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The Implications of Section 7 of the *Charter* for Health Care Spending in Canada

by

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Highlights

- Three principal questions emerge from the section 7 case law to date: whether section 7 of the *Charter of Rights and Freedoms* guarantees a right to refuse non-consensual care, whether it establishes a right to receive care, and whether it guarantees the right to provide health care services. The answers to each of these questions have potential significance for health care spending.

- When the issue comes before it, the Supreme Court of Canada is likely to confirm that section 7 guarantees the right to refuse unwanted treatment.

- In several recent cases, courts have shown greater openness to the argument that section 7 guarantees access to health care services.

- Institutional or corporate health care providers will not be able to invoke section 7 to challenge restrictions on their ability to provide health care services. For individual health care providers, the potential of section 7 is also limited.

- Section 7 rights are not absolute: only interferences with life, liberty and security that do not conform with the principles of fundamental justice are objectionable.

- At the individual treatment level, fundamental justice can be met by providing patients an opportunity to participate in decisions about their care; in the policy and regulatory setting, by ensuring that decisions are publicly debated before they are implemented.

- Section 1 provides an opportunity for governments to introduce considerations relating to the sustainability of the health care system into the analysis of whether rights violations are justifiable.

- The cost implications of recognizing and protecting health related rights under section 7 are mixed. The obligation to respect principles of fundamental justice will likely increase process-related costs of health care decision-making. Where the refusal to provide health care cannot be shown to be fundamentally just, increased spending may also be required.

- However, requiring decision-making to become more inclusive and accountable may generate better decisions at the individual treatment level. At the broader regulatory and policy level, decision-making which is more equitable and rational may also be more cost effective.

- From this perspective, the introduction of *Charter* values into the health care system is a positive development.

Executive Summary

Introduction

Following the Supreme Court of Canada's decision in *Eldridge* (1997) the applicability of section 7 of the *Charter of Rights and Freedoms* in the health care context has expanded significantly. Three principal questions emerge from section 7 case law to date: whether section 7 guarantees a right to refuse unwanted health care, whether it establishes a right to receive care, and whether it guarantees the right to provide health care services. The answers to each of these questions have potential significance for health care spending.

The Right to Refuse Health Care

In light of the *Morgentaler* (1988), *Rodriguez* (1993), and *B.(R.)* (1995) decisions, it is probable that when the issue comes before it, the Supreme Court will confirm that section 7 guarantees the right to refuse unwanted medical treatment.

The Right to Receive Health Care

In many cases, lower courts have been unsympathetic to health-related challenges brought forward under section 7. In several recent cases, however, the courts have shown greater receptivity to the argument that section 7 guarantees access to care.

For example, in *Chaoulli* v. *Québec* (2000) the plaintiffs alleged that the lack of timely access to provincially insured health care services, coupled with legislative restrictions on access to private care, violated section 7. The Québec Superior Court found that the right to receive health care services was protected under section 7 and that the right to purchase full-coverage private health insurance or to contract privately for hospital services was also included. However, the Court found that limits on private health services would only violate section 7 where the public system was unable to effectively guarantee access to similar care.

The Right to Provide Health Care

The Supreme Court has concluded that section 7 protects the rights of human beings, and not of corporate or other non-human entities (*Irwin Toy* 1989). Institutional or corporate health care providers will therefore not be able to invoke section 7 to challenge governmental limits on their ability to provide health care services. In the case of individual health care providers, the potential of section 7 as a basis for challenging government regulation is also limited.

The Potential Implications of Fundamental Justice as a Standard for Health Care Decision-Making

If section 7 guaranteed an unqualified right to refuse, to receive or to provide health care services, the implications for health care spending would be enormous. However, the rights under section 7 are not absolute: only violations of the right to life, liberty and security of the person that do not conform with the principles of fundamental justice are objectionable.

In the individual treatment setting, fundamental justice can be met relatively easily by providing individual patients an opportunity to participate in decisions about their care. In the policy and regulatory setting, fundamental justice can be met by ensuring that decisions relating to the allocation of health care resources and services are publicly debated before they are implemented.

Aside from responding to procedural concerns, increased individual and collective participation in health care decision-making is also consistent with the more substantive dimensions of fundamental justice. In particular, the Supreme Court has referred to international treaties ratified by Canada, and *Charter* equality and other domestic human rights norms as sources of section 7 principles of fundamental justice.

The cost implications of section 7 principles of fundamental justice are mixed. On the cost side, a significant consequence of increasing due process in health care decision-making relates to the additional time required to make decisions. At the individual level, requiring health care providers to spend more time ensuring meaningful patient participation in health care decision-making will likely result in higher short-term costs. The requirements of fundamental justice may also mean that decision-making at the broader policy or regulatory level becomes more time-consuming, and therefore more costly.

In weighing the financial implications of fundamental justice as a standard for health care decision-making it is important to note, however, that while respecting due process may increase process-related costs at both the individual and broader regulatory level, such expenditures may be outweighed by the savings achieved through more effective health care decisions.

The Balancing of Individual and Collective Interests under Section 7 and Section 1

Section 1 provides an opportunity for governments to introduce considerations relating to the fiscal sustainability of the health care system into the analysis of whether violation of individual rights is permissible. However, because section 7 principles of fundamental justice and section 1 consider many of the same factors, such as the importance of the objective being pursued and the rationality of the measures that interfere with a *Charter* right, it is difficult to conceive of a situation in which a decision found to violate the principles of fundamental justice would nevertheless be upheld under section 1.

In the absence of any evidentiary basis, an allegation that a rights violation is justified because it furthers the public interest in containing health care costs is unlikely to succeed. Conversely, where it can be shown that a refusal to provide a particular health care service was made fairly, in light of all available evidence about its benefits, effectiveness and cost, and in light of competing health care priorities, the decision will likely be upheld.

Conclusion

Health care is a pre-eminent value in Canadian society. It therefore stands to reason that fundamental health related interests should be constitutionally recognized, and health care decisions that will have a significant adverse effect on human dignity, autonomy, and physical and psychological integrity should respect basic constitutional norms.

Requiring health care decision-making to become more inclusive and accountable may generate better decisions at the individual treatment level. At the broader regulatory and policy level, decision-making that is more equitable and rational may also be more cost effective. Seen from this perspective, the introduction of *Charter* values into the Canadian health care system is a positive development.

