

TITLE: Universality and Medical Necessity: Statutory and Charter Remedies to Individual Claims to Ontario Health Insurance Funding

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1. Overview

¶ 1 The Canada Health Act (CHA) represents the foundation stone of Canada's system of publicly funded health insurance. [See Note 1 below] The primary objective of Canadian health care policy is described in section 3 as being:

Note 1: Canada Health Act, R.S.C. 1985, c. C-6 [CHA].

to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

¶ 2 The CHA establishes the criteria that provincial and territorial governments must meet in order to qualify for federal transfer payments. These guiding principles define the Canadian health care system, which has become the flagship of this country's social service infrastructure and our most valued social program. The celebrated five pillars of the CHA are: public administration, comprehensiveness, universality, portability and accessibility. For the purposes of this paper, we will focus on the concept of universality in terms of what it means for publicly funded health care as an ideal, as well as a practical matter. [See Note 2 below]

Note 2: While "universality" is defined in the CHA, we adopt here a broader view of it, which is framed by the accompanying statutory principles of comprehensiveness and accessibility, and viewed through the lens of the Charter's equality guarantee. We believe this is true to the popular understanding of universality and consistent with the purposive approach the courts take to rights-conferring legislation.

¶ 3 Universality means that health care services are available to all, regardless of personal circumstances such as socio-economic status, citizenship, place of residence or other grounds typically covered by provincial human rights legislation and the Charter of Rights and Freedoms (Charter). Universality promotes equality among Canadians by mandating that there is to be a single-tier system for all users, which entitles "one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions" (s. 10). It frowns upon

prospective line-jumpers and favour-seekers, by vigilantly guarding against the "apartheidization" of health care -- the move towards a multi-tier system that segregates users based on socio-economic factors. Moreover, the requirement of universality ensures equal opportunity and reciprocity, which in turn promote national unity and social cohesion. [See Note 3 below]

Note 3: Hugh Armstrong, "Social Cohesion and Privatization in Canadian Health Care" (2001) 16:2 Can. J.L. & Soc'y 65 at 67.

¶ 4 While universality holds that everyone is covered, it has never meant coverage for everything. [See Note 4 below] Comprehensive coverage under the CHA extends only to those services that are deemed "medically necessary". As will be discussed, medical necessity is a contentious battleground in which citizens and government are locked in an interpretive struggle over the scope of this coverage, and the types of services deemed to be medically necessary. Disputes about medical necessity can arise when services that had previously been listed are de-listed, whether based on "evidence-based" analysis, physician-government negotiations designed to respond to financial constraints or the political viewpoint of the government of the day. Alternatively, they may arise when a new treatment has been developed and remains to be decided whether or not its claim for recognition is warranted. [See Note 5 below] This paper will not directly address problems of whether waiting lists or the conditions attached to coverage of a particular treatment frustrate the goal of universality. [See Note 6 below] It will focus on the circumstances when an individual may challenge an outright refusal of coverage by the Ontario government. While governments express concern that individual challenges to the government's exercise of discretion represent a threat to the viability of medicare as we know it, [See Note 7 below] individuals who feel they are not receiving the health care to which they are entitled are highly motivated to attempt to widen the reach of the public system. Because they are the ones who suffer if their needs are not being met, they can legitimately claim to better reflect the changing needs of society and evolving approaches to health care and wellness. They must, of course, be prepared for the eventuality that the treatment for which they are seeking coverage is ultimately found not to be medically necessary.

Note 4: The CHA s. 2 defines "insured health services" as "hospital services, physician services and surgical-dental services".

Note 5: For example, there is currently a hearing ongoing concerning the de-listing of sex change surgery before the Ontario Human Rights Tribunal under the Human Rights Code: Hogan v. Ontario (Minister of Health and Long-Term Care), [2003] O.H.R.T.D. No. 16, File Nos. HR-0507 to 0510-02.

Note 6: The Supreme Court of Canada is currently considering an appeal from the decision of the Quebec Court of Appeal in Chaoulli v. Quebec (Procureur general) [2002] J.Q. No. 759; see also Cilinger v. Centre

hospitalier de Chicoutian, [2004] J.Q. no. 2058; AQuebec cancer patients sue over wait@ Globe and Mail, March 11, 2004 at A6.

Note 7: Armine Yalnizyan & Robert McMurtry, "Counting health-care trouble" Globe and Mail, February 26, 2004 at A21.

