

The Uncertain State of the Law regarding Health Care and Section 15 of the *Charter*

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Introduction

Access to a system of universal, publicly funded health care is often described as a fundamental value for Canadians. Indeed, in its recent report, the Romanow Commission on the Future of Health Care in Canada stated Canadians believe access to medically necessary health care services is a “right of citizenship.”¹ As medical sciences advance and public expectations for health care services grow, governments will undoubtedly face demands to fund an increasing array of services. However, public resources for health care are finite, so it is inevitable governments will not fund all conceivable treatments or therapies, even if those services may offer some benefit to some people.

Individuals or groups who feel aggrieved by a government’s refusal to fund specific health care services may turn to section 15 of the *Canadian Charter of Rights and Freedoms*² (the “*Charter*”) to challenge the government’s decision. In such cases, the claimant argues the government has failed to fund a service that is medically necessary for him or her and this failure amounts to discrimination, usually on the basis of disability. Such claims involve the application of evolving s. 15 jurisprudence in a policy context — health care — marked by almost constant debate, often about issues of resource allocation and fiscal sustainability. As a result, these cases provide rich fodder for debate on many intersecting issues of constitutional law and health care policy.

This paper focuses on two elements that bring uncertainty into s. 15 cases in which claimants seek public funding for health care services. The first element of uncertainty arises from the lack of clarity regarding the term “medically necessary,” which is used in the *Canada Health Act*³ (the “*CHA*”) and in provincial health care insurance legislation to describe the services to which Canadians are entitled through the public health care system. In essence, s. 15 litigation about access to

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¹Commission 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) (Commissioner: Roy J. Romanow, Q.C.), online: Commission on the Future of Health Care in Canada <<http://www.healthcarecommission.ca>> at xvi [Romanow Report].

²*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.

³R.S.C. 1985, c. C-6.

health care begins with an argument between the claimant and the government about whether a service is medically necessary. After a court considers whether a service can be considered medically necessary for persons in the position of the claimant, the question is whether denial of public funding for that service constitutes discrimination contrary to s. 15(1) of the *Charter*.

The second element of uncertainty is found within the s. 15(1) analysis itself; namely, the focus on human dignity as the core interest protected by *Charter* equality rights. As with the concept of medical necessity, the notion of human dignity is ambiguous. While general attributes of both concepts can be articulated, precise definitions are impossible. In s. 15 challenges to government resource allocation decisions in health care, these two vague notions come into play, resulting in the difficult challenge of determining when a government's decision not to fund a particular health care service violates human dignity and therefore amounts to discrimination.

The s. 15(1) analysis involves questions that precede an examination of whether impugned governmental action infringes dignity. Before considering the impact of governmental action on human dignity, courts must first determine whether the claimant is treated differently from others and whether the differential treatment is based on a ground enumerated in s. 15(1) or an analogous ground. While acknowledging the importance of these two questions in the discrimination analysis, I focus on the dignity aspect for the primary reason that it is likely to be the most difficult to address since dignity is such a malleable notion. In many cases, though certainly not all, it may be relatively clear that a claimant is treated differently from others because of an enumerated or analogous ground. However, the challenge will arise in deciding if that differential treatment is an affront to dignity and therefore constitutes discrimination. Certainly, in the health care context, this issue is likely to be the thorniest, so it is the focus of this paper.

I begin with a brief discussion of the value Canadians place on access to universal, publicly funded health care, which is an important contextual factor in considering when a denial of public funding for a health care service violates human dignity. Next, I examine the use of medically necessary as a term that purports to establish parameters around the health care services governments are obligated to fund and, therefore, to which patients are entitled access. I then discuss the Supreme Court of Canada's most recent effort in *Law v. Canada*⁴ to synthesize a framework for analysing discrimination claims under s. 15(1), considering especially the Court's statements about dignity as the key value underlying equality rights.

I then comment on two cases in which claimants have used s. 15(1) to claim a right to public funding for specific health care services, *Cameron v. Nova Scotia*⁵

⁴[1999] 1 S.C.R. 497 [*Law*].

⁵(1999), 177 D.L.R. (4th) 611 (N.S.C.A.) [*Cameron*, N.S.C.A.], aff'g (1999), 172 N.S.R. (2d) 227 [*Cameron*, N.S.S.C.], leave to appeal to S.C.C. refused, [1999] S.C.C.A. No. 531 (QL).

and *Auton v. British Columbia*.⁶ In particular, I examine how the courts in these two cases analysed the notion of what constitutes a medically necessary service and when a distinction regarding access to health care amounts to a violation of dignity. After analysing these two cases, I consider several problematic aspects of basing s. 15(1) claims, especially in the health care context, on malleable concepts of medical necessity and human dignity. My conclusion is that current jurisprudence on the issue of discrimination and access to health care raises more questions than it answers and I hope this effort to identify questions will help frame future discussion about possible responses to those questions.

The Value of Health Care and Health Care as a Value

Health care is often described as a fundamental value for Canadians and, increasingly, individuals and groups in Canada are turning to the language of rights to seek access to health care services. In s. 15(1) *Charter* cases, this is exemplified by the claim that, as a matter of equality, individuals have a right to access certain state-funded health care services. Dr. Nuala Kenny recently noted that “[i]n the Canada of the twenty-first century, our medical benefits for individuals are being coupled with a strong sense of individual rights and freedoms.”⁷ Claims to a “right” to health care services seem to stem from the value, both real and symbolic, individuals place on health care.

At a symbolic level, many Canadians agree that “[u]niversal publicly funded health care is part of what it means to be a Canadian and reflects our core values.”⁸ Because individuals believe access to health care services will protect and promote their health, they value it and want to claim rights to it. As one commentator has noted:

good health is not simply one among many components of the ‘good life’. Health enjoys a high priority, perhaps the very highest priority in our hierarchy of values, because it is important for virtually every other life project we may have.⁹

⁶ (2002), 6 B.C.L.R. (4th) 201 (C.A.) [*Auton*, B.C.C.A.], aff’d (2000), 78 B.C.L.R. (3d) 55 (S.C.) [*Auton*, B.C.S.C.], leave to appeal to S.C.C. granted, [2002] S.C.C.A No. 510 (QL).

