finance, *BC Budget and Fiscal Plan – 2010/11 to 2012/13*, at 25.

⁹² See Ministry of Health, *Setting Priorities*, Appendix A, at 40-42.

801. As can be seen from the graph, the Ministry of Health's funding allocation has been capped at 38% of the Province's revenues for each fiscal year since 2010/11.
802. This amount of spending by the Ministry of Finance will not increase in the near term.⁹³
803. Therefore, if revenues do not grow faster than health care costs, the shortfall between the funds made available and the funds needed to provide everyone with medically necessary treatment must grow ever larger.
804. The Ministry of Finance does not consider whether the amount is sufficient to meet the projected needs of all British Columbians.
805. The Government is focused on sustainability, i.e. what the Government can afford to pay.
806. It does not matter to the Ministry of Finance if funding levels only allow the Ministry of Health to – at best – sustain a system that fails to meet the health care needs of British Columbians, and causes many them to suffer unnecessarily.
807. The goal is to make the system sustainable.
808. In other words, the budget for health care has been set on the basis of what the Government believes *it can afford to spend* on health care, and not on *what is necessary* to provide all British Columbians with timely and appropriate health care services under the public health care plan.
809. And, once the global budget is set, trying to provide medically necessary services within those arbitrarily fixed constraints becomes the problem of the Ministry of Health, which allocates payments to doctors and to the Health Authorities who manage the hospital expenditures.

⁹³ CSC00023670 - B.C. Budget and Fiscal Plan 2016/17 to 2018/19, at 17, 83.

810. This is a big problem for access to timely health care, because the funding provided to the Ministry of Health is not in any way tied to the amount it needs to provide medically necessary health care services to BC residents in a timely way.
811. It is tied to how much the Government has been willing to pay, which is arbitrarily capped, as noted above (e.g. at 38% of the Province's revenues since 2010, or by capping yearly increases to approximately 2.5%, well below previous increases).
812. The Ministry of Health must make do with the amount that the Ministry of Finance allocates to it, and so in turn the Health Authorities must make do with the amount of money they are allocated from the Ministry of Health's budget.
813. The Ministry of Health prepares a budget that allocates its funding to the public bodies that actually provide health care to patients, including the Medical Services Plan, PharmaCare, and the Regional Health Authorities.⁹⁴
814. There are a number of ways the Ministry of Health can cut or control spending.
815. For instance, the *Act* places express restrictions on the total amount that MSC may pay practitioners for providing benefits.
816. Under s. 25 of the *Act*, the MSC is required to limit its spending on physician services to the amount provided by the Government each fiscal year:

25 (1) The commission may set the available amount for a category that may be paid under all payment schedules to practitioners in the category for rendering benefits under this Act in the fiscal year specified by the commission.

(2) The total amount that may be paid by the commission to all practitioners in a category for rendering benefits under this Act in a fiscal year must not be greater than the available amount for the fiscal year.

⁹⁴ BC2044107 - Email from Ministry stating that the ministry has the final say in funding allocation.

817. The key way that the Government controls health care costs is by limiting the amount of funding provided to Health Authorities, who in turn meet these budgetary controls by limiting the provision of services, i.e. rationing medically necessary health care.

(vi) Cutting Costs Through Health Authorities

818. Just as the Government has downloaded its inability to afford the increases in medically necessary health care costs to the Ministry of Health, the Ministry of Health has in turn downloaded those problems onto the Health Authorities.
819. Under the *Hospital Insurance Act*, the Government provides the Health Authorities with an amount of money for hospital services, which cannot be exceeded by the Health Authorities.
820. Funding for regional Health Authorities is rationed using a method called "Population Needs-Based Funding" ("PBNF").⁹⁵
821. PBNF takes into account population demographics, service utilization, inter-regional migration, and regional cost factors to determine funding allocations.
822. The PBNF model assigns every British Columbian into one of 13 health status groups, with each different group tied to an anticipated level of need and health care utilization. This provides a rationale for different levels of funding for members of each group.
823. But the term "Needs Based Funding" is misleading.
824. That is because that the PBNF model is used to allocate a pre-determined pool of available operating funds among the regional health authorities.
825. The PBNF model does not determine the amount of the Ministry's operating budget or the amount of total operating funds available for the allocation to the regional health authorities.

⁹⁵ BC5090346: 2013.08.02 - Fact Sheet re Population Needs-Based Funding.

826. Nor does it ensure that the Ministry of Health has sufficient funding to meet the health care needs of British Columbians across the Health Authorities, as noted above.
827. The PBNF model also does not specify how health authorities are to use the funding allocated via the PBNF model.⁹⁶
828. Thus, the amount of funding that a Health Authority receives is not tied to what is necessary to provide medically necessary health care services to its community of patients.
829. Rather, the PBNF is used to determine how to ration the Ministry of Health's funding allotment fairly as *between* the Health Authorities.
830. Thus, just as the Ministry of Health must make do with the amount granted to it by the Ministry of Finance, the Health Authorities must make do with the amount granted to them by the Ministry of Health.
831. That is where a second level of rationing occurs.
832. Because the Health Authorities are not allocated enough money to meet their constituents' medically necessary needs, they have done the only thing possible to keep spending within the fixed limits: they have reduced or limited the provision of medically necessary services.
833. For this reason, Health Authorities have expressed significant challenges in balancing their operating budgets.
834. For instance, in 2007, Vancouver Coastal Health faced a budget shortfall of \$35 million for the upcoming fiscal year, despite budgeted efficiency and cost savings of \$47 million and budgeted revenue increases.

⁹⁶ : BC4051957 - Future Directions for Surgical Services in British Columbia 2015, at 35/58.

835. Vancouver Coastal Health noted that there was significant risk that the actual deficit could be larger than \$35 million, if budgeted efficiency and costs savings were not realized. The Health Authority indicated this deficit may rise in 2010/11 to \$72 million.
836. The Ministry's position on Vancouver Coastal Health's deficit crisis was that it was expected to balance its budget,⁹⁷ i.e., to make do with what it was given, regardless of whether this amount was sufficient to provide its constituents with medically necessary health care in a timely way.
837. The Northern Health Authority faced the same problems – it advised the Ministry that funding for 2008/09 was not sufficient to maintain current levels of activity and that balancing the budget in 2009/10 to 2010/11 would necessitate very difficult service reductions.
838. Northern Health noted that much of the Region's physical plant was old, in poor condition, not designed for current program accommodation needs, and did not hold up to current design standards.⁹⁸
839. Northern Health advised that, in order to balance budget, it would have to realize the following expenditure *reductions* over three year period: \$4.7 million of efficiency gains, \$3.5 million through changes in service delivery, and \$14.9 million through service reductions.⁹⁹
840. The Ministry responded that the service reductions may not be acceptable, that Northern Health was not meeting accessibility standards for emergency and acute/inpatient services in a number of communities, and that the Health Authority would not be able to meet the targets for hip/knee targets.¹⁰⁰

⁹⁷ BC2161282: 2007.10.13 - Advice to Minister Health Authority Service Plans Posted.

⁹⁸ BC2161272: 2008.04.28 - Advice to Minister Draft Service Plan Northern Health Authority; BC5006151: 2008.04.22 - Ministry of Health Information Briefing Document, Title: Summary of Northern Health Authority 2008/09 Service Plan, Cliff # 722657.

⁹⁹ BC5006163: 2008.04.23 - Briefing Note - Minister Summary HASPs.

¹⁰⁰ *Ibid.*

841. The cost containment strategy has caused other problems. As the Northern Health Authority noted, health human resources was already major issue for this region but some of the cost-cutting planned would further exacerbate the staff recruitment and retention situation.¹⁰¹
842. In other words, instead of *increasing* spending and providing *more* treatments, as would be required to meet health care needs in a timely way, the health authorities like Northern Health and Vancouver Coastal Health have been forced to *reduce* treatment to stay within their budgets.
843. Other Health Authorities are facing the same problems, and providing the same “solution”: rationing.
844. In the Interior Health Authority, despite a more than 20% increase in funding over three years, rising costs, increasing demand, and a growing and aging population required cutting costs across program areas.
845. In 2008/2009, the Interior Health Authority surgery program budget was exceeded by \$2-3 million. Due to increasing costs, the surgical department was forced to find savings.
846. Interior Health achieved these cost savings by closing down ORs resulting in a 48% increase above the “normal” closures.
847. And in responding to its own service reductions, the Vancouver Island Health Authority publicly stated:

We recognize this will impact on patients, physicians, and staff – but this is not the first time surgical activity has been reduced – in the past health authorities have used Reduced Activity Days (RAD) to manage budget pressures and this is no different).¹⁰²

¹⁰¹ *Ibid.*

¹⁰² BC5013828: 2010.02.05- VIHA Elective Surgery Reductions.

848. In 2007, the Fraser Health Authority (the fast-growing health authority in BC) stated it had a \$65 million budget shortfall in March. By October, it had managed to reduce this deficit to \$20 million.¹⁰³
849. Two years later, in October 2009, Fraser Health stated it was experiencing substantial growth in demands for services and unprecedented financial challenges due to unavoidable cost pressures. Fraser Health noted that while the Province was increasing funding for health care in this year to record levels, Fraser Health was facing budget shortfalls of up to \$160 million.¹⁰⁴
850. In 2009, after the health authorities expressed such concerns, the Ministry mandated that each health authority manage within their budget for the 2009/10 fiscal year, and requested and received mitigation strategies from the health authorities.¹⁰⁵
851. As an example of the strategies proposed, VCHA proposed a reduction of 4,700 elective OR cases (in addition to closing an emergency shelter, maternity ward/NICU at SPH, ICU at MSJ and an abortion clinic).¹⁰⁶
852. In July 2009, then Health Minister Kevin Falcon sent a letter to the Board Chairs of each of BC's health authorities,¹⁰⁷ stating:

When I was first elected to government, health care spending consumed 40 percent of our overall budget. Today that figure stands at 45 percent and could be as high as 85 percent in just over a decade if we continue on the path we are on today. By 2011, total provincial spending on health care will rise to \$17.5 billion, an 87 percent increase since 2001. In fact, over the next three years, 90 percent of all new government spending will go to health care. At the same time, your budgets as health authorities will grow by 20 percent in the same time period.

Despite unprecedented investments, we know as our population ages and grows, the demands on our health care system continue to escalate. We identified those demands in our budget in February as follows: "Health authorities and hospital

¹⁰³ BC2161282: 2007.10.13 - Advice to Minister Health Authority Service Plans Posted.

¹⁰⁴ BC2132852: 2009.10.09- Confidential Issues Note Ambulatory Care Reductions.

¹⁰⁵ BC2147641: 2009.05.14 - Information Briefing Document, Cliff # 783023 - Review of Vancouver Coastal Health Authority 2009/10 Operational Plan.

¹⁰⁶ BC2147641: 2009.05.14 - Information Briefing Document, Cliff # 783023 - Review of Vancouver Coastal Health Authority 2009/10 Operational Plan.

¹⁰⁷ BC2132959 - Budget newsletter items, at 3-4.

societies have identified annual spending pressures of approximately 3.5 percent of the provincial funding provided to health organizations. The Ministry of Health Services will continue to work with the health authorities to manage these spending pressures." As you are well aware, those pressures amount to roughly \$360 million in 2009/10, representing 3.5 percent of the over \$11 billion dollars you will spend this year delivering high quality patient care. We expect a large portion of those savings will be found by cutting your administration and overhead costs and accelerating shared services activities such as joint purchasing and procurement. **You will also face some tough choices in the year ahead to live within your means.**

In recent days, I have talked to many of you about the challenges you face in meeting the expectations of patients and families who turn to you for care in some of the most vulnerable moments of their lives. We are confident you will manage your budgets in a way that is thoughtful and protects the priority patient services British Columbians rely on. That will undoubtedly mean being leaner, digging deeper and embracing more innovative ways of delivering care that ensures the best outcomes for patients. In these difficult economic times the 20 percent increase in your budgets over the next three years is a substantial investment that represents our strong commitment to protecting and preserving our health care system. **In that context, it is my expectation health authorities will both live within their means and set our health care system on a path to a sustainable future.** I encourage you to embrace that challenge and work with me and with our many health care partners to ensure our world-class health care system is there for future generations.

853. These fiscal problems did not end in 2009.

854. In 2013, the Ministry of Health reviewed the status of each Health Authority.¹⁰⁸ The summary was bleak, stating as follows:

- Fraser Health Authority, with a population of 1.7 million people projected a \$43.8 million deficit for fiscal year 2013/14. The deficit was projected to increase in the out years. The budget challenges were a result of wage increases, increasing demands for services, facing holdbacks for not meeting Ministry targets, and attempting to sustain services improvements. Fraser Health had proposed strategies to address the deficit which the Ministry determined to be "high risk" including reduce services, adjust a number of facilities' capacity, and hours of operations (both acute and community), and potentially close a facility.
- Interior Health Authority, with a population of 750,000, projected a balanced budget, but identified \$11 million in "unspecified savings" needed to balance, and indicated that it may be further challenged to balance its budget in the out years. The budget challenges were a result of wage increases, increasing demand for services, and facing holdback for not meeting Ministry targets. Interior Health proposed strategies to

¹⁰⁸ BC2158657 - Report on Health Authorities (July 2013).

address the challenges which the Ministry determined to be “high risk” including the reduction of services, shutting down centres, and limit the hours at other centres.

- Vancouver Coastal Health Authority, with a population of 1.7 million people, projected a deficit of \$26-30 million. The deficit was projected to increase in the out years. The budget challenges were a result of wage increases, increasing demand for services, facing holdbacks for failing to meet Ministry targets, a reduction in VCHA’s annual funding allocation of \$55.7 Million to off-set funding to support the Cerner project (electronic health records) and attempting to sustain service volumes previously funded through HSPO one time funding initiatives (ie. oncology surgery).

855. The problems have continued.

856. In 2014, the Minister initiated a strategic and operational review of FHA to address ongoing service and fiscal challenges in the Health Authority.

857. Due to Fraser Health Authority’s projected deficit, and inability to meet its budget for three years in a row, the Ministry of Health ordered a review of the Fraser Health Authority.

858. Minister Lake said that if the review determines the authority needs more funding, the difference would have to come from core ministry operations, as the Ministry is expected to meet its budget:

The cost of health care can’t outpace the growth we see in our economy...We’ve been very clear that we need to bend the cost curve down on increases in health because it’s simply not sustainable.¹⁰⁹

859. As these examples show, a primary means used by the Health Authorities to keep spending within their budgetary parameters is to reduce services.

860. The aggregate numbers tell the same story: as a result of insufficient funding, health care providers have been forced to ration services.

861. The Province has stated that 82% of its main ORs are “regularly staffed”, meaning the ORs are staffed between 8 am and 4 pm. Funding was cited as the most common reason by

¹⁰⁹ CSC00024133 - B.C. government orders review of Fraser Health Authority (11/02/2013).

hospitals for unstaffed ORs.¹¹⁰ For example, Fraser Health Authority only has 77% of its ORs regularly staffed primarily due to funding limitations.¹¹¹

862. The Canadian Institute of Health Information (“CIHI”) completed a project that measured OR utilization rates across Canada. While an OR utilization rate of approximately 85% is considered optimal, CIHI found that BC’s rate was 54%.¹¹²
863. By limiting access to the ORs, the Health Authorities and the Province are able to control health care costs – they do not have to pay physician fees, nurse fees, facility costs, etc.
864. But these service reductions necessarily increase wait times for medically necessary services, with all of the severe health and personal consequences that flow from that.
865. In fact, operating room closures and reductions in surgeries are an especially effective way for the Government to control costs because the reductions have a cascading impact on other parts of the health care system, such as MSP.
866. Unlike the Health Authorities, the Commission does not have the discretion to close doctor's offices or reduce the volume of services in order to ration care. The Commission's primary method of cutting costs is by limiting the scope of services that are deemed benefits and therefor payable by MSP, and by limiting the amount it will pay for particular benefits.¹¹³
867. MSP spending is reduced when there are surgery reductions because physicians bill MSP for their services in performing each surgery. If the surgeries are not performed, MSP does not have to pay for those services.

¹¹⁰ BC5110322 - BC Perioperative Excellence, An Analysis of Surgical Volumes and Physical Operating room Inventory in BC, at 56/89.

¹¹¹ BC5111468: 2014.06.04 - Briefing Note re FHA Surgical Services, at 1/4.

¹¹² BC5106974:2014.04.29 – CIHI OR Utilization Project, at 18/27; BC5145236 - CIHI OR Utilization Project Presentation.

¹¹³ BC5117895 - Information Request for Terry Lake re MRI not covered by MSP.

868. In 2009/2010, for instance, MSP was projected to reduce its physician billing cost by 5,200 reduced surgeries at Fraser Health Authority, 1,643 reduced surgeries at Interior Health Authority, and 1,310 reduced surgeries at Vancouver Island Health Authority.¹¹⁴
869. Thus, in addition to the direct costs cut at these Health Authorities, a total of 8,153 surgeries that ought to have been billed to MSP were not performed and so not billed, cutting many millions of dollars from MSP's expenses.
870. As Harry Hitchman, Director of Health Authority Funding for VCHA and FHA, has stated: "I find it a very strange business model that [Health Authorities] have little or no information or control over physicians services and costs, and yet physicians are a major provider of services within each [Health Authority], and a significant driver of [Health Authorities'] costs."¹¹⁵
871. In government documents disclosed in this litigation, various plans to save money are discussed.
872. The Ministry of Health exerts immense pressure on Health Authorities to balance their operating budgets within the funding allocations they receive from the Ministry.
873. Because these allocations are often insufficient to sustain even the *same* level of services, much less the *higher* level of services required to meet the health care needs of BC residents, Health Authorities are caught in a vice, with no realistic option other than to reduce services in order to try and contain costs.¹¹⁶
874. The Government is not blind to the fact that its insufficient funding allocations leads to the rationing of services, and therefore to failing to provide timely medical treatment to those who need it.
875. One Government presentation, called "Health Sector Budget Management Strategies and Implications", states the objective of "flattening the rate of increasing share of

¹¹⁴ BC2208984 - Email chain re MSP Projections 2009/10.

¹¹⁵ *Ibid.*

¹¹⁶ BC2178129: 2009.09.29 - Re Deficit Mitigation and Services Reduction.

government spending". The presentation discusses the difficulty in meeting this objective in light of cost pressures mentioned above, including inflation, population growth, demographics, technological change, and pharmaceutical costs.¹¹⁷

876. The presentation also outlines the budgetary cutbacks required to meet the Government's fiscal priorities, and states under the heading "Implications" that these cut back are "(n)ot a problem this year but budget increases in out years will not meet growth in demand for physician services – will require trade-off with Health Authority budget increases that will cause tension across system between doctors and health authorities."
877. The presentation also states that while health authorities have become accustomed to close to 5.0% funding increases a year, they will be required to "balance their budgets based on lower growth targets". As such, the "increased demand for services, aging populations, increasing expectations, rising costs must be absorbed and managed".
878. In other words, the question the Government asks itself is not "how much is needed to meet everyone's health care needs in a timely way?", but rather, "how much can we afford to spend?"
879. To this end, it lists the priorities for each Health Authority in the province, which includes a range of measures to ration available services, or "capacity reductions":
 - "Changing hours of [Interior Health Authority] operation from 24/7 to reduced levels, e.g. reviewing ED services in Kaslo, New Denver, Sparwood facilities from 24/7 to 8:00 am to 4:00pm Mon-Fri"
 - Capacity reductions [for the Fraser Health Authority], including a 20 bed reduction at its Highland Lodge mental health residential care facility, elected OR reductions at 3 sites (Langley, Eagle Ridge, Delta), reduced ambulatory care capacity across all cities"
 - "Capacity reductions [for the Vancouver Coastal Health Authority]: reduce 6 rehabilitation beds at GF strong; reduction in services provided by Cardiac Services BC, vision screening from 3 yr olds to 5 yr olds"; and

¹¹⁷ BC2158602: 2013.07 - Presentation re Budget Management.

- “Capacity reductions [for the Vancouver Island Health Authority]: closing 11 residential care beds in Victoria; reducing home support hours by 200 hours across VIHA”
880. The presentation concludes by noting that investment in hospital projects is important, but “We can’t afford to pay for everything at once” and “Expectations for Projects need balancing with fiscal realities”.
881. Therefore, as can be seen, rationing care through capacity reductions is not aberrant or exceptional – it is a key part of the strategy to control spending costs.
882. In 2010, the Government also considered a plan to generate revenue by providing health services on a for-profit basis to non-beneficiaries (e.g. out of country patients).¹¹⁸ The report titled “Medical Tourism in British Columbia”, concludes that “it is unlikely that BC would be competitive in the global medical tourism market”.
883. Notably, the report identifies physicians and medical imaging equipment as components of the health system with “excess capacity” in BC, while shortages exist in hospital human resources and inpatient beds.
884. These excess capacities and shortages can be seen as two sides of same coin – they are both results of rationed care caused by insufficient funding.
885. The management of surgical operating rooms is further evidence of rationing in BC.
886. In an article in the BC Medical Journal, Dr. Hamish Huang reports that “[o]perating days per month per full time-equivalent surgeon significantly decreased from 5.6 days in 1992 to 4.6 days in 2012.”¹¹⁹
887. The summary of Dr. Huang’s findings include the following:

Results: Questionnaires completed by 75 respondents indicate there were 141 general surgeons practising in BC in 1992 and 158 in 2012. BC is thus 74 surgeons short of meeting the Canadian average, with a further 28 surgeons needed by 2022.

¹¹⁸ BC2086622: 2010.11.24 - Report re Medical Tourism in British Columbia.

¹¹⁹ H. Huang, “Dividing the pie into smaller slices: A qualitative and quantitative analysis of the general surgery workforce in British Columbia, 1992–2012” (2013) 55 BC Med J 26.

A significant majority of respondents (65%) described an immediate need to recruit but an inability to do so because of insufficient hospital resources. Operating days per month per full-time-equivalent surgeon significantly decreased from 5.6 days (95% CI, 5.2–5.9) in 1992 to 4.6 days (95% CI, 4.3–5.0) in 2012 ($P=.011$). Wait times increased by 54% between 1992 and 2012; this meant an increase from 2.8 months (95% CI, 2.2–3.3) to 3.8 months (95% CI, 3.5–4.1) for cholecystectomy, 3.5 months (95% CI, 2.8–3.9) to 4.5 months (95% CI, 4.2–4.7) for inguinal hernia, 1.3 months (95% CI, 0.6–1.9) to 2.3 months (95% CI, 2.1–2.6) for bowel resection, and 3.0 months (95% CI, 0.7–3.7) to 5.2 months (95% CI, 5.0–5.5) for colonoscopy. The majority of respondent comments expressed frustration with lack of resources, increased workload, increased volume of cancer cases, more bureaucracy, and longer wait times. [emphasis added]

888. In large part, it is the “insufficient hospital resources” – i.e. the lack of public sector funding – that is leading to lengthy delays in treatment.
889. In *Chronic Condition*, Jeffrey Simpson describes a similar situation occurring across Canada:

There is an evident problem across Canada with the way operating rooms are used. On the one hand, there is large unmet demand for surgeries, witness to which are the long wait times; on the other, there is large unused capacity, witness to which are the yawning hours when the operating rooms are idle. When unmet demand meets unused supply, something ought to be done to match better available supply to evident demand. First-year economics textbooks instruct undergraduates on available solutions to this matching challenge. Within the Canadian health-care system, however, this matching does not happen enough – to the frustration of patients and surgeons alike – because the system does not allow for the kind of market economics found in the textbooks. It relies instead on making hospitals work within global budgets, regardless of demand. As a consequence, the Canadian health-care system, by international comparative studies, has the longest wait times among Western industrialized countries.

The Ottawa General has one hundred operating rooms. Four of them are kept open twenty-four hours a day, seven days a week, for emergency surgeries. Sometimes these four are not all needed; nonetheless, they are prudently kept available. The other ninety-six operating rooms open... at 8 am and close at 4 or 5 p.m., unless a particular surgery runs late. The ninety-six are closed Saturdays and Sundays. By cheeky contrast, Walmart is open from 7 a.m. to 11 p.m., seven days a week. Banks that decades ago opened at 10 a.m. and closed at 3 p.m., Monday to Friday, now offer seven-day-a-week service at some branches from 9 a.m. to 5 p.m.

Do the math. Twenty-four hours a day for seven days means 168 hours. Since there are one hundred ORs, that means 16,800 available hours, theoretically, for surgeries. But since only four ORs are open 24/7 and the other ninety-six for only nine hours a

day, five days a week, that means actual use of the OR rooms amounts to 4992 hours, or slightly less than one-third of the time.

Nobody suggests 24 hour a day use. There wouldn't be enough staff, even if there were enough money. Suppose, for the sake of argument, however, that the ORs could be kept open on weekends for nine hours per day. Very few patients would object to an operation on Saturday or Sunday as opposed to Wednesday if it meant a shorter wait. Ninety-six rooms kept open nine hours a day for two days would mean another 1728 hours of operating time. Too much? How about three more hours a day, then, for five days a week for half of the rooms, or 720 total hours?

Play with the numbers any way you want. The point is simply that unmet demand is not meeting unused capacity when so many rooms remain idle for so long. There are ways of dealing with this chronic problem, but the Canadian system forbids some of them, such as deploying any unused operating-room time for patients willing to pay privately. Governments are very tentatively finding the courage to try what other health-care systems have implemented, such as letting money follow patients, thereby creating incentives for hospitals to do more procedures. Nor can they break union rules that make surgeries happen to fit the convenience of providers instead of patients, an endemic problem everywhere in the Canadian system. A system that boasts brilliant surgeons.... accomplished staff, wonderfully furnished facilities but uses them only a fraction of the available time in the face of unmet demand is a system straitjacketed by ideology. [Simpson, *Chronic Condition*, at 40-41]

890. A recent report from the Royal College of Physicians and Surgeons of Canada (Frechette, 2013) has shown that government funding reductions have led to restricted access to a range of surgical resources, including hospital beds, operating room time, surgical nursing and the availability of post-operative treatment.¹²⁰
891. This leaves doctors to compete with each other for scarce operating room resources for their patients in the public system.¹²¹
892. The problem, therefore, is not a lack of doctors, or mere inefficiencies. The problem is a lack of funding to allow all medically required services to be provided within clinically reasonable time frames in the public system.

¹²⁰ Expert Report of John McGurran, dated March 17, 2014, at 16, citing Frechette, D., D. Hollenberg, A. Shrichand, C. Jacob & I. Datta (2013), "What's really behind Canada's unemployed specialists? Too many, too few doctors? Findings from the Royal College's employment study" the Royal College of Physicians and Surgeons of Canada, Ottawa.

¹²¹ Expert Report of John McGurran, dated March 17, 2014, at 16.

893. In short, the amounts allocated to the Ministry of Health – and, in turn, the Health Authorities and other medical service providers – have not been sufficient to provide timely hospital services for all British Columbians.
894. The undeniable fact is that without a massive increase in spending, health care services must necessarily be rationed in the public system to make the system affordable and sustainable.¹²² And that is exactly what is occurring.
895. This is confirmed by a review of the Plaintiffs' evidence from doctors forced to navigate a system that is based on fixed budgets and the rationing of care.

(ii) Plaintiffs' Evidence Regarding Rationing of Care

Dr. Les Vertesi

896. Dr. Les Vertesi is an emergency physician with about 40 years of continuous clinical experience, mostly at a large trauma and referral hospital in New Westminster. Dr. Vertesi has worked in a number of management roles in hospitals, including 13 years as department head and another 3 years as Medical Director. He has witnessed the effect that spending limits can have on the provision of necessary medical services.
897. Dr. Vertesi describes the situation in his practice area, and notes that the waiting times for medically necessary procedures – even for serious cases – tend to result from rationing the supply of those services. In turn, these long wait times create further systemic problems as patients who have waited too long are required to resort to treatment in hospital emergency rooms:

The constraint here is not just a surgeon and operating time, but also available hospital beds which involves a higher cost. (Actually the two streams (daycare and inpatient care) are not independent because inpatient care uses the lion's share of operating capacity and can deplete the time available for same day care as well).
Canada starts off with a relatively low bed base per population (2nd lowest only behind Mexico according to OECD) however a lean bed base is not necessarily all bad if care can be shifted to out-of-hospital locations.

¹²² BC2178129: 2009.09.29 - Re Deficit Mitigation and Services Reduction; BC2210101: 2010.06.11 Re Case Volumes.

But the problem is this: the proportion of hospital beds in British Columbia used for planned admissions (i.e. for people waiting) is lower than in any other Canadian province and dropping more quickly. And for the same reason, the use of beds for unplanned admissions through Emergency is higher than in any other province, because patients that deteriorate have nowhere else to go. This is a problem I wrote to the minister about last December. Aside from the added risk and discomfort this creates for patients, admissions through Emergency stay longer because they are generally more ill, but they also come in on weekends or get admitted under doctors who don't know them, all of which contributes to higher cost and increased hospital congestion. The cycle is difficult to stop because limiting planned admissions is the easiest way for a hospital to meet a fixed annual budget (trying to limit Emergency admissions has not been terribly successful). The resulting increasing length of stay and rising costs are often assumed to be signs of poor performance because the change in patient mix is not usually tracked or noticed.

My point is that this is an existing cycle that is measurable and quite aside from the effect on patient experience, is a rising trend that continues to add millions to our costs of health care.¹²³

898. As discussed by Dr. Vertesi in his expert report, the increase in admissions to hospital through emergency departments is making the wait times for surgeries for some patients even worse by reducing the number of planned surgeries that can be conducted as scheduled.
899. As discussed in the next section, these reductions lead to real world costs for those affected.

The Experiences of Other Doctors

900. Other doctors, who practice across a range of areas, have witnessed the effect of spending limits on the supply of services, and how this has required rationing of medically necessary treatment.
901. In this case, specialists (including ophthalmologists, dermatologists, and neurosurgeons) as well as family physicians, will explain that their patients suffer considerably as a result of rationing.

¹²³ Response Report of Dr. Les Vertesi, dated July 15, 2014, at 7.

902. One of the ophthalmologists testifying in this case will explain how he is only allotted one and half days per week of operating time for procedures such as cataract surgery.
903. There simply is not enough funding to meet the need for cataract surgeries.
904. As a result, the waitlists to see ophthalmologists such as himself are six to twelve weeks for a consultation, over a year for surgery of the first eye, and over a year after that for surgery on the second eye.
905. As he will explain, cataracts are a progressive disease, and complications may arise while patients wait for operating room time to open up. Patients experience increasing social isolation and loneliness.
906. These wait times are only getting worse, as health care spending fails to keep up with demands caused by an aging population, and population growth generally.

RebalanceMD

907. Even where efficiencies are found in one aspect of the system – that is, at one point along the wait to ultimate treatment – these improvements will be negated where there is a lack of funding in place to carry out the other necessary steps in the treatment plan.
908. RebalanceMD is a physician-owned and operated interdisciplinary orthopaedic care clinic. Every orthopaedic surgeon in Victoria now uses RebalanceMD, which commenced operations in January 2013.
909. RebalanceMD uses the FAAST (First Available Appropriate Specialist Triage) model for consultations, which can reduce waiting times for consultations.
910. Prior to RebalanceMD, the wait time for a consultation with an orthopaedic surgeon in Victoria was between nine and 36 months. This has been reduced to between four and eight weeks through RebalanceMD's FAAST model.¹²⁴

¹²⁴ BC5104177: 2014.02.20 - RebalanceMD Final Project Report.

911. But, as the Government's documents show, this has only served to increase the waiting time from the time of the consultation to the surgery.¹²⁵
912. The Vancouver Island Health Authority ("VIHA") noted in January 2015 that the Government's target for hip & knee replacements was not being met (ie. cases were waiting longer than the 26 week benchmark).¹²⁶
913. As of June 2014, 30% of hip replacement surgery patients and 33% of knee replacement surgery had waited over 26 weeks. The VIHA noted this was a worsening of wait times from the same time the year before.
914. The VIHA also noted that the RebalanceMD model had decreased the wait time between referral from a GP and the first visit to the surgeon, but that this has resulted in an increase in the number of people waiting for surgery at the next stage.¹²⁷
915. Indeed, despite the increase in the efficiency of scheduling and providing consultations, there are still over 3000 patients waiting for the actual surgeries they need.
916. This shows that while efficiencies can be found at one point along the path to treatment and recovery, the lack of funds dedicated by the Government will be felt somewhere else along that path.
917. Nor is this an isolated experience.
918. In one study in the Canadian Medical Association Journal, it was found that fewer than half of orthopaedic surgeons are working at full capacity because of restrictions on operating room time.¹²⁸

¹²⁵ BC5109186: 2014.05.22 - Briefing Note re RebalanceMD; BC4290661: 2015.06.25 - Complaint from [Patient].

¹²⁶ BC5145403: 2015.01.00 - Target for Hip and Knee Replacements Not Being Met.

¹²⁷ *Ibid.*

¹²⁸ P. Comeau, "Crisis in orthopedic care: surgeon and resource shortage" (2004) CMAJ Vol. 171(3), cited in Expert Report of John McGurran, dated March 17, 2014, at 16.

919. This rationing exists despite the fact that the Ministry is aware that the need for surgery continues to increase.
920. In a 2015 report by the Ministry of Health entitled “Future Directions for Surgical Services in British Columbia”, the Ministry states that a variety of factors have increased the demand for surgery, including an growing and aging population, a growing seniors’ population who enjoy increased longevity, an increasing prevalence of obesity, improvements in surgical procedures and technology which shorten length of stay in hospital and speed recovery following surgery, a trend towards more day procedures, and “preference” or choice in understanding the risks and benefits of surgery at different points in a person’s life.¹²⁹
921. Notably, this report states that the Province’s lack of a comprehensive Health Human Resources strategy creates a range of issues on the surgical services front. Factors include an aging workforce, pending retirements, examples of both oversupply (orthopaedic surgeons) and undersupply (anesthesiologists, specialty nurses), and compensation models.¹³⁰
922. Again, the problem is not a lack of doctors – it is a lack of sufficient funding for medical treatment in the public sector, leading to rationing.
923. Indeed, outside of this litigation, the Government has never indicated that a lack of physician man-hours (particularly of surgeons) is a reason for the extremely lengthy wait times.
924. Despite the oversupply of orthopaedic surgeons, patients typically wait for over a year following their consultations, as a result of the limited operating room time available for orthopaedic surgeons.

¹²⁹ BC4051957 - Future Directions for Surgical Services in British Columbia 2015, at 4/58.

¹³⁰ *Ibid.*

The Experiences of the Orthopaedic Surgeons

925. This Court will also hear from orthopaedic surgeons across British Columbia.
926. They will discuss the inadequate funding and rationing of resources they face when trying to provide their patients with timely care.
927. They will explain that their wait list for surgeries in the public system are so long that they is unable to provide surgeries within a medically reasonable period of time for most of their patients.
928. In large part, this is because they have only been allocated 4-5 days of operating room time per month.
929. While surgeons seek to maximize their operating room time in order to provide timely care to their patients, they will testify that there is simply not enough operating room capacity in the BC public health care system to provide timely care to BC residents who require medically necessary care.
930. The lack of operating room time in the public system is exacerbated by cost saving measures. For instance, operating rooms are closed down on what are called ‘Reduced Activity Days’, due to funding restrictions.¹³¹
931. Again, the problem is not the lack of doctors able and ready to provide the services, but the Government’s inability or unwillingness to pay for those services.
932. The surgeons will explain that having more surgeons in the public health care system would not solve this problem.
933. Put differently, the Government could double or triple the number of available surgeons, but the total number of surgeries completed in BC each year would remain the same unless the Government also increased funding for operating room time or otherwise funded more surgeries.

¹³¹ BC5013828: 2010.02.4 - VIHA Issues Note re Surgery Reductions, at 3.

934. Further, while issues arising from the limited resources were previously largely relevant to elective surgeries, the rationing is now starting to impact access to emergency and urgent care.
935. This is because some hospitals do not have adequate emergency operating room capacity or resources to address all of the emergency procedures that arise each day, and the Government will penalize a hospital by imposing a fine if individuals requiring emergency surgery are not treated within 48 hours.
936. As stated in a government briefing note regarding Surrey Memorial Hospital, "...Priority 3 cases should be completed within 24 hours, however, depending on how busy it is, Priority 3 cases often wait a few days to be done."¹³² Even these highest priority cases sometimes have to wait several days for surgery, during which the patients are unable to eat or leave the hospital.¹³³
937. This tends to crowd out scheduled elective surgeries, because if a patient requires emergency surgery but cannot be operated on overnight because of the limited operating room access, surgeons must cancel their elective or other non-emergent surgeries scheduled for the following day to perform the emergency surgery.
938. This simply increases the length of time BC residents must wait for non-emergent but medically necessary surgeries.
939. The Government also utilizes other methods of rationing surgical services to limit spending.
940. For instance, operating rooms are not utilized on statutory holidays, and when a surgeon is on vacation, his operating room time is not given to another surgeon.