¶ 5 This paper will provide an overview of recent jurisprudence exploring the meaning of universality and medical necessity in today's dualistic reality of fiscal responsibility and cost-cutting on the one hand, and the expansion of health services into innovative and non-traditional directions on the other. The paper is divided into two principal parts: the first will deal with cases in which provincial statutory remedies were sought; the second with Charter and human rights claims. While not covered in this paper, readers may wish to examine an approach proposed by academics but virtually untested in the courts, which suggests that the CHA criteria create enforceable statutory duties on the part of the federal government that could form the basis for actionable individual claims. [See Note 8 below]

Note 8: See for e.g. Sujit Choudhry, "The Enforcement of the Canada Health Act" (1996) 41 McGill L.J. 461.

II. Provincial Statutory Remedies

General Principles

¶ 6 Under section 11.2(1) of the Ontario Health Insurance Act (OHIA), insured services are:

1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.
 2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
 3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed. [See Note 9 below]
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Note 9: Health Insurance Act, R.S.O. 1990, c. H-6, s. 11.2(1).

¶ 7 Prescribed services are those which are listed in the Act's Regulations. The Ministry of Health and Long-Term Care publishes a "Schedule of Benefits -- Physician Services" (SOB-PS), which serves as a comprehensive and exhaustive list of services covered under the Ontario Health Insurance Plan (OHIP). [See Note 10 below]

Note 10: Regulation 552, "General," R.R.O. 1990, am. to O.Reg. 295/04, s. 1(1).

Medically Necessary

¶ 8 The courts have strictly applied the OHIA and highlighted the importance of medical necessity as a precondition to insurance coverage:

The primary purpose of the Health Insurance Act is to insure hospital and medically necessary physician services. The purpose of the SOB-PS is to define the vast array of medically necessary services and to set fair and reasonable compensation for these services, keeping in mind the budgetary restrictions affecting the government. [See Note 11 below]

Note 11: *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, [2001] O.J. No. 5057 (Sup.Ct.Just.Div. Ct.) at para. 26 [per Pardu J.].

¶ 9 The problem is that medical necessity has not been clearly defined in the CHA or in provincial health insurance legislation. The Nova Scotia Court of Appeal has considered the issue in that province in *Cameron*, where the preamble of the fee schedule defines "medically necessary" as services provided by a physician for the diagnosis, treatment or prevention of physical or mental disease or dysfunction. [See Note 12 below] The Court did not accept this as a binding definition, and noted that the word "services", which is used in the health insurance statute and regulations, is not confined to diagnosis, treatment and prevention, suggesting that the scope of medical necessity could potentially be wider than the definition allowed.

Note 12: *Cameron v. Nova Scotia (Attorney General)*, [1999] N.S.J. No. 297 (C.A.) at para. 76.

¶ 10 The Court in *Cameron* cited the Canadian Bar Association Task Force on Health Care Reform, which has criticized the federal government's failure to include a definition of "medical necessity" in the CHA. [See Note 13 below] This, according to the Task

Force, leaves too much discretion with provinces to establish their own definitions, with most preferring to avoid committing themselves to a substantive definition. Consequently, "the scope of 'medically required services' and indeed, all 'insured health services', is a policy decision" as opposed to a principled and legally enforceable one. [See Note 14 below] The Court went on to adopt the CBA's conclusion that, while there is a statutory right to health insurance, the current legislative framework does not create a right to health care, since the content of insured services is decided as a matter of policy rather than law, and there is no guarantee of procedural fairness in the listing or de-listing of those services. [See Note 15 below]

Note 13: Canadian Bar Association Task Force on Health Care Reform, *What's Law Got to do with it?: Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994) at 31, cited in Cameron, *ibid* at para. 78.

Note 14: *Ibid*.

Note 15: *Ibid*. at paras. 79-80.

Experimental Treatment

¶ 11 An important exception to the list of insured services is any "[t]reatment for a medical condition that is generally accepted within Ontario as experimental", even if it is medically necessary and administered by a physician in a hospital. [See Note 16 below] The term "experimental" is not defined anywhere in the legislation and has been the subject of significant confusion. In a number of decisions, the Health Services Appeal and Review Board (HSARB) has used dictionary definitions of "experimental" in an attempt to give substantive meaning to this clause. It has cited such terms as "tentative", "unproven", "test" and "trial" in its efforts to bring clarity to the issue. [See Note 17 below] In one instance, the Board posited that an experimental procedure is one which seeks to discover or confirm new results, as opposed to a procedure which is an accepted practice with proven beneficial results based on objective standards. [See Note 18 below]

Note 16: *Supra* note 10 at s. 24(1).

Note 17: See for example the Ontario Health Services Appeal and Review Board [HSARB] decisions in *Kehren* (file # s. 5389), *Jackson* (file # s. 5262) and *Fisher* (file # s. 6207), on file with the authors or at HSARB office.

Note 18: HSARB, *Steggles* (file # 02-HIA-0001).