⁷ Nuala Kenny, *What Good is Health Care?* (Ottawa: Canadian Healthcare Association Press, 2002) at 170. See also Barbara von Tigerstrom, “Human Rights and Health Care Reform: A Canadian Perspective” in Timothy A. Caulfield & Barbara von Tigerstrom, eds., *Health Care Reform & the Law in Canada: Meeting the Challenge* (Edmonton: University of Alberta Press, 2002) 157 where she states, at 157: “Rights language is often used to make claims about health care, ranging from general claims that the public has a right to health or to health care, to specific claims to particular treatments or standards of treatment.”

⁸ Conference Board of Canada, *Canadians’ Values and Attitudes on Canada’s Health Care System: A Synthesis of Survey Results* (Ottawa: Conference Board of Canada, 2000) at 11.

⁹ Arthur Shafer, *Waiting for Romanow: Canada’s Health Care Values Under Fire* (Ottawa: Canadian Centre for Policy Alternatives, 2002) at 10.

Canadian courts have recognized the value attached to health care in Canadian society. Quite succinctly, the British Columbia Supreme Court has stated, "Health care has fundamental value in our society."¹⁰ The Supreme Court of Canada has also alluded to the significance of health care in our society: "Simply put, government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."¹¹

Despite the value Canadians attach to a system of publicly funded health care, it is a reality that government health care budgets are finite and choices must be made about what services will be covered and which will fall outside the boundaries of the public health care system. This challenge leads to the tricky question of delimiting the scope of public health care insurance which, in Canada, is accomplished (albeit ambiguously) by the phrase "medically necessary".

The Concept of "Medically Necessary" in the Canadian Health Care System

The structure of the health care system is set out in the *CHA*, which describes in expansive language the purpose of Canadian health policy:

It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.¹²

The *CHA* sets out five criteria the provinces must meet in order to receive a full financial contribution from the federal government for health care. These criteria are: public administration, comprehensiveness, universality, portability and accessibility.¹³ The criterion of comprehensiveness is linked with medical necessity and the *CHA* states:

In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must 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.¹⁴

The *CHA* defines "insured health services" to mean "hospital services, physician services and surgical-dental services provided to insured persons...."¹⁵ In turn,

¹⁰ *R. v. Lewis* (1996), 139 D.L.R. (4th) 480 at 522 (B.C.S.C.).

¹¹ *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 544.

¹² *Supra* note 3, s. 3.

¹³ *Ibid.*, s. 7.

¹⁴ *Ibid.*, s. 9.

¹⁵ *Ibid.*, s. 2.

“hospital services” are defined as specific 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 “any medically required services rendered by medical practitioners.”¹⁶ The *CHA* does not define the terms “medically necessary” or “medically required.” Provincial health care insurance legislation throughout Canada also uses the phrases “medically required” or “medically necessary” to describe health care services that are publicly funded, but, as with the *CHA*, the provincial statutes offer no definition.¹⁷

As a result, decisions regarding what services will be covered under health care insurance legislation become a matter of provincial policy-making. Typically, these decisions have been made through negotiation between provincial health ministries and provincial medical associations.¹⁸ In 1994, the Canadian Bar Association Task Force on Health Care¹⁹ remarked:

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 substantive definition, so the scope of ‘medically required services’ and indeed, all ‘insured health services’, is a policy decision.²⁰

This statement is as true today as it was almost ten years ago.

The Canadian Bar Association Task Force and other commentators have suggested the term “medically necessary” should be explicitly defined in order to provide greater certainty and uniformity across Canada about what health care services will be publicly insured and to control health care costs.²¹ Others argue

¹⁶ *Ibid.* The listed hospital services include the following services provided to in- or out-patients at a hospital: accommodation and meals; nursing care; diagnostic procedures; drugs administered in the hospital; and use of medical and surgical equipment.

¹⁷ For example, the British Columbia *Medicare Protection Act*, R.S.B.C. 1996, c. 286, insures “medically required services” (s. 1). In Alberta, the *Health Care Insurance Act*, R.S.A. 2000, c. A-20 defines “insured services” as “all services provided by physicians that are medically required...” (s. 1) Under the Ontario *Health Insurance Act*, R.S.O. 1990, c. H.6, “insured services” include “medically necessary services rendered by physicians...” (s. 11.2). The terms “medically necessary” or “medical required” are not defined.

¹⁸ Colleen M. Flood, “The Anatomy of Medicare” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2d ed. (Markham, Ont.: Butterworths, 2002) 1 at 23. See also Colleen M. Flood, Mark Stabile & Carolyn Hughes Tuohy, “The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care” (2002) 12 *Health Matrix* 297 at 303.

¹⁹ 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).

²⁰ *Ibid.* at 31.

²¹ For example, based on concerns about lack of clarity and predictability in what services are considered

this term is not amenable to precise definition and efforts to do so will inevitably be fruitless.²² As Jeremiah Hurley and his colleagues note:

Many systems of publicly funded health care espouse medical necessity (or a close variant such as need) as a guiding principle for allocating resources (even if not all enshrine it in legislation). Yet, logic and experience demonstrate that it is likely impossible to develop a concise, explicit, operational definition of medical necessity that could be used as an administrative tool.

...

It follows that we should refrain from further efforts to develop such an operational definition of medical necessity.²³

If the term medically necessary cannot be defined precisely, are there at least some identifiable boundaries around the services it encompasses? Even without an exact definition of the phrase, is there value in attempting to define the goals or interests that underlie the term? Hurley *et al.* seem to think so:

Even if medical necessity cannot be defined precisely, it seems useful to explore the range and boundaries of its meanings, its essential constitutive elements, and the imperatives that follow from them, not with the intention of developing a definition, but to understand the key concepts better, to inform the policy discourse that surrounds it, and to facilitate its use in health policy as a guiding principle.²⁴

medically necessary, the Canadian Bar Association Task Force made the following recommendations (*ibid.* at 41-42):

Each province and territory and the federal government should enact a definition of the term "medically necessary", which would apply equally to the term "medically required". Explicit criteria should be used to define this term...

The definition of "medically necessary" should be arrived at through an open process of cooperation and negotiation among the federal and provincial governments, to achieve uniformity to the greatest possible extent.

In regard to the cost-saving potential of explicitly defining what constitutes medically necessary services, many commentators have argued this potential is largely empty and de-insuring health care services does not result in significant savings. See e.g. Cathy Charles *et al.*, "Medical Necessity in Canadian Health Policy: Four Meanings and ... a Funeral?" (1997) 75:3 *Millbank Q.* 365 at 376-78.

