

Lieberman Award

Section 15 of the *Charter* and the Allocation of Resources in Health Care: A Comment on *Auton v. British Columbia*

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On 19 November 2004, the Supreme Court of Canada released its decision in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*¹. Contrary to both the lower courts,² the Court held that the refusal of the Province of British Columbia to fund a particular treatment for autistic children did not violate the right to equality under the *Canadian Charter of Rights and Freedoms (Charter)*.³ As McLachlin C.J.C. explained, the issue before the Court was “not what the public health system should provide, which is a matter for Parliament and the legislature. The issue [was] rather whether the B.C. Government’s failure to fund these services under the health plan amounted to an unequal and discriminatory denial of benefits under that plan, contrary to s. 15 of the *Charter*.”⁴ The petitioners, however, failed to establish that the denial of benefits violated the *Charter*.⁵ While the government must provide services authorized by law in a non-discriminatory manner, discrimination was not established because the benefit claimed, funding for all medically required services, was not provided by law, nor had the government excluded autistic children on the basis of disability.⁶

Determining which denials of a health care service violate equality rights and which do not is a difficult task.⁷ Moreover, this issue will likely continue to be “contentious ... as the availability of a growing array of new and often expensive modalities challenges those responsible for allocating limited health care budgets

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¹ *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, (2004), S.C.J. No. 71, 2004 SCC 78.

² *Auton (Guardian ad litem of) v. British Columbia (Attorney General)* (2002), 220 D.L.R. (4th) 411, [2002] B.C.J. No. 2258, 2002 BCCA 538 [*Auton, B.C.C.A.*]; *Auton (Guardian ad litem of) v. British Columbia (Minister of Health)*, [2000] B.C.J. No. 1547, 2000 BCSC 1142 [*Auton, B.C.S.C.*].

³ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

⁴ *Supra* note 1 at para. 2.

⁵ *Ibid.*

⁶ *Ibid.* at para. 3.

⁷ Nola M. Ries, “The Uncertain State of the Law regarding Health Care and Section 15 of the *Charter*” (2003) 11 Health L.J. 217 at 232.

in a fair and efficient manner.”⁸ The Supreme Court of Canada’s decision in *Auton* sets an important legal precedent and framework for examining the issue of the equitable allocation of resources. This comment examines two components to this framework: “medical necessity” and the equality analysis under s. 15. After summarizing the facts and the two lower court decisions, I shall argue that the Supreme Court of Canada’s analysis in *Auton* is consistent with prior case law, and though not groundbreaking, provides useful clarification and guidance.

Facts

The four infant petitioners suffer from autism, a neuro-behavioral syndrome caused by dysfunction of the central nervous system.⁹ A 1987 study published by Dr. O. Ivar Lovaas suggested that Applied Behavioral Analysis (ABA) or Intensive Behavioral Invention (IBI) may help some autistic children between ages three and six.¹⁰ This intensive therapy costs between \$45,000 and \$60,000 per year for a single child.¹¹ The petitioners and other individuals lobbied the Province of British Columbia to provide funding for the therapy.¹² At the time of trial, the government funded several programs for young autistic children and seemed to be moving toward funding some form of early intervention therapy.¹³ Nevertheless, the government had not established funding for ABA/IBI therapy.¹⁴ Among the factors contributing to the government’s hesitance were financial constraint and “the emergent and somewhat controversial nature of ABA/IBI therapy.”¹⁵

The petitioners sought a declaration that the denial of funding for Lovaas therapy (a particular type of ABA/IBI therapy) by the Ministries of Health, Education and Children and Families violated s. 7 and s. 15 of the *Charter*. They also sought an order of *mandamus* requiring the Crown to pay for the costs of past and future treatment.

⁸ Barbara von Tigerstrom, “Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*” (1999) 11:1 Const. Forum Const. 30 at 30 [von Tigerstrom]. von Tigerstrom notes that “[c]ontroversies surrounding allocation of resources in health care have given rise to a number of legal claims in Canada,” including *Brown v. British Columbia (Minister of Health)* (1990), 66 D.L.R. (4th) 444, [1990] B.C.J. No. 151 (B.C.S.C.); and *Ontario Nursing Home Assn. v. Ontario* (1990), 74 O.R.(2d) 365, (1990), 72 D.L.R. (4th) 166 (Ont. H.C.J.). For a recent case in which the issue was dealt with see *Wynberg v. Ontario*, *infra* note 115 and accompanying text.

⁹ *Supra* note 1 at para. 4.

¹⁰ *Ibid.* at paras. 5-6.

¹¹ *Ibid.* at para. 5.

¹² *Ibid.*

¹³ *Ibid.* at para. 9.

¹⁴ *Ibid.*

¹⁵ *Ibid.* at paras. 10-11 (explaining that one of the interveners in the appeal, an autistic person, argued against the controversial therapy).

Decision of the British Columbia Supreme Court

Allan J. addressed only the claim against the Ministry of Health because she considered the claim to primarily a health care issue.¹⁶ Having thus narrowed the claim, Allan J. found that applied behavioral therapy is a “medically necessary service” for autistic children.¹⁷ In making this finding, she rejected the Crown’s “narrow definition of a ‘medically necessary service’ as one that must be provided by a health care practitioner.”¹⁸ Instead, she determined that a more precise definition was “whatever cures or ameliorates illness.”¹⁹ By denying a particular “medically necessary” service to a disadvantaged group (namely autistic children, a subset of the mentally disabled), while providing other “medically necessary” services to non-autistic children and mentally disabled adults, the government discriminated against autistic children, since “the absence of treatment programmes for autistic children must consciously or unconsciously [have been] based on ... a misconceived stereotype ... that one cannot treat autistic children.”²⁰ Allan J. concluded that the Crown had “failed to take into account and accommodate the infant petitioners’ already disadvantaged position, resulting in differential treatment,” and that this unequal treatment constituted discrimination on the basis of the enumerated ground of mental disability.²¹