¹³² BC1027246 - Government Briefing note re priority 3 case waitlist.

¹³³ BC4074180: 2015.3.30 - Re Emergency Surgery Wait Messaging.

941. The Plaintiffs will call several other physicians whose testimony will further demonstrate the Government rationing of medical services and the impact of this rationing on the health and well-being of BC patients.

(vii) Conclusion on the Causes of Rationing

942. The result of the above situation - ever increasing costs, coupled with insufficient revenues in a closed system - is that the Government is currently not spending nearly enough to meet the health care needs of all British Columbians in a timely way.¹³⁴
943. The lack of adequate funding is an open secret, with the Ministry of Health directing Health Authorities not to mention insufficient funding in their service plans.¹³⁵
944. The Government's "solution" to this lack of funding has been to reduce the supply of services, i.e. rationing, based not on need but on the amount the Government is prepared to pay.
945. What this rationing means is that there is unmet need in the public system. People are not receiving the medically necessary treatment they need within a medically reasonable period of time.
946. This is explained by Mr. John McGurran, an expert witness in this case.
947. As Mr. McGurran explains in his expert report, lengthy waits for medically necessary care are primarily the result of insufficient supply – that is, rationing of health services.¹³⁶
948. He notes that while many argue that "better management of existing resources" will solve the problem of timely access to medically necessary procedures, increased public expenditure has been shown to be the single most effective tool for reductions in waiting times (at least in the short term).

¹³⁴ BC2134223: 2011.02 - Briefing Note re Cap on Bariatric Volumes.

¹³⁵ BC2225752: 2008.11.27 - Email re Review of Health Authority Service Plans.

¹³⁶ Expert Report of John McGurran, dated March 17, 2014, at 5.

949. However, because governments have been unable or unwilling to spend the amount necessary to meet the health care needs of British Columbians, the result is that health services have been rationed as a means of cost control.¹³⁷
950. In other words, while the Government has apparently drawn a line in the sand – this far and no further in terms of spending increases – that has not stopped the growth in medical need for these services.
951. The Government’s failure to increase spending in line with increases in need necessarily leads to an ever-widening gap between what the government is willing to spend and the health care that British Columbians need.
952. In particular, the lack of operating room time – and the considerable waiting times resulting from this restricted capacity – is caused by an inability or unwillingness to dedicate the resources necessary to meet the health care needs of all British Columbians in the public system.
953. Doctors in BC want to work in the public system. They want to provide services through the public system. But the Government simply will not pay for the facilities needed to provide the services required.
954. As Claude Castonguay has observed:

Many medical specialists vigorously deplore that they cannot treat their patients on a regular basis, due to unavailability of operating rooms or clinical equipment. This situation is all the more unacceptable in that operating rooms and clinical equipment are far from being used optimally.¹³⁸

955. This lack of spending on medically necessary procedures, while perhaps more fiscally responsible than the alternatives, nevertheless inflicts very significant costs on the health and well-being of British Columbians.

¹³⁷ *Ibid.*

¹³⁸ CSC00015650 – C. Castonguay, J. Marcotte & M. Venne, *Getting Our Money’s Worth, Report of the Task Force on the Funding of the Health System* (Government du Quebec, February 2008) [**Castonguay Report**], at 92.

956. As this harm grounds the constitutional violation in this case, it is important to spell out the impacts of rationing health care services on patients across the system.

V. HARMS CAUSED BY RATIONING AND WAIT TIMES GENERALLY

A. Wait-times – The Evidence

957. Rationing of medically necessary treatment has the obvious result of increasing the time that patients must wait before they can get the treatment they need in the public system.
958. Senator Michael Kirby has described the cause of long wait times for medically necessary services in the following, appropriately blunt, terms:

Long waiting times are a result of the rationing of services that every provincial government must address. As it is currently constituted, our system allows governments and providers to shift the consequences of excessive waiting times onto the backs of patients and their families. This gives them a ‘cost-free’ way to control costs. Patients suffer; governments do not – at least not immediately.¹³⁹

959. Notwithstanding the constant efforts over the past thirty years to make the system more ‘efficient’, and to increase spending – both in absolute terms and as a proportion of the provincial budget – the wait time situation in British Columbia is getting *worse*, not better.
960. Nadeem Esmail is a Senior Fellow in Health Policy at the Fraser Institute, and a health care economist with over a decade of experience. Along with the Wait Times Alliance, the Fraser Institute is the only non-governmental body collecting data on medical waiting times across the country.
961. As Mr. Esmail explains in his Expert Report, the wait times in British Columbia are higher than in most other provinces, and are unacceptably long from a clinical perspective. He summarizes the statistics as of 2013 as follows:

Among the provinces, wait times in British Columbia were longer than the national average for both consultations with a specialist and for treatment after an appointment with a specialist. Combined, the **19.9 week** total wait time in British

¹³⁹ CSC00020411 - Michael Kirby, “The Only Two Options for Funding the Wait-Time Guarantee” *Policy Options* (July-August 2006) [**Kirby, “Two Options”**] at 66.

Columbia (the sum of the two) compared with an 18.2 week wait time nationally. For the GP to specialist consultation wait, the **9.5 week** wait in British Columbia compared to an 8.6 wait nationally. For the treatment after specialist appointment wait, the **10.4 week** wait in British Columbia compared to a 9.6 week wait nationally.

Wait times in British Columbia have increased considerably since the early 1990s. Specifically, the total wait time of 19.9 weeks in 2013 was 91% longer than the 10.4 week wait time measured in 1993. Broken down into its two components, the GRP referral to specialist consultation wait time has increased by 188% (9.5 weeks in 2013, 3.3 weeks in 1993), while the specialist consultation to treatment wait time has increased by 46% (10.4 weeks in 2013, 7.1 weeks in 1993). This lack of improvement comes in spite of considerable increases in health expenditures early in the period and sustained high level of spending throughout the later part.¹⁴⁰

962. In his updated expert report, Mr. Esmail found that:

Among the provinces, wait times in British Columbia were longer than the national average for treatment after an appointment with a specialist, but slightly shorter than the national average for consultations with a specialist. Combined, the **22.4 week** total wait time in British Columbia (the sum of the two) compared with an 18.3 week wait time nationally. For the GP referral to specialist consultation wait, the **8.4 week** wait in British Columbia compared to an 8.5 week wait nationally. For the treatment after specialist appointment wait, the **14.0 week** wait in British Columbia compared to a 9.8 week wait nationally.¹⁴¹

963. Overall, Mr. Esmail reports that progress on waiting times in BC has been mixed, but that “wait times in British Columbia were found to be 56% longer than the clinically reasonable wait times reported by physicians in the survey” for the time between specialist consultation and treatment.¹⁴²
964. As described in more detail below, even if the province had met its ‘benchmarks’, or had provided services at or above the national average, this does not mean that the province is providing a service that is constitutionally acceptable.
965. It is quite possible, and indeed likely, that all provinces are in breach of the *Charter*, in so far as they prohibit access to necessary medical care where that care is not being provided in the public system in a timely way consistent with clinically reasonable wait times.

¹⁴⁰ Expert Report of Nadeem Esmail, dated March 17, 2014, at 5 (emphasis added).

¹⁴¹ Updated Expert Report of Nadeem Esmail, dated July 27, 2016, at 3 (emphasis added).

¹⁴² Expert Report of Nadeem Esmail, dated March 17, 2014, at 13.

966. Professor Daniel Kessler is a tenured professor at Stanford University, and an expert in health economics. He is cross-appointed to the Stanford School of Law, Graduate School of Business, and the Medical School.
967. He has undertaken a thorough review of the literature surrounding wait times, and has found that the amount of time some BC residents wait for surgeries is almost uniformly higher than clinically reasonable waiting times.
968. Professor Kessler provides a sampling of the findings of these scientific studies, from a range of various ailments, injuries and diseases:
- Back and Spinal Surgery: Waiting more than 12 weeks for back and spinal surgery – as some BC residents do – leads to significantly less postoperative improvement in pain and function.
 - Hip Replacements: Waiting more than 26 weeks for hip replacement – as some BC residents do – leads to significant declines in postoperative function.
 - Cardiac Surgery: Waiting longer than recommended by BC provincial guidelines for cardiac surgery – as some BC residents do – leads to reduced survival, declines in physical health, and declines in social functioning. There is a significant survival benefit from treatment within the time frame recommended by the stricter Canadian Cardiac Society's guidelines versus the BC provincial guidelines.
 - Gallbladder Removal: Waiting more than 20 weeks for elective gallbladder removal – as some BC residents do – leads to significant increases in the risk of suffering or complications.
 - Knee Replacement: Waiting more than 26 or 39 weeks – as some BC residents do – leads to significantly worse pain, loss of function, and quality of life.
 - Cataract Surgery: Waiting more than 26 weeks for cataract surgery – as some BC residents do – leads to a significant increase in the risk of accidental injury, significant declines in postoperative function and quality of life.
 - Carotid Imaging and Endarterectomy: Waiting more than 12 weeks for carotid endarterectomy – as some BC residents do – leads to significant increase in the risk of preventable strokes.¹⁴³

¹⁴³ Expert Report of Daniel Kessler, dated March 17, 2014, at 27-33 (First Report).

969. Unacceptably long wait times for medically necessary care are not unique to British Columbia – they are endemic to a funding model which places no cost on users of the health care system, while at the same time prohibiting individuals from accessing services outside of that system.

970. Indeed, Canada as a whole has much longer wait times in the public system when compared with many OECD countries, despite comparable levels of spending.

971. As Nadeem Esmail observed in his expert report:

(E)very developed nation that has a universal access health insurance program save Canada also has a private option for patients. Yet wait times for access to medically necessary care in these nations are, according to the available evidence, shorter than in Canada where no such option exists. This performance is not the result of higher health expenditures: Canadian health expenditures (total, public and private) are among the highest in the developed world on a share of GDP basis.¹⁴⁴

972. Findings across Canada suggest that wait times in the Canadian model tend to be significantly higher than in most OECD countries which provide universal public health care systems.

973. The 2010 Commonwealth Fund survey, mentioned earlier, shows that Canadians are likely to endure longer delays in treatment than all of the other countries surveyed which provide universal public coverage (Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom).¹⁴⁵

974. The survey showed that Canada had longer waiting times than these countries across all opportunities for health intervention: emergency care, primary care, specialist consultations, and ultimate treatment.

975. As summarized by the Canadian Institute of Health Information in 2012:

In a 2010 comparison with other countries, Canada ranked lowest (along with Norway) for wait times to see a doctor or nurse when sick, with only 45% of Canadians reporting having seen a doctor or nurse on the same or next day. Over time, Canada's performance has not improved. In 2004, one in four (25%) Canadians reported

¹⁴⁴ Expert Report of Nadeem Esmail, dated March 17, 2014, at 18.

¹⁴⁵ *Ibid* at 6, citing to 2010 Commonwealth Fund International Policy Survey data tables.

waiting six or more days to see a doctor when sick or in need of medical attention; by 2010, one in three (33%) waited six or more days.(...)

In an international comparison (among 11 countries) of wait times for specialist appointment, Canadians again reported the longest waits for a specialist appointment. More specifically, 41% of Canadians waited two or more months, while only 7% and 9% of Germans and Americans waited that long.(...)

(...) Canada has one of the longest reported wait times for elective surgery. One in four Canadians reported waiting four months or more for elective surgery, similar to the proportion of patients in the United Kingdom (21%) but much higher than in Germany (almost 0%) and the United States (7%).¹⁴⁶

976. These findings were confirmed in the 2013 Commonwealth Fund survey, which showed that Canadians were more likely to report long waits for primary, specialist, and emergency care than in any of the other countries which provide universal public coverage.¹⁴⁷
977. Finally, in the 2014 Commonwealth Fund report, Canada was ranked last with respect to timely access to medical treatment. That is, all 10 other countries surveyed provided more timely care to patients than did Canada, which “ranks last or near-to-last on most measures of timeliness of care.”¹⁴⁸
978. These excessively long waiting times also lead to inefficiencies, which percolate through the system: patients “in Canada and the U.S. were most likely to visit the emergency department for a condition that could have been treated by a regular doctor had one been available, with rates twice as high as that of the United Kingdom and France”. (Both the UK and France permit duplicate private health insurance.)¹⁴⁹
979. As summarized by Alistair McGuire, Professor of Health Economics at the London School of Economics, in his expert report:

¹⁴⁶ CSC00017792 – Canadian Institute for Health Information, "Wait Times for Priority Procedures in Canada" (Ottawa: CIHI, 2012), at 13, 15, 41.

¹⁴⁷ Expert Report of Nadeem Esmail, dated March 17, 2014, at 9, citing to 2013 edition of the Commonwealth Fund International Health Policy Survey data tables.

¹⁴⁸ CSC00019618 - Commonwealth Fund, "Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally" (2014) [Commonwealth Fund 2014] at 7.

¹⁴⁹ *Ibid* at 22.

There is a capacity issue associated with the present organization of funding and delivery of health care in BC. This has been noted nationally, as witnessed by the wait list initiative adopted by Canada in 2004, and discussed relative to other countries. Canada has a relatively high level of health care expenditure, yet this is accompanied by high waiting lists. Countries with similar levels of *per capita* health care expenditure to Canada, such as Germany and France, do not appear to have such wait time problems. (...)

The data on excessive waiting times... are taken from the OECD Health at a Glace 2011 report. Excessive waiting times are defined as a wait greater than 4 months, and are reported for a number of countries. While in the early 2000s a number of countries had excess waiting times longer than Canada, by 2010 all the countries had achieved significant reductions, and all (excessive) waiting times were below Canada.¹⁵⁰

980. The causes of these excessive waits for treatment are clear. As Professor McGurran, another expert witness in this case, explains: "the root cause is the shortage of supply in BC's publicly funded system"¹⁵¹ combined with the prohibition on private health care.
981. Increasing the supply of these services – including through permitting a private treatment option – will relieve some of the pressure from the waiting lists in the public system.
982. Professor McGuire states in his report that reductions in wait times in England were associated with increased capacity provided through the private system:

This capacity increase was achieved through increasing hospital competition, and the increased use of the private sector. Moreover, these achieved reductions in waiting times improved equality of access to hospital care within the public National Health Service (NHS) in England, such that lower socio-economic groups saw a greater improvement in access than the higher socio-economic groups.¹⁵²

983. Whether this will occur in British Columbia depends on the extent of the pent-up demand for surgeries in the public system.
984. But what we do know for certain is that if British Columbians are allowed to access private surgeries, the total number of surgeries will increase, assuming there is no corresponding decrease in surgeries in the public system as a result of even more rationing to save money.

¹⁵⁰ Expert Report of Alistair McGuire, dated March 17, 2014, at 10-11.

¹⁵¹ Expert Report of John McGurran, dated March 17, 2014, at 23.

¹⁵² Expert Report of Alistair McGuire, dated March 17, 2014, at 11.

985. And it must be emphasized that the success of the Plaintiffs' constitutional challenge in no way rests on them being able to establish that wait lists in the public system will be reduced if the prohibitions on access to private health care are removed.
986. The Plaintiffs case is based solely on the fact that British Columbians are being harmed by the legislative barriers to private health care because the public system is unable to meet their medical needs in a timely manner.
987. Justice Deschamps put it this way in the conclusion to her decision in *Chaoulli*:

The relief sought by the appellants does not necessarily provide a complete response to the complex problem of waiting lists. However, it was not up to the appellants to find a way to remedy a problem that has persisted for a number of years and for which the solution must come from the state itself. Their only burden was to prove that their right to life and to personal inviolability had been infringed. They have succeeded in proving this. The Attorney General of Quebec, on the other hand, has not proved that the impugned measure, the prohibition on private insurance, was justified under s. 9.1 of the Quebec Charter. [*Chaoulli* at para 100].

B. Wait times - Diagnostics

988. Among the most damaging examples of lengthy wait times are those at the outset of treatment.
989. Timely access to diagnostic tests, such as MRIs and colonoscopies, are necessary for physicians to provide timely diagnoses to their patients and provide the required treatment.
990. As the Ministry has recognized, medical imaging (including MRI) is an essential part of the patient pathway for all patient populations, from healthy to the end of life in all health service delivery areas of BC.
991. Accurate diagnosis is required for physicians to make key clinical decisions about treatment, and delays will impact patient outcomes and patients' experience of care.¹⁵³

¹⁵³ BC4410706: 2015.09.17 - Ministry of Health Decision Briefing Note, Title: Advanced Imaging Strategy, at 1.

992. Timely access to advanced imaging is needed to reduce delays for surgery, and to reduce the incidence of primary care practitioners sending patients to emergency departments to bypass long lines for imaging.¹⁵⁴
993. Without timely access to appropriate diagnostic procedures, patients languish on wait lists, the flow of patient (from diagnosis to surgery) is slowed, physicians' ordering of alternative and less-ideal diagnostic tests such as CT scans (which unnecessarily exposes patients to ionizing radiation and may result in physicians performing exploratory surgery (ie. knee arthroscopy)) is increased, all which could be avoided if timely MRIs were available.¹⁵⁵
994. However, British Columbians do not have timely access to MRIs.
995. The Ministry set Maximum Wait Time benchmarks for MRIs, which it defined as the time within which the 90th percentile should receive their care.
996. Moreover, these wait times only include a portion of British Columbians who need MRIs, because these wait times are for patients with symptoms needing investigation (i.e., this does not include individuals seeking a screening MRI).¹⁵⁶
997. The Government's benchmark wait times for MRIs are as follows:
- 24 hours for emergent cases (P1),
 - 7 days for urgent cases (P2),
 - 30 days for semi-urgent cases (P3), and
 - 60 days for non-urgent cases (P4).¹⁵⁷
998. Unlike many other provinces, BC does not publicly report its MRI wait times – so we do not know from the Government whether it has met these benchmarks.¹⁵⁸

¹⁵⁴ *Ibid.*

¹⁵⁵ BC5080091: 2013.02.14- Access to Magnetic Resonance Imaging Services.

¹⁵⁶ BC4265205: 2015.04.02 - Briefing Note Magnetic Resonance Imaging (MRI) Access Issues; BC4081120: 2015.02.18 - Backgrounder on MRI Strategy.

¹⁵⁷ BC5135120: 2015.01.29 - Medical Imaging Database CT & MRI Wait Time Reports, at 2/16.

¹⁵⁸ *Ibid* at 10/16.

999. However, we do know that in 2015, the 90th percentile wait time for MRI, across all priorities, was 255 days. That is almost 200 days more than the longest amount of time that anyone should have to wait, according to the Government's own benchmarks.

1000. This is the longest wait time in Canada for MRIs.

1001. This is likely why there are 17 private MRI clinics in BC, to fill the need.

1002. The gap between BC's annual MRI rate and the national average is about 87,000 exams. BC would require a 66% increase in exams to even be on par with the national average.¹⁵⁹

1003. BC has the second lowest per capita rate of MRI exams in Canada, and the Ministry states that 11 of the 25 MRI machines in the health authorities are at, or beyond, the recommended replacement age.¹⁶⁰

1004. In its June 2014 Report Card on Wait Times in Canada, the Wait Time Alliance gives British Columbia a failing grade of "F" for wait times for non-urgent MRIs. The benchmark is 60 days. An "F" grade means that less than 50% of B.C. residents are obtaining MRIs within 60 days in the public health care system.¹⁶¹

1005. Those long delays are attributable in large part to the underfunding of MRIs by the Government.

1006. Long MRI wait times cannot be attributed to an inadequate supply of MRI machines.

1007. That is because many MRI machines in BC have excess capacity, and their operating hours are below the Ontario benchmark of 112 hours per week.

1008. In fact, British Columbia has the second worst MRI utilization-rate in the country.

¹⁵⁹ BC5080091: 2013.02.14 - Access to Magnetic Resonance Imaging Services.

¹⁶⁰ BC4418311: 11.12.2015 - Briefing Note re Advanced Imaging Strategy.

¹⁶¹ CSC00019446 - Report Card on Wait Times in Canada, the Wait Time Alliance (June 2014).

1009. In a 2013 internal Ministry of Health report entitled “Report on Access to Health Authority MRI Services”, the government’s own statistics show that only one MRI machine in the province is currently working at full capacity.

1010. Despite the highest waiting times in Canada, most MRI machines in the province are working below half capacity.

1011. In its summary section of the report, the Government officials state:

- Long wait times...and getting longer
- BC tied for lowest utilization in Canada
- Regional variation in utilization – appropriate???
- Lumpy growth rate that does not match changes in health need
- Suboptimal use of existing infrastructure (idle machines)
- Long travel times to access MRI for residents in some regions
- Limited access to publicly-funded MRI creative business opportunities for private providers
- No publicly-funded 3T (Tesla) MRI for eligible patients

1012. Under the heading “Consequences of restricted access”, the document then states as follows:

Consequences of restricted access

- Patients languish on wait lists
- Retardation of patient flow (e.g., from diagnosis to treatment)
- Increased ordering of suboptimal tests (e.g., CT, US, XR)
- Increased out-of-province (OOP) claims (e.g., patients going to Alberta)
- Concerns about increase in unnecessary exploratory surgeries (e.g., knee arthroscopy)
- May result in higher overall system costs (difficult to quantify)
- Economic and social costs of waiting (also difficult to quantify)
- Lack of 3T MRI hinders physician recruitment

1013. Furthermore, the Ministry acknowledges that the wait times for MRI do not result from “inappropriate” ordering of MRIs (MRI exams that were conducted that did not meet the guidelines). A study funded by the Ministry of Health concluded that there was a very small proportion overall of MRIs ordered that were inappropriate.¹⁶²
1014. To contrary, there was evidence that CT scans may be inappropriately ordered due to the significant wait lists for MRIs.¹⁶³
1015. The Ministry has stated that the *key* issue leading to these lengthy and harmful wait times is the funding model, and limited allocation of funding to MRI exams.
1016. Unlike all other outpatient diagnostic services, MRI is wholly funded by Health Authorities through their global budgets, because the MSC has declined to recognize MRI clinics as approved diagnostic facilities for the purpose of the MSP.
1017. This means that Health Authorities must absorb the full cost of volume increases in the demand for MRI services, which would in turn reduce the funds available for other health authority programs and services.
1018. The reason MRI is funded only in this way is because they are high-cost services.¹⁶⁴
1019. In November 2014, due to the serious concern about MRI wait times, the Ministry considered a proposal to address MRI wait times by increasing service volumes by 10% year over year for the next 4 years.
1020. However, even if these increases were achieved, they would still not be sufficient to achieve parity with the Canadian average utilization per capita.
1021. The long waiting times for diagnostic services is not limited to MRI exams.

¹⁶² XFD transcript of Tricia-Braidwood-Looney at 328; Kathleen Eddy, et al. "Appropriate use of CT and MRI in British Columbia." (2013) 55 BCMJ at 22-25.

¹⁶³ BC2210452 - RE: MRI Additional Funding memo (Aug 10, 2010).

¹⁶⁴ BC5117895 - Information Request re MRI not covered under MSP.

1022. For instance, the Province also admits that there are extremely lengthy wait times for colonoscopies.¹⁶⁵

1023. Colonoscopies are performed for screening, diagnostic, and therapeutic purposes.

1024. The Canadian Association of Gastroenterologists (CAG) recommends a maximum wait time of less than two months for symptomatic patients.¹⁶⁶

1025. But the Government has not been meeting these timelines.

1026. In a 2014 briefing in response to an inquiry from an MLA, the Ministry of Health stated as follows:

The wait time benchmark for screening colonoscopy for FIT positive patients is 8 weeks. Currently in Nanaimo/Parksville, 67 percent of the patients on the waitlist are within the benchmark. It is working to improve access and performance to 80 percent.¹⁶⁷

1027. In other words, even assuming that the average wait time of two months was a medically reasonable amount of time for each patient, 33% of patients were required to wait longer than that.

1028. In 2013, 233 people had been waiting longer than 1 year for a colonoscopy in Vancouver Island Health Authority. In Vancouver Coastal Health Authority, approximately 300 people had been waiting longer than 1 year.¹⁶⁸

1029. In 2014, only 64% of symptomatic patients in Vancouver Island Health Authority, and 34% of symptomatic patients in Interior Health Authority were seen within the 60 day target.¹⁶⁹

¹⁶⁵ BC4419407: 2016.01.00 - BC's Colonoscopy Services Sustainability Project Phase 2; BC4413864 – Briefing Note discussing problematic colonoscopy wait times.

¹⁶⁶ BC4418714: 2015.11.03 - Colonoscopy Services Sustainability Project Phase 1 Final Report, at 6/75.

¹⁶⁷ BC2250894 - Cliff # 999895 - MLA Stillwell re: constituent [Patient Name] FIT testing and colonoscopy wait times.

¹⁶⁸ BC5089096: 07.00.2013 - Colonoscopy Wait Times (July 2013).

¹⁶⁹ BC4414849 (Parent ID: BC4414847) - Appendix B - Colonoscopy Volumes and Wait Times.

1030. As of June 2015, almost 40,000 people were waiting for a colonoscopy in British Columbia. The Province has determined that in order to address this backlog, an investment of an additional \$27.5 million would be required.¹⁷⁰
1031. The Government has undertaken a major Colonoscopy Services Sustainability Project on the basis that concerns have been raised over long wait times for access to colonoscopy services and, with an aging population and a new screening program, the volumes and related wait times are likely to increase.¹⁷¹
1032. Historically, there has been no provincial monitoring of colonoscopy wait times in general.¹⁷² However, it is clear that symptomatic patients, such as the plaintiff Mandy Martens, are waiting far too long.
1033. Ms. Martens, despite having disturbing symptoms, was told that she would have to wait six months for a colonoscopy. When she attempted to go to Emergency, she was told her situation was not sufficiently emergent. Her privately paid colonoscopy, obtained at Cambie, revealed that she had Stage 4 colon cancer.
1034. She is alive today only because of the existence of a private option to obtain this service, albeit one which is contrary to the *Act*.

C. Benchmarks and Wait Time Targets: a Constitutional Red Herring

1035. In light of the unacceptably long wait times in the public system, and the increasing public consciousness of these wait times, governments across Canada tried to take steps to address the problem.
1036. In 2004, Canadian First Ministers convened a meeting on “The Future of Health Care” in Canada.

¹⁷⁰ BC4419407: 2016.01.00 - BC's Colonoscopy Services Sustainability Project Phase 2.

¹⁷¹ BC4418714: 2015.11.03 - Colonoscopy Services Sustainability Project Phase 1 Final Report, at 6/75

¹⁷² *Ibid* at 7/75.

1037. Following discussions, the First Ministers released a statement describing the motivation behind, and the urgency of, their commitment to reduce wait times in Canada:

In recent years, through an ongoing dialogue between governments, patients, health care providers and Canadians more generally, a deep and broad consensus has emerged on a shared agenda for renewal of health care in Canada. This agenda is focused on ensuring that Canadians have access to the care they need, when they need it.

Foremost on this agenda is the need to make timely access to quality care a reality for all Canadians. First Ministers remain committed to the dual objectives of better management of wait times and the measurable reduction of wait times where they are longer than medically acceptable.

First Ministers also recognize that improving access to care and reducing wait times will require cooperation among governments; the participation of health care providers and patients; and strategic investments in areas such as: increasing the supply of health professionals (e.g. doctors, nurses and pharmacists); effective community based services, including home care; a pharmaceuticals strategy; effective health promotion and disease prevention, and adequate financial resources.¹⁷³

1038. To this end, the First Ministers agreed to the following commitments:

- Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005.
- Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.
- Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.
- Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.

1039. In effect, the federal and provincial governments endeavored to establish benchmarks for certain “priority areas”, and the Federal Government established a “Wait Times Reduction Fund” to help fund wait times reduction measures in these priority areas.

¹⁷³ CSC00024496 - Canadian First Ministers, “A 10-year Plan to Strengthen Health Care” (September 16, 2004).

1040. In 2005, the First Ministers agreed to national benchmarks, purporting to outline maximum “medically reasonable” wait times in each of the priority areas.

1041. These medically reasonable wait times – and British Columbia’s commitment with respect to them – are as follows:¹⁷⁴

Procedure	Federal Benchmark	British Columbia Target
Radiotherapy	Within 4 weeks of being ready to treat	Maintain greater than 90% within benchmark
Coronary Artery Bypass Graft	Level 1: within 2 weeks Level 2: within 6 weeks Level 3: within 26 weeks	90% within benchmark by priority level by March 2010
Cataract Surgery	Within 16 weeks for patients who are at high risk	90% within benchmark by March 2010
Hip Replacement	Within 26 weeks	90% within benchmark by March 2010
Knee Replacement	Within 26 weeks	90% within benchmark by March 2010
Fixation of Hip Fracture	Within 48 hours	95% within benchmark by March 2010
Screening Mammography	Women aged 50-69 every two years	70% within benchmark by March 2017
Cervical Screening	All women starting at 18 yrs old, every three years to age 69	Maintain greater than 70% within benchmark

1042. While benchmarking may help governments measure their successes and failures in reducing wait times in the aggregate – at least for this small range of services – it does nothing in itself to solve the overall problem of a lack of capacity to provide necessary services.

¹⁷⁴ BC Ministry of Health, “Wait Time Targets”, online: <<http://www2.gov.bc.ca/gov/content/health/accessing-health-care/surgical-wait-times/understanding-wait-times/wait-time-targets>>.

1043. Although these benchmarks are often put forward as a form of progress, they accomplish nothing in themselves. They are like a new (and flawed) meteorological device that tells us a bit more about the conditions, but does nothing to change the weather.

Benchmarks are flawed

1044. First, many of the Government's benchmarks do not accurately reflect a medically reasonable amount of time to wait for the procedures. Indeed, the federal benchmarks just discussed have been disputed by physicians.

1045. The Wait Times Alliance is made up of the leading physician associations across the country, including: the Canadian Medical Association, Canadian Association of Nuclear Medicine, Canadian Association of Radiologists, Canadian Cardiovascular Society, Canadian Medical Association, Canadian Orthopaedic Association, Canadian Ophthalmological Society and Canadian Association of Radiation Oncologists.

1046. The Wait Time Alliance used an expert panel to derive benchmarks, based on "the maximum amounts of time that a patient should wait for specific treatments, tests, or procedures; beyond that, evidence shows that waiting will likely have adverse effects on a patient's health".¹⁷⁵

1047. While some of the Wait Time Alliance's targets correspond with the federal benchmarks, others differ considerably.

1048. According to the Wait Time Alliance's website:

In some areas, Provincial and Territorial benchmarks are less demanding than the Wait Time Alliance's benchmarks. For example, governments say that a cancer patient who needs radiation therapy should be treated within 28 days, while the Wait Time Alliance thinks these patients need this care within 14 days. The Wait Time Alliance bases its benchmarks on the broad consensus of physicians on medically reasonable wait times for health services delivered to patients.¹⁷⁶

¹⁷⁵ CSC00020265 - Wait Time Alliance, "No More Time to Wait: Towards benchmarks and best practices in wait time management" (March 2005).

¹⁷⁶ CSC00020330 - Wait Times Alliance, "Frequently Asked Questions".

1049. Similarly, the Fraser Institute has shown that the wait times benchmarks do not reflect the consensus in the medical community. In the Fraser Institute publication entitled “Reducing Wait Times for Health Care”, Dr. Brian Day explains why:

It is worth noting that many of the studies reviewed earlier in this chapter tell us that some patients can wait for short periods without much greater medical risk, at least for most non-emergent conditions. However, the Pan-Canadian Benchmarks seem to take this concept to a whole new level of delay. According to Canada’s provincial and federal governments, it is acceptable in a health system that claims excellence as a feature, for an elderly Canadian to wait in pain, and possibly housebound, for 6 months for joint replacement. This is clearly not an appropriate benchmark. Nor is it appropriate to wait 6 months for necessary cardiac bypass surgery, or four months for sight restoring cataract surgery.

A second important point is that governments have committed to benchmark wait times that are longer than Canada’s physicians consider medically reasonable. The Wait Time Alliance, an alliance of several national physician societies published wait time benchmarks for radiation therapy (10 working days to consultation and treatment within 10 working days of consultation) and bypass surgery (within 6 weeks) that are substantially shorter than the governmental targets (Wait Time Alliance, 2005). Further, a national survey of physicians finds that doctors are far less tolerant of long waits than are governments with regards to their definition of clinically reasonable waits (Barua and Esmail, 2012). It seems there is some possibility that the Pan-Canadian Benchmark Wait Times were defined according to a standard that was not entirely focused on the well-being of ill Canadians. Patient input into their perception of appropriate benchmarks should form an essential part of a patient-focused system.¹⁷⁷

Benchmarks count only part of the wait

1050. Second, government benchmarks for treatment do not take into account the lengthy delays *before* the surgeries are booked – delays in seeing a general practitioner about a medical problem, delays in seeing a specialist, and delays in obtaining the necessary diagnostic testing before the surgeon can determine whether surgery is necessary.

1051. The waiting time before a surgery is booked is not even calculated, let alone considered, by the wait time benchmarks measured by the Ministry.

1052. The Plaintiffs’ expert witness, Mr. McGurran, explains:

¹⁷⁷ CSC00016395 – Steven Gliberman ed, “Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Practice” (2013), Ch. 3 – The Consequences of Waiting, at 63-65.

Consider the example of a woman with hip pain who has come to the point where she feels medical care is needed to relieve her pain and allow her to resume normal life activities. After she has been assessed by her family doctor to the point where medical management is no longer appropriate; after she waits for an assessment by an orthopedic surgeon and waits for imaging or other diagnostic tests; after she and the surgeon agree that hip replacement is the appropriate next step; and after she is deemed ready for surgery, medically and otherwise, a booking is made at the hospital. She has now reached the point when the wait time posted on the BC surgical website takes on meaning. However, she will not likely have the certainty of a date for medical care that she desires and deserves.¹⁷⁸

1053. As Mr. McGurran states, “wait times published on most provincial websites (including BCs) are incomplete from a patient’s point of view... The official wait clock in BC starts long after the patient has started on the journey to care, relief of symptoms and return to function.”¹⁷⁹
1054. What makes the wait times much worse is the lengthy delay in having the surgery booked at the hospital, including the wait for consultation and diagnostics.
1055. While the statistics most at issue in this case involve wait times for surgeries, there are a number of queues before one even gets scheduled for a surgery, such as for specialist consults and MRIs – therefore, the Government’s statistics miss a significant portion of the actual wait experienced by those needing treatment.¹⁸⁰
1056. As a result, waiting times can often be two to three times longer than those reflected in the Government statistics.¹⁸¹
1057. Thus, whether the government meets its ‘benchmark’ is essentially meaningless if individuals are waiting twice as long to get into the queue before the benchmark wait time even starts.

¹⁷⁸ Expert Report of John McGurran, dated March 17, 2014, at 6-7.

¹⁷⁹ *Ibid* at 14.

¹⁸⁰ BC2250100 - Patient complaint re misleading waitlist times; BC1028834 - Letter from the orthopedic surgeons of Cowichan Valley to Ministry re misleading article on wait times.

¹⁸¹ Expert Report of Nadeem Esmail, dated March 17, 2014, at 5.

Benchmarks are not being met

1058. Leaving aside whether ‘acceptable’ wait times have been appropriately set or accurately measured, the B.C. Government has consistently failed even to meet its own commitments, which were to *almost* meet the commitments set out in the federal benchmarks.
1059. The Canadian Institute for Health Information (“CIHI”) compiles statistics on wait times for Canadian governments.
1060. In its 2012 report, CIHI found that with respect to four of the five ‘priority’ areas identified by Canadian governments (hip replacement, knee replacement, hip fracture repair, cataract surgery, and radiation therapy), the BC government failed to meet the national benchmarks.¹⁸²
1061. According to CIHI, BC’s performance for these priority clinical areas improved between 2008 and 2010 but then dropped more than 20 points to its 2015 level of 61% of cases completed within the benchmark. BC’s 2015 performance is 20 points poorer than that of all provinces combined.¹⁸³
1062. CIHI notes that the biggest gains in Canada (including BC) were seen in the first few years after the federal wait times priorities were set, from 2004-2005 to 2006-2007, following which improvement leveled off, and as discussed below, started to decline in certain provinces.¹⁸⁴
1063. This is not disputed by the Government.¹⁸⁵
1064. In fact, in its 2014 report, Setting Priorities for the BC Health System, the Ministry states:

¹⁸² Expert Report of John McGurran, dated March 17, 2014, at 19, citing to CIHI, “Wait Times for Priority Procedures in Canada” (Ottawa: Canadian Institute for Health Information, 2010).