Introduction

Section 7 of the *Canadian Charter of Rights and Freedoms* provides that "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." With the Supreme Court of Canada's decision in *Eldridge* v. *British Columbia* (1997) the applicability of section 7, and of the *Charter* generally, in the health care context has expanded significantly (Jackman 2000). In the *Eldridge* case, the Court held that the actions not only of governments, but of hospitals and other non-governmental health care providers planning and delivering publicly funded health care services, are subject to *Charter* scrutiny. The *Eldridge* decision has generated renewed interest from legal and health care policy commentators alike in the possible impact of the *Charter* on the future direction of the Canadian health care system (Laverdière 1998/1999; Karr 2000; Von Tigerstrom 2002; Hartt and Monahan 2002; Manfredi and Maioni 2002). While the full parameters of section 7 have yet to be established, three principal questions emerge from the case law to date. These are, first, whether section 7 of the *Charter* guarantees a right to refuse unwanted health care; second, whether it establishes a right to receive care and; third, whether it guarantees the right to provide health care services. The answers to each of these questions have potential significance for health care spending. The following paper will examine the relevant case law in each of these areas in order to consider what this impact might be.

Part I of the paper will review the claim that section 7 guarantees the right to refuse unwanted health care. Part II will consider the argument that section 7 guarantees the right to receive health care. Part III will examine the claim that section 7 guarantees the right to provide health care services. Part IV will consider the potential impact of section 7 on health care spending in light of the requirement that decision-making respect the "principles of fundamental justice." Part V will consider the cost implications of section 7 in view of the recognition, under sections 7 and 1 of the *Charter*, that interferences with individual rights must be balanced against the interests of Canadian society generally.

I The Right to Refuse Health Care

Although the Supreme Court has only begun to address the issue of whether health or other welfare-related interests are protected under the *Charter*, the profound impact of health care decisions on an individual's right to "life, liberty, and security of the person" has been recognized in a number of cases. In *R*. v. *Morgentaler* (1988) the Court was called upon to assess the constitutionality of the therapeutic abortion provisions under section 251 of the *Criminal Code*. In his majority judgment, Chief Justice Dickson held that "forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person" (*Morgentaler* 1988, 56-57). He also concluded that delays faced by women seeking abortions, which increased the level of complication and risk in the procedure, amounted to an infringement of both the physical and psychological aspects of the right to security of the person (*Morgentaler* 1988, 60).

In her concurring judgment in *Morgentaler*, Justice Wilson agreed that the right to security of the person under section 7 protects an individual's physical and psychological security, and she noted that: "State enforced medical or surgical treatment comes readily to mind as an obvious invasion of physical integrity" (*Morgentaler* 1988, 173). Justice Wilson held that a pregnant woman's section 7 rights were violated by the therapeutic abortion provisions because the control exercised by the state over her reproductive capacity and choices "is not ... just a matter of interfering with her right to liberty in the sense ... of her right to personal autonomy in decision-making, it is a direct interference with her physical 'person' as well" (*Morgentaler* 1988, 173).

The Supreme Court's decision in *Rodriguez* v. *British Columbia* (1993) also has particular relevance in the health care context. At issue in the case was the constitutionality of the prohibition against assisted suicide under section 241 of the *Criminal Code*. In her dissenting opinion in the case, Justice McLachlin argued that the right to security of the person under section 7 of the *Charter* protects "the dignity and privacy of individuals with respect to decisions concerning their own body" and that "it is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body" (*Rodriguez* 1993, 618). In his majority decision, Justice Sopinka noted that "a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law" (*Rodriguez* 1993, 588). Justice Sopinka agreed with Justice McLachlin's conclusion that, by interfering with an individual's ability to make autonomous choices about his or her own bodily treatment, the prohibition on assisted suicide violated the right to security of the person under section 7 (*Rodriguez* 1993, 588-589).

In *B. (R.)* v. *Children's Aid Society of Metropolitan Toronto* (1995) the issue of whether section 7 guarantees the right to refuse unwanted medical treatment was raised indirectly. The appellants in the case challenged a wardship order under which the Children's Aid Society authorized blood transfusions for their infant daughter, against their religious beliefs as Jehovah's Witnesses. The appellants claimed that the wardship order and the child welfare legislation upon which it was based violated their right to parental liberty under section 7 of the *Charter*. In his judgment for a plurality of the Supreme Court, Justice LaForest found that

section 7 included the right to make fundamental personal decisions without interference from the state and, in particular, that "the right to nurture a child, to care for its development, and to make decisions for it in fundamental matters such as medical care, are part of the liberty interest of a parent" *(B.(R.)* 1995, 370). In their dissenting judgment in the case, Justices Cory, Iacobucci and Major held that "although an individual may refuse any medical procedures upon her own person" section 7 of the *Charter* does not give a parent the right to deny a medical treatment which is necessary to preserve the child's life or health *(B.(R.)* 1995, 432).

The question of whether section 7 provides a barrier against unwanted medical care was squarely addressed by the Ontario Court of Appeal in *Fleming* v. *Reid* (1991), a case dealing with the rights of involuntary psychiatric patients to refuse treatment. In reviewing the provisions of the Ontario *Mental Health Act*, which allowed the prior wishes of a mentally competent patient to be overridden by a government appointed review board, the Court of Appeal argued that:

> The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive (*Fleming* v. *Reid* 1991, 88).

The Court of Appeal went on to find that psychiatric patients do not, by reason of their mental illness, lose their section 7 right to be free from non-consensual invasions of their person, including the administration of unwanted drugs.

If the right to refuse health care is recognized as an aspect of the right to life, liberty and security of the person under section 7, it follows that decisions which impinge upon that right must respect the "principles of fundamental justice." An infringement of a section 7 right will offend the principles of fundamental justice if it violates "basic tenets of our legal system" (*Re B.C. Motor Vehicle Act* 1985, 503). These tenets "may be reflected in the common-law and statutory environment which exists outside of the *Charter*, they may be reflected in the specific and enumerated provisions of the *Charter*, or they may be more expansive than either of these" (*R.* v. *S. (R.J.)* 1995, para. 49). Principles of fundamental justice include those recognized both in domestic law and under international human rights conventions (*Re B.C. Motor Vehicle Act* 1985, 512; *United States* v. *Burns* 2001, paras. 79-81). As Justice Sopinka explained in *Rodriguez* (1993, 594), the principles of fundamental justice also require a balancing of the interest of the individual and the state: "where the deprivation of the right in question does little or nothing to enhance the state's interest ... a breach of fundamental justice will be made out. "

Thus, in Justice Dickson's view in *Morgentaler* (1988, 70), the arbitrariness, vagueness and unfairness of the decision-making and administrative procedures put in place by section 251 of the *Criminal Code*, including the failure to define the concept of "health", violated section 7 principles of fundamental justice. Justice Wilson found that section 251 violated the principles of fundamental justice because it interfered with other *Charter* guarantees, in particular with the

right to freedom of conscience under section 2 (*Morgentaler* 1988, 180). While, in *Rodriguez* (1993, 624), Justice McLachlin found that the prohibition on assisted suicide was arbitrary and therefore fundamentally unjust, Justice Sopinka held that the prohibition reflected the fundamental value of respect for the sanctity of life and thus accorded with the principles of fundamental justice (*Rodriguez* 1993, 608).

