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COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	Calgary
APPLICANT	**Darcy Allen**
RESPONDENT	**Her Majesty the Queen in right of Alberta**
DOCUMENT	**BRIEF**

Clerk's Stamp

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BRIEF of MINISTER OF JUSTICE and SOLICITOR GENERAL and ATTORNEY GENERAL

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I. INTRODUCTION

1. This Application raises novel issues of law under s.7 of the Canadian *Charter of Rights and Freedoms* (*Charter*):

(i) Can delays experienced in waiting for medical treatment support a claim for a breach of s.7 *Charter* rights to security of the person? If so, under what conditions?

(ii) Can a publicly funded health care program be recognized as a principle of fundamental justice under s.7 of the *Charter*?

To date the s.7 *Charter* right to security of the person has been recognized where physical and psychological harm has been caused by state interference in the adjudicative context or one involved in the administration of justice. A publicly funded health care system falls outside this context. In addition, to date "principles of fundamental justice" have been interpreted as comprised of legal principles that are vital to our societal notion of justice and capable of being identified with precision and applied with predictable results. A publicly funded health care program falls outside this criteria.

2. In the spring of 2008 Darcy Allen (the Applicant) experienced lower back pain which he attributes to a hockey injury he suffered on December 23, 2007. His pain progressed over time as did his treatment and pain management in response. This consisted of over-the-counter pain medications in the spring and summer of 2008 followed by prescription pain medication, physiotherapy and acupuncture treatment in the fall of 2008. In September 2008 the Applicant paid for an MRI which he shared with his doctor. In December 2008 his doctor referred the Applicant to a specialist. The Applicant consulted with a specialist in February 2009 and received prescription pain medication and Facet Injections in February and April 2009. In May, 2009, his specialist recommended a discogram, which the specialist required before booking surgery. The Applicant received the discogram in September 2009 and was then scheduled for back surgery in September 2010. However, due to a cancellation, he was offered a date in December 2009. As it turns out this date was cancelled by the specialist due to a family funeral. The Applicant then proceeded with surgery out-of-country on December 18, 2009. He never applied for out-of-country funding for his surgery because he satisfied himself, after inquiries made to the department of Alberta Health and his own reading of the *Out-of-Country Health Services Regulation*, Alberta Regulation (AR) 78/2006, that he would not be approved.

3. The Applicant seeks a declaration that his right to security of the person under s.7 of the *Charter* has been breached. He claims that he suffered physical and psychological pain due to delays he experienced in receiving medical treatment, which were caused by two pieces of legislation acting together: the *Out-of-Country Health Services* Regulation and the prohibition on private insurance found in s.26(2) of *the Alberta Health Insurance Act*. He relies on the Supreme Court of Canada's 2005 decision in *Chaoulli* v. *Quebec (Attorney General)*[1] as support for his position. This decision was based on the Quebec *Charter*. The Applicant seeks a similar outcome under the Canadian *Charter*. He seeks as remedies:

(i) Pursuant to s.24(1) of the *Charter,* a declaration that his s.7 *Charter* rights have been infringed, and, judicial permission to commence a legal action to prove damages.

(ii) In the alternative a declaration that the impugned legislation is of no force and effect under s.52 of the *Charter*.

4. The Minister of Justice and Solicitor General and Attorney General of Alberta (Alberta) intervenes as of right pursuant to section 24(4) of the *Judicature Act*, RSA 2000, c. J-2, as amended. Alberta responds that this application cannot succeed for the following reasons:

(i) The Applicant never applied for out-of-country funding as provided by the OOCHS Regulation. Accordingly there is no causal link between the OOCHS Regulation of his alleged breach of security of the person.

(ii) The Applicant has not proved on a balance of probabilities that the prohibition on private insurance caused his alleged breach of security of the person. Without evidence the Court is in effect being asked to assume that private health care insurance would in fact eliminate wait times.

(iii) No principle of fundamental justice is engaged. Public health care is a social program and does not fall within the three formal requirements of "fundamental justice"; a legal principle on which there is societal consensus vital to justice that is can be identified with precision.

[1] [2005] 1 S.C.R. 791, 2005 CarswellQue 3276

II. IMPUGNED LEGISLATION

5. The Impugned Legislation consists of s.26(2) of the *Alberta Health Care Insurance Act*, R.S.A. 2000, c.A-20, as amended (AHCIA), as well as the *Out-of-Country Health Services Regulation*, Alberta Regulation (AR) 78/2006, (OOCHS Regulation).

6. Section 26(2) AHCIA:

> (2) An insurer shall not enter into, issue, maintain in force or renew a contract or initiate a self-insurance plan under which any resident or group of residents are provided with any prepaid basic health services or extended health servicesor indemnification for all or part of the cost of any basic health services or extended health services

Section 1(2) and 2(1) of the OOCHS Regulation:

> For the purposes of this Regulation, a service is available in Canada if a resident could have obtained the service in Canada within the time period generally accepted as reasonable by the medical or dental profession for any resident with a similar condition.
>
> 2(1) Subject to subsections (2) and (3), an application may be made to the OOCHS for approval of the payment of expenses with respect to insured services or insured hospital services received outside of Canada, where the resident of the resident's dependent has endeavoured to receive the services in Canada and the services are not available in Canada.

7. The *Charter*, sections 7, 1, 24(1) and 52:

> s.7 Everyone has the right to life, liberty and security of the person and right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> s.1 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.
>
> s.24(1) Anyone whose rights or freedoms, as guaranteed by this *Charter*, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.
>
> s.52(1) The *Constitution* of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the *Constitution* is, to the extent of the inconsistency, of no force or effect.

8. *Charter* principles relevant to this proceeding include the following:

- The Applicant bears the burden of proof that legislation violates his/her *Charter* rights;[2]
- The burden of proof is on a balance of probabilities;

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[2] *Chaoulli v. Quebec (A.G.)*, at paragraph 30

- The State bears the burden of justifying the *Charter* breach as reasonable and justifiable under s. 1;
- The s.7 *Charter* burden is two-fold: there must be both a violation of the right to life, liberty, or security of the person, and, this violation must breach the principles of fundamental justice;[3]
- There must be a direct and significant connection between the state action and the harm done;
- The further a challenged state action lies from the traditional adjudicative context, the more difficult it will be for a claimant to identify a violation of a principle of fundamental justice;
- *Charter* rights must be analyzed in context, including the legislation and historical background.

