Date: 19990914
Docket: CA 153793

NOVA SCOTIA COURT OF APPEAL
Cite as: Cameron v. Nova Scotia (Attorney General), 1999 NSCA 14
Chipman, Pugsley and Bateman, JJ.A.

BETWEEN:		)	
		)	
ALEXANDER MACBAIN CAMERON		)	Appellants
and CHERYL DAWN SMITH		)	appeared in person
		)	
	Appellants	)	
		)	
- and -		)	
		)	
THE ATTORNEY GENERAL OF NOVA		)	Daniel M. Campbell, Q.C.
SCOTIA, representing Her Majesty the		)	for the Respondents
Queen in right of the Province of Nova		)	
Scotia, THE MINISTER OF HEALTH,		)	
THE DEPARTMENT OF HEALTH and		)	
THE ADMINISTRATOR, INSURED		)	
PROFESSIONAL SERVICES		)	Appeal Heard:
		)	May 19, 1999
	Respondents	)	
		)	
		)	
		)	
		)	Judgment Delivered:
		)	September 14, 1999

THE COURT: The appeal is dismissed without costs as per reasons for judgment of Chipman, J.A. and Pugsley, J.A., concurring; Bateman, J.A., concurring by separate reasons.

CHIPMAN, J.A.:

1. INTRODUCTION:

[1] The appellants appeal from the dismissal by Chief Justice Joseph P. Kennedy of the Supreme Court of their action seeking benefits under the **Health Services and Insurance Act**, R.S.N.S., 1989, c. 20 for certain medical and hospital services they have received and paid for, and for similar such services as they may receive in the future.

[2] The male appellant is a litigation lawyer employed by the Nova Scotia Department of Justice. He represented the appellants at trial and on the hearing of this appeal. The female appellant is a medical doctor and a resident obstetrician/gynecologist. Both appellants were at all material times residents of the Province.

[3] The appellants are a married couple that has been unsuccessful in having children because the male appellant suffers from “severe male factor infertility” due to reduced sperm count and quality. After this condition was diagnosed and other procedures - surgery on the male appellant, three cycles of intrauterine insemination of the female appellant and removal of fibroids from her uterus (myomectomy) - failed, the appellants were referred by their physicians for, and received, services known as intra cytoplasmic sperm injection (ICSI) which is a specialized form of in vitro fertilization (IVF).

[4] New reproductive technology is a very rapidly expanding field. In 1993, the federally appointed Royal Commission on New Reproductive Technologies made its report. In a comment thereon, the Society of Obstetricians and Gynecologists of Canada said

(Volume 16, 1994, p. 1260):

> . . . on the subject of in vitro fertilization, changes in new reproductive technologies are happening with such speed that it is surprising for us to find today that some information contained in the Report is already out of date. Since the information was compiled over a three-year period, the Commission's recommendations pertaining to in vitro fertilization are based on data that are out of date. Based on what we know today, we call upon governing bodies to ensure the availability and funding of this technique across the country.

[5] IVF is a medical procedure whereby ova surgically removed from the female partner are introduced to sperm from the male partner in a laboratory where, hopefully, fertilization will occur. If it does, one or more fertilized ova are then reimplanted in the female partner by a surgical procedure. While IVF has been helpful in treating some forms of infertility it has been of little value in treating male factor infertility, the condition suffered by the male appellant. Where there is a seminal defect, placing the semen in proximity to the egg is rarely sufficient to attain fertilization.

[6] ICSI is a recently developed variant of IVF whereby rather than simply bringing the egg and the sperm together to permit fertilization, a single sperm is actually implanted into an egg. The success rate in the treatment of male factor infertility by the use of ICSI is significantly better than with conventional IVF. It is considered the treatment of choice for cases of male factor infertility.

[7] IVF is performed at the I.W.K. Grace Centre in Halifax. ICSI had not, at the time of trial, been available in Nova Scotia. It was scheduled for introduction at the I.W.K. Grace Centre in 1999.

[8] The appellants had, prior to the trial, participated in four cycles of ICSI; two in Toronto and two in Calgary. The female appellant also had two frozen embryo transfers. None of these procedures succeeded.

[9] The total cost to the appellants of these procedures was approximately $40,000, including cost of treatments, drugs, travel and lodging. On July 24, 1996, Maritime Medical Care Inc. (M.M.C.) advised the appellants that they were not insured services in Nova Scotia. Their claim for reimbursement in this proceeding is limited to the medical and hospital costs of the procedures - $23,402.00 - plus interest. No claim is advanced for the cost of drugs or travel.

[10] Some medical procedures used to diagnose and treat infertility are covered under the **Act**, but the position of the respondents is that IVF has never been. Indeed, IVF is not covered by the public health care insurance plans in any Province of Canada with the exception of Ontario, where three cycles are insured - only in cases where the female partner has a total bilateral blockage of the fallopian tubes. ICSI is not covered anywhere in Canada.

[11] After the appellants were denied reimbursement of the costs of their ICSI procedures, this action was brought against the Attorney General of Nova Scotia representing Her Majesty the Queen in right of the Province, the Minister of Health, the Department of Health and the Administrator, Insured Professional Services under the **Act**.

[12] The appellants sought the cost of out-patient hospital services and medical services relating to ICSI, a declaration that they are entitled to coverage for further treatment, punitive damages related to the process by which their claim for payment was denied, an order in the nature of mandamus directing the Minister to establish a tariff for payment of IVF and ICSI procedures and, if necessary, a remedy under the **Charter**.

[13] While the appellants did not access IVF, they sought public interest standing with respect to it. They sought as well, a declaratory decision with respect to coverage for hospital services and medical services relating to IVF. The trial judge, after considering the case of **Canadian Council of Churches v. Canada** (1992), 88 D.L.R. (4th) 193 (S.C.C.) concluded that the appellants met the three-fold test for standing in this respect and accordingly granted standing to them. This decision has not been challenged by the respondents.

[14] There were five days of evidence at the trial before Chief Justice Kennedy.

[15] The male appellant testified and called three medical experts.

[16] Dr. Joseph O'Keane is a specialist in reproductive medicine. He is Clinical Associate Professor of Obstetrics and Gynecology at the University of Calgary. Previously he had been Director of the Reproductive Endocrine Division, Dalhousie University. He discussed IVF and ICSI. The latter is routine therapy for male infertility and is the method of choice in treating it once the limited traditional methods have failed. In the seven years

since it was developed it has gained widespread acceptance throughout the world. It requires very sophisticated instrumentation.

[17] As a general rule, three cycles of IVF or ICSI would be undertaken to achieve pregnancy in an infertile couple. With an average per cycle pregnancy rate of approximately 30%, it would be expected that a cumulative pregnancy rate of 70% would be reached after three cycles. He agreed that a live birth rate of 20% per cycle was a reasonable estimate; the success rates vary greatly from one clinic to another.