In *B. (R.)* (1995, 377), Justice LaForest found that, because the appellants were able to participate in the judicial proceedings in which the wardship determination in relation to their child was made, the principles of fundamental justice had been met. In *Fleming* v. *Reid* (1991), however, the inadequacies of the hearing process provided for under the Ontario *Mental Health Act* led the Court of Appeal to conclude that the principles of fundamental justice had been violated. In particular, the Court found that:

> A legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination to be defeated, without affording a hearing as to why the substitute consent-giver's decision to refuse consent based on the patient's wishes should not be honoured, in my opinion, violates "the basic tenets of our legal system" and cannot be in accordance with the principles of fundamental justice (*Fleming* v. *Reid* 1991, 93).

In summary, the Ontario Court of Appeal's decision in *Fleming* v. *Reid* (1991), that involuntary medical treatment infringes the right to liberty and security of the person, is consistent with the Supreme Court's interpretation of section 7 as a general guarantee against threats to, or interferences with, individual bodily integrity. In light of the reasoning in *Morgentaler* (1988), *Rodriguez* (1993), and *B.(R.)* (1995), it is probable that when this issue does come directly before it, the Supreme Court will confirm that section 7 guarantees the right to refuse unwanted medical treatment, and that any interference with this right must respect the principles of fundamental justice.

II The Right to Receive Health Care

While it seems clear that the right to refuse medical treatment is protected under the *Charter*, the issue of whether section 7 also guarantees a right to receive health care, and what the scope of such a right might be, remains to be resolved. In *Irwin Toy Ltd.* v. *Québec* (1989, 1003-1004), the Supreme Court expressly left open the possibility that "economic rights fundamental to human life or survival", such as the social and economic rights included under international human rights treaties ratified by Canada, might be protected under section 7. In his decision in *Rodriguez* (1993, 585), Justice Sopinka held that "security of the person is intrinsically concerned with the well-being of the living person." In discussing the scope of the right to security of the person in *Singh* v. *Canada* (1985), Justice Wilson cited the Law Reform Commission of Canada's assertion, in its working paper on *Medical Treatment and the Criminal Law* (1980, 6) that "the right to security of the person means not only protection of one's physical integrity, but the provision of necessaries for its support." Justice Wilson also referred to the Federal Court's decision in *Collin* v. *Lussier* (1983), in which the transfer of a federal inmate suffering from heart disease from a medium to a maximum security penitentiary, where emergency medical services were limited, was found to infringe the section 7 right to security of the person. In his judgment in the case, Justice Decary held that "increasing the applicant's anxiety as to his state of health, is likely to make his illness worse and, by depriving him of access to adequate medical care, is in fact an impairment of the security of his person" (*Collin* v. *Lussier* 1983, 239). Justice Wilson's subsequent judgment in *Stoffman* v. *Vancouver General Hospital* (1990, 544) underscored the fact that: "government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."

In many cases, however, lower courts have been unsympathetic to health-related challenges brought forward under section 7. Such claims have been rejected on the grounds that the legislative history of the *Charter* precludes recognition of "economic" rights of this kind, and that a reading of section 7 which recognizes individual rights to health would lead to unwarranted judicial interference in the health care system. For example, in *Ontario Nursing Home Association* v. *Ontario* (1990, 177), the Ontario High Court rejected the plaintiffs' argument that the level of provincial funding to nursing homes was inadequate and that this under-funding violated the residents' rights to security of the person, on the basis that section 7 does not deal with property rights, or guarantee "additional benefits which might enhance life, liberty or security of the person." Similarly, in *Brown* v. *British Columbia (Minister of Health)* (1990, 467-469), the British Columbia Supreme Court rejected the plaintiffs' challenge of the province's decision not to subsidize the costs of the AIDS drug AZT, on the grounds that section 7 did not protect against economic deprivations or guarantee benefits which might enhance life, liberty, or security of the person. And, in *Cameron* v. *Nova Scotia* (1999), which involved a challenge to Nova Scotia's failure to fund *in vitro* fertilization under the provincial health insurance plan, the Nova Scotia Supreme Court concluded that "finding the public funding of particular medical services to be considered an element of the right to life, liberty or security of the person would expand the parameters of judicial review, well beyond its present scope" (*Cameron* 1999, para. 160).

In three recent cases, however, the courts have shown greater receptivity to the claim that section 7 guarantees access to health care services. In *Sawatzky* v. *Riverview Health Centre Inc.* (1998) the Manitoba Court of Queen's Bench granted an interlocutory injunction preventing the Riverview Health Centre from imposing a "do not resuscitate" order on an elderly patient suffering from advanced Parkinson's disease and pneumonia, against his spouse's wishes, based in part on the argument that such an order might violate section 7 rights to life, liberty and security of the person. In *R*. v. *Parker* (2000), the Ontario Court of Appeal found that the *Criminal Code* prohibition on the possession and cultivation of marijuana violated the accused's section 7 right to liberty and security of the person because it prevented him from accessing marijuana as a medical treatment for his epilepsy. Justice Rosenberg found that, akin to the situation in *Fleming* v. *Reid* (1991), "the choice of medication to alleviate the effects of an illness with life-threatening consequences is a decision of fundamental personal importance" falling within the liberty interest protected under section 7 (*Parker* 2000, para. 102). In terms of the accused's right to security of the person, relying on the Supreme Court's reasoning in *Morgentaler* (1988) and *Rodriguez* (1993), Justice Rosenberg found that preventing the accused from using marijuana to treat his medical condition by threat of criminal prosecution constituted an unconstitutional interference with his physical and psychological integrity (*Parker* 2000, para. 110).

