

Quality v. Equality: The Divided Court in *Chaoulli v. Quebec*

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I. Introduction

On June 9, 2005, the Supreme Court of Canada issued its anxiously awaited decision in *Chaoulli v. Quebec*.¹ The legal issue before the Court was whether Quebec legislation prohibiting private insurance for physician and hospital services provided by the publicly funded system contravened the Canadian *Charter of Rights and Freedoms*² and/or the Quebec *Charter of Human Rights and Freedoms*.³ The Court divided on this question, rendering three separate decisions. The majority of the Court found that the legislative provisions unjustifiably infringed rights protected by the Quebec *Charter*; consequently, the provisions were struck down. Additionally, six of the seven judges were evenly split on whether the impugned legislation contravened the Canadian *Charter*.⁴

In deciding on the legal question before it, the Court was performing an act of great moment that, unavoidably, would have ramifications in an ongoing public policy drama. Canadian society has been divided on the policy issue intersected by this legal decision, and quite passionately. It has powerful symbolic and dramatic elements of near epic proportions. Fundamental values connected to the publicly funded health system — and indeed the delicate, precarious and ambiguous balance of values hitherto constitutive of Canadian society — were engaged and at stake.

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¹ 2005 SCC 35, [2005] 1 S.C.R. 791 (CanLII) [*Chaoulli* cited to S.C.R.]. Note that in this case the Court comprised seven judges rather than the usual nine.

² Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11 [Canadian *Charter*].

³ R.S.Q. c. C-12 [Quebec *Charter*].

⁴ Justice Deschamps, the seventh judge, based her decision solely on an infringement of the Quebec *Charter*. Given the splits in the Court and the different grounds for reaching the decisions, it is difficult to speak accurately about majority and minority opinions. For our purposes we use the term ‘majority’ to indicate those judges who struck down the legislation, which in some contexts will include Justice Deschamps and in others will include the three judges whose decision combined with Justice Deschamps to strike down the legislation on the basis of the Quebec *Charter* and who were evenly split with the ‘minority’ with respect to Canadian *Charter*, recognizing that the term ‘majority’ in this latter context is not strictly accurate. For further discussion on the breakdown of the decisions in this case see Peter H. Russell, “Chaoulli: The Political versus the Legal Life of a Judicial Decision” in Colleen M. Flood, Lorne Sossin & Kent Roach, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 5 at 6-7 [Flood et. al. “Access to Care”].

The Court was well aware of the stakes in the broader policy drama, and aware of the thorny ancillary issues raised by this case concerning the proper role of the Court in a democratic society *vis-à-vis*, and in deference to, the role of the legislature and the executive. Yet, as Chief Justice McLachlin and Justice Major (Bastarache J. concurring) noted, the mere fact that the legal question “may have policy ramifications does not permit” the Court “to avoid answering it.”⁵

In discussing the role played by the judicial *vis-à-vis* the legislative branch, Justice Deschamps approvingly quotes legal scholar K. Roach: “Judges can add value to societal debates about justice by listening to claims of injustice and by promoting values and perspectives that may not otherwise be taken seriously in the legislative process.”⁶ Whether judges *should* be “promoting values and perspectives” at all — and if they should, which or whose values and perspectives — is debatable of course.⁷ That judges *do* promote “values and perspectives” is a less controversial proposition; at the very least, they *reflect* or *exhibit* them. We believe that, in this latter sense, the division in the Court mirrors “values and perspectives” that have been in tension in Canadian health policy, and more broadly in Canadian society. Using the division in the Court to clarify this tension can indeed add value to the “social debate” about health policy, albeit not quite in the way intended by K. Roach.

We argue that the division in the Court about the application of the Quebec and Canadian *Charters* was significantly rooted in a subordinate division about the purpose behind the impugned legislation. The determination of the legislation’s purpose or objective was an essential element of the legal analysis. In order to establish that the Canadian *Charter* right (s.7) had been infringed it was necessary to determine that the measures in the Quebec legislation were not arbitrary. For the three judges in the majority, the measures would be arbitrary if they were not rationally connected to the purpose sought to be achieved and for the three in the minority, they would be arbitrary if the measures bore no relation to the purpose sought to be achieved. Once it had been established that the legislation infringed guaranteed rights then the legislation could only be ‘saved’ under the Quebec *Charter* or found to be constitutional under the Canadian *Charter* if the government

⁵ *Supra* note 1 at para. 108. See also McLachlin C.J.C. and Major J. at para. 107: “The fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance when citizens challenge it.”

⁶ *Ibid.* at para. 89. See K. Roach, “Dialogic Judicial Review and its Critics” (2004) 23 Sup. Ct. L. Rev. (2d ser.) 49 at 69-71.

⁷ Although Deschamps J. quotes Roach approvingly in this context, based on her comments in relation to Binnie and LeBel JJ. (which we will later discuss) we are doubtful whether she would endorse the view that judges *should* be “promoting values and perspectives”. This view, however, seems at least implicit in an article written by L’Heureux-Dubé J., who did not sit on this case. The Honourable Claire L’Heureux-Dubé, “The Dissenting Opinion: Voice of the Future” (2000) 38 Osgoode Hall L.J. 15. For a discussion of issues concerning the role of values and perspectives in judicial reasoning, see Martin P. Golding, *Legal Reasoning* (Peterborough, Ont.: Broadview Press, 2001) especially 1-23.

could show that the legislation had a pressing and substantial objective or purpose and used means that were rationally connected to meeting that objective.

Although not explicitly acknowledged or frontally addressed in the Court, the majority and the minority construed the purpose of the legislation prohibiting private insurance quite differently. For the majority, the purpose was to preserve the *quality* of the public health system. The purpose thus identified, the pivotal question was reduced, essentially, to whether removal of the prohibition against private insurance would cause a loss of quality or integrity in the publicly funded system.

The minority, in addition to construing the purpose in *practical* terms of preserving the *quality* of the public system (and disagreeing with the majority about the hypothesized effects of private insurance on the public system), also construed the purpose *in principle*, in terms of ensuring *equality* in the matter of access to health care across society. With respect to equality as a ground for prohibiting private insurance, the empirical question of whether private insurance would undermine the public system is beside the point. Regardless of what its impact on the public system might be — positive, negative or neutral — private insurance, in principle, undermines the equality purpose.

That the Justices differently construed this purpose is not surprising. It has been unclear and ambiguous in health policy, harboring an important values tension or ambivalence with respect to equality. In dividing in the construal of the purpose of the legislation as it did, the Court mirrored, reproduced and writ large the poles of this values tension. And on the way to judgment about the *legal issue* concerning whether the legislation prohibiting private insurance infringed protected rights, the Court also settled, indirectly and by interpretative fiat as it were, the subordinate *policy issue* about the purpose of the prohibition.

The ruling in *Chaoulli* will surely have what McLachlin C.J.C. and Major J. gently call “policy ramifications.”⁸ Whether it will “precipitate a seismic shift in health policy”⁹, as Justices Binnie and LeBel (Fish J. concurring) suppose, will depend on what governments and other stakeholders do in response as they accommodate their agendas to the decision and accommodate the decision — spin it and influence its interpretation in policy analysis and debate — to their agendas. Our contribution is at some remove from these heated policy debates: what we seek to show and what was not remarked upon in the judgment itself and has not been remarked upon in the academic literature to date, is that underlying the legal reasoning of the justices there are fundamentally competing conceptions of equality.¹⁰

⁸ *Supra* note 1 at para. 108.