[18] Dr. O'Keane outlined the relevant medical history of the appellants. He saw them initially in consultation on March 21, 1995. The male appellant was then 34 years of age and the female appellant 33. Dr. O'Keane said that it was the view of all of the physicians involved in their care that ICSI was the appropriate procedure for them. It was clinically indicated and medically required for their situation. In his report, he spoke of the "necessity of ICSI as a therapeutic modality".

[19] Dr. William Wrixon is a gynecologist at the Reproductive Endocrine Centre at the I.W.K. Grace Hospital in Halifax. IVF is presently available there. The cost is $2,900.00 per cycle, excluding the cost of drugs. At the Grace, the live birth rate over the last five years averaged 25%. The "wait list" to get into the clinic at the Grace is almost one year.

[20] Tubal surgery is an insured procedure in the Province for female infertility. The risks include those of anesthesia, abdominal surgery and ectopic pregnancy which can be

life threatening. The cost of the procedure ranges from $4,000.00 to $6,000.00. It takes two to four hours to perform and has only limited success in restoring the patient's ability to conceive naturally if the tubal disease is severe. There are many patients with tubal disease who are better served by IVF.

[21] Dr. John E. Grantmyre is a urologist specializing in male infertility. He was one of the physicians who recommended the appellants for ICSI. A varicocele ligation performed on the male appellant had not been effective. ICSI was the procedure of choice. He said:

> We are able to offer a 30% take home baby rate in male factor. IVF using ICSI is an almost revolutionary treatment in this situation.

[22] The respondents called Dr. John Collins, Professor and Acting Chair of the Department of Obstetrics and Gynecology, Faculty of Health Sciences, McMaster University, Hamilton, Ontario. He spoke of the history of IVF and ICSI, their effectiveness and their risks. Live birth rates very from clinic to clinic. IVF's success range is between 15 - 20% per cycle; ICSI averages 13.3%. The risks common to IVF - ICSI are:

(a) ovarian hyper stimulation syndrome - 5% of cycles result in this condition. In one out of five of these the situation is serious enough to require hospitalization;

(b) multiple gestation pregnancy; and

(c) complications from ovarian induction hormones, including weight gain, headaches and fatigue.

[23] A controversial issue relating to ICSI side effects is that of congenital malformations. A study in Brussels shows an overall rate of anomalies of 5.2% in babies born as a result of the procedure, as against an average of approximately 2% of all human births. The Brussels study involved a mere 420 children born after ICSI.

[24] Dr. Collins spoke of the cost of fertility treatment and addressed the issue whether IVF and ICSI were medically necessary treatments. He personally favoured the inclusion of these procedures among the insured services of Medicare. His conclusion, however, was that it was doubtful whether the prerequisites of cost justification in a constrained health care system "can be fulfilled by the present action". I will refer to his evidence more fully later.

[25] The respondents also called Derrick Dinham, Executive Director of Insured Programs for the Department of Health. He spoke of the policy developed and implemented pursuant to the **Act**, services available thereunder, the history of IVF as an excluded service, of costs, and of the further exclusion of services as a result of financial pressures on the Department.

[26] The respondents' final witness was Catherine Hampton, Executive Director of Strategic Planning and Policy Development of the Department. She spoke of the financial constraints faced by the Department in recent years. I will refer to her evidence again in these reasons.

[27] Following the trial and submissions of written briefs, Chief Justice Kennedy dismissed the appellants' action. See **Cameron v. Nova Scotia (Attorney General)** (1999), N.S.J. No. 33; (1999), 172 N.S.R. (2d) 227.

[28] There are two issues in this appeal:

(i) Whether the trial judge erred in not finding that under the policy established by the **Act** and the relevant Regulations, IVF and ICSI are insured services available to residents of the Province.

(ii) In the event that the services sought by the appellants are not insured services, whether the policy is in breach of s. 15(1) of the **Canadian Charter of Rights and Freedoms** in that it discriminates against them, and if so, whether the discrimination is justified under s. 1 of the **Charter**. A claim based on s. 7 of the **Charter** advanced before the trial judge was not pursued at the hearing of this appeal.

2. FIRST GROUND OF APPEAL:

[29] I will outline briefly the history of the provision by government of medical and hospital care in this Province.

[30] Hospital services and medical care services have different origins. They have been, and still are, administered by different administrative structures.

[31] The Province began the program of insured hospital services for residents in

1958, pursuant to the **Hospital Insurance Act**, S.N.S. 1958, c. 3. The Hospital Insurance Commission was established to administer the plan.

[32] Ten years later, the Province provided insured medical care services to its residents pursuant to the **Medical Care Insurance Act**, S.N.S. 1968, c. 9. This **Act** established a Medical Service Insurance Corporation for the purpose of administering the **Act**, and the program was administered for it under contract by M.M.C. The Governor in Council made Regulations known as **Medical Services Insurance Regulations** which were first adopted as O.I.C. 69-267.

[33] In 1973 the two **Acts** were brought together as the **Health Services and Insurance Act**, S.N.S. 1973, c. 8. This legislation provided for a single commission - the Health Services and Insurance Commission (the Commission) upon which devolved the powers and duties of the former Medical Care Insurance Commission and the Hospital Insurance Commission. However, although the two Commissions were combined, their functions were not. The two programs - hospital services on the one hand and medical care services on the other - continued to be administered separately under separate legislative provisions and subject to separate regulations.

[34] There had always been an appeal procedure within the former Medical Care Insurance Commission to deal with claims not paid by M.M.C. It was an informal in-house arrangement that generally did a paper review of disputed claims on request. This

arrangement was continued, and at the present time, there is one person in the Department whose function is to review claims.

[35] The Commission and its predecessors were originally independent. However, in 1976 the **Act** was amended to provide that in exercising its functions and powers under the **Act** the Commission was required to report to and be responsible to the Minister and, at the Minister's direction, through his Deputy.

[36] In 1977 the **Act** was further amended to transfer to the Minister all powers and responsibilities and functions of the Commission with respect to the hospital insurance program. The Commission continued to perform its functions with respect to the Medical care program, but this continued as previously to be administered by M.M.C.

[37] In 1978 the **Act** was amended to authorize the Governor in Council to make regulations respecting payments in such amounts and on such terms as the Governor-in-Council deemed proper for hospital and medical services provided outside the Province to Nova Scotia residents.

[38] The first tariff of fees for insured medical services to which our attention was drawn was established in 1981 by the Commission and was approved by Order-in-Council, O.I.C. 81-379. It included a procedure for amendments to the fee schedule. If a physician considered a fee inadequate or a procedure not listed, the physician would notify the Chair of the fee committee of the appropriate section of the Medical Society of Nova Scotia. Such

Chair, after discussion and consideration could refer the request to the officers of the Medical Society who, in turn, might initiate discussion with the Commission to have the change approved as an insured service. When approved, the amendments would be published in the M.S.I. physicians' manual.