9. The context relevant to this proceeding includes (i) the federal health care legislation, (ii) the Alberta Health Care legislation, (iii) the development of the Alberta Out-of-Country Health Services funding scheme, including the independent Ombudsman's report on this scheme; (iv) and the wait time initiatives implemented since the Supreme Court's decision in *Chaoulli*.

III. LEGISLATIVE CONTEXT

10. Health care is predominantly a matter falling within provincial jurisdiction.[4] However, the federal government exerts influence over provincial governments in the health care services sphere by means of its spending power established through the *Canada Health Act*, R.S.C. 1985, c. C-6 (CHA). The CHA establishes the federal health contribution which is provided to a province by the federal government. In order to receive a full federal cash contribution provincial plans must conform to the five principles set out in CHA as well as prohibiting user charges and extra billing. These five principles include the requirements for a provincial plan to be:

- publicly administered;
- comprehensive;
- universal;
- portable from one province to another; and,
- accessible to insured persons.

11. The CHA defines "insured person" as a resident of the province other than a member of the Canadian Forces, a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or a resident of a province who has not completed such minimum period of

[3] *Chaoulli v. Quebec (A.G.)*, at paragraph 29
[4] Matters of a local or private nature, s.92(16); property and civil rights, s.92(13); the establishment of hospitals, asylums, charities and eleemosynary institutions,

residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services.

12. For the purposes of the CHA, "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons. Insured health services do not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation. Health services provided pursuant to worker's compensation schemes are therefore not considered to be insured health services for the purposes of a provincial health care plan, and similarly for the federal cash contributions under the CHA.

13. Those hospital services, physician services and surgical-dental services that must be insured are those considered medically necessary or medically required.[5]

14. The CHA permits provinces at their discretion to fund non-core medical services.

15. Alberta's health care insurance plan is governed by the AHCIA and associated Regulations. Above those considered "insured health services" in the CHA, Alberta also funds additional "basic health services" for residents, including podiatric benefits and optometric benefits.[6] The specific services that are insured are identified in the Schedule of Medical Benefits (SOMB) as well the procedure lists for podiatry, podiatric surgery, optometry, and oral and maxillofacial surgery (Allied Schedules) and further specified in the Regulations.[7]

16. The definition of "insured services":

> 1. In this Act, (n) "insured services" means
>
> (i) all services provided by physicians that are medically required,
>
> (ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations, and
>
> (iii) any other services that are declared to be insured services pursuant to section 2,
>
> but does not include any services that a person is eligible for and entitled to under any Act of the Parliament of Canada or under the *Workers' Compensation*

[5] See *Ibid*, CHA, s. 2 for definitions of "hospital services", "physician services" and "surgical-dental services".
[6] Basic health services are defined in section 1(b) of the AHCIA. See also the Alberta Health Care Insurance Regulation. Podiatry and Optometric Benefits are further specified in the *Podiatric Benefits Regulation*, AR 87/2006; *Podiatric Surgery Benefits Regulation*, AR 137/2006; *Optometric Benefits Regulation*, AR 202/2007, Oral and Maxillofacial Surgery Benefits Regulation, AR 86/2006..
[7] SOMB Available online at: http://www.health.alberta.ca/professionals/SOMB.html and allied schedules available http://www.health.alberta.ca/professionals/allied-services-schedule.html. See Alberta Health Care Insurance Regulation,

Act or any law of any jurisdiction outside Alberta relating to workers' compensation.

2. The Lieutenant Governor in Council may by regulation declare any basic health service referred to in section 1(b)(ii), (iii), (iv), (v), or (vi) to be insured services for the purposes of the Plan.

17. Those services provided in hospitals are also insured services and are further specified in the *Hospitals Act* and the *Hospitalization Benefits Regulation*.[8]

18. Health care services not falling within either the AHCIP or the Hospitalization Benefits Plan are not insured services and can be provided at a cost to the patient.

19. MRIs are not on the SOMB, but are publically funded in hospital settings and some contracted private facilities when medically necessary. If a physician determines that an MRI is not "medically necessary" but a patient in his opinion wishes to obtain an MRI to expedite their diagnosis or treatment a patient can pay to obtain an MRI at a private MRI facility.

20. OOCHS Regulation: Since 1981 Alberta has provided a process for funding Out-of-Country health services in certain circumstances. The funding request was initially made by the individual (registrant) to the Minister of Health, who had the discretion to accept in whole or in part, the recommendation of a Financial Assistance Committee tasked with reviewing the application.

21. In 1996, the Out-of-Country Health funding scheme was improved by replacing Ministerial discretion with an Out-of-Country Health Services Committee and creating a right to appeal to an Appeal Panel. The OOCHS Committee consisted of 4 physicians appointed by the Minister. The Appeal Panel consisted of 5 members appointed by the Minister, comprised of 3 physicians, 1 ethicist, and 1 member of the public.[9]

22. In 1998 the OOCHS Committee was expanded to include a Chair with non-voting status on the Committee. In 2003 the quorum of the Appeal Panel was established as consisting of 3 members, 2 of whom must be physicians and one of whom must be either the ethicist or the member of the public.[10]

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[8] *Hospitals Act*, R.S.A. 2000, c. H-12 as amended; *Hospitalization Benefits Regulation* AR 244/1990 as amended
[9] paragraphs. 4 & 5, and Exhibit "B" (AR 52/96), Affidavit of Stella Hoeksema, dated May 27, 2013.
[10] paragraphs 7 & 8, affidavit of Stella Hoeksema, dated May 27, 2013

23. In 2006 the regulations for the OOCHS Committee were codified separately from the *Alberta Health Care Insurance Regulation.*[11] At this time the duties of the Chair were elaborated to include carrying out the initial screening of an application and, if necessary, conducting independent investigations necessary in order to complete the initial screening of an application. In addition, an explanation of 'available in Canada' was added in section 1(2) of AR 78/2006 as follows:

> (2) For the purposes of this Regulation, a service is available in Canada if a resident could have obtained the service in Canada within the time period generally accepted as reasonable by the medical or dental profession for any resident with a similar condition.