Further, Allan J. found that the violation of s. 15 was not justified under s. 1 of the *Charter*. While she accepted that the government was entitled to judicial deference in allocating finite resources among vulnerable groups, she held that it did not follow that the government’s decision to deny funding for ABA/IBI was immune from *Charter* scrutiny, considering that the exclusion of ABA/IBI therapy “undermine[d] the primary objective of the medicare legislation, which is to provide universal health care.”²² Ultimately, Allan J. granted first, a declaration that the failure to fund ABA/IBI breached s. 15 of the *Charter*; second, a direction that the Crown fund early intensive behavioral therapy for children with autism; and third, a “symbolic” award of \$20,000 under s. 24(1) of the *Charter* to each of the adult petitioners as damages for the financial and emotional burdens of litigation.²³

Decision of the British Columbia Court of Appeal

The Court of Appeal affirmed the trial judge’s ruling that the government had infringed s. 15 of the *Charter*. Saunders J.A. identified discrimination in “the failure of the health care administrators of the Province to consider the individual

¹⁶ *Auton*, B.C.S.C., *supra* note 2 at para. 88.

¹⁷ *Ibid.* at para. 102.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.* at para. 127.

²¹ *Ibid.* at para. 139.

²² *Ibid.* at para. 151.

²³ *Ibid.* at paras. 64-65.

needs of the infant complainants by funding treatment.”²⁴ According to Saunders J.A., this failure was essentially “a statement that their mental disability is less worthy of assistance than the transitory medical problems of others,” thereby creating a “social constructed handicap” that exacerbated the position of an already disadvantaged group.²⁵ Also, Saunders J.A. found that the government had failed to satisfy the justificatory burden under s. 1 of the *Charter*.²⁶

Decision of the Supreme Court of Canada

The Justices of the Supreme Court of Canada gave a unanimous judgment, written by McLachlin C.J.C. The Court held that the B.C. Government’s failure to fund ABA/IBI therapy under the province’s public health plan did not amount to an unequal and discriminatory denial of benefits under that plan, contrary to s. 15 of the *Charter*. The Court’s analysis of s. 15(1) was based on the Supreme Court of Canada’s seminal decision in *Law v. Canada (Minister of Employment and Immigration)*²⁷, which set out three requirements for establishing a violation of s. 15(1): (1) differential treatment under the law; (2) on the basis of an enumerated or analogous ground; (3) which constitutes discrimination.²⁸ McLachlin C.J.C. noted that “[t]here is no magic in a particular statement of the elements that must be established to prove a claim under s. 15(1).”²⁹ Since different issues will be raised by different facts, the key is to ensure that all the requirements of s. 15(1), as they apply to the facts in issue, are met.³⁰ The following three issues arose from an application of s. 15(1):

Is the claim for a benefit *provided by law*? If not, what relevant benefit is provided by law?

Was the relevant benefit denied to the claimants while being granted to a comparator group alike in all ways relevant to the benefit, except for the personal characteristic associated with an enumerated or analogous ground?

If the claimants succeed on the first two issues, is discrimination established by showing that the distinction denied their equal human worth and human dignity?³¹

²⁴ *Auton*, B.C.C.A., *supra* note 2 at para. 51.

²⁵ *Ibid.*

²⁶ *Ibid* at para 67.

²⁷ *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, (1999), 170 D.L.R. (4th) 1.

²⁸ *Ibid.* at para. 88.

²⁹ *Supra* note 1 at para. 23.

³⁰ *Ibid.*

³¹ *Ibid.* at para. 26.

Based on this test, the first question addressed was whether the benefit claimed was one conferred by law. McLachlin C.J.C. identified the benefit claimed as essentially “funding for all medically required treatment,”³² and then she scrutinized the legislative scheme to determine whether this benefit was provided by law. First, as required by the *Canada Health Act*³³, the scheme provides complete funding for services delivered by medical practitioners, referred to as “core” services.³⁴ McLachlin C.J.C. noted that many medically necessary or required services, including ABA/IBI therapy for autistic children, lie outside the scope of this core.³⁵ Secondly, the *CHA* gives the provinces a discretionary authority to fund services that are not delivered by physicians, called “non-core” services.³⁶ McLachlin C.J.C. concluded that this legislative scheme “does not promise that any Canadian will receive funding for all medically required treatment.”³⁷

Moreover, McLachlin C.J.C. looked to the broader issue of whether the legislative scheme was discriminatory in denying funding for ABA/IBI therapy to autistic children, while providing funding for non-core services to some groups.³⁸ However, the scheme was by its very nature “a partial health plan” and was not intended to meet all health needs.³⁹ Therefore, the mere exclusion of certain non-core services could not be viewed as discrimination.⁴⁰

Next, McLachlin C.J.C. considered the question of whether, on the basis of an enumerated or analogous ground, there was a denial of a benefit that was granted to a comparator group.⁴¹ McLachlin C.J.C. determined that the appropriate comparator was “a non-disabled person or a person suffering a disability other than a mental disability (here autism) seeking or receiving funding for a non-core therapy important for his or her present and future health, which is emergent, and only recently becoming recognized as medically required.”⁴² She found that in the absence of evidence suggesting that the government’s approach to ABA/IBI therapy was different than its approach to comparable, novel therapies for non-disabled persons or persons with a different form of disability, a finding of discrimination could not be substantiated.⁴³

³² *Ibid.* at para. 30.

³³ R.S.C. 1985, c. C-6 [*CHA*].

³⁴ *Supra* note 1 at para. 32.

³⁵ *Ibid.*

³⁶ *Ibid.* at para. 33.

³⁷ *Ibid.* at para. 35.

³⁸ *Ibid.* at para. 39.

³⁹ *Ibid.* at para. 43.