[39] In 1984 the **Act** was further amended to make more explicit the function and power of the Commission to negotiate with the Medical Society on behalf of physicians for the purposes of establishing a tariff of fees for insured medical services. This process of consultation with the Medical Society before establishing or altering a tariff was thus further reinforced.

[40] In 1989 the Nova Scotia Royal Commission on Health Care Services recommended dissolution of the Commission and amalgamation of its status into the Ministry of Health, thus integrating the administration of the hospital insurance program and the medical care program in one place. As a result of these recommendations, the **Act** was amended in 1992 (S.N.S. 1992, c. 20) to transfer all remaining substantive duties of the Commission to the Minister and to transfer all the Commission's staff to the Department. The amendments included an amendment to s. 37 of the **Act**:

> 37 A reference in any Act of the Legislature or in any rule, order, regulation, by-law, ordinance or proceeding or in any document whatsoever to the Hospital Insurance Commission, the Medical Care Insurance Commission or the Health Services and Insurance Commission, whether the reference is by official name or otherwise shall, as regards any subsequent transaction, matter or thing be held and construed to be a reference to the Minister or the Commission, as the case may be.

[41] Since 1992, the hospital insurance program and the medical care program have

been managed by separate divisions within the Department. The medical care program continues to be administered under contract by M.M.C. The legislation which created the Commission was not repealed, but the only function of the Commission remaining was to "perform the duties and functions assigned to the Commission by the Minister or the Governor-in-Council". The Commission has not met since December, 1992 and as vacancies have occurred among its members they have not, in the main, been filled. The Commission has not been appointed to quorum since 1991. In theory, at any rate, it was intended **inter alia** to serve as an appeal body to both providers of services and patients who wish to appeal a decision made by administration. It was simply allowed to lapse.

[42] Throughout the life of the medical care program in Nova Scotia, the introduction of new fees for medical services has been subject to a process of joint review and negotiation by the tariff making authority (now the Minister) in consultation with the Medical Society. No new fees are introduced except in accordance with this procedure. The procedure is carried out in the context of a cap system whereby, with limited funds, the introduction of new programs can impact on amounts available for existing ones.

[43] The **Act** makes provision for insured hospital and medical services to residents of the Province.

2.1. Insured Hospital Services:

[44] Section 3(1) of the **Act** provides:

> 3 (1) Subject to this Act and the regulations, all residents of the

Province are entitled to receive insured hospital services from hospitals upon uniform terms and conditions.

[45] The term “hospital” is defined in the **Act**:

2 In this Act,

. . .

(d) “hospital” means a hospital that has been approved under the *Hospitals Act* and any other hospital or facility that has been approved as a hospital by the Minister for the purposes of this Act;

[46] The term “insured hospital services” is defined in the **Act**:

2 In this Act,

. . .

(f) “insured hospital services” means the in-patient and out-patient services to which a resident is entitled under the provisions of this Act and the regulations;

[47] The Hospital Insurance Regulations are made under the authority of s. 17 of the **Act**:

17 (1) The Governor in Council may make regulations respecting the Hospital Insurance Plan

(a) establishing the Hospital Insurance Plan;

(b) prescribing the in-patient and out-patient services to which residents of the Province are entitled;

(c) prescribing the terms and conditions under which residents are entitled to insured hospital services;

(d) prescribing the terms and conditions under which payments will be made to hospitals for services provided by them;

. . .

(m) respecting reciprocal arrangements with other provinces for the provision of insured hospital services;

[48] The Regulations define the terms “in-patient” and “out-patient” and list a number of in-patient and out-patient services and procedures. Neither IVF nor ICSI are listed as such among the list of services and procedures. With respect to in-patient and out-patient procedures, Regulation 2(1)(a) and Regulation 3 provide:

> 2 (1) Subject to the Health Services and Insurance Act and these regulations,
>
> (a) a resident is entitled to receive in-patient and out-patient services that are medically required by him, without charge as insured services, commencing on the first day of the third month immediately following the month in which he becomes a resident of Nova Scotia;
>
> . . .
>
> 3 A resident is entitled to insured in-patient services for the period of time following admission during which such in-patient services are medically required.
>
> (emphasis added)

[49] Regulation 6 provides:

> 6 (1) If, in the opinion of the Commission, any of the services provided to the patient are or were not medically necessary the patient shall not be entitled to such services as insured services.
>
> (2) When, in the opinion of the Commission, a doubt exists concerning the medical necessity for in-patient or out-patient services in any case, the Commission may appoint and empower a medical review board to report on the case.
>
> (emphasis added)

[50] While the Regulations reinforce the conclusion that the Commission (now the Minister) has the role of determining what is medically necessary, it was not suggested that this has the effect of precluding access to the courts. These Regulations provide the mechanism for resolving what is medically necessary on a day to day basis.

[51] Section 10 of the **Act** provides for payment for hospital services outside the

Province:

> 10 Subject to the regulations, the Minister shall make payments to hospitals in respect of the cost of insured hospital services rendered by them under this Act to residents of the Province and may make payments with respect to the cost of insured hospital services that have been rendered to residents of the Province by hospitals that are owned or operated by the Government of Canada or are situated outside the Province.

[52] Regulations 7 and 8 deal with hospital services outside of Nova Scotia and so far as material provide:

> 7 (1) Subject to subsections (2) and (3), where a resident receives insured in-patient services in a hospital, including a federal Hospital, outside Nova Scotia, the Commission shall reimburse him, or the person who on his behalf pays for the services, for the cost of the services, or the Commission shall make payment directly to the hospital for the services, provided that
>
> (a) the services were required because of accident or sudden attack of illness or the receipt of the services is approved by the Commission;
>
> (b) the out-of-province hospital which supplied the treatment is a federal Hospital or is licensed or approved as a hospital by the governmental hospital licensing authority in whose jurisdiction the hospital is situate; or is approved by the Commission if there is no such authority;
>
> . . .
>
> (d) the Commission is satisfied that the person is entitled to receive the services and that they were medically necessary.
>
> (emphasis added)

[53] Out-patient services out of the Province but within Canada are not specifically mentioned in the Regulations, but under s. 10 of the **Act** the Minister has the power to provide payment for them, and does so on a discretionary basis. See for example Regulation 7(6). Presumably, they must be insured hospital services and must be medically required or medically necessary. Moreover, as I have shown, the term “hospital” is defined in the **Act**, and there is no evidence that any of the out-patient treatments the

appellants received outside the Province were either at hospitals approved under the **Hospitals Act**, R.S.N.S. 1989, c. 208 or at any other hospital or facility that had been approved as such by the Minister for the purposes of the **Act** (**Act** s. 1(d)).

[54] I agree with the trial judge that there is no general right to receive insured hospital services outside of the Province.