24. The rationale for this amendment was to clarify that a resident may receive benefits if they decide to obtain the service outside of Canada, when the time they would have to wait to receive the treatment in Canada would not be considered reasonable by the medical or dental community for that resident's medical condition.[12]

25. Subsequent amendments changed the application process to require the application to be made by the physician or dentist on behalf of the applicant. As deposed to by the Chair of the OOCHS Committee:

> "The OOCHS Committee generally relies on the applicant's treating physician's knowledge and expertise, as well as, their own knowledge or information available from medical colleagues, as to whether or not a service is offered in Canada. However, regarding "the time period generally acceptable as reasonable", the Committee relies upon the physician's assessment of urgency specific to the patient. The applications are considered on a case-by-case basis."[13]

26. The OOCHS scheme was independently reviewed by the Alberta Ombudsman, starting in December 2008.[14] The purpose of his investigation was to review the administrative fairness of:

i) How Albertans are informed of the availability of funding for out-of-country health services;
ii) How medical practitioners are informed about the requirements and availability of funding for out-of-country health services;
iii) How out-of-country claims are reviewed;
iv) The decision making process of the Out-of-Country Health Services Committee (the Committee) and the Out-of-Country Health Services Appeal Panel (the Appeal Panel);
v) How wait times factor into the decision making process; and,

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[11] *Out-of-Country Health Services Regulation* 78/2006, Exhibit "E", affidavit of Stella Hoeksema, Mary 27, 2103
[12] paragraphs 8 and 9, Affidavit of Stella Hoeksema, dated May 27, 2013
[13] paragraph13, affidavit of Stella Hoeksema, May 27, 2013
[14] Paragraph 22, Affidavit of Stella Hoeksema, May 27, 2103

vi) How decisions are conveyed to Albertans.

27. In May 2009, the Ombudsman released his findings and observations arising from his investigation in a Special Report entitled, "Prescription for Fairness".[15] The Ombudsman reaffirmed the need for a program such as the out of country health services program to compensate residents of Alberta who must travel outside of Canada when necessary to avail themselves of specialist medical services in a timely manner.[16] However, he identified shortcomings in the delivery of the program to Albertans. Specifically, he listed 53 recommendations required to improve administrative fairness, function and transparency of the out of country health services program.

28. The Minister of Health and Wellness provided the departmental response to these recommendations, accepting all but one of the recommendations.[17]

IV. WAIT TIMES SINCE *Chaoulli*

> Many factors combine to create the long waits that Canadians sometimes experience. It is the analysis and remediation of these factors that will help to ensure that our achievements in establishing benchmarks show lasting benefits to Canadians.[18]

A. Pan-Canadian Wait Time Initiatives

29. Since the Supreme Court of Canada heard arguments in *Chaoulli* v. *Quebec* there has been a pan-Canadian focus on ensuring access to timely, high-quality health services. Starting in 2004, the First Ministers agreed on a "*10-Year Action Plan to Strengthen Health Care*", ("10-Year Plan") to commit to achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging services, hip and knee replacements and sight restoration. In December 2005, to further the 10-Year Plan the Federal, Provincial and Territorial Ministers of Health reached agreement on ten evidenced-based benchmarks for these priority areas. The Canadian Institute for Health Information (CIHI) was tasked with reporting on progress on wait times across jurisdictions.

30. In July 2005, Dr. Brian Postl, federal advisor on Wait Times, was tasked with inquiring into factors contributing to long wait times and to discuss with provinces, territories and stakeholders efforts that could contribute to more timely access to health care services. He

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[15] paragraph 23 and Exhibit "J" , Affidavit of Stella Hoeksema, dated May 27, 2013
[16] Page 51, Exhibit "J", Affidavit of Stella Hoeksema, dated May 27, 2013
[17] paragraph 24 and Exhibit K, Affidavit of Stella Hoeksema, May 27, 2013
[18] Exhibit "A", page 3, Affidavit of Marie Lyle, May 16, 2013

issued his report, *Final Report of the Federal Advisor on Wait Times,* (Postl Report)[19] in June 2006. In this report Dr. Postl acknowledges the important milestone reached with the declaration of evidence-based benchmarks in the ongoing efforts to reduce wait times. However, he stressed that benchmarks alone will not solve the problem of timely access to the health care system.

31. In his report, Dr. Postl provided key recommendations on how to improve wait times: (i) ongoing research to support benchmarking and operational improvements; (ii) adoption of modern practices and innovations in health systems; (iii) accelerated implementation of information technology (IT) solutions; (iv) cultural change among health professions; (v) development of regional surge capacity; and (vi) public education to support system transformation.

32. *Benchmarking and operational improvements*: Dr. Postl noted that since evidence-based benchmarks were announced on December 12, 2005, the provinces and territories were in the process of implementing changes to achieve these benchmarks by December 2007. First Ministers also committed to establish comparable indicators of access to health care professionals, diagnostic procedures and medical treatments. Provincial and territorial governments indicated that, as of March 30, 2006 comparable indicators to measure progress against the benchmarks had been developed and approved. Dr. Postl noted that continued research is essential and, as work progresses, more comprehensive knowledge and more conclusive evidence is needed.

33. *Management and innovation*: Dr. Postl reported that many practices can be adapted from the experiences of business and industry to increase the efficiency and effectiveness of Canada's health care system. He noted that in many respects the provincial and territorial health care systems have fallen behind other human service sectors in adopting modern management practices and the innovations that guarantee that services are provided at a high level of quality, consistency and timeliness. These systems can adapt high standards of performance from wherever they exist, using leaders to influence change and training programs to bring the workforce up to new performance standards. Among his recommendations he included:

> 7. That provinces and territories adopt best practices for wait times including: the use of single common waiting lists; an approach that permits patients to be referred to a speciality service that prioritizes the patient by acuity and offers the

[19] Exhibit "A", Affidavit of Marie Lyle, May 16, 2013

first available slot for intervention; the use of queuing theories to alter current processes; innovative case management; team based care; appropriateness; and pre-habilitation programs to ensure fitness for surgery.

34. *Information Technology*: Dr. Postl noted that the rapid acceleration of efforts to develop information management and technology will play an important role in supporting innovation. Its most important aspect of this role will be to ensure that the right information is in the right hands at the right time. Although information technology (IT) initiatives are costly to implement, the resulting efficiencies and rebuilding of public confidence will mitigate the expense. He identified numerous features of IT that require development, including: a system-wide electronic health record for all Canadians that will ensure that each physician, specialist, nurse or other appropriate health care professional has current and accurate information on which to base a diagnosis or treatment decision; electronic patient registries that will allow a fluent flow of patients through the system; digitalization of diagnostic images that provides the opportunity for faster access to images and elimination of duplicated diagnostic testing, resulting in faster diagnosis; and tele-health to provide increased access to patients who may be in remote areas or have mobility challenges, as well as providing new opportunities for professionals to provide team-based care. Each of these technological advances increases the accuracy of and access to information for patients and professionals alike. Patients can expect to receive better care in a more timely manner as a result.