⁹ *Ibid.* at para. 176.

¹⁰ It is important to note that ‘equality’ as it is raised (implicitly or explicitly) in the decision concerns the *policy purpose* of the impugned legislation. Equality rights as guaranteed by s.15 of the Canadian *Charter*

II. The Facts of the Case and the Fundamentals of the Decision

Dr. Chaoulli and Mr. Zeliotis challenged the validity of legislative provisions¹¹ that prohibited private health care insurance for physician and hospital services provided by the publicly funded system, claiming that these provisions violated rights found in the Quebec and Canadian *Charters*. Two lower courts had ruled against Chaoulli and Zeliotis and upheld the provisions;¹² these decisions were being appealed to the Supreme Court of Canada.

Chaoulli was a physician prevented from providing private services under the prohibition. Zeliotis was a patient who had experienced delays obtaining a hip replacement.¹³ In addition to the main parties, a number of others sought and were granted leave to intervene in the case and to present written and, in most cases, oral arguments. These included a number of provinces,¹⁴ the individual members of a Senate committee that had produced a comprehensive report on access to health

had been raised in the limited sense of discrimination on the basis of place of residence (see *supra* note 1 at para. 10) and the Court did not review the impugned legislation from the perspective of an infringement with s.15.

Almost immediately, the judgment generated a firestorm of comment and controversy in the media and in the academic literature, with partisans of various stripes lining up in rather predictable ways to shape public opinion toward their preferred futures. The media references are too numerous to cite. A sample (albeit selective) is available on the website of the University of Toronto Health Law and Policy Group <<http://www.law.utoronto.ca/healthlaw/>>. The academic literature also quickly proliferated, with a volume produced by a conference published within months of the judgment. See Flood *et. al.*, "Access to Care", *supra* note 4. Notwithstanding the deluge of commentary that has appeared to date, in our review we have not found any commentators who have remarked on the competing conceptions of equality underlying the divide in the Court. Even those critical of the judgment, who one might expect to notice this, have tended to take for granted the majority's implicit conception of equality and merely taken issue, on essentially empirical grounds, with the conclusions reached. For example, Marmor complains that the way "the Supreme Court made use of evidence from other systems of publicly financed medical care is both (sic) complicated, flawed and ironic." Ted Marmor, "An American in Canada Another View of the Supreme Court Decision on Health Care" (September 2005) Policy Options 63 at 64. Flood and Sullivan claim: "The majority of the court says there is no evidence to support the concern raised about depleted human resources except the assertions of various social scientists called as witnesses. In doing so they chose to ignore the mass of scholarly input compiled in the Senate hearings and the reports by Romanow and Kirby. But, in actual fact, this problem of limited resources is supported by evidence from other countries and within Canada." Colleen M. Flood & Terrence Sullivan, "Supreme Disagreement: The Highest Court Affirms an Empty Right" (2005) 173:2 CMAJ 142 at 142.

¹¹ S. 15 of the *Health Insurance Act*, R.S.Q. c. A-29 and s.11 of the *Hospital Insurance Act*, R.S.Q. c. A-28.

¹² [2000] R.J.Q. 786, [2000] J.Q. no. 479 (C.S.), *aff'd* [2002] R.J.Q. 1205, [2002] J.Q. no. 759 (C.A.).

¹³ There was some discussion as to whether Chaoulli and Zeliotis were proper parties before the Court, and it was determined that they were. However, status was not granted them on the basis of their individual claims but in recognition that the issues they raised were of sufficient public interest. "However, the question is not whether the appellants are able to show that they are personally affected by an infringement. The issues in the instant case are of public interest and the test from *Minister of Justice of Canada v. Borowski*, [1981] 2 S.C.R. 575, applies." *Supra* note 1 at para. 35.

¹⁴ Ontario, New Brunswick, Saskatchewan, Quebec and the Government of Canada were parties to the action.

care,¹⁵ physician organizations,¹⁶ health and poverty law activists,¹⁷ and a group of private clinics.¹⁸

Under both the Quebec and Canadian *Charters* there is a two-step process to challenging legislation. First, an infringement of an enumerated right or freedom must be established. The main rights at issue in this case were the right to life and security of the person found in s.1¹⁹ of the Quebec *Charter* and s.7²⁰ of the Canadian *Charter*. These two sections, while similar in the rights they guarantee, are not identical.²¹ S.7 of the Canadian *Charter* has the additional complexity that in order to establish an infringement it must be shown not only that a deprivation of one of the rights guaranteed has occurred but also that the deprivation was not “in accordance with the principles of fundamental justice.”²²

Once an infringement is established then, under s.9.1²³ of the Quebec *Charter* and s.1²⁴ of the Canadian *Charter*, the second step of the analysis is for government to demonstrate that: the infringement is justified in light of the importance of the legislative purpose; there is a rational connection between the purpose and the impugned measure; and the measure is duly limited to ensure that rights and freedoms are minimally impaired. The application of these principles has come to be known as the *Oakes* test,²⁵ which was described by Deschamps J. as follows:

First, the court must determine whether the objective of the legislation is pressing and substantial. Next, it must determine whether the chosen means to attain this legislative end are reasonable and demonstrably justified in a free and democratic society. For this second part of the

¹⁵ Canada, Senate Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians — The Federal Role — Final Report* (Ottawa: October 2002) [Kirby, “Report”].

¹⁶ Canadian Medical Association and Canadian Orthopedic Association (co-intervenors).

¹⁷ Charter Committee on Poverty Issues and Canadian Health Coalition (co-intervenors).

¹⁸ This group comprised clinics for surgery, plastic surgery, cosmetic surgery and MRIs as well as one provincial association representing orthopedic surgeons and another representing anesthesiologists.

¹⁹ *Supra* note 3 at s. 1 (S. 1 provides: “Every human being has the right to life, and to personal security, inviolability and freedom.”).

²⁰ *Supra* note 2 at s. 7 (S. 7 provides: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”).

²¹ Deschamps J. notes that the sections are almost identical except that the Quebec *Charter* contains the additional term ‘inviolability.’ In addition Deschamps J. notes the greater analytical complexity of s.7 of the Canadian *Charter*. *Supra* note 1 at paras. 28-30.

²² *Supra* note 2.

²³ *Supra* note 3 at s. 9.1 (S.9.1 provides: “In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Quebec. In this respect, the scope of the freedom and rights, and limits to their exercise, may be fixed by law.”).

²⁴ *Supra* note 2 at s. 1 (S.1 provides: “The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”).

²⁵ *R. v. Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200 (which articulates the justificatory requirements for s.1 of the Canadian *Charter*).

analysis, three tests must be met: (1) the existence of a rational connection between the measure and the aim of the legislation; (2) minimal impairment of the protected right by the measure; and (3) proportionality between the effect of the measure and its objective.²⁶

The majority found that the legislative provisions did infringe rights and that the infringement was not justified. Deschamps J. based her decision solely on the Quebec *Charter*, finding that the legislative provisions unjustifiably infringed s.1. McLachlin C.J.C. and Major J. based their decision, not only on an unjustified infringement of the Quebec *Charter*, but also on an unjustified infringement of s. 7 of the Canadian *Charter*.