2.2. Appellants' out of Province Hospital Expenses:

[55] It follows that the expenses incurred by the appellants for out-patient services in Toronto and Calgary are not insured services, unless at the very least they can be shown to be medically necessary.

[56] With respect to services rendered in the Province, even if, as the appellants forcefully contend, IVF and ICSI, (although not specifically named as in-patient or out-patient services) fall within the broad categories of services listed, they must still be shown to be medically necessary or medically required. The trial judge found that they were not. I will address this issue later.

2.3. Insured Medical Services:

[57] Section 3(2) of the **Act** provides:

> 3 (2) Subject to this Act and the regulations, all residents of the Province are insured upon uniform terms and conditions in respect of the payment of the cost of insured professional services to the extent of the tariffs.

[58] The term “tariff” is defined in s. 2(n) of the **Act**:

> 2 In this Act,
>
> . . .
>
> (n) “tariff” means a tariff established by the Minister pursuant to Section 13.

[59] The M.S.I. Regulations are made under the authority of s. 17(2) of the **Act**.

> 17 (2) The Governor in Council may make regulations respecting the M.S.I. Plan
>
> (a) establishing a plan or plans for the payment of the cost of insured professional services received by residents;
>
> (b) prescribing the insured professional services to which residents are entitled;
>
> . . .
>
> (k) prescribing services which for purposes of a plan shall not be deemed to be services that are medically required;

[60] There is no regulation to which our attention was drawn providing that IVF and ICSI are not deemed to be medically required.

[61] Regulation 1(e) provides:

> 1 In these regulations
>
> . . .
>
> (e) “insured services” means all services rendered by physicians which are medically required or which are deemed by the Commission to be medically required but does not include
>
> . . .
>
> [Here is listed a large number of exceptions not immediately relevant.]
>
> (emphasis added)

[62] Section 13 of the **Act** provides in part:

> 13 (1) It is the function of the Minister and the Minister has the power to

> (a) negotiate, in good faith, compensation for insured professional services on behalf of the Province with the professional organizations representing providers;
>
> . . .
>
> (c) establish the tariff or tariffs of fees or other system of payment for insured professional services determined in accordance with this Section and, with the approval of the Governor in Council, authorize payments in respect thereof;
>
> (d) interpret tariffs and determine their application to the assessment of claims;
>
> . . .
>
> (emphasis added)

[63] Thus s. 13 sets out the functions and powers of the Minister with respect to negotiating on behalf of the Province with the professional organizations representing providers of insured services. The Minister is given the power to establish the tariff or tariffs of fees and the power to interpret tariffs and determine their application to the assessment of claims. I have previously referred to the process of consultation and joint management between the Medical Society and the Commission, now the Minister, in connection with changes to the tariffs. Since 1992 this process has continued through committees, and an internal arbitration process if a matter cannot be resolved at the committee stage.

[64] Neither IVF nor ICSI were listed in the 1981 tariff. In 1985, a representation on behalf of the Medical Society to the Commission that IVF be included was declined "at this time" on the ground that the Commission did not deem the procedure to be medically necessary. The Medical Society has not since then called for the addition of either IVF or ICSI to the tariffs. In 1990, the Commission issued a "Physicians' Bulletin" listing a number of uninsured services. IVF was included among them. IVF was included again in a list of

uninsured services in a poster sent to physicians by a committee of the Department and the Medical Society. IVF was also listed as an exclusion in the preamble to the fee schedule of the 1994 tariff and subsequent tariffs. In short, no tariff ever established in this Province has included IVF or ICSI. These services thus have failed to make their way through the medical system to the point of acceptance as an insured service.

[65] Effective January 20, 1997, as a result of an agreement between the Medical Society and the Department, several procedures were “deinsured”. According to Derrick Dinham this was the result of severe financial restrictions. The expected savings from the deinsurance was between 2.5 and 3 million dollars annually. It was stated that items were evaluated on the basis of quality of care and economical and ethical considerations, and that the primary bench mark for deinsurance was that it would not adversely affect the general health of the patient. Among the services deinsured were artificial and intrauterine insemination. Others included surgical assist for cataract surgery for most cases, excision of benign superficial cysts, removal of warts, removal of wax from ear, diagnosis of bone fracture without reduction, gastroplasty or gastric bypass for morbid obesity, breast reduction/augmentation surgery, circumcision of the newborn, insertion of testicular prosthesis, surgical fat removal from abdomen peritoneum and omentum, and routine vision care from 10th to 19th birthday.

[66] With respect to medical services outside of Nova Scotia, there is no corresponding regulation to s. 7 of the Hospital Insurance Regulations. However, in 1988 the Ministers of Health of all provinces and territories other than Quebec agreed to a

process of reciprocal billing and payment, and entered into a series of bilateral agreements to implement it. These agreements provided for payment in accordance with the tariff established in each province for services provided to non-residents there. Thus Nova Scotia agrees to pay for procedures which may not be insured professional services in Nova Scotia so long as they are insured professional services in the province where they were rendered. The agreements are subject to a list of exceptions. IVF and ICSI are excluded under all of them.

2.4. Appellants' out of Province Medical Expenses:

[67] The medical expense component of the appellants' treatment cost in Toronto and Calgary is therefore not insured.

2.5. Whether IVF and ICSI are Insured Medical Services within the Province:

[68] Although the appellants' out-of-province costs for hospital and medical services are not insured for the reasons given, it is necessary, in view of the standing given to the appellants, to deal with their claim that IVF (and inferentially ICSI) are insured services within the Province.

[69] It should be observed that a number of services other than IVF and ICSI are available to the infertile under the policy. Diagnostic services, including all hospital and laboratory services in connection therewith are covered. Various procedures such as testicular surgery on the male (two different procedures), and myomectomy and tubal surgery on the female are covered.

[70] The appellants take the position that Regulation 1(e) above establishes entitlement to reimbursement for medical services rendered in connection with IVF and ICSI. It is not necessary, they submit, to show that these procedures were included in the tariffs.

[71] The Minister's functions and powers with respect to the tariffs are set out in s. 13 of the **Act**. Once the Minister has established the tariff, payments in respect thereof must be authorized by the Governor in Council. The appellants' submission is that the tariffs merely establish machinery for determining the amount of the payment to be made for a service, having nothing to do with entitlement therefor. They point to the Minister's power under s. 13(1) of the **Act**, to "establish the Tariff or Tariffs of fees or other systems of payment for insured professional services". They say these words imply that the tariffs are but a system of payment and not the entire foundation for Medicare entitlement. The **Act** was passed at a time when extra billing was not prohibited, as it has been since 1984. The words "to the extent of the Tariffs" do not restrict the services to which residents are entitled; rather they restrict the amount a physician would be paid by the Province for a service.