35. *Professional Roles and Responsibilities*: Dr. Postl reported that the issue of wait times is a systemic problem that requires a systemic solution. Specific measures are required to advance solutions. Physicians have played a large and important role in defining needs and solutions for wait list management in the health care systems. The continuous role of physicians is essential for any changes in how wait list issues are managed. In ensuring their involvement, a cultural shift is needed from individual contributions to system involvement and problem solving.

36. Dr. Postl further noted that physicians represent only one group of professionals involved in patient care. Other groups play important roles in the continuum of modern health care. These professionals organize and deliver care across facilities, in and out of acute care, in the home, in private offices and in community settings. The roles that physicians play as "gatekeepers" of the system, as leaders and independent professionals mean that they are key to system change. Their support and involvement is needed but also their commitment to full participation. Their ability to adopt the measures of change and the culture of change will serve as an important guide for other health care professions.

37. *Additional Issues*: Dr. Postl identified and reported on several issues that emerged early in his consultations that were not included in his mandate as Federal Advisor on Wait times but were sufficiently important to comment on. These issues are: wait time benchmarks for children, surge capacity, health human resources, "Cinderella" diseases and gender-based analysis.

38. Dr. Postl noted that the issue of health human resources (HHR) has been high profile both before and during the discussion of wait times. Shortages of family physicians, anaesthesiologists, nurses or other specialists and health care professionals have added to the stresses and pressures on the health care system. Shortages can add to the problem of wait times and prevent the implementation of solutions.

39. *Public Education*: Dr. Postl noted that the growing perception that long wait times are pervasive and that little can or is being done to improve them is eroding Canadians' confidence in the system's future. He advised that as efforts are advanced to address wait times and implement system transformation initiatives, the Canadian public must not only understand why change is necessary but be fully informed of changes as they occur.

B. Alberta Wait Time Initiatives

40. Alberta implemented a number of wait time initiatives consistent with the recommendations of the Postl Report.

41. *Alberta Website Tracking Record:*[20] The Alberta Wait Time Reporting (AWTR) website provides retrospective wait time information for publicly funded services provided in public facilities and in facilities under contract to Alberta Health Services (AHS). For purposes of this website, a wait time is the time between when a patient and specialist decide that a procedure or diagnostic test is required and the date the procedure or test is performed. The website does not include people who need emergency surgery or treatment. It does include people who need urgent, semi-urgent, or non-urgent medical procedure. The classification of category (urgent, semi-urgent, non-urgent) is the responsibility of the treating physician or surgeon. A patient may change categories depending on changes to his/her medical condition. Wait times for health services vary depending on a number of factors, which include the number of specialists practising in the area, the number of urgent cases that need attention, the capacity of health facilities and changing needs of the community

[20] Paragraph 9, Affidavit of Marie Lyle, dated May 16, 2013

42. *Primary Care Networks:*[21] Alberta established Primary Care Networks to use a team approach to coordinate care for patients. Family physicians work with health regions to better integrate health services by linking to regional services such as home care, as well as by linking patients with specialists for some services. Family physicians also work with other health providers such as nurses, dieticians, pharmacists, physiotherapists and mental health workers who help to provide some services within the networks.

43. *Health Link Alberta:*[22] Alberta created the Health Link Alberta, which provides Albertans with toll-free 24-hour health advice and information.

44. *Netcare:*[23] Netcare electronic health record (EHR), was developed as a province-wide clinical health information system that links physicians, pharmacists, laboratories, hospitals, home care and other providers across the province. There are over 14,000 providers using Netcare today primarily consisting of physicians, nurses and pharmacists. Netcare stores pertinent patient information online to allow health care providers secure access to a patient's prescription history, allergies and laboratory test results by computer. The result is more accurate diagnosis and efficient treatment for better, safer patient care.

45. *Telehealth:*[24] Telehealth was developed as an electronic network that provides clinical services, and educational and administrative communications. By using video-conferencing and specialized medical instruments, patients can be examined or monitored through Telehealth as if they were in the same facility as their care providers. Alberta's Telehealth network includes more than 200 Telehealth sites across the province, including 25 that offer tele-ultrasound or other radiology services.

46. *Alternate Relationship Plans:*[25] Alberta has pursued Alternate Relationship Plans (ARPs) to provide physicians with stable compensation in return for providing services to a defined group of patients.

47. *Health Action Workforce Plan*:[26] A Health Action Workforce Plan was established to ensure that Alberta has an adequate supply of health care providers to sustain the overall health care system as well as to support specific initiatives such as Primary Care Networks, Alternate

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[21] Paragraph 11, Affidavit of Marie Lyle, dated May 16, 2103
[22] Paragraph 12, Affidavit of Marie Lyle, dated May 16, 2013
[23] Paragraph 13, Affidavit of Marie Lyle, dated May 16, 2012
[24] Paragraph 14, Affidavit of Marie Lyle, dated May 16, 2012
[25] Paragraph 15, Affidavit of Marie Lyle, dated May 16, 2012
[26] Paragraph 16, Affidavit of Marie Lyle, dated May 16, 2012

Relationship Plans, Health Link Alberta, Telehealth and access to specialized services including MRIs, cancer care, heart surgery and major joint replacements.

48. *Home Care Programs*:[27] Alberta provides home care programs including short-term care, long-term care, and palliative care.

49. *Prevention:*[28] Alberta developed health promotion and disease and injury prevention initiatives to assist in reducing pressure on the health care system.

50. In 2007, Alberta launched an initiative, the Alberta Wait Times Management Initiative (AWTMI)[29] comprised of twelve projects aimed at system-wide change with a focus on improving patients' access to health services. As well as improving access and reducing wait times for treatment, the initiative helped to develop and implement comprehensive integrated approaches to patient care and improve quality of care for patients and across services by providing navigation, support education and ensuring evidence-based practice.

51. The Alberta Wait Times Management Initiatives Summative Evaluation 2011, examined the impact and outcomes of these initiatives from June 2007 to September 30, 2010.[30] The Appendices 1 to 12 listed on page 58 of the Evaluation and produced at the pages following provide a concise description of the project overview, goals, outcomes and impact on the Alberta Healthcare system for each project.