¶ 12 The Board has also noted the importance of local medical practices. The treatment must be considered experimental within Ontario, meaning that even if a particular treatment enjoys widespread acceptance and practice elsewhere, if it is considered new and original in Ontario, it will not be insured under the OHIA.

¶ 13 In a case dealing with multi-modality cancer treatments, the HSARB required that a treatment satisfy all of the following criteria in order to be accepted as non-experimental:

1. The procedure is accepted as appropriate in a number of respected academic and clinical cancer centres;
 2. It is supported by published peer reviewed articles in respected journals;
 3. It is publicly funded and funded by private insurers;
 4. It is merely an extension of pre-existing and widely accepted therapeutic modalities. [See Note 19 below]
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Note 19: HSARB, Kramer (file # s. 6310), September 10, 2001.

¶ 14 The HSARB has distinguished between developmental and experimental procedures. While the former is an extension of procedures already developed and accepted in the field (and thus not necessarily experimental), the latter are unproven and are based on novel principles. [See Note 20 below] In another decision, the Board found that if one aspect of the treatment is experimental, the whole treatment will be tainted and deemed experimental. [See Note 21 below] However, ongoing testing for the purposes of diagnosis and treatment -- as opposed to testing for the purpose of research -- may be found to be insurable. [See Note 22 below]

Note 20: HSARB, Zappone (file # s. 6346), December 13, 1999; HSARB, Tuggart (file # s. 6616), April 11, 2000.

Note 21: HSARB, Bell (file # s. 6799), February 12, 2001; but see HSARB, Cundari (file # s. 6990) July 28, 2001, which seems to suggest otherwise.

Note 22: HSARB, Proctor (file # s. 6784), March 23, 2001.

¶ 15 When seeking coverage for procedures that are not routinely performed and recognized by OHIP, it is difficult to predict with any degree of certainty which procedures will be deemed experimental. The HSARB is not bound by its precedents,

which makes litigating in this area extremely precarious in terms of managing client expectations. In very general terms, the following are examples of the type of evidence used in determining whether a treatment is experimental:

1. Academic research noting the positive effects of the therapy;
2. The extent of the therapy's usage and the length of time it has been practised;
3. If the practice enjoys limited use, whether this is due to the high cost of the therapy and not doubts about its effectiveness;
4. The number of clinical trials.

¶ 16 There is presently a case before the HSARB, Baldassini, concerning a contentious procedure used to treat angina known as Enhanced External Counter Pulsation (EECP). [See Note 23 below] The appellants are arguing that EECP, which is not explicitly mentioned in the SOB-PS, is nonetheless a prescribed service because it fits the definition as a "circulatory assist device", which is listed in the Schedule. The appellants called numerous experts who were all of the opinion that EECP is indeed a percutaneous circulatory assist device within the meaning of the SOB-PS. Their witnesses also gave evidence to the general acceptance of the procedure both in Ontario and across the United States, where Medicare and the Food and Drug Administration have approved EECP and provide reimbursement for it. Neither agency approves or reimburses experimental procedures. Despite this evidence, the Ontario Ministry continued on appeal to oppose coverage of EECP on the grounds that it is not listed in the SOB-PS, and that it is an "experimental" service.

Note 23: HSARB, Baldassini (file # 02-HIA-0210) et al. The hearing of the appeal concluded on December 1, 2003 and a decision is expected anytime.

¶ 17 In support of their case, and in addition to drawing upon a variety of expert evidence, the appellants raised strong interpretive arguments in favour of funding EECP. They noted that the HIA is a piece of social welfare legislation that has been enacted to further the public good and, as such, must be given a liberal interpretation. Any doubt, it was argued, must be resolved in favour of the claimant.

Out-of-Country Coverage

¶ 18 If Baldassini represents an example of the Ministry taking a restrictive approach to health insurance coverage, the opportunity to claim reimbursement for out-of-country medical services has proved to be an area in which the scope of medical coverage is widening beyond the confines of procedures proscribed in the SOB-PS. The statutory basis for out-of-country claims can be found in a safety valve provision hidden in Regulation 552, which allows for residents to seek reimbursement from OHIP for health

services received abroad. [See Note 24 below] Section 28.4(4) of the Regulation provides that a patient may, in certain circumstances, seek out-of-country treatment and then be reimbursed in an amount equal to the "usual and customary amount charged by similar facilities under similar circumstances to major insurers for services provided".

Note 24: Supra note 10.