²² See e.g. Jeremiah Hurley *et al.*, "Medical necessity, benefit and resource allocation in health care" (1997) 2 *J. Health Serv. Res. Policy* 223; Timothy A. Caulfield, "Wishful Thinking: Defining 'Medically Necessary' in Canada" (1996) 4 *Health L.J.* 63; Michael M. Rachlis, "Defining Basic Services and De-Insuring the Rest: The Wrong Diagnosis and the Wrong Prescription" (1995) 152:9 *Can. Med. Assoc. J.* 1401, and Glenn Griener, "Defining Medical Necessity: Challenges and Implications" (2002) 10 *Health L. Rev.* 6. For commentary on "medical necessity" in the U.S. context where many private health insurance contracts use the term to define the scope of coverage under the contract, see e.g. E. Haavi Morreim, "The Futility of Medical Necessity" (2001) 24 *Regulation* 22 and Linda A. Bergthold, "Medical necessity: Do we need it?" (1995) 14 *Health Affairs* 180.

²³ Hurley, *ibid.* at 223.

²⁴ *Ibid.*

They suggest the concept of benefit is a key element in determining what constitutes a medically necessary health care service. However, they acknowledge the difficulty in deciding what counts as a benefit and “[i]n particular, when does a benefit of a particular type and magnitude make it reasonable to draw on public resources to meet the need?”²⁵ In their view, assessing the benefit of a health care service can focus on an individual patient (for example, assessing whether a service improves the person’s health or well-being, however those terms are defined) or on broader social benefits and costs associated with allocating funding to certain services over others.

The most skeptical (and perhaps most realistic) view is that it is extremely difficult to arrive at any consensus about the types of benefits that count in assessing whether a service is medically necessary, or even in agreeing about what health outcomes are desirable and warrant drawing on public resources. Cathy Charles and colleagues suggest:

...attempts to achieve consensus on the meaning of medical necessity are likely to fail. Stakeholders have a vested interest in preserving their favoured meaning and advocating for its broader acceptance. Consensus regarding a definition of medical necessity is difficult to achieve precisely because its value to stakeholders lies in the ease with which it can be construed to serve multiple policy and ideological ends.

...

It seems an obvious point that the meaning of necessary services depends, to a large extent, on the goals of the health care system. Yet there is no consensus in Canada on this issue.²⁶

Finally, as the most recent addition to the Canadian health care policy debate, it is worth noting the Romanow Report’s commentary on the issue of medical necessity and comprehensiveness in the health system. Romanow states that “essential health care services must be available to all Canadians on the basis of need and need alone”²⁷ and argues the health care system currently falls below what a truly comprehensive, publicly insured system of medically necessary care would provide:

The current *Canada Health Act* includes the principle of comprehensiveness. However, for the last 35 years, comprehensiveness has been limited to ‘insured health services’ defined as medically necessary hospital and physician services.... This is not how the average person would define comprehensive.

...

Despite this, comprehensiveness should be retained as a principle, not

²⁵ *Ibid.* at 224.

²⁶ *Supra* note 21 at 386, 388.

²⁷ *Supra* note 1 at 61.

so much as a description of existing coverage under the *Canada Health Act* but as a continuing goal. It 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...²⁸

Ultimately, we are left with the following understanding of the term medically necessary in Canadian health care policy: the term is not defined, nor is it susceptible of precise definition; individuals will advocate their preferred definition based on policy goals they seek to attain, so achieving consensus in defining the term is likely impossible; and, ultimately, an undefined notion permits the health care system to evolve. But where does this leave us when assessing claims by individuals that a government discriminates against them by not funding services they assert are medically necessary? In the context of *Charter* litigation about access to health care services, it is important to consider how an adversarial forum focused on the adjudication of individual rights and liberties shapes how litigants construct arguments of benefits, costs and desired outcomes.

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

As noted earlier, individuals and groups who want access to services that are not funded by their provincial health care plan are turning to litigation under s. 15(1) of the *Charter* to attempt to compel governments to fund these services. The essence of their argument is that government discriminates against them by not funding a service they consider medically necessary.

Section 15(1) of the *Charter* provides individuals with legal protection from discrimination and states:

Every individual is equal before and under the law and has the right to the equal protection and equal 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.

In its 1989 decision in *Andrews v. Law Society of British Columbia*,²⁹ the Supreme Court of Canada set out the authoritative definition of discrimination in Canadian law:

...discrimination may be described as a distinction, whether intentional or not, but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations or disadvantages on such individual or group not imposed upon

²⁸ *Ibid.* at 62-63.

²⁹ [1989] 1 S.C.R. 143 [*Andrews*].

others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.³⁰

In *Andrews*, the Court emphasized that not every law that draws a distinction will violate s. 15(1) of the *Charter*. Indeed, the Court has emphasized governments must draw distinctions to govern effectively:

It is not every distinction or differentiation in treatment at law which will transgress the equality guarantees of s. 15 of the *Charter*. It is, of course, obvious that legislatures may — and to govern effectively — must treat different individuals and groups in different ways. Indeed, such distinctions are one of the main preoccupations of legislatures. The classifying of individuals and groups, the making of different provisions respecting such groups, the application of different rules, regulations, requirements and qualifications to different persons is necessary for the governance of modern society.³¹

The question is then: How do courts determine what distinctions amount to discrimination contrary to s. 15(1) of the *Charter*? The Supreme Court of Canada provided its most recent guidance for answering this question in its unanimous decision in *Law v. Canada*.³²

In *Law*, the Court set out a general framework for analysing claims of discrimination under s. 15(1) of the *Charter*. In examining whether a law or governmental action constitutes discrimination, a court must ask itself the following questions:

First, does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is differential treatment for the purpose of s. 15(1). Second, was the claimant subject to differential treatment on the basis of one or more of the enumerated and analogous grounds? And third, does the differential treatment discriminate in a substantive sense, bringing into play the *purpose* of s. 15(1) of the *Charter* in remedying such ills as prejudice, stereotyping, and historical

³⁰ *Ibid.* at 174, McIntyre J.

³¹ *Ibid.* at 168.