⁴⁰ *Ibid.*

⁴¹ *Ibid.* at para. 47.

⁴² *Ibid.* at para. 55.

⁴³ *Ibid.* at para. 62.

Analysis

The Concept of “Medically Necessary”

Auton involves “the notoriously difficult task of defining and applying the concept ‘medically necessary.’”⁴⁴ Many health care policy commentators have noted the “lack of clarity regarding the term ‘medically necessary,’ which is used in the Canada Health Act ... and in provincial health care insurance legislation to describe the services to which Canadians are entitled through the public health care system.”⁴⁵ Therefore, before proceeding, a brief look at the relevant legislation will be useful.

The principle of comprehensiveness under the CHA requires a provincial health care plan to “insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.”⁴⁶ The CHA defines “insured services” as “hospital services, physician services, and surgical-dental services provided to insured persons....”⁴⁷ “Hospital services” are defined as certain listed services that “are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability”, and “physician services” are described as “any medically required services rendered by medical practitioners.”⁴⁸ The CHA does not provide definitions of the terms “medically necessary” or “medically required.” Similarly, “medically necessary” is not defined under the *B.C. Medical Protection Act*⁴⁹, though a benefit must be “medically required” before it is an insured service.⁵⁰

Consequently, policies about what services will be encompassed under health care insurance legislation are governed by the provinces. In 1994 the Canadian Task Force on Health Care⁵¹ reported:

Much of the debate over Medicare in Canada revolves around the definition of what services are “medically required”. By not including a definition of this term in the CHA, the federal government seems to have left it up to each province and territory to establish its own definition. the provinces have also chosen not to provide a substan-

⁴⁴ von Tigerstrom, *supra* note 8 at 34.

⁴⁵ *Supra* note 7 at 217.

⁴⁶ *Supra* note 33 at s. 9.

⁴⁷ *Ibid.* at s. 2.

⁴⁸ *Ibid.*

⁴⁹ R.S.B.C. 1996, c. 286 [MPA].

⁵⁰ *Ibid.* at s. 1.

⁵¹ Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994).

tive definition, and the scope of “medically required services” and indeed, all “insured health services”, is a policy decision.⁵²

Timothy Caulfield comments that the ambit of services funded by the provinces has generally encompassed “those services which are deemed medically necessary and ... this has simply meant whatever a physician viewed as required.”⁵³

Thus, in deciding cases involving the concept of medically necessary, the courts find themselves in ambiguous territory. As Caulfield points out, the courts have been hesitant to expressly set out medically necessary services.⁵⁴ Instead, “Canadian case law has simply utilized the broad and amorphous concepts and terms present in the relevant legislation and literature.”⁵⁵ Ultimately, courts tend to “incorporate the traditional circular definition – that is, medically necessary is that which is physician performed.”⁵⁶ For example, in *Eldridge v. British Columbia (Attorney General)*, in which the plaintiffs sought a declaration that the government’s failure to fund interpreting services for the deaf was a violation of s. 15, the Court found that “[i]nterpreting services are not medically required services. Even if they could be classified as medically required services, they are not rendered by medical or health care practitioners [and are therefore not insured].”⁵⁷

In *Cameron v. Nova Scotia*⁵⁸, the judiciary was called on to consider whether particular fertility treatments were medically necessary. In this case, an infertile couple argued that the Province of Nova Scotia discriminated against them by failing to fund fertility treatments, in-vitro fertilization (IVF) and intra-cytoplasmic sperm injection (ICSI), which help infertile persons to have a biologically-related child. At trial, Kennedy C.J.S.C. decided that although IVF and ICSI might be medically “indicated” for infertile individuals, it did not follow that the services were “medically necessary” and therefore covered under the provincial health care insurance plan.⁵⁹ In concluding that the services were not medically necessary, he observed that there were alternative treatments available, that the success rate of the procedures was low, and that the procedures had inherent risks.⁶⁰

⁵² *Ibid.* at 31.

⁵³ Timothy A. Caulfield, “Wishful Thinking: Defining ‘Medically Necessary’ in Canada” (1996) 4 Health L.J. 63 at 68.

⁵⁴ *Ibid.* at 77.

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

⁵⁷ *Eldridge v. British Columbia (Attorney General)* (1992), 75 B.C.L.R. (2d) 68 at 87, [1992] B.C.J. No. 2229 (S.C.).

⁵⁸ *Cameron v. Nova Scotia (Attorney General)* (1999), 172 N.S.R. (2d) 227, [1999] N.S.J. No. 33 (N.S. S.C.) [*Cameron*, N.S.S.C.], aff’d (1999), 177 D.L.R. (4th) 611, [1999] N.S.J. No. 297 (N.S.C.A.) [*Cameron*, N.S.C.A.], leave to appeal to S.C.C. refused, [1998] S.C.C.A. No. 531.

⁵⁹ *Cameron*, N.S.S.C., *ibid.* at para. 91.

⁶⁰ *Ibid.* at paras. 95-96.

On appeal, the majority of the Nova Scotia Court of Appeal rejected Kennedy C.J.S.C.'s narrow interpretation of medically necessary as requiring a "medical end." Instead, in the Court's view, the goal of medical treatment is simply to improve quality of life.⁶¹ In light of the ultimate objective of IVF and ICSI, the Court was satisfied that they were "procedures that could qualify as being medically necessary."⁶² Nevertheless, the Court concluded that the trial judge's finding that IVF and ICSI "were not shown to be medically required, as a matter of interpretation of the Act, the Regulations and the administration of the policy [had] not been shown to be in error."⁶³ Therefore, although *Cameron* illustrates the malleability of the term "medical necessity"⁶⁴, both court levels ultimately agreed that IVF and ICSI were not medically necessary according to the relevant legislation.