¶ 19 Cases in this area test the reach and depth of the universality principle, and also raise difficult questions about how universal the system really is. An application can be initiated in one of two ways, either by seeking prior approval for the out-of-country service, or by seeking approval after the fact. The process is one which favours the wealthy because, unless one is able to afford to pay for the treatment up front, an entitlement to reimbursement later is of no use, as most of these cases involve circumstances that demand immediate care. Where there is urgency, it is not always feasible to seek prior approval, although the Ministry is capable of making decisions within a matter of days, if not hours. For those who commence treatment without prior Ministry approval, there can be no guarantee that money expended will be recoverable. As discussed above, the Ministry has made little effort to provide assurances that certain types of treatment, even if reimbursed in the past, will continue to be deemed "insured services". Each case proceeds on its own merits, which makes managing client expectations somewhat difficult. The unpredictability of the process also makes it difficult for individuals to successfully apply for reimbursement without the assistance of a lawyer, serving as a further financial obstacle to patients with limited resources.

Hospital or Health Facility

¶ 20 For out-of-country reimbursement, the Regulation establishes the same twin requirements as for services within Ontario: the procedure must be both medically necessary and non-experimental. "Services" are not limited to those which are "prescribed" in the SOB-PS. Treatment which meets this criteria and is administered at a "hospital" or health facility" will be prescribed as an "insured service" and qualify for OHIP coverage. Section 28.4 lays out the test that applicants must meet:

- (2) Services that are part of a treatment and that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,
 - (a) the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and
 - (b) either,

- (i) that kind of treatment that is not performed in Ontario by an identical or equivalent procedure, or
- (ii) that kind of treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.

¶ 21 The lack of a clear definition of "health facility" has opened the door to cases arguing for an expansive interpretation of the term, in an effort to widen the reach of OHIP coverage to reflect the principle of universality contained in the CHA. The jurisprudence has begun to reflect the evolving clinical approaches to a variety of health care services. The area in which a lot of progress has occurred is with respect to adolescent addiction treatment. At present, residential drug treatment services are available to adults in the province of Ontario, but not to adolescents. There is a general consensus amongst health care practitioners that adult facilities are not appropriate or effective for adolescent addicts. Child psychiatrists, psychologists and therapists engaged in addiction treatment all agree that recovery models must be specifically tailored to the needs of teenagers.

¶ 22 A potential problem, from the Ministry's perspective, is that such treatment does not follow an exclusively medical approach, often involving other health practitioners as well as doctors, and is often not administered in a conventional hospital setting. In the case of C.M.K., [See Note 25 below] these issues were engaged within the context of a fifteen-year-old claimant with severe mental health and drug addiction problems, who was referred to the United States to undergo short-term detoxification followed by long-term residential treatment. For adolescent males, health care professionals have identified two principal detoxification options: outdoor treatment with an accredited health facility or inpatient treatment in an adolescent acute care setting. The claimant's parents had tried unsuccessfully to seek various forms of inpatient detoxification throughout Toronto, but his non-compliance made effective treatment impossible. As the situation escalated to the point of crisis, the claimant's child psychiatrist and crisis workers recommended immediate care in a secure treatment program. The only such program in Toronto could not admit the adolescent due to long waiting lists, which is a constant problem in such cases and is even worse elsewhere in the province. The claimant was thus taken abroad to receive the treatment his health care providers had deemed was medically necessary in his circumstances.

Note 25: HSARB, C.M.K., 01-HIA-0071, November 21, 2002.

¶ 23 He attended a therapeutic outdoor youth program operated in Utah and licensed under the State's Human Services Code as a "nonresidential program designed to provide behavioral, substance abuse or mental health services to minors". [See Note 26 below]

The Ministry accepted that the type of services offered by the program were performed in Ontario, but objected on the grounds that the service was not provided in a hospital or health facility. Indeed, the program involved taking groups of patients -- teenage drug addicts -- into the wilderness for several weeks with just the bare necessities of life. The youths were accompanied by a multi-disciplinary team of professionals including Physician's Assistants (PAs), who are licensed health practitioners in the state of Utah, in addition to licensed psychologists, social workers and family therapists. While a physician is not usually physically present, the PAs were in regular telephone contact with the Medical Director and doctors were always on call to attend to any medical emergencies.

Note 26: Utah Human Services Code, c. 2 at s. 62A-2-101(25)(a).

¶ 24 The claimant argued before the Board that the term "health facility" in Regulation 552 must be given a large and liberal interpretation, in accord with the remedial purposes of the OHIA and the guarantee of universal coverage of all "medically necessary" treatment under the OHIA and the CHA. Similarly, it was submitted that an interpretation of "health facility" should not be adopted that would deny adolescents with substance addictions an equal level of health care service to that enjoyed by adults. This argument highlighted the inextricable link between universality as a statutory obligation and equality as a Charter right.

¶ 25 The C.M.K. case widened the boundaries of what OHIP will recognize as a health facility by approving reimbursement for the services rendered at an outdoor treatment program, in addition to the long-term residential treatment in a more conventional in-patient facility. [See Note 27 below] This victory marked a notable paradigmatic shift away from OHIP's insistence on traditional health care settings, such as hospitals and clinics. The case may help bolster the efforts of those seeking to extend OHIP's coverage to alternative therapeutic environments and home care.