¹⁸³ Updated expert report of John McGurran, dated June 30, 2016, citing to CIHI, “Waiting Times for Priority Procedures in Canada” (2014, 2015, 2016).

¹⁸⁴ CSC00017792 – Canadian Institute for Health Information, “Wait Times for Priority Procedures in Canada” (Ottawa: CIHI, 2012), at 43.

¹⁸⁵ BC4051957 - Future Directions for Surgical Services in British Columbia 2015, at 28/58.

Overall, Canadian elective surgical waitlist reduction strategies have been expensive, narrow in focus and only partially successful. A negotiated 2003/04 agreement committed funding of \$5.5-billion over 10 years to the Wait Time Reduction Fund in order to reduce wait times for five procedures. In 2011, the Canadian Institute for Health Information showed that there were reported improvements for three years, but also noted the very generous timelines being used by the health sector to measure the success of the strategy.

Despite the attention paid to surgical waitlists and increases in volumes of elective surgeries, B.C.'s wait times for many procedures have not declined and performance is either stagnant or slipping....the percentage of non-emergency surgeries completed within the benchmark wait time in B.C. currently stands at 66 per cent (Q2 2013/12), down from 82 per cent in 2010/11.¹⁸⁶

1065. In its 2012/13 Annual Service Plan Report, the Ministry states that its target for achieving the Ministry's 2012/13 – 2014/15 service for percent of non-emergency surgeries completed within the benchmark wait time is 75%.
1066. The Report states that this target was not achieved, as only 68% of non-emergency surgeries were completed within the benchmark wait time.¹⁸⁷
1067. A recent report from the BC Ministry of Health very candidly summarizes in some detail the ongoing challenges of meeting even the modest benchmarks the province has set for itself:

Many large emergency departments remain congested. The total number of emergency visits continues to increase each year (an 8.6 per cent increase from 2009 to 2013), and the per capita number of visits has also increased (by three per cent from 2009 to 2013). There are now over two million emergency department visits per year. The percentage of emergency patients admitted within 10 hours of decision to admit remains at 67 per cent, while the percentage admitted within two hours has declined from 39 per cent to 38 per cent (2009 and 2013).

Most medium and large hospitals operate consistently at capacity levels close to and over the nominally funded 100 per cent bed level. This is predominantly driven by demand for medical inpatient beds from the populations identified above.

Overall, Canadian elective surgical waitlist reduction strategies have been expensive, narrow in focus and only partially successful. A negotiated 2003/04 agreement committed funding of \$5.5-billion over 10 years to the Wait Time Reduction Fund in order to reduce wait times for five procedures: cataract removal, hip and knee

¹⁸⁶ Ministry of Health, *Setting Priorities*, at 26.

¹⁸⁷ CSC00024139 - "2012/13 Annual Service Plan", at 12.

replacements, diagnostic imaging, cardiac bypass surgery and cancer radiation therapy. In 2011, the Canadian Institute for Health Information showed that there were reported improvements for three years, but also noted the very generous timelines being used by the health sector to measure the success of the strategy.

Despite the attention paid to surgical waitlists and increases in volumes of elective surgeries, B.C.'s wait times for many procedures have not declined and performance is either stagnant or slipping. For example, the average wait time for the top 20 surgical procedures declined slightly from 2009 to 2010, but has remained mostly the same since then. The percentage of non-emergency surgeries completed within the benchmark wait time in B.C. currently stands at 66 per cent (Q2 2013/14), down from 82 per cent in 2010/11. In 2002/03, 90 per cent of patients received their procedure within 23 weeks. Ten years later (2012/13), 90 per cent of patients received their procedure within 26 weeks. Over the same time period, the number of procedures increased from 206,000 to 218,000 per year, pointing to increased use based on procedural improvements.

Finally, in the area of diagnostic imaging, and despite the needed debate on appropriateness, B.C. has one of the lowest rates of MRI and CT exams in Canada and has only recently begun measuring wait times for diagnostic procedures.¹⁸⁸

1068. Moreover, even where the Government has made improvements in some wait times areas, this tends to lead to slower progress and wait time increases in other areas. It's like a balloon – without an increase in spending and capacity, squeezing on one end of the balloon only forces the air into the other end.¹⁸⁹

1069. As Mr. McGurran explains:

Long-term wait time data on the Ministry's website describes how waits have changed between 2001 and 2013... while there is reduction in wait time in the five priority areas, waits lengthened for the surgical caseload as a whole and remain very long, especially when compared to other OECD countries. Again, [these wait times are] a fraction of the total wait experienced by patients.¹⁹⁰

1070. CIHI reports show that an increase in treatment in the priority areas has corresponded with a slight decrease in treatment and surgery in all other areas.¹⁹¹

¹⁸⁸ Ministry of Health, *Setting Priorities*, at 26.

¹⁸⁹ BC2028554 - Government briefing note recommending paying more for MRIs but reducing the price for gastrointestinal endoscopies.

¹⁹⁰ Expert Report of John McGurran, dated March 17, 2014, at 19.

¹⁹¹ CSC00017792 – Canadian Institute for Health Information, "Wait Times for Priority Procedures in Canada" (Ottawa: CIHI, 2012), at 44.

1071. The data from CIHI reflects poorly on BC. With regard to joint replacement surgery (hip replacement, knee replacement) and cataract surgery, BC has seen a significant decrease over the last five years in the proportion of people treated within the benchmarks and is performing significantly worse than most other provinces.

Priority Area and Benchmark	Target	% patients treated within benchmark ³						
		CAN	BC	VCHA	NHA	FHA	IHA	VIHA
Hip replacement surgery (26 wks.)	90	83	67	82	76	74	66	39
Knee replacement surgery (26 wks.)	90	79	57	73	72	59	56	26
Hip fracture surgery (48 hrs.)	90	84	89					
Radiation therapy (4 wks.)	90	98	95					
Cataract surgery (16 wks.)	90	80	70					

1072. In an internal government briefing, the Ministry notes:

When comparing the median wait times for hip and knee replacements at the pan-Canadian, provincial, and international levels, Canada compares favorably well; however BC's average is not as favorable.¹⁹²

1073. The Ministry then notes, in a footnote, that other OECD countries in the CIHI report provided statistics for waiting times from specialist referral to treatment, whereas for Canada, it is from the surgical booking date to treatment.

1074. Notably, the most recent data from CIHI shows that the percentage of people treated within the benchmarks have dropped even further for these procedures (hip replacements from 67% to 61%; knee replacements from 57% to 47%; and cataract surgery from 70% to 64%).¹⁹³

1075. Therefore, Canada and BC do not actually compare favorably well to other OECD countries, as our "favorable" data does not include a significant component of the wait time that other countries are disclosing.

¹⁹² BC4415057: 2015.04.13 - Ministry of Health Information Briefing Note, Summary of Wait Times for Priority Procedures in Canada 2015.

¹⁹³ Canadian Institutes for Health Information data tables, online:<<http://waittimes.cihi.ca/BC>> (accessed September 5, 2016).

1076. Moreover, when the entire waiting time is taken into account, a large number of patients are waiting well over a year for needed surgeries.

1077. Therefore, as the evidence will show, the Government is not even meeting its commitments to almost meet the flawed and partial benchmarks it has set for itself.

No Accountability for Missing the Benchmarks

1078. The scientific literature confirms the common sense proposition that “Maximum waiting time guarantees are most successful when linked to targets with sanctions”.¹⁹⁴

1079. This issue was discussed by the BC Medical Association Policy Statement, with reference to international experience with care guarantees:

A care guarantee implies that, in cases where care cannot be provided within the agreed-upon timeframe at the usual public facility, recourse is available for individual patients to ensure that they receive timely treatment. (...)

Comprehensive care guarantees supported by legislation exist in a number of countries including the UK, Sweden, Denmark, and Finland. The UK has the longest record of care guarantees, dating back to 1991. Currently, the UK offers a maximum wait time guarantee of 18 weeks from date of referral to treatment for non-urgent conditions as well as guarantees for other specific conditions.

Sweden has supported care guarantees since 1992, with the current policy being that a doctor visit is guaranteed within seven days and if the patient is referred to a specialist this visit must take place within 90 days, with eventual treatment within a further 90 days. If the time limit expires, patients are offered care elsewhere; the cost, including any travel costs, is then paid by their own county council. Denmark currently has a wait time guarantee of one month, while Finland sets out a “three days, three weeks, and three months” guarantee for patients to be examined and treated at primary health care centres and hospitals.¹⁹⁵

1080. While there has been much discussion in Canada of implementing wait times guarantees, that has not been done in this province.

¹⁹⁴ Expert Response Report of Nadeem Esmail, dated July 15, 2014, at 8, citing Borowitz, Moran & Ciciliani (2013) “A Review of Waiting Times Policies in 13 OECD Countries” in Siciliani, Borowitz & Moran eds *Waiting Times Policies in the Health Sector: What Works?* (OECD Health Policy Studies).

¹⁹⁵ CSC00020332 - BC Medical Association, “Wait Times and Patient Care Guarantees” (2012), at 2-3.

1081. In 2007, the Federal Budget provided \$612 million in additional funding for the provinces and territories to improve access to health care services and to encourage them to establish Patient Wait Time Guarantees to ensure that all Canadians receive necessary medical treatment within medically acceptable waiting times.
1082. Along with the \$612 million for Patient Wait Time Guarantees, the federal government in its 2007 budget provided \$30 million over three years for pilot project relating to establishing guarantees. BC did not pursue any funding for such pilot projects as it considered this to be insufficient funding, and feared that it would bind the province to further guarantees,¹⁹⁶ which it knew it could not meet.
1083. As the BC Medical Association has observed, the “benchmarks reflect the time that clinical evidence shows is appropriate to wait for a particular procedure; they are not care guarantees or legal obligations to individual patients”.¹⁹⁷
1084. While the *Canada Health Act* and the *MPA* seek to guarantee ‘accessibility’ to the system, “there are no legislative means to enforce minimum access standards in Canada.”¹⁹⁸
1085. Despite the benchmarks derived from the 2004 Health Accord, governments “continued to operate on the basis of the traditional paradigm, one in which governments and provider groups control the healthcare delivery system without any direct accountability to individual patients”. They reflect a “series of non-binding political commitments that could not be enforced by individuals”.¹⁹⁹
1086. If the Province misses the benchmarks in aggregate – which it has consistently been doing – or with respect to a specific patient - which occurs on a daily basis with sometimes devastating consequences - there is no opportunity for the affected persons to seek redress or pursue a reasonably alternative.

¹⁹⁶ BC4319006: 2009.02.04 - Wait Time Guarantee Fact Sheet, at 1/2.

¹⁹⁷ BC1015693 - BC Medical Association, “Waiting Too Long: Reducing and Better Managing Wait Times in BC” (2006) at 8.

¹⁹⁸ CSC00020332 - BCMA Wait Times and Patient Care Guarantees, at 1.

¹⁹⁹ Monahan, “*Chaoulli v. Quebec*”, at 18-19.

1087. This is contrary to the central holding in *Chaoulli*, which was that governments must be accountable to individuals who are in need of care, to the extent that it seeks to prevent those persons from accessing the care they need.

1088. That is exactly why this constitutional challenge is necessary.

1089. Even if the government's benchmarks were generally medically appropriate, and were generally being met, there is still no recourse to ensure that each and every individual is getting the treatment they need. And yet those individuals are still effectively prohibited from meeting their needs outside of the system. So they are left untreated.

1090. Every time individuals fails to receive timely medical care for medical conditions, and are prevented from seeking private care to protect their health and well-being, their *Charter* right are violated.

Shifting Benchmarks

1091. Moreover, the Province has altered the established benchmarks, seemingly whenever it believes it is not politically wise to publish the fact that its previously established benchmarks are not being met.

1092. In 2010, the Ministry led a collaborative process to develop a diagnosis-based patient prioritization tool which links a patient's diagnosis and individual clinical condition to a recommended maximum wait time target.²⁰⁰

1093. A comprehensive listing of the diagnosis descriptions/patient conditions and their associated priority levels was produced. These prioritization codes were based on expert opinion.

1094. The wait time targets related to six surgical priority levels, ranging from 2 weeks to 26 weeks. Every patient scheduled for surgery is given a priority rating that matches their level of urgency for the type of surgery that they need.

²⁰⁰ BC4051957 - Future Directions for Surgical Services in British Columbia 2015, at 24/58.

1095. More specifically, the five priority levels correspond with the maximum recommended wait time benchmarks (Priority Level 1 – 2 weeks, PL2 – 4 weeks, PL3 – 6 weeks, PL4 – 12 weeks, PL5 – 26 weeks). Under such a system the time limit attached to the lowest urgency category for a procedure (ie. usually PL5) is by definition, the maximum acceptable wait time, or the time threshold by which *all* patients, no matter the urgency of their case, should receive the service in question.²⁰¹
1096. Based on this work, in 2012/13, the publicly reported performance measure relating to surgery was to be whether patients received their surgery within the benchmark timeframe for their priority level.²⁰²
1097. The performance measure for surgical wait times was “the proportion of non-emergency surgeries completed within the benchmark wait time” which, as described, was specific for each elective procedure.
1098. However, the Ministry did not meet its 2013/2014 target of having 75% of patients receive their surgery within the acceptable wait time for their specific type of surgery. In fact, only 66% of patients received their care within the wait times deemed acceptable for by the Government.²⁰³
1099. And the Province did not believe it would be able to meet its target of 80% in the following year.²⁰⁴
1100. So the Ministry decided to change the publicly reported performance measure to the percent of patients that were provided surgery within 26 weeks (the maximally acceptable wait time for the lowest priority level).²⁰⁵

²⁰¹ BC5037057: 03.16.2011 - Establishing surgical prioritization and wait time targets for all elective surgeries in B.C., at 9/15.

²⁰² BC5100842: 2013.06.06 - Ministry of Health Service Plan Measures and Targets, at 4/5.

²⁰³ BC4407622 - E-mail regarding MOH Service Plan surgical benchmark measure 2013.12.13; BC5135648: 2014.10.15 - Fact Sheet: 2013-14 to 2015-16 Service Plan Measures - Regional Health Authority.

²⁰⁴ BC5127423: 2014.11.27 - Ministry of Health Decision Briefing Note: Performance measures and targets in Ministry of Health 2013/14 - 2015/16 Service Plan.

²⁰⁵ BC4205163 - Estimates note; Ministry of Health 2014/15 - 2016/17 Service Plan Overview.

1101. In the Ministry of Health's 2014/2015-2016/2017 Service Plan, there was no mention of the Ministry's inability to meet its previous benchmark, nor the fact that the performance measure was altered due to concerns about optics.

1102. Rather the Ministry simply reported the following data²⁰⁶:

Performance Measure 4: Access to non-emergency surgery.

Performance Measure	2013/14 Baseline	2014/15 Target	2015/16 Target	2016/17 Target
Per cent of non-emergency surgeries completed within 26 weeks	90.6%	92%	93%	95%

Data Source: Surgical Patient Registry Excel Cube on December 15, 2013. Includes all elective adult and pediatric surgeries.

Notes: Baseline is for surgeries completed from April 1, 2012 to March 31, 2013. Target per cents are for surgeries completed in the fiscal year.

1103. Needless to say, the Government's willingness to ignore and even change previous benchmarks undermines any value or accountability they could possibly provide.

1104. Data from 2015 shows that the Ministry has not been able to achieve even the newly revised performance targets.²⁰⁷

1105. The Ministry noted that most Health Authorities continue to fall short of targets for the percentage of scheduled surgical cases completed within 26 weeks, and that this was true for the majority of procedures, whether performed as day surgery, in-patient short stay (up to 3 days) or in-patient longer stay.

1106. The Minister found that at the procedure/specialty level, there are wait list "hot spots" being knee replacement, hip replacement, cataract surgery and varicose vein ligation/stripping.

²⁰⁶ BC4160067: 2015.02.06 - 2015/16 - 2017/18 Service Plan.

²⁰⁷ BC4414432: 2015.07.30 - Ministry of Health Decision Briefing Note, Title: Opportunities Related to Private Surgical Facilities in BC, Cliff #1037092; BC4292059: 2015.07.07- Percent of non-emergency Surgeries completed within 26 weeks.

1107. When looking at the actual data, it is clear that the percent of non-emergency surgeries completed within 26 weeks from 2010/11 to 2014/15 has decreased for every health authority except Northern Health, and some Health Authorities have dropped almost 10%.²⁰⁸
1108. Although the BC goal for 2014/2015 was to have 92% of patients receive their surgery within 26 weeks, the BC average actually fell below its 2013/2014 baseline, to 87%, and this number is trending downwards.²⁰⁹
1109. And, then there are the significant number of people who give up waiting and drop off the wait list, even though they still require surgery.
1110. This is discussed by Dr. Vertesi in his expert report as follows:

I will explain this statement using as an example an analysis I did on the BC waitlist (all daycare bookings excluding cataracts) in 2012. The number of drop-offs across BC had been averaging 17% of the number of cases actually being completed (22% in one Health Authority). The average time on the waitlist for these patients until they dropped off was 300 days. Some might suspect those who dropped off must have been less urgent, but 63% of these drop-offs had been given “Higher Priority” scores indicating a “recommended” wait time (RWT) of less than 16 weeks (112 days); the average wait to drop-off within that higher priority subgroup was 240 days. The average wait of those still waiting on the waitlist at that time was 200 days. Of these, 24% had already exceeded their RWT and were still not done. Of more concern, the number exceeding their RWT in the higher priority group (RWT of 16 weeks) was 52%. In other words, the higher priority groups were failing to meet the ministry’s recommended targets to an even greater extent than the average (perhaps because higher priority cases usually require longer operating times and are therefore more difficult to schedule). In the meantime, completed cases had only waited 71 days on average and the median of that (49 days) is the only number that would have appeared on the website. Effectively the waitlist ends up (not intentionally) operating as a two-tiered system with two classes of patients, those that get completed and those that for some reason go into a prolonged holding pattern or eventually drop off. Their respective wait times are very different, and the website reveals only the first.

I know this is more detail than most people need or can handle on a website, but the point is that the numbers appearing on the website significantly underestimate the

²⁰⁸ BC4292059: 2015.07.07- Percent of non-emergency Surgeries completed within 26 weeks.

²⁰⁹ *Ibid.*

actual patient experience. People may not know exactly what is wrong, but the gap is large enough to generate mistrust which may be a factor in the slow uptake. Having said all of that, I still agree that the relative values shown on the website are accurate enough to be a guide for avoiding the longest waits.²¹⁰

1111. In summary:

- A. The benchmarks set by the Government are longer than is medically acceptable, and in any event, only measure a part of the overall wait times experienced by BC residents;
- B. For those few procedures deemed priority areas, the Government has only committed to meeting the benchmarks for some patients, and has routinely failed to even meet these modest objectives;
- C. There is no way to hold the Government to even these modest commitments; and
- D. When the Government fails to meet its targets, it changes them retroactively, depriving them of any limited value they might otherwise have.

Benchmarks are a Constitutional Red Herring

- 1112. It is important to note that benchmarks and wait times targets generally are an abstraction, particularly in the absence of a legal obligation enforceable by patients to provide care within a medically acceptable period of time.
- 1113. Benchmarks are important to help large systems understand where improvement needs to be made, and to measure that improvement (or deterioration).
- 1114. However, wait times statistics are abstract numbers. They tell an important part of the story, but they are the forest, not the trees.

²¹⁰ Response Report of Dr. Les Vertesi, dated July 15, 2014, at 4.

1115. *Charter* rights are not distributed in the aggregate – each individual is entitled not to have his or her rights violated, in his or her own individual circumstances.
1116. In the context of medically necessary treatment, each individual patient is different. Some can wait for medical treatments with only minimal cost to themselves or the economy.
1117. Others cannot wait without significant costs being imposed on themselves, their families, their employers and the economy.
1118. Some may be able to wait longer than the ‘benchmark’ period for treatment without much pain, deterioration of their health or reduced mobility, while others will experience considerable pain and risk to their health even if they are treated in a timely fashion and much more if they are not.
1119. Because each situation is different, it is impossible to apply a uniform wait time to everyone.
1120. As the Centre for Spatial Economics stated in its 2008 study, there is no ‘optimal’ wait time for all persons:

What is optimal?

An analysis of optimal wait times is complicated by a lack of agreement on what is optimal. Governments, clinicians, patients and economists all have different notions of what is optimal.

For governments, optimally is determined by making decisions that they perceive to be the best ones from society’s point of view. Cynics would argue that this simply means finding a solution that yields the most votes. From the perspective of clinicians and consumers, what is optimal is frequently based on the notion that the marginal cost of providing additional services is zero (or almost zero). Services should be available for all those that provided to the point where the marginal value to the consumer of providing the service is equal to the marginal cost of their provision, where marginal cost reflects the value of those resources in their next best use.²¹¹

²¹¹ BC4050039 - Centre for Spatial Economics, “The economic cost of wait times in Canada” (January 2008) at 10-11.

1121. Mr. McGurran states in his expert report that the “obsession” with abstract waiting times is misguided:

This focus on performance vis-à-vis national benchmarks notwithstanding, it is important to remember that the actual wait time a given patient faces is not accurately described in the data that is publicly available. The Ministry’s website depicts the median (average) and the 90th percentile measured over a recent three month interval. These statistics are useful for monitoring operational performance but of no value to the individual patient.²¹²

1122. Doctors attempt to give urgent cases greater priority. But even with elective surgery, there is no “one size” waiting time that fits everyone’s medical needs or individual circumstances.
1123. The indisputable fact is that the Government cannot meet every BC resident’s medical needs in the time frame that is medically appropriate and acceptable their own individual circumstances.
1124. Put another way, even if the Government could treat everyone within benchmark times that are acceptable for many, or even most, people, which it has been unable to do, there are still unacceptable costs being imposed on at least some individual patients within the benchmark waiting times.
1125. This means that even if the Government met its goal of having all medically necessary surgeries performed within one year, this is a constitutional “red herring”, because that will still be far too longer for some patients.
1126. Some British Columbians would still be denied their constitutional right to be able to take the steps necessary to protect their own bodily integrity.
1127. From the perspective of each individual patient – the holder of the *Charter* rights – whether or not the Government has provided treatment within a ‘reasonable’ time *in general* is irrelevant.

²¹² Expert Report of John McGurran, dated March 17, 2014, at 18.

1128. If an individual is being denied the ability to access medically necessary health care treatment – that is, to take the steps they need to with their own body – the government must have a justification for depriving them of that right.
1129. Of course, on the evidence, thousands of patients each year are not treated within even the somewhat arbitrary benchmarks fixed by government.
1130. So the situation where benchmarks are met within the public system, and where those benchmarks are actually reasonable for most people, remains hypothetical.
1131. The point is that those who are not provided with care in a timely fashion must have another option, whether they are the minority or the majority.

D. Conclusions on Wait Times and Benchmarks

1132. This court will likely hear much about the government's intent to improve wait times. From a constitutional standpoint, this is very much beside the point.
1133. That is because even if the benchmarks reflected medically reasonable wait times (which they do not), even if they were measured properly from the moment the patient seeks medical care, (which they are not), even if the Government was consistently meeting these benchmarks (which it is not), even if the benchmarks reflected the entire period of wait for the patient (which they do not), and even if there possibly was a way for individual patients to enforce the benchmarks (which there is not), it would still not negate the constitutional harm being caused by the prohibitions on access to private care.
1134. The legal prohibition on individuals making their own choices about their physical and mental well being by electing treatment in a private clinic, is a violation of s. 7.
1135. The Government has had ample time to fix the public health care system and has not been able to do it.

1136. In these circumstances, the Constitution requires the court to act to compel the Government to implement real and meaningful reform to protect the health of all British Columbians.

1137. I will now turn to the significant harms caused by rationing public sector care, while prohibiting access to timely medical care outside the public system.

VI. THE COSTS OF WAIT TIMES – GENERALLY

A. Deterioration of Physical Health and Risk to Life

1138. It is undeniable that waiting for medically necessary services inflicts physical, psychological and economic cost on patients.

1139. Most obviously, individuals are often suffering pain and psychological anguish while they wait for treatment. Sometimes, this pain and suffering can endure for months or even years while the patient winds his or her way through the system, before ultimately being treated.²¹³

1140. If the Government had actively imposed this same pain and suffering on British Columbians, there would be no doubt that it had acted unconstitutionally.

1141. However, for some reason, the Government seems to believe that *preventing* people from accessing treatment to *alleviate* pain and suffering is constitutionally permissible.

1142. That is simply wrong. The result of the government action in both cases is to cause pain and suffering, and in some cases, death. This is unconstitutional.

²¹³ BC1028489 - Patient complaint re son's medical issues; BC2249558 - Patient complaint re unbearable pain while on waitlist; BC2250076 - Patient complaint re pain experienced while on waitlist; BC2249844 - Patient complaint re pain and suffering while on waitlist; BC4065275 - Report on acute inpatient comments/complaints; BC5127768 - Letter from MLA re constituent being forced to wait 8 months for a colonoscopy when the recommended wait time is 8 weeks.

1143. There is, therefore, no morally or legally relevant distinction between the two cases: in both, the direct result of the decisions of the government is increased and prolonged pain and suffering, imposed as a direct result of government action.

1144. Moreover, by preventing individuals from accessing timely care, the Government is causing at least some individuals long term damage to their physical health. As Mr. McGurran explains:

Waiting for care can be harmful in many ways and the extent of this harm varies from one patient to another. As the length of the wait time increases, so does pain and suffering associated with the illness; there will also be a need for intermediary treatment such as pain medication. Clinical research indicates that with a longer wait, the patient's condition, by definition, worsens and this may increase risk of a poor outcome for the procedure the patient is waiting for. Often while waiting the patient cannot fully participate in work or school and the activities of daily living. This may contribute to emotional and financial stress.²¹⁴

1145. Professor McGuire, another of the Plaintiffs' expert witnesses similarly states:

There is a large literature that shows treatment delay, due to longer waiting time, is associated with deterioration in health during the waiting time for some individuals, as well as causing pain and distress. This literature finds that individuals waiting for orthopaedic surgery for example, suffer pain, reduced morbidity and deterioration in their quality of life. There is also a literature that states that longer wait times are associated with longer in-patient stay and increased resource use.²¹⁵

1146. The Wait Time Alliance has observed that wait times impose a significant cost on patients beyond pain and suffering, as their "health often suffers and deteriorates while waiting unnecessarily for care". This creates "medical complications requiring more invasive treatment and follow-up".²¹⁶

1147. Wait times can even put persons' lives at risk, as many studies have shown. For instance, as Professor Kessler notes with reference to Coronary Artery Bypass Graft (CABG) surgery:

...For people with serious cardiac illness, more rapid receipt of elective surgery leads to lower mortality. Patients who waited less were less likely to die, either in the hospital or on the wait list. This finding is striking because physicians naturally seek to prioritize sicker patients first, which would tend to induce a *negative* association

²¹⁴ Expert Report of John McGurran, dated March 17, 2014, at 9.

²¹⁵ Expert Report of Alistair McGuire, dated March 17, 2014, at 13.

²¹⁶ CSC00019446 - Wait Time Alliance, "Time to Close the Gap", at 1-2.

between waiting time and death. Second, at least for CABG, BC's provincial waiting time guidelines are insufficiently strict. Although waiting longer than recommended by the guidelines (6 weeks for semi-urgent, 12 weeks for non-urgent patients) leads to reduced survival, achieving a significant survival benefit requires care to be delivered within the more-rapid guidelines suggested by the Canadian Cardiac Society (semi-urgent patients treated within 2 weeks, nonurgent patients treated within 6 weeks). Table 3 shows that this was still a concern as of October 2013 when 10% of CABG patients were waiting longer than 11.5 weeks, almost double the six-week maximum found to be necessary to minimize the risk of death from waiting for less severely-ill patients. Third, the current way of prioritizing patients by disease severity is flawed. Longer waiting times for nonurgent versus semiurgent patients results in greater mortality among *nonurgent* patients, despite their lower initial severity. Although prioritizing sicker patients might have the potential to mitigate health harms from waiting in theory, it is not succeeding in practice.²¹⁷

1148. This potential result of such wait times – where patients are also prevented from having their health care needs met outside the public system – was agreed by all members of the Court in *Chaoulli*:

- “Inevitably, where patients have life-threatening conditions, some will die because of undue delay in awaiting surgery... there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care” [at paras 112, 123, *per* McLachlin CJ & Major J.; emphasis added]
- “... when a person is diagnosed with cardiovascular disease, here or she is ‘always sitting on a bomb’ and can die at any moment. In such cases, it is inevitable that some patients will die if they have to wait for an operation.” [at para 40, *per* Deschamps J.; emphasis added]
- “we accept the trial judge’s conclusion that in some circumstances some Quebecers may have their life or “security of the person” put at risk by the prohibition against private health insurance” [at para 191, *per* Binnie & Lebel JJ.; emphasis added]

1149. Indeed, such considerations are not limited to those conditions that are most often considered ‘life-threatening’. As observed by the majority in *Chaoulli*, the risk of long pre-operative wait times for other surgeries may also pose the risk of premature death:

The same applies to other health problems. In a study of 200 subjects aged 65 and older with hip fractures, the relationship between pre-operative delay and post-operative complications and risk of death was examined. While the study found no relationship between pre-operative delay and post-operative complications, it

²¹⁷ Expert Report of Daniel Kessler, dated March 17, 2014, at 4 (First Report).

concluded that the risk of death within six months after surgery increased significantly, by 5 percent, with the length of pre-operative delay: A. Laberge, P. M. Bernard and P. A. Lamarche, "Relationships between the delay before surgery for a hip fracture, postoperative complications and risk of death" (1997), 45 *Rev. Epidém. et Santé Publ.* 5, at p. 9. [at para 113]

1150. The possibility that the absence of timely access to medical treatment may result in the unnecessary and premature death of the patient, underlines the gravity of the prohibitions at issue in this case.

1151. The fact that the government is preventing persons from mitigating the risk of harm or even death is, morally and legally, the same as imposing that risk directly.

1152. When individuals' very lives are on the line, we are no longer debating what form of financing of the health care system would be best from a policy perspective. We are asking whether the alleged benefits of the government's decision to impose a monopoly on the provision of health care could justify the risk that it poses to the health and sometimes survival of BC residents.²¹⁸

B. Emotional and Psychological Damage

1153. The pain and suffering, increased risk of negative health consequences, and risk of an untimely death, is only part of the harm caused by waiting times.²¹⁹

1154. The OECD has observed that focusing only upon deteriorating health and less favorable clinical outcomes resulting from waiting times is only part of the story, because waiting times also "generate disutility to patients due to postponed benefits from treatments, pain while waiting, [and] anxieties due to uncertainty about the date of treatment."²²⁰

²¹⁸ BC1025336 - Email response from Ministry acknowledging wait times; BC2250062 - Patient Complaint re the poor quality responses used to address complaints.

²¹⁹ BC1028544 - Complaint from Doctor of conditions at hospital and the patients bearing the brunt of the neglect; BC1028550 - Complaint from Doctor of conditions at hospital.

²²⁰ Expert Report of John McGurran, dated March 17, 2014, at 9 citing Siciliani, L., M. Borowitz and V. Moran (eds.) (2013), "Waiting Time Policies in the Health Sector: What Works?" OECD Health Policy Studies, OECD Publishing, Paris.

1155. Mr. McGurran is of the opinion that “medical care causes harm to patients in many ways: clinically, socially and emotionally. Therefore, waits must be as short as practicable. Increasing the supply of private medical care has the potential to reduce waiting and its consequences”.²²¹

1156. Following a review of an extensive body of research on the deleterious effects of wait times, Mr. Esmail summarizes the costs as follows, which are not limited to the pain, suffering, and psychological harm caused by waiting for treatment:

More generally, waiting for health care can result in extended experience of pain (and extended consumption of medicines for pain relief), reductions in mental well-being, lost productivity at work, reduced engagement at leisure, and negative impacts on personal relationship. The consequences of these can be significant in terms of reduced quality of life. For example, individuals may engage in fewer personal activities including with friends but also with children, grandchildren, spouses and other family members. They may also be less able to travel to see friends and family or receive them as guests. Some may even face restricted mobility in their own homes due to the need to negotiate stairs for example. Individuals may also become more reliant on others both for general activities as well as personal matters such as bathing. Vacations may also be put off or foregone entirely either in response to the untreated medical condition (and possibly greater risk of travel) or in response to the uncertain nature of waiting where surgical bookings may suddenly become available or be cancelled. The significant emotional and mental impacts from such reduced activity and engagement, increased loneliness, and increased dependence on others may also be accompanied by frustration, feelings of helplessness, and depression.²²²

1157. This point was made by the majority in *Chaoulli*, where it found that the prohibitions on private insurance contained in the Quebec legislation imposed a serious enough psychological harm on patients to constitute a breach of security of the person, even leaving aside the risk of physical pain, suffering and deterioration of physical health:

In addition to threatening the life and the physical security of the person, waiting for critical care may have significant adverse psychological effects. (...)

Studies confirm that patients with serious illnesses often experience significant anxiety and depression while on waiting lists. A 2001 study concluded that roughly 18 percent of the estimated five million people who visited specialists for a new illness or condition reported that waiting for care adversely affected their lives. The majority suffered worry, anxiety or stress as a result. This adverse psychological impact can

²²¹ Expert Report of John McGurran, dated March 17, 2014, at 10.

²²² Expert Report of Nadeem Esmail, dated March 17, 2014, at 15.

have a serious and profound effect on a person's psychological integrity, and is a violation of security of the person (Access to Health Care Services in Canada, 2001, at p. 20). [Choulli at paras 116-117]

1158. The Statistics Canada Survey, which specifically examines access to specialist visits, non-emergency surgeries and diagnostic tests, was updated in 2005.²²³
1159. Approximately 18% of individuals who visited a specialist indicated that waiting for the visit affected their life, while 11% of individuals waiting for non-emergency surgery indicated that the wait time affected their life.
1160. As stated in that survey:

Most of those affected reported that they experienced worry, stress and anxiety during the waiting period: ranging from 49% among those whose lives were affected by waiting for non-emergency surgery to 71% among those affected by waiting for a diagnostic test....Between 38% and 51% of individuals waiting for specialist services experienced pain and close to 36% of those who were affected by waiting for non-emergency surgery indicated that they experienced difficulties with activities of daily living. Approximately 28% of those who were affected by waiting for a diagnostic test indicated that it resulted in worry, stress and anxiety for their friends and family.

C. Economic Cost on Patients, the Economy, and the Health Care System

1161. The impact of long waits goes even beyond the patient's physical, psychological and emotional health, and reduced quality of life, to include an economic cost to both the patient and society.
1162. For individuals and their families, a lengthy wait can mean a substantial loss of income, particularly if they do not have insurance to cover any period of economic inactivity associated with the wait. ²²⁴

²²³ Statistics Canada, "Access to health care services in Canada: Waiting Times for Specialized Services (January to December 2005), online: <<http://www.statcan.gc.ca/pub/82-575-x/82-575-x2006002-eng.htm>>.

²²⁴ BC2250073 - Patient complaint re inability to work while injured; BC2249955 - Patient complaint re brain tumour and inability to work and support themselves; BC22500028 - Patient complaint re unable to work because requiring cataract surgery; BC1027056 - Patient complaint re off work while waiting for an MRI; BC2250108 - Patient complaint re off work while waiting for an MRI; BC1023946 - Patient complaint response re too ill to start a new job.

1163. These costs are described as follows by the Centre for Spatial Economics in a 2008 study prepared for the British Columbia Medical Association and the Canadian Medical Association:

Costs of Waiting

The costs of waiting can be determined in terms of the impacts on individual economic agents – individuals, businesses, and governments – and the resulting impacts on the resources available to the economy as a whole and the efficiency of the resulting resource allocation.

The cost to individuals of waiting depends on the nature of the illness and the circumstances of the individual. It is determined by the impact on the ability of the individual to work or play. For those in the labour force, illness can lead to a temporary loss of employment, including the postponement of skills development and the possibility of advancement, and the associated income. It could also lead to a permanent loss of employment and income from death or disability. Individuals must also contend with out of pocket costs for purchases related to waiting, a reduction in the quality of their leisure time, and the impact on their extended family.

Businesses face increased human resource costs of replace lost or affected employees. Productivity is reduced when employees take time off work to visit health care providers. The productivity of some employees who are still working may be reduced, as they are not able to perform at required levels. From a broader perspective, businesses face reduced sales as a result of the lost employment income of affected individuals throughout the economy and a reduction in the ability of individuals to engage in leisure activities.