³² [1999] 1 S.C.R. 497 [*Law*].

disadvantage? The second and third inquiries are concerned with whether the differential treatment constitutes discrimination in the substantive sense intended by s. 15(1).³³

The third question asks whether the differential treatment brings into play the purpose of s. 15(1), which the Court in *Law* summarized as follows:

It may be said that the purpose of s. 15(1) is to *prevent the violation of essential human dignity and freedom* through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration.³⁴

The Court elaborated at some length on the notion of human dignity:

What is human dignity? There can be different conceptions of what human dignity means. For the purpose of analysis under s. 15(1) of the *Charter*, however, the jurisprudence of this Court reflects a specific, albeit non-exhaustive, definition. . . . *the equality guarantee in s. 15(1) is concerned with the realization of personal autonomy and self-determination. Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment.* Human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits. It is enhanced by laws which are sensitive to the needs, capacities and merits of different individuals, taking into account the context underlying their differences. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.³⁵

The Court also stated that “[h]uman dignity within the meaning of the equality guarantee... concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?”³⁶ Although the Court emphasized the discrimination analysis must be undertaken from the perspective of the claimant, the claimant’s subjective view must be supported by an objective assessment of her or his situation.³⁷ In

³³ *Ibid.* at para. 39 [emphasis in original].

³⁴ *Ibid.* at para. 51 [emphasis added].

³⁵ *Ibid.* at para. 53 [emphasis added].

³⁶ *Ibid.*

³⁷ *Ibid.* at paras. 59-61.

addition, various “contextual factors” must be considered in determining whether governmental action demeans the claimant’s dignity, including the purpose and effect of the impugned law or action, the circumstances of the person or group alleging discrimination, and the nature of the claimant’s interests that are affected by the governmental action.³⁸

Limitations of Human Dignity in the Discrimination Analysis

A number of academic writers have commented on the limitations of basing the discrimination analysis under s. 15(1) on the concept of human dignity. Referring to the *Law* decision, Sheilah Martin notes:

My fear is that the Court’s selection of human dignity as the main defining standard may not prove as helpful as it initially appears. Dignity is a basic value and it is hard not to be in favour of it but the first problem is one of definition. The Court notes that ‘no single word or phrase can fully describe the content and purpose of section 15(1)’ and that is true. However, the focus on human dignity and defining rights by reference to other general concepts provides little clarity. If constitutional rights enshrine vague but meaningful generalities, human dignity suffers the defect that it is a proxy which is even less meaningful and more vague.³⁹

Martin goes on to argue that “a dignity based equality standard is inherently malleable. While it may be easier to determine when human dignity is demeaned, it will be more difficult to articulate why it is not.”⁴⁰ As I discuss below, this is precisely the major difficulty inherent in discrimination claims in the health care context.

Martin also suggests the “subjective/objective test” for assessing whether a person’s dignity has been violated is another problematic aspect of the *Law* framework. She notes:

Someone who has taken the trouble to become a complainant under section 15 will almost always meet the subjective portion of this standard. The Court will therefore be left to determine the reasonableness of that person’s subjective experience of inequality. Someone whose claim is rejected under section 15 is therefore either suffering from false consciousness (subjectively) and/or else is being unreasonable (objectively). The reasonable person is a notoriously malleable

³⁸ *Ibid.* at paras. 62-75.

³⁹ Sheilah Martin, “Balancing Individual Rights to Equality and Social Goals” (2001) 80 Can. Bar. Rev. 299 at 329.

⁴⁰ *Ibid.*

construct, often invoked to put distance between decision-makers and their conclusions, but why is it needed here?⁴¹

Donna Greschner shares Martin's concerns about the malleability and imprecision of the notion of human dignity as the underlying purpose of s. 15(1).⁴² Greschner states that one of the problems with dignity is that it "becomes an assertion, not an analysis. To ask whether a law offends 'dignity' gives precious little guidance to litigators and judges; conclusions about dignity become masks for the exercise of judicial discretion."⁴³ She adds that

casting discrimination in the language of dignity is too loaded. From the claimants' perspective, they must prove that a distinction violates their dignity, which is a bit unseemly. Draping an allegation of discrimination in dignity language deeply personalizes it and brings it to the heart of an individual's sense of self-worth. This makes the allegation more emotion-laden, and thus more rhetorically powerful. But can we say convincingly that every discriminatory act involves attacks of this magnitude on the individual's sense of self-worth? Moreover, do we want to do so? Dignity is indeed a feeling...but equality rights are legal rights and law is a discipline of reason and persuasion. The problem with feelings is that no one can argue against them.⁴⁴

Peter Hogg adds another voice in criticizing the predominance of human dignity in the discrimination framework set out in *Law*:

The element of human dignity that has now been injected into the s. 15 jurisprudence is, in my view, vague, confusing and burdensome to equality claimants. Although various 'contextual factors' were listed in *Law* to assist in the task of determining whether a distinction impairs human dignity, the factors are not very helpful and the concept of human dignity is inherently vague and unpredictable in its application.⁴⁵

As these critiques suggest, the emphasis on human dignity in the discrimination analysis will likely be problematic in many s. 15(1) claims and, in my view, concerns regarding the notion's pliability, vagueness and emotional appeal are exemplified in *Charter* claims regarding access to health care services.

⁴¹ *Ibid.* at 330.

⁴² Donna Greschner, "Does *Law* Advance the Cause of Equality" (2001) 27 *Queen's L.J.* 299.

⁴³ *Ibid.* at para. 25.

⁴⁴ *Ibid.*

⁴⁵ Peter W. Hogg, *Constitutional Law of Canada*, Stud. ed. (Toronto: Carswell, 2001) at 1014. Hogg argues (at 1014-15) the dignity aspect is burdensome to claimants because they must, in essence, convince the court that the impugned distinction is unfair or unreasonable, an approach that Hogg notes the S.C.C. rejected in *Andrews*.

Section 15(1) Claims and Access to Health Care Services

To date, Canadian courts have had several opportunities to consider s. 15(1) claims in which litigants challenged government decisions not to fund specific services in the health care context. I will focus here on two such cases, *Cameron v. Nova Scotia* and *Auton v. British Columbia*.⁴⁶

Cameron v. Nova Scotia

In *Cameron*, an infertile couple argued the Province of Nova Scotia discriminated against them by not funding fertility treatments, in-vitro fertilization (“IVF”) and intra-cytoplasmic sperm injection (“ICSI”),⁴⁷ that could assist infertile persons in attempting to have a biologically related child. They argued fertile people have access to publicly funded health care services, such as prenatal and childbirth care, to assist them in having children, but the infertile are denied the chance of having a child because they are denied funding for IVF and ICSI.