Note 27: Louise Elliott, "Ontario pays family \$150,000 for drug-addicted teen's U.S. treatment - Beds here were full" National Post, December 21, 2001 at A8.

Statutory Limitations

¶ 26 Applicants for out-of-country reimbursement should be aware of a relatively obscure regulation under the OHIA, entitled Submission of Accounts. [See Note 28 below] The Regulation, which was quietly adopted in 2002 and only applies to claims arising after January 1, 2002, sets a twelve-month limitation period on prospective

claimants filing accounts with OHIP for reimbursement of "insured services" received abroad. Section 2 provides as follows:

Note 28: Ontario Regulation 22/02, am. to O.Reg. 46/04.

2. A physician, practitioner, health facility or, in the case of a patient who is billed directly, the patient shall submit an account for an insured service to the General Manager no later than the following:
 1. For insured services rendered in Ontario, no later than six months after the service is rendered.
 2. For insured services rendered outside Ontario,
 - i. no later than 12 months after the date of the patient's discharge for services rendered to in-patients, and
 - ii. in all other cases, no later than 12 months after the service is rendered.

¶ 27 The Regulation can work a great hardship for the unwary, particularly those who do not learn that they were eligible for reimbursement for such expenditures until after the limitation has run. This is of particular concern from an access perspective. The Ministry may wish to consider whether it is appropriate to have the Regulation apply in out-of-country cases where people are seriously out-of-pocket for medical treatment they required and could not receive in Ontario.

¶ 28 Most surprising is the Ministry's contention that the limitation runs against claimants who are minors. In so holding, OHIP has departed from a centuries-old legal principle that postpones limitation periods until a minor reaches adulthood. This remains the law in virtually all common law jurisdictions to this day. Effective January 1, 2004, a small exception to this principle was introduced in Ontario pursuant to section 6(b) of the Limitations Act 2002, [See Note 29 below] whereby a limitation period starts to run against a minor once the minor is formally represented by a litigation guardian in relation to the claim in question. Where a minor is not represented by a litigation guardian, the Limitations Act 2002 continues to postpone limitation periods until the minor reaches the age of majority for claims arising after January 1, 2004. Prior to that date, the applicable law was to be found in the Limitations Act, [See Note 30 below] which contained no applicable exception to the rule against applying limitations to minors.

Note 29: Limitations Act 2002, S.O. 2002, c. 24.

Note 30: Limitations Act, R.S.O. 1990, c. L.15.

¶ 29 The OHIA and its regulations must be read in conjunction with the applicable limitations legislation. Regulation 22/02 makes no explicit exception for minors, meaning that the general rule should be applied unless an exception can be identified. Section 47 of the Limitations Act, in effect until December 31, 2003, provides:

47. Where a person entitled to bring an action mentioned in section 45 or 46 is at the time the cause of action accrues a minor, mental defective, mental incompetent or of unsound mind, the period within which the action may be brought shall be reckoned from the date when such person became of full age or of sound mind.

¶ 30 The courts have read this provision into the limitation periods of all Ontario statutes, not only those governing the commencement of an action in the courts, ruling that it is a "section of general application". [See Note 31 below] The leading case in Ontario involved a pupil who was sixteen years old at the time his claim arose, and who was met with the objection that the claim was not filed within the time period prescribed in section 11 of the Public Authorities Protection Act (PAPA). [See Note 32 below] The Court of Appeal held the limitation period in the PAPA must be read in conjunction with section 47 of the Limitations Act, which it said applies generally to limitation periods prescribed by the Limitations Act and, in the absence of clear wording to the contrary, by other statutes which provide for the limitation of an action. This reasoning was affirmed by the Supreme Court of Canada, which has ruled that such situations do not involve an inconsistency between two statutes because there exists a "presumption of coherence between related statutes". [See Note 33 below] In that case, the Supreme Court ruled that section 47 of the Limitations Act postponed the operation of the shorter limitation period in the Highway Traffic Act.

Note 31: *Papamonolopoulos v. Board of Education for the City of Toronto* (1986), 56 O.R. (2d) 1.

Note 32: *Ibid.*; Public Authorities Protection Act, R.S.O. 1990, c. P.38 [PAPA].

Note 33: *Murphy v. Welsh*, [1993] 2 S.C.R. 1069 at para. 10.