The minority, Binnie and LeBel JJ., also found that the legislative provisions infringed s. 1 of the Quebec *Charter* and deprived individuals of life and security of the person under s.7 of the Canadian *Charter*. However, in terms of the Quebec *Charter*, they found that the infringement was justified under s.9.1. In terms of the Canadian *Charter*, under the s.7 analysis, they found that although the rights to life and security of the person were engaged, there had been no deprivation contrary to the principles of fundamental justice.

III. The Divide in the Construal of the Purpose

The legal issue distilled to the nature of the fit between the legislative prohibitions against private insurance, on the one hand, and the purpose or state interest behind the prohibitions, on the other. Determining the purpose of the impugned legislation was, thus, crucial to the legal analysis. The Justices differ, albeit implicitly, in the articulation of this purpose. A brief review of each of their positions follows.

The precise terms by which Deschamps J. characterizes the purpose vary. Typically, she construes it in terms of “preserving the integrity of the system”²⁷ or “the objective of preserving the public plan.”²⁸ ‘Preserving the integrity of the system’ or ‘the public plan’ essentially means preserving its *quality*.

McLachlin C.J.C. and Major J. typically construe the purpose in terms of “the goal of a quality public health system.”²⁹ For example, they note the govern-

²⁶ *Supra* note 1 at para. 48. Note that although Deschamps J. articulates the test as it used to justify Canadian *Charter* infringements, she applies the test to the justificatory requirements of the Quebec *Charter*. Her appropriation of the s.1 Canadian *Charter* analysis to the Quebec *Charter* has been criticized by some scholars. See for example Jean-François Gaudreault-Desbiens & Charles-Maxime Panaccio, “Chaoulli and Quebec’s Charter of Human Rights and Freedoms: The Ambiguities of Distinctness” in Flood *et. al.*, “Access to Care”, *supra* note 4.

²⁷ *Supra* note 1 at para. 55 (quoting the Attorney General of Quebec).

²⁸ *Ibid.* at para. 57.

²⁹ *Ibid.* at para. 139.

ment's argument that prohibiting private insurance "is necessary to providing effective health care under the public health system."³⁰

Essentially, the two majority decisions describe the purpose in the same way: to preserve the integrity or quality of the public system. To be sure, they construct the arguments differently, given that they employed different analytic tests. For Deschamps J., the issue turned on the minimal impairment test: "prohibition is not necessary to guarantee the integrity of the public plan."³¹ For McLachlin C.J.C. and Major J., the crux of the issue was arbitrariness. This turned on whether there is a "real connection in fact between prohibition of health insurance and the goal of a quality public health system."³² In both cases, the purpose having been construed as it was, the question reduced to an empirical one concerning a relationship between means and end: is the prohibition in fact necessary to effect the end (purpose) of preserving the integrity or quality of the system? What impact, in fact, would permitting private insurance have on the integrity or quality of the system? Whatever measures of quality are deemed relevant — wait times, success rates of various procedures, population health indicators, and the like — would quality go up, down, or remain the same if the prohibition were not in effect? Government, most of the experts and the lower courts, with the minority concurring on this point, argued that quality would suffer. The majority were unconvinced.

The minority also construed the purpose of the impugned legislation as being to ensure the quality of the public system. However, additionally and independently of this characterization, they also construed the purpose in terms of equal treatment with respect to health services. Moreover, they construed this equality purpose not just in terms of equal access *within* the publicly funded system, but also equal access to health care in general throughout Quebec or Canadian society. They quote approvingly the trial judge: "*The purpose of the impugned provision is to guarantee equal and adequate access to health care for all Quebecers.*"³³

Thus, the minority analysis did not turn solely on the empirical relationship between the prohibition as means, on the one hand, and a quality health system as end (or purpose), on the other. They considered the issue, not just in terms of quality, but also in terms of equality; and not just in fact, but also in principle.

Indeed, the distinction between in fact and in principle figures prominently in the minority's analysis. They invoke this distinction no less than three times, most sharply as follows:

As stated, we accept the finding of the courts below that a two-tier health care system would likely have a negative impact on the integrity,

³⁰ *Ibid.* at para. 135.

³¹ *Ibid.* at para. 74.

³² *Ibid.* at para. 139.

³³ *Ibid.* at para. 241 [emphasis in original].

functioning and viability of the public system . . . Although this finding is disputed by our colleagues the Chief Justice and Major J. . . it cannot be contested that as a matter of *principle*, access to *private* health care based on wealth rather than on need contradicts one of the key social policy objectives expressed in the *Canada Health Act*. The state has established its interest in promoting the *equal* treatment of its citizens in terms of health care.³⁴

Binnie and LeBel JJ. argue that prohibiting private insurance is appropriately connected to the state interest in ‘*equal* treatment of its citizens’, not on the empirical ground that private insurance will undermine the integrity or quality of the public system, but on the principled ground of equality of access across the system. Whether as a *matter of fact* removing the prohibition would have an adverse impact *vis-à-vis* the quality purpose, it is ‘incontestable’ that it would contradict the equality purpose as a *matter of principle*. If the majority does not follow the minority to this ‘incontestable’ conclusion, it is because they do not construe the purpose or state interest behind the impugned legislation in these equality terms.

To be sure, Deschamps J. does explicitly mention equality in her construal of the purpose: “Quality of care and equality of access are two inseparable objectives under the statutes.”³⁵ She even quotes Claude Castonguay, Quebec’s Minister of Health when the Quebec legislation was enacted, who said at trial that “[w]e wanted access to health care to be as equal as possible everywhere in Quebec, regardless of place of residence, regardless of financial circumstances”³⁶ However, having quoted Castonguay’s rather strong and plain statement about how equality figured in the legislator’s intention, Deschamps J. immediately shifts the emphasis, by a questionable inference, from equality to quality: “The quality objective is not formally stated [in Castonguay’s quoted remarks], but it seems clear that a health care service that does not attain an acceptable level of quality cannot be regarded as a genuine health...service”³⁷ In her subsequent analysis, equality, notwithstanding its prominent emphasis in Castonguay’s remarks, and notwithstanding that she discerned it and quality of care to be ‘inseparable objectives under the act,’ drops out. In her substantive analysis, the purpose of the prohibitions is construed exclusively in terms of quality, which, by her own admission, was ‘not

³⁴ *Ibid.* at para. 181 [emphasis added in italics; original emphasis is underscored]; *ibid.* at para. 174 they write: “[...] the underlying policies flow from the Canada Health Act and are the same: i.e. as a matter of *principle* health care should be based on need, not wealth, and as a matter of *practicality* the provinces judge that the growth of the private sector will undermine the strength of the public sector and its ability to achieve the objectives of the Canada Health Act.” [emphasis in original]; see also *ibid.* at para. 239 (where the same distinction is made).

³⁵ *Ibid.* at para. 49 (Deschamps J. does not say what she means by equality. However, in context it seems that she must mean equality of access *within the system*. Binnie and LeBel JJ., by contrast, understand it to mean equality across or throughout society. Interpreted in this latter way, differential access premised on ability to pay, as would be facilitated by private insurance, is plainly inconsistent with the objective of equality. This point is discussed at greater length later in the paper).

³⁶ *Ibid.*

³⁷ *Ibid.* at para. 50.

formally stated in Castonguay's remarks and equality as such does not figure in her analysis at all. And neither does it figure explicitly in the analysis of C.J.C. McLachlin and Major J.