The costs to governments of waiting are in terms of both higher spending and lower revenues. Government expenditures, excluding health, are increased as unemployment rises and increased transfer payments to persons are required. Government revenues fall as reduced individual income and business sales lead to lower taxes. Finally additional health care resources must be supplied while waiting for treatment, which increases demands on and costs for the health sector. These include additional visits to medical practitioners, additional drugs, and other additional cost associated with work required both before and after treatment.²²⁵

1164. This study also discussed the “benefits” of waiting:

Benefits of Waiting

While the costs of waiting usually receive considerable attention, there are also benefits that accrue from wait lists. The primary benefit is that wait lists alleviate the problem of overconsumption of health care. This benefit is achieved by imposing a

²²⁵ BC4050039 - Centre for Spatial Economics, "The economic cost of wait times in Canada", at 10.

non-monetary price – the time cost of waiting – on health care that reduces its consumption. A reduction in wait times reduces this non-monetary price, which is likely to lead to an increase in demand for service.

Wait lists can also lead to the substitution of foreign resources for domestic resources. Consumers who do not wish to obtain health care services and can afford to go elsewhere, do so. There are also businesses that benefit from the added costs of waiting: higher drug sales, higher sales of medical devices, increased provision of certain medical services. Finally, wait lists allow resources to be allocated to the rest of the economy that might otherwise be used to increase health care services.²²⁶

1165. As can be seen, the alleged “benefit” of waiting is that it reduces demand on the public system by causing patients to forego the medical service or go elsewhere to obtain it.
1166. It also increases consumption of other health-care related products and services, which may be a benefit to the providers of those products and services, but are an overall cost to the health care system as well as to the patient.
1167. These costs tend to be compounded: a longer wait can mean greater deterioration in the patient’s health and a longer recovery time, potentially leading to a further loss of income.²²⁷
1168. The substantial financial costs of lengthy waits for both patients and Canada’s economy have been previously documented.
1169. A 2008 study prepared by The Centre for Spatial Economics for the Canadian Medical Association and the British Columbia Medical Association calculated the economic impact of excess wait times for five procedures (hip and knee replacement surgery, MRIs, CABG surgery and cataract surgery) in all 10 provinces.²²⁸
1170. It found that, in addition to the obvious emotional, physical and financial toll endured by patients and their families, lengthy waits for these medical treatments cost Canada’s

²²⁶ *Ibid* at 10-11.

²²⁷ BC5005808 - Advice to minister considering report stating costs to Canadian economy for longer than recommended wait times.

²²⁸ BC4050039 - Centre for Spatial Economics, “The economic cost of wait times in Canada”, at 1.

economy an estimated \$14.8 billion overall in 2007 in reduced economic activity (\$16.9 billion in 2014 dollars).

1171. This reduced federal and provincial government revenues by \$4.4 billion.
1172. It should be noted that this study examined only a limited number of procedures and therefore underestimates the full cost of waiting that Canadians experience for a wider range of services.
1173. Moreover, these wait times exacerbate the costs on the monopoly public system, creating a cycle of increased costs of the system, insufficient funding, and therefore insufficient supply of medically necessary services.²²⁹
1174. This is because there are also the extra costs incurred as a result of the delay in the surgery, such as more visits to doctors to deal with pain and other related issues caused by the medical condition requiring surgery, additional drug expenditures for relief against the consequences of the condition and various forms of therapy, and in many cases visits to emergency rooms which would otherwise be unnecessary.
1175. Dr. Les Vertesi discusses what he describes as “queue costs” in his book *Broken Promises*:

On the other hand, we could reject SBF [Service Based Funding] and simply continue what we are doing now. We fool ourselves into thinking that artificial limits placed on funds will control the cost of health care, but we are forgetting one of its most expensive aspects – something I call “queue costs.” These are simply the costs directly related to maintaining the queue that results when we limit access to hospital resources. A real-life example might help make this clear.

Mrs. J.B. arrived in my emergency department at six a.m., complaining of abdominal pain that had kept her up all night. She had given birth three months earlier and since then had experienced an exacerbation of her gallbladder problems. Originally diagnosed by ultrasound a year earlier with gallstones, she had declined surgery at that time because she had only had a few attacks of pain, and the long waitlist had deterred her. Her doctor had agreed it would be better to wait until her pregnancy was over before she contemplated surgery.

In the last two weeks she had four episodes of pain, and had been seen in another emergency department the previous day, where another ultrasound was done. It,

²²⁹ BC1022091 - Patient complaint outlining concerns with the current system.

again, confirmed the presence of stones in her gallbladder. Because she was not deemed to be having a life-threatening emergency, she was sent home with Demerol tablets for pain, but was told to come back to hospital if things became worse. Of course, things were going to get worse. When I saw her, it was a Saturday and the emergency department was completely full with no spare beds. I had already referred several people with recurrent gallbladder pain to the general surgeon on call earlier in the week, but I knew all of them had been sent home. Even though the surgeon had the ability to completely cure their pain with a one-hour procedure, he had sent them home instead because there was no hope of getting the necessary operating room time. Perhaps the surgeon had become somewhat inured, because he had a line-up of people seen through his office who had already been waiting three months or more with the same condition.

Something about this particular patient made me sympathetic, perhaps because she kept breaking into tears. I examined her but found little unusual. The pain, in fact, had gone away by the time I saw her (as it usually does), and she did not seem terribly sick.

I told her the chances of my being able to help her were small unless she was much sicker than she appeared to be. Merely having pain all the time was no longer a criterion for immediate action in our hospital. But she kept complaining that she still had a dull ache that wouldn't go away and was having trouble breast-feeding her baby, because she had been unable to eat any food for two days without vomiting. I also was suspicious that her eyes might be more yellow in colour than normal, although I couldn't be sure that it was due to jaundice. I told her that I would at least do some blood tests to make sure there was no infection or obstruction, but that if those tests were normal, I would be forced to send her home again with more Demerol. She tearfully agreed.

As it turned out, the blood tests were quite abnormal, showing not an infection, but an obstruction of the biliary tract with bile backing up into the liver. The bilirubin levels did indeed indicate that she was jaundiced, and I had been correct in my suspicions about the colour of her eyes. I told her the good news. Yes, she was indeed obstructed with a stone in her biliary tract, and that changed her status to urgent. I would admit her to hospital, even though there were no beds and she would stay in our orthopaedic plaster room overnight. The good news was that the surgeon would be forced to do something now. Her tears became a torrent, but they were tears of joy as she told her husband the good news, that her liver was bursting with bile.

I read her operative report a few days later. A repeat ultrasound had confirmed that one of the stones in her gallbladder had slipped down into the common bile duct, the small tube leading into her intestine, causing a high degree of obstruction to the flow of bile, and a backup of bile in the liver. Simply taking her gallbladder out would no longer solve her problem, since the gallbladder was only the source of the stone, but the stone that had travelled and was causing the problem would still be there. What she needed now was an extraction of the stone from the duct below the gallbladder.

ERCP is a technique in which a fibre-optic tube is passed down the throat into the stomach, threading it into the duodenum and visually locating the tiny Ampulla of Vater – the opening where the bile duct empties into the duodenum. The doctor then threads the tiny scope up into this opening and into the common bile duct where the stone is, locates the stone, and mechanically pulls it out. The entire procedure takes about an hour, but because it requires only some sedation and not a full anaesthetic, it did not require precious operating room time. In this patient's case, this was successfully done on the Monday, relieving her obstructed duct and corrected the urgent part of the situation.

The tragedy was that after all that, she was sent home again with her gallbladder still full of stones, to wait her turn for gallbladder removal. Instead of having one procedure and dealing with the entire problem when it first arose, she had to put up with weeks of pain, have a different procedure done, take up numerous doctor's visits and a hospital bed, and still she was sent home with her original problem.

Quite aside from the humanitarian issues, how did forcing this woman to wait with her gallbladder pain save any money? Not only did it not save money, it cost extra for the additional visits and the procedure that should have been unnecessary – not to mention the personal costs her family had to bear in lost wages and time looking after an ill family member.²³⁰

1176. Improving timely access to necessary care therefore has both health and economic benefits for all, including for the public health care system itself.

D. Conclusion on the General Harms of Lengthy Wait Times

1177. Unnecessary waiting leads to substantive health and economic costs to patients and their families. Individuals' health, well-being and lives are jeopardized by long wait times.
1178. Often while waiting the patient cannot fully participate in work or school and the activities of daily living, contributing to emotional and financial stress.
1179. Ultimately, there is no benefit for the individual patient and no net benefit to the economy or government revenues. Instead substantial harm is inflicted.
1180. In order to understand these effects in context, it is important to describe in some detail the experience of the Plaintiffs and others, who were among the thousands of British

²³⁰ Les Vertesi, *Broken Promises: Why Canadian Medicare is in Trouble* (2003) at 261-264.

Columbians left behind by the public system and prohibited from accessing necessary health care.

VII. EXAMPLES OF HARM CAUSED BY WAIT TIMES TO THE PLAINTIFFS AND OTHERS

A. Overview

1181. Constitutional rights are possessed by individuals. “Everyone” has the “right to life, liberty and security of person”. “Everyone” has the right to be equal before and under the law, and to derive equal protection and benefit of the law.
1182. It is easy to get mired in a debate about acceptable waiting times that would *generally* be harmful but not *too* harmful, or about when the Government is *roughly*, or in most cases, providing adequate care.
1183. We could debate endlessly what is an appropriate or acceptable amount of time an average person can suffer while on a waiting list.
1184. But constitutional rights are held by each individual. All British Columbians have these rights. And the harm they suffer when those rights are violated is no less because others might have had their rights respected or may have suffered a lesser violation of their rights.
1185. Therefore, even if wait times in B.C. were *generally* acceptable, and even if there were not overwhelming evidence that these wait times are generally far longer than medically optimal, this would not negate the constitutional harm caused by prohibiting individuals from accessing the medical care they need when the wait time for that individual is too long for his or her personal circumstances.
1186. A few real-life examples will help demonstrate the serious harm caused by rationing health services.

B. Walid Khalfallah

1187. The first example is the case of the Plaintiff Walid Khalfallah.

1188. Walid became paralyzed because he had to wait too long for spinal surgery.

1189. His mother wrote to the Minister of Health about the delay in his surgery, but to no avail.

1190. Her letter to the Minister dated August 3, 2011, reads as follows:

Good morning Honourable Michael de Jong,

I have been busy for the last four months advocating for my son, Walid, who requires serious surgery for his back. Since his back started to rapidly change two years ago we have heard the word wait at every step of our journey —now after two years he still has no MRI, no CT scan and no surgical date. I have attached a letter written by my father published in our local paper; a shorter version was published in Macleans magazine. Here is a link for a video made by a friend - <http://youtu.be/nBjDBb9vnTQ> and a local news story <http://youtu.be/iOcfpClkBvQ>.

I have done some research and heard many stories from others facing waitlists of their own; I am disturbed by the degree to which waitlists have become normalized. Working as a nurse with the geriatric population I see the negative effects of waitlists on a daily basis but to now discover how many children are also waiting is shocking. I have spoken to my MLA's office here in Kelowna and also met with him last week. He was empathetic. I have formalized a complaint with BC children's hospital whose reply was that the wait times although not ideal are acceptable and in line with wait times in other provinces. I am also working with Shriner's Canada who help children that are on waitlists. In February of this year, I was told Walid is no longer on a waitlist because his condition had deteriorated further and would need the surgery by summer ... today August 3 still no plans for the diagnostics nor surgery.

My immediate focus is a surgical date for my son. My secondary focus has become it is time [] for a new conscious awareness that waitlists do not belong in healthcare. Waitlists are a treatment that do not promote healing nor wellness — in fact they increase illness. Health isn't everything but without it nothing else matters. I believe there are more than enough resources what we need is better management of the resources — more accountability, better more efficient delivery of healthcare and more individual responsibility to take better care of ourselves and each other.

As a response to the studies of wait times for healthcare, Dr. Douglas Courtemanche of the BC Children's Hospital noted that these studies of wait times, costly as they are, only identify the problem. But they do not provide a solution. He concludes "one of the benefits of living in Canada should be that we can afford to look after each other." I agree.

If you can offer me some support for either focus, tremendous ... any thoughts are also appreciated. Thank you Honourable Michael de Jong,

Walid's Mom, Debbie Waitkus²³¹

1191. As can be seen, Walid had already been waiting two years without an MRI, CT scan or surgery date.

1192. The Ministry of Health responded as follows:

Dear Ms. Waitkus:

Thank you for your email of August 3, 2011, regarding the scheduling of your son Walid's orthopaedic surgery. I am responding on behalf of the Honourable Michael de Jong, QC, Minister of Health.

The Ministry of Health and the health authorities work collaboratively to ensure you receive the services and care you require. I understand how frustrating it is for families who must wait for a child's surgery.

There are a number of factors to be considered in each case and for this reason prioritization of cases is based on medical necessity and urgency. In order to complete life-saving, emergency, and urgent surgical cases, non-urgent cases may be delayed.

British Columbia Children's Hospital (BCCH) is actively working to reduce wait times, in particular for paediatric orthopaedic surgical procedures. Effective January 2011, the Provincial Health Services Authority (PHSA) increased funding and capacity for these procedures, doubling the number of spine surgery corrections performed each week.

In addition to increasing operating room capacity, BCCH is continuing efforts to recruit an additional orthopaedic surgeon.

²³¹ BC1023387: 08/03/2011 - FW: No More Waiting for Walid.

I understand you have been in contact with the Patient Care Quality Office for PHSA, and I encourage you to continue to work with them and with your son's surgeon at BCCH.

Again, thank you for writing. I appreciate the opportunity to respond.

Sincerely,

Teri Collins

Executive Director²³²

1193. The Ministry's response was that it was doing the best it could.

1194. But it was not good enough.

1195. Walid eventually had to go to the United States for surgery, which was paid for by the Shriners Hospital in Seattle and not by the BC Government.

1196. He suffered complications from the surgery which included paralysis below the navel.

1197. Walid was transferred to a facility in Sacramento, California for spinal cord injury rehabilitation.

1198. In a subsequent letter to Walid's mother from the Patient Care Quality Review Board, dated May 1, 2012, the Board acknowledges that Walid did not receive quality care in the province's public health care system:

The Board found that Walid did not receive quality care. The delay in treatment allowed Walid's condition to unnecessarily deteriorate and increased the risk to his health.²³³

1199. Later in that same letter, the Board states:

The Board found the initial PCQO response to you on July 15, 2011 to be primarily comprised of standardized messaging lacking in empathy for the extensive wait that Walid had already experienced at the time of the letter...²³⁴

²³² BC1027299: 08/17/2011 - E-mail response to Ms. Debbie Waitkus, dated August 17, 2011.

²³³ CSC00000889: 05/01/2012 - Review Board Decision dated 05012012 - 14541064v1.PDF, at 2.

²³⁴ *Ibid* at 5.

1200. It was not the fault of Walid's doctors that he didn't receive timely health care in British Columbia, as the Defendants are claiming in this action.

1201. It was the result of a public health care system that cannot provide timely surgeries to all B.C. residents who need them.²³⁵

1202. The Defendants blame Dr. Christopher Reilly, the surgeon who was going to operate on Walid in BC, for the lengthy wait time that Walid experienced in the public system in British Columbia.

1203. However, as the evidence, including that of Dr. Reilly, and the conclusions of the Patient Quality Review Board, makes clear, Dr. Reilly's hands were tied by the lack of surgical resources at the BC Children's Hospital.

1204. The harm to the life and security of the person of Walid was caused by a public health care system that was unable to provide timely spinal surgery to everyone who needed it.

1205. Walid's case is not a rare exception or aberration.

1206. The Government documents reveal that it is commonplace for patients requiring spinal surgery to wait well over a year for their surgery after it is booked, and that there is considerable delay in having the surgeries booked.

1207. For example in 2011, a patient complained to his MLA that he had been waiting a year and a half for back surgery "and was told yesterday that he is still on the wait list and they cannot even give him an estimated date."

1208. The Government's recommended response to the patient was:

- I appreciate that waiting for surgery can be a frustrating and stressful experience.
- A patient's priority for surgery is determined by the surgeon.

²³⁵ BC4073171 - Internal Ministry email discussing why Walid and others were not sent out of the country for an earlier surgery.

- I understand that you are contacting [the doctor's] office regularly requesting a surgery date.
- [The doctor's] office indicated that it is impossible to accurately predict a surgery date, aside from estimating approximately an 18 month wait for surgery [after it is booked].
- Wait time for neurosurgical procedures are affected by unexpected and urgent cranial surgeries, which may cause longer wait times for neck and spinal surgeries.
- If you feel that your condition is deteriorating or warrants reassessment, I encourage you to bring your specific concerns to the attention of [the doctor].
- Additionally, your family physician may refer you to a surgeon with a shorter wait time, even if the surgeon is not in your geographic area.
- You may wish to check the Ministry's Wait Time Wait List website at: www.health.gov.bc.ca/waitlist/ and look up spinal surgery which will indicate how many patients each neurosurgeon has on their wait lists.²³⁶

1209. Another example is a patient who fell in 2009 resulting in two broken vertebrae in his neck and several broken ribs.

1210. In January 2011 he complained to the Minister of Health about waiting too long for a spinal MRI which had been recommended by a neurosurgeon in September 2010.

1211. The Government's recommended response in this case included the following:

- [Patient name] was informed that the hospital radiologist prioritizes bookings for MRIs based on urgency.
- His place on the waitlist will not change unless his condition changes and his family physician [doctor's name] decides to change the urgency of the shoulder MRI.
- [The Patient] was already angry when he answered the telephone.
- After being given the information about his place on the waitlist, [the patient] became more upset and began yelling, eventually hanging up.²³⁷

²³⁶ BC1022690: 2011.02.15 – Email re MLA Mary Polak re [Patient Name] – Wait time for Back.

²³⁷ BC1022723: 03.21.2011 - MO Request for Phone Call/Report Back re [Patient's Name] - MRI Wait Time (Cliff 873476/DMA Log #8).

1212. I will refer to one other example from the Government's file of complaints (there are many others in this file).

1213. A young teenager was suffering from scoliosis (curvature of the spine).

1214. In 2011, the teenager's mother contacted the Government about the wait time for her daughter's surgery.

1215. Her daughter had been diagnosed with scoliosis three years earlier when she was twelve.

1216. She was put on a surgeon's wait list at that time.

1217. The surgeon in question was one of only two surgeons at B.C. Children's Hospital capable of performing the surgery in question.

1218. Her surgery had been scheduled for March 11, 2011.

1219. However, the surgery was bumped for a more urgent case.

1220. The Government's response was:

- Health Authorities Division (HAD) Patient and Client Relations staff contacted the Provincial Health Services Authority (PHSA) and PHSA confirmed that [the teenager's] surgery date of March 10, 2011 was bumped for a more urgent case.
- HAD Patient and Client Relations staff contacted [patient name] on March 8, 2011, where she explained that [the surgeon] clarified that BCCH is the only hospital in B.C. able to perform scoliosis surgery.
- A combined wait list is monitored regularly to ensure those patients with the most urgent needs are prioritized appropriately.
- [The surgeon] explained that PHSA has increased funding and capacity for these procedures, doubling the number of spine surgery corrections performed each week and that each surgery is assessed and based on medical necessity.

1221. As these examples show, there is absolutely no doubt that patients are waiting too long for surgeries even from the time they are booked.

C. Krystiana Corrado

1222. These examples are not limited to those seeking spinal surgery, like Walid and others.
1223. The case of the Plaintiff Krystiana Corrado shows how damaging long wait times can be, not only to the physical and psychological health of patients, but also to their life goals and aspirations.
1224. Ms. Corrado is an elite level soccer player, and hoped to turn her hard work and talents in soccer into a scholarship at a top university.
1225. In April 2011, while a teenager, Ms. Corrado twisted her knee, and experienced intense pain.
1226. She attended the hospital, where the doctors did not suspect any permanent damage.
1227. They sent her home with painkillers and crutches.
1228. She also attended her family doctor, who advised her to return once the swelling had subsided.
1229. A month later, Ms. Corrado's knee was still very swollen, and she was still in intense pain.
1230. Her family doctor was concerned, and arranged for an MRI to be conducted two weeks later, and for Ms. Corrado to see an Orthopaedic surgeon at the BC Childrens Hospital.
1231. She was told that she would not be able to get a consultation with a specialist in the public system until four months later.
1232. She finally had her consultation in October of 2011, at which time the surgeon determined that she would require surgery for a torn ACL.
1233. However, Ms. Corrado was not put on a waitlist at that time, because by the time she would have been able to obtain the surgery, she would be over the age limit for surgery at the BC Childrens Hospital.

1234. She was instead referred to a doctor at Burnaby General, who informed her that the first available surgery date was in July of 2012, over a year after her injury had occurred.

1235. During her time waiting in the public system, Ms. Corrado missed soccer playoffs, playing and practicing with the summer team, and was unable to try out for the grade 11 school team or the City league team.

1236. Throughout this period she continued to experience severe pain and difficulty sleeping.

1237. She had difficulty concentrating at school, and was generally depressed due to her injury.

1238. If she had waited another year for necessary surgery, she would have missed the 2012-2013 soccer season, which would have been her only chance to qualify for a scholarship.

1239. Krystiana and her parents were very concerned, not only about her present pain and depression, but about how this would impact her future plans.

1240. They went to Dr. Day in January of 2012, and Krytiana underwent knee surgery just a few days later.

1241. The family took this step in the best interests of their child, but without the ability to acquire private insurance, was very concerned about how to pay for it. To them, however, Krystiana's well-being came first.

1242. Ultimately, in light of their inability to pay, the surgery was done by Cambie almost entirely *pro bono*.

D. Erma Krahm

1243. In Ms. Corrado's case, the costs of long wait times was delaying her treatment, and limiting her options at the start of her adult life, with potential ramifications for the whole of her adult life.

1244. In the case of others, it involves limiting options and enjoyment of life in its twilight.

1245. Erma Krahn joined this action when it began in 2009. Sadly, she has since passed away. However her story is important, as it describes the experience of those arguably most affected by wait times, BC's senior population.
1246. Ms. Krahn had surgery for lung cancer in 2008, and later that year felt a popping sensation in her left knee, causing severe pain. Her x-rays did not show any damage to her knee, and Ms. Krahn was advised that her knee was simply inflamed.
1247. Ms. Krahn had continued pain in her knee and difficulty walking, and so sought further care. After an appointment with a specialist in February of 2009, Ms. Krahn paid for an MRI privately in Abbotsford to expedite the process of obtaining a diagnosis. She was advised in May 2009 that she had a torn meniscus and needed surgery, but should expect to wait at least one year for the surgery. In September of 2009, Ms. Krahn was advised that there was now a three year wait for surgery.
1248. Ms. Krahn did not want to endure a three year wait in a painful and incapacitated state as this would have wholly undermined her ability to enjoy her life, and therefore she decided to inquire into private surgical services.
1249. She met with Dr. Day at Cambie in October of 2009, and had her operation just over a week later.
1250. As a result of her speedy treatment, Ms. Krahn recovered quickly, and was surprised to discover that she was able to drive again without pain within two days.
1251. For the next few years, Ms. Krahn was able to enjoy her life without the limited mobility and pain she had previously experienced.
1252. Had Ms. Krahn waited for surgery in the public system, she would have been largely unable to do those things which she enjoyed in life— such as walking, golfing, and exercising – and would have been in constant pain throughout the duration of her three year wait.

1253. In 2012, Ms. Krahn was again diagnosed with cancer, and again suffered a torn meniscus, this time in her other knee.
1254. She again sought private treatment, so that she could be mobile and pain-free as soon as possible so that she could enjoy her remaining life to the fullest extent.
1255. In Ms. Krahn's case, the treatment she obtained in the private system permitted her to live the final years in her life doing what she wanted to do, instead of being laid up and in severe pain.

E. Chris Chiavatti

1256. Chris Chiavatti has been studying at McGill University for the past few years.
1257. He injured his knee in a high school Phys-Ed class in 2009.
1258. He received x-rays and was told to contact his family physician, who referred him to an Orthopaedic surgeon at BC Childrens Hospital.
1259. Although Mr. Chiavatti was able to obtain an MRI within four months from the date he was injured, he was advised he would have to wait approximately 18 months in order to have a consultation regarding the results of his MRI.
1260. His mother called frequently to inquire as to whether there were cancellations that would speed up her son's access to treatment, and was eventually told to stop calling.
1261. During this waiting, Mr. Chiavatti suffered considerable pain.
1262. Straightening his knee was excruciating, and he had difficulty sleeping as a result.
1263. He could not participate in sporting activities or engage fully in physical activities of any kind during this time.
1264. That was a huge blow for Mr. Chiavatti, who was always very active.

1265. After eight months of waiting, and no end in sight, Mr. Chiavatti booked an appointment with Dr. Day at Cambie. He was seen a few weeks later, and was able to get the surgery he needed to start his quality life again.
1266. He underwent physical therapy and was able to return to his normal, active lifestyle in about a month.
1267. During the surgery, it was determined that his wait for surgery had caused deterioration in his knee, and that further delay would likely have resulted in irreversible joint damage.
1268. As Mr. Chiavatti and his family would have encountered significant financial duress from the cost of the treatment (in the absence of private insurance), the surgery was performed by Cambie almost entirely pro bono.

F. Waiting for Bariatric Surgery

1269. Others have not been so lucky.
1270. Bariatric surgeries are one example of treatments that cannot be provided in a timely way for everyone in BC's public health care system.
1271. One of the witnesses in this case will testify that, in 2009, he was obese and suffering from a range of ailments, including Crohn's disease, diabetes and sleep apnea as a result.
1272. He was unable to lose weight through conventional measures, and his family doctor informed him about various surgical procedures that would have helped him to become healthy again.
1273. He became very concerned about the overall quality of his life, and the lasting impacts obesity and related medical conditions would have on his life.
1274. His doctor advised him in 2009 that he was a potential candidate for weight loss (bariatric) surgery.

1275. He suffered from morbid obesity, which is defined as having a Body Mass Index greater than 40. Approximately 1.3% of BC's population is morbidly obese, and this group's health costs (hospitalization, physicians' fees and pharmaceutical) are approximately 71% higher than those with "normal" weights.²³⁸
1276. Living with obesity, and complications from obesity, can cause significant health consequences, including heart disease, hypertension, diabetes and associated problems, joint problems, and mental health issues.²³⁹
1277. Indeed, a 19 year old girl wrote to the Ministry saying that she worried that she would die on the wait list for bariatric surgery.²⁴⁰
1278. Clinical evidence shows bariatric surgery is a more effective intervention than less invasive interventions. After receiving this surgery, patients can achieve a weight loss of 50% of their excess weight within two years, improving their overall health status and reducing the overall health costs for this patient population.²⁴¹
1279. The Vancouver Island Health Authority (VIHA) provides bariatric surgical services for the entire province.
1280. Vancouver Island Health Authority and Vancouver Coastal Health Authority proposed a Provincial Centre for Bariatric Surgery in January 2007.²⁴² The Ministry of Health did not accept the proposal.²⁴³
1281. One of the Ministry of Health documents provided to us in this case by the Government is a 2007 internal e-mail regarding the proposed Bariatric Surgery Centre from Bindi Sawchuck, who was a financial analyst in the Ministry of Health.

²³⁸ BC5003778: 2007.07.11 - Access to Bariatric Surgery in BC.

²³⁹ BC5022975: 2009.01.13 - Program Proposal Bariatric Services Provision in BC.

²⁴⁰ BC1023769 - Email dated 02/09/2012 - FW: 19 year old female Dies Waiting for Bariatric Funding.

²⁴¹ BC5019507: 2009.02.13 - Access to Bariatric Surgery in British Columbia.

²⁴² BC2275755: 2006.08.28 - Summary of Proposal for VIHA and VCHA Tertiary Centres for Bariatric Surgery; BC5002557: 2007.01.17 - Proposal for VIHA and VCHA Tertiary Centers for Bariatric Surgery.

²⁴³ BC5019515: 2008.09.15 - Bariatric Surgery - Potential Changes in Service.

1282. Ms. Sawchuck states as follows in the e-mail:

I agree with Harry, the BN [briefing note] as currently set out (the note recommends HA's [Health Authority's] jointly fund a provincial Bariatric surgery program) – does not address the issue of the HA's having little or no incentive to provide these Bariatric services, even if they could. This is due to the savings on their HA budget (under the current arrangement) due to the \$54,000 (per case) cost of the surgery being performed in the U.S is picked up by the Ministry/MSP budget...²⁴⁴

1283. In 2007, there were 100 surgeries performed in BC each year, which represented 10% of the estimated demand of approximately 1025.²⁴⁵

1284. In 2007, the median wait time was 54.4 weeks, and there were 559 people on the wait list. In 2005, the Medical Services Division started sending the most urgent cases (BMI 50+) to the United States at an average cost of \$43,755 per case.²⁴⁶

1285. An internal review noted that the number of out-of-country bariatric surgery patients has increased annually since 2005, and the number of MSP funded bariatric surgeries has decreased from a high of 145 in 2002/03 to 80 in 2009/10.²⁴⁷ The volume of publicly funded bariatric surgeries dropped further to 67 in 2010/11.²⁴⁸

1286. In October 2010, there were 477 people on the wait list for bariatric surgery, with almost 90% waiting longer than one year, and 50% waiting longer than two years. The acceptable wait time for bariatric surgery in non-urgent cases is 26 weeks, and in urgent cases it is six weeks.²⁴⁹

1287. The number of bariatric surgeries provided in 2010/2011 was then reduced and capped at 52 cases per year.

²⁴⁴ BC2145019: 02.26.2007 - Email Exchange RE: Draft BN for Bariatric Surgery Business Case.

²⁴⁵ BC5003778: 2007.07.11 - Access to Bariatric Surgery in BC.

²⁴⁶ *Ibid.*

²⁴⁷ BC2270857: 2011.02.00 - Health Operations Committee Briefing Document: Recommendations for a Provincial Bariatric Surgery Strategy in British Columbia.

²⁴⁸ BC5073638 Bariatric Surgery - Need for immediate capacity to meet demand for bariatric surgery.

²⁴⁹ BC2270857: 2011.02.00 - Health Operations Committee Briefing Document: Recommendations for a Provincial Bariatric Surgery Strategy in British Columbia.

1288. In previous years, the volumes of surgery done were “outpacing” the budgeted levels, and therefore, the Vancouver Coastal Health authority implemented a monitoring and reporting system to “ensure the new cap is maintained”.²⁵⁰
1289. At that time, 90% of people were waiting longer than a year, and 50% were waiting longer than two years for bariatric surgery.
1290. By June 2013, no decision had been made regarding the Bariatric Services Business Case. In the previous two years, funding for only an additional 76 surgeries had been provided in 2011/12 and 112 surgeries in 2012/13.²⁵¹
1291. In 2015, CIHI released a report showing that between 2006/07 and 2013/14, the volume of completed bariatric surgery increased 854% in Ontario.
1292. BC had the lowest rate of increase of 23% during the same time period.
1293. Our witness will explain how he also experienced this problem first-hand. He wanted to obtain surgical treatment for his condition, however he was placed on a waitlist with over 800 other patients.
1294. He followed up with the surgeon every 6 months or so, but was repeatedly told that there was not enough operating room time for his procedure to be done yet.
1295. He considered obtaining treatment in the US or Mexico, but was not comfortable doing so.
1296. So he continued to wait, despite the fact that his condition limited his ability to live a healthy and active life, and posed a threat to his long term health and well-being.
1297. His surgeon was Dr. Amson, who performs bariatric surgery on patients from across BC. The Ministry acknowledged that Dr. Amson’s wait list is over 450 people, but said that

²⁵⁰ BC2134223: 2011.02 - Briefing Note re Cap on Bariatric Volumes.

²⁵¹ BC5090962 - Issues note dated 06/14/2013 re Advice to Minister - Bariatric Surgery.

access to bariatric surgery has to be balanced against “all the other important surgical procedures that VIHA performs”.

1298. In 2011, 340 of Dr. Amson’s patients had been waiting over 2 years for surgery.²⁵²

1299. Our witness finally had his surgery in 2013 -- four years after it was recommended for him.

1300. The surgery changed his life.

1301. He lost 120 pounds. His health has improved, he has been able to become more active, his sleep apnea subsided, and he no longer has to take the medications he was on before.

1302. He had to give up four years of healthy, happy and active living, as a result of the long wait times in the public system, and his inability to obtain treatment outside of that system.

1303. As of February 2014, there were 185 people waiting for bariatric surgery, which was a decrease from previous years due in part to targeted funding in 2011/12 and 2012/13.

1304. At this time, the Province sought to develop a comprehensive plan to address the wait times.

1305. While the recommended option was to confirm that bariatric services is a priority action, and direct Fraser Health and Interior Health to develop a service plan for implementation, the Ministry noted that FHA and IHA may not consider bariatric services a priority given other fiscal pressures.²⁵³

G. Mandy Martens

1306. This court will also hear from another Plaintiff, Mandy Martens.

²⁵² BC4409227: 2011.08.22 – Email.

²⁵³ BC5106075: 2014.04.14 - BC Bariatric Services Implementation Plan.

1307. At age 35, Ms. Martens noticed mucous and blood in her stool.
1308. She went to her general practitioner in April 2011, who referred her to a specialist for a diagnostic colonoscopy. She was told the first available appointment was seven months later.
1309. In May 2011, Ms. Martens started to experience increased pain and symptoms.
1310. She went to a walk in clinic and was told to go to emergency if the pain got worse, which she did a few days later. She asked the emergency doctor for a colonoscopy, but he said that her symptoms did not warrant calling in a surgeon for an urgent colonoscopy.
1311. In the case of colorectal cancer, early screening, diagnosis and treatment is critical, as survival rates for early detection is five times higher than in later stages.
1312. Ms. Martens sought to get her colonoscopy expedited, but was told this was unlikely.
1313. She was very concerned about her symptoms, and considered obtaining her colonoscopy privately. She discussed this with her family doctor, who told her it would be a good option to expedite her diagnosis and treatment, if she could afford it.
1314. Ms. Martens booked an appointment with the Cambie Surgery Centre in June of 2011, and she had a colonoscopy done two weeks later which confirmed the presence of colon cancer.
1315. Her doctor at Cambie helped arrange for Ms. Martens to obtain colon cancer surgery immediately at St. Paul's Hospital.
1316. Ms. Martens also received further cancer treatment, including liver surgery and chemotherapy. She has survived her cancers to date, due in large part to being able to access private treatment for her colonoscopy at the outset.
1317. Ms. Martens diagnosis, chemotherapy, and surgeries, all took place within the time she would have been required to wait for her initial consultation in the public system. Had

she been confined to the resources of the public system, her chances of survival would have been dramatically reduced.

H. Summary of Harms to the Plaintiffs and Others

1318. These are not exceptional cases. There are many others who have suffered similar harms as a result of rationing public care while effectively prohibiting access to care outside of the public system.
1319. These harms are reflected in the thousands of complaints received by the Government from patients who are suffering due to waiting for necessary care.
1320. These harms are the inevitable consequences of a public system that is unable, within its financial constraints, to provide timely medical services to all B.C. residents who need them.
1321. This rationing of health care services is devastating to those affected by it.
1322. However, what makes this a constitutional violation is that the Government has *also* prevented those affected by rationing from taking steps to improve and secure their own health and well-being.

VIII. THE WAIT TIMES CHALLENGE – AN ETHICAL ISSUE FOR OUR TIMES

1323. It is difficult to overemphasize just how damaging wait times are to those affected by them, and who are at the same time effectively prohibited from escaping the harm caused.
1324. I have spent some time telling the stories of the Plaintiffs and others, because for those who have not suffered these costs, it can be just numbers on a sheet.
1325. Normally, we might think that achieving 75% of a target is a good thing. But in the context of wait times for health care treatment, it is indicative of at least 25% of people being left

to suffer longer than medically acceptable, even leaving aside those whose health needs do not fall within one of the ‘target’ types of care.

1326. But this is no small burden on those people left behind.
1327. The issue of wait times has – rightly – become an abiding focus of Canadians and policy makers across the country.
1328. In 2004, a group of doctors very concerned over the issue of increased wait times across Canada, and delayed access to health care treatment, formed the Wait Time Alliance.
1329. The Alliance’s mission statement is to “work collaboratively with our stakeholders to inform, advocate, and provide solutions to achieve timely, appropriate and equitable access to high-quality health care.”
1330. In its June 2014 report, the Alliance discussed the serious ethical challenges produced by systems in which wait times are longer than are necessary, and which preclude individuals from accessing health care elsewhere:

It has now been a decade since the 2004 Health Accord was signed by First Ministers. Among other things, the Health Accord called for the establishment of evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements and sight restoration as part of an effort to achieve “meaningful reductions” in wait times. Have meaningful reductions in wait times been achieved such that Canadians can access medical care to levels consistent with those available to the citizens of other leading industrialized countries?