¶ 31 There is no principled reason why Regulation 22/02 should be treated any differently than any other Ontario legislation. Regulation 22/02 must be consistent with the law of general application protecting the rights of minors. The courts have upheld this principle for hundreds of years, and have been extending rather than limiting its application. Even when the legal disability does not fall within those enumerated in section 47 of the Limitations Act, the courts have been prepared to utilize section 15(1) of the Charter to extend the postponement principle. For example, in one case, the court extended the postponement principle to persons with physical disabilities where this was

relevant to the person's ability to comply. [See Note 34 below] Rigid limitation periods which do not account for the situations of minors or persons with disabilities have not withstood judicial Charter scrutiny.

Note 34: *Speerin v. North Bay (City)* (1991), 5 O.R. (3d) 492 (Ont.Ct.Gen.Div.).

¶ 32 The law therefore requires that the limitation period contained in the OHIA Regulation must be read in conjunction with section 47 of the Limitations Act and the common law governing the running of limitation periods against minors. To the extent that there are any exceptions to the statutory and common law principle of postponement, section 15(1) of the Charter would apply. If, as it seems likely, the Ministry is attempting to curb the flow of out-of-country applications brought forth on behalf of adolescents who have received residential treatment abroad, misapplying a limitation period in a way which discriminates against minors is not the appropriate manner of effecting policy change. If indeed there has been a policy decision to begin closing the door on reimbursement for treatment abroad that is, admittedly, often quite expensive, the government would be advised to adopt appropriate legislative changes coupled with measures to provide such necessary medical treatment within the province. A failure to do so will put the Ministry at risk of trampling upon the Charter rights of the province's most vulnerable members.

3. Charter Remedies

Section 15, Auton and Positive Action

¶ 33 The Supreme Court is presently considering the appeal from the British Columbia Court of Appeal in the *Auton* case, which concerns government funding of intensive behavioural intervention (IBI) for children with autism spectrum disorder (autism). [See Note 35 below] Significantly, IBI is not a service provided by physicians, but rather by specialized therapists trained in IBI techniques. The appellants are a group of parents with autistic children who claim that IBI is the most beneficial treatment for their children. [See Note 36 below] They sought and were awarded by the British Columbia Court of Appeal a Charter remedy on the basis of section 15, requiring the provincial insurer to recognize IBI as a "medically necessary" procedure, and compelling it to cover the cost of IBI for pre-school autistic children.

Note 35: *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, (2002) 220 D.L.R. (4th) 411, affirming 197 D.L.R. (4th) 165.

Note 36: In this case, they argued specifically for *Lovaas Autism Treatment (LAT)*, a form of IBI.

¶ 34 The courts have traditionally sought to avoid being perceived as interfering in social programs administered by the provinces. This is especially true where the province is acting within an area of its discretionary competence and adopts a policy position based on its considered appreciation of the surrounding circumstances, notably financial considerations. [See Note 37 below] However, certain situations require the courts to craft remedies that extend legislative benefits where the law is underinclusive. The Supreme Court in *Eldridge* has emphasized the need for a "broad and purposive" approach to section 15, which promotes substantive equality as opposed to mere formal equality. [See Note 38 below] With its purpose of eradicating historical disadvantage, stereotyping and marginalization, section 15 therefore mandates the promotion of "equal enjoyment of the valued social interests historically available to the advantaged". [See Note 39 below] While the Charter does not require the province to provide its residents with health care services, it does require the government, having undertaken to operate a publicly funded health care system, to administer the system in a non-discriminatory manner.

Note 37: For example, in *Shulman*, supra note 11, the court rejected the applicant's section 15(1) claim in refusing to interfere with the province's decision to stop insuring the cost of hearing aid evaluations and to attach conditions to the terms of payment to physicians for diagnostic hearing tests.

Note 38: *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 at para. 61.

Note 39: *Helena Orton*, "Section 15, Benefits Programs and Other Benefits at Law" (1990) 19 Man. L.J. 288 at 299.

¶ 35 Thus, the section 15 equality guarantee can serve not only as a shield against discriminatory action, [See Note 40 below] but also as a sword with which to battle discriminatory inaction on the part of government. As in other areas, section 15 can compel government to take positive steps to remedy inequality in a province's health care system. Litigation based on claims of discriminatory underinclusion in health care should enjoy a higher rate of success because the universality guarantee in the CHA, which each province has committed itself to upholding, assures a comprehensive program from which exceptions are not to be made. [See Note 41 below] This creates a broad impetus for government to re-examine its social institutions and programs to ensure that they adequately represent and serve those who have been historically prevented from benefiting from those programs. Section 15(2) lends support to this purposive interpretation of section 15, to the extent that it provides a constitutional justification for measures that seek to redress systemic inequality.

Note 40: See for e.g. the decision to exclude a particular treatment from coverage, supra note 5.

Note 41: *Nova Scotia (WCB) v. Martin*, [2003] S.C.J. No 54 at para. 94 [per Gonthier J.]; *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566.