At trial, Kennedy C.J.S.C. concluded that while IVF and ICSI may be medically *indicated* for individuals with infertility,⁴⁸ this does not inevitably mean the services are medically *necessary* and subject to coverage by the provincial health care insurance plan. In deciding these services are not medically necessary, he noted infertile people have other options for becoming parents (such as adoption), the success rate of having a child through IVF and ICSI is low (around 15%

⁴⁶The S.C.C. decision in *Eldridge v. British Columbia*, [1997] 3 S.C.R. 624, where several deaf individuals challenged the decision of the Province of B.C. not to cover sign language interpreter services as a benefit under the provincial health insurance plan, also involved a s. 15 discrimination claim in the health care context, however I have chosen not to address *Eldridge* here for two reasons. First, that case predates *Law* and thus the analysis in *Eldridge* does not follow the *Law* framework (clearly, though, the claimants in *Eldridge* would satisfy all elements of the *Law* analysis). More importantly, I consider *Eldridge* to be distinguishable from *Cameron* and *Auton* because the deaf claimants in *Eldridge* sought funding for a service that would allow them to have equivalent access to the health care services the government had already decided to fund; that is, they wanted meaningful access to the health system, something non-deaf people take for granted. *Cameron* and *Auton* differ because the claimants in those cases wanted the government to fund an additional health care service that was not available to anyone. This distinction can be understood by analogy to a library’s obligation to offer reasonable accommodation for wheelchair users. In *Eldridge*, government funding for sign language interpreters to ensure deaf patients have meaningful access to the health care system is analogous to a library providing a ramp for patrons who use wheelchairs to enter the building. In contrast, the applicable analogy in *Cameron* and *Auton* is to an individual claiming the library must spend money to buy specific books the patron believes should be in the library.

⁴⁷During IVF, egg cells are introduced to sperm cells in a laboratory in the hope fertilization will occur. If one or more eggs are fertilized, they are then surgically implanted into a woman’s uterus, again in hopes a successfully pregnancy will result. ICSI is a form of IVF in which a single sperm is injected into an egg cell, forcing fertilization to occur. See *Cameron*, N.S.C.A., *supra* note 5 at paras. 5,6.

⁴⁸The evidence at trial was that ICSI is “medically indicated” and, indeed, the “treatment of choice” in cases involving male factor infertility, the form of infertility with which Mr. Cameron has been diagnosed, characterized by poor sperm count and quality: *Cameron* N.S.C.A., *supra* note 5 at paras. 6, 10-12.

to 20%), and there are health risks associated with the procedures.⁴⁹ Ultimately, he concluded:

The desire to produce one's own child is both understandable and natural. I do though, agree, with the defendants' position that this is not a medical end and in this matter the medical procedures used to attempt to have a child, although 'medically indicated' and 'standard' have not been shown to me to be 'medically required.'⁵⁰

Justice Kennedy went on to consider whether the government's denial of funding for these fertility services amounted to discrimination against those with infertility and concluded it did not.⁵¹ He accepted that the decision not to fund IVF and ICSI had a differential impact on individuals with infertility who sought access to the treatments compared to the fertile, but he stated the government's funding decision was "based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking the funding, the infertile."⁵² Ultimately, he concluded that "[t]he non-funding of I.V.F. and I.C.S.I. is...based on the failure of these medical treatments to come within the criteria necessary before a medical procedure is funded."⁵³ So, in essence, because the government had valid reasons for determining the services were not medically necessary, the refusal to insure them did not amount to discrimination.

On appeal, the majority of the Nova Scotia Court of Appeal (Chipman J.A., Pugsley J.A. concurring) found the government's funding decision contravened the claimants' rights under s. 15(1), but the violation was justified under s. 1. The majority held that IVF and ICSI are medically necessary services for infertile individuals, the denial of which offended their dignity. In addressing the infringement of the claimants' dignity, Chipman J.A. focused largely on pre-existing disadvantages the infertile experience. Specifically, he noted infertility has been viewed historically as "an unworthy state, the object of derision, banishment and disgrace."⁵⁴ The third justice, Bateman J.A., ruled that infertility does not constitute a disability under s. 15(1) but, even if it did, the denial of funding for IVF and ICSI would not demean the claimants' dignity. As discussed further below, these two opposing views in the Court of Appeal clearly highlight some of the difficulties and ambiguities in determining when a denial of public funding for a health care service constitutes discrimination in the substantive sense contemplated under s. 15(1).

⁴⁹ *Ibid.* at paras. 95, 96.

⁵⁰ *Ibid.* at para. 99.

⁵¹ The trial decision predated the S.C.C.'s decision in *Law*, so the judge did not structure his analysis on the *Law* framework.

⁵² *Cameron*, N.S.S.C., *supra* note 5 at para. 154.

⁵³ *Ibid.* at para. 155.

⁵⁴ *Ibid.* at para 183.

Auton v. British Columbia

In the recent *Auton* decisions, the British Columbia Supreme Court and Court of Appeal considered whether the B.C. government discriminated against children with autism by not funding early intensive behavioural intervention, a therapy that can be very effective in reducing autistic behaviour in many children with the disease. The parents of several children with autism challenged the government's refusal to fund the therapy, arguing that "by failing to fund effective treatment for autism, the government has misinterpreted its legislative mandate to provide health care services."⁵⁵ Further, they argued that lack of funding for autism therapy "neglects to take into account the disadvantaged position of autistic children and results in substantively different treatment, placing an additional burden on them"⁵⁶ that those without the disease do not face. Both the trial court and the Court of Appeal held the government discriminated against the children with autism and the denial of funding could not be justified under s. 1 of the *Charter*.

The autism intervention therapy at issue in the *Auton* case is delivered by behavioural therapists who are not health care practitioners recognized by the B.C. Medical Services Commission, thus the government argued the therapy could not be considered medically necessary. The trial judge, Allan J., rejected this argument as an overly narrow definition of medical necessity and stated that instead of defining a medically necessary service by who provides it, "a more accurate definition of medical treatment is whatever cures or ameliorates illness."⁵⁷ She added that "Canadians are entitled to expect medical treatment for their physical and mental diseases. This is so, even when a disease cannot be 'cured'."⁵⁸ Considering the needs of the children with autism and the purpose of the universal public health care system, Allan J. had no difficulty concluding the early intensive behavioural therapy at issue constituted a medically necessary service for the children with autism,⁵⁹ the denial of which violated their dignity.