In the Québec Superior Court case of *Chaoulli* v. *Québec* (2000), the question of whether section 7 of the *Charter* creates an affirmative right to receive health care services was raised directly. The plaintiffs in *Chaoulli* alleged that the lack of timely access to provincially insured health care services, because of financial and human resource constraints within the public system, coupled with legislative restrictions on access to private care, amounted to a violation of the section 7 right to life, liberty and security of the person. In addressing the plaintiffs' claim, Justice Piché reviewed the evidence brought forward by the parties on the issue of the accessibility and efficiency of private *versus* public health care delivery systems. After examining the evidence at length, Justice Piché concluded that the development of a parallel private health care system would have deleterious effects on the existing public one. In this regard, she cited U.S. health economist Ted Marmor's testimony that:

> ... allowing private insurance to be available as an alternative to Medicare would have profound negative impacts on the public system rather than none as is assumed. It would not increase availability of services in the public sector or reduce waiting lists. Instead, it would divert resources from the publicly financed program to be available to private activities and it would increase total Canadian expenditures on health. It would also give those able to secure private coverage an advantage over others. (*Chaoulli* 2000, para. 107).

After reviewing Supreme Court case law on the scope of section 7, Justice Piché concluded that the Court had left the door open to recognizing economic rights intimately connected to life, liberty or personal security. In answer to the question whether access to health care services was such a right, she concluded in the affirmative. In Justice Piché's view: "s'il n'y a pas d'accès possible au système de santé, c'est illusoire de croire que les droits à la vie et à la sécurité sont respectés" [Translation: … if there is no access to the health care system, it is illusory to think that the rights to life and security are respected…] (*Chaoulli* 2000, para. 223). On the further question of whether the right to purchase full-coverage private health insurance or to contract

privately for hospital services, currently restricted under provincial health insurance legislation, was also protected under section 7, Justice Piché also found the answer was yes. To the extent that legislative restrictions on private insurance rendered private health care uneconomical, and access to private health care illusory, Justice Piché held that section 7 rights were affected. In her view, however, limits on access to private services would only violate section 7 where the public system was unable to effectively guarantee access to similar care: "Le Tribunal ne croit pas par contre qu'il puisse exister un droit constitutionnel de choisir la provenance de soins médicalement requis" [Translation: The Court does not think, however, that there is a constitutional right to choose where medically required health care will come from …] (*Chaoulli* 2000, para. 227).

On appeal, Justice Piché's decision was upheld by the Québec Court of Appeal in three concurring judgments (*Chaoulli* 2002). Justice Delisle found that access to publicly funded health care was a fundamental right under section 7. However, he held that the right to purchase private health insurance was an economic claim, which was not fundamental to human life, and which was not therefore protected under section 7 (*Chaoulli* 2002, para. 25). Justice Forget agreed with Justice Piché that, while the plaintiffs' health rights were threatened by the limits placed on private health services, the province's decision to favour the collective interest in the public health care system was in accordance with the principles of fundamental justice (*Chaoulli* 2002, para. 63). For his part, Justice Brossard found that the evidence failed to show that the statutory restrictions on private health care had in fact imperilled the plaintiffs' rights to life or health (*Chaoulli* 2002, para. 66).

As discussed in the context of unwanted medical treatment, once the right to receive health care is recognized as an aspect of the right to life, liberty and security of the person, measures limiting access to such care must respect the principles of fundamental justice. In *Collin* v. *Lussier* (1983), the Federal Court found that, by failing to provide the plaintiff with notice of the decision which would adversely affect his ability to receive medical treatment; by failing to provide him with an opportunity to make representations about his particular circumstances; and by failing to ensure that the relevant decision-making authority would render an impartial decision on the basis of all the evidence presented to it, the decision-making process at issue did not conform with the principles of fundamental justice (*Collin* v. *Lussier* 1983, 240). In *Parker* (2000), Justice Rosenberg found that the blanket prohibition on possession and cultivation of marijuana was contrary to the principles of fundamental justice for a number of reasons, including because it did little or nothing to promote state interests (*Parker* 2000, para. 144); because it was irrational in its adverse impact on the health of those affected; because it was inconsistent with the principle of the sanctity of life (*Parker* 2000, para. 137); and because, in Justice Rosenberg's view: "the right to make decisions that are of fundamental importance includes the choice of medication to alleviate the effects of an illness with life threatening consequences. It does not comport with principles of fundamental justice to subject that decision to unfettered ministerial discretion" (*Parker* 2000, para. 188).

In summary, while a number of lower courts have rejected the claim that section 7 guarantees the right to health services, others have seen access to health care as a necessary component of the right to life, liberty and security of the person. Where health care has been recognized as a section 7 right, decisions affecting access have been subject to scrutiny for conformity with the

principles of fundamental justice. Like in other section 7 contexts, the principles of fundamental justice applicable in the health care setting include due process guarantees, such as the requirement to provide the person whose health is at issue with an opportunity to be fully and fairly heard by an impartial decision-maker (*Collin* v. *Lussier* 1980). Fundamental justice has also been held to impose substantive requirements, such as respect for the principle of the sanctity of life (*Parker* 2000), and for domestic and international human rights guarantees (*Morgentaler* 1988). Finally, courts have balanced the interests of the individual claiming a right to receive health care services against the state interests involved in limiting access to such care (*Chaoulli* 2000; *Parker* 2000).

III The Right to Provide Health Care

A third issue raised by section 7 of the *Charter* is whether the right to life, liberty and security of the person guarantees the right to provide health care services. In its decision in *Irwin Toy* (1989, 1004), the Supreme Court held that section 7 protects the life, liberty and personal security of human beings, and not of corporate or other non-human entities. Based on a reading of the legislative history, the Court also rejected the argument that economic rights of a corporate or commercial nature are entitled to protection under section 7. Government control over the activities of institutional health care providers will be subject to constitutional scrutiny where it interferes with other *Charter* rights that corporations do enjoy, such as the right to freedom of commercial expression under section 2(b) (*Rocket* v. *Royal College of Dental Surgeons* 1990; Shirreff 2000). As discussed above, such limits may also be subject to *Charter* review where the section 7 rights of individual patients are directly affected. However, the Court's reasoning in *Irwin Toy* makes it clear that institutional or corporate health care providers will not be able to invoke section 7 to challenge governmental limits on their own ability to provide health care services (Jackman 1995).

In the case of individual health care providers, the *Charter's* potential as a basis for challenging government regulation and control also appears to be limited. In *Wilson* v. *British Columbia (Medical Services Commission)* (1988), the appellant physicians challenged the validity of the British Columbia *Medical Services Act Regulations* which enabled the province to restrict the types and geographic locations of doctors' practices covered by the provincial health insurance plan, through the allocation of practitioner billing numbers. In its decision in the case, the British Columbia Court of Appeal invalidated the regulations on the grounds that "denying doctors the opportunity to pursue their profession falls within the rubric of "liberty" as that word is used in section 7" (*Wilson* 1988, 189). In response to the suggestion that the appellants' claim involved a purely economic interest, the Court of Appeal maintained that: "denial of the right to participate under the plan is not the denial of a purely economic right, but in reality is a denial of the right of the appellants to practise their chosen profession within British Columbia" (*Wilson* 1988, 187).