¶ 36 Given this approach to section 15, the most appropriate remedy usually in most cases of underinclusive legislation would be to read in an extension of the wrongfully denied benefit. While this is the most intrusive type of constitutional remedy because it imputes to the legislature words and deeds that are not its own, positive remedies have been held by the Supreme Court of Canada to be a proper and just remedy in circumstances where invalidation would fail to address the root cause of the inequality. [See Note 42 below]

Note 42: *Schachter v. Canada*, [1992] 2 S.C.R. 679 at 701-702.

¶ 37 In the health services field, the imposition of a positive obligation was embraced and affirmed in *Eldridge*, where the Supreme Court of Canada recognized government's role in promoting the good health and quality of life of all persons. [See Note 43 below] In that case, the Court held that not providing the service of free sign language interpreters for hearing impaired patients was not consistent with the Charter's guarantee of substantive equality. In doing nothing, the province was actually complicit in the perpetuation of systemic discrimination against a historically disadvantaged group.

Note 43: *Eldridge*, supra note 38.

¶ 38 The principle of universality in health care complements the approach to equality which holds that treating likes alike will not always amount to equal treatment and, in fact, often results in the opposite. [See Note 44 below] The notion that equality requires treating people differently based on their particular personal circumstances is central to the *Auton* case. The B.C. Court of Appeal has now recognized, as has the highest court in Nova Scotia, [See Note 45 below] that the government's failure to address the health care needs of a particular group, identifiable by a disability, amounts to differential treatment that may constitute a violation of section 15.

Note 44: The similarly situated test as an equality law methodology was decisively rejected in *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 at 165-168.

Note 45: Cameron, *supra* note 12. A section 15 violation was held to be justifiable under section 1 on the basis of the government's need to control health care costs.

¶ 39 Some critics of *Auton* have warned of bursting floodgates if there is an onset of section 15 underinclusiveness claims that will push government health care spending to unsustainable levels. [See Note 46 below] Such critics are suspicious of those who use the Charter to expand the scope of public health insurance by requiring the coverage of new service types:

Note 46: Donna Greschner & Steven Lewis, "Auton and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82 Can. Bar Rev. 501.

They will change the mix of public and private financing, one case at a time. Money is on the table, and lots of it. So, too, since health care resources are not unlimited, is equity. [See Note 47 below]

Note 47: *Ibid.* at 504-505.

¶ 40 Certainly, the suggestion that the goals of equity and equality can only be achieved in a world of infinite resources and wealth is misdirected. Implicit in Charter rights is the notion that giving life to one person's right will often require sacrifices on the part of another. The redistribution of power and privilege always involves the redistribution of scarce resources. Health care resources are no different than other government resources and the public policy areas that are the battlefields of equality litigation in Canada today. Whatever the cause, promoting equality is almost never a zero sum gain. Moreover, it is settled law that the issue of money is one which is reserved for the section 1 justification test. Limited resources will never defeat a section 15 claim at the breach stage, and even at section 1, financial considerations alone may not be sufficient to justify a Charter violation. [See Note 48 below]

Note 48: *Eldridge*, *supra* note 38 at para. 85.

¶ 41 Eldridge is the standard-defining section 15 disability case, in which the Supreme Court of Canada recognized that Canada's long tradition of providing comprehensive, accessible and universal health care to its citizens, along with the statutory requirements of the CHA, provided the political context within which the applicants' right to health care without discrimination was to be determined. The Court clarified that the potential violation of section 15 was found in the discretion exercised by individual hospitals and the Medical Services Commission rather than in the legislation itself. [See Note 49 below] As a result, it reasoned that provincial health insurance legislation should be read in conformity with section 15, with the understanding that legislatures may not enact laws that infringe the Charter and they cannot authorize or empower administrative decision makers to do so either. [See Note 50 below]

Note 49: Ibid. at para. 34.

Note 50: Ibid. at para. 32.

¶ 42 While critics seek to distinguish Eldridge from Auton, the grounds for distinguishing must be clarified. [See Note 51 below] Indeed, Eldridge was about accommodating the needs of particular disabled persons to allow them to enjoy the full and equal benefit of hospital services. Auton, on the other hand, is a pure underinclusiveness case that engages the universality principle of the CHA directly: having undertaken a universal public health care system, the government is bound to include everybody in it, or to include nobody. A plan which provides necessary services to some, but not to others (in this case, autistic children), is not only flawed in respect of the CHA, but also in respect of the Charter. If the Charter is only capable of ameliorating "social conditions" that prevent disabled persons from accessing health care services, but not inequalities in the identification and provision of those services, then we are stepping backward to an era in which the guarantee of substantive equality, at least for persons with disabilities, is rendered meaningless.