Others have continued to struggle to make any sustained improvements over the past three to four years. In addition to this provincial variation, there remains significant variation in wait times within provinces and within communities. However, while wait time reductions vary across the country, the volume of procedures handled by provincial health care systems—particularly those five initial areas identified in the 2004 Health Accord—has increased. This fact should not be overlooked. (...)

While there has been considerable effort over the past 10 years toward improving timely access to care for Canadians, much work remains to achieve the levels of performance seen in other countries.

Some may argue that long waits are the price Canadians must pay for having a universal health care system. Some also argue that the focus on wait times in Canada

over the past decade has been misguided and has detracted from efforts to address other pressing health reforms. We do not see it this way. The focus on wait times is necessary for several reasons.

First and foremost, it is not right to force Canadians to wait two or three times longer for necessary medical care than citizens of other countries that also have universal publicly funded health systems. Furthermore, as seen in many other countries with universal health systems, it is indeed possible to have timely access to medical care — long waits are not an unavoidable price to pay nor are they tolerated by their citizenry.²⁵⁴

1331. As set out in a report done by the BC Medical Association, British Columbians have identified reducing surgical waitlists as the top priority to them, above such things as ensuring everyone has a family doctor and ensuring quick access to emergency assistance.²⁵⁵
1332. Indeed, beyond being a political hot button issue, excessive waiting times in the Canadian health care system are a significant ethical issue in the medical community.
1333. According to a distinguished panel of Canadian bioethicists, the issue of wait times was ranked the second most pressing ethical issue of our times.²⁵⁶
1334. In a summary of the discussion, there is the following:

The second highest ranked ethical challenge facing the public in health care, with 102 total points, was waiting lists. This has been a growing problem in Canadian health care as progressively increasing demand for health care services has put mounting pressure on the already strained Provincial health care systems in the country. According to the panel, waiting for needed care may in some cases compromise the health status and outcomes of patients, impede their ability to return to normal functioning at work and at home, and may also contribute to psychological distress. Waiting lists may also contribute to inappropriate use of scarce resources as is the case when acute care beds are used for long-term care patients, or ICU beds for chronic care patients. Waiting lists also raise the issue of geographical inequities among regions or various health centres.

²⁵⁴ CSC00019446 - Wait Time Alliance, "Time to Close the Gap" at 4-5.

²⁵⁵ BC5057125 2012.01.00 - BCMA Report "Charting the Course", at 19.

²⁵⁶ CSC00024175 - BCM Medical Ethics, "Top 10 health care ethics challenges facing the public: views of Toronto bioethicists" (2005),

1335. Wait times are the subject of a bioethics module on the Royal College of Surgeons website, which includes the following discussion:

...Since there are alternative pathways such as out-of-province referral or referral to a private facility...it could be argued that [a long wait time] to decide whether [a patient] needs surgery is unreasonable when it keeps him out of the workforce and places stress on his family. It therefore could be argued that [doctors] have an ethical obligation to disclose the availability of alternative treatment pathways and to facilitate a referral if this will provide the best care for the patient.

Some physicians would argue that referral to a private facility would constitute queue jumping, which is against the ethical principles of social justice and equitable access to care. Do these principles override physicians' fiduciary responsibility to their patients to seek the best care for them? If a physician believes in these principles, how should he or she manage a patient who is seeking a referral to a private facility? (...) If a physician does not feel that using private services to expedite care is acceptable, then he or she has an ethical obligation to transfer the patient's care to a physician who would be willing to provide such a referral. A case could also be made that, if he does not already have one, Dr. White needs to develop an appropriate waiting list policy of his own with a mechanism to prioritize the cases on his waiting list.

The conflict arises here because there are no accepted standards for waiting lists and no widely used systems for prioritizing patients. There are also well-established and government-sanctioned routes to bypass public waiting lists that raise questions about the ethics of the whole system. In Canada, the workers' compensation boards in some provinces contract for faster services in order to return employees to work faster and reduce the burden of their disability patients.¹² The same patient sustaining the same injury in a non-employment-related environment does not have the same access. If the arguments used to justify the Workers' Compensation Board system are related to returning a patient to work faster for the patient's benefit, why would they not apply if the patient was not injured on the job? If the purpose is to allow the Workers' Compensation Board and employers to reduce their disability costs, then why is it not acceptable for a patient to seek faster treatment in order to preserve income opportunities? The same argument applies to priority treatment of Royal Canadian Mounted Police (RCMP) officers and the Canadian military. If it is acceptable for these employers to bypass queues in order to return their employees to work as quickly as possible, why is it not equally acceptable for individuals to seek faster treatment in order to return to work as soon as possible? Some might argue that members of the military and the RCMP are serving society more broadly and that it is in the public interest to ensure that they can return to work as quickly as possible. As a counterpoint, for health care that is not provided anywhere besides within the public health care framework in Canada and where no one is receiving special consideration or priority treatment, the ethical basis of waiting lists can be much more easily supported.

The issue of ultimate responsibility for funding a patient's treatment is also open for argument. The government collects taxes to help fund the health care system and thereby spreads the costs of an individual's care over the entire population. The government has many other priorities, however, and an individual patient may not agree with how his or her tax dollars are being spent, especially when the patient or a family member may require care. If a government chooses to fund a system to the point that waiting lists are required to ration care, does a patient with the means to afford care have an obligation to stay in the waiting list? (...)²⁵⁷

1336. While it is easy to be distracted by the technicalities of spending levels, benchmarks, and budget numbers, the issue of wait time is also very much an ethical issue and challenge.
1337. It is made even more so by the Government preventing British Columbians from accessing private health care to meet their medical needs.
1338. Again, as Professor Bliss stated, "a country that as a matter of public policy bars treatment to the sick in the hour of their need and pain has lost its moorings and drifted into the unnecessary acceptance of a bizarre form of social cruelty."²⁵⁸
1339. In the 2004 federal Throne Speech, the Federal Government stated that "the length of waiting times for the most important diagnoses and treatments is a litmus test of our health care system [and] these waiting times must be reduced."²⁵⁹
1340. British Columbia has failed that litmus test.
1341. The Plaintiffs do not understand the Government in this case to be denying that many BC residents are waiting too long for medical services.
1342. Nor do the Plaintiffs understand the Government to be claiming that there are no BC residents whose physical and psychological wellbeing has been harmed by lengthy waiting times for surgeries in the public system.

²⁵⁷ Royal College of Surgeons, "Module 7.1.1 – Waiting Times", online: <<http://www.royalcollege.ca/rcsite/bioethics/cases/section-7-physicians-patients-health-care-system-e>>.

²⁵⁸ Response Report of Michael Bliss, dated July 31, 2014, at 18.

²⁵⁹ BC1015693 - BCMA, Waiting too long: Reducing and better managing wait times in BC (June 2006).

1343. Rather, the Government says that the public system is doing the best it can within its budgetary constraints to meet the medically required needs of BC residents.

1344. The Government also says it is justified in effectively prohibiting BC residents from accessing health care outside of the public health care system, because this is necessary to protect the public system and to ensure that all BC residents have equitable access to health care.

1345. These myths will be addressed in more detail later on.

1346. For now, the short answer is that the best that the Government can do within its budgetary constraints is not good enough constitutionally.

1347. Even if the BC government had a rigorous means of ensuring roughly adequate wait times for most people (which it does not), and even if it were meeting those wait times targets generally (which it is not), that would still not negate the constitutional harm imposed upon individuals.

1348. Before turning to an outline of the Plaintiffs' constitutional argument, it will be helpful to tell the story of the Cambie Surgery Centre and other private clinics like it. This will explain how the rationing of public health care led to the development of a private sector option and how this came to be accepted by successive governments in BC who could not provide medically necessary care to all.

IX. PRIVATE HEALTH CARE AND THE CAMBIE SURGERY CENTRE

1349. In their response to the Plaintiffs' claim, the Defendants appear to concede that if the public system were to provide timely, quality medical services to all British Columbians, there would be no demand for private health care services.

1350. That is no doubt correct, and hence there would then be no need for the constitutional challenge to the prohibition on private health care in the *Medicare Protection Act*.

1351. But that is not the case.

1352. The public system has not been able to provide timely surgeries for all British Columbians.

1353. Surgeries are rationed to save costs.

1354. This has led to lengthy wait lists, causing harm to the health and well-being of British Columbians.

1355. The lack of operating time in the public system, and the unmet need for medically necessary services, led a group of leading surgeons to open the Cambie Surgery Centre in 1996.

1356. Cambie was followed by other private surgical clinics and by private diagnostic clinics.²⁶⁰

1357. The Specialist Referral Clinic (“SRC”) was established in 2002 and serves to provide British Columbians with access to specialists for assessment and diagnosis, as well as medical-legal and other services.

1358. These private clinics were established to address the rationing of surgeries in the public system.²⁶¹

1359. This development was inevitable.

1360. When people are not receiving medically necessary treatment, with their health and well-being and even life is being jeopardized, they will seek other treatment options.²⁶²

1361. And when surgeons and other specialists see patients suffering and know they have the capacity to help, they will seek to do so.

²⁶⁰ BC2277922 - Letter from Dr. Day to the Ministry laying out the purpose of Cambie Surgery Centre; BC2089929 - Cambie Surgery Centre brochure.

²⁶¹ BC2277922 - Letter from Dr. Day to the Ministry laying out the purpose of Cambie Surgery Centre.

²⁶² BC1000023 - Letter from patient to Ministry requesting reimbursement for private surgery done to address life threatening condition.

1362. Many Canadians are unwilling to subject themselves to the pain, suffering and risk of mortality imposed by a public system which does not provide adequate care to all within a medically reasonable period of time.²⁶³

1363. As Professor Bliss has pointed out:

In the real world of health care, as in education, citizens become insistent and resourceful in overcoming unnecessary hindrances to the meeting of their needs. If one system, of schooling or of health care, is performing less than adequately, they try to turn to another system.²⁶⁴

1364. It is also difficult to tell surgeons that they should limit the use of their surgical skills to a few days per month, when they know that there are patients waiting in need of treatment.

1365. The combination of these two factors – demand from patients and unused capacity of surgeons - led to the establishment of private surgical clinics using enrolled doctors.

1366. It is in this context that the emergence of private clinics in BC must be understood.

1367. Private surgical clinics using enrolled doctors have played an important, indeed essential, role in the provision of health care services in British Columbia since 1996, when the Cambie Surgery Centre commenced operating.²⁶⁵

1368. The diagnostics laboratory at Cambie has been accredited by the College of Physicians and Surgeons of British Columbia.²⁶⁶

1369. The physicians in these private clinics are enrolled in the MSP system.

²⁶³ BC1000033 - Patient complaint re private clinic saved his life; BC1000016: Patient complaint re use of private clinic to salvage athletic career; BC1000026 - Patient complaint re use of private clinic to salvage athletic career.

²⁶⁴ Response Report of Michael Bliss, dated July 31, 2014, at 16.

²⁶⁵ BC2018020 - Ministry email correspondence listing provision of services by private clinics.

²⁶⁶ BC4056590 - Letter from diagnostic accreditation program to Cambie.

1370. They all fully utilize their limited quota of operating times in the public system.²⁶⁷

1371. It is only their excess capacity that is utilized in the private clinics.²⁶⁸

1372. One of the studies the Defendants' own experts rely upon states:

We found that waiting times for cataract surgery in the public sector were longest for surgeons who also had a private practice. The reasons for this finding are unclear. It is not the case here that surgeons who operated in both sectors devoted less time to their public sector patients, since they made maximum use of the public-sector operating room time available to them.²⁶⁹

1373. Furthermore, the fact that the Health Authorities contract out surgeries to private clinics shows that there is ample supply of doctors to do the work.

1374. Clearly the surgeons have capacity that is not being used.²⁷⁰

1375. This is important to emphasize.

1376. These doctors are not working privately *instead of* in the public system.

1377. They are not even working *less* in the public system, in order to work *more* in the private system.

1378. They remain committed to the public system, and recognize it is needed,

1379. As such, they work to the full extent they are permitted in the public system.

²⁶⁷ BC2208177 - Fraser Health Briefing note: clinical capacity optimization plan, 4; BC5073638 - government briefing note re need for immediate capacity to meet demand for bariatric surgery;

²⁶⁸ BC1028834 - Complaint from orthopedic surgeons of Cowichan Valley re lack of funding to perform more surgeries; BC4418966 - Patient complaint in Times Colonist article re funding quota preventing husband's surgery.

²⁶⁹ Waiting Times for Surgery:1997/98 and 1998/99 Update, *Manitoba Centre of Health Policy and Evaluation* (emphasis added).

²⁷⁰ BC2018020 - Ministry email correspondence listing provision of services by private clinics.

1380. Some of the procedures performed in the private clinics are for BC residents covered by the Workers Compensation insurance plan or other BC residents who come within one of the exceptions under the *Medicare Protection Act*.²⁷¹
1381. Enrolled doctors are permitted under the *Act* to perform these exempted procedures outside of the public health care plan.
1382. They are also legally able to provide surgical services and other procedures privately to residents of other Canadian provinces - just not BC residents.
1383. However, some of the procedures performed were for BC residents who did not come within one of the exemptions.
1384. These patients had to pay for these procedures without being able to use their existing disability insurance or obtain other private insurance to cover costs.²⁷²
1385. Because they were performed by enrolled doctors, these procedures are in breach of the *Act*.
1386. This combination of WCB and other private procedures performed by enrolled doctors is the norm at the other surgical clinics in the Province.
1387. All of the private clinics have been using enrolled doctors to perform private surgeries and other procedures.
1388. Up until September 2014, the physicians at Cambie billed MSP for the physician fees for surgeries provided to BC residents not covered by Workers Compensation insurance or some other exemption.
1389. The patients were not charged for the physician's fee. Those were paid for by the Medical Services Plan.

²⁷¹ BC2270304 - WCB surgical volumes; BC2237846 - Article on the WCB expedited medical care system

²⁷² BC1000026 - Patient letter re expenditures on private surgeries.

1390. The patients were charged a separate “facility fee” by Cambie to cover the costs for the facilities, nursing staff and equipment.
1391. Cambie split the cost in this way because Cambie and the doctors wanted to reduce the out-of-pocket costs to the patients as much as possible.
1392. Since Sept 2014, the patient pays both the physician’s fees and the facility fee at Cambie.
1393. This change was made because the Federal Government clawed back transfer monies because the surgical fees portion of the private surgery was paid by the public health plan.
1394. Now, the public plan pays no part of the cost of a private surgery at Cambie, to avoid any Federal Government clawback of transfer monies.
1395. The patient pays both the surgical fee and the facility fee.
1396. It was common knowledge that the private clinics like Cambie were operating in breach of the *Act* by using enrolled surgeons to perform private surgeries that were not paid for by the Workers Compensation insurance plan, or other exempt plans.²⁷³
1397. In response to pressure from the Nurses Union, as early as 2000, then Premier Dosanjh stated publicly that it made no sense to shut down the private surgical clinics when the Government could not provide timely service.
1398. From the very beginning, the Government was well aware of the situation, and condoned it. There was no attempt to keep the operation of Cambie secret from the Government.
1399. Why did the Government condone the breach of the *Act*?
1400. It was because the private clinics were and are a necessary supplement to the public health care system.
1401. The Plaintiffs will lead evidence from former members of the Medical Services Commission that the Commission discussed the issue of private clinics operating in breach

²⁷³ BC2270246 - New release describing demands of Nurse's union.

of the Act prior to the Government's law suit in 2008. But they decided not to do anything about it because the clinics were providing needed medical services in the Province.

1402. The Government says that its hands were tied until the *Act* was amended to give the Commission the power to audit private clinics to determine whether they were complying with the *Act*.

1403. However, as the Nurses Union pointed out in a 2005 press release about alleged violations of the *Canada Health Act* and the *Medicare Protection Act*:

Mr. Campbell even passed a law through the legislature in 2003 that would have given him more power to audit and investigate violators, but after protests from the private clinics he said he would not enact it. McPherson [the then Union President] says "It's time for the Premier to take some time off the campaign trail and make good on his promises to protect public health care.

1404. This again shows the unwillingness of the Government to take steps to prevent the private surgical clinics from using enrolled doctors to provide private surgeries, despite the almost constant pressure from the Nurses Union and other interest groups.

1405. In any event, the Commission certainly did not need this audit power in the case of the Cambie Surgery Centre.

1406. Cambie openly admitted it was using enrolled doctors to perform private surgeries.

1407. In a 2003 press release in which it states that the private clinics were acting in breach of both the *Canada Health Act* and the *Medicare Protection Act*, the Nurses Union used the following example of one of its members who had obtained a private surgery:

Ms. Hamer, a Registered Nurse, has been off work in severe pain for several months, could not straighten her leg, and could not walk. The doctors – whose office displays a sign advertising a private clinic – told Ms. Hamer she needed the operation but she would have to wait about six months to have it done under MSP. Ms. Hamer asked when laparoscopic surgery would be available at the private clinic and was told that the doctor could perform the surgery himself at the clinic within one week, at a direct cost to Ms. Hamer of \$1500.00 for each knee," the letter says.

1408. In this same press release, the Union states as follows:

The letter to MSP says the union does not dispute the doctor's right to set up a private, for-profit medical facility outside of the *Medicare Protection Act* without access to payment by MSP. "We understand that section 13 of the *Medicare Protection Act* allows medical practitioners to choose whether to enroll with MSP and receive the benefit of the payment by MSP under the *Medicare Protection Act*. However, in our opinion the *Medicare Protection Act* requires (the doctors) to make this critical choice: Practice within the public health care system and receive the benefit of payment from the public health care system, or practice in the private health care system and seek payment from private sources."

The union is particularly disturbed by the spectre of physicians such as this one reaping personal gain by meeting patients referred to them through the public health care system, and then persuading them to pay large amounts from their own pockets for benefits to which they are entitled under medicare.

1409. What the Union does not say in its press release, although it is well aware of this, is that enrolled surgeons have very limited operating times in the public system, and therefore, have a long waiting list for public surgeries.

1410. The wait lists are created by the rationing of public surgical facilities, not by a shortage of doctors' time.

1411. The surgeon told Ms. Hamer he had a long waiting list for a public surgery, which no doubt was true.

1412. He also told her that she could obtain a private surgery more quickly if she wanted to pay for it.

1413. That also was true.

1414. And it was very responsible advice to Ms. Hamer – something that she needed to know.

1415. She needed to know about the option of a faster private surgery.

1416. This is similar to New Zealand, where the Government tells its citizens that if you want the surgery faster than we can provide it in the public system, you are free to opt for a private surgery which you must pay for, either directly or through your insurer.

1417. In BC, the private surgery was contrary to the prohibition in the Act on dual practice.

1418. But that prohibition was not being enforced by the Government and the only way Ms. Hamer could have had a private surgery was by an enrolled doctor.
1419. So, to eliminate the pain and inconvenience, and to be able to return to work sooner, Ms. Hamer chose to have a private surgery rather than wait for a surgery in the public system, as many other British Columbians have done, even though this was in breach of the *Act*.
1420. Because of the delays in the public system, Ms. Hamer wanted the Government to pay the costs of the private surgery.
1421. Ms. Hamer was presumably working as a nurse for a public sector health employer at the time and therefore, she would have been covered by disability insurance.
1422. If there was no prohibition in the *Act* on private insurance, the insurer could have paid for Ms. Hamer's surgery to save itself the cost of her disability payments.
1423. But because of the legislative prohibition on private insurance, this could not be done.
1424. So Ms. Hamer had to pay for the surgery herself.
1425. This made her unhappy.
1426. But the public plan is under no obligation to pay the cost of her private surgery even though it could not provide her with a timely surgery in the public system.
1427. However, this example shows why the prohibition on private insurance, as well as on dual practice, needs to be eliminated, so that Ms. Hamer and other British Columbians with disability or other insurance do not have to bear the cost of private surgeries in order to meet their medical needs.
1428. In a 2004 poll conducted by Ipsos-Reid, 91% of nurses responded that they were concerned about the negative impact that wait times have on patients.

1429. The Nurses Union has also been vocal in its criticism of the Government's closure of Operating Rooms.²⁷⁴

1430. So, the Nurses Union understands the problem – the public system is rationing health care and this harms British Columbians.

1431. In 2007, the Nurses Union stepped up its pressure on the Government to prevent the private surgical clinics from using enrolled doctors by commencing a legal action to compel the Government to prevent the private clinics from using enrolled doctors.

1432. As set out in a Nurses Union press release issued shortly after it filed its lawsuit, the Nurses Union argues that access to private health care harms the public health care system:

[The then Nurses Union President] McPherson says private clinics undermine the public health care system by drawing nurses, doctors and other resources away from public facilities. They are more expensive to operate than public operating rooms. There is substantial unused operating room capacity in public hospital across B.C., limited only by funding and staffing. [emphasis added]

1433. The Union is wrong about private clinics drawing resources away from the public system.

1434. That has not been the case with the private surgical clinics.

1435. The Unions is also wrong about the cost of a private surgery being more than in a public hospital.

1436. The Health Authorities save money by contracting out surgeries under the public plan to private clinics.

1437. But the Nurses Union is right that there is an unused capacity in the public system.

1438. The Nurses Union wanted the Government to put sufficient money into the public system so that Ms. Hamer and other British Columbians would be able to obtain timely surgeries

²⁷⁴ BC1021428 - Media article re Nurses union's denunciation of government's OR closures.

in the public system, and thereby avoid the pain and suffering that comes with lengthy wait lists for surgeries.

1439. But that has not happened.

1440. In response to the Nurses Union's lawsuit, the Government moved to prevent the private clinics from using enrolled doctors – which the clinics depend upon – to perform private surgeries.

1441. But in order to meet the new sustainability principle it added to the *Act* in 2008, the Government also reduced its annual increases in health care funding.

1442. In effect, the Government made access to timely surgeries worse in two ways.

1443. It sought to prevent access to private surgeries while at the same time capping health care spending at levels which are too low to even maintain, let alone improve, access to timely health care in the public system.

1444. The Government started the enforcement process against Cambie and SRC by conducting an audit of Cambie and SRC to find out whether their physicians were providing services in both systems to BC residents who did not come within an exemption.

1445. This was done even though Cambie admitted it was acting in breach of the *Act* by using enrolled doctors to perform private surgeries and that this had been known for years by the Government.

1446. The audit of the Cambie Surgery Centre *and SRC* took over two years. The Commission has now moved on to auditing each of the surgeons who provide services at Cambie.

1447. The Commission has not initiated audits of any of the other private clinics in British Columbia, including the False Creek Clinic.

1448. It says that it does not have the financial resources to carry out these audits.

1449. The question that must be asked is why is the Government taking even these very slow steps to stop the surgical clinics from using enrolled doctors to perform private surgeries?

1450. The answer is very simple.

1451. The Government knows that it cannot provide timely surgeries in the public system while also maintaining the public system on a sustainable basis.

1452. The Government knows that the private clinics are not harming the public system and that they are providing some needed relief for British Columbians from lengthy wait lists in the public system, as well as cost relief for the public system itself.

1453. It knows that fundamental changes are required to the delivery of health care in the province which necessarily involves more private financing.

1454. It knows from its health care mission to examine European health care systems that a mixture of public and private health care for core health services will lead to better quality and more timely health care for British Columbians.

1455. Why then doesn't the Government amend the Act to eliminate the restrictions on private health care?

1456. The answer is politics – the “third rail” as Jeffrey Simpson put it – not good public policy.

1457. The Government is unable to do what it knows is necessary because of the political backlash it will suffer from certain quarters.

1458. That is why it is necessary for the courts to confirm the constitutional right of British Columbians to protect their own bodily integrity in the face of a public health care system that is incapable of meeting their individual health care needs.

1459. This is the only way meaningful change consistent with the constitutional rights of British Columbians can occur.

1460. It should not be forgotten that the Plaintiffs are seeking to preserve what has become the status quo in British Columbia, with respect to the private surgical clinics.

1461. BC has had private clinics providing much needed private diagnoses and surgeries through enrolled doctors for many years now.

1462. But, it would also help British Columbians like Ms. Hamer enormously if they could use their existing disability insurance or obtain other insurance to cover the cost of these private surgeries.

1463. That is what this case is about.

1464. It is about the constitutional right of British Columbians to continue to be able to access private health care from enrolled doctors and to now be able to use private insurance to cover the cost of the private health care they receive.

X. PROHIBITING BRITISH COLUMBIANS FROM PROTECTING THEIR OWN BODILY INTEGRITY DOES NOT SERVE ANY VALID OBJECTIVE

1465. Ultimately, in light of the significant and widespread bodily and psychological harm caused by excessive waiting times in the public system, coupled with the prohibitions on persons carrying for their health outside that system, the question in this case is not whether *Charter* rights are being infringed.

1466. They clearly are.

1467. Rather, the real question in this case is whether there is a constitutionally sound justification for the imposition of this harm on so many British Columbians.

1468. The Government has provided a range of reasons why the significant harm caused by prohibiting private care, while at the same time rationing public care is nevertheless an acceptable and indeed necessary cost for ordinary British Columbians to bear.

1469. It will be helpful to lay out the Government's justifications for the prohibitions from the outset, in order to frame the legal analysis to follow.

A. The 'Blame the Doctors' strategy, and the 'Greater Efficiency' Myths

1470. The need to ration care, and the inevitable toll this has on the health and well-being of British Columbians, is evitable in a system in which the service is free to the customer, costs are constantly growing, but revenues are relatively fixed.

1471. The problem is structural; it is inherent in the system.

1472. To combat these fiscal realities, the Government must ration care.

1473. And this rationing has a significant adverse effect on the physical, psychological, emotional and economic well-being of British Columbians.

1474. This structural funding deficiency, and the necessary wait times and serious health problems wait times cause, will not and cannot, be cured by wringing more efficiencies out of the public health care system as the Government hopes.

1475. Past efforts are a testament to this.

1476. As the Government itself says, that "much of the low hanging fruit" has already been harvested – now it will get tougher".²⁷⁵

1477. Doctors cannot be blamed for the harms being suffered by some B.C. residents in the public system.

1478. Blaming the doctors for the structural deficiencies of the public system is wrong both as a matter of principle and as a matter of fact.

²⁷⁵ BC2158602: 07.00.2013 - Health Sector Budget Management Strategies and Implications, at 16.

1479. And even if doctors could do more within the constraints of the public system to ameliorate the harms from waiting – and there is no evidence whatsoever that this is true – the Government cannot offload responsibility for this harm onto individual physicians.

1480. If we are to accept the Government’s position that the prohibitions on access to private health care are justified by a balancing of its benefits and costs, then this balancing must be done taking the world as it is – not how the Government would like the world to be.

1481. The Government cannot justify the prohibition on private health care based on what might happen if the health care system were different.

1482. It must be justified based on what is happening now, given all of the real world’s constraints.

1483. The excuse that the doctors are to blame is also wrong as a matter of fact. Waiting and its resulting harm are inherent in the current system of health care financing.

1484. It is not the fault of individual physicians that their patients have to wait for care.

1485. This will be clear from the evidence in this case from doctors.

1486. There is no formal ‘wait list’ in the public health care system.

1487. Surgeries and other procedures are scheduled at the discretion of the surgeons.

1488. Physicians try to schedule their most urgent cases first.

1489. But, there are more urgent cases than they have operating time to handle.

1490. The surgeons are also extremely limited in what they can do to expedite surgeries as they must prioritize urgent cases, and virtually all patients who are waiting for surgery are suffering to at least some degree.

1491. This is illustrated by a 2005 patient complaint to the Government:

I contacted your office last June 17, 2004 complaining about the eighteen (18) months that I had to wait to have my knee replaced. Your office was kind enough to call me and state that I should call my surgeon, as he had the authority to send me to any hospital in Canada or the United States.

I then called my surgeon, Dr. Naude, and he informed me that he did indeed have the authority to send me to any hospital in Canada or the United States but the requirement was that I needed to be dying. Since I was not dying, the waiting was to remain at eighteen (18) months.²⁷⁶

1492. It is difficult to compare and assess the urgency of cases. And, any time one patient is prioritized, that means that other patients already on the wait list are being displaced.
1493. The Government's Surgical Wait Times website does not provide much help in finding a surgeon who can do a surgery sooner.
1494. As explained by Dr. Tredwell in his expert report:

Significant weight is often given to the B.C. Wait Times website. This website has been most valuable in identifying trends, in underlining emerging unmet needs (e.g. total joint replacement waits) and in charting improvement of system outcomes (e.g. times for the 50% and 90% cohorts to receive services). The site however has a significant flaw that makes its use for individual cases on a day to day basis quite inaccurate and that is its inability to define capacity. Each individual hospital has variables unknown to the Wait Times project. Surgeons are assigned set operating room access by their hospitals, usually in one half day multiples per week, these are set allocations and are rarely subject to change. A hospital that has previously allocated a surgeon with 20 patients on his or her wait list 2 operating days per week has the same capacity as a sister hospital that has assigned a similar surgeon with 10 patients one day and a third hospital will have like capacity for 5 patients on another surgeon's list with a one half day allocation (one half day allocations per week do indeed exist). The lack of this data makes interpreting the raw numbers on the web site impossible for case by case referral in that the particular circumstances of time and place are unknown. Add to this the variability introduced by problems with bed availability or with the expanded surgical team such as lack of resource personnel, sickness, work schedules, that may result in the cancellation of procedures and the true capacity of any hospital becomes very difficult to measure.²⁷⁷

1495. This is also discussed by Dr. Vertesi in his expert report:

The opinions expressed by certain of the Defendants' Experts that the information contained on the BC Surgical Wait Times website constitutes full and accurate

²⁷⁶ BC1027923 - Patient complaint re wait time for surgery.

²⁷⁷ Response Report of Dr. Tredwell dated July 25, 2016, at 7.

information about the wait times for various types of surgery and the relative availability of specialists to perform those surgeries...

I agree ... that the wait times website represents a major advance and can give useful guidance to physicians or patients on avoiding the worst parts of the waitlist. It has evolved over the past few years and improved substantially, but unfortunately is still underused. Partly this is because of what not-for-profit marketers call "diffusion time" which always takes longer than we would like. But part of it I believe has also been credibility. The information is accurate, but not complete. The public website contains only the median wait times for recently completed surgeries as well as the total number still waiting. It does not for example give the number of cases done per month, which would allow one to calculate how long it would take to get to the front of the queue. More importantly, it does not include the wait times of those currently waiting which are typically about three times as long as the completed cases, nor the waits of those that have dropped off.

Please allow me to put this into perspective and explain why it is important. Most people assume that waitlists for surgery progress in an orderly fashion like a lineup at a coffee shop. Nothing could be farther from the truth. The surgical waitlist operates more like a pool, and one with a built-in bias.

I will explain this statement using as an example an analysis I did on the BC waitlist (all daycare bookings excluding cataracts) in 2012. The number of drop-offs across BC had been averaging 17% of the number of cases actually being completed (22% in one Health Authority). The average time on the waitlist for these patients until they dropped off was 300 days. Some might suspect those who dropped off must have been less urgent, but 63% of these drop-offs had been given "Higher Priority" scores indicating a "recommended" wait time (RWT) of less than 16 weeks (112 days); the average wait to drop-off within that higher priority subgroup was 240 days. The average wait of those still waiting on the waitlist at that time was 200 days. Of these, 24% had already exceeded their RWT and were still not done. Of more concern, the number exceeding their RWT in the higher priority group (RWT of 16 weeks) was 52%. In other words, the higher priority groups were failing to meet the ministry's recommended targets to an even greater extent than the average (perhaps because higher priority cases usually require longer operating times and are therefore more difficult to schedule). In the meantime, completed cases had only waited 71 days on average and the median of that (49 days) is the only number that would have appeared on the website. Effectively the waitlist ends up (not intentionally) operating as a two-tiered system with two classes of patients, those that get completed and those that for some reason go into a prolonged holding pattern or eventually drop off. Their respective wait times are very different, and the website reveals only the first.

I know this is more detail than most people need or can handle on a website, but the point is that the numbers appearing on the website significantly underestimate the actual patient experience. People may not know exactly what is wrong, but the gap is large enough to generate mistrust which may be a factor in the slow uptake. Having

said all of that, I still agree that the relative values shown on the website are accurate enough to be a guide for avoiding the longest waits.²⁷⁸

1496. Further, as the physician witnesses in this case will testify, the Surgical Wait Times Website does not provide information about the level of experience of the surgeon or the types of procedures in which he or she specializes.

1497. Moreover, the wait times publicly reported on the Surgical Wait Times Website do not reflect the true experience of many BC residents.

1498. For example, in January 2016, a patient on Vancouver Island wrote the following letter to the Ministry of Health:²⁷⁹

I have been on a wait list for hip replacement surgery since March 2015, to be performed by Dr. Lucas Pugh. I have called Rebalance several times enquiring about the wait times, each time I'm told 12 to 18 months.

This website however seems to indicate differently. As of 30 November 2015, Dr. Pugh had 168 cases waiting. 50% of the cases were completed within 27.2 weeks, while 90% of cases were completed within 35.7 weeks. If this data is indeed correct, why are patients being told 12 to 18 months? I spoke to Rebalance this past week and again was told 12 to 18 months, the person I spoke to couldn't or wouldn't explain the information I got from this website.

For your consideration Sir/Madam.

1499. After already waiting well over 40 weeks, this patient was still being told that there was a wait time of 12 – 18 months (or at least another 40 weeks).

1500. On June 1, 2015, the Ministry announced an additional \$10 million to increase surgical capacity to address patients who had been waiting 40 weeks or more.²⁸⁰

1501. The Ministry also says that it plans to make it easier for doctors to manage the waitlists so BC residents are not waiting so long for medically necessary services.

²⁷⁸ Response Report of Dr. Les Vertesi, dated July 15, 2014, at 4.

²⁷⁹ BC5146956: 2016.01.08 - Hip Replacement – patient complaint.

²⁸⁰ BC4414394: 2015.06.30 - Ministry of Health Information Briefing Note, Title: update on Surgical Services Strategy in British Columbia, at 1/2.

1502. But, as the evidence in this trial will show, the Government's existing and planned wait list management systems will not solve the problem that some BC residents are waiting too long for medically necessary services.

1503. The government simply has not provided sufficient funding in the public system to come anywhere near what is necessary to provide adequate access in the public system.

1504. It is this spending limitation on capacity in the public system that has led to excessive and ultimately unconstitutional wait times for treatment.

1505. Blaming the doctors will not erase this reality.

1506. Dr. Tredwell puts it this way in his expert report:

[T]he common "doctor as a gate keeper" model often seen as a house with many rooms, the doorways to the house and its various rooms being managed by the doctors. Most of us who have practiced in the trenches so to speak realize that there are many locks on these doors and we have but one of the many needed keys. In the case of my own practice, my key only indicated that surgery was indicated, admission to an overcrowded hospital was a key that I did not have, nor did I to a crowded operating room slate, nor to the much needed intensive care unit for post operative care. The gatekeeper analogy is a gross oversimplification of 21st century medicine. In response to assertions of misplaced trust I would submit that the doctors involved in Ms Marten's case made the patient aware of all the rooms in the "house of medical care" to which they had actual keys.²⁸¹

1507. Thus, the claim that doctors are to blame for the deficiencies of the public health care system is simply incorrect, both as a matter of principle and a matter of fact.

B. The 'Blame the Federal Government', or The 'Canada Health Act', Strategy

1508. The Government argues that it must prohibit private care on the basis that if it does not, it will lose federal funding as a result of the *Canada Health Act*.

1509. Again, this is incorrect, both as a matter of fact and as a matter of principle.

²⁸¹ Response Report of Dr. Tredwell, dated July 25, 2016, at 5.