[72] The position taken by the respondents is that the language of the **Act** is clear and unambiguous. In addition to the limitation imposed by Regulation 1(e) that services must be medically required, payment they submit is limited "to the extent of the tariffs". No payment can be made unless a tariff is established by the Minister and approved by the Governor in Council. This is the prerequisite for payment.

[73] If the trial judge was correct in his conclusion that IVF and ICSI were not medically required, it is not necessary to decide whether or not they need be provided for in the tariffs, nor is it necessary to decide whether they are included in the listed categories of in-patient and out-patient hospital services.

[74] As the respondents point out, the terms “medically required” and “medically necessary” have been employed in Canadian health care legislation from the earliest times but they have not been legislatively defined. The trial judge was of the view that it was not necessary to give meaning to these words beyond what was necessary to resolve the specific issue before him. He said:

> The courts can be asked to and will assess whether governments are complying with the process set out in legislation for determining if a procedure should be funded and will, when asked, insure that government is not acting in a discriminatory manner that is contrary to the *Charter*, when determining which services it insures, but to give general meaning to these words beyond this specific case is probably impossible and certainly unnecessary.

[75] I agree that the trial judge correctly stated his mandate. I accept his implied conclusion that the two terms “medically necessary” and “medically required” mean the same thing, and I will refer hereafter to either of them as including the other.

[76] The preamble to the fee schedule of the current tariff defines “medically necessary”:

> Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction.

[77] I do not accept this as a binding definition, but it does suggest the thinking behind the Commission's and subsequently the Department's decisions not to fund IVF and ICSI. The **Act** and Regulations refer to hospital and medical services that are rendered. The word "services" appearing therein is not limited to diagnosis, treatment and prevention of disease or dysfunction.

[78] The Canadian Bar Association Task Force on Health Care Reform, *What's Law Got To do with It?*: Health Care Reform in Canada (Ottawa, The Canadian Bar Association: 1994) reported at p. 31:

> 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. As we shall see, the provinces have also chosen not to provide a substantive definition, and the scope of "medically required services" and indeed, all "insured health services", is a policy decision.

[79] The Task Force observed at p. 37:

> The approach followed in [provinces other than Quebec] is not to declare a right to health care and to circumscribe its limits on a policy basis, but rather to simply list those services which are "medically required" and will therefore be publicly insured. Like the federal government, the provinces (including Quebec) have not advanced the definition of medically required services in their health care legislation. A non-exhaustive review of provincial legislation reveals that provinces simply classify services as "medically required" by regulation, without reference to any substantive or policy-based definition of that term. A presumption is therefore created that whatever is not on the list of insured services is not medically required. Where circumstances warrant, new services may be added to the list, just as services may be de-insured. While this procedure is flexible, it is arguably susceptible to political and economic winds, as it does not seem to be grounded in any principled definition.
>
> Much of the decision making in this area is therefore with the discretion of provincial cabinets or medical commissions appointed by provincial governments . . ..
>
> CONCLUSION:
>
> There is an expressed or implied right to health insurance under provincial health insurance acts, but this does not constitute a right to health care because there is no

> guarantee of content of health insurance (i.e., provinces may de-insure services as they choose). Further, there is no guarantee of procedural fairness in how insured services are selected or delisted (de-insured).

[80] This appears to be an accurate description of the policy established under the **Act** and the Regulations. Clearly, there is room for differing opinions on whether a given procedure is "medically required". In such circumstances, the trial judge's approach of placing the onus on the appellants to show that the Minister's position is wrong is, in my opinion, the correct approach.

[81] There was really not much difference among the medical experts who testified at the trial. The trial judge, in addressing Regulation 1(e), concluded that IVF and ICSI were not procedures that were medically necessary or medically required. In coming to his conclusion, he referred to the fact that all of the medical experts agreed that IVF was medically indicated for the treatment of infertility. He continued:

> In the case of ICSI, both the plaintiffs' expert, Dr. Joseph O'Keane, from the University of Calgary, and the defendants' expert Dr. John Collins, from McMaster University, agree that in cases such as the plaintiffs', ICSI is also "medically indicated".
>
> All medical experts who testified agreed, in addition, that IVF is "standard medical procedure" for certain types of infertility and that ICSI is now, or is rapidly becoming, the "treatment of choice" for male factor infertility. Dr. William Wrixon testified that it provides those diagnosed with this condition with "new hope".
>
> I accept these opinions as correct.
>
> However, neither "medically indicated" nor "standard medical procedure" equates to "medically required".
>
> I was particularly impressed by the testimony of Dr. John Collins, who is now Chair of the Department of Obstetrics and Gynaecology at McMaster University and previously had been Head of the Department at Dalhousie Medical School here in Nova Scotia. He is an advocate of infertile couples and an advocate of both of these medical procedures and yet maintained objectivity when addressing the issue of government health insurance coverage.

> He testified both IVF and ICSI are "effective" and have been "adopted" for clinical use. He believes that Medicare should cover both procedures and hopes that it eventually will.

[82] The trial judge reviewed the testimony of Dr. Collins respecting the different choices infertile couples have in response to the condition of childlessness, the limited success rate of the treatments, and the risks involved both to the parties and to any children they may have. The Department of Health's position that IVF and ICSI are not medically required was, in the trial judge's opinion, a valid one. 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".
>
> The decision of the Minister to deny insurance coverage for these procedures because they are considered "not medically required" has not been shown by the plaintiffs to be wrong. To the extent that their claims rest upon the application of regulation 1(e) to the specific facts it fails.

[83] These findings are based principally on the trial judge's assessment of the expert testimony. He also referred to Derrick Dinham's evidence that the Department considered that the procedures were not medically required and that one of the factors the government considered was the risks of them. The trial judge said he was satisfied that this concern had validity. Mr. Dinham did not testify with respect to the risks of the procedures. His background was health administration.

[84] The goal of IVF and ICSI treatment is not to treat disease or correct a condition or dysfunction, but to attain what the respondents' counsel would categorize as a "non

medical end" - the birth of a child. The infertile person's condition is not treated at all. The disease or dysfunction still remains. Nevertheless, if the procedure succeeds the infertile couple becomes parents. On the other hand, the treatments now made available by the policy under the **Act** to infertile persons will, if successful, make them fertile. Respondents' counsel states in his factum:

> However, if the Court finds that it is appropriate to consider a definition, the Respondents argue that IVF is not "medically necessary". "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 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).
>
> In the context of the provision of health care services, "medically necessary" must capture the first category and only the first category, i.e., medical means to medical ends. Applying this definition to the case at bar, the Respondents argue that IVF is not a medical necessity. It is a medical means but it does not serve a medical end; IVF can have no impact on Mr. Cameron's medical condition (medical end) although it may have an impact of the Appellants' childlessness (non-medical end). Therefore, it is not medically necessary in the context of health care services insurance legislation.