Note 51: Greschner & Lewis, *supra* note 46, advance the argument that Eldridge was about accessibility - a CHA principle -- while Auton is about amelioration. The argument goes that, in Eldridge, the claimants were merely seeking to access their fair share of the health care pie by being provided with government-paid interpreters (social disability model), while in Auton the claimants are seeking a bigger piece than their fair share of the pie and asserting a false "right" to be "cured" of their disability.

¶ 43 One major critique of the Auton decision is what has been called the lack of "evidence-based decision making" by the court. [See Note 52 below] Critics assert that the court was not equipped to make such a determination where the scientific data is not

conclusive, and that the implications of the decision were so profound that the court's decision amounted to an overly interventionist invasion of an area of provincial discretionary policy making. A series of *Auton*-like cases have made their way into the court system, particularly in Ontario, where the positive impact of IBI treatment has been noted and accepted by trial judges. [See Note 53 below] Moreover, an issue which was ancillary to the decision in *Auton* but which is certain to be a contentious point of litigation in the autism context, is the cut-off age of six years at which point governments stop funding IBI treatment. The court in *Auton* deliberately steered clear of pronouncing on the constitutionality and/or statutory validity of this cut-off age. In *Lowrey*, Gans J. granted an application for an interlocutory injunction brought on behalf of a six-year-old boy with autism, requiring the government to continue funding his IBI treatment pending the outcome of the case on the merits. While the decision is not conclusive, it was largely seen as a positive application of the *Auton* principles and part of an emerging trend of progressive decisions concerning services for autistic persons, especially children. The *Lowrey* case is based on sections 7 and 15(1) of the Charter, as well as the U.N. Convention on the Rights of the Child. On the motion, the government all but conceded that the section 15(1) claim raised a serious issue to be tried, suggesting that section 15 remains an effective and potent tool for advancing equality rights with respect to health care services. [See Note 54 below]

Note 52: *Greschner & Lewis*, supra note 46 at 507.

Note 53: See for e.g.: *Lowrey (Litigation Guardian of) v. Ontario* (2003), O.R. (3d) 222 (Sup.Ct.Just.); *Clough (Litigation guardian of) v. Ontario*, [2003] O.J. No. 1074 (Div.Ct.); *Fleischmann (Litigation guardian of) v. Toronto District School Board*, [2004] O.J. No. 160 (Div. Ct.); *Wynberg v. Ontario*, [2004] O.J. No. 1066 (Sup.Ct.Just.). It should be noted that not all of the listed cases were brought in a health care context, so the argument could be made that while IBI may be helpful or even necessary to the well-being of autistic children, its medical necessity may still be unproved. The debate over whether IBI is best administered through health care or through the education system is a live one.

Note 54: *Lowrey*, *ibid* at para. 10.

4. Conclusion

¶ 44 1. It is likely that the financial pressures on government combined with perceived benefits to health care providers by keeping certain health services in the private domain will result in an ever-increasing pressure on individuals to secure public funding for health care services. Governments simply do not have the motivation to ensure the preservation of a single-tier health care system, by policing legislation designed to achieve this goal. [See Note 55 below] For many years, it was assumed that Health Canada would insist that experimental procedures (i.e. clinical trials) would be offered free of charge to participants. This is no longer the case. By modifying procedures somewhat from those "prescribed" under the SOB-PS, health practitioners can provide services that are not covered by OHIP. If the nature of the service is such that a

significant number of persons exist who are willing to pay a private fee for the service, the practitioners may perceive it as being in their interests to prolong the period of experimentation indefinitely. It is not clear that government has any interest in making services, such as sleep disorder treatment, generally available at public expense. Until a significant number of people bring applications based on statute to the HSARB or, alternatively, file human rights complaints or launch Charter challenges, the issue of whether or not public funding is required for a particular procedure will not be determined on a principled and consistent basis.

Note 55: This legislation included the Health Insurance Act, R.S.O. 1990, c. H.6, the Private Hospital Act, R.S.O. 1990, c. P.24 and the Independent Health Facilities Act, R.S.O. 1990, c. I.3.

¶ 45 Clearly, the commitment to universality set out in the CHA will prove an illusive goal to define, since treatments will be coming into favour and going out again on an ongoing basis. Moreover, the assumption that services provided in hospital or by physicians are entitled to a higher claim in the public purse than other services will be subjected to ongoing scrutiny. Since the primary objective of the CHA is, as stated, "to protect, promote and restore the physical, and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers", [See Note 56 below] it is difficult to see how "health services" can remain the private preserve of one professional group. All of this means the courts are likely to be faced with a significant and increasing role in defining how universal and comprehensive Canada's health care services will be.

Note 56: Supra note 1 at s. 3.

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