1510. First as explained previously, the *Canada Health Act* does not require a prohibition on private services, as a matter of law. [see *Chaoulli*, at para 16-17, *per* Deschamps J.]
1511. To obtain federal transfer monies for health care, the Government cannot permit user fees or extra billing.
1512. But, BC has gone beyond prohibiting user fees and extra billing in the *Act*.
1513. It also prohibits blended practice and private insurance as a means of preventing British Columbians from accessing private health care.
1514. Under the *Act*, British Columbians who cannot obtain timely medical services in the public system can go to the United States or another country to meet their health care needs, and even obtain private insurance to cover medical care outside of Canada.
1515. They just cannot do this in Canada, the reasoning being that this prohibition will deter most British Columbians from obtaining private health care even when their medical needs cannot be met in a timely way within the public system.
1516. The federal transfer payments will not be cut if BC voluntarily removed the prohibitions on private insurance and blended practice.
1517. As stated before, five Provinces already allow private insurance and four allow dual practice.
1518. Second, even if allowing private health care as a supplement to a universal public system did result in a reduction of federal funding, this is not a defence to a constitutional violation.
1519. One level of government cannot induce or coerce another to breach the *Charter*.
1520. The Province cannot justify a breach the *Charter* on the basis that the Federal Government is inducing the Province to do so by paying money to it to commit the breach.

1521. And, it is not legally open to the Federal Government to induce a province to breach the *Charter* by an offer of money.
1522. Just as the Federal Government could not place conditions on the transfer of federal money which require a Province to undertake unreasonable search and seizures or to prohibit constitutionally protected expression, nor can it require a province to violate the s. 7 rights of its population in order to access federal funds.
1523. Therefore, if the Court finds that the prohibitions on private insurance and blended practice are unconstitutional, the Federal Government cannot refuse to pay the full amount of transfer payments to British Columbia because these prohibitions have been removed pursuant to a court order.
1524. The Government has raised a number of other arguments as to why it must breach the s. 7 and s. 15 rights of the claimants, and British Columbians across the province, which should be addressed.
1525. As we will see, these arguments are either based on pure speculation or misconceptions, which are not sufficient to justify a breach of the *Charter*.

C. Prohibitions Not Necessary to Preserve the Integrity of a Universal Public System

1526. Importantly, the prohibitions on access to private care are not necessary to preserve the quality and integrity of a universal, high-quality public health care system, available to all on the basis of need and not ability to pay.
1527. There is simply no factual basis for concluding that the public system can only be maintained by prohibiting any access to the private system.
1528. This was the conclusion of the majority in *Chaoulli*. According to Madam Justice Deschamps:

Even if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity. In fact, because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved. The example illustrated by a number of other Canadian provinces casts doubt on the argument that the integrity of the public plan depends on the prohibition against private insurance. Obviously, since Quebec's public plan is in a quasi-monopoly position, its predominance is assured. Also, the regimes of the provinces where a private system is authorized demonstrate that public health services are not threatened by private insurance. It can therefore be concluded that the prohibition is not necessary to guarantee the integrity of the public plan.

(...)

As can be seen from the evolution of public plans in the few OECD countries that have been examined in studies produced in the record, there are a wide range of measures that are less drastic, and also less intrusive in relation to the protected rights. The Quebec context is a singular one, not only because of the distinction between participating physicians, non - participating physicians and physicians who have withdrawn (s. 1 HEIA), but also because the Minister may require non-participating physicians to provide health services if he or she considers it likely that the services will not be provided under uniform conditions throughout Quebec or in a particular region (s. 30 HEIA). A measure as drastic as prohibiting private insurance contracts appears to be neither essential nor determinative. [*Chaoulli* at paras 74, 83]

1529. As such, Madam Justice Deschamps determined that it "cannot therefore be concluded from the evidence relating to the Quebec plan or the plans of the other provinces of Canada, or from the evolution of the systems in place in various OECD countries", that the objective of protecting the public system justified the prohibition on private insurance.

1530. This finding was echoed by the other judges in the majority. According to McLachlin CJ & Major J.:

This brings us to the evidence called by the appellants at trial on the experience of other developed countries with public health care systems which permit access to private health care. The experience of these countries suggests that there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system.

The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care. (...)

In summary, the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care. (...)

When we look to the evidence rather than to assumptions, the connection between prohibiting private insurance and maintaining quality public health care vanishes. The evidence before us establishes that where the public system fails to deliver adequate care, the denial of private insurance subjects people to long waiting lists and negatively affects their health and security of the person. The government contends that this is necessary in order to preserve the public health system. The evidence, however, belies that contention. [at paras 139, 140, 149, 152]

1531. Professor McGuire has noted in his expert report that there are a wide range of ways to regulate the interaction between public and private health care options, in order to preserve the quality and accessibility of the former, without relying on an outright or effective prohibition on the latter:

In those countries that allow dual practice there are wide variations in the regulation of this behavior. Some, including the UK, regulate the degree of dual practice through the operation of the public sector contracts to restrict the hours worked in the private sector. Others, including France, restrict the level of income that can be earned by public practitioners operating in the private sector.

Both France and the UK also allow limited scope for private practice through public sector hospitals. Italy appears to allow unlimited dual practice once all public sector obligations have been met. Historically Australia and New Zealand have not maintained any restrictions on public sector physicians working in private practice. Denmark even allows private patients of individual specialists to be treated within public facilities as regulated by local agreements. None of these countries claim to face a physician shortage. Neither are there any estimates of the cost of imposing restrictions on dual practice.²⁸²

1532. Mr. Esmail puts it this way in his expert report:

According to the experience of other developed nations, a universal access health care system can successfully operate alongside a private system. All of the developed world's highest performing universal access health care systems, whether higher

²⁸² Expert Report of Alistair McGuire, dated March 17, 2014, at 17.

performers in timeliness (Belgium, France, Germany, Japan, Luxembourg, the Netherlands and Switzerland), or high performers in outcomes from the health care process (Australia, Japan, Sweden, France, and Switzerland, for example), operate alongside private systems/private options. While regulations surrounding the private system and its interface with the public system exist in these countries, for example private system care must be fully privately paid for in Japan, while in Australia private care can be delivered by both public and private hospitals and receives taxpayer support, none of these nations has seen fit to or needed to prohibit a private system/private option in order to maintain a high quality public system.²⁸³

1533. Moreover, there is good reason to believe that permitting a private option may well improve the quality and accessibility of the public health care system, which is the very objective of the Act.

1534. Alistair McGuire explains this as follows:

(I)ncreased choice for patients in health care systems, when coupled with competition appears to increase the quality of care generally. To emphasize, the case for duplicate [private health insurance] support of a private sector does not rest on this argument. This benefit augments the fundamental case for increasing capacity through the private sector. Again England provides recent empirical evidence on this, incorporating the influence of a dual private market. A number of studies have documented the subsequent improvement in public sector (NHS) hospital quality.

There is strong evidence that the policy of promoting patient choice and increasing competition, partly through increased access to private facilities, increased overall public hospital quality and stimulated productivity within the public sector. Moreover, capacity was freed within the NHS (public) sector such that coupled with waiting time targets, increased demand was services and waiting times were reduced.²⁸⁴

1535. As the international experience shows, there are many other ways in which governments can preserve the integrity of a public health care system without prohibiting individuals whose needs have not been met in that system from accessing care.

1536. According to Senator Kirby, one viable option for preserve the priority of the public system would be as follows:

²⁸³ Expert Response Report of Nadeem Esmail, dated July 15, 2014, at 22, citing Borowitz, Michael, Valerie Moran, and Luigi Siciliani (2013a). Waiting Times for Health Care: A Conceptual Framework. In Luigi Siciliani, Michael Borowitz, and Valerie Moran (eds.). *Waiting Time Policies in the Health Sector: What Works?* (OECD Health Policy Studies): 19-32 and Esmail, Nadeem and Michael Walker (2008). *How Good is Canadian Health Care?* Fraser Institute.

²⁸⁴ Expert Report of Alistair McGuire, dated March 17, 2014, at 8-9.

Under the system I have described, however, doctors could take private pay patients once they had worked up to their cap in the public system. In this way, they could see more patients and do more procedures. This would, in turn, lead to shorter wait times in the publicly funded system because patients treated privately would no longer remain on the publicly funded wait list.

Since all specialists would be required to work up to their capped income in the publicly funded system, there would be no reduction in the supply of services to the publicly funded system. The new procedures would be over and over what doctors are currently permitted to perform, while not costing the public system anything. (...)

Such a system would closely resemble the British and Australian health care systems. In Britain, for example, a doctor must first fulfill his contract with the National Health Service before taking private pay patients. In many cases, this means that the doctor treats private pay patients only on weekends. [Kirby, "Two Options", at 71-72]

1537. Senator Kirby goes on to describe why "maintaining the ban on doctors taking both public and private pay patients is an inefficient use of health human resources".

In provinces that ration the supply of specialists' services by capping their income, it is common for a cardiologist to reach his or her income cap by working only three and a half days a week. I am personally aware of a specific case in which a cardiologist spends the other day and a half a week at home with his young family.

What a waste of highly trained, very expensive talent! Surely it would be better to allow — indeed encourage — this cardiologist to see patients that extra day and a half a week. If the province in question is unwilling to pay for his time, then it makes sense to remove the rationing constraint and let the cardiologist take private pay patients for the remaining day and a half a week.

The second example is an orthopedic surgeon in a province which rations the supply of health care by restricting the number of operating room hours available to the surgeon, thus rationing the number of procedures the surgeon can do. Over the past decade or so, this surgeon has had his operating room hours reduced from approximately 22 hours per week to about 8 hours per week. Clearly wait times would improve if the rationing of this surgeon's services was eliminated by allowing him to take private pay patients once he had completed his maximum eight hours per week in the operating room treating publicly funded patients.

To maintain the rationing constraint makes no sense! It is a colossal waste of human resources and exacerbates the waiting times for procedures such as hip and knee replacements. These examples illustrate why — if provinces continue to ration the supply of doctors' services as tightly as they do now — Canadians may well agree to support allowing doctors to take both public pay and private pay patients under the conditions described above. [Kirby, "Two Options", at 72; emphasis added]

1538. As Patrick Monahan notes, referencing the Supreme Court's decision in *Chaoulli*, Senator Kirby's proposal is "merely one option among many":

The point is that governments cannot justify continuing to impose pain or even death on innocent patients through prohibiting them from taking measures to protect their own health, merely on the basis that lifting the ban on private health insurance will create policy challenges. These same policy challenges exist in other jurisdiction that do not have a similar ban on utilizing one's own resources to protect one's health. *Chaoulli* decides that if government wishes to establish a monopoly on the provision of medically necessary care, then it must be legally accountable to patients for the timeliness of medical care provided.

Far from destroying medicare, this requirement of patient accountability adds an essential element that was previously missing from the principles established by the Canada Health Act. Pre-*Chaoulli*, governments were apparently free to ration access to healthcare without legal limitation, and those sick or dying individuals who were forced to bear the costs of such excessive rationing were deprived of all legal recourse or remedy. What *Chaoulli* decides is that such a state of affairs is constitutionally unacceptable in a free and democratic society that places a proper value on individual human dignity. *Chaoulli* requires only that in making a choice between a single-tier and a two-tier healthcare system, governments respect the constitutional rights of Canadians. If governments choose to maintain Canada's single-payer, universal healthcare model, they must ensure that there are clinically valid and legally enforceable limits on waiting times for medically necessary care. If governments are unable or unwilling to put such accountability mechanisms in place, Canadians cannot be prohibited from utilizing their own resources to protect their health. But this will have been a choice ultimately made by governments and legislatures, rather than the courts. Moreover, as explained above, in this event there will undoubtedly be ample policy tools and options available to government to ensure that waiting lists within the public system do not grow. [Monahan, "*Chaoulli v. Quebec*", at 16-17]

1539. In summary, there are many ways, used throughout the world, to ensure that we have a thriving public health care system without banning people from seeking medical treatment privately.
1540. As Jeffrey Simpson has noted, "over time and under the hammer blow of cascading realities", we have come to realize that such harmful measures [prohibiting private care] are not the only means of preserving the public health care system. [Simpson, *Chronic Condition*, at 373]

1541. In light of international experience with different models of health care delivery, it is simply not credible to argue that prohibiting private care for core medical services is the only or even the best way to preserve a universal public health care system.
1542. Indeed, after years of blindly embracing the national mythology and tropes about ‘line-jumping’, this is increasingly becoming the consensus.
1543. The Supreme Court of Canada, Senator Kirby, Claude Castonguay, and so many others have come to acknowledge that the important objective of sustaining and improving our universal public health care system can be accomplished (and indeed may be best accomplished) without a ban on private insurance and dual practice.

D. Prohibitions Not Necessary to Preserve an Equitable Public Health Care System

1544. The impugned prohibitions are also not necessary to preserve an equitable system, with health care available to all regardless of their ability to pay.
1545. From the outset, the argument that the Government must prohibit British Columbians from accessing timely and effective medical treatment, in pursuit of unattainable notions of equality, is simply a perverse enforcement of unfounded dogma.
1546. First, there is nothing fair or equitable about making some people suffer from a lack of timely medical treatment in the public health care system in the service of ideology.
1547. If it is the Government’s argument that these prohibitions are necessary so that all will suffer, but suffer *equally*, that is surely neither in accordance with principles of fundamental justice nor can it be a pressing and substantial government objective.
1548. Equity is not promoted or achieved by preventing BC residents from accessing private health care if they cannot receive timely medical services in the public health care system.
1549. Equality is not achieved by guaranteeing the equal misery of all.

1550. Second, it is important to recognize that any belief that health care could be *perfectly* equal is a delusion.

1551. The reality is that the very wealthy will always have more options available to them, unless the Government seeks to prohibit individuals from travelling (which it could not do). They can always have their health care provided faster elsewhere.

1552. Professor Michael Bliss makes this point in his expert report in this case:

In the real world of health care, as in education, citizens become insistent and resourceful in overcoming unnecessary hindrances to the meeting of their needs. If one system, of schooling or of health care, is performing less than adequately, they try to turn to another system. If the public system seems to be performing badly, then the pressure is to expand a private system. Successful private systems challenge public systems to become better, establishing a positive symbiosis describable as a win-win situation. While no mixed system, in the provision of education or any other social services, can by definition operate on principles of exact equality – a desiderata always in danger of amounting to a fetish - such systems deliver equal outcomes in assuring that basic needs are met.²⁸⁵

1553. The point is also explained by Professor Yanick Labrie in his expert report.

1554. Professor Labrie is a tenured professor at CEGEP Saint-Jean-sur-Richelieu, and an economist and health care policy analyst.

1555. As he explains, all health care systems, to some degree or another, involve some inequality in care.

(W)hat is recognized is that inequity in access to care, as generally defined in the economic literature, exists to varying degrees in most countries. It is not clear that the presence of a duplicate private insurance market leads to greater inequity when it comes to access to medical services. In a recent analysis of 19 countries, for instance, OECD researchers found that Denmark and the United Kingdom, where duplicate insurance covers 27% and 16% of the population respectively, were the two most egalitarian countries in this regard. In fact, among the countries analyzed, Denmark is the only one where the probability of consulting a doctor is higher among low-income people (bottom quartile) than among high-income people (top quintile). In the UK, people with lower incomes are as likely to consult a doctor as those with

²⁸⁵ Response Report of Michael Bliss, dated July 31, 2014, at para 26.

higher incomes when needs are taken into consideration. Conversely, Canada fares poorly by this measure in this international ranking.

[Moreover], there is a large body of empirical evidence showing that access to care varies with socioeconomic status in Canada, despite the prohibition of duplicate private health insurance. Many studies conducted over the past two decades have shown that it is the poorest Canadians who have the least access to health care, especially when it comes to a first contact with the health care system. According to one of those studies, 30% of Quebecers among the poorest segment of the population (compared to 16% of among the richest one) reported in 2005 having unmet needs when it comes to health care, primarily due to long wait times or the impossibility of seeing a doctor when needed. Available evidence also indicates that the richest in Canada generally enjoy privileged access to the public health care system, because of personal relationships and other factors that allow them to jump the queue.²⁸⁶

1556. Indeed, Professor Labrie's observation is all the more evident, when we take into account that currently in British Columbia, only the very wealthy are able to pay directly out of pocket (i.e. without insurance), or by travelling out of the country for treatment.
1557. In this regard, opening up private insurance to all income levels – typically through employment plans – would level the playing field, as opposed to the opposite.
1558. This also may have broader positive effects on the overall socio-economic equality, by improving equity more generally. As Professor Labrie explains:

Indeed, health economists generally recognize that duplicate private insurance has advantages, from a public standpoint. Among these are the potential to improve overall access to care by bringing additional resources into the system on a voluntary basis and the potential to improve equity in the funding of the health system by favouring a redistribution from the rich to the poor.

Insofar as those covered by duplicate insurance policies use the private system while continuing to contribute to the funding of the public system through their taxes, more resources can be devoted to each patient in the public system. Thus, duplicate insurance has the potential to reduce waiting times for treatment and improve access to care for all, not only for the privately insured. According to a group of Danish researchers who looked into the matter, private duplicate insurance coverage "was associated with an average 10% reduction in the use of public hospitals. This means that the public health care budget was relieved and that overall access to health services, ceteris paribus, bust have improved for the uninsured as well as the insured."

²⁸⁶ Response Report of Yanick Labrie, dated July 31, 2014, at 7-8.

Some economists also argue that duplicate private health insurance accentuates the progressivity of the financing of the health care system. Researchers who recently sought to evaluate this thesis using data from Italy concluded that ‘the better off individuals, who more frequently buy VHI [voluntary health insurance] coverage, opt out of the public provision, so that the Intalian NHS [national health system] redistributes, from high income to low income individuals, through the operation of the VHI market.²⁸⁷

1559. Thus, the Government cannot rely on a fantasy of ‘perfect equality’ to justify a breach of *Charter* rights.

1560. Moreover, the system put in place through the *Act* does not even *purport* to treat everyone equally.

1561. The government only imposes a monopoly on the funding of those services it has deemed ‘medically necessary’. This excludes a wide range of services which are critical to a person’s health and wellbeing, which are left to the vagaries of the market.

1562. Further, the *Act* generally, and the specific provisions at issue in this case, are not aimed at ensuring equality of treatment for all.

1563. As detailed above, many British Columbians needing medical assessment and treatment are exempt from the prohibitions, and others with the ability to pay out of pocket are able to access the private system in other jurisdictions.

1564. Under the *Act*, certain classes of B.C. residents are able to access private health care to obtain more timely medically required health care services, such as workers who are injured or become ill at work and inmates in Federal prisons.

1565. The *Act* itself, by its very terms, treats B.C. residents inequitably in terms of timely access to health care, even leaving aside its real world impact.

1566. It is clearly not the objective of the *Act* to promote perfect equality in terms of access to medical treatment.

²⁸⁷ *Ibid* at 12-13.

1567. It is also important in this regard to realize that many Canadians – not merely the well-off – currently have private health care insurance through their employer plans.
1568. This is used for pharmaceuticals, home care, dental care, and other important health care services which are not provided through the public system.
1569. The coverage rate for private health insurance differs considerably across OECD countries, but it is hardly the exclusive preserve of the well-off.
1570. In the Netherlands, for instance, 92% of the population is covered by some form of private health insurance. In France, that number is 86%, while in Switzerland, it is 80%. ²⁸⁸
1571. Many Canadians, not only the well-off, already have disability or supplemental health insurance through their employers, or coverage as a beneficiary on a family member's private insurance plan.
1572. Over two thirds of Canadians currently have some form of private health care coverage.
1573. In Ontario, that number is almost 80%.²⁸⁹
1574. Professor Kessler notes in his Expert Report:

I searched for studies that quantified the utilization of privately-financed care in Canada by income level. Although few studies have investigated this question, they are important because of their direct relevance to this case. Manitoba's experience with privately-financed cataract surgery in the 1990s shows that income is not the sole, or even the most important, determinant of utilization of privately-financed care. [The evidence] shows the number of privately-financed cataract procedures performed in Winnipeg in 1995/96 by patients' neighbourhood income quintile. Each income quintile contains 20% of the city's population. As the figure shows, the distribution of privately financed cataract procedures by income quintile is flat, with the highest two income quintiles receiving only 2 more procedures (out of a total of 358) than the lowest two income quintiles.

A 2013 survey of patients who obtained privately-financed care in Quebec reaches the same conclusion in an analysis conducted by the Montreal Economic Institute,

²⁸⁸ CSC00016979 - F. Colombo & N. Tapay, "Private Health Insurance in OECD Countries" (2004) *OECD Health Working Papers No. 15*, at 11-12.

²⁸⁹ Response Report of Yanick Labrie, dated July 31, 2014, at 9.

55% of private-clinic clients reported having household income below C\$75,000 whereas the median household income in the Province in 2011 was around \$68,000. This shows that the income distribution of private-clinic clients is similar to that of the Province as a whole.²⁹⁰

1575. Nevertheless, and to the extent that the existence of private health insurance might lead to some equity concerns, private health insurance could be subsidized, regulated or promoted by the government, to ensure that all Canadians have access to private insurance, to be used where the public system is not meeting their needs in a timely way.²⁹¹
1576. Finally, the suggestion that only the Canadian model can adequately protect equality of care is directly at odds with the evidence.
1577. In particular, there is no evidence that our current system makes health care provision more equitable than systems which permit a private care option.
1578. To repeat, the Commonwealth Fund has found that Canada ranked 9th out of the 11 counties in terms of equitable treatment of patients.
1579. The fact that Canada ranks poorly in terms of equity in this study shows that mixed public and private health care systems provide more equitable access to health care than our monopoly public health care system. This effectively rebuts the equity concerns that are expressed by some about allowing BC residents to access private health care.
1580. Therefore, the Act is neither designed to achieve perfect equality in treatment, nor does it have that effect. To the contrary, our current monopoly system is more unequal than those in which private care options are available.
1581. All other advanced countries, except the United States, have mixed systems, and have more equal systems.

²⁹⁰ Expert Report of Daniel Kessler, dated March 17, 2014, at 14-15.

²⁹¹ CSC00016979 - F. Colombo & N. Tapay, "Private Health Insurance in OECD Countries" (2004) *OECD Health Working Papers No. 15*, at 44-47.

1582. Thus, even if the serious harm to the constitutional rights to life, liberty and security of the person could be justified based on abstract notions of perfect equality, contrary to how the scheme actually operates, prohibiting private health care is simply not necessary order to promote equality in access to health care - indeed, we are an outlier in the OECD countries for *not* permitting it.

1583. As Professor Labrie has explained:

(T)he policy goal of providing good quality services to all without considerations based on means is shared by all developed OECD countries with universal health care systems. Nevertheless, many of them allow their citizens to voluntarily purchase duplicate health insurance, while still retaining the coverage offered by the public plan. Duplicate health insurance is indeed available in many OECD countries with universal health care systems including Australia, Denmark, Finland, Greece, Ireland, Israel, Italy, Norway, New Zealand, Portugal, Spain, Sweden and the United Kingdom. Conversely, Canada is often characterized as being unique in banning the coverage of medically required services by private insurance companies.

It is after having reviewed the evidence on this matter that the *Task Force on the Funding of the Health System*, chaired by Claude Castonguay, recommended in its 2008 report a greater role to private duplicate insurance in Quebec. According to the *Task Force*, the fact that a certain proportion of the population in many developed countries voluntarily decides to purchase duplicate private insurance is not incompatible with having health services accessible to all.²⁹²

1584. Professor Labrie cites the Castonguay report, which was discussed in the introduction.

There, the father of Quebec Medicare had the following to say:

[T]he question of private insurance raises the whole question of freedom of choice.

Freedom of choice is compatible with a public plan accessible to all. An individual's freedom of choice will not have the effect of limiting the rights and freedoms of other citizens, if it is well governed. On the contrary, it will have the indirect consequence of increasing the overall supply of care, and thus its accessibility.

This is not only a matter of choice for higher-income individuals. The following very real case clearly illustrates the importance of this freedom of choice for everyone. It concerns a truck driver who, instead of having to wait weeks for an operation, decided to pay out of his pocket to return to work faster. On the basis of what principle can he be refused the right to obtain insurance against such a risk, when the public system is unable to meet his needs satisfactorily?

²⁹² Response Report of Yanick Labrie, dated July 31, 2014, at 12

The freedom to obtain insurance against these risks exists in several other Canadian provinces, and nowhere has this had significant negative effects on the public health care system.²⁹³

1585. In countries with mixed public and private health care systems, residents are able to obtain more timely and more equitable access to health care than in Canada at lower per capita costs, without access to a universal public system being reduced or threatened.

1586. In other words, as the international experience unavoidably demonstrates, “the private sector can be assigned a role while respecting the foundations of the public system”.²⁹⁴ This can be done, as Castonguay notes, by imposing other restrictions that do not prevent people from securing their own health and well-being:

In most industrialized countries, physicians can practice both in the public system and privately, outside the system. However, physicians who choose this possibility must satisfy certain obligations to the public system, before providing care on a purely private basis. (...)

The health care systems of most of the industrialized countries allow various degrees of mixed practice. They see the mix of public and private practice as a choice offered to people whose demand for care cannot be covered satisfactorily by the public system.²⁹⁵

1587. This shows us that we have nothing to fear and everything to gain in terms of access to health care services by eliminating the prohibitions on private health care and adopting, like most other countries, a mixed private and public health care system.

1588. As we have repeatedly shown, there is also no evidence that the existence of private surgical clinics in BC for 18 or so years have harmed the public system by taking resources away from the public system.

1589. Nor will permitting clinics to continue to operate result in U.S. style private health care.

1590. As Professor Bliss states in his 2010 Lecture:

²⁹³ C. Castonguay, J. Marcotte & M. Venne, *Getting Our Money's Worth, Report of the Task Force on the Funding of the Health System* (Government du Quebec, February 2008) [**Castonguay Report**] at 95.

²⁹⁴ *Ibid* at 14.

²⁹⁵ *Ibid* at 42, 92.

Why not get over the obsession with being different from the United States and learn lessons from the mixed private-public healthcare systems of countries such as Sweden, France, and even Britain (whose venerable National Health System had always had to compete with private medicine).²⁹⁶

1591. In summary, the system established in the *Act* which prohibits access to private care for most, but not all, BC residents, while forcing everyone else to suffer in a public system unable to meet their medical needs, does not create more equality.
1592. It simply creates a wider gap between the rich and poor, because the rich can afford to get private care elsewhere.
1593. If this constitutional challenge is successful, the private option available to the wealthy, and those exempt under the *MPA*, would become available to many more British Columbians.
1594. This would create a more equal system of health care provision in this province.

E. Prohibitions Not Necessary to Preserve Health Outcomes

1595. Even if it were thought that there is a possibility that lifting the ban on private insurance and blended practice would harm the public system, any justification for the continuation of the ban would have to balance the benefits of the ban against the costs.
1596. There is no evidence that permitting private care would negatively affect health outcomes – indeed, the evidence suggests the opposite.
1597. In the 2014 Commonwealth Fund study, Canada ranked 10th overall out of the 11 countries that were included in the study with respect to quality of health care. The other countries in the study were Australia, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

²⁹⁶ CSC00024094 - M. Bliss, "Critical Condition: A Historian's Prognosis on Canada's Aging Healthcare System" *C.D. Howe Institute Benefactors Lecture* (2010), at 13.

1598. The country that ranked first overall, and first with respect to quality, access, and efficiency, was the United Kingdom – a country which provides the opportunity for duplicate private health insurance.²⁹⁷

1599. And there is no evidence the private surgical clinics have been providing inferior care over the past 20 years.

1600. If they had been providing inferior health care services, the Health Authorities would not be been contracting with them to provide medically necessary surgical services within the public health care system.

1601. If there were quality problems, they would have become apparent. But there have been no such problems.

1602. And the Government can, and does, regulate the operation of private clinics to ensure that there are no quality problems.

1603. Government can always require doctors in the public system to fulfill certain quotas or maximize their time in the public system before performing services in the private system.

1604. In this way, there would be no loss of services to the public system, with the private system relying entirely on excess capacity.

F. Conclusion

1605. In summary, and as will be explained in more detail below, the Government has not and cannot provided any sound basis for concluding that the impugned provisions are necessary for any viable legislative objective, nor that it should not be held accountable for breaching the Plaintiffs' *Charter* rights.

²⁹⁷ CSC00019587: 06.00.2014 - Commonwealth Fund, "Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally" (2014) at 12.

1606. It cannot blame the doctors for failing to do the impossible and provide more services than the Government is willing to pay for.
1607. It cannot blame the federal government for conditioning transfer payments on the breach of *Charter* rights, even if the federal government had done so, which it has not.
1608. It cannot claim that prohibitions on private insurance or blended practice are necessary to maintain a high-quality, viable, and universal public health care system, access to which is based on need, not on ability to pay. The international evidence from mixed health care systems, which provide more equitable, efficient and effective universal health care to their citizenry, unequivocally refutes this claim.
1609. And it cannot claim that the private surgical clinics are providing inferior care, or that the quality of care in private clinics is not regulated and scrutinized.
1610. With that in mind, we can now turn to how all of this – the significant harm caused by the Government’s failure to provide necessary health services while prohibiting a private option, and the absence of any reasonable justification for doing so – fits into the legal analysis underlying this case.

XI. LEGAL ANALYSIS – PROHIBITIONS ON PRIVATE CARE BREACH SECTIONS 7 AND 15

A. Section 7 Breach - Overview

1611. The *Canadian Charter of Rights and Freedoms* is designed “to provide a continuing framework for the legitimate exercise of governmental power and... *the unremitting protection of individual rights and liberties*” [*Hunter v. Southam* at pp. 155].²⁹⁸
1612. Section 7 of the *Charter* protects the rights to life, liberty and security of person.

²⁹⁸ *Hunter v. Southam Inc*, [1984] 2 SCR 145 [**Hunter v. Southam**] at 155 (emphasis added).

1613. These rights are “basic to our conception of a free and democratic society” [*Charkaoui* at para 66].²⁹⁹

1614. No interests are more central to our constitutional order than a person’s life, liberty and security of the person; without protection for these basic interests, all other *Charter* protections are illusory.

1615. Section 7 is designed to ensure that any deprivation of these interests can only be justified under section 1 by laws of exceptional importance and necessity.

1616. An inquiry under section 7 involves a two-step process:

- first, it must be demonstrated that a section 7 interest – life, liberty or security of the person – is infringed; and
- second, it must be determined whether such infringement is in accordance with the principles of fundamental justice.

1617. If a law infringing on these fundamental interests is arbitrary, overbroad, or grossly disproportionate, it will not be in accordance with the principles of fundamental justice.

1618. Such laws will violate section 7 and must be struck down, unless there are exceptional circumstances that justify a breach under section 1 [*Bedford* at paras 124-129].³⁰⁰

1619. At the first stage of the section 7 analysis, it is clear that the challenged *Medicare Protection Act* provisions in this case deprive persons of their right to life, liberty and security of person.

1620. The right of everyone to protect and secure his or her own mental and physical health, well-being and survival are central to the values underlining section 7, including the personal integrity, autonomy and dignity of each individual.

²⁹⁹ *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9 [*Charkaoui*] at para 66.

³⁰⁰ *Canada (Attorney General) v. Bedford*, [2013] 3 SCR 1101, 2013 SCC 72 [*Bedford*] at paras 124-129.

1621. Legislation that prevents individuals from acting to protect and secure their life, health and wellbeing deprives individuals of their core rights.
1622. In recognition of this, the Courts have consistently found that the right to choose one's own health care treatment is central to the interests protected by the section 7 guarantee.
1623. The Supreme Court of Canada recently confirmed in the *Carter* assisted-dying case the “tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity” [*Carter* at para 67; emphasis added].³⁰¹
1624. Section 7 entitles persons to decide the course of their own medical care, and requires that restrictions on the ability to care for one's health must be absolutely necessary in order to achieve a more important and pressing purpose.
1625. The Plaintiffs in this case are not seeking a “positive” right to a certain quality or timeliness of publicly-funded health care.
1626. Whether the Government has a constitutional obligation to do more to improve the public health care system is not an issue before the Court.
1627. Rather, the Plaintiffs challenge the legislative restrictions on BC patients’ ability to make decisions about their bodily integrity, to take steps to alleviate their pain and suffering, and to ensure their health and survival.
1628. They are not seeking to compel the Government to provide more and better medical services to prevent harm, they ask only that the Government stop interfering with their right to act and choose for themselves how best to address their health care needs.
1629. These options are currently foreclosed by the prohibitions found in the Act.

³⁰¹ *Carter v. Canada (Attorney General)*, [2015] 1 SCR 331, 2015 SCC 5 [*Carter*] para 67, citing *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 [*A.C.*] at paras 39-40.

1630. The Government seeks to justify the statutory restrictions depriving persons of their right to life, liberty, and security of person on the basis of the supposed benefit that flows to society as a whole from those restrictions.

1631. I have already explained why the Government's justifications are not persuasive in showing that it is necessary to impose this serious harm in order to ensure a strong and universal public health care system.

1632. Indeed, as discussed, the Government's chosen means are making health care less accessible and timely for *everyone*.

1633. However, even if certain public benefits flowed from the restrictions (which is not the case), the rights protected under section 7 cannot be lightly sacrificed for the purpose of achieving public objectives.

1634. As Professor Hamish Stewart has explained, a core purpose underlying section 7 is to ensure that individuals "must be able to be, and to see themselves as, more than mere means or resources for the state to use in its pursuit of public objectives".³⁰²

1635. This is exactly the principle that was upheld by the majority in *Chaoulli*.

1636. The majority in *Chaoulli* found that imposing significant physical and psychological harms on persons by preventing them from caring for their health was not required in order to have a strong universal health care system.

1637. And because it was not necessary to violate their constitutional interests in order to achieve the Government's important objective, the laws in Quebec prohibiting private insurance were unconstitutional.

1638. The prohibition on dual practice was not challenged in *Chaoulli*.

³⁰² H Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Toronto: Irwin Law, 2012) at 309.

1639. But, as discussed before, this prohibition is a significant barrier preventing people in this province from being able to access timely private health care treatment.

1640. While the *Chaoulli* decision has provoked some opposition, its true effect was to uphold values central to our constitutional order.

1641. As Patrick Monahan has explained, and as quoted in the introduction:

Largely overlooked in this academic debate was whether anyone had an answer to the fundamental question of principle that had moved the Court to intervene in the first place. This question was simply whether it was legally and morally justifiable for the state, on the one hand, to require individuals to access healthcare services only through a universal, single-payer system and then, on the other, to deny them access to needed service when they were sick or dying. In such circumstances, which the Court found to prevail in Canada today, was it legitimate for the state to prohibit individuals from using their own resources to access the care they needed? Could the sick be legally compelled to wait indefinitely for care without legal consequences of any kind, even if it resulted in a serious deterioration of their health or even their death? Yet critics of the decision largely ignored this fundamental question, preferring to focus attention on subsidiary questions, such as whether the Supreme Court had a proper appreciation of the complex operation of health insurance in other OECD countries, or whether the courts had any business interfering in a complex policy area such as medicare.

Given the importance of this issue to the argument that follows, it bears explaining briefly why it cannot be legitimate in a free and democratic society to prevent individuals from utilizing their own resources to protect their health, in circumstances where the publicly funded system does not provide medical care in a timely manner. In these circumstances, the state is essentially forcing individuals to endure pain and even death in aid of the efficient operation of a social program. This offends the basic liberal principle that all persons should be treated “as equals”; that is, as entitled to equal concern and respect. No one citizen may be treated as a mere instrument to improve the welfare of another. Government fails to observe this bedrock moral principle when it imposes a “sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning his sense of his equal worth” (Dworkin 1985, 204). By way of illustration, as a democratic society we believe it would be wrong and immoral to put an innocent person to death, even if by so doing we might increase the health or welfare of others in society. The fundamental defect in such a proposal is that it treats the person to be sacrificed as a mere means to increase the welfare of others in society, rather than as an equal person entitled to the same concern and respect as those who stand to benefit from his or her death.

Nor is this merely a moral principle. The Supreme Court of Canada has indicated that the “ultimate standard” for justifying limits on rights must be the values of a free and democratic society, which values include respect for the “inherent dignity of the

human person” (*R. v Oakes*, 136). It is for this reason that any healthcare system which deliberately and systematically imposes pain or even death on innocent individuals in the name of improving healthcare provided to others cannot be justified either morally or legally, since it fails to treat all individuals as equally deserving of concern and respect. Nor could such a system be regarded as being in accordance with the “principles of fundamental justice” enshrined in section 7 of the Canadian *Charter*, since any legal regime which treated one person as a mere instrument for the satisfaction of the needs of another must be regarded as odious and fundamentally unjust. It is for this reason that the Supreme Court’s conclusion in *Chaoulli* was correct, both legally and morally. [Monahan, “*Chaoulli v. Quebec*” at 4-5]³⁰³

1642. Dean Monahan poses the fundamental question – legal and moral – before the court in this case: Can the state force individuals to risk their own health, well-being and, in extreme circumstances, life, in order to preserve the state’s monopoly on the provision of health care?

1643. For the reasons that follow, the answer to this must be no.

1644. The prohibitions on access to private medical care in the *Act* violate the rights to life, liberty and security of the person in a manner inconsistent with the principles of fundamental justice, and this deprivation cannot be justified under section 1.