52. Next phase initiatives include transforming the current waitlist registry into a prospective tool. The goal of the aCATS project is to develop and implement a standardized diagnosis-based priority system to book surgeries across the continuum of surgical services offered throughout the Province.[31] In addition, the Closed Loop Referral Management Program is aimed at transforming the referral process in order to improve navigation and access.[32]

53. As reflected in Alberta's 5 Year Health Plan 2012 - 2015[33] the planning continues to strengthen the health care plan for Albertans.

54. Benchmarks: The wait times provide some information on wait times for health care services. They are tracked, both by the CIHI as well as through the Alberta Wait Time

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[27] Paragraph 17, Affidavit of Marie Lyle, dated May 16, 2012
[28] Paragraph 18, Affidavit of Marie Lyle, dated May 16, 2012
[29] Paragraph 19 - 20, Affidavit of Marie Lyle, dated May 16, 2012
[30] Exhibit "F", Affidavit of Marie Lyle, May 16, 2013
[31] Paragraph 24, Affidavit of Marie Lye, dated May 16, 2013
[32] Paragraph 26, Affidavit of Marie Lyle, dated May 16, 2013
[33] Exhibit "G", paragraph 23, Affidavit of Marie Lyle, dated May 16, 2013

Reporting website. The CIHI 2012 Report[34] provides the following information regarding the proportion of patients in Alberta receiving care within benchmarks from April 1 to September 30, 2011: 82% Hip Replacement, 70% Knee Replacement, 79% Hip Fracture Repair, 82% Cataract, 99% Bypass, and 97% Radiation Therapy. The CIHI reported Alberta wait times for the priority areas, cancer, heart, diagnostic imaging services, hip and knee replacements and sight restoration for the years 2012, 2011, 2010, 2009, and 2008, are found at Exhibit "C" to the affidavit of Marie Lyle.

V. *CHARTER* SECTION 7

> s.7 Everyone has the right to life, liberty and security of the person and right not to be deprived thereof except in accordance with the principles of fundamental justice.

55. Section 7 requires a two-step process. First, there must be a finding that there has been a deprivation of the right to life, liberty, or security of the person. Second, the deprivation must be contrary to principles of fundamental justice. If no interest in the Applicant's life, liberty, or security of the person is implicated, the s.7 analysis stops there.[35]

56. There must be a sufficient causal connection between the state-caused delay and the prejudice suffered.[36]

57. The further a challenged state action lies from the traditional adjudicative context, the more difficult it will be for a claimant to identify a violation of a principle of fundamental justice.

A. Right to Security of the Person

58. The Applicant in this case asserts that the Impugned Legislation has breached his s.7 *Charter* right to security of the person contrary to the principles of fundamental justice.

59. The right to security of the person has been judicially recognized as protecting against state provisions that seriously compromise a person's physical and psychological integrity in the criminal law context.[37] The right to security of the person also encompasses serious state-imposed psychological stress in state proceedings relieving a parent of the custody of his or her children. The parental interest in raising one's children was recognized as one of fundamental

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[34]Page 5, Figure 2, Exhibit "B", Affidavit of Marie Lyle
[35] Paragraph 47, *Blencoe* v. *British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 CarswellBC 1860
[36] Paragraphs 58 - 60, *Blencoe* v. *British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 CarswellBC 1860
[37] *R* .v. *Morgentaler,* [1988] 1 S.C.R. 30, 1988 CarswellOnt 45; re abortion provisions, *Rodriguez* v. *British Columbia (A.G.),* [1993] 3 S.C.R. 519, 1988 CarswellOnt 45 – re assisted suicide;

importance, requiring the parent be guaranteed a right to a fair hearing.[38] In *Blencoe* v. *British Columbia (Human Rights Commission)*[39] the Court extended the recognition of s.7 security interests to the human rights proceedings, an administrative law context not a criminal context.[40]

60. To date, the Courts have not read s.7 of the *Charter* as imposing on the state a positive obligation to ensure each person enjoys life, liberty or security of the person[41].

61. In *Chaoulli* the Applicants challenged the Quebec legislative provision prohibiting private insurance as violating their rights under s.1 of the *Quebec Charter* as well as s.7 of the *Canadian Charter*. The Applicants complained that delays in waiting for health care treatment in Quebec violated their right to life and to personal security.

62. Deschamps J., speaking for a 4-3 majority, decided the case on the *Quebec Charter*, not, the *Canadian Charter of Rights*. Deschamps J.ruled, based on the witnesses at trial,[42] that the Quebec legislative prohibition on private insurance, when health care was not accessible due to wait lists, violated the Applicant's right to life and security of the person under s.1:

> Every human being has the right to life, and to personal security, inviolability and freedom.

63. The six justices that addressed the Canadian *Charter* were evenly split on whether or not s.7 *Charter* rights were breached, and if so, whether the breach was contrary to principles of fundamental justice. In light of the 3-3 split between the justices addressing the *Canadian Charter* in *Chaoulli*, there is no settled law extending the scope of s.7 to social policies.

64. Chief Justice McLachlin, along with Justices Major and Bastarache, agreed with Deschamps J. on her ruling under the *Quebec Charter*. However, they went further, commenting on s.7 of the *Canadian Charter* as well. These three justices found that based on the witnesses at trial,[43] delays in treatment giving rise to psychological and physical suffering engage the s.7 protection of security of the person just as they did in *Morgentaler:*[44]

> "We conclude, based on the evidence, that prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby

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[38] *New Brunswick (Minister of Health & Community Services)* v. *G. (J.), [*1999] 3 S.C.R. 46, paragraph 61, 1999 CarswellNB 305
[39] [2000] 2 S.C.R. 307
[40] See also *New Brunswick (Minister of Health & Community Services)* v *G. (J).*, [1999], 3 S.C.R. 46; 1999 CarswellNB 305
[41] *Gosselin* v. *Quebec (Attorney General)*, [2002] 4 S.C.R. 429, paragraph 81, 2002 CarswellQue 2706
[42] [2005] 1 S.C.R. 791,paragraph 40, 42, 2005 CarswellQue 327
[43] [2005] 1 S.C.R. 791,paragraph 111 to 114, 2005 CarswellQue 327
[44] [2005] 1 S.C.R. 791,paragraph 119, 2005 CarswellQue 3276

> increasing the risk of complications and death, interferes with life and security of the person as protected by s. 7 of the *Charter*."[45]

65. Justices Binnie, LeBell and Fish dissented on both the *Quebec*[46] and *Canadian Charter*. They acknowledged that some encounters in the health care system may engage s. 7 rights.[47]

> While we do not accept that there is a constitutional right "to spend money", which would be a property right, we agree that if the public system fails to deliver life-saving care and an individual is simultaneously prevented from seeking insurance to cover the cost of that care in a private facility, then the individual is potentially caught in a situation that may signal a deprivation of his or her security of the person.
>
> This is not to say that every encounter with a waiting list will trigger the application of s. 7. The interference with one's mental well-being must not be trivial. It must rise above the ordinary anxiety caused by the vicissitudes of life, but it need not be so grave as to lead to serious mental anguish or nervous breakdown. Some individuals that meet this test are to be found entangled in the Quebec health system. The fact such individuals do not include the appellants personally is not fatal to their challenge because they come here as plaintiffs purporting to represent the public interest.