IV. The Divide in Values and Perspectives

The analytic tests employed in each of the decisions require that the purpose of the impugned legislation be discerned. We have shown that the majority and the minority divided in how they construed this purpose, which proved crucial to the ultimate divide about the issues before the Court. However, even as the majority and minority address points of division in each other's reasons, nowhere do they *explicitly* address, or even acknowledge, this crucial and even decisive divide about purpose. This is quite remarkable!

Even though the Justices do not acknowledge the significant difference in their construal of purpose, they do indicate a sharp awareness of differences in the 'values and perspectives' at work in each other's decisions.³⁸ These differences inform their characterization of that purpose and, we believe, account for the divide in that characterization. In this section, we illustrate the tension in the Court concerning these values and perspectives and comment on the tone and rhetoric of the discourse.

The *Canada Health Act*³⁹, the provisions and validity of which were neither at issue nor determined by this case, was nonetheless extensively discussed and its interpretation disputed. This discussion, often acrimonious and acerbic, is especially revealing with respect to the divide in values and perspectives in the Court as these bear on the interpretation of the purpose of the impugned legislation.

Deschamps J.'s remarks set the stage for our examination of this discussion. The principles of the *Canada Health Act* she writes:

[...] have become the hallmarks of Canadian identity. Any measure that might be perceived as compromising them has a polarizing effect on public opinion. The debate about the effectiveness of public health care has become an emotional one. The Romanow Report stated that the

³⁸This divide about values and perspectives could properly be called 'ideological'. However, the term 'ideology' is much abused in contemporary parlance, and often used as a pejorative. One discredits someone by calling his or her argument 'ideological'. We invoke the term here rather in a scholarly, analytic sense. Paul Ricoeur, for example, notes that "it is by no means obvious that 'ideology' is an exclusively negative phenomenon, that it is merely something like 'false consciousness', a 'deception', a 'distortion of reality' . . ." Paul Ricoeur, "Ideology and Ideology Critique" in Bernhard Waldenfelds, Jan M. Broekman & Ante Pažanin, eds., *Phenomenology and Marxism*, trans. by J. Claude Evans, Jr. (London: Routledge and Kegan Paul, 1984) 134 at 134. Rather, ideology is a system of ideas that "is not thematic, but rather operative". Ricoeur notes that in large measure it operates behind our backs, as it were, such that we "think from its point of view rather than thinking about it" at 137.

³⁹R.S.C. 1985, c.C-6.

Canada Health Act has achieved an iconic status that makes it untouchable by politicians ...⁴⁰

In Deschamps J's view, the polarizing effect of the *Canada Health Act* in its symbolic meaning extends further than *the public policy forum*; it infiltrates — in her view illicitly — into *the Court*. She continues:

The tone adopted by my colleagues Binnie and LeBel JJ. is indicative of this type of emotional reaction. It leads them to characterize the debate as pitting rich against poor when the case is really about determining whether a specific measure is justified under either the Quebec *Charter* or the Canadian *Charter*. I believe that it is essential to take a step back and consider these various reactions objectively.⁴¹

In effect, Deschamps J. charges that, caught up in the emotion attaching to this national icon, her colleagues inappropriately “characterize the debate as pitting rich against poor” to the point that they lose sight of the narrow issues before the Court.⁴²

In considering Deschamps J's criticism, it is fair to say that throughout their reasoning Binnie and LeBel JJ. do give greater prominence to the situation of the poor *vis-à-vis* the rich than do the two majorities, although not always in their discussion of the *Canada Health Act* as such. In several places they evoke the principle of “health care based on need rather than on wealth or status.”⁴³ They assert that “the people of Quebec, through their elected representatives, opted for a need-based, rather than a wealth-based, health care system.”⁴⁴ However, this emphasis on income status does not, as Deschamps J. implies, illicitly impose the

⁴⁰ *Supra* note 1 at para. 16.

⁴¹ *Ibid.* In their classic textbook on rhetoric, Brooks and Warren note that just as “tone of voice” can communicate quite diverse meanings, “the ‘tone’ of a piece of writing, in the same way, may show the writer’s attitude, and in so doing may heavily qualify the literal meaning of the words.” Cleanth Brooks & Robert Penn Warren, *Modern Rhetoric: Shorter Edition* (New York: Harcourt, Brace & World, Inc. 1961) at 291. Ironically, there is much tone in Deschamps J.'s accusation of tone in her colleagues. Tone, and the rhetorical dimension of language in general, is more closely tied to natural language than is propositional content, which is less resistant to translation. It is important to note that Deschamps J. is cited here in translation. Her tone is somewhat amplified and harsher in English than in the original. Indeed, the reference to objectivity (the lack of it being implied) does not appear as such in the French. The translation reads: “I believe that it is essential to take a step back and consider these various reactions objectively.” The original reads: “Je crois, quant à moi, qu’il est indispensable de prendre du recul par rapport à ces diverses réactions.”

⁴² Deschamps J.'s remarks amount to an *ad hominem* argument (enthymeme), with an implied premise to the effect ‘emotional reaction is inappropriate’. In public policy debate, the charge Deschamps J. makes is one typically made against opponents of private insurance who invest symbolic or ‘iconic’ meaning in the *Canada Health Act*. Rational debate about policy in this area, the argument would have it, is impeded by ‘rhetoric’ or ‘ideology’, as if only opponents of private insurance have ‘ideology’ or employ ‘rhetoric’.

⁴³ *Supra* note 1 at para. 164.

⁴⁴ *Ibid.* at para. 172.

age-old motif of the rich against the poor upon the legal issues.⁴⁵ That Canadians are differently situated with respect to their ability to obtain private health insurance is essentially relevant to the purpose behind the impugned legislation as Binnie and LeBel JJ. construe this purpose in terms of equality.⁴⁶

Moreover, many of Binnie and LeBel JJ.'s comments that might be construed as "pitting the rich against the poor" are responses to what they no doubt perceive as illicit 'values and perspectives' in their colleagues' comments about income differences. For example, they take issue with Deschamps J.'s claim that the "essence" of the question before the court is "whether *Quebeckers who are prepared to spend money* to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state."⁴⁷ To this they acerbically rejoin that they "do not accept that there is a constitutional right 'to spend money', which would be a property right."⁴⁸ And if private insurance is a solution for "*Quebeckers who are prepared to spend money*", Deschamps J. omits to mention that it is not a solution for the many *Quebeckers* who will not be 'prepared' or able to afford to purchase private insurance, but whose life or security of the person may be equally endangered as they rely upon a publicly funded system.

It is against that background of such omissions in their colleagues' statements that Binnie and LeBel JJ. emphasize — as if by way of reminder — those who will be unable to purchase private insurance:

Those who seek private health insurance are those who can afford it and can qualify for it. They will be the more advantaged members of society. They are differentiated from the general population, not by their health problems, which are found in every group in society, but by their income status."⁴⁹

With reference to section 9.1 of the Quebec *Charter*, they argue that defeating the legislation would not "have proper regard for the 'general well-being of the citizens of Québec' . . . and in particular for the well-being of the less advantaged *Quebeckers*."⁵⁰ Concluding their reasons, they assert, against Deschamps J., that

⁴⁵ The rhetoric of 'rich against the poor' frames but one of several dramatic sub-texts in the Court in which competing underlying values and perspectives are at odds. There is much drama in the Court concerning the propriety of its intervention in this case *vis-à-vis* the theme of the 'courts versus the legislature'. There is also undercurrent of drama concerning 'Quebec versus Canada' as pertains to Deschamps J.'s decision to base her analysis on the Quebec rather than the Canadian *Charter*.