[85] The trial judge accepted this reasoning. I am not impressed with it. The goal of medical treatment is surely not so narrowly defined. There is nothing in the wording of the **Act** or the Regulations to support this narrow approach. While there is some superficial logic to it, it does not address the issue of substance. 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.

[86] Nor was I impressed with the suggestion that the availability of other choices to the condition of childlessness such as donor insemination, adoption or simple acceptance was in itself a convincing reason for deeming IVF and ICSI to be not medically necessary.

[87] I much prefer, however, the primary approach of Dr. Collins which simply was that in the scheme of things - in the order of priorities - these two procedures, having regard to costs, the limited success rate and the risks do not, at this time, rank sufficiently high to warrant payment for them from public funding. From a review of the entire record, particularly the history of IVF before the Commission, the history of the tariffs and the evidence of Dr. Collins and Mr. Dinham, I am satisfied that this is the real explanation why these procedures were considered not medically necessary and did not find their way into the tariffs.

[88] Dr. Collins referred to the success rate, the risks and side effects involved in the procedures, which I have summarized. However, he and the other medical experts routinely recommended these procedures in appropriate cases. The risks were not sufficient to contraindicate them.

[89] Dr. Collins concluded his report:

> One reason for the difficulty in defining treatment as “medically required” is the fact that different choices are made in response to the condition of childlessness. IVF and ICSI is one of a number of choices available to couples with severe male infertility. The options include simple acceptance, empiric treatments, donor insemination, IVF with ICSI and adoption. Given two couples virtually identical in clinical, cultural and economical respect, one couple might choose ICSI while another might decline ICSI. That does not appear to be consistent with the definitions “medically required”.

. . .

4. **Problems With A Definition of "Medically Required"**

Even with a generous program, along the lines of the Netherlands, where three cycles of IVF or ICSI therapy would be covered by the insurer, a high proportion of couples would not have conceived after completing this plan of treatment. Would a definition of "medically required" require the insurer to continue providing such treatment? Would there be some sort of legal problem for the insurer if any limit were imposed on a "medically required" service?

These difficult questions clearly cannot be answered by individuals. The Canadian health care system is one of the best in the world, and it has evolved as a result of numerous political, historical and economic circumstances. It appears to have the objective of providing the greatest benefit for the largest number of Canadians at an affordable cost. It is unimaginable that such a plural system could ensure that every individual would have an unlimited right to every known treatment.

Conclusions

The desire to have a child that is biologically related is admirable and deserving of the utmost societal consideration. Of course, infertile couples and their physicians would prefer to make decisions about IVF and ICSI without having to consider the cost. In order to achieve that objective it is necessary to determine whether the public is willing to include IVF and ICSI in its constrained health care system, and to have discussions about the trade-offs that would be needed to ensure that the public health interests were represented. It seems doubtful whether these pre-requisites can be fulfilled by the present action.

[90] On considering the entire record and recognizing the advantage enjoyed by the trial judge in his opportunity to assess the expert witnesses - particularly Dr. Collins - I say that the appellants have failed to satisfy me that the trial judge erred in accepting his reasoning. I do not, for the reasons I have given, consider that the risks of the procedures or the fact that they do not have a "medical end" or that there are other alternatives form of sound basis for the key finding . However, his finding overall that the services consisting of 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 has not been shown to be in error. Whether, on the other hand, the decision to exclude IVF and ICSI as not medically

required in the circumstances here violates s. 15(1) of the **Charter** will be considered later.

[91] I wish to address two points the appellants have advanced before us.

2.5.1. **Philosophy of Medicare**:

[92] The conclusion reached by the trial judge is clearly not in accord with the appellants' philosophy of Medicare. It is the position of the appellants that so long as medical treatment is of an acceptable standard of care, all-inclusive coverage for it must be available. The appellants assert that the Hall Commission recommended in 1964 the establishment of a universal comprehensive medical care program in Canada. Its report stated, Volume 1, p. 10:

> OBJECTIVE:
>
> As we examined the hundreds of briefs with their thousands of recommendations, we were impressed with the fact that the field of health care services illustrates, perhaps better than any other, a paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other.
>
> What the Commission recommends is that in Canada this gap be closed. That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind. All our recommendations are directed towards this objective. There can be no greater challenge to a society of free men . . .

[93] While it is true that medical and hospital services are universal in the sense that they are available to all residents of the Province, and may be described as comprehensive, they are not all-inclusive. Rather, they are limited at least to treatments that are medically necessary or medically required in the judgment of those who administer the scheme - in this case, the Department in consultation with the medical profession and

ultimately, the Minister.

[94] Reliance is placed on statements of the Minister of Health of Canada at the time of the introduction of the **Medical Care Act**, S.C. 1966, c. 64, and at the time of amendments to the **Canada Health Act**, S.C. 1984, c. 7. The appellants rely on s. 9 thereof which provides so far as is material:

> 9 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 . . .

[95] Health services were defined in s. 2 as "hospital services, physicians services and surgical - dental services provided to insured persons . . ."

[96] The appellants refer to the fact that the **Canada Health Act** authorizes federal payments to provinces which establish provincial medical care programs that comply with the principles set out in the **Canada Health Act**. They argue that the policy under the **Act**, if it does not provide for IVF and ICSI, is in violation of the **Canada Health Act**.

[97] If, without deciding that the **Act** fails to meet the standards or objectives of the **Canada Health Act**, it does not follow that the appellants would be entitled to relief in this Court. Jurisdiction over health care is exclusively a provincial matter. Failure of a province to comply with the **Canada Health Act** may result in the Government of Canada imposing a financial penalty on the province. It raises a political, not a justiciable issue. It does not render the provincial legislation unconstitutional. I refer to **Brown v. British Columbia**

(Attorney General) (1997), 41 B.C.L.R. (3d) 365; (1998), 5 W.W.R. 312 (B.C.S.C.) and **Lexogest Inc. v. Manitoba (Attorney-General)** (1993), 101 D.L.R. (4th) 523 (Man.C.A.).

[98] The appellants state that this Court is being asked to decide what medical treatments and procedures Medicare must cover. They say that the Court is presented with a "stark choice". They say that on the one hand the Court could find that Medicare coverage is confined to a finite list of medical treatments and procedures; if a particular treatment or procedure is not on the list, it is not covered. The list, they say, is compiled without reference to principle; it is compiled in the arbitrary discretion of bureaucrats in consultation with the body responsible for representing the economic interests of medical practitioners. On the other hand, they say a very different option is available. They say that Medicare coverage is ascertained by reference to principle, not by a mere list. The principle is, that there is universal comprehensive (in the sense of all-inclusive) medicare.

[99] The appellants submit that IVF is a safer and more effective treatment than tubal surgery. The latter is covered in this Province, the former, less expensive and more effective, they say, is not. The Royal Commission on New Reproductive Technologies has recommended that IVF be an insured service under provincial medical care programs. The appellants also refer to a number of other procedures covered under the **Act** which they say are less deserving of coverage than IVF and ICSI. This Court should order that all sound medical procedures be insured, they submit.