The malleability of the concept of medically necessary comes to the fore in *Auton*. At trial, the B.C. government argued that ABA/IBI therapy could not be considered medically necessary because it is delivered by behavioral therapists who are not health care practitioners recognized by the B.C. Medical Services Commission. Allan J. rejected this argument as a narrow definition of a "medically necessary service" and stated that "a more accurate definition of medical treatment is whatever cures or ameliorates illness."⁶⁵ In describing a medically necessary service, Allan J. focussed on the ameliorative purpose of the health insurance legislation, which is "is designed to assist people with health care needs."⁶⁶ On this basis, Allan J. characterized ABA/IBI therapy as a "medically necessary service."⁶⁷ In doing so, Allan J. essentially challenged the conventional definition of medically necessary as that which is physician performed.

The Supreme Court of Canada did not deny that the claim was "for funding for a 'medically necessary' treatment."⁶⁸ But crucially, McLachlin C.J.C. drew attention to the fact that Allan J. "used the term 'medically necessary' to mean, in a general way, a medical service that is essential to the health and medical treatment of an individual."⁶⁹ McLachlin C.J.C. accepted the petitioners' argument that the therapy is "medically necessary," but limited the term to its general meaning, perhaps recognizing that attempts to achieve consensus on the meaning of medical necessity are unlikely to succeed. As Cathy Charles et al. suggest, "[s]takeholders have a vested interest in preserving their favoured meaning [of "medical necessity"] and advocating for its broader acceptance."⁷⁰ The value of the term to stakeholders

⁶¹ *Cameron*, N.S.C.A., *supra* note 57 at para. 85.

⁶² *Ibid.*

⁶³ *Ibid.* at para. 90.

⁶⁴ *Supra* note 7 at 234.

⁶⁵ *Auton*, B.C.S.C., *supra* note 2 at para. 102.

⁶⁶ *Ibid.* at para. 126.

⁶⁷ *Ibid.* at para. 127.

⁶⁸ *Supra* note 1 at para. 30.

⁶⁹ *Ibid.* at para. 13.

⁷⁰ Cathy Charles et al., "Medical Necessity in Canadian Health Policy: Four Meanings and ... a Funeral?" (1997) 75: 3 *Millbank Q.* 365 at 386.

lies in the ease with which it can be interpreted to further various ideological and policy goals, and thus consensus regarding a definition of medical necessity is difficult to reach.⁷¹ McLachlin C.J.C.'s analysis in *Auton* removes some of this contentious debate from the legal arena. Although the term "medical necessity" may be easily construed to the advantage of stakeholders such as the petitioners for ABA/IBI therapy, this interpretation does not automatically translate into "medical necessity" under the relevant legislation. This distinction recalls the Nova Scotia Court of Appeal's analysis in *Cameron* that although IVF and ISCI *could* qualify as being medically required, they did not "as a matter of interpretation of the *Act*."⁷² In *Auton*, McLachlin C.J.C. makes this distinction even clearer.

In drawing this bold distinction *Auton* has profound consequences, firstly, for the public imagination. As Glenn Griener comments,

To say that a service is medically necessary is also symbolically important: it is to say that the service is a necessity of a particularly important sort. An individual's *medical* necessity has a particularly strong claim on the public imagination. In the public mind medical necessity is in a class by itself, separate from any other necessity one might identify. It is a necessity which should not go unmet, even in an era of reduced government involvement in the provision of social services. If the government has an obligation to provide for any of the needs of its citizens, it surely has an obligation to meet medical needs.⁷³

Griener points out that much of the discussion of medical necessity is undertaken "to decide whether treatment should be paid for out of the public purse."⁷⁴ The analysis proceeds on the basis that by simply finding the boundary between the necessary and the optional, we will find a logical place to set the limit on insured services.⁷⁵ Yet, as Griener argues, we frequently move too rapidly from the diagnosis of a condition needing treatment to an entitlement to insurance coverage for a treatment.⁷⁶ The mere recognition that an individual has a medically diagnosed need does not entail that the province has an obligation to pay for treatment.⁷⁷ This view is echoed in McLachlin C.J.C.'s blunt statement in *Auton* that although early intervention therapy is medically necessary, the legislative scheme "does not promise that any Canadian will receive funding for all medically required treatment."⁷⁸

⁷¹ *Ibid.*

⁷² *Cameron*, N.S.C.A., *supra* note 58 at para. 90.

⁷³ Glenn Griener, "Defining Medical Necessity: Challenges and Implications" (2002) 10:3 Health L. Rev. 6 at 6.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ *Ibid.* at 7.

⁷⁷ *Ibid.*

⁷⁸ *Supra* note 1 at para. 35.

Very little scrutiny of the Canadian health care system is needed to reveal that publicly-funded health services in Canada are not comprehensive.⁷⁹ Drugs required outside of hospital are not publicly-funded for most Canadians.⁸⁰ Although most people have the majority of the cost of drugs covered by employer-sponsored private insurance plans, 12 percent of the population lacks any form of public or private insurance coverage for drugs needed outside of hospital.⁸¹ In addition to drugs, other important health care services that are generally not publicly-funded include: home care; long-term nursing services; medical devices and equipment used outside hospital such as artificial limbs, hearing aids, and wheelchairs; ambulance services; dental and vision care; and psychological, chiropractic, physiotherapy, and other "alternative" health care services.⁸² The *CHA* entrenches the predominance given to hospital and physician services in the health care system.⁸³ As a result, "the system is geared toward the place of provision of services and the provider of services rather than toward health needs."⁸⁴ The system's inflexibility has been revealed by advances in technology; for example, while the need for hospital-bound health care services has decreased, the needs for drugs prescribed for use outside the hospital and for home care services have increased.⁸⁵

This problem is discussed in the Romanow Report, which states, "We ... need to renovate our concept of medicare and adapt it to today's realities. In the early days, medicare could be summarized in two words: hospitals and doctors. That was fine for the time, but it is not sufficient for the 21st century."⁸⁶ The Report goes on to recommend that the *CHA* be strengthened and modernized "by expanding insured health services beyond hospital and physician services to immediately include targeted home care services followed by prescription drugs in the longer term."⁸⁷ Furthermore, the Report suggests that the principle of comprehensiveness under the *CHA* "should be redefined to mean that, as financial resources permit and as the health care system changes, the definition of comprehensiveness (and of services insured under provincial plans) should continue to evolve."⁸⁸

The deficiencies of the health care insurance scheme and the need for reform are implicitly recognized by McLachlin C.J.C.'s statement that the legislation does

⁷⁹ Colleen M. Flood, "The Structure and Dynamics of Canada's Health System" in Jocelyn Downie & Timothy Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 5 at 9.