⁴⁶ For example: "The policy of the Canada Health Act . . . and its provincial counterparts is to provide health care based on need rather than on wealth or status." *Supra* note 1 at para. 164.

⁴⁷ *Ibid.* at para. 4 [emphasis added].

⁴⁸ *Ibid.* at para. 203.

⁴⁹ *Ibid.* at para. 274 (where they continue: "We share the view of Dickson C.J. that the *Charter* should not become an instrument to be used by the wealthy to 'roll back' the benefits of a legislative scheme that helps the poorer members of society.").

⁵⁰ *Ibid.* at para. 273.

the evidence they have reviewed “establishes that the impugned provisions were part of a system which is mindful and protective of the interests of all, not only of some.”⁵¹

The construction “*some*” (who can afford to purchase private insurance) versus “*all*” (which includes many who cannot) indicates a key point of emphasis in Binnie and LeBel JJ.’s response to the arguments of their colleagues.⁵² In some places the majority discuss the burdens imposed by the prohibition as if they applied to *all* in society without noting that there are *some* who are unable to purchase private insurance. These ‘less advantaged’ members of society — and there are at least *some* in society — become virtually invisible. At one point in her remarks about the burden imposed by the prohibition, Deschamps J. asserts simply that “Quebeckers are denied a solution that would permit them to avoid waiting lists”,⁵³ omitting to mention the qualification ‘who are prepared to spend money’ to characterize the Quebeckers thus burdened by the prohibition.

McLachlin C.J.C. and Major J. likewise tellingly exclude the less advantaged members of society when they evoke the figure of ‘ordinary’ Canadians burdened by the prohibition. To this, Binnie and LeBel JJ. rejoin:

The argument for a ‘two-tier system’ is that it will enable ‘ordinary’ Canadians to access private health care. Indeed, this is the view taken by our colleagues the Chief Justice and Major J. who quote the appellants’ argument that “disallowing private insurance precludes the vast Majority of Canadians (middle-income and low-income earners) from accessing” private health care . . . For 45 million Americans, as for those “ordinary” Quebeckers who cannot afford private medical insurance or cannot obtain it because they are deemed to be ‘bad risks’, it is a matter of public health care or no care at all.⁵⁴

⁵¹ *Ibid.* at para. 278.

⁵² See also *ibid.* at para. 277 (“... we should bear in mind that the legislative provisions challenged under s. 1 concern all citizens of Quebec. They address concerns shared by all and rights belonging to everyone. The legislative solution affects not only individuals but also the society to which all those individuals belong. It is a problem for which the legislature attempted to find a solution that would be acceptable to everyone in the spirit of the preamble of the Quebec *Charter*...”).

⁵³ *Ibid.* at para. 45. To be fair, Binnie and LeBel JJ. also make important omissions. For example, they fail to consider an important limitation of the “safety valve” they propose, *ibid.* at para 264. Deschamps J. points this out, *ibid.* at para. 44 (“In the opinion of my colleagues Binnie and LeBel JJ., there is an internal mechanism that safeguards the public health system. According to them, Quebeckers may go outside the province for treatment where services are not available in Quebec. This possibility is clearly not a solution for the system’s deficiencies. The evidence did not bring to light any administrative mechanism that would permit Quebeckers suffering as a result of waiting times to obtain care outside the province. The possibility of obtaining care outside Quebec is case-specific and is limited to crisis situations.”).

⁵⁴ *Ibid.* at para. 175 [references omitted].

Speaking about the “virtual monopoly for the public health scheme”, McLachlin C.J.C. and Major J. assert that the “state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance.”⁵⁵ Here the figure of the ‘very rich’ is evoked in a claim of justice as it were, but one that pits the rich not against the poor but against the not so rich (who nonetheless are not so poor that they cannot afford private insurance). If Binnie and LeBel JJ.’s remarks privilege the perspective of the poor or disadvantaged, McLachlin C.J.C. and Major J. privilege the justice claim of the middle class as it were.⁵⁶

This inter-collegial banter concerning the characterization and relevance of income status helps explain the difference in the interpretation of the principles of the *Canada Health Act* as these principles relate to the purpose of the prohibition in the Quebec legislation. It is important to note that each of the decisions backs up to, and in varying measure relies upon, the *Canada Health Act* as an authority for the discernment of the purpose of the prohibitions. The division in the construal of the purpose can be seen as linked to a division concerning the interpretation of the *Canada Health Act* and in the construal of *its* policy purpose.

In more than one place, Binnie and LeBel JJ. claim to find support for their equality-based construal of the purpose in the *Canada Health Act*. “[I]t cannot be contested that as a matter of *principle*,” they say, that “access to *private* health care based on wealth rather than on need contradicts one of the key social policy objectives expressed in the *Canada Health Act*.”⁵⁷ In polemic against McLachlin C.J.C. and Major J.’s use of the international evidence, they further assert that their “tour d’horizon ... leaves out of consideration the commitment in principle in *this* country to health care based on *need*, not wealth or status, as set out in the *Canada Health Act*.”⁵⁸

Binnie and LeBel JJ. do not quote the *Canada Health Act* to ground the rather strong “commitment in principle”⁵⁹ that they claim is “set out in the *Canada Health Act*.”⁶⁰ They do not say precisely where in the *Act* a “key social policy objective is expressed”⁶¹ that is contradicted by “access based on wealth rather than need.”⁶²

⁵⁵ *Ibid.* at para. 106.

⁵⁶ Deschamps J. likewise frames the issue in terms of the plight of the ‘rich against the middle class’. *Ibid.* at para. 55 she states: “The prohibition on private insurance creates an obstacle that is practically insurmountable for people with average incomes. Only the very wealthy can reasonably afford to pay for entirely private services.” This is certainly true. However, it is also true — and significant that Deschamps J. omits to mention this — that only those who are wealthy relative to the financially disadvantaged can afford to purchase private insurance!).

⁵⁷ *Ibid.* at para. 181 [emphasis in original].

⁵⁸ *Ibid.* at para. 230 [emphasis in original].

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ *Ibid.* at para. 181.

⁶² *Ibid.*

One would search in vain for a citation in the *Act* that could decisively ground these strong claims.

McLachlin C.J.C. and Major J., however, do cite the *Canada Health Act*, and moreover cite what is plainly its most authoritative statement of its health policy purpose or objective: “The primary objective of the *Canada Health Act*,” they assert (quoting directly from section 3 of the *Act* that has the telling heading ‘Canadian Health Policy’ and the even more telling sidebar ‘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.”⁶³ This is a rather different, and less strong statement, than the principle of ‘health care based on need, not wealth’ that Binnie and LeBel JJ. claim is set out in the *Act*. And on a plain reading of the *Act* one certainly can contest their claim that “access to *private* health care based on wealth rather than on need” contradicts the “health policy objective”⁶⁴ that is expressed in the *Act*. The policy objective that is expressed in the *Act* is significantly different from what they claim the policy objective to be.⁶⁵

That Binnie and LeBel JJ.’s strong equality-oriented construal of the social policy objective or purpose of the *Canada Health Act* does not hold up well against the plain meaning of the text of the *Act* would appear to lend some support to Deschamps J.’s chastisement of them for ‘emotional reaction’ and lack of objectivity. But would it be fair to say that, perhaps led astray by prejudicing values and perspectives, they are simply wrong in their interpretation of the *Canada Health Act* and its social policy objective? Would it be fair to say that, by contrast, the majority is simply correct in their interpretation, viewing the matter more ‘objectively’ and not prejudicing their interpretation with their own ‘values and perspectives’?