The soundness of the Court of Appeal's conclusion in *Wilson* was put into serious doubt by Justice Lamer's concurring judgment in *Reference Re the Criminal Code* (1990). In his decision, Justice Lamer held that while the non-economic or non-pecuniary aspects of work are important to the individual, the rights under section 7 do not include the right to exercise one's chosen profession (*Reference Re the Criminal Code* 1990, 1179). On the basis of Justice Lamer's reasoning, government restrictions on the activities of individual health care providers, including on the ability of physicians or other health care professionals to provide health care services, would not be subject to section 7 review.

In several recent decisions, lower courts have taken the view that the *Wilson* (1988) decision has been overturned by the Supreme Court. In *Waldman* v. *British Columbia* (1999), the appellant physicians challenged a series of post-*Wilson* billing restrictions imposed by the British Columbia Medical Services Commission to control the number and distribution of physicians within the province. The British Columbia Court of Appeal upheld the trial court's conclusion that *Wilson* (1988) had been overruled, and that while physicians' interprovincial

mobility rights under section 6 of the *Charter* were affected, section 7 had no application in the case (*Waldman* 1997, para. 293; *Waldman* 1999, para. 52). In *Rombaut* v. *New Brunswick* (2001) the New Brunswick Court of Appeal rejected the plaintiff's attempts to distinguish the *Wilson* (1988) case, and concluded that a provincial plan designed to regulate the number and distribution of physicians in the province by controlling billing numbers did not engage physicians' liberty or other section 7 rights (*Rombaut* 2001, para. 104). Justice Piché came to a similar decision in *Chaoulli* (2000), that section 7 did not guarantee physicians' rights to provide health care services. In this regard, she asserted: "l'article 7 de la *Charte* ne protège pas le droit d'un médecin d'exercer sa profession sans contrainte dans le domaine privé. Ceci est un droit purement économique" [Translation: … section 7 of the *Charter* does not protect physicians' right to practice their profession without constraint in the private domain. This is a purely economic right …] (*Chaoulli* 2000, para. 226).

This case law suggests that the likelihood of individual health care providers being able to successfully claim a section 7 right to provide health care services, within or outside the publicly funded system, is doubtful, inasmuch as government control over the supply of health care services has been characterized by the courts as affecting economic interests which fall outside the scope of section 7.

IV The Potential Implications of Fundamental Justice as a Standard for Health Care Decision-Making

If section 7 guaranteed an unqualified right to refuse, to receive or to provide health care services, the implications for health care spending would be enormous. However, as discussed above, the rights under section 7 are not absolute. It is not every interference with the right to life, liberty or security of the person that is objectionable, but rather those violations that do not conform with the principles of fundamental justice. As outlined in the preceding section of the paper, the principles of fundamental justice identified by the courts are both procedural and substantive in nature. At the due process level, the case law (*Collin* v. *Lussier* 1983; *Singh* 1985; *Morgentaler* 1988) suggests that decisions which are likely to have a significant impact on an individual's health will fail section 7 scrutiny unless certain procedural safeguards are provided. These safeguards include the right to adequate notice of a decision, the right to respond, and the right to be heard by a fair and impartial decision-maker. Such due process guarantees are designed to ensure not only that the decision-maker has all the information needed to make an accurate and appropriate decision, but also that the decision-making process itself respects the dignity and autonomy of the person whose life, liberty or security is at stake.

An individual whose health rights are threatened, either by non-consensual treatment or because he or she is being denied care, would therefore have the right to know that a treatment decision was being made, and on what basis. He or she would have the right to discuss the treatment decision with the person responsible for making it; to understand and assess all the available treatment options; and to convey his or her particular priorities and concerns. A person whose health was at risk would have the right to fairness and open-mindedness on the part of the ultimate decision-maker. It would have to be shown that any decision made was not the result of inadequate or arbitrary standards, and that the standards that did exist were not applied in an irrational or unfair way. In short, the principles of fundamental justice would require physicians and other health care providers not only to state what treatments were being offered and their attendant risks, but to treat patients as active participants in their own care.

In order to effectively protect the life, liberty and security interests at issue in health care decision-making, however, respect for the principles of fundamental justice would have to extend beyond the individual treatment setting. Otherwise, the entire burden of ensuring *Charter* compliance would be placed on those most immediately and directly dependent upon the health care system and the decision-makers operating within it. Limiting the requirements of fundamental justice to individualized decision-making would also fail to address the fact that primary care decisions are frequently the product of resource allocation and other considerations beyond health care providers' immediate control (Caulfield 1994). A person whose health is threatened by an individualized treatment decision has the right to participate in the decision-making process. As the reasoning in *Singh* (1985) and *Morgentaler* (1988) suggests, where a more general health care policy or regulatory decision threatens to have a similar impact on life, liberty and personal security, but on a larger scale, the same due process requirements should apply (Jackman 1995/1996; Canadian Bar Association 1994).

Thus, when governments or other publicly funded health care providers make policy or regulatory decisions affecting the allocation of health care resources and services, they should ensure that those whose fundamental interests are at risk are adequately involved. As in the individualized treatment setting, in order for regulatory decisions that adversely affect health-related interests to be characterized as fundamentally just within the meaning of section 7, decision-making must become more inclusive and accountable. In the individualized service delivery setting, due process requirements can be met relatively easily by providing an opportunity for individual patients to participate in decisions about their care on a case-by-case basis. In the policy and regulatory setting, due process can be met by ensuring that decisions relating to the allocation of health care resources and services are publicly debated before they are put in place.

Possible mechanisms for securing collective input into health policy-making include public hearings and other forms of public consultation. Public consultation should extend to such matters as the restructuring of delivery models; the development of treatment criteria; the design of cost-containment and rationing mechanisms; the elaboration of practice guidelines; the design and implementation of consent-to-treatment standards; and the listing and de-listing of services under public health insurance plans. Alternative mechanisms for broadening participation in decision-making might include better dissemination of information; effective public, patient and advocacy group representation on health policy decision-making bodies, whether at the governmental or service delivery levels; and greater decentralization of decision-making (Abelson, Forest, Eyles et al. 2002).