B. Principles of Fundamental Justice

66. Chief Justice McLachlin, along with Justices Major and Bastarache, found, based on the evidence at trial, that the Quebec prohibition on private insurance was arbitrary because other developed countries with public health care systems permit access to private health care.[48] Accordingly the prohibition was not in accordance with the principles of fundamental justice.

67. Justices Binnie, LeBel, and Fish found, based on the evidence,[49] that no principle of fundamental justice was engaged. They identified three formal requirements of a principle of fundamental justice:[50]

(i) It must be a legal principle;
(ii) The reasonable person must regard it as vital to our societal notion of justice, implying a significant societal consensus; and
(iii) It must be capable of being identified with precision and applied in a manner that yields predictable results.

68. The evidence in *Chaoulli* showed that there was no consensus about what constitutes "reasonable" wait times. The evidence was not clear or obvious that a reorganization of the health system with a parallel private system would solve all the existing problems of delays or

[45] [2005] 1 S.C.R. 791, paragraph 124, 2005 CarswellQue 3276
[46] 2005] 1 S.C.R. 791, paragraph 273, 2005 CarswellQue 3276
[47] [2005] 1 S.C.R. 791, paragraph 203, 204, 2005 CarswellQue 3276
[48] [2005] 1 S.C.R. 791, paragraph 139, 140, 2005 CarswellQue 3276
[49] [2005] 1 S.C.R. 791, paragraph 209, 2005 CarswellQue 3276
[50] [2005] 1 S.C.R. 791, paragraph 209, 2005 CarswellQue 3276

access.[51] There was a lack of accurate data regarding the wait list problem.[52] It was difficult to generalize about the potential impact of a waiting list on a particular patient.[53] As wait times are not only found in public systems, they are found in all health care systems, whether single-tier private, single-tier public, or the various forms of two-tier public/private. The consequences of a quasi-unlimited demand for health care coupled with limited resources, whether public or private, is to ration services.[54] The Justices raised the question of who should be allowed to "jump the queue". In a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status. The evidence also showed that persons who are in greater need are prioritized and treated before those with a lesser need. Where there are exceptions, they can and should be addressed on a case-by-case basis. Section 10 of *Quebec's Health Insurance Act* provided for public funding for Out-of-Province medical care. If administered properly, this "safety valve" provided for an individual remedy and an important element of flexibility.

69. Justices Binnie, LeBel, and Fish approached the issue of "arbitrariness" in three steps: (i) what is the "state interest" to be protected; (ii) what is the relationship between the "state interest" and the prohibition against private health insurance; and, (iii) have the applicants established that the prohibition bears no relation to, or is inconsistent with, the state interest.

70. They found that Quebec (along with the other provinces and territories) subscribes to the policy objectives of the *Canada Health Act*. This includes (i) the equal provision of medical services to all residents, regardless of status, wealth or personal insurability, and (ii) fiscal responsibility.

71. As for relationship, in *principle*, Quebec wants a health system where access is governed by need rather than wealth or status. Quebec does not want people who are uninsurable to be left behind. To accomplish this objective endorsed by the *Canada Health Act*, Quebec seeks to discourage the growth of private-sector delivery of "insured" services based on wealth and insurability. The prohibition is rationally connected to Quebec's objective and is not inconsistent with it.

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[51] [2005] 1 S.C.R. 791, paragraph 215, 2005 CarswellQue 3276
[52] [2005] 1 S.C.R. 791, paragraph 217, 2005 CarswellQue 3276
[53] [2005] 1 S.C.R. 791, paragraph 220, 2005 CarswellQue 3276
[54] [2005] 1 S.C.R. 791, paragraph 221, 222, 2005 CarswellQue 3276

72. The Justices agreed with the trial judge that based on the evidence and the expansion of private health care would undoubtedly have a negative impact on the public health system. The appellants failed to make out a case of "arbitrariness" on the evidence.

73. After reviewing all of the evidence they agreed with the conclusion of the trial judge and the Quebec Court of Appeal that in light of the legislative objectives of the *Canada Health Act* it is not "arbitrary" for Quebec to discourage the growth of private sector health care. Prohibition of private health insurance is directly related to Quebec's interest in promoting a need-based system and in ensuring its viability and efficiency. Prohibition of private insurance is not "inconsistent" with the state interest; still less is it "unrelated" to it.[55]

VI. THE CASE AT THE BAR

74. The Applicant bears the burden of proving both a breach of his security of the person and that the breach is contrary to principles of fundamental justice. His reliance on *Chaoulli* requires a note of caution. The *Chaoulli,*[56] case was decided on the *Quebec Charter*, not the *Canadian Charter*. There are differences between the *Quebec Charter* and the *Canadian Charter*, causing judicial caution in assuming similar outcomes under both *Charters*. Most importantly, the *Quebec Charter* has no reference to principles of fundamental justice. Applicants claiming a breach of s.7 *Charter* rights have the added burden of proving the breach runs contrary to principles of fundamental justice. The scope of the *Quebec Charter* is accordingly broader. The *Quebec Charter* has an added feature of placing on the claimant the obligation to exercise *Quebec Charter* rights with "proper" regard to "democratic value, public order and general well-being of the citizenry of Quebec. The *Quebec Charter*, absent an express provision to the contrary applies not only to state action but also to many forms of private relationships.[57]

A. Access to MRIs

75. The Applicant chose to pay for MRIs rather than be put on a wait list. As described above, MRIs are not on the SOMB, but will be publically funded in hospitals and some private facilities when "medically necessary". If a patient in his own opinion wishes to obtain an MRI to expedite their diagnosis or treatment a patient can pay to obtain an MRI at a private MRI facility. The Supreme Court has acknowledged that there are different categories in funding treatment

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[55] [2005] 1 S.C.R. 791, paragraph 256, 2005 CarswellQue 3276
[56] [2005] 1 S.C.R. 791, 2005 CarswellQue 3276
[57] [2005] 1 S.C.R. 791, paragraph 28, 29, 30, 269, - 272, 2005 CarswellQue 327

based on service. Some will be fully funded as required by the CHA. Others may be partially funded at the discretion of the provinces.[58]

76. In the case at bar the Applicant was not deprived of his MRIs and accordingly his right to security of the person was not breached.