We believe that the situation is rather more complicated than that. In the first place, what the *Canada Health Act* expressly says about the ‘primary objective of Canadian health policy’ is general enough and sufficiently open to interpretation that it does not rule out Binnie and LeBel JJ.’s interpretation.⁶⁶ In the second place,

⁶³ *Ibid.* at para. 105.

⁶⁴ *Ibid.* at para. 181.

⁶⁵ The purpose statement contained in the *Canada Health Act*, which follows the statement of objective, is of no more help to Binnie and LeBel JJ. It reads: “The purpose of this *Act* is to establish criteria and conditions in respect of insured services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.” *Supra* note 39, s.4.

⁶⁶ The rules of interpretation by which to interpret the *Canada Health Act* (or any other statute) are themselves complex, and at issue in the Supreme Court of Canada today. Madame Justice L’Heureux-Dubé gives us a very interesting review and analysis of the rules of statutory interpretation from a perspective in the Court in her decision, dissenting in the reasons, in 2747-3174 *Québec Inc. v. Québec (Régie des permis d’alcool)* [1996] 3. S.C.R. 919 at paras. 147-200. At para. 165 she discusses what she calls the “wavering” of the Court between the “plain meaning” method and the “modern” method or approach of interpretation. Such “wavering” as exists in the Supreme Court today concerning the theory of statutory interpretation is of considerable dramatic significance, and a subject deserving careful

although the *Act*'s own explication of the primary objective of Canadian health policy and its statement of purpose is certainly privileged and indispensable evidence of that purpose, it is not exhaustive. Much of the evidence and testimony Binnie and LeBel JJ. considered concerning the purpose of Canadian health policy lends support to their interpretation of this purpose, and indeed of the purpose behind the *Canada Health Act*. Thirdly, if Binnie and LeBel JJ.'s reading of the policy purpose behind the *Canada Health Act* is contentious, so too is limiting this purpose to ensuring the quality of the publicly funded system, as the majority do.

Moreover, if Binnie and LeBel JJ. interpret the social policy objective of the *Canada Health Act* in view of contextual considerations beyond the letter of the *Act*; Deschamps J. also goes beyond the *Act* in specifying the purpose of health policy in Canada. "Initially limited to extreme cases, such as epidemics or infectious diseases,"⁶⁷ she encapsulates the relevant social history, "the government's role has expanded to become a safety net that ensures that the poorest people have access to basic health care services."⁶⁸ No doubt ensuring 'that the poorest people have access to basic health care services' is a purpose of Canadian health policy, but would a careful reading of the very complex history here — taking into account the full range of 'values and perspectives' effective in making this history — support such a flat statement? Deschamps J. goes on to add that "[t]he enactment of the first legislation providing for universal health care was a response to a need for social justice."⁶⁹ No doubt it was. But it is certainly debatable whether the operative and historically effective concept of social justice can be reduced to Deschamps J.'s rather glib statement about ensuring that the poor have access to basic health care.

If interpreters as practiced and sophisticated as Supreme Court Justices could come to such different interpretations or construals of the purpose behind the impugned legislation, the *Canada Health Act*, and more generally the purpose behind Canadian health policy, it seems unreasonable simply to suppose that *as a matter of interpretation* one side got it right and the other side got it wrong.⁷⁰ A more likely explanation, we believe, is that this purpose itself is and has been

attention. At para. 160 she elaborates the modern approach as follows: "I will here use the term 'modern approach' to designate a synthesis of the contextual approaches that reject the 'plain meaning' approach. According to this 'modern approach', consideration must be given at the outset not only to the words themselves but also, *inter alia*, to the context, the statute's other provisions, provisions of other statutes *in pari materia* and the legislative history in order to correctly identify the legislature's objective." Suffice to say that Binnie and LeBel JJ.'s interpretation is more plausible on the 'modern' than on the 'plain meaning' approach.

⁶⁷ *Supra* note 1 at para. 56.

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ As evidence of there being at least an ambiguity in the question of purpose, one needs also to take account of the fact that the lower courts also interpreted the purpose of the impugned legislation along lines similar to Binnie and LeBel JJ. *Ibid.* at para. 241 (they quote the trial judge: "The enactment of s. 15 HEIA and s. 11 HOIA was motivated by considerations of equality and human dignity..." [emphasis in original]).

unclear and ambiguous in Canadian health policy. And such evidence as the Justices had before them from which to construe this purpose — such as statements by government officials about the purposes, statements in and surrounding the *Canada Health Act* and other documents in the relevant historical record — was at least sufficiently unclear and ambiguous that they were able to construe it differently.

Canadian health policy prohibiting private insurance, we believe, has harbored and left unsettled a values tension or even ambivalence about its purpose. In their different construals, the Justices give expression to different poles held in tension and hitherto unresolved one way or the other. In doing so, they mirrored a divide not just in the purpose itself as available to the Justices for discernment, but also behind this purpose a divide in public debate about health policy and more broadly in Canadian society.

V. The Divide in the Purpose of Health Policy in Canada

The Court was not asked to adjudicate the question of the purpose of health policy in Canada. Nevertheless, in order to answer the questions before it, the Court had to identify this purpose as expressed in the Quebec legislation. In doing so, and in its division, the Court both reflects and amplifies an unresolved values tension harbored in Canadian public policy and policy debate. We believe that there is a divide in the values underpinning the purpose of health policy in Canada which has not been explicitly expressed — much less reconciled — in policy debate. In view of this, it is not surprising that the Justices divided as they did in construing the purpose of the prohibition against private insurance, which in our view reflects an unresolved but latent tension in the values informing Canadian health policy. The division in the Court, we believe, is useful to illuminate and distinguish two quite different sorts of policy reasons, both of which receive recognition in current policy, which can be adduced in support of prohibiting private insurance. These policy reasons and the values that they reflect have been in a tension that has not been well articulated or rendered quite explicit.

The two different construals of the purpose behind the prohibition in the Court correspond to two quite different reasons or lines of argument that can be adduced in support of the prohibition. One line of argument is premised on the value of preserving the quality or integrity of the publicly funded system. It turns on a subordinate premise that private insurance would have the effect of undermining the quality of the publicly funded system. This is an empirical proposition, the truth or falsity of which is dependent on the evidence. If it were found true that private insurance would not undermine the quality of the publicly funded system, the objection to private insurance on this ground would be removed.⁷¹

⁷¹ Of course, supporters of the prohibition who argue their case on these empirical grounds will not grant that this premise fails on the evidence. However, they are bound by rudimentary rules of logic or argument to accept that *if* they premise their argument on this proposition, *then* should this premise turn out to be

The majority, construing the policy purpose of the prohibition in terms of maintaining the quality of the publicly funded system, can be taken to reflect this value position. And on the empirical evidence before them they were unconvinced that private insurance would have an adverse effect on the quality of the publicly funded system, or that prohibition was necessary to preserve the system in its quality. The prohibition, thus, was found not to be appropriately connected with its purpose so construed.