Aside from responding to concerns at a procedural level, increased individual and collective participation in health care decision-making is also consistent with the more substantive dimensions of fundamental justice identified by the Supreme Court. In particular, the Court has referred to international human rights treaties ratified by Canada as a source of section 7 principles of fundamental justice (*Re B.C. Motor Vehicle Act* 1985; *United States* v. *Burns* 2001). Over the past 50 years, Canada has assumed extensive international obligations to protect and promote individual health and welfare, and to ensure universal access to health care services in the event of illness (Von Tigerstrom, 2002). These international health-related rights have not been directly incorporated into Canadian law, and so cannot be claimed at the domestic level. However, the Supreme Court has held that Canada's international human rights obligations are a clear source of guidance in interpreting not only the Charter, but federal and provincial laws and policies (*Baker* 1999).

Of particular force, article 25(1) of the *Universal Declaration of Human Rights* (1948), adopted by Canada along with other members of the United Nations General Assembly, provides that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including ... medical care." Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* (1966) (*ICESCR*), ratified by Canada in 1976 after lengthy discussions with the provinces, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." And Article 12(2)(d) of the *ICESCR* sets out States Parties obligations to take all steps necessary for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The *International Convention on the Elimination of all Forms of Racial Discrimination* (1969), the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979), the *Convention on the Rights of the Child* (1989), and more recent international agreements such as the *Vienna Declaration* and *Programme of Action* (1993), all contain anti-discrimination and other substantive provisions designed to ensure that the health rights recognized under the *Universal Declaration* and the *ICESCR* are enjoyed equally by all members of society, including the most vulnerable (Sholzberg-Gray 1999; Von Tigerstrom 2002). Given the status and scope of the right to health at the international level (Toebes 1999), and Canada's clear international treaty obligations in this area, a failure to recognize and protect individual and collective rights to participate in health care decision-making at the domestic level would not conform with section 7 principles of fundamental justice.

Respect for other Canadian *Charter* and domestic human rights norms has also been identified by the Supreme Court as a requirement of fundamental justice (*Morgentaler* 1988). Of special significance in the health law context are the substantive equality principles set out under section 15 of the *Charter*, and under federal and provincial human rights laws. As discussed below in relation to *Eldridge* v. *British Columbia* (1997), health care decision-making which has a disparate impact on the basis of gender, race, disability or other prohibited grounds of discrimination will violate principles of fundamental justice, whether or not the discriminatory effects were intentional. In the individual treatment context, for example, compelled medical treatment of a pregnant woman in the interests of her foetus would clearly offend the principles of fundamental justice on sex equality grounds (Jackman 1993; Rogers 2002). Similarly, limiting eligibility for treatment on the basis of gender (*J.C.* v. *Forensic Psychiatric Service Commissioner* 1992), disability (*Cameron* 1999a), or age (Canadian Bar Association 1994, 59; Gilmore 2002) would constitute a fundamentally unjust deprivation of section 7 rights.

At the broader policy or regulatory level, whatever the mechanisms adopted to increase public participation in health related decision-making, the principles of fundamental justice would require that affirmative steps be taken to guarantee the representation of historically disadvantaged groups, such as aboriginal people (Royal Commission on Aboriginal Peoples 1995, 247-60) and people living in poverty (Swanson 2001; Raphael 2001), who are lacking in resources and influence, and do not have a history of inclusion in health care decision-making. Such additional measures are necessary to ensure that increasing collective participation in decision-making actually results in a more equitable distribution of decision-making authority and health care resources, and doesn't simply reinforce existing decision-making patterns and structures which are inconsistent with equality rights principles (Abelson, Forest, Eyles et al. 2002, 72).

Assessed in light of these broader procedural and substantive concerns, the cost implications of section 7 principles of fundamental justice are mixed. On the cost side, a significant consequence of increasing due process in health care decision-making relates to the additional time that is required to make decisions. At the individual level, most health care treatment decisions are made by physicians whose time is expensive, in both opportunity and dollar terms. While physicians must currently meet private law standards of informed consent (Caulfield 2002), requiring them to spend more time ensuring meaningful patient participation in

health care decision-making will likely result in higher short-term costs to the health care system. To fully inform and involve patients in decision-making around their own care, other types of health care expertise may also be required, for example, to provide counselling or to educate patients about non-medical or non-traditional treatment options about which physicians have limited knowledge or interest (Haigh 1999). Expanding the nature and scope of patient interaction with a wider range of health care providers may also result in additional costs.

The requirements of fundamental justice may also mean that decision-making at the broader policy or regulatory level becomes more time-consuming, and therefore more costly. An example of this is provided in the facts of the *Eldridge* case (1997). The appellants in *Eldridge* were Deaf residents of British Columbia who had all experienced problems within the provincial health care system because of their inability to communicate with health care providers in the absence of sign language interpretation services. For example, one of the appellants underwent an emergency caesarean delivery without the attending medical and nursing staff being able to communicate with her because interpretation services were not available in the hospital. In 1990, a non-profit agency that had been providing free medical interpretation in the lower mainland applied to the B.C. Ministry of Health for funding necessary to continue the service. Following a brief discussion, the Ministry's Executive Committee turned down the funding request on the summary explanation, set out in an internal Ministry memorandum, that: "it was felt [that] to fund this particular request would set a precedent that might be followed up by further requests from the ethnic communities where the language barrier might also be a factor" (*Eldridge* 1992, para. 75). Given the centrality of effective communication to the delivery of health care services, the Supreme Court concluded that the province's failure to provide interpretation services denied the Deaf equal benefit of the law relative to the hearing, in violation of section 15 of the *Charter* (*Eldridge* 1997, para. 80).

Apart from its discriminatory character, the Ministry of Health's refusal to fund interpretation services in the *Eldridge* case was also deficient in terms of section 7 principles of fundamental justice. The decision was taken without any meaningful input from those whose life, liberty and security was directly affected: Deaf residents of the province who were unable to communicate with health care providers in the absence of interpretation services. The refusal to fund medical interpretation services was not based on any evidence presented to the Executive Committee, but rather on factors totally unrelated to the health care needs of the Deaf. Finally, there was no opportunity for those affected to address the Committee's concerns either before or after the decision was made. In each of these regards, the decision-making structure in *Eldridge* violated the due process requirements of section 7. To remedy these deficiencies, a more inclusive and accountable process would have been required. By increasing the time required for each funding decision, reforming the decision-making process in *Eldridge*, like the procedure for insuring and de-insuring health care services in other provinces, would likely have meant increased expenditures.