On appeal, Saunders J.A.⁶⁰ stated that the fact children with autism did not receive the health care service they most needed to address their disease constituted differential treatment in the s. 15(1) analysis and she rejected the government's argument that a finding of discrimination was not warranted because the "health care system does not serve all health care needs and is not designed to do so."⁶¹ In her view, the government discriminated against the children with autism by withholding funding for a treatment that held real promise of mitigating the effects of their devastating condition. She also noted that no alternative therapy was

⁵⁵ *Auton*, B.C.S.C., *supra* note 6 at para 125.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.* at para. 102.

⁵⁸ *Ibid.* at para. 109.

⁵⁹ *Ibid.* at para. 102.

⁶⁰ Hall J.A. concurred. Lambert J.A. agreed s. 15(1) was violated and could not be justified under s. 1, but he dissented in part on a cross-appeal issue regarding remedy.

⁶¹ *Auton*, B.C.C.A., *supra* note 6 at para. 46.

available and the health care system funds services to address other, less serious ailments.

More Questions than Answers?

In my view, the decisions in *Cameron* and *Auton* raise more questions than they answer. In part, this may be attributed to the relative newness of *Charter* claims in which litigants seek access to specific health care services based on arguments of discrimination and equality under s. 15(1).⁶² As well, the Supreme Court's decision in *Law* is a recent synthesis of discrimination jurisprudence. Newness aside, though, it seems the real challenge in these cases stems from ambiguity and divergence in views about the notions of medical necessity, human dignity, and their interrelationship in the s. 15 context.

Before focussing on problems and questions, it is important to acknowledge one point of agreement that should be uncontroversial given its generality: not all government decisions that exclude funding for particular health care services will amount to discrimination under s. 15(1) of the *Charter*. This statement is consistent with Justice McIntyre's comment in *Andrews* that "[i]t must be recognized at once...that every difference in treatment between individuals under the law will not necessarily result in inequality..."⁶³ and Justice McLachlin's caution in *Miron v. Trudel* that "calling all distinctions discrimination" would "trivialize" s. 15(1).⁶⁴

In addition to the general statement that not every government health care funding decision will constitute discrimination, a common (though, again, general) point of law can be derived from *Cameron* and *Auton*: if a government denies funding for particular health care services without ensuring the decision does not deprive an individual or group of equal benefit of the publicly funded health system based on a ground protected under s. 15(1), then the decision may well amount to discrimination. Yet, it is unclear which denials will violate equality rights and which will not. In *Cameron*, Chipman J.A. stated that "[n]ot every person denied a procedure can successfully mount a *Charter* challenge,"⁶⁵ a point Saunders J.A. reiterated in *Auton* when she stated "[t]here is no doubt that not all refusals to treat a health care problem will be seen as discrimination."⁶⁶ Yet, the fundamental

⁶² *Brown v. British Columbia*, [1990] B.C.J. No. 151 (S.C.) (QL), one of the earliest efforts to use s. 15(1) to gain access to a specific health care service, was unsuccessful. In that case, two individual plaintiffs, together with the Vancouver Persons with AIDS Society, challenged the B.C. government's decision to require persons with HIV/AIDS to pay for part of the cost of expensive drug therapy. The plaintiffs pointed out that individuals with other serious diseases such as cancer have access to free drug coverage and argued persons with HIV/AIDS were subject to differential and discriminatory treatment because of the nature of their disease (which, at the time, was predominantly a disease of gay men). The Court dismissed the s. 15 claim, ruling that the different drug coverage policy regarding medication for HIV/AIDS related to the nature of the drug, not the personal characteristics of the patients. I speculate that the plaintiffs in *Brown* would perhaps be successful if they made their claim today.

⁶³ *Supra* note 29 at 164.

⁶⁴ [1995] 2 S.C.R. 418 at para. 131.

⁶⁵ *Cameron*, N.S.C.A., *supra* note 5 at para. 170.

question is: How do we tell when a denial of health care discriminates and when it does not and how effectively can vague concepts of medical necessity and human dignity help us answer this question?

What comes first, the necessity or the dignity?

A significant problem in considering the interrelationship between medical necessity and human dignity is one of circularity: is human dignity demeaned because a claimant is denied access to a medically necessary health care service or is a service medically necessary because a person's dignity will be infringed if they do not have access to that service? Put another way, what comes first, the necessity or the dignity?

In *Cameron*, the trial judge and Bateman J.A. seemed to examine the question of whether IVF and ISCI are medically necessary without factoring in the effect of a denial of funding on individuals who are infertile. The trial judge was persuaded by the fact that these treatments are just one way to address a desire to have a child and they offer little success at achieving that outcome. In contrast, Justice Chipman's view that IVF and ICSI are medically necessary was foreshadowed by his finding that infertility constitutes a disability:

I do not think it can be seriously disputed that a person unable to have a child has a physical disability. ... the perpetuation of the human race has, in almost all cultures and at all times, been assigned a very high value. One's inability to participate in this great plan must, for one willing to do so, be a major and deep felt disappointment.⁶⁷

Clearly he was concerned with the impact on the claimants' dignity. He also criticized the position that IVF and ICSI are not medically necessary as "'main-stream' thinking which fails to make reasonable accommodation for the infertile."⁶⁸ According to Chipman J.A., the policy process of determining which services are medically necessary must respect the values underlying s. 15(1) of the *Charter*. However, when these values are defined in such broad terms — such as "dignity" and "equality" — one can feel some sympathy for the difficult task confronting government policy makers as they try to decide what services should be funded.⁶⁹

⁶⁶ *Auton*, B.C.C.A., *supra* note 6 at para. 49.

⁶⁷ *Cameron*, N.S.C.A., *supra* note 5 at para. 145.

⁶⁸ *Ibid.* at para. 164.

⁶⁹ The challenge of reaching consensus about what health care services ought to be publicly funded is exemplified by government efforts to delist services. In 2002, the Alberta government struck a committee to review funding for various health care services. In January 2003, the Minister of Health, Gary Mar, announced the committee could not reach agreement about what services should be excluded from public insurance. He was reported as stating, "Whether something is beneficial or not to an individual is sometimes difficult to quantify. Answers don't come in black-and-white packages. They normally come in shades of grey." See Darcy Henton "Alberta plan to delist medical services has hit snag: health minister" *Canadian Press* (8 January 2003).