B. The Impugned Provisions Jeopardize Life, Liberty and Security of the Person

1645. At the first stage of the section 7 analysis, the impugned provisions in this case clearly impinge upon all three section 7 interests: life, liberty and security of the person.

(i) The Right to Liberty is Infringed

1646. First, prohibiting persons from accessing timely medical treatment violates their right to liberty under section 7.

1647. The liberty interest under s. 7 is engaged where the state interferes with decisions that are “fundamentally or inherently personal such that, by their very nature, they implicate

³⁰³ Patrick J. Monahan, “*Chaoulli v. Quebec* and the Future of Canadian Healthcare: Patient Accountability as the ‘Sixth Principle’ of the Canada Health Act” *C.D. Howe Institute, Benefactors Lecture, 2006* (Toronto, November 29, 2006) [Monahan, “*Chaoulli v. Quebec*”] at 4-5.

basic choices going to the core of what it means to enjoy individual dignity and independence” [*Godbout* at para. 66; *Blencoe* at paras 49-54].³⁰⁴

1648. Deciding whether and how to access health care treatment is among the most fundamental life choices an individual can make [see *Carter* at paras 66-68; A.C. at paras 41-45].

1649. Or, as the Court found in *Carter*, interference with “fundamentally important and personal medical decision-making” will implicate the section 7 liberty interest [*Carter* at para 65-66].

1650. Therefore, a prohibition on access to health care outside the public system monopoly, particularly where that public system cannot provide adequate and timely care, infringes the liberty interest of section 7.

1651. This alone is sufficient to require the court to ensure that the laws are not arbitrary, overbroad, grossly disproportionate or otherwise contrary to the principles of fundamental justice.

1652. However, it is important to recognize that the state interference with section 7 interests goes well beyond the interference with “liberty”.

1653. These restrictions also infringe everyone’s right to security of person and life as well.

(ii) The Right to Security of Person is Infringed

1654. An infringement of the security of person interest has been described by the Courts in a number of ways.

1655. For instance, an infringement of security of the person has been described as

- “state interference with bodily integrity” and “serious state-imposed psychological stress” [*Morgentaler* at 56, *per* Dickson CJ]³⁰⁵;

³⁰⁴ *Godbout v. Longueuil (City)*, [1997] 3 SCR 844 [*Goudbout*] at para 66; *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 [*Blencoe*] at paras 49-54.

³⁰⁵ *R. v. Morgentaler*, [1988] 1 SCR 30 [*Morgentaler*] at 56, *per* Dickson C.J.

- “state interference when a person’s life or health is in danger” [*Morgentaler*, at 90, *per* Beetz J.]; and
- “state action which has the likely effect of impairing a person’s health” [*Monney* at 685].³⁰⁶

1656. Section 7 is therefore engaged by “state interference with an individual’s physical or psychological integrity, including any state action that causes physical or serious psychological suffering” [*Carter* at para 64].

1657. As described in some detail previously, B.C. residents are routinely subject to exactly this type of harm as a result of long wait times in the public system, coupled with the prohibitions on having those needs met outside of that closed system.

1658. Put simply, by preventing people from accessing medically necessary health care treatment, the prohibitions on private health care in the Act interfere with their physical and psychological integrity, and cause physical and psychological harm, which infringes the right to security of the person.

1659. All of the members of the Court in *Chaoulli* found that the similar Quebec restrictions on access to private insurance infringed the right to security of person.

1660. The Court also decided unanimously that the deprivation was caused by the impugned provisions [see Hogg, *Constitutional Law*, at §32.6].³⁰⁷

1661. As leading constitutional scholar Peter Hogg has observed, *Chaoulli* was not the first case to decide that limiting accessibility to necessary medical procedures violated the constitution.

1662. The first case was *Morgentaler*, a case in which the state imposed arbitrary and unnecessary restrictions on access to abortion services, which had the effect of harming

³⁰⁶ *R. v. Monney*, [1999] 1 SCR 652 [*Monney*] at 685.

³⁰⁷ Peter W. Hogg, *Constitutional Law of Canada* (Toronto: Thompson Carswell, looseleaf) [Hogg, “Constitutional Law”] at §32.6.

the health of women who sought to make important personal life decisions regarding their reproductive health.

1663. The majority of the Court in *Chaoulli* considered *Morgentaler* as a controlling precedent with respect to violations of security of the person, and as Professor Hogg observed, “surely they were right” [Hogg, *Constitutional Law*, at §32.6].
1664. In *Chaoulli*, the majority explicitly drew the critical links between the constitutional violation in that case and the violation in *Morgentaler*, and explained how prohibitions on access to private care impinge security of the person under section 7.
1665. As explained by McLachlin CJ and Major J:

In this appeal, delays in treatment giving rise to psychological and physical suffering engage the s. 7 protection of security of the person just as they did in *Morgentaler*. In *Morgentaler*, as in this case, the problem arises from a legislative scheme that offers health services. In *Morgentaler*, as in this case, the legislative scheme denies people the right to access alternative health care. (That the sanction in *Morgentaler* was criminal prosecution while the sanction here is administrative prohibition and penalties is irrelevant. The important point is that in both cases, care outside the legislatively provided system is effectively prohibited.) In *Morgentaler* the result of the monopolistic scheme was delay in treatment with attendant physical risk and psychological suffering. In *Morgentaler*, as here, people in urgent need of care face the same prospect: unless they fall within the wealthy few who can pay for private care, typically outside the country, they have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails. As in *Morgentaler*, the result is interference with security of the person under s. 7 of the Charter.

(...)

The issue in *Morgentaler* was whether a system for obtaining approval for abortions (as an exception to a prohibition) that in practice imposed significant delays in obtaining medical treatment unjustifiably violated s. 7 of the *Charter*. Parliament had established a mandatory system for obtaining medical care in the termination of pregnancy. The sanction by which the mandatory public system was maintained differed: criminal in *Morgentaler*, “administrative” in the case at bar. Yet the consequences for the individuals in both cases are serious. In *Morgentaler*, as here, the system left the individual facing a lack of critical care with no choice but to travel outside the country to obtain the required medical care at her own expense. It was this constraint on s. 7 security, taken from the perspective of the woman facing the health care system, and not the criminal sanction, that drove the majority analysis in

Morgentaler. We therefore conclude that the decision provides guidance in the case at bar.

In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, Sopinka J., writing for the majority, held that security of the person encompasses “a notion of personal autonomy involving, at the very least, control over one’s bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress” (pp. 587-88). The prohibition against private insurance in this case results in psychological and emotional stress and a loss of control by an individual over her own health.

Not every difficulty rises to the level of adverse impact on security of the person under s. 7. The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged. Access to a waiting list is not access to health care. (...) [Chaoulli at paras 119-123; emphasis added]

1666. This was also the conclusion of the other judges in *Chaoulli*, all of whom agreed that the restrictions on access to private care infringed the right to security of the person.

1667. For instance, Justice Deschamps observed:

Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays. In [*Morgentaler*], Dickson C.J. found, based on the consequences of delays, that the procedure then provided for in s. 251 of the [*Criminal Code*], jeopardized the right to security of the person. Beetz J., [...] with Estey J. concurring, was of the opinion that the delay created an additional risk to health and constituted a violation of the right to security of the person. Likewise, in [*Rodriguez*], Sopinka J. found that the suffering imposed by the state impinged on the right to security of the person. (...) If the evidence establishes that the right to security of the person has been infringed, it supports, a fortiori, the finding that the right to the inviolability of the person has been infringed. (...)

I find that the trial judge did not err in finding that the prohibition on insurance for health care already insured by the state constitutes an infringement of the right to life and security. (...) Quebeckers are denied a solution that would permit them to avoid waiting lists, which are used as a tool to manage the public plan. (...) [Chaoulli at paras 43, 45; emphasis added]

1668. Similarly, Justices Binnie and Lebel stated that “(l)ike our colleagues McLachlin C.J. and Major J., we accept the trial judge’s conclusion that in some circumstances some Quebecers may have their life or ‘security of the person’ put at risk by the prohibition against private health insurance” [Chaoulli at para 191].

1669. As in *Morgentaler* and *Chaoulli*, the legislative regime at issue in this case leaves the individual facing a lack of timely medical care with no meaningful choices if they are without the means to travel outside the country to seek treatment [see e.g. *Chaoulli* at para 121, *per* McLachlin CJ and Major J.].

1670. Because patients in B.C. “may be denied timely health care for a condition that is clinically significant to their current and future health, s.7 protection of security of the person is engaged” [*Chaoulli* at para 123; emphasis added].

1671. Professor Hogg describes the central holding of *Morgentaler* and *Chaoulli* as follows:

The similarities are that, in both cases, medical treatment inside the legislatively provided system was not provided in time to avoid risks to life or security of the person, while medical treatment outside the system was effectively prohibited. Both cases decide that, when the state assumes a monopoly power over the provision of a medical service that affects life or security of the person, it is under a constitutional duty to ensure that the service is provided in a timely fashion. What that means for Canada’s public health system is that it is no longer constitutional for the provinces to ration health-care resources by allowing dangerous waiting times to develop for procedures that affect life or security of the person. The ‘reasonable access’ to health care services that is required in theory by the Canada Health Act has become a constitutional obligation that is required in practice. [Hogg, *Constitutional Law*, at §32.6]

1672. This applies equally to the case at hand.

1673. Consistent with *Morgentaler* and *Chaoulli*, the Supreme Court has since found that restrictions preventing individuals from accessing “lifesaving and health-protecting services” infringe upon security of the person [*PHS Community Services*, at paras 91-92].³⁰⁸

1674. Also, as in both *Morgentaler* and *Chaoulli*, the Courts have consistently found that an interference with the *psychological* integrity of the person can be so severe as to constitute a violation of security of the person under section 7.

³⁰⁸ *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 SCR 134, 2011 SCC 44 [**PHS Community Services**] at paras 91-92.

1675. In *G.(J.)*, for instance, the Court found that while ordinary stresses and anxieties will not constitute an infringement, a “serious and profound effect on a person's psychological integrity” will [*G. (J.)*, at 77].³⁰⁹

1676. As described before, even beyond the significant harm imposed on individual's bodily integrity and physical health by the prohibitions on accessing timely care, the impugned provisions also impose a significant degree of psychological harm upon those unable to access timely and medically necessary treatment.

1677. Therefore, as all the judges found in *Chaoulli*, the restrictions on access to private care in this case constitute an infringement upon security of the person.

(iii) The Right to Life is Infringed

1678. While a majority of section 7 cases involve a breach of the right to liberty or the right security of the person, this is among the rare cases where state action will also engage the right to life, the most basic and fundamental right in the *Charter*.

1679. The fundamental importance of the right to life is obvious, as noted by the South African Constitutional Court:

The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. [*Makwanyane* at para 325]³¹⁰

1680. Needless to say, laws which risk depriving a person of their life or increasing the risk to a person's continued survival, must be subject to the closest possible scrutiny by the Courts.

1681. The unanimous Court in *Carter* explained that the right to life will be engaged where laws or state action “impose[] death or an increased risk of death on a person, either directly or indirectly” [*Carter* at para 64; emphasis added].

³⁰⁹ *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 SCR 46 [*G.J.*] at 77.

³¹⁰ *S. v. Makwanyane and Another* [1995] ZACC 3 at para 325, O'Regan J, cited in *Carter v. Canada (Attorney General)*, 2013 BCCA 435 at para 87, Finch CJ, dissenting.

1682. On the evidence that will be presented in this case, it is clear that the restrictions on access to private treatment can, in some cases, impose at least an increased risk of death on a person, where they are prevented from obtaining surgeries or other necessary treatment.

1683. The Court in *Chaoulli* unanimously recognized the potential for a violation of right to life caused by the restrictions on accessing private care.

1684. Madam Justice Deschamps explained that waiting lists are “real and intentional”, and referred to evidence similar to that found in this case and discussed above, in concluding that the laws at issue infringed the right to life:

Dr. Daniel Doyle, a cardiovascular surgeon, testified that when a person is diagnosed with cardiovascular disease, he or she is [translation] “always sitting on a bomb” and can die at any moment. In such cases, it is inevitable that some patients will die if they have to wait for an operation. Dr. Doyle testified that the risk of mortality rises by 0.45 percent per month. The right to life is therefore affected by the delays that are the necessary result of waiting lists. (...) [*Chaoulli* at para 40; emphasis added]

1685. Like Deschamps J., McLachlin C.J. and Major J. observed that the right to life was also engaged by the restrictions on access to private treatment:

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

1686. Finally, and as noted above, Binnie & Lebel JJ also accepted that the restrictions on access to private care meant that some persons would have their right to life imperiled [*Chaoulli* at para 191].

1687. This unanimous conclusion of the Court in *Chaoulli* has been confirmed in subsequent jurisprudence of the Court.

1688. In *Carter*, the Court – again unanimously – confirmed that the restrictions on private insurance in *Chaoulli* constituted a deprivation of the right to life [*Carter* at para 62].

1689. Therefore, there can be no doubt, and as the evidence in this case establishes, that precluding access to private health care serves to not only jeopardize individual liberty and security of person, but also poses an increased risk to an individual's right to life.

(iv) Conclusion on the Violation of the Rights to Life, Liberty & Security of the Person

1690. As all of the judges found in *Chaoulli*, this is among the unique cases in which a law infringes all of the section 7 interests: life, liberty and security of the person.

1691. Overall, an individual's choice about medical care “is rooted in their control over their bodily integrity”, and their decisions with respect to treatment will often represent a “deeply personal response to serious pain and suffering” [*Carter* at para 68].

1692. By denying the individuals the ability to access treatment of their choosing, a law will infringe the rights guaranteed by section 7 [*Carter* at para 68].

1693. In *PHS Community Services*, the Court helpfully summarized the state of the law as follows:

“(w)here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out... Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer” [*PHS Community Services*, at para 93; emphasis added].

1694. This formulation precisely captures the deprivation in the case at bar.

1695. The prohibitions in the Act prevent individuals from making inherently personal life decisions about their health and bodily integrity, and condemns them to physical and psychological pain and suffering they would not need to suffer in the absence of the impugned laws.

1696. And in some cases, the lack of timely public care, when coupled with the effective prohibition on accessing private care may even lead to death.

1697. As such, the first stage of the section 7 analysis is overwhelmingly met in this case.

C. The violation of the rights to life, liberty and security of the person is not in accordance with the principles of fundamental justice

(i) Overview of the Principles of Fundamental Justice

1698. Laws that jeopardize a person's life, liberty or security of person must be tailored in such a way that they do not cause unnecessary harm, and in a way that does not interfere with basic values that the Courts must uphold under the *Charter*.

1699. That is what the principles of fundamental justice require.

1700. As explained by the Court in *Bedford*:

The *Motor Vehicle Reference* recognized that the principles of fundamental justice are about the basic values underpinning our constitutional order. The s. 7 analysis is concerned with capturing inherently bad laws: that is, laws that take away life, liberty, or security of the person in a way that runs afoul of our basic values. The principles of fundamental justice are an attempt to capture those values. Over the years, the jurisprudence has given shape to the content of these basic values. (...)

The overarching lesson that emerges from the case law is that laws run afoul of our basic values when the means by which the state seeks to attain its objective is fundamentally flawed, in the sense of being arbitrary, overbroad, or having effects that are grossly disproportionate to the legislative goal. To deprive citizens of life, liberty, or security of the person by laws that violate these norms is not in accordance with the principles of fundamental justice. [*Bedford* at paras 96, 105; emphasis added]

1701. If a law violates the rights to life, liberty or security of person in a way that is arbitrary, overbroad, or grossly disproportionate, it undermines these pillars of our legal and constitutional order.

1702. This is because the law causes harm to persons in a manner that is unnecessary to achieve the objectives of the legislation in question.

1703. For instance, a law will be considered “arbitrary” if it infringes upon fundamental interests in a manner that is not necessary to achieve or is unconnected to an important objective.

1704. The Court explained the arbitrariness principle in *Bedford*, making specific reference to *Chaoulli* as an example where the law infringed section 7 interests in a way that is arbitrary:

Arbitrariness was used to describe the situation where there is no connection between the effect and the object of the law. In *Morgentaler*, the accused challenged provisions of the *Criminal Code* that required abortions to be approved by a therapeutic abortion committee of an accredited or approved hospital. The purpose of the law was to protect women’s health. The majority found that the requirement that all therapeutic abortions take place in accredited hospitals did not contribute to the objective of protecting women’s health and, in fact, caused delays that were detrimental to women’s health. Thus, the law violated basic values because the effect of the law actually contravened the objective of the law. (...)

In *Chaoulli*, the applicant challenged a Quebec law that prohibited private health insurance for services that were available in the public sector. The purpose of the provision was to protect the public health care system and prevent the diversion of resources from the public system. The majority found, on the basis of international evidence, that private health insurance and a public health system could co-exist. Three of the four-judge majority found that the prohibition was “arbitrary” because there was no real connection on the facts between the effect and the objective of the law.

Most recently, in *PHS*, this Court found that the Minister’s decision not to extend a safe injection site’s exemption from drug possession laws was arbitrary. The purpose of drug possession laws was the protection of health and public safety, and the services provided by the safe injection site actually contributed to these objectives. Thus, the effect of not extending the exemption — that is, prohibiting the safe injection site from operating — was contrary to the objectives of the drug possession laws. [*Bedford* at paras 98-100; emphasis added]

1705. It is not a coincidence that each of the examples of arbitrariness given by the court – *Morgentaler*, *Chaoulli* and *PHS Community Services* – involved cases addressing restrictions on access to necessary health care and medical treatment.

1706. As noted above, those rights are so fundamental that the laws must be very closely tailored to their objectives in order to withstand constitutional scrutiny.

1707. Put simply, such laws will not be constitutionally sound if they cause unnecessary harm.

1708. If the same goals – such as the protection of a universal public health care system – can be achieved in ways that do not impose the same harms, section 7 will have been breached.

1709. The principle of overbreadth is similar to arbitrariness, in that it prevents governments from imposing unnecessary harm to a person's life, liberty or security of the person.

1710. That is, both principles render unconstitutional laws that cause more harm than is necessary to achieve the objects of the laws.

1711. While arbitrariness involves laws that do not *generally* achieve their objectives or are not necessary to achieve those objectives, overbreadth involves laws which achieve their objectives in *some respects*, but go further than is necessary to achieve those objectives.

1712. The Court explained the overbreadth principle in *Carter* as follows:

The overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object: *Bedford*, at paras. 101 and 112-13. Like the other principles of fundamental justice under s. 7, overbreadth is not concerned with competing social interests or ancillary benefits to the general population. A law that is drawn broadly to target conduct that bears no relation to its purpose “in order to make enforcement more practical” may therefore be overbroad (see *Bedford*, at para. 113). The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled. [*Carter* at para 85; emphasis added]

1713. Finally, a law will violate section 7 where the harm caused is grossly disproportionate to the law's objectives.

1714. This means that the courts must look at what the law is designed to achieve, and determine whether the objectives are worth the harm caused.

1715. Unlike arbitrariness and overbreadth, which focus on whether the means chosen are necessary to achieve the law's objectives, gross disproportionality requires the Court to

ensure that the harm caused by the law is roughly proportionate to the benefit to be achieved.

1716. For instance, the Court in *Bedford* gave the example of *PHS Community Services* as an illustration of the principle of “gross disproportionality”, as follows:

In *PHS*, this Court found that the Minister’s refusal to exempt the safe injection site from drug possession laws was not in accordance with the principles of fundamental justice because the effect of denying health services and increasing the risk of death and disease of injection drug users was grossly disproportionate to the objectives of the drug possession laws, namely public health and safety. [*Bedford* at para 104]

1717. The essence of all of these principles of fundamental justice is to ensure that laws which deprive someone a fundamental interests protected by section 7 do not impose unnecessary or gratuitous harm.
1718. Needless to say, governments must be able to show that a law is very carefully designed in order to justify depriving a person of their rights to life and security of person in particular.
1719. The government’s reasons must not only be *necessary* to achieve their objectives (i.e. cannot be arbitrary), and go *no further than is necessary* to achieve those objectives (i.e. cannot be overbroad), but also must be sufficiently weighty to impose the risk of serious bodily harm and even death (i.e. cannot be grossly disproportionate).
1720. Laws which impinge upon section 7 interests in a manner that violates those principles can only be countenanced in a free and democratic society in the most exceptional circumstances.
1721. Two additional observations are important to emphasize at this stage of the analysis, in light of recent clarifications to the case law under section 7 that have occurred after the Court decided *Chaoulli*.
1722. First, the Supreme Court has recently confirmed that if the impact of the law is arbitrary, overbroad, or grossly disproportionate to the legislative objective, with respect to even a single person, it will violate section 7 [*Bedford* at para 123].

1723. The fact that a law may be *reasonably* well tailored to an objective, or that only a *few* people fall through the cracks and have their rights infringed, does not mean that the law is not arbitrary, overbroad or grossly disproportionate.

1724. As the Court explained in *Bedford*:

All three principles — arbitrariness, overbreadth, and gross disproportionality — compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness. That is, they do not look to how well the law achieves its object, or to how much of the population the law benefits. They do not consider ancillary benefits to the general population. Furthermore, none of the principles measure the percentage of the population that is negatively impacted. The analysis is qualitative, not quantitative. The question under s. 7 is whether anyone's life, liberty or security of the person has been denied by a law that is inherently bad; a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7. [*Bedford* para 123; emphasis added]

1725. This reflects the critical importance of these fundamental interests to an individual's physical and psychological integrity, autonomy, dignity, and overall well-being, and the unremitting protection such interests are rightly afforded by the courts.

1726. Indeed, the entire point of section 7 is that *everyone* has these rights, and the government cannot deprive even a single person of their rights to life, liberty or security of the person unless the law causes no more harm than is necessary to achieve a more pressing objective.

1727. For the same reason, the *Charter* does not state or imply that the government can deprive a person of his or her life, liberty, or security of person so long as it deprives everyone *equally*.

1728. The fact that the deprivation of these important interests is relatively widespread – as in this case – makes the constitutional harm *more* egregious, rather than less.

1729. Second, any alleged benefits to society flowing from the *Medicare Protection Act* are not relevant in determining whether a law violates the principles of fundamental justice.

1730. The Court made this point clear in both *Bedford* and *Carter*, where the Court emphasized that any competing moral claims or broad societal benefits are considered at the stage of justification under section 1 [*Carter* at paras 79-81; *Bedford* at paras 124-129].
1731. In assessing whether a law operates in accordance with the principles of fundamental justice, a court does not look to “how much of the population the law benefits” nor does it consider “ancillary benefits to the general population” [*Bedford* at para 123].
1732. Therefore, the question at this stage is not whether the Government’s objectives are good or important, but whether the objectives of the law cannot be reasonably achieved in any other way that would avoid imposing the serious constitutional harms, and are important enough to justify harming those constitutional interests.
1733. For the following reasons, the restrictions in the *Act* are arbitrary, overbroad, and grossly disproportionate to the government’s objectives because those objectives can be achieved in a less harmful manner that does not deprive anyone of their right to life, liberty and security of person.
1734. Therefore, the prohibitions on accessing private medical care in the *Act* are not consistent with the principles of fundamental justice just described and violate section 7.
- (ii) *The Objective of the Impugned Provisions*
1735. Properly defining the objective of the impugned provisions is critical, both to the section 7 analysis, as well as to the analysis under section 1.
1736. As such, the government’s objective must be defined carefully, in order for the broader purposes of the *Charter* to be realized.
1737. As the Supreme Court has cautioned, the Court need not accept the government’s purported objectives.
1738. Rather, it must determine the objectives that the law actually are designed to achieve.

1739. While a purpose clause in the legislation – such as section 2 of the *Medicare Protection Act* – will be relevant, the Courts are not bound by it for the purposes of a section 7 or section 1 analysis [*Chatterjee* at para 19].³¹¹

1740. Rather, the Courts must look to any purpose stated in the act, as well as the text, context and scheme of the legislation, in order to determine the objectives the government actually sought to achieve.

1741. That is, the Court will look to the way the law actually operates in practice, based on the entire scheme of the statute, to determine its purpose.

1742. For instance, in a recent decision involving changes to credit for pre-sentence custody,³¹² the government argued that the sentencing law had a broad range of objectives, including to enhance public confidence in the integrity of the justice system, to enhance the safety and security of Canadians, to ensure adequate punishment, and to promote rehabilitation.

1743. The Court rejected that submission, finding that a close review of the actual legislation – “by its words and how it operates” - showed that the real purpose or objective was more narrow: to “enhance public safety and security by increasing violent and chronic offenders’ access to rehabilitation programs” [*Safarzadeh-Markhali* at paras 44, 47].

1744. *Carter* provides another useful example of how the courts will identify the purposes of challenged legislation.

1745. In *Carter*, the Federal Government argued that the purpose of the prohibition on assisted dying was the “preservation of life” [*Carter* at para 75].

1746. The Court rejected this proposed objective for the purpose of the section 7 analysis, because framing the purpose of the assisted-dying prohibitions in those terms was so

³¹¹ *Chatterjee v. Ontario (AG)*, 2009 SCC 19 [*Chatterjee*] at para 19.

³¹² *R. v. Safarzadeh -Markhali*, 2016 SCC 14 [*Safarzadeh -Markhali*].

broad that it “has the potential to short-circuit the analysis” at section 7 [*Carter* at para 77].

1747. The Court emphasized that the object of the impugned provision must “be defined precisely” for the purposes of section 7, and therefore will require the court to look at exactly what the provision is designed to achieve [*Carter* at para 78].
1748. For instance, in *Carter*, the Court noted that the Government’s proposed purpose – the preservation of life generally – went beyond the ambit of the provision itself.
1749. The prohibition on assisted suicide was “not directed at preserving life, or even at preventing suicide — attempted suicide is no longer a crime” [*Carter* at para 78].
1750. Rather, the “direct target of the measure is the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness” [*Carter* at paras 76-78].
1751. In other words, the Government cannot design a law to achieve a relatively narrow objective, and then try to justify that on the basis of a broader purpose that it has not in fact tried to achieve through the law being challenged.
1752. In this case, the broad purposes of the impugned provisions are to maintain a viable public health care sector, in order to ensure high quality and universal public health care coverage, and to have that public health care system available to all regardless of ability to pay.
1753. But there is nothing in the Government’s broad objectives that includes *entirely prohibiting private care*, and no sign of this objective in the purpose clause of the MPA.
1754. Nor is there any indication – either in the law itself, or how it is applied – to suggest that the objective is to ensure that everyone must receive identical health care treatment.
1755. Section 2 of that Act states:

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

1756. Defining the purpose of the provision more broadly, such as the creation of a just and equal health care system, is too general.
1757. It would short circuit the analysis, as the Government tried to do in *Carter* by defining the objective of the law as “the preservation of life” generally.
1758. Conversely, describing the purpose of the law as “limiting access to the private health care system” would be too narrow, because it amounts to a “a virtual repetition of the challenged provision” [*Safarzadeh -Markhali* at para 27].
1759. Put differently, if the purpose of the clause is defined by the means used to accomplish it, this would also serve to undermine the Court’s analysis at the section 7 stage.
1760. In this case, describing the purpose of the impugned measures as “limiting access to private care” would be the equivalent of describing the objective of the assisted dying provision in *Carter* as “prohibiting assisted dying”.
1761. Such a legal tautology would not permit a meaningful section 7 analysis.
1762. As the legislation’s purpose clause suggests, the purpose of the impugned provisions of the *Act* is to preserve a universal and accessible, publicly-funded health care system. It is not to preserve a publicly-funded health care system *to the exclusion of all other health care options*.
1763. Nor can the Government’s objective, as it suggests in its pleadings, be to ensure “access to necessary medical care in British Columbia is based on need and not an individual’s ability to pay”.
1764. As in *Carter*, such an objective is simply not supported by what the *Act* actually does.

1765. The variety of exemptions in the Government's own regulations, the number of aspects of care for which individuals are required to pay, and the ability of very wealthy BC residents to pay privately for health care elsewhere, are testament to this.

1766. Given the similarities of the provisions challenged in *Chaoulli*, this court should be guided by the legislative purpose described by the Court in that case.

1767. The majority in that case correctly understood the purpose of the impugned provisions as "to preserve the integrity of the public health care system", "preserving the public plan", or "preserving the public health system" [*Chaoulli* at para 56, per Deschamps J., and at para 152, McLachlin C.J. and Major J.].

1768. Therefore, the objective of the impugned provisions in this case – for the purposes of the section 7 and section 1 analysis – must be the preservation of a high quality, sustainable, and universal public health care option, available to all regardless of ability to pay.

1769. And, as noted above, for the impugned provisions to be in accordance with the principles of fundamental justice in this case, they must be

- A. reasonably directed at achieving this purpose (arbitrariness);
- B. go no further than is necessary to achieve this purpose (overbreadth); and
- C. cannot be so severe in their effects as to outweigh this purpose (gross disproportionality).

1770. In this case, the legislation is not in accordance with these principles of fundamental justice, for the reasons described below.

(iii) The Law is Arbitrary

1771. As discussed above, and as the comparative and expert evidence in this case will demonstrate, the legislation in this case undermines the important government objective of preserving a universal, sustainable and high quality public health care system available to all.

1772. Instead of achieving this objective, the prohibition on private insurance overburdens the public health care system, increasing wait times for everyone and decreasing the overall quality of care.

1773. As the majority found in *Chaoulli*, “there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system” [*Chaoulli* at para 139].

1774. Indeed, maintaining a public sector monopoly “is not necessary or even related to the provision of quality public health care” [*Chaoulli* at para 140].

1775. As noted above, the prohibition on private insurance at issue in *Chaoulli* was recently cited by the unanimous Court in *Bedford* as an example of a law that was arbitrary, within the meaning of section 7 [at para 99].

1776. On this basis alone, the impugned provisions in the *Act* need to be justified under section 1.

(iv) The Law is Overbroad

1777. The impugned provisions also go far beyond what is necessary to ensure the legislation’s purpose, and are therefore overbroad as well as arbitrary.

1778. As described above, a law will be overbroad where it captures conduct which is not necessary to achieve the purpose of the legislation.

1779. As the experience in other jurisdictions shows, it is possible to maintain a viable and universal public health care system, with health care available to all regardless of their ability to pay, while at the same time permitting individuals to access private insurance and treatment.

1780. There is no reason in logic or in evidence for finding that an effective prohibition on access to treatment outside the public system is necessary to preserve the public health care system.

1781. As shown by the experience of every other OECD country, there are other, less harmful measures that would accomplish the legislation's objectives equally or more effectively, and which do not have the effect of denying persons access to necessary medical treatment entirely.
1782. In particular, with respect to the overbreadth analysis, the prohibitions in this case capture conduct entirely unrelated to the preservation of a viable and universal public health care system.
1783. For instance, it prevents doctors from privately providing medically necessary treatment – thereby freeing up time on public sector wait lists – *even if those doctors have already reached their maximum operating time in the public system.*
1784. This was the experience at the Cambie Surgery Centre – the doctors were able to provide medically necessary treatments *after* having provided all of the treatments that the Government's allocation of resources would permit them to do in the public system.
1785. The protection of a universal public health care system does not require forcing doctors to sit idle, and refrain from treating patients in need.
1786. That does not further the purpose of a viable and universal public healthcare system, and therefore creates unnecessary harm.
1787. By enacting provisions with the purpose and effect of preventing access to affordable and effective private care for all but wealthy or privileged members of society, the legislature has impinged on the Plaintiffs' life, liberty and security of person in a way that captures far more conduct than is required in order to achieve an effective and universal public health care system.

(v) The Law is Grossly Disproportionate

1788. Finally, in light of the severity of the impact on those denied effective treatment within a reasonable time – including the potential deprivation of life for those prevented from

accessing timely life-saving treatment – the impugned laws are grossly disproportionate to the state’s valid objectives.

1789. As described above, rationing health care in the public system while prohibiting access elsewhere severely impacts an individual’s physical, psychological and emotional health; imposes undue and serious suffering on those forced to languish for months and years waiting for treatment; and ultimately may jeopardize a person’s life.

1790. In the words of McLachlin CJ & Major J. in *Chaoulli*:

Finally, the benefits of the prohibition do not outweigh the deleterious effects. Prohibiting citizens from obtaining private health care insurance may, as discussed, leave people no choice but to accept excessive delays in the public health system. The physical and psychological suffering and risk of death that may result outweigh whatever benefit (and none has been demonstrated to us here) there may be to the system as a whole. [Chaoulli at para 157; emphasis added; see also PHS Community Services at para ; Bedford at para 104]

1791. When weighed against the benefits derived from the prohibition, which are nil, such a cost is clearly far beyond what is constitutionally acceptable.

1792. And to the extent that it is found that an objective of the legislation is to support absolute equality in accessing health care treatment – which is entirely inconsistent with the way that the law is designed and actually operates – the harm caused is grossly disproportionate to this objective as well.

1793. The Court has recently come to a similar conclusion in *PHS Community Services*, where the government sought to justify a breach of the rights to life, liberty and security of person on the basis of a commitment to a symbolic principle – the importance of presenting a uniform stand against the use and possession of illegal drugs.

1794. The Court unanimously found that causing a risk of bodily harm and even death was grossly disproportionate to this objective:

The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate

government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics. [PHS Community Services at para 133]

1795. Similarly, the devastating impact imposed by the restrictions on accessing timely health care in this case is out of all proportion to any benefit to be served by pursuing a national mythology of absolute equality of access to health care treatment, which in any event bears no relation to how the law actually operates, or what it is designed to achieve.

(vi) Conclusion – Violation of the Rights to Life, Liberty and Security of Person Are Inconsistent with the Principles of Fundamental Justice

1796. For all the reasons described above, it is clear that the impugned laws impose a serious harm upon individuals, and that these harms are simply not necessary to achieve the objective of maintaining a viable universal public health care system, available to all regardless of their ability to pay.

1797. The Supreme Court of Canada has already found in *Chaoulli* that prohibitions on private health care, where the public health care system fails to deliver adequate care, violate section 7 of the *Charter*.

1798. This holding was summarized by McLachlin CJ and Major J. as follows:

By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the Charter.

The *Canada Health Act*, the *Health Insurance Act*, and the *Hospital Insurance Act* do not expressly prohibit private health services. However, they limit access to private health services by removing the ability to contract for private health care insurance to cover the same services covered by public insurance. The result is a virtual monopoly for the public health scheme. The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person. Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so. [*Chaoulli* at paras 105-106; emphasis added]

1799. From this, and based on the similar evidence in this case, it flows that the serious deprivation of these critical *Charter* rights is not in accordance with the principles of fundamental justice, and must be justified by the Government under section 1.

1800. Professor Peter Hogg has described the majority holding in *Chaoulli* as part of a number of cases – including *Morgantaler*, *PHS Community Services*, *Bedford* and *Carter* - in which the legislative restrictions at issue were properly found to violate section 7.

1801. In the course of that analysis, Professor Hogg also explained why it was necessary in these cases for the courts to step in and vindicate these fundamental *Charter* rights in cases like *Chaoulli*:

The doctrines of overbreadth, disproportionality and arbitrariness are all at bottom intended to address what Hamish Stewart calls “failures of instrumental rationality”, by which he means that the Court accepts the legislative objective, but scrutinizes the policy instrument enacted as the means to achieve the objective. If the policy instrument is not a rational means to achieve the objective, then the law is dysfunctional in terms of its own objective. A law that restricts life, liberty or security of the person, when subjected to an evidence-based review of its operation, may be shown to be not in fact fulfilling the law’s objective, or even to be undermining the law’s objective by doing more harm than good. That was the thrust of the evidence in the abortion, drug addiction, assisted suicide, prostitution and health care cases. In an ideal world, such failures of policy would be remedied by the responsible legislative body. But if the persons harmed by the dysfunctional law have little popular appeal or political power, then legislators may be uninterested in their problems and disinclined to take any action, especially if they believe that a remedial law is likely to be unpopular. In that situation, there is a case for judicial review of the deprivation of life, liberty or security of the unpopular minority. [Hogg, “Brilliant Career”, at 209].³¹³

1802. Or, as Justice Deschamps explained in *Chaoulli* in a passage quoted in the introduction:

For many years, the government has failed to act; the situation continues to deteriorate. This is not a case in which missing scientific data would allow for a more informed decision to be made. The principle of prudence that is so popular in matters relating to the environment and to medical research cannot be transposed to this case. Under the Quebec plan, the government can control its human resources in various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services (s. 30 HEIA) or by implementing less restrictive measures, like those adopted in the four Canadian provinces that do not prohibit private insurance or in the other OECD

³¹³ Peter W. Hogg, “The Brilliant Career of Section 7” (2012) 58 SCLR 195.

countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebecers' right to security. The government has not given reasons for its failure to act. Inertia cannot be used as an argument to justify deference. [Chaoulli at para 97]

1803. As the evidence in this case shows, the BC Government has known for years that it cannot provide timely necessary medical treatment to everyone who needs it within the public health care system.
1804. That is why it permitted Cambie and other private clinics to operate, and why it provides exemptions to the restrictions set out in the *Medicare Protection Act* for certain privileged groups of people.
1805. However, it has now decided to enforce this harmful and unjustifiable law, which prohibits persons caring for their health and wellbeing outside of the public system, while it continues to ration medically necessary health care as a means of cost control.
1806. There is no reason for the Government to have kept these prohibitions on private health care, or to have now decided to enforce them after 20 years, other than political pressure.
1807. This is precisely the type of situation that section 7 of the *Charter* was designed to remedy.