In weighing the financial implications of fundamental justice as a standard for health care decision-making it is important to note, however, that while respecting due process may increase process-related costs at both the individual and broader regulatory level, such expenditures may be outweighed by the savings achieved through more effective health care decisions. At the collective level, a lack of inclusiveness and accountability in decision-making may lead to

irrational and ineffective spending. For example, in *Eldridge* the Ministry of Health was unable to provide any evidence that its refusal to fund interpretation services, at a projected cost of $150,000 a year or 0.0025% of the provincial health care budget (*Eldridge* 1997, para. 87), was economically rational. The appellants raised the question whether, by forcing Deaf patients to make longer and more frequent visits to doctors and hospitals in the absence of interpretation services, and in view of the mis- or delayed diagnoses of health conditions likely to result from the inability of Deaf patients to communicate effectively with health care providers, the actual costs to the public health care system of the refusal to fund interpretation services may have been much greater than any purported savings.

In *Auton* v. *British Columbia* (2000), the British Columbia Supreme Court came to the same conclusion with respect to the provincial Ministry of Health's refusal to fund autism treatment for children as a medically insured service. Having concluded that the failure to provide effective health treatment for autistic children was discriminatory on the basis of mental disability, Justice Allan considered the province's section 1 argument that health care funds were limited, and that providing treatment for autistic children would divert resources away from other health care priorities. In light of the evidence presented, Justice Allan concluded that: "it is apparent that the costs incurred in paying for effective treatment of autism may well be more than offset by the savings achieved by assisting autistic children to develop their educational and societal potential rather than dooming them to a life of isolation and institutionalization" (*Auton* 2000, para. 147). On that basis, Justice Allan found that the violation of the rights of children deprived of autism treatment could not be justified under section 1.

Similarly, at an individual level, where patients are more fully informed and involved in health care decisions, they and the health care providers advising them may make better and more effective long-term treatment choices. In some cases, this may result in additional treatment being requested, with the associated increase in health care expenditures. However, in other cases, greater information and patient involvement may result in the choice of less costly alternative treatments, or in the choice not to be treated at all (Haigh 1999; Royal Commission on New Reproductive Technologies 1993, 94-95). Providing patients with a meaningful opportunity not only to decide what treatments they want, but to decide against receiving any treatment at all, is particularly important at the end of life (Canada Senate 2002). A decision to terminate treatment against a patient's wishes, such as was at issue in the *Sawatzky* (1998) case, must clearly respect all procedural and substantive requirements of fundamental justice. However, as the facts of the *Rodriguez* (1993) and *Nancy B.* (1992) cases illustrate, life-prolonging treatment may not always be consistent with the patient's own interests and wishes. While health care providers may feel an imperative to treat in order to prolong life, patients who are fully informed of their health status and prognosis and who are given a meaningful opportunity to direct their own care, may make different choices. Irrespective of any financial considerations, as the Supreme Court underscored in *Rodriguez* (1993), ensuring an individual's full and informed involvement is equally, if not more, important to human dignity and autonomy in end of life decision-making as it is in other health care contexts (Sneiderman 2002; Manitoba Law Reform Commission 2002).

In summary, decisions within the health care system that impinge upon individual life, liberty and security, including the threat of non-consensual treatment or the denial of care, must respect the principles of fundamental justice. Decisions which are procedurally defective, or which offend the substantive principles of fundamental justice reflected in domestic and international equality and other basic legal norms, will fail a section 7 review. As outlined above, respecting the procedural and substantive requirements of fundamental justice may result in higher immediate costs to the health care system, because of the increased time required for health care decision-making and because additional treatments may be made available. However, to the extent that more rational and effective health care decisions are made, increased participation and accountability may also lead to reductions in spending, both within and beyond the health care system.

V The Balancing of Individual and Collective Interests under Section 7 and Section 1

In *Rodriguez* (1993, 594-95), Justice Sopinka held that, in order to determine whether a violation of the right to life, liberty and security of the person conformed with the principles of fundamental justice under section 7, the interests of the individual had to be balanced against those of the state. As Justice LaForest expressed it in *Godbout* v. *Longueuil* (1997 p. 900), the idea that "individual rights may, in some circumstances, be subordinated to substantial and compelling collective interests" is a basic tenet of our legal system. In *Chaoulli* (2000), having found that section 7 guarantees a right to health care services, and that the right to life, liberty and security of the person was affected by provincial statutory restrictions on access to private care, Justice Piché went on to consider whether such measures were in conformity with the principles of fundamental justice. Applying the balancing of interests test articulated by Justice Sopinka (*Rodriguez* 1993), Justice Piché pointed out that the provincial health insurance legislation was designed to create and maintain a public health care system, universally accessible to all residents of the province without barriers related to individual economic circumstances, and that restrictions on private care were put in place to prevent a transfer of resources out of the public system (*Chaoulli* 2000, para. 259). As she explained:

> La preuve a montré que le droit d'avoir recours à un système parallèle privé de soins, invoqué par les requérants, aurait des répercussions sur les droits de l'ensemble de la population ... L'établissement d'un système de santé parallèle privé aurait pour effet de menacer l'intégrité, le bon fonctionnement ainsi que la viabilité du système public. Les articles [contestés] empêchent cette éventualité et garantissent l'existence d'un système de santé public de qualité au Québec (*Chaoulli* 2000, para. 263).
>
> [Translation: The evidence has shown that the right, claimed by the plaintiffs, to use a parallel, private health care system would have repercussions on the rights of the general population … The creation of a parallel, private health care system would threaten the integrity, proper operation and viability of the public system. The (challenged) sections prevent such an occurrence and guarantee the existence of a quality, public health care system in Quebec].

This balancing of interests in favour of the collective benefit to all residents of the province of preserving a viable and effective public health care system, Justice Piché found, was in conformity with the principles of fundamental justice: "le gouvernement limite les droits de quelques-uns pour assurer que les droits de l'ensemble des citoyens de la société ne soient pas brimés" [Translation: … government restricts the rights of a few to ensure that there is no interference with the rights of all citizens …] (*Chaoulli* 2002, para. 262). Thus, restrictions on access to private health care under provincial health insurance legislation did not, Justice Piché concluded, violate section 7.

The balancing exercise that the courts have engaged in at the fundamental justice stage of section 7 analysis is similar to what is required under section 1 of the *Charter*. Section 1 provides that the *Charter* "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." In *R.* v. *Oakes* (1986), the Supreme Court proposed a framework for deciding whether an

infringement of an individual right can be justified under section 1. First, the government must show that the objective in violating the individual rights is "pressing and substantial." Second, it must show that the means adopted to achieve this objective are "proportionate" in the sense of being rationally connected to their objective; of impairing the individual right as little as possible; and of producing benefits to society that outweigh the harm to the rights of the individual.