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 18 (Commissioner: Roy J. Romanow, Q.C.), online: Commission on the Future of Health Care in Canada <<http://www.healthcarecommission.ca>>.

⁸⁷ *Ibid.* at 59.

⁸⁸ *Ibid.* at 63.

not provide for all “medically necessary” treatments. Importantly, though, McLachlin C.J.C.’s analysis reorients this problem from the legal to the political arena. While the Supreme Court of Canada (understandably) does not take the opportunity in *Auton* to give a precise definition of the term “medically necessary,” it does clarify that health care insurance legislation creates boundaries for the term, and that claimants must turn to legislatures to alter this framework.

The Discrimination Analysis under Section 15(1) of the *Charter*

Section 15 litigation about allocation of health care resources starts with an argument between the claimant and the government about whether a service is medically necessary.⁸⁹ In *Auton* the Supreme Court of Canada essentially finds that this threshold is met because ABA/IBI are “medically necessary” in a general sense. The next question is whether denial of public funding for that service constitutes discrimination contrary to s. 15(1)⁹⁰ of the *Charter*.⁹¹ Here the claimants’ argument is essentially that government discriminates against them by failing to fund a service they consider medically necessary.⁹² In the result, if a government’s decision to deny funding for particular health care services deprives an individual or group of equal benefit of the publicly funded health care system based on a ground protected under s. 15(1), then the decision may amount to discrimination.⁹³ Determining which denials violate equality rights and which do not is a difficult task, and *Auton* provides some important guidance. As explained above, McLachlin C.J.C. highlighted three issues involved in *Auton* to determine whether the government discriminated against the claimants by not funding ABA/IBI therapy. I will analyze each of these issues in turn.

Is the Claim for a Benefit Provided by Law?

McLachlin C.J.C. emphasized that “[i]n order to succeed, the claimants must show unequal treatment under the law – more specifically that they failed to receive a benefit that the law provided, or were saddled with a burden that the law did not impose on someone else.”⁹⁴ This analytical framework reflects how, as Benjamin Berger comments, “in fidelity to the liberal roots of the *Charter*, the courts have adopted a highly formalistic approach to the language of ‘before and under the law,’ thereby excluding claims early in the section 15 analysis.”⁹⁵ *Auton* reveals the

⁸⁹ *Supra* note 7 at 217-18.

⁹⁰ Section 15(1) of the *Charter* provides the following legal protection from discrimination: “Every individual is equal before and under the law and has the right to the equal protection and benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion sex, age or mental or physical disability”, *supra* note 3.

⁹¹ *Supra* note 7 at 218.

⁹² *Ibid.*

⁹³ *Supra* note 7 at 232.

⁹⁴ *Supra* note 1 at para. 27.

⁹⁵ Benjamin L. Berger, “Using the *Charter* to Cure Health Care: Panacea or Placebo?” (2003) 8:1 Rev. Const. Stud. 20 at 36.

accuracy of this observation, for the Court did exclude the claim on the ground that the legislative scheme does not guarantee that any Canadian will receive funding for all medically required treatment.⁹⁶ The Court explained that the legislation simply confers “funding for services provided by medical practitioners, with funding for non-core services left to the Province’s discretion. Thus, the benefit here claimed – funding for all medically required services – was not provided for by the law.”⁹⁷

The Supreme Court of Canada’s rejection of the petitioners’ claim on the first ground may possibly disappoint commentators who view s. 15 as a promising tool to remedy social inequities⁹⁸, and may be criticized as a formal approach to equality. This potential attack may be imagined in the following terms:

If substantive equality is different from formal equality, it must be concerned with what lies outside the lens of formal equality: the actual distribution of resources, opportunities and choices within a society.... Legislators enact laws for a society that already has unevenly distributed its social goods, such as money, choices, recognition and status. Every new law affects that distribution. Accordingly, an assessment of whether a law promotes or retards substantive equality requires looking at people’s economic, social and political circumstances – at the existing distribution of resources – and asking how the impugned law affects them. Does it make disparities and inequalities worse, or better?⁹⁹

Yet even this argument reveals that the question of “how the impugned law affects them” remains key. As McLachlin C.J.C. emphasized in *Auton*, while “[i]t is not open to Parliament or a legislature to enact a law whose policy objective and provisions single out a disadvantaged group for inferior treatment ..., a legislative choice not to accord a particular benefit absent demonstration of discriminatory purpose, policy or effect does not offend this principle.”¹⁰⁰ Accordingly, the Supreme Court of Canada “has repeatedly held that the legislature is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided the benefit is not conferred in a discriminatory manner.”¹⁰¹

⁹⁶ *Supra* note 1 at para. 35.

⁹⁷ *Ibid.*

⁹⁸ See e.g., Martha Jackman, “Poor Rights: Using the *Charter* to Support Social Welfare Claims” (1993) 19 *Queen’s L.J.* 65.

⁹⁹ Donna Greschner, “Does *Law* Advance the Cause of Equality?”, Case Comment (2001) 27 *Queen’s L.J.* 299 at 303. I take Greschner’s comment here simply as a helpful elucidation of the concept of “substantive equality” for the purpose of speculating how the Supreme Court of Canada’s decision might be criticized. I do not wish to suggest that Greschner would necessarily apply this argument to the Supreme Court of Canada’s decision in *Auton*.