Equality as such does not figure in the majority's analysis. To the extent that the value of equality operates in the background, this would be something like equality of access *within* the public system. For example, one needs to develop measures of quality and ensure that the system performs to what McLachlin C.J.C. and Major J. call "reasonable standards"⁷² (although what these are is no small question, as Binnie and LeBel JJ. remark). Provided those standards are met, and those within the system have equal access *within* the system to treatment meeting those standards, it would not offend the policy objective if there were inequality *throughout* society in access to health care. Inequality as between the services available within the system and those additionally available (for Canadians who could afford it) in a private parallel system or second tier would not be an issue as long as the private parallel system did not adversely impinge on the quality of the public system. This perspective is supported by the Court's decision in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*⁷³, which considered the matter of equality directly. In *Auton*, the province's decision not to fund behaviour therapy for autism was challenged on the basis that it infringed equality rights guaranteed by s.15 of the Canadian *Charter*. In deciding that there was not an infringement of s.15, a unanimous Court clearly considered the issue of equality from within the existing system of health care benefits provided by government.⁷⁴

false, the prohibition is defeated. Indeed, should the evidence point to the conclusion (which the supporters of the prohibition would of course deny, but which theoretically at least is possible) that private insurance would actually enhance the quality of the publicly funded system (for example, and assuming for the sake of argument that other things would be equal, because people who would otherwise be on the waiting list in the public system would not be if they went to a private system, thus shortening the list) those who premised their argument exclusively on the value of maintaining the publicly funded system would be bound to welcome private insurance!

⁷² *Supra* note 1 at para. 105.

⁷³ 2004 SCC 78, [2004] 3 S.C.R. 657 (CanLII) [*Auton*] (It is interesting to note that this case was heard the day before the *Chaoulli* hearing although the decision was rendered more than six months earlier than the decision in *Chaoulli*).

⁷⁴ For example *ibid.* at paras 43-44 the Court states: "The legislative scheme in the case at bar, namely the *CHA* and the *MPA*, does not have as its purpose the meeting of all medical needs. As discussed, its only promise is to provide full funding for core services, defined as physician-delivered services. Beyond this, the provinces may, within their discretion, offer specified non-core services. It is, by its very terms, a partial health plan. It follows that exclusion of particular non-core services cannot, without more, be viewed as an adverse distinction based on an enumerated ground. Rather, it is an anticipated feature of the legislative scheme. It follows that one cannot infer from the fact of exclusion of ABA/IBI therapy for autistic children from non-core benefits that this amounts to discrimination. There is no discrimination by effect. The correctness of this conclusion may be tested by considering the consequences to the legislative scheme of obliging provinces to provide non-core medical services required by disabled

However, there is another and different line of argument that can, alternatively or additionally, be adduced in support of the prohibition, which does not turn on the empirical evidence concerning cause and effect. Along these lines, the prohibition of private insurance serves the purpose not just of quality but of equality; support for the prohibition, therefore, is not dependent on an empirical premise to the effect that prohibiting private insurance is necessary to preserve the quality of the public system (or equality within the public system).

Binnie and LeBel JJ. reflect this equality values position as they construe the policy purpose not just in terms of *quality* but also *equality*. Their two pronged argument in support of the prohibition appeals *additionally* to equality, which matters ‘in principle’. On Binnie and LeBel JJ.’s idea of equality, such inequality as private insurance would permit is problematic *in principle*, and not just on the supposition that enhanced private health care would undermine the quality of that available in the publicly funded system. Consequently, if the argument in support of the prohibition on the empirical ground that it is necessary to preserve the quality of the public system should fail, the ‘in principle’ equality argument remains unscathed.

Some such conceptualization of equality — even if it is not explicitly elaborated — is evident in a number of places in Binnie and LeBel JJ.’s decision. Their oft repeated phrase ‘health care based on need, not ability to pay’ suggests that health care should be equally available regardless of differences in wealth. Difference in access based on ability to pay would offend against equality thus understood. They speak about the state’s “interest in promoting the *equal* treatment of its citizens in terms of health care”⁷⁵, indicating that equality means for them not just something independent of quality but also something more than equal access *within* the publicly funded system to quality services. They speak of a “public system founded on the values of equity, solidarity and collective responsibility”⁷⁶, thus locating the idea of equality in a broader programme of what might be called ‘social justice’.

To bring this sense of equality operative in Binnie and LeBel JJ.’s analysis more sharply into view, the following statement by Romanow that they quote is helpful:

Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private

persons and people associated with other enumerated and analogous grounds, like gender and age. Subject to a finding of no discrimination at the third step, a class of people legally entitled to non-core benefits would be created. This would effectively amend the medicare scheme and extend benefits beyond what it envisions — core physician-provided benefits plus non-core benefits at the discretion of the Province.” Note, however, the comments in *supra* note 10 that clarify that Chaoulli engages ‘equality’ solely from the perspective of discerning the *policy purpose* behind the legislation.

⁷⁵ *Supra* note 1 at para. 181.

⁷⁶ *Ibid.* at para. 223.

provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care.⁷⁷

What value is perverted or offended by some Canadians being able to ‘purchase faster treatment from a private provider’? Clearly, this does not offend equality in whatever sense it may be implicitly operative in the majority’s construal of the policy purpose behind the prohibition. On their account, there would be reason for offense only if the ability to ‘purchase faster treatment from a private provider’ would undermine the publicly funded system in its quality or integrity.

But Romanow here identifies a categorical or ‘in principle’ objection, the ground of which must surely be equality in some such sense as Binnie and LeBel JJ. intend it, however sketchy their elaboration of this value may be. This value — albeit somewhat vaguely articulated — has played a considerable part in the public debate about health policy. In some measure, we maintain, this value informs health policy in Canada and the purpose behind the prohibition.

Commenting on Romanow’s statement, Binnie and LeBel JJ. write: “Whether or not one endorses this assessment, his premise is that the debate is about ‘social’ values.”⁷⁸ The debate about social values is not reducible to the question of whether private insurance would adversely impinge on the public system. Indeed, one would be at a loss to understand what is and has been so deeply contentious about policy in this area if the value of equality, in some such sense as Binnie and LeBel intend it, is not figured in the policy debate.⁷⁹ For such contention as could be admitted in the majority account of the purpose is about an empirical question, the answer to which will stand or fall on the relevant empirical evidence about the impact of the prohibition on the public system. But even if its removal would have no adverse impact in terms of quality measures, there would still be cause for objection to private insurance on the ground that Romanow adduces, which concerns not quality as such but equality.⁸⁰ Equality — the value in question

⁷⁷ *Ibid.* at para.166 (citing Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa: November 28, 2002) at p. xx (Commissioner: Roy J. Romanow, Q.C.) [Romanow, “Building on Values”]).

⁷⁸ *Ibid.*

⁷⁹ To be sure, private pay is also a problem from an equality perspective. That the very rich who can afford to pay for health services privately are able to do so also offends against equality in the sense in which it figures for at least some people in public debate. We are not suggesting that the idea of equality is clearly articulated as it figures in these debates, or that there is not contention among those who subscribe to some version of this notion. Indeed, depending on how one construes this equality perspective, the mere fact of inequality in wealth alone may be taken to offend equality, although typically even proponents of a very strong notion of equality offer argument to distinguish why inequality in access to health care is problematic in a way that inequality in access to restaurants or sea cruises is not.