Section 1 provides an additional opportunity for governments and other health care providers to introduce considerations relating to the cost of health care services, and the fiscal sustainability of the health care system, into the analysis of whether the violation of individual rights is constitutionally permissible. In *Cameron* (1999a), for example, the Nova Scotia Court of Appeal accepted the province's argument that its failure to fund *in vitro* fertilization (IVF) and *intra* cytoplasmic sperm injection (ICSI) as a treatment for infertility, was justified in view of the severe financial constraints facing the provincial health care system. Justice Chipman accepted the government's evidence that, having regard to the costs, the limited success rate and the risks of IVF and ICSI, they were not yet ready to be accepted as insured services. Justice Chipman concluded that:

> The evidence makes clear that the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims ...The policy makers require latitude in balancing competing interests in the constrained financial environment ... We should not second guess them, except in clear cases of failure on their part to properly balance the Charter rights of individuals against the overall pressing objective of the scheme under the Act (*Cameron* 1999a, para. 234, 236).

In *Eldridge* (1997), however, the province was unsuccessful in arguing that its actions were justified in view of the multiple competing demands it faced for scarce health care resources. Assuming, without deciding, that the province had shown that its refusal to fund medical interpretation services for the Deaf was rationally connected to an important objective of controlling health care expenditures, Justice LaForest found that the denial of interpretation services was not a minimal impairment of the equality rights of the Deaf. In coming to this decision, Justice LaForest pointed to the modest sum required to provide such services as a proportion to the total provincial health care budget, and the fact that the Ministry had failed to consider any other alternative that would have constituted a lesser limitation on Deaf persons' rights. Justice LaForest also rejected the province's argument that, if compelled to fund interpretation services for the Deaf, they would be required to provide interpreters for non-English speakers, thereby severely straining the fiscal sustainability of the provincial health care system. Justice LaForest characterized this claim as speculative, given the province's failure to provide any evidence of the potential cost and scope of providing oral language interpretation services, in the event they were found to be constitutionally mandated (*Eldridge* 1997, para. 87-93). In concluding that the province's refusal to fund interpretation services could not be justified under section 1, Justice LaForest asserted:

> The evidence clearly demonstrates that, as a class, deaf persons receive medical services that are inferior to those received by the hearing population. Given the central place of good health in the quality of life of all persons in our society, the provision of

> substandard medical services to the deaf necessarily diminishes the overall quality of their lives. The government has simply not demonstrated that this unpropitious state of affairs must be tolerated in order to achieve the objective of limiting health care expenditures (*Eldridge* 1997, para. 94).

The Supreme Court has underlined that administrative convenience (*Singh* 1985) and the government's desire to save money (*Schachter* v. *Canada* 1992, 709) are not sufficient grounds for justifying a rights violation under section 1. Rather, it has held that the cost of respecting a *Charter* right is relevant at the remedial stage. As Chief Justice Lamer expressed it in *Schachter* (1992, 709): "Any remedy granted by a court will have some budgetary repercussions ... the question is not whether courts can make decisions that impact on budgetary policy; it is to what degree they can appropriately do so." Where cost is a significant consideration, the Court has shown considerable deference to the legislature in its choice of how to remedy the rights violation at issue. Even in *Eldridge* (1997), where the financial implications of its decision were held to be relatively modest, the Supreme Court did not order specific remedial measures, but instead issued a declaration that the province's failure to provide sign language interpretation for the Deaf was unconstitutional. As Justice LaForest explained: "A declaration, as opposed to some kind of injunctive relief, is the appropriate remedy in this case because there are myriad options available to the government that may rectify the unconstitutionality of the current system. It is not this Court's role to dictate how this is to be accomplished" (*Eldridge* 1997, para. 96). The Court also suspended its declaratory order for six months, with a further extension of twelve months, to allow the province time to formulate an appropriate response.

In principle, section 1 provides an opportunity for governments and other publicly funded health care providers to defend health care decisions that interfere with section 7 rights. However, because the section 7 principles of fundamental justice identified by the courts and the *Oakes* standard of section 1 review consider many of the same factors, such as the importance of the objective being pursued and the rationality of the measures which interfere with a *Charter* right, it is difficult to conceive of a situation in which a decision found to violate the principles of fundamental justice would nevertheless be upheld under section 1 (Hartt and Monahan 2002, 24-25). Both section 1 and the procedural and substantive requirements of fundamental justice obligate decision-makers to explain and justify their objectives and the means chosen to achieve them, in a principled way, supported by evidence. In the absence of any evidentiary basis, an allegation that a decision which violates individual rights is justified, because it furthers pressing public interests in the containment of health care costs, is unlikely to succeed (*Eldridge* 1997; *Auton* 2000). Conversely, where it can be shown that a refusal to provide a particular health care treatment or service was made carefully and fairly, in light of all available evidence about its benefits, effectiveness and cost, and in light of competing health care priorities and objectives, the decision is likely to be upheld (*Cameron* 1999a; *Chaoulli* 2000).

Conclusion

Health care is a pre-eminent value in Canadian society. It therefore stands to reason that fundamental health-related interests should be constitutionally recognized, and that health care decisions which are likely to have a significant adverse effect on human dignity, autonomy, and physical and psychological integrity should respect basic constitutional norms. Canadian courts have begun to recognize the right to refuse non-consensual treatment and the right to receive health care as aspects of the right to life, liberty and security of the person under section 7 of the *Charter*, and to hold that decisions impinging upon these rights must conform with the principles of fundamental justice. In determining whether these principles have been met, the courts have considered both procedural and substantive concerns, including respect for fairness and due process and compliance with Canada's equality rights and other domestic and international human rights obligations in relation to health. The courts have also found that the decision whether the right to life, liberty and security has been violated requires a balancing of individual and societal interests, in accordance with section 7 principles of fundamental justice, and under section 1.

As suggested in the preceding section of the paper, the cost implications of recognizing and protecting health related rights under section 7 of the *Charter* are mixed. One the one hand, the obligation to respect principles of fundamental justice will likely increase process-related costs of health care decision-making. To the extent that the refusal to provide health care cannot be shown to be fundamentally just, increased spending may also be needed. However, requiring health care decision-making to become more inclusive and accountable may generate better decisions at both the individual treatment and broader regulatory levels. As the facts of the *Eldridge* (1997) case illustrate, decision-making that is more equitable and rational may also be more cost effective in the immediate and longer term. Seen from this perspective, rather than a source of concern, the introduction of *Charter* values and principles into the Canadian health care system is a positive development. Given the fundamental importance of health care to individual well-being and to the welfare of society as a whole, Canadians should be confident that health care decision-making respects basic constitutional values and, in particular, the values of security, dignity and equality which are at the heart of the Canadian health care system.

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