[100] In my opinion, the hospital and medical care available under the policy of the **Act**

is universal in that it applies to all residents of the Province without restriction. It is comprehensive, but by no means all-inclusive. A wide array of medical services is covered. No doubt for economical reasons, the scheme falls short of the limitless objective stated by the Hall Commission that "all the fruits of the health services [be] available to our residents without hindrance of any kind". The recent pressures on the Department, to which I will refer, and the list of services that were deinsured makes this point abundantly clear.

[101] A very important limitation in the policy is that insured services be medically necessary or medically required. Of necessity, what is or is not medically required must be judged by those placed in charge of the administration of the policy. The judgment call requires an appreciation not only of medical procedures, but the availability of funds to finance them. The exercise of such judgment is not a function of this Court. Our role is limited to requiring that those who make and administer the policy follow their own rules - in particular, the **Act** and the Regulations - in doing so. We are not accountable for the raising and expenditure of public monies. The persons who make these decisions under the policy are persons who are directly or indirectly so accountable. **Charter** considerations aside, as long as their decisions are reached in good faith and are not shown to be clearly wrong, we have no power to overturn them.

[102] Of course, another role that this Court does have, in questioning the actions of government in connection with the policy, is found in our duty to ensure that constitutional requirements and, in particular, those in the **Charter** are met. This will be addressed later.

2.5.2. Lapse of the Commission:

[103] The appellants point to the failure of the Governor in Council to appoint members to the Commission. This, they say, deprives them of a private appeal to the Commission of the Department's refusal to provide funding for their treatment.

[104] While from the perspective of consumers of health care, it would be desirable to have an independent tribunal to review decisions of the Department to fund or not to fund procedures, there is no requirement at law that such an appellate procedure be a part of the scheme.

[105] I also accept the respondents' argument that there is no connection between the assertion and the remedy sought.

[106] The appellants' claim that the absence of the Commission obliged them to adopt the more public and embarrassing route of going directly to court does not give rise to a cause of action known to law.

[107] The appellants' claim for punitive damages arising out of the failure to maintain the Commission as a review body must fail.

[108] Subject to the impact of the **Charter**, I conclude that the appellants are not entitled to any of the relief that they claim.

3. SECOND GROUND OF APPEAL:

3.1. The Charter:

[109] Section 1:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[110] Section 15(1):

> 15(1) 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.

3.1.1. Section 15 of the Charter:

[111] Having found that IVF and ICSI were not insured services, the trial judge addressed the issue whether the policy under the **Act** in so denying this coverage violated s. 15(1) of the **Charter**.

[112] The trial judge pointed out that s. 15(1) is concerned with the application of the law. The source of the exclusion of funding for IVF and ICSI was the policy of the government, including the **Act**, the Regulations, the decisions of the Commission and the Minister with the participation of the medical profession in developing the M.S.I. Tariff. This policy was, the trial judge held, “law” for the purposes of the **Charter** challenge.

[113] The trial judge referred to the two-step process referred to in **Vreind, et al. v. Alberta** (1998), 156 D.L.R. (4th) 385 (S.C.C.) and the approach taken by McLachlin, J. in

Miron and Valliere v. Trudel et al., [1995] 2 S.C.R. 418 at p. 485. The claimant must show a denial of equal protection or equal benefit of the law as compared with others, and that the denial constitutes discrimination. At the second stage, the claimant must show that the denial rests on one of the grounds enumerated in s. 15(1) or an analogous ground, and that the unequal treatment is based on the stereotypical application of presumed group or personal characteristics.

[114] The trial judge concluded that the policy of not providing coverage for IVF and ICSI is a denial of funding for specific medical treatments and should not be characterized as broader than that. The distinction drawn by the law is between funded and unfunded medical services. The appellants, he reasoned, must argue that the distinction is between funded services provided to fertile persons and unfunded services denied infertile persons based on personal characteristics. Under the scheme of the **Act**, numerous individual services are denied to fertile as well as infertile people. Some insured services are available to infertile people for their condition. The trial judge concluded that the distinction drawn is between services that have passed the process for inclusion as funded and those that have not. The non-funding is based on the nature of the treatment, not the personal characteristics of those seeking it. For these reasons, the claim based on s.15(1) of the **Charter** failed.

[115] Subsequent to Chief Justice Kennedy's decision and prior to the hearing of this appeal, the Supreme Court of Canada rendered its judgment in **Law v. Canada (Minister of Employment and Immigration)** (1999), 170 D.L.R. (4th) 1; [1999] 1 S.C.R. 497. In

Law, supra, the court summarized and commented upon the basic principles relating to the purpose of s.15(1) of the **Charter** in order to provide guidelines for courts when called upon to adjudicate a discrimination claim made thereunder.

[116] In **Law, supra**, the Supreme Court of Canada suggests a three-step analysis in resolving a s. 15(1) discrimination claim. The court summarizes this at para. 88:

> (3) Accordingly, a court that is called upon to determine a discrimination claim under s. 15(1) should make the following three broad inquiries:
>
> A. 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?
>
> B. Is the claimant subject to differential treatment based on one or more of the enumerated and analogous grounds?
>
> and
>
> C. Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?

[117] In making these inquiries, a purposive and contextual approach to the analysis is required. The "large remedial component" of s. 15(1) must be taken into account. The Court discusses the purpose of the s. 15(1) guarantee commencing at para. 42 and summarizes at para. 51:

> All of these statements share several key elements. 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. Legislation which effects differential treatment between individuals or groups will violate this fundamental purpose where those who are subject to differential treatment fall within one or more enumerated or analogous grounds, and where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, or otherwise has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society . . .
>
> (emphasis added)

[118] A discrimination inquiry involves a comparative approach: para. 56 **et seq**. The focus of the inquiry is both subjective and objective. The relevant point of view is that of a reasonable person, dispassionate and fully apprised of the circumstances, possessed of similar attributes to, and under similar circumstances as, the claimant. The perspective of the "reasonable person" is not solely appropriate because it could, through misapplication, serve as a vehicle for the imposition of community prejudices (**Law, supra**, paras. 59-61).

[119] Contextual factors for consideration in a discrimination inquiry are discussed by the court in para. 62 **et seq**. Four factors in particular are mentioned and with respect to these and others, guidance can be found from decisions of the court. The court concludes:

> . . . The general theme, though, may be simply stated. An infringement of s. 15(1) of the *Charter* exists if it can be demonstrated that, from the perspective of a reasonable person in circumstances similar to those of the claimant who takes into account the contextual factors relevant to the claim, the legislative imposition of differential treatment has the effect of demeaning his or her dignity: see *Egan, supra*, at para. 56, per L'Heureux-Dubé J. Demonstrating the existence of discrimination in this purposive sense will require a claimant to advert to factors capable of supporting an inference that the purpose of s. 15(1) of the *Charter* has been infringed by the legislation.