In *Auton*, it seems the Courts' decisions that early behavioural intervention therapy is medically necessary for children with autism was clearly linked to the fact that, without the therapy, the children were doomed to an existence largely devoid of dignity; they would likely be institutionalized, could not pursue an education or employment, and would lack skills and abilities to communicate effectively with those around them. Thus, if the likely outcome of a failure to fund a service is an undignified existence, then perhaps the service is more likely to be characterized as medically necessary. But medical necessity may be defined in other ways.

How is medical necessity defined?

As discussed earlier, the term medically necessary is susceptible of many definitions and different stakeholders⁷⁰ will characterize medical necessity to suit a desired outcome. The factors courts consider in deciding s. 15(1) cases about access to health care services will certainly impact on the meanings that will be given to the term medically necessary. The opposing views in *Cameron* about the medical necessity of IVF and ICSI demonstrate the malleability of the term. At trial, Justice Kennedy agreed with the government's argument that the definition of medically necessary services should be confined to medical means to a medical end⁷¹ and IVF and ICSI are not medically necessary because they do not address a medical end (the underlying medical cause of the male claimant's condition of infertility), even though they may result in a non-medical end (the claimants becoming parents). While the trial judge was persuaded by the government's "medical-means-to-a-medical-end" definition, the majority of the Court of Appeal was not. Indeed, Chipman J.A. disagreed with the trial judge, largely because of a differing conception about what range of ends or outcomes may be appropriately associated with a medical need. He rejected the argument that medically necessary services are only those with so-called medical ends:

The goal of medical treatment is surely not so narrowly defined. ... Surely the end of all medical treatment is to improve the quality of life. The immediate end may or may not be medical, but this seems to me to be a distinction without much, if any, difference. Having in mind their ultimate objective, I am satisfied that IVF and ICSI are procedures that could qualify as being medically necessary.⁷²

⁷⁰In *Charter* litigation, relevant "stakeholders" include claimants, respondents, interveners and judges.

⁷¹In its factum, the government argued (quoted in *Cameron*, N.S.C.A., *supra* note 5 at para. 84):

"Medically necessary" should be defined with reference to a matrix involving medical and non-medical means and ends. There are four categories in this matrix: medical means to a medical end (e.g. surgical removal of an intestinal blockage); non-medical means to a medical end (e.g. alleviation of poverty); medical means to a non-medical end (e.g. growth hormone for a boy who is expected to grow to be 5'6" so that he will grow to be 6'4" and have a better likelihood of a basketball career); and non-medical means to a non-medical end (e.g. basketball lessons for the 5'6" boy).

⁷²*Cameron*, N.S.C.A., *supra* note 5 at para. 85.

Likewise, in *Auton*, the trial judge rejected the government's attempt to limit the definition of medical necessity by reference to the type of practitioner who delivers the service.

A service may be considered medically necessary if it addresses a burden or disadvantage a person suffers (which may be medical or non-medical). However, in the health care context, it is arguable, as both Chipman and Bateman J.J.A. noted in *Cameron*, that almost any decision to deny funding for a health care service disadvantages the person who is denied the treatment and to anyone else in a similar position. If, as Chipman J.A. also argues, the goal of medical treatment is to improve quality of life, and health care services ought to be considered medically necessary if they further this goal, then numerous services will be considered necessary. For example, it may be argued that lack of public funding for so-called cosmetic surgery may enhance some patients' sense of dignity and worth. In a recent article, a plastic surgeon argued breast augmentation surgery should be funded through the British National Health Service.⁷³ He argued some women suffer "significant psychological distress due to the social stigma of having small breasts" and "while it may be true that society is overly concerned about appearances, this is not an argument that those who take the brunt of these prejudices should be used as ammunition to fight against it."⁷⁴ Since many women experience "significant improvement in emotional and social functioning, mental health and self-esteem"⁷⁵ after surgery, the service ought to be publicly funded.

In *Cameron*, Justice Chipman noted "[t]he question might be asked whether everybody requiring medical services is disabled, mentally or physically" but stated "[t]hat need not and cannot be decided here."⁷⁶ This is clearly an important question that requires careful consideration in the context of s. 15(1) claims regarding access to health care. Because it is so problematic to determine when a denial of health care infringes human dignity, Chipman J.A.'s statement suggests courts may attempt to limit the scope of discrimination claims in the health care context not by reference to dignity, but by deciding that certain conditions do not constitute a disability for the purposes of *Charter* protection.

Finally, a medically necessary service may be described in relation to the goals or limitations of the health care system as a whole. This can lead to a broad or narrow definition of medical necessity, depending on what feature of the overall health system is emphasized. In *Auton*, Allan J. focussed on the broad, ameliorative purpose of the health insurance legislation. In her words:

⁷³ Ben Horner, "Breast augmentation should be on the NHS: a discussion of the ethics of rationing" (2002) 84 *Ann. R. Coll. Surg. Engl.* 82.

⁷⁴ *Ibid.* at 82-83.

⁷⁵ *Ibid.* at 83.

⁷⁶ *Cameron*, N.S.C.A., *supra* note 5 at para. 173.

The purpose of the legislation is relevant to a determination whether *Charter* rights have been breached. Here funding appropriate treatment for autism is entirely consistent with the ameliorative purpose of the health legislation. The [B.C.] Medical Services Plan is designed to assist people with health care needs. ...the values of the health care system are to promote health, prevention and treatment of illness and disease and to realize those values through a publicly funded health care system. Having created a universal medicare system of health benefits, the government is prohibited from conferring those benefits in a discriminatory manner.⁷⁷

Based on this broad purpose, many services could be considered medically necessary. In contrast, Bateman J.A. emphasized the limits of the public health care system:

Acknowledging the reality of the finite resources available for health care, treatment for every disability or dysfunction cannot be offered. It is integral to the administration of health care that choices are made among, literally, thousands of treatments and procedures — treatments that are changing and evolving rapidly. Indeed it must be determined not only for what medical conditions treatments or procedures will be funded but also which of the array of alternative procedures or treatments for the same ailment will receive funding.⁷⁸

Interestingly, Justice Bateman considers the limits on the services the health system can fund in her s. 15 analysis, while the majority of the Nova Scotia Court of Appeal evaluated this factor in s. 1, stating that “[t]he evidence makes clear the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims.”⁷⁹ In *Auton*, the B.C. Court of Appeal stated the scope of the health care system, presumably the degree of comprehensiveness the government can afford, is a matter to consider under s. 1, but the Court also indicated this issue about “the extent of the health care scheme...bears...upon the root question of discrimination.”⁸⁰ Although discussion of s. 1 of the *Charter* is beyond the scope of this paper, the decisions in *Cameron* and *Auton* reveal that the demarcation between s. 15 and s.1 considerations in claims regarding access to health care is, at present, quite blurred.