⁸⁰ *Supra* note 1 at para. 230 (Binnie and LeBel also quote from the ‘Kirby Report’ (*supra* note 15 at 321) where virtually the same idea of equality as Romanow’s (*supra* note 77) is expressed: “Repeated public opinion polling data have shown that having to wait months for diagnostic or hospital treatment is the greatest concern and complaint that Canadians have about the health care system. *The solution to this problem is not, as some have suggested, to allow wealthy Canadians to pay for services in a private health*

— is infringed simply by the fact that someone is able to purchase faster treatment, and regardless of whether or how this might impact others waiting in line in the publicly funded system.

We do not know if the majority, who do not frontally address Binnie and LeBel JJ.'s equality construal of the purpose, considered and rejected it. In any event, that they did not acknowledge it does not mean that Binnie and LeBel JJ., perhaps carried away by what Deschamps J. calls 'emotional response', were illicitly projecting their 'values and perspectives' into the purpose. This explanation seems to us not just uncharitable but unlikely given the evidence. Indeed, even in Deschamps J. we find evidence of at least an echo of this value when she claims that the "enactment of the first legislation providing for universal health care was a response to a need for social justice."⁸¹ No doubt some such concept as 'social justice' — with all that is entailed in this much contested term — has figured in the policy history and debate about health policy in Canada in general, and private insurance in particular. It figures at least in the Canadian past, if not the Canadian future. But 'social justice' as it has figured in health policy debate is hardly reducible, as Deschamps J. has it, to ensuring "that the poorest people have access to basic health care services,"⁸² or even to 'quality services', whatever criteria are assumed for determining what is 'basic' and whatever level or standard of quality these services should meet. This leaves out of account a more robust concept not just of social justice but of equality, linked to values like 'solidarity' and 'collective responsibility', across society, and not just within the public health system.⁸³

care institution. Such a solution would violate the principle of equity of access. The solution is the care guarantee as recommended in this report" [emphasis of Binnie and LeBel JJ]. The rhetorical or dramatic dimension of this judgment as concerns how these two giant icons of contemporary debate — Kirby and Romanow — are used in the decision would make for a fascinating study. The apparent agreement of Kirby and Romanow on the idea of equality, we believe, does not run very deep or extend very far. Indeed, we believe (but can not argue this here) that there is an underlying division of 'values and perspectives' between Kirby and Romanow corresponding to that between the majority and the minority.

⁸¹ *Supra* note 1 at para. 56.

⁸² *Ibid.*

⁸³ The contemporary literature on equality has been dominated by the philosopher John Rawls, whose famous difference principle is very useful for contrasting the two constructions of the purpose in the Court. According to the difference principle, inequalities in society are morally justified if these inequalities are "to the greatest benefit of the least advantaged". John Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971) at 302. To the extent those least advantaged are better off when others have even more than they do, this inequality is justified.

In the context of the private insurance debate, some such position is at least implicit among those who argue that private insurance is just on the condition that it does not diminish the quality of the public system, and notwithstanding that those with private insurance will have superior quality and access to those in the public system. On other accounts, the very fact of the inequality, even if the least advantaged are not worse off because of it, is unjust. This view is sometimes called radical egalitarianism. A contemporary proponent is the Canadian philosopher Kai Nielsen, who argues that equality matters independently of whether persons are worse or better off under conditions of equality than they otherwise would be. See Kai Nielsen, "Class and Justice" in John Arthur & William H. Shaw, eds., *Justice and Economic Distribution* (Englewood Cliffs, N.J.: Prentice-Hall, 1978) and also Kai Nielsen, "Radical Egalitarianism Revisited: On Going Beyond the Difference Principal" (1996) 15 Windsor Y.B. Access

Our explanation for the difference in the construal of the purpose is that the purpose itself, as available to the Justices to be discerned, has been unclear and ambiguous. This purpose, we believe, has harbored a values tension or ambivalence; in their different interpretations of this purpose the Justices mirror the poles of this ambivalence. Hitherto this ambivalence has been left unresolved in Canadian health policy as a kind of compromise between different and competing ‘values and perspectives’, neither side of the issue being able to claim decisive victory in public policy debate.

VI. Conclusion

We have argued that the divide in the Court about the purpose of the prohibitions in question reflects and amplifies an underlying divide in values and perspectives concerning equality that has hitherto opaquely been held in tension in Canadian health policy debate. *Chaoulli* can help to bring explicitness and clarity about this values divide as this divide figures and becomes resolved in ongoing policy debate in the court of public opinion. However, if this is to occur explicitly, it is necessary for the divide in question to be recognized as a *values* divide.

To date, this has not occurred. Indeed, quite the opposite has occurred. Proponents and critics of the judgment alike have construed the divide in narrow terms as an essentially empirical issue: will private insurance lead to reduced quality in the publicly funded system. Along these lines, one debates the evidence that is available relevant to predictions of cause and effect.⁸⁴ However, in the dissent of Binnie and LeBel JJ there is also a principled argument grounded in values. To be sure, the conception of equality operative in this principled argument is not as explicit as it could be, and it is faint enough that the majority either did not notice it or noticed it and did not deign it worthy of comment. But it is there to be heard.

It may be that, for future historians, *Chaoulli* will be a monument to an older conception of equality rooted in egalitarian and socialist traditions that have since disappeared from the Canadian landscape — a last dying breath as it were. And it would be sadly ironic if the last nails in the coffin of this notion of equality were hammered, not by proponents of private health care, but by its detractors. These detractors would argue their case on technical, empirical grounds. In doing so, they

Just. 121. The philosophical issues here are complex and beyond the scope of this paper. For a review of these issues, see the papers collected in the volume by Arthur and Shaw (above). Kymlicka gives a very good overview of the positions and issues concerning equality. Will Kymlicka, *Contemporary Political Philosophy: an introduction* (New York: Oxford University Press, 1990) The discussion of the ‘envy test’ is especially relevant to the concept of equality engaged in the debate about private insurance at 197 note 9. For a discussion of Canadian jurisprudence concerning the impact (or lack thereof) of s.15 of the Canadian *Charter* on substantive equality see Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Markham, Ont.: LexisNexis Butterworths, 2006).

⁸⁴ See text accompanying note 10.

would unwittingly surrender the values ground of equality as solidarity to a newer, emerging conception — shared by their opponents — in which equality is thought in technocratic terms of promoting the quality of the publicly funded system.⁸⁵ Time will tell.

⁸⁵This would be consistent with the theory of value change in modern society articulated by Neil Postman. As an older value perspective (in his terms, ‘thought-world’) rubs up against an emerging one that has the inertia of technological change on its side, the older one is not explicitly annihilated; rather, it is made invisible by an emerging value perspective that redefines the meaning of the terms of debate and thereby eclipses the older one without much notice. “With the rise of Technopoly, one of those thought-worlds disappears. Technopoly eliminates alternatives to itself in precisely the way Aldous Huxley outlined in *Brave New World*. It does not make them illegal. It does not make them immoral. It does not even make them unpopular. It makes them invisible and therefore irrelevant. And it does so by redefining what we mean by religion, by art, by family, by politics, by history, by truth, by privacy, by intelligence, so that our definitions fit its new requirements.” Neil Postman, *Technopoly: The Surrender of Culture to Technology*, (New York: Vintage Books, 1993) at 48.