¹⁰⁰ *Supra* note 1 at para. 41.

¹⁰¹ *Ibid.*

*Eldridge v. British Columbia (Attorney General)*¹⁰², the first time the Supreme Court of Canada considered a challenge to a government's decision not to fund specific health care services, is consistent with McLachlin C.J.C.'s analysis in *Auton*. In *Eldridge*, a group of four deaf individuals argued that the British Columbia government violated their right to equality by failing to fund sign language interpreters to assist them during medical treatment. More specifically, they argued that this failure constituted adverse effects discrimination on the basis of physical disability because the inability to communicate effectively with health care providers denied them equal benefit of the province's Medicare program. They claimed "adverse affects" discrimination: the law did not make an explicit "distinction" based on disability, but nevertheless rendered them unable to benefit from the legislation to the same extent as hearing persons.¹⁰³ The Supreme Court of Canada, in a unanimous decision, agreed that the failure to fund sign language interpreters violated the claimants' rights to equality under the *Charter*, and directed that the government provide sign language interpreters.¹⁰⁴

Eldridge directed the government to provide a particular health care service, and therefore, the case perhaps appeared to offer an avenue for future claims for expansion of health care services, such as *Auton*, in which the claimants relied on *Eldridge* for support. However, in *Eldridge* the Supreme Court of Canada provided a very careful, telling characterization of the petitioners' claim: it was not a claim "for a benefit that the government, in the exercise of its discretion to allocate resources to address various social problems, has chosen not to provide" but rather a claim "only for equal access to services that are available to all."¹⁰⁵ Critically, this case involved the regulation of access to existing services rather than a claim for an expansion of services or increased health benefits.¹⁰⁶ *Eldridge* did not impose "a positive obligation upon the government to remedy social and economic inequalities – the systemic determinants of health and health care."¹⁰⁷ In *Auton*, McLachlin C.J.C. distinguished *Eldridge* on the logical basis that "*Eldridge* was concerned with unequal access to a benefit that the law conferred and with applying a benefit-granting law in a non-discriminatory fashion."¹⁰⁸ In contrast, as McLach-

¹⁰² *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86 [*Eldridge*, S.C.C.].

¹⁰³ *Ibid.* at para. 60.

¹⁰⁴ *Ibid.* at para. 95.

¹⁰⁵ *Ibid.* at para. 92.

¹⁰⁶ *Supra* note 95 at 36.

¹⁰⁷ *Ibid.*

¹⁰⁸ *Supra* note 1 at para. 38. The Supreme Court of Canada's decision in *Vriend v. Alberta*, [1998] 1 S.C.R. 493, (1998), 156 D.L.R. (4th) 385 [*Vriend*] may be distinguished on a similar basis. In *Vriend* the law challenged was a provincial human rights statute that prohibited employment discrimination on a number of grounds, but did not include sexual orientation as a prohibited ground. The government of Alberta argued that the exclusion of sexual orientation did not constitute differential treatment because it was merely a "neutral silence." Nevertheless, the Court found that the exclusion constituted adverse effects discrimination. The statute's failure to prohibit discrimination on the basis of sexual orientation created a distinction between homosexuals and heterosexuals with respect to the impact of the omission. While the exclusion of sexual orientation perhaps met a formal equality standard, in that neither heterosexuals

lin C.J.C. points out, *Auton* dealt with access to a benefit that the law had not conferred.¹⁰⁹

McLachlin C.J.C. noted that absence of a benefit conferred by law was not determinative, because the Court then needed to consider “the broader issue of whether the legislative scheme is discriminatory.”¹¹⁰ At this point, the argument was that the scheme discriminated by funding some non-core therapies while denying ABA/IBI therapy.¹¹¹ McLachlin C.J.C. reasoned that the purpose of the legislative scheme in the case at issue was not discriminatory because the purpose was not to meet all medical needs: “It is by its very nature a partial health plan. It follows that the exclusion of particular non-core services cannot without more be viewed as an adverse distinction based on an enumerated ground.”¹¹² As von Tigerstrom points out, it cannot be true “that whenever funding is denied for a treatment or procedure that is specifically relevant to or required by persons with a particular medical condition or disability, the mere fact of the denial will be sufficient for a finding of discrimination.”¹¹³ *Auton* reveals that future claims for funding for particular health care services may be successful if the exclusion is accompanied by something “more” than the simple fact of the denial. Of course, the question that remains to be explored in future case law is what will constitute something “more” for the purposes of establishing discrimination.

Another indication of how *Auton* might be distinguished in future is provided by McLachlin C.J.C.’s statement that if “the situation [had] been different, the petitioners might have attempted to frame their legal action as a claim to the benefit of equal application of the law by the Medical Services Commission.”¹¹⁴ As McLachlin C.J.C. elaborated, such a claim would not be a substantive claim for funding for a particular medical service, but rather a procedural claim based on the argument that benefits provided by the law were not distributed equally.¹¹⁵ This claim, McLachlin C.J.C. stated, would be supported by *Eldridge*. In *Auton*, since the legislature did not designate ABA/IBI therapists, or a broader group of therapists that included them, as “health care practitioners,” there was no benefit provided by law. And McLachlin C.J.C. could find “no administrative duty to

nor homosexuals were able to complain of discrimination on the basis of sexual orientation, it imposed a greater hardship upon homosexuals because they were much more likely than heterosexuals to suffer discrimination on the ground of their sexual orientation. Because homosexuals suffer a disproportionate impact from the exclusion of the ground, the statute’s underinclusiveness denied substantive equality to gays and lesbians. In *Vriend*, unlike in *Auton*, the source of the inequality was an under inclusive law, and the Court ordered the extension of a benefit that was already provided by law.