B. OOCHS – No Breach of Rights to Security of the Person

77. There is no causal link between the OOCHS Reg. and the Applicant's alleged breach of security of the person. The Applicant did not apply for out-of-country funding. Therefore, on this record, the asserted deprivation by the OOCHS Reg. is more theoretical than proven. An adequate evidentiary record is required[59] in order to prove that the OOCHS Reg. in whole violated his personal right to security of the person.

78. Even if the Applicant had applied to the OOCHS Committee for funding, s.7 of the *Charter* provides a right *not to be deprived* of security of the person. The OOCHS funding scheme does not deprive benefits. It provides them. Further it does not create an impediment to individuals in securing out-of country treatment. The Ontario out-of-country health funding scheme was judicially found not to breach s.7 *Charter* rights precisely because the scheme provided benefits and did not deprive individuals to seek treatment out-of-country.[60]

79. The Applicant deposes to having discussed with staff of the Alberta Health Minister's office "options as to out-of-country treatment". He deposes to being told that Alberta Health Services would only cover out-of-country treatment if the treatment was not provided anywhere in Alberta or Canada, and was medically necessary. "The length of time that a person might need to wait before receiving necessary surgery in Canada was not a factor taken into consideration under the government's policy".[61]

80. The applicant further deposes to relying on his own interpretation of the OOCHS Reg. in concluding that,

> "It was pointless and futile to make an application for payment of my surgery expenses at Benefits Hospital in Montana. The regulation made it abundantly clear to me that such application would certainly have been denied, because I

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[58] *Auton (Guardian ad litem of)* v. *British Columbia (A.G.)* [2004] 3. S.C.R. 657, paragraphs 30-37; 2004 CarswellBC 2675

[59] *Gosselin* v. *Quebec (Attorney General),* [2002] 4 S.C.R. 429, paragraph 75,83, 2002 CarswellQue 2706; *Beauchamp v. Canada (Attorney General)* (2009), 342 F.T.R. 131, 2009 CarswellNat 888, paragraph 23

[60] *Flora* v. *Ontario Health Insurance Plan*, (2008), 295 D.L.R. 94th) 309 (Ont. C.A.), 2008 CarswellOnt 3879

[61] Paragraph 28, Affidavit of Darcy Allen, dated December 15, 2011

> was eligible to receive surgery in Canada if prepared to live in a state of severe and continuous pain for another year."[62]

For this reason he deposes he never applied for out-of-country funding from the OOCHS Committee.

81. The Affidavits of both Lisa Thompson and Wendy Stiver, both Information Specialists in the issues management office of Alberta Health, confirm that records of four incoming queries were received in 2009 regarding a person named, Mr. Darcy Allen.

82. While both deponents state that they have no personal recollection of communicating with the Applicant, both affidavits describe standard protocol in providing information. They state that, "If a caller asked whether the OOCHS Committee would consider an application based on time they had been waiting to obtain their medical procedure, the practice of the issues management office is to advise the caller that the time a person has been waiting for a medical procedure is not a factor considered by the OOCHS Committee."[63]

83. In addition, both deponents Lisa Thompson and Wendy Stiver depose that when callers inquire about the OOCHS Committee they attempt to offer the person as much information as possible related to the OOCHS Committee protocols, while reminding that the OOCHS Committee is an arms-length committee involving medical professionals. Callers may be referred to the website where they can find both the information sheet on the OOCHS process and an application form.[64]

84. The definition of when a service is "available in Canada" in the OOCHS Reg. includes time as a factor:

> (2) For the purposes of this Regulation, a service is available in Canada if a resident could have obtained the service in Canada *within the time period generally accepted as reasonable by the medical or dental profession* for any resident with a similar condition.

85. The evidence of the Chair of the OOCHS Committee is that time is a factor in funding out-of-country treatments.

86. The evidence the Chair of the OOCHS Committee is that:[65]

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[62] Paragraph 29, Affidavit of Darcy Allen, dated December 15, 2011
[63] Paragraph 10, Affidavit of Lisa Thompson, dated May 16, 2103; Paragraph 10, Affidavit of Wendy Stiver, dated May 16, 2103
[64] Paragraphs6-8, Affidavit of Lisa Thompson, dated May 16, 2103; Paragraphs 6-8, Affidavit of Wendy Stiver, dated May 16, 2103
[65] Paragraphs 13, 14, Affidavit of Stella Hoeksema, dated May 27, 2103

> "The OOCHS Committee generally relies on the applicant's treating physician's knowledge and expertise, as well as, their own knowledge or information available from medical colleagues, as to whether or not a service is offered in Canada. However, regarding "the time period generally acceptable as reasonable", the Committee relies upon the physician's assessment of urgency specific to the patient. The applications are considered on a case-by-case basis."
>
> Applications have been approved where the treatment is not available in Canada within the time period generally accepted as reasonable by medical professionals."

The Out-of-Country funding is provided on a case-by-case basis, not as a wait time guarantee.

87. Pursuant to the OOCHS Reg. the application must be submitted by the Applicant's physician. There is no evidence in his Affidavit that the Applicant discussed or requested his doctor apply for out-of-country funding to the OOCHS Committee. The evidence of the Chair of the OOCHS Committee is that applications have been approved for the musculoskeletal system. The musculoskeletal system includes the spine. On this record it will never be known whether his application would have been approved or denied.

C. OOCHS – Not Contrary to Principles of Fundamental Justice

88. Since the OOCHS Reg. does not breach the Applicant's security of the person there is no need to consider whether it violates principles of fundamental justice. There is nothing on the record to show such violation.