What benefits count?

My final question asks how the benefit associated with a health care service relates to the determination of whether the service is medically necessary or if its

⁷⁷ *Auton*, B.C.S.C., *supra* note 6 at para. 126.

⁷⁸ *Cameron*, N.S.C.A., *supra* note 5 at para. 268.

⁷⁹ *Ibid.* at para. 234.

⁸⁰ *Auton*, B.C.C.A., *supra* note 6 at para. 48.

denial compromises dignity. In *Cameron*, public funding for IVF and ICSI would give some individuals a relatively small chance of having a child but, for two appeal court justices, this possibility of achieving a desired outcome was enough to satisfy them the service is medically necessary and a denial of funding constituted discrimination. This raises the question: Is a claimant's dignity infringed by the denial of, at most, a *chance*? On the trial judge's reasoning in *Cameron*, the denial of funding for IVF and ICSI could not be viewed so broadly to mean a denial of an opportunity to become parents because there are ways other than IVF and ICSI to achieve that goal. But, for the claimants, characterizing the denial of the service as a denial of parenthood would tug more strongly on the heartstrings of dignity. I say this not to discount the claimants' genuine feelings, but to demonstrate Donna Greschner's point that framing discrimination on a violation of dignity loads the analysis with emotion.

While the service at issue in *Cameron* seemed to offer a small chance of achieving a desired outcome, the therapy in *Auton* promised a much greater likelihood of improving the condition of children with autism. This fact clearly influenced the decisions that the service was medically necessary and its denial infringed the children's dignity. This distinction may persuade some that the majority in *Cameron* reached the wrong decision and the judicial reasoning in *Auton* was correct. However, defining medical necessity and human dignity by the degree of benefit a service may offer clearly engages questions about what benefits ought to be counted. In regard to IVF, some commentators have stated "IVF produces important benefits even when it fails to produce a baby."⁸¹ For example, it may provide diagnostic information about reasons for a couple's infertility and can also provide "emotional closure"⁸² for couples who can be satisfied they have tried everything possible to have a child.

Further, if, as *Law* instructs, a court should approach the discrimination analysis from the perspective of the claimant — with the relevant question being "How would a reasonable person in the position of the claimant feel when confronted with the government's decision not to fund a health care service?" — then the claimant's perspective on the benefit of the service ought to be considered. So if the benefit goes beyond a medical end, and even if it offers simply a *chance* at achieving a medical or non-medical end, it is still important to the claimant. This may have the effect of broadening the notion of what constitutes a medically necessary service, at least from the perspective of government policy-makers who are likely concerned with basing funding decisions on measurable evidence, such as how many births result from fertility therapies, and how many children with autism experience improvement in specific skills after receiving behavioural intervention therapy. Although some benefits may not be amenable to empirical measurement (such as improved feelings of self-worth or a sense of emotional

⁸¹ M. Giacomini, J. Hurley & G. Stoddart, "The many meanings of deinsuring a health service: the case of in vitro fertilization in Ontario" (2000) 50 Soc. Sci. & Med. 1485 at 1492.

⁸² *Ibid.*

closure), they may still have value for a claimant and, according to *Law*, are relevant in their impact on human dignity.

However, the limitation of attempting to assess feelings from the perspective of a claimant is demonstrated in *Cameron*, where both Chipman and Bateman JJ.A. purported to do so, yet reached opposite conclusions. In his analysis, Justice Chipman asked, somewhat rhetorically:

What would the reasonably informed and dispassionate infertile person legitimately think when confronted with inclusion of full services for pregnancy and childbirth for the fertile...and the exclusion of IVF and ICSI...? What of their human dignity? Of their self-worth? The answer becomes clear.

...

The impact of the denial of these procedures to the infertile perpetuates the view that they are less worthy of recognition or value. It touches their essential dignity and self-worth. I agree with the appellants that this denial sends a powerful message to the infertile.⁸³

Justice Bateman reached a different conclusion, perhaps because she placed greater emphasis on the objective side of *Law*'s subjective/objective perspective:

The appellants here say that the denial of funding for the IVF procedure demeans their dignity. From a purely subjective perspective one cannot but accept that this is so. As directed in *Law*, however, we must be satisfied that such a claim is objectively supported.

...

I am not satisfied that the policy of excluding funding for the IVF procedure functions by stereotype or otherwise to perpetuate the view by society that the infertile are less deserving of concern, respect or consideration than others. ...it is an inevitable consequence of the administration of health care that choices are made among procedures and treatments offered.⁸⁴

Conclusion

The concluding question I will ask is whether there is any advantage in having an inexact definition of medical necessity as the basis for our system of public health insurance and an expansive notion of dignity as the basis for constitutional protection from discrimination. Despite the critique I have offered here, I acknowledge some value in these notions. From a policy perspective, leaving the concept of medical necessity largely undefined is beneficial as it permits the health care system to be flexible in the services it insures and responsive to the evolving health needs

⁸³ *Cameron*, N.S.C.A., *supra* note 5 at paras. 200, 202.

⁸⁴ *Ibid.* at paras. 277, 280.

and expectations of Canadians. As the Romanow Report notes, "...the last thing Canadians want is for their health care system to remain as a static entity, fixed in time and unable and unwilling to change."⁸⁵ From a legal perspective, constructing *Charter* rights to equality on a broad conception of human dignity ensures robust protection for such rights and leaves room for future evolution of s. 15 jurisprudence.

However, in the context of s. 15(1) litigation, we are presently left with considerable uncertainty regarding the important question of when a denial of funding for a health care service will amount to discrimination. Ultimately, to paraphrase Charles *et al.*,⁸⁶ the meanings of medical necessity and human dignity are not intrinsic, but depend on how litigants and courts interpret and use the concepts. "Meanings are created through an interpretive and interactive process,"⁸⁷ so, as individuals and governments continue to debate and interact about funding for health care services, and as courts continue to interpret equality rights under s. 15 of the *Charter*, perhaps some of the questions I have discussed will be addressed and resolved.

⁸⁵ *Supra* note 1 at 60.

⁸⁶ *Supra* note 21 at 386.

⁸⁷ *Ibid.*