D. Breach of Section 15

1808. In addition to the violation of section 7, the impugned provisions also violate section 15 of the *Charter*.
 - (i) Breach on the basis of protected grounds
1809. The underlying purpose of the *Charter's* equality rights is to promote “a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration” [Andrews at 171].³¹⁴

³¹⁴ *Andrews v. Law Society of British Columbia*, [1989] 1 SCR 143 at 171 [*Andrews*].

1810. In *Andrews*, the Court explained that a law will violate section 15 if it imposes unequal treatment on the basis of an enumerated or analogous ground [see *Andrews* at 180-181].
1811. The enumerated grounds are listed in the text of the section, and include race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
1812. Analogous grounds are those that are similar to those enumerated in that they involve “a personal characteristic that is immutable or changeable only at unacceptable cost to personal identity”, and have been found to include citizenship status, sexual orientation, and marital status [see *Corbiere* at para 13].³¹⁵
1813. According to the traditional section 15 test, in order to demonstrate that a law or statute violates section 15(1) of the *Charter*, the law must:
- A. draw a distinction;
 - B. be based on, or impose a disproportionate effect connected to, a prohibited or analogous ground;
 - C. the distinction has the effect of perpetuating arbitrary disadvantage based on an individual’s membership in an enumerated or analogous group [*Kapp* para 17; *Taypotat* at paras 17-21].³¹⁶
1814. A law or scheme of laws will draw a distinction, for the purposes of section 15(1) where the law “has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others”, or if it “imposes obligations [on some] that are not imposed on others” [*Quebec (Attorney General) v. A*, at para 187 per Lebel J. and para 322 per Abella J.; and see *Andrews* at 174]³¹⁷
1815. The focus of the section 15 analysis is on these harmful and disadvantaging effects of a law, where they are imposed unequally in a manner linked to a protected ground.
1816. As the Supreme Court of Canada explained in *Taypotat*:

³¹⁵ *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 SCR 203 [*Corbiere*] at para 13

³¹⁶ *R. v. Kapp*, [2008] 2 SCR 483, 2008 SCC 41 [*Kapp*] at para 17; *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30 [*Taypotat*] at paras 17-21.

³¹⁷ *Quebec (Attorney General) v. A*, 2013 SCC 5 [*Quebec v. A*] at para 187.

The focus of s. 15 is therefore on laws that draw discriminatory distinctions — that is, distinctions that have the effect of perpetuating arbitrary disadvantage based on an individual's membership in an enumerated or analogous group: (...). The s. 15(1) analysis is accordingly concerned with the social and economic context in which a claim of inequality arises, and with the effects of the challenged law or action on the claimant group (...) [at para 18]

1817. The objective of a section 15 analysis is to determine the effect of impugned provisions as they operate in the real world, and in the entire legislative scheme at issue, on the persons or groups effected.
1818. Therefore, section 15 is not only concerned with laws which *directly* impose unequal benefits or burdens, or that do so by drawing a distinction *explicitly* on the basis of prohibited or analogous grounds.
1819. Neutral rules can have a disproportionate impact or negative effect linked to a prohibited or analogous grounds that can constitute discrimination under section 15 [*Eldridge* at paras 60-66].³¹⁸
1820. In this case, the effect of the impugned provisions of the *Act* is to impose an unequal burden in a manner linked to protected grounds of discrimination, particularly age and disability.
1821. That is because the *Act* prohibits access to private treatment for many BC residents, but exempts others from this harmful restriction – such as those injured at work.
1822. A distinction drawn on the basis of workplace or worker status is not necessarily discriminatory.
1823. However, in this case, the laws have a discriminatory effect on the basis of age and disability because:
 - (a) workers are disproportionately between the ages of 18 and 65;

³¹⁸ See *Eldridge v. British Columbia (Attorney General)*, [1997] 3 SCR 624 [*Eldridge*] at paras 60-66; see also *Canadian National Railway Co. v. Canada (Canadian Human Rights Commission)*, [1987] 1 S.C.R. 1114 at 1139.

- (b) workers will disproportionately require medical treatment for injuries that can be caused in the course of work (i.e. physical trauma, workplace-related diseases), and not injuries and illnesses that arise from other sources (i.e. genetic disabilities); and
- (c) individuals must be physically and mentally able to enter the workforce in order to benefit from the exemptions.

1824. Therefore, the *effect* of applying the impugned provisions generally, but not applying them to individuals who are injured at work, is a disproportionate and unequal impact on individuals who:

- (a) because of their age, do not or cannot work;
- (b) because of a mental or physical disability, do not or cannot work; and
- (c) because their mental or physical disability is caused by non-work related factors, will not have the same access to timely and necessary medical treatment as those whose disabilities stem from workplace related illnesses or injuries.

1825. In effect, the Government has said that if you do not work, because you are either too young or too old, or because of your disability, you cannot qualify for the exemptions that are available to ensure that workers get the health care that they need in a timely fashion.

1826. And it has said that if your mental or physical disability is of the type caused by non-work related circumstances (e.g. a genetic disorder), then you will not be eligible for the exemptions, which apply only to those whose injury or illness is caused by participation in the workforce.

1827. The Plaintiffs' claim under section 15 is therefore quite simple: enforcing the impugned provisions against some, but not others, has the effect of imposing a burden on some persons that is not imposed on all.

1828. And by tying exemptions to that burden to an individual's participation in the workforce, as this legislative scheme does, it discriminates against those who are unable to enter the workforce due to their age or disability, or whose injuries or illnesses are caused by factors unrelated to work.
1829. These distinctions in turn have the effect of perpetuating or causing arbitrary disadvantage.
1830. Children and those of an advanced age, as well as those with disabilities, are subject to disadvantage in today's society. Effectively preventing those groups from accessing timely medical treatment due to their inability to work, or due to the type of their disability, perpetuates this disadvantage.
1831. Because this adverse treatment is both linked to protected grounds of discrimination and is substantively discriminatory, it violates the right to equality under section 15, on the traditional test outlined above.
1832. It therefore can only be upheld, if at all, under section 1.

(ii) Breach on the basis of fundamental Charter interests

1833. However, there is another reason why the *Medicare Protection Act* violates section 15.
1834. In addition to significant harms imposed that are tied to protected grounds of age and disability, the *Medicare Protection Act* also treats people unequally on the basis of a fundamental personal interest: namely, the interest in one's bodily integrity, personal health and well-being, and the interests in access to timely medical care.
1835. In other words, where the Government unequally deprives people of a fundamental *Charter* interest – like equal access to timely and necessary health care – that constitutes

a breach of section 15, even if the unequal treatment is not directly tied to a protected ground of discrimination.³¹⁹

1836. The courts have historically required that discrimination be linked to a protected ground of discrimination, and have not yet recognized an additional ‘interest-based’ route to finding a breach of section 15.

1837. But that does not prevent this court from doing so.

1838. As the Supreme Court of Canada has recently stressed, past precedents may be revisited by trial courts “if new legal issues are raised as a consequence of significant developments in the law, or if there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate” [*Bedford* at para 42].

1839. The Court put it this way in *Bedford*:

The intervener, the David Asper Centre for Constitutional Rights, argues that the common law principle of stare decisis is subordinate to the Constitution and cannot require a court to uphold a law which is unconstitutional. It submits that lower courts should not be limited to acting as “mere scribe[s]”, creating a record and findings without conducting a legal analysis (I.F., at para. 25).

I agree. As the David Asper Centre also noted, however, a lower court is not entitled to ignore binding precedent, and the threshold for revisiting a matter is not an easy one to reach. In my view, as discussed above, this threshold is met when a new legal issue is raised, or if there is a significant change in the circumstances or evidence. This balances the need for finality and stability with the recognition that when an appropriate case arises for revisiting precedent, a lower court must be able to perform its full role. [*Bedford* at para 43-44]

1840. This case is a perfect example of why adding a second, ‘interest-based’ route to our understanding of equality rights in Canada is necessary.

1841. Under the traditional test discussed above, governments could deprive persons of access to important benefits, institutions and relationships – such as marriage, education or

³¹⁹ See Robin Elliot & Michael Elliot, “The Addition of an Interest-Based Route into Section 15 of the Charter: Why It’s Necessary and How It Can Be Justified” (2014) 64 SCLR (2d) 462 [**Elliot & Elliot**]; see also Brian Langille & Benjamin Oliphant, “The Legal Structure of Freedom of Association” (2014) 40 Queen’s LJ 249 at 284-285.

health care – because of their name, hair colour, political views, or occupation, without violating the equality rights under the *Charter*.

1842. That is because an individual's name, hair colour, political views, and occupation are not protected grounds of discrimination, under the traditional analysis.
1843. But the impact of the unequal treatment of such persons is so severe when it comes to interests of fundamental importance like access to health care, that the government should have to justify the unequal and discriminatory treatment under section 1.
1844. The essence of the unequal treatment in this case is that the government has decided that certain persons – such as those exempt from the restrictions in the *Act*– are entitled to access timely and potentially lifesaving private treatment and others are not.
1845. The time has come for the courts in Canada to recognize that there are some interests so fundamental – such as the ability to access an education or necessary health care – that persons should not be unequally or arbitrarily deprived of those interest by the state.
1846. Beyond the fact that this additional avenue to finding a breach of section 15 is justified on the facts of this case, it is consistent with the fact that section 15 – perhaps more than any other right in the *Charter* – is the product of a consistent process of evolution.
1847. The current understanding of section 15 is largely a result of an evolving conception of equality and discrimination, established through what would have once been considered “novel” claims.
1848. In particular, what amounts to ‘discrimination’, as opposed to a mere legislative ‘distinction’, has been the subject of much judicial disagreement over the *Charter’s* existence, continuing on to the most recent case of *Quebec (Attorney General) v. A.*³²⁰

³²⁰ *Quebec (Attorney General) v. A.*, [2013] 1 SCR 61, 2013 SCC 5 [*Quebec v. A.*].

1849. In the 1990s, the Court was deeply divided in how a violation of section 15 was to be established.³²¹

1850. Ultimately, in the 2000s, the Court agreed on a four part “human dignity” analysis in *Law v. Canada*. This analysis required the demonstration of unequal treatment between two ‘comparator’ groups,³²² and that the distinction drawn on the basis of a prohibited ground perpetuated disadvantage, prejudice or stereotyping.³²³

1851. Since those decisions, however, the Supreme Court has gradually moved away from the rigid, formulaic analyses in the context of section 15, preferring instead to focus on the purpose of the guarantee: achieving substantive equality.

1852. In *Kapp*, for instance, the Court rejected the four stage human dignity analysis outlined in *Law*, as it had “proven to be an *additional* burden on equality claimants”, which was not its intention [see *Kapp* at para 22; emphasis added].

1853. Following *Kapp*, a claimant was only required to show a distinction on the basis of an enumerated or analogous ground, and that the distinction was caused by or perpetuated disadvantage, prejudice or stereotyping.

1854. Next, the Court rejected the need for a formalistic ‘mirror’ comparator group analysis.

1855. As Madam Justice Abella emphasized in *Withler*: “(c)onfining the analysis to a rigid comparison between the claimant and a group that mirrors it except for one characteristic may fail to account for more nuanced experiences of discrimination” [*Withler* at para 58].³²⁴

³²¹ See the discussion in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497 [*Law v. Canada*] at paras 31-39; and see generally the varying judgments in *Miron v. Trudel*, [1995] 2 SCR 418; and *Egan v. Canada*, [1995] 2 SCR 513.

³²² See e.g. *Hodge v. Canada (Minister of Human Resources Development)*, 2004 SCC 65.

³²³ *Kapp*, at paras 17-18, 24.

³²⁴ *Withler v. Canada (AG)*, 2011 SCC 12 [*Withler*] at para 58.

1856. Instead, a more flexible approach was adopted in *Withler*, simply requiring “that the claimant establishes a distinction based on one or more enumerated or analogous grounds” [*Withler* at para 63].

1857. Most recently, a majority of the Court rejected the need to demonstrate, in every case at least, some prejudice or stereotyping resulting from the differential treatment, as was suggested in *Kapp*.

1858. In *Quebec v. A*, the majority of the court emphasized that “prejudice and stereotyping are neither separate elements of the *Andrews* test, nor categories into which a claim of discrimination must fit” [*Quebec v. A* at para 327].

1859. As such, the majority emphasized that courts must be careful not to consider the case law to be “establishing an additional requirement on s. 15 claimants” (*Quebec v. A* at para 329).

1860. Thus, the Court’s case law in the context of section 15 has evolved considerably over the years, and continues to evolve in light of the changing needs of society.

1861. In particular, the Court has increasingly rejected rigid, formalistic tests, or necessary preconditions to the protection of equality rights.

1862. It has come to prefer “flexible and contextual” inquiries aimed at ensuring the purpose of the section 15 guarantee – substantive equality – is achieved.

1863. As this evolution shows, section 15 clearly demonstrates the evolving, “living tree” quality of the *Charter*, and how our understanding of section 15 has continuously progressed over the lifetime of the *Charter*.

1864. In light of this continuing evolution, it is time for the courts to recognize that section 15 can be invoked, not only when governments have treated people differently on the basis of an enumerated or analogous ground, but also when governments have treated people differently in relation to an interest of fundamental importance.

1865. In other words, where the interest being unequally distributed by the government is important enough, there should be no need to show that the unequal treatment was based on, or created a disadvantage linked to, protected grounds.

1866. As explained by Professor Robin Elliot and Michael Elliot in an article in the Supreme Court Law Review:

An interest-based conception of equality has deep roots within the liberal democratic philosophical tradition, is reflected in the constitutional jurisprudence of other liberal democratic countries, has been adopted as the governing approach in international human rights instruments with which Canada has aligned itself, is being championed by leading equality rights theorists here in Canada and has already found favour with one of its former members. It furthers the underlying purpose of section 15. It would allow the courts to assess the merits of claims... on the basis of the true gravamen of the concern underlying them. And in part for that reason, it would also allow for a more consistent and coherent approach to the *Charter* as a whole, freeing other provisions from bearing a burden which section 15 is much better suited to carry. [Elliot & Elliot at 530]

1867. As such, in addition to the unequal and discriminatory impact linked to age and disability, this court should additionally recognize a breach of section 15 on the basis that a fundamental interest (here, the ability to access timely and effective health care) has been distributed unequally and arbitrarily.

1868. However you look at it, and whatever test is applied, the impugned provisions orchestrate a grossly unequal outcome because a person's ability to access necessary medical treatment is premised on whether one is injured or becomes ill at work.

1869. This fails to achieve substantive equality.

1870. The *Act* does not reflect the recognition that all are equally deserving of concern and respect – it rather creates a privileged group who are exempted from the harmful restrictions in the law, while depriving most others of this fundamental right.

1871. All persons should have equal opportunity to access to necessary and essential health care, particularly where that care is not being adequately provided by the public system.

1872. This does not mean that the Government cannot treat people differently when it comes to laws in relation to health care, which impose a burden on some not imposed on others.

1873. It only means that when it does so, and when doing so has an impact on fundamental interests, it must justify those distinctions under section 1.

1874. The Government must, in other words, show that in drawing the distinctions with respect to fundamental interest of access to timely health care, it has treated everyone as equally deserving of concern and respect.

1875. The *Medicare Protection Act* fails to meet this standard.

1876. In this case, the infringements of sections 7 and 15 are not saved by section 1, for the reasons given below.

E. Oakes Test: No Section 1 Justification

(i) Overview of the Oakes Test

1877. For the purposes of the section 1 analysis, the focus is on the objective of the impugned provisions – maintaining a viable public health care system – and whether the costs of the measures in terms of the *Charter* rights violated are worth the benefits derived to society as a whole.

1878. The *Oakes* test under section 1 is well known.

1879. It requires the Government to demonstrate that the law has a pressing and substantial objective, and that the means chosen by the law are proportionate to the objective.

1880. Laws that are not rationally connected to their objectives, have a greater impact on rights than is reasonably necessary to achieve their objectives, or have negative consequences on rights that are not outweighed by the benefits to be achieved by the law, will not be justified under section 1.

1881. The *Oakes* analysis varies depending on the context of the case, and in particular, the types of harms being caused by government action.
1882. In this case, it is particularly important that one of the *Charter* breaches is of section 7 of the *Charter*.
1883. The Courts have recognized that a law which violates a person's life, liberty or security of person in a manner not in accordance with the principles of fundamental justice is unlikely to be saved under section 1.
1884. That is the case for two reasons.
1885. First, the rights protected by section 7 are among the most fundamentally important in a free and democratic society, and are therefore "not easily overridden by competing social interests" [G.(J.) at para 98; *Charkaoui* at para 66].
1886. Second, as the Court recently stated in *Bedford*, a law which violates section 7 is "inherently flawed", and will therefore not easily provide a justification under section 1 [*Bedford* at para 96].
1887. In fact, the Supreme Court of Canada has *never* found that a law which violated section 7 has been justified under section 1 [Hogg, *Constitutional Law*, at §38.14(b)].
1888. And in fact, some judges have questioned whether it is even possible to uphold a breach of section 7 under section 1.
1889. For instance, Justice Wilson wrote in the *Motor Vehicle Reference* as follows:

If, however, the limit on the s. 7 right has been effected through a violation of the principles of fundamental justice, the enquiry, in my view, ends there and the limit cannot be sustained under s. 1. I say this because I do not believe that a limit on the s. 7 right which has been imposed in violation of the principles of fundamental justice can be either "reasonable" or "demonstrably justified in a free and democratic society". (...) [BC *Motor Vehicle Reference*, at 523]³²⁵

³²⁵ *Re B.C. Motor Vehicle Act*, [1985] 2 SCR 486 [**Motor Vehicle Reference**] at 523, *per* Wilson J.

1890. Therefore, although the Court has confirmed that it is at least theoretically possible for a breach of section 7 to be justified under section 1 – for instance - in “exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like” [*Motor Vehicle Reference*, at 518, *per* Lamer J.], it is clear that such a justification will be incredibly rare.

1891. The section 1 analysis in this case must take place in the rigorous spirit required of laws that jeopardize these fundamental interests in a manner inconsistent with the principles of fundamental justice.

(ii) Pressing and Substantial Objective

1892. In this case, the Plaintiffs concede that the preservation of a viable and effective public health care system available to all regardless of ability to pay, is a pressing and substantial objective under section 1.

1893. In the Plaintiffs’ submission, permitting a private treatment option will in fact further this pressing and substantial objective by reducing at least some pressure on the public system.

1894. However, it is not the Plaintiffs’ burden to show that striking down these prohibitions would *improve* the public system.

1895. It is the Government’s burden to demonstrate that it has chosen rational, minimally impairing, and proportionate measures to achieve its objectives, given the significant harm that the health care regime in this province imposes on individuals who are deprived of the opportunity to care for their own health.

1896. To the extent that the Government will seek to define the purpose of the impugned provisions as ensuring absolute equality in the provision of health care – which is inconsistent with the actual design and operation of the laws – this cannot be accepted as an objective of sufficient importance to override the *Charter* rights of those affected.

1897. Were this objective to underlie the impugned measures, the Government would effectively be saying that - notwithstanding the considerable and sometimes catastrophic harm caused by preventing individuals from accessing private care - it is nevertheless justified in prohibiting access to medical care so that all may suffer *equally*.

1898. With respect, this cannot be an objective sufficiently pressing and substantial to justify the significant deprivation of section 7 rights demonstrated above.

1899. Moreover, as discussed previously, the *Act* does not in fact treat all BC residents equally. So that cannot be the objective.

(iii) Rational Connection

1900. As noted above in discussing the evidence showing that the restrictions imposed are unnecessary to achieve any valid objective, the means chosen to achieve the Government's objective are not – in fact – rationally connected to that objective.

1901. There is no basis in the evidence or in logic for concluding that the prohibitions on access to private treatment, particularly where there is both unmet need *and* unmet capacity to provide for that need, are rationally connected to preserving a universal public health care system.

1902. For the same reasons given above, and particularly in light of the fact that a viable and universal public system can co-exist with the option to obtain private treatment, there is simply no rational connection between the impugned laws and the Government's objective.

1903. This is sufficient to dispose of the section 1 argument.

(iv) Not Minimally Impairing

1904. However, even if there was a rational connection between the restrictions and the purpose of the impugned provisions, the Government has not chosen the least restrictive means to accomplish its objective.

1905. The Court has recently confirmed that the Government cannot rely on mere assertions of risk or speculation regarding exaggerated negative outcomes to justify a breach under section 1.

1906. The Government must show that there is no other way that could reasonably accomplish its pressing and substantial objectives of the law, which in this case, is the maintenance of a viable and universal public health care regime.

1907. And it is not the Plaintiffs' burden to show that some other regime will perfectly achieve the Government's objectives.

1908. As the unanimous Supreme Court recently explained in *Carter*, with specific reference to the majority conclusion in *Chaoulli*:

Canada also argues that the permissive regulatory regime accepted by the trial judge "accepts too much risk", and that its effectiveness is "speculative" (R.F., at para. 154). In effect, Canada argues that a blanket prohibition should be upheld unless the appellants can demonstrate that an alternative approach eliminates all risk. This effectively reverses the onus under s. 1, requiring the claimant whose rights are infringed to prove less invasive ways of achieving the prohibition's object. The burden of establishing minimal impairment is on the government.

The trial judge found that Canada had not discharged this burden. The evidence, she concluded, did not support the contention that a blanket prohibition was necessary in order to substantially meet the government's objectives. We agree. A theoretical or speculative fear cannot justify an absolute prohibition. As Deschamps J. stated in *Chaoulli*, at para. 68, the claimant "d[oes] not have the burden of disproving every fear or every threat", nor can the government meet its burden simply by asserting an adverse impact on the public. Justification under s. 1 is a process of demonstration, not intuition or automatic deference to the government's assertion of risk (RJR-MacDonald, at para. 128).

Finally, it is argued that without an absolute prohibition on assisted dying, Canada will descend the slippery slope into euthanasia and condoned murder. Anecdotal examples of controversial cases abroad were cited in support of this argument, only to be countered by anecdotal examples of systems that work well. The resolution of the issue before us falls to be resolved not by competing anecdotes, but by the evidence. The trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide. We should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against

the taking of lives will prove impotent against abuse. [Carter at paras 118-120; emphasis added]

1909. As described above, there are many other means available to the Government to ensure a viable, universal and high quality public health care system, available to all regardless of their ability to pay.

1910. For instance, as Mr. Castonguay has observed, and as quoted above:

(...) Yet in countries where private insurance plays a large role in the financing of health services, it is interesting to note that there is nothing to suggest that access to health care is inequitable towards the poorest. In the majority of countries, the health systems are universal or quasi-universal and the goal of universality of access is generally to guarantee equitable access to all. According to the OECD, private health insurance is one of the numerous tools which can contribute to improve the reactivity of health care programs, to facilitate the realization of public health care objectives, and to respond to the needs of consumers and of society.

(...)

The co-existence of public and private systems in the OECD countries show that it is possible to establish a healthy equilibrium between the two by means of an appropriate framework. In these systems, generally, the doctors must fulfill well-defined responsibilities within the framework of the public system as a prerequisite to permitting them to provide private services. These conditions can take the form of a limit on the amount of revenue in the private sector. Numerous examples show that it is possible to establish efficient control while at the same time avoiding the introduction of heavy bureaucratic controls. Obviously, ethical standard would be necessary to avoid possible conflict of interest and to ensure equitable treatment for all. Such standards are within the jurisdiction of the College of Physicians.... [emphasis added]

1911. If there was any legitimate concern supported by evidence – as opposed to speculation – that permitting dual practice and private insurance would lead to a ‘flight’ of capacity (i.e. doctors) out of the public system, the Government could put in place measures which required that all doctors must provide the treatment in the public system, before providing services outside of that system.

1912. The Cambie situation is a perfect example.

1913. The doctors at the Cambie Surgery Centre are not providing private services *instead of* publicly funded services. They are providing all of the publicly funded services that the Government is willing to pay for.
1914. The problem is simply that the Government can or will only pay for a portion of that capacity, because it must ration its funding of services to keep the system affordable.
1915. This leaves considerable capacity to provide more surgeries, faster, and to alleviate the strain on wait lists.
1916. The problem is that because of the government monopoly, there is no one to pay for these surgeries, other than those who can afford to do so without private insurance, and they can only do so in breach of the *Act*.
1917. As the evidence will show, there are countless other ways that jurisdictions across the OECD are able to maintain a viable public health care system without prohibiting persons from accessing care outside of that system, particularly where there is unmet need and capacity in the public system, some of which are canvassed above.
1918. Indeed, the fact that the vast majority of OECD countries are able to maintain strong and viable public health care systems – and indeed, more equal and effective public health care systems than Canada – without resorting to the drastic prohibitions contained in the *Medicare Protection Act*, shows that those prohibitions are not necessary to achieve the Government’s objectives.
1919. For all these reasons, and as will be shown in the evidence throughout this trial, the blanket prohibition on private insurance and on blended practice is not the most minimally impairing way to accomplish the Government’s objectives.

(v) *Harm Caused Entirely Disproportionate to Any Benefit Derived*

1920. Finally, in light of the severity of the deprivation, and the minimal salutary effects of the law, if any can be found, any speculative benefits do not outweigh the grave deleterious impact on those affected.

1921. The severe deprivation caused by the prohibitions on accessing medical care are described above. Cases like Walid's are not aberrations – they are endemic to a system where demand far outstrips the capacity to fund all medically necessary procedures.
1922. The lack of benefits achieved by the law have been discussed above, in some detail.
1923. These prohibitions do not create a more effective system; they do not create a more efficient system; and they do not create a more equitable system.
1924. They produce worse, not better, health outcomes for the population. There are simply no salutary effects to speak of.
1925. This is why the Government has, up until the challenge by the Nurses Union, permitted clinics like Cambie to co-exist with the public system.
1926. The Government realized that private clinics and private medical treatment are an integral and necessary adjunct to the public system.
1927. However, it has now succumbed to political pressure and refuses to publicly acknowledge what it has known for years – that private health care is part of the solution, not the problem.
1928. For the above reasons, the Government is not able to meet its burden under section 1, to justify the breach of the rights of BC Residents under sections 7 and 15. As such, the impugned provisions of the *Medicare Protection Act* must be struck down.

F. Legal Analysis - Conclusion

1929. The Plaintiffs constitutional case can be simply put.
1930. The current health care regime in BC imposes significant bodily and psychological harm on those in need of medical treatment.
1931. That is because the Government cannot afford to provide everyone with timely medical treatment in the public system. So it rations those services.

1932. This rationing leaves individuals to suffer on wait lists, further jeopardizing their health and increasing the risk of premature death.
1933. What makes this unconstitutional is not that the Government is unable to ensure that everyone receives adequate treatment in the public sector health care system.
1934. The problem – from a constitutional perspective – is that the Government *also* places restrictions on the ability of most BC residents to safeguard their health and well-being by obtaining medical treatment privately, where those needs are not being met by the public health care system.
1935. The Government cannot fail to provide necessary and timely medical treatment in the public system, and also make it illegal for people to care for their own health and wellbeing in other ways.
1936. To make matters worse, the Government imposes these restrictions *unequally*, by permitting certain privileged persons to access timely and necessary medical care in the private system, while preventing most other BC residents from doing so.
1937. And there is simply no good reason to impose these serious constitutional harms.
1938. Eliminating the prohibition on private insurance and blended practice will not reduce access to the public system.
1939. It will not jeopardize the law's objective of ensuring a viable universal health care system, available to all regardless of their ability to pay.
1940. That has been the experience of every other OECD jurisdiction, in which a viable and equitable universal public health care system is able to thrive in conjunction with access to private care.
1941. If there is any risk to the viability of the public system, controls can be put in place to ensure doctors provide the services required of them in the public system before working in the private system.

1942. The Government is unable to show that its drastic restrictions are necessary, given that every other jurisdiction in the developed world is able to provide high quality, equitable, and universal public health care, without prohibiting access to private care.
1943. In fact, eliminating these prohibitions to enable British Columbians to access private health care will increase access for everyone, by taking people out of the public system and increasing overall resources for health care.
1944. In short, everyone will be made better off.
1945. The evidence in this case shows that health care systems which permit blended practice and private insurance actually achieve better and more equitable overall health outcomes.
1946. The justification put forward for the drastic restrictions in the *Act* – which are not adopted by any other developed country – is based on a dogmatic commitment to a perverse ideological position: that because the Government has not and cannot take steps to ensure that everyone has access to necessary and timely medical treatment in the public system, everyone should be forced to suffer equally.
1947. This is an ideological commitment to pure formal equality; to the idea that it would be better to put everyone's life and well-being at risk than allow any difference in care; to the idea that it would be better to ensure no one is advantaged, even if it means everyone must be made worse off.
1948. This fanatical commitment to some pure form of equality of suffering is not only alien to our values, it is entirely impractical and unrealistic, as the current system already demonstrates.
1949. The OECD has already found that Canada does not rank highly in the equality of access to health care, despite the public sector monopoly.
1950. The *Act* permits numerous exceptions, when it serves the financial interest of other government programs, like WorkSafe BC.

1951. And the very rich have always been able to receive private care elsewhere.
1952. The defenders of this prohibition are chasing an ideological fantasy that is not only unsupported by all available evidence, but is causing real and significant harm to ordinary people.
1953. It is time for this to stop.
1954. That “equality of suffering” justification is inconsistent with the fundamental values that the courts must uphold under the *Charter*, and it is inconsistent with Canadian values.
1955. The health, well-being and even survival of individuals cannot be sacrificed to achieve a principle of equal suffering for all, particularly by a law that already treats people unequally, and permits the wealthiest and others to avoid its restrictions.
1956. Because the prohibitions on private insurance and blended practice go beyond what is necessary to protect access to the public system, they cannot be justified under section 1 of the *Charter*, and must be struck down.

XII. CONCLUSION

1957. The concluding paragraphs of Jeffrey Simpsons’ book summarize the present state of the public health care system:

Canadians are so wedded to the medicare status quo, so fearful of change lest medicare somehow slip away and so ignorant of what other countries are doing that the political risks of candid talk, let alone serious reform, are intimidating. We are clinging to a system that exists nowhere else in the world: narrow and statist for hospitals and doctors, U.S.-style private and public health care for everything else. Countries with largely public systems have been shaking up the statist approach for hospitals and doctors, while ensuring that public coverage extends beyond these services to other patient needs, especially elderly ones. That is the trade-off that other countries have made; that is the trade-off Canada needs.

Canadian health care is not in crisis, if by that we mean that it cannot continue without collapse. There is much that is good about it, and many excellent people who work within it. Medicare, rather, manifests chronic conditions — perpetual financing squeezes, long wait times, dysfunctional decision making, federal-provincial bickering

and wrong incentives—and a system that is not what everyone believes it should be: patient-centred. Public institutions, like individuals, can exist with chronic conditions for a long time. There are means of lessening some of Medicare's chronic conditions if we have the courage to talk about them, banish foolish fears of sliding into a U.S. model and understand that the only two options that will ensure the deepening of chronic conditions is to do nothing or to spend more doing the same. [Simpson, *Chronic Condition*, at 370-371]

1958. The public health care system has become paralyzed.
1959. The BC Government has been tinkering at the edges of this system, trying to wring out more efficiencies, while at the same time capping spending increases for health to meet its overriding sustainability principle.
1960. It is clear that it is politically incapable of doing more to reform the system to protect constitutional rights without an order from the courts to do so.
1961. When governments fail to protect rights, it is the obligation of the courts under the constitution to intervene.
1962. The court needs to fulfill its constitutional role of putting politics aside and providing a dispassionate reasoned assessment of the facts and the restrictions on private health care, grounded in the constitutional guarantee of fundamental rights to life, liberty and security of the person and the equal treatment of all British Columbians under the law.
1963. Specifically the court needs to confirm that what the Supreme Court of Canada found and ordered in *Chaoulli* applies equally to British Columbia.
1964. That it is a breach of the constitutional rights of Canadians to prevent them from accessing private health care when the public system cannot provide everyone with timely medical services.
1965. BC has not been able to fix the access problem in the 10 or so years since *Chaoulli*, and there is no sign that it will ever be able to do so.
1966. British Columbians cannot wait any longer to be free of the legislative restrictions on private health care that are inflicting significant physical and mental harm on them,

particularly in light of the Government's attempt to take away the present access they have to private surgical care from enrolled doctors.

1967. When fundamental rights are seriously and persistently violated and governments fail to act, the Court is bound by the Constitution to intervene and enforce the guarantees of the *Charter*.
1968. Eliminating the prohibitions on dual practice and private insurance will enable British Columbians to protect their own bodily integrity and not be dependent upon the Government monopoly which has proven to be incapable of providing timely service to everyone.
1969. This will result in a much needed transformation of our health care system.
1970. In June, 2007, after the Premier's fact finding mission to Europe, the Government held a "focused workshop" to provide "an opportunity for experts, policy-makers and practitioners to consider some of the solutions raised in the Conversation on Health".³²⁶
1971. The Government has provided us with a document which sets out the solutions which had been raised in the Conversation on Health. Significantly, the Government states in the introductory paragraph of this document that:

All solutions need to be reviewed in the context of sustainability of our health care system; how does the solution contribute to sustainability? Does the solution positively impact sustainability in the short or long term? Or, if the solution requires funding, how is this funding offset through specific savings?³²⁷
1972. This shows the concern of the Government about the mounting costs of the public health care system and its "crowding out" of other government services if costs are not restrained.
1973. Soon after, in 2008, sustainability was added as a principle in the *Act*.

³²⁶ BC4340377: 06/18/2007 - Conversation on Health Health Care Delivery Models Focused Workshop

³²⁷ *Ibid.*

1974. None of the proposed solutions involved spending more money on surgeries to reduce wait lists.

1975. Under the heading “Models of Health Care Financing”, the following solutions, amongst others, were considered:

- Re-examine the definition of “medically necessary” procedures and BC private insurance (as an option to MSP or provided by a private health insurance provider) could be instituted or allowed in order to offset the costs of procedures that are not defined as “medically necessary”
- Higher premiums could be instituted to charge those who make unhealthy or dangerous lifestyle choices, such as higher premiums for those participate in extreme sports, smoke, are obese, etc. MSP premiums and/or some type of private insurance could be structured like the ICBC model.
- A mixed public-private model, similar to models currently used in the UK or other European countries could be used as a template for the restructuring of B.C’s health care system.
- People with means could have the option of paying for health services, “we have a choice in every other area, why not health? The public system could run alongside the private system.”
- A regulated “guaranteed access” mechanism that permits the limited use of private insurance, limited to specific procedures, could be an option in addressing wait-list issues for non-emergency surgeries.³²⁸

1976. And then under the heading “Sustainability of the Health Care System” is the following:

- Define sustainability of the B.C health care system by some sort of quantifiable instrument (e.g. linking to GDP or % of the provincial budget) that effectively measures sustainability and links to a definition of sustainability for this purpose.

1977. Something has to be done. The Government knows that.

1978. It also knows that spending more money is not the answer. We already spend more money in Canada than most other countries, and we have poorer results.

³²⁸ BC4340377: 2007.06.18 - Conversation on Health Health Care Delivery Models Focused Workshop, at 5/6.

1979. The problem is the very structure of our public health care system, which provides very limited coverage of health care needs on a monopoly basis.

1980. This isn't working in a way that is consistent with the needs and rights of British Columbians.

1981. The objective of the Plaintiffs constitutional challenge is to liberate the Government from the constraints of the existing system and permit it to openly and rationally consider better solutions.

ALL OF WHICH IS RESPECTFULLY SUBMITTED BY

A handwritten signature in blue ink, appearing to read "Peter A. Gall".

Peter A. Gall, Q.C.,
Counsel for the Plaintiffs