89. Having said that, the Ombudsman's 53 recommendations to improve the administrative fairness of the scheme were, with one exception accepted by the government. The OOCHS Scheme provides a Committee, an Appeal Panel, and a right to judicial review. The Committee and Appeal Panels are independent of the government and comprised of physicians and the Appeal Panel includes physicians, an ethicist and a member of the public. The definition of what is "available in Canada" is set out in the Regulation. The Alberta OOCHS funding scheme is not arbitrary in structure or process.

D. Section 26(2) – No Breach of Rights to Security of the Person

90. Section 26(2) is a prohibition on purchasing private insurance. In *Chaoulli* the Court split evenly on how it characterized Quebec's equivalent prohibition.

91. Chief Justice McLachlan, and Justices Major, and Bastarache, concluded that the prohibition prevented access to health care in circumstances where the government is failing to

deliver health care in a reasonable manner, thereby interfering with life and security of the person as protected by s. 7 of the *Charter*.

92. Justices, Binnie, LeBel, and Fish, noted that the ability to purchase private health insurance is "a right to spend money", a right not recognized under s.7 of the *Charter*. They conceded however that some encounters with a waiting list may trigger the application of s.7 provided the interference with one's mental well-being is not trivial. It must rise above the ordinary anxiety caused by the vicissitudes of life, but it need not be so grave as to lead to serious mental anguish or nervous breakdown.

93. It is possible that the Applicant suffered the level of pain required to meet the standard under s.7. It is also possible that the pain was caused by delays for purposes of s.7. Having said that, the question arises what time period qualifies for delay versus the process of non-surgical treatment before a decision is made to operate. What is also not clear on this record is whether the delays and pain experienced were caused by the prohibition on private insurance.

94. Justices, Binnie, LeBel, and Fish make it is clear that many assumptions must be made in order to connect the right to purchase private insurance with an absence in wait times. These include assuming eligibility for coverage, affordable premiums, and most importantly, no wait times.

95. The Applicant bears the burden of proving that the prohibition on private insurance breaches his right to security of the person. This he has not done. Instead an assumption is required that without the prohibition on insurance, the Applicant would expect to have private insurance in place. A further assumption is that with private insurance there would be no wait times.

96. The nexus between the alleged harm done to the Applicant and the prohibition on private insurance is remote. Saskatchewan's health care legislation contains no equivalent prohibition on private insurance. Yet the evidence shows that Saskatchewan has wait times.

E. Section 26(2) – Not Contrary to Principles of Fundamental Justice

97. Assuming that the Applicant's right to security of the person has been violated in the case at bar, the important question remains, what is the principle of fundamental justice violated by the prohibition on private health insurance?

98. As noted above, Justices Binnie, LeBel, and Fish identified three formal requirements of a principle of fundamental justice:[66]

(i) It must be a legal principle;
(ii) The reasonable person must regard it as vital to our societal notion of justice, implying a significant societal consensus; and
(iii) It must be capable of being identified with precision and applied in a manner that yields predictable results.

99. The evidence in *Chaoulli* failed to meet these requirements. Some of the problems highlighted included the lack of consensus about what constitutes "reasonable" wait times, lack of clear evidence that a reorganization of the health system with a parallel private system would solve all the existing problems of delays or access, the recognition that wait times are not only found in public systems, they are found in all health care systems, whether single-tier private, single-tier public, or the various forms of two-tier public/private. Other problems identified included the question of who should be allowed to "jump the queue". In a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status. The evidence also showed that persons who are in greater need are prioritized and treated before those with a lesser need.

100. These observations apply with equal force to Alberta. Alberta, like Quebec, subscribes to the policy objectives of the CHA. This includes (i) the equal provision of medical services to all residents, regardless of status, wealth or personal insurability, and (ii) fiscal responsibility. Also, like Quebec, Alberta wants a health system where access is governed by need rather than wealth or status. Alberta does not want people who are uninsurable to be left behind. To accomplish this objective endorsed by the *Canada Health Act*, Alberta seeks to discourage the growth of private-sector delivery of "insured" services based on wealth and insurability. The prohibition is rationally connected to Alberta's objective and is not inconsistent with it.

101. The evidence is clear that many factors combine to create the long waits that Canadians sometimes experience. Since *Chaoulli*, there have been numerous ongoing initiatives to enhance access to health care in Canada and Alberta. These initiatives are not arbitrary.

102. What is unclear is, how allowing private health insurance would accomplish the goal of these initiatives.

[66] [2005] 1 S.C.R. 791,paragraph 209, 2005 CarswellQue 3276

103. Applying the approach of Justices McLachlin, Major, and Bastarache to s.7 provides no manageable constitutional standard. Justices Binnie, LeBel, and Fish, ask the following questions: what are constitutionally required "reasonable health services"? What is treatment "within a reasonable time"? What are the benchmarks? How long a waiting list is short enough? How many MRIs does the *Constitution* require?

> "The public cannot know, nor can judges or governments know, how much health care is "reasonable" enough to satisfy s.7."[67]

104. At the end of the day, the Applicant did not in fact wait for his surgery, choosing instead to have it done out-of-country.

VII. REMEDIES

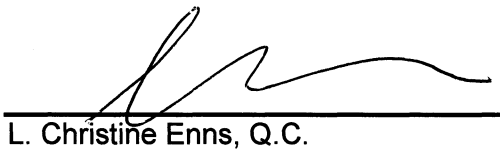
105. For the reasons stated above, the Applicant has failed to prove on a balance of probabilities that his s.7 right to security of the person has been breached by either the OOCHS Reg. or s.26(2) of the AHIA. Accordingly no remedies should be granted under either s.24(1) or s.52 of the *Charter*. Moreover, the request to bring an action to prove damages as part of a s.24(1) *Charter* remedy would provide the Applicant indirectly with a property right that lies outside the scope of s.7.[68]

106. Accordingly Alberta requests that this application be dismissed.

All of which is respectfully submitted.

DATED this 10th day of June, 2013.

ALBERTA JUSTICE AND SOLICITOR GENERAL
AND ATTORNEY GENERAL



L. Christine Enns, Q.C.
Counsel for Her the Minister of Justice and Solicitor General and Attorney General of Alberta

Estimated time for argument: 60 minutes

[67] [2005] 1 S.C.R. 791, paragraph 163, 2005 CarswellQue 3276
[68] Hogg, *Constitutional Law of Canada*, 5th Edition Supplemented (Loose Leaf), section 47.9

LIST OF AUTHORITIES