¹⁰⁹ *Supra* note 1.

¹¹⁰ *Ibid.* at para. 39.

¹¹¹ *Ibid.*

¹¹² *Ibid.* at para. 43 [emphasis added].

¹¹³ von Tigerstrom, *supra* note 8 at 38.

¹¹⁴ *Supra* note 1 at para. 45.

¹¹⁵ *Ibid.*

distribute non-existent benefits equally.” Hence McLachlin C.J.C. offers clear guidance about how the Court’s decision could be distinguished in future.¹¹⁶

Furthermore, *Cameron* seems compatible with the Supreme Court of Canada’s reasoning on this point. In *Cameron*, the Nova Scotia Court of Appeal agreed with the trial judge that the source of the exclusion of funding for IVF and ICSI was the policy of the government, including the decisions of the Commission and the Minister in developing lists of insured non-core services. Crucially, IVF and ICSI could fall under the benefits of hospital services and physician services. Therefore, unlike in *Auton*, the petitioners in *Cameron* could specifically claim that the Minister’s distribution of benefits was discriminatory.

For rejecting the plaintiffs’ discrimination claim on the ground that the particular service sought does not fall under benefits provided by law, the Court’s decision in *Auton* might be viewed as patently unfair or insensitive. Certainly though, as McLachlin C.J.C. stated in her introduction to the *Auton* judgment, “[o]ne sympathizes with the petitioners, and with the decisions below ordering the public health service to pay for their therapy.”¹¹⁷ But we must keep clearly in mind that the issue before the Court was “not what the public health system should provide, which is a matter for Parliament and the legislature. The issue [was] rather whether the B.C. Government’s failure to fund these services under the health plan amounted to an unequal and discriminatory denial of benefits under that plan, contrary to s. 15 of the Charter.”¹¹⁸ This observation echoes McLachlin C.J.C.’s comments in “Courts, Legislatures and Executives in the Post-Charter Era”:

In a society as diverse and complex as ours, enacting laws is rarely a simple process of codifying the will of the people. It is rather a delicate task of accommodating conflicting interests and rights. Compromise is the watchword of modern governance. Judicial decision-making, on the other hand, is necessarily a blunt instrument, incapable of achieving the balances necessary for a workable law acceptable to society as a whole.¹¹⁹

Arguably, this principle is particularly relevant in the health care context, in which, as the Romanow Report explains, “[s]ustainability relies on achieving the right balance among the services that are provided, the health needs of Canadians,

¹¹⁶ This point distinguishes *Auton* from the recent decision, *Wynberg v. Ontario*, [2005] O.J. No. 1228, (2005), 252 D.L.R. 4th 10 (S.C.). In this case IBI funding was provided for children 2-5 years. The Ontario Supreme Court held that the Minister’s decision to cease those benefits for children 6 years of age and older infringed s. 15.

¹¹⁷ *Supra* note 1 at para. 2.

¹¹⁸ *Ibid.*

¹¹⁹ Hon. Beverley McLachlin, “Courts, Legislatures and Executives in the Post-Charter Era,” in Paul Howe & Peter H. Russell, eds., *Judicial Power and Canadian Democracy* (Kingston: McGill-Queen’s University Press, 2001) 63 at 72.

and the resources we are prepared to commit to the system.”¹²⁰ Public resources for health care are limited and thus governments will not provide funding for all possible health care services, even if they may offer some help to some individuals.¹²¹

In this context, an important consideration is that “[d]ifferent approaches, different priorities and different visions of what the health care system should look like are part and parcel of living in a country as large and as diverse as Canada.”¹²² While a certain level of disagreement will always exist, disagreements can be approached in either a productive or unproductive manner.¹²³ Disagreements “can lead to finger pointing and distrust where the goal is to lay blame for a problem rather than resolve it.”¹²⁴ In the alternative, “disagreements can lead to a tradition of compromise and negotiation that results, in the end, in decisions that are in the best interests of Canadians and the health care system itself.”¹²⁵

Rights litigation under the *Charter* is in many ways an inflexible tool for achieving balance between different approaches and priorities. As Christopher Manfredi and Antonia Maioni argue, “rights discourse narrows the range of feasible policy alternatives,”¹²⁶ especially in the health care policy context. Rights claims under the *Charter* “narrow the scope of policy discussion by equating legally enforceable rights with a single, ‘correct’ policy choice.”¹²⁷ Moreover, “rights talk delegitimizes concern with the financial costs of alternative solutions to complex policy problems.”¹²⁸ Ultimately,

rights-based claims allow stakeholders in the system to redistribute significant public resources through a process outside the ordinary arena of political conflict where alternative views about resource allocation must be considered. Rights-based claims present courts with a choice between an allegedly rights-deficient allocation and a new, constitutionally mandated policy regime consistent with a claimant’s own interests.¹²⁹

Nola Ries and Timothy Caulfield note that the political arena “is not wholly dysfunctional in that public pressure for health policy change can and does occur and elected decision-makers recognize the importance Canadians place on health

¹²⁰ *Supra* note 86 at 79.

¹²¹ *Supra* note 7 at 217.

¹²² *Supra* note 86 at 81.

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ Christopher P. Manfredi & Antonia Maioni, “Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada” (2002) 27:2 J. Health Pol. 213 at 215.

¹²⁷ *Ibid.* at 218.

¹²⁸ *Ibid.*

¹²⁹ *Ibid.* at 222.

care.”¹³⁰ Since, as *Auton* demonstrates, the mere fact of the exclusion of a particular non-core health service from insurance coverage will not be deemed discrimination under s. 15(1), claimants desiring funding for particular health services must consider exploring the political avenue.

Denial of a Benefit Granted to a Comparator Group, on an Enumerated or Analogous Ground

Although the Supreme Court rejected the petitioners' claim on the first element of the s. 15 analysis, it determined that since *Auton* was the first case of this type to reach the Supreme Court of Canada, it was appropriate to consider how the analysis would have proceeded. In its analysis, the Court provided some useful guidance in selecting the appropriate comparator group in cases of this type. Applying the criteria for choosing comparators established in *Hodge v. Canada (Minister of Human Resources Development)*¹³¹, McLachlin C.J.C. concluded that the appropriate comparator was “a non-disabled person or a person suffering a disability other than a mental disability (here autism) seeking or receiving funding for a non-core therapy important for his or her present and future health, which is emergent and only recently becoming recognized as medically necessary.”¹³² McLachlin C.J.C. emphasized that individuals claiming relatively novel non-core benefits are in a different position than individuals receiving established non-core therapies.¹³³ As McLachlin C.J.C. pointed out, the formulation of the comparator group in the decisions below erred in failing to account for the recent, emergent status of ABA/IBI therapy.¹³⁴ The reasoning on this point will likely be salient in future cases, since, as von Tigerstrom points out, “[t]he funding of innovative technologies and treatments will continue to be a contentious issue,” especially with the “availability of a growing array of new and often expensive modalities.”¹³⁵

¹³⁰ Nola M. Ries & Timothy A. Caulfield, *Accountability in Health Care and Legal Approaches* (Ottawa: Canadian Policy Research Networks, 2004) at 8-9 (explaining that public pressure influences governments to expand health care benefits. For example, as a result of the recommendations of the Romanow Commission, and Senator Kirby's health care committee, the federal and provincial governments have agreed to develop a national home care program and a catastrophic drug program. Also, various provinces are moving to reduce waiting lists to provide timelier access to surgical and diagnostic services).

¹³¹ *Hodge v. Canada (Minister of Human Resources Development)*, [2004] 3 S.C.R. 357, 2004 SCC 65. In *Auton*, S.C.C., *supra* note 1 at paras. 50-54, McLachlin C.J.C. highlighted the propositions from *Hodge* as follows: first, the choice of the appropriate comparator is crucial, since it infuses every stages of the analysis; second, while the starting point is the comparator selected by the claimants, the Court must substitute an appropriate one if the one chosen by the claimants is inappropriate; third, the comparator group should reflect the characteristics of the claimant relevant to the benefit sought, with the exception of the personal characteristic related to the enumerated or analogous ground; and fourth, a claim based on a personal characteristic related to disability may invite comparison with the treatment of those suffering a different or more severe type of disability.

¹³² *Supra* note 1 at para. 55.

¹³³ *Ibid.*

¹³⁴ *Ibid.* at para. 56.

¹³⁵ *Supra* note 8.

McLachlin C.J.C. further considered whether the petitioners were denied a benefit extended to the comparator group.¹³⁶ She determined that the government's approach to ABA/IBI therapy did not differ from its approach to comparable, novel therapies for non-disabled individuals or individuals with a different type of disability.¹³⁷ Therefore, a finding of discrimination could not be supported.¹³⁸ The Court's reasoning thus suggests that in attempting to substantiate future claims of this type, petitioners may wish to bring forth detailed evidence of the government's response to other requests for new therapies or treatments by the comparator group. In turn, *Auton* highlights the wisdom of Donna Greschner's suggestion that governments "can reduce the risk of judicial disruption of health care policies by explicitly taking *Charter* values into account in their health care policies, and justifying their decisions with the best available evidence."¹³⁹

Discrimination

Worth briefly mentioning for its absence, *Auton* does not provide guidance as to whether, if a distinction had been found, it would have been considered discriminatory. This question would have involved determining whether the distinction treated autistic children as second-class citizens and denied their fundamental human dignity.¹⁴⁰ McLachlin C.J.C. held that the failure to establish the basis for a discrimination claim deprived the Court of the required foundation for this inquiry.¹⁴¹ As Ries argues, the focus on human dignity as the central interest protected by s. 15(1) creates uncertainty.¹⁴² Further, deciding whether a government's decision not to fund a specific health care service violates human dignity and consequently constitutes discrimination is a "difficult challenge."¹⁴³ *Auton* does not provide direction for dealing with this challenge, and it will likely fall to later case law to confront the issue.

Conclusion

While *Auton* does not address the notion of human dignity nor provide a groundbreaking analysis of "medical necessity," it sets a crucial framework for examining the equitable allocation of resources. The case clarifies a fundamental issue: what the public health system should provide is a matter for Parliament and the legislature. Although the Supreme Court of Canada will use s. 15 effectively to

¹³⁶ *Supra* note 1 at para. 57.

¹³⁷ *Ibid.* at para. 62.

¹³⁸ *Ibid.* Also, a finding of s. 7 infringement could not be sustained. This point involved limited and fleeting submissions, and was dealt with summarily by the Court at paras. 64-67.

¹³⁹ Canada, Commission on the Future of Health Care in Canada, *Discussion Paper No. 20: How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?* by Donna Greschner (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at vii.

¹⁴⁰ *Supra* note 1 at para. 63.

¹⁴¹ *Ibid.*

¹⁴² *Supra* note 7 at 218.

¹⁴³ *Ibid.*

address the equitable provision of existing medical services, it does not seem willing to use the provision to remedy policy choices about the scope of coverage for insured medical services. Thus the Court affirms that these policy decisions involve “relatively messy compromise – the kind of compromise difficult to justify by the strict standards of judicial rationality, but precisely the kind attractive to representative assemblies.”¹⁴⁴ Individuals wishing to challenge governments’ decisions about the scope of coverage for insured medical services, and lacking any evidence of discrimination beyond the failure to provide funding, must take recourse in political and social mobilization.

¹⁴⁴Rainer Knopff, “Courts Don’t Make Good Compromises” in Paul Howe & Peter H. Russell, eds., *Judicial Power and Canadian Democracy* (Kingston: McGill-Queen’s University Press, 2001) 87 at 90.