[120] The relationship between s. 15(1) and s. 1 of the **Charter** should be kept in mind. In **Miron v. Trudel, supra**, McLaughlin, J. said at para. 127 that the Supreme Court of

Canada has charted a middle course between employing s. 1 almost exclusively on the one hand and employing s. 15(1) as the principal approach, leaving little to s. 1 on the other hand. The burden of establishing discrimination under s. 15(1) lies on the claimant. The burden of justifying it under s. 1 lies on the government or those defending the law. Courts should interpret the enumerated rights in a broad and generous fashion, leaving the task of narrowing the **prima facie** protection thus granted to conform to conflicting social and legislative interests to the s. 1 analysis. This, she said, is an approach which does not trivialize s. 15(1) by calling all distinctions discrimination (paras. 130-131). See also Gonthier, J. in **Miron v. Trudel, supra**, paras. 31-38; **Law, supra**, para. 81.

[121] It is necessary first to examine the basis of the appellants' claim that the policy amounts to discrimination within the meaning of s. 15(1) of the **Charter** by reason of its failure to fund IVF and ICSI. The delisting of artificial and intrauterine insemination is not a part of this discussion as it was not raised in the pleadings or argued before us. I note in passing that while they must have been considered medically necessary procedures before, they were dropped without consultation with the two physicians in the Province who did them.

[122] The appellants say that the trial judge's conclusion that the denial of coverage was based not upon their personal characteristic (infertility), but on the nature of the treatment, operates to single them out as infertile persons for distinct treatment. This distinct treatment is a denial of "comprehensive Medicare coverage". Fertile persons receive Medicare coverage for all manner of treatment including prenatal workups, care at

childbirth, tubal ligation, etc. As Mr. Dinham testified, “every aspect of having children” is covered by Medicare. For infertile persons, however, IVF and ICSI - two critical treatments - the treatments of choice - are only available if they can pay for them.

[123] The appellants also say that infertility is a disability and that the application of the policy at issue has a disparate impact on them, the disabled. If, say the appellants, they are not physically disabled, they are an “analogous group” entitled to receive s. 15(1) **Charter** protection. They produced materials showing what they say is “bigotry, ignorance and medieval thinking” that has characterized the way in which infertility is regarded. They also refer to materials showing opposition to treatments such as IVF from religious spokespersons.

3.1.2. Law for the Purpose of the Charter:

[124] The **Act** and the Regulations are, on their face, neutral. There is nothing in them that one can point to in support of a claim of discrimination. The complaint has to lie in the way the legislation has been administered by the Commission and later the Minister in cooperation with private bodies - the Medical Society and the various committees and individuals who have examined the issue of IVF and ICSI leading up to the decision to exclude them from the category of medical necessity. Since the Legislature cannot enact laws that discriminate within the meaning of s. 15(1), it cannot delegate the power to do so to others. That is why it is the “policy” that flows from the **Act** that requires examination to see if it discriminates within the meaning of s. 15(1) either in intention or in effect. See **Eldridge v. B.C.,** [1997] 3 S.C.R. 624; 151 D.L.R. (4th) 577, paras. 19-34.

[125] In **Eldridge**, the plaintiffs were deaf persons who communicated by sign language. They were users of health services under the provincial medical plan of British Columbia. Hospital services were funded by the provincial government under the **Hospital Insurance Act** and medical services under the **Medical and Health Care Insurance Act.** The plaintiffs claimed that they were discriminated against contrary to s. 15(1) of the **Charter** because the plan set up under the legislation failed to provide them with paid interpreters to enable them to access medical and hospital services. An appeal to the Supreme Court of Canada following dismissal of their application for a declaration that the legislation violated their s. 15 **Charter** rights by failing to provide interpretation services was allowed. La Forest, J. for the Court referred at para. 21 to the following passage from Hogg, **Constitutional Law of Canada** (3rd Ed. looseleaf) at pp. 34-8.3 - 34-9:

> Action taken under statutory authority is valid only if it is within the scope of that authority. Since neither Parliament nor a Legislature can itself pass a law in breach of the Charter, neither body can authorize action which would be in breach of the Charter. Thus, the limitations on statutory authority which are imposed by the Charter will flow down the chain of statutory authority and apply to regulations, by-laws, orders, decisions and all other action (whether legislative, administrative, or judicial) which depends for its validity on statutory authority.

[126] La Forest J. said at para. 24:

> . . . it is not the legislation that is constitutionally suspect, but rather the actions of delegated decision-makers in applying it. In my view, this is the correct approach to the Charter application issue in this case.

[127] After reviewing the plan under the British Columbia legislation, La Forest, J. concluded at para. 34:

> Consequently, the fact that the *Hospital Insurance Act* does not expressly mandate the provision of sign language interpretation does not render it constitutionally vulnerable. The *Act* does not, either expressly or by necessary implication, forbid

> hospitals from exercising their discretion in favour of providing sign language interpreters. Assuming the correctness of the appellants' s. 15(1) theory, the *Hospital Insurance Act* must thus be read so as to require that sign language interpretation be provided as part of the services offered by hospitals whenever necessary for effective communication. . . . the potential violation of s. 15 inheres in the discretion wielded by subordinative authority, not the legislation itself.

[128] Here too we must consider the decision making process in the policy under the **Act** to see if the appellants' s. 15(1) **Charter** rights have been violated. I have already examined the manner in which the policy was developed and the basis upon which coverage for hospital and medical services rendered in connection with IVF and ICSI was excluded. They were not included because they were not considered medically necessary by the decision makers. In some instances they were specifically excluded. The issue is simply whether the administrative decision to exclude these procedures is **ultra vires** because it offends s. 15(1) of the **Charter**. The enabling legislation cannot authorize such administrative acts.

[129] In no case to which our attention was drawn has a situation exactly like that presented by the appellants been dealt with. We must approach the matter by the application of general principles. **Eldridge, supra**, is distinguishable in that the court was not asked to question a judgment that services were not medically required, but simply to order the provision of services to enable the disabled to access the same services that were available to all. What is preferred here to a rigid approach is a "flexible and nuanced analysis". This accommodates new and different understandings of equality and enables us to address a new issue raised by a varied fact situation. See **Law, supra**, para. 3.

[130] If there is discrimination here, it is, as I shall suggest later, adverse effect discrimination because in my view the **Act** and the policy on their face are neutral and draw no formal distinction relevant here.

3.1.3. Adverse Effects Discrimination:

[131] Does the policy fail to take into account the appellants' already disadvantaged position with the result that they receive substantially different treatment from others on the basis of one or more personal characteristics?

[132] We are told that the approach to a discrimination inquiry must be generous, and fully mindful of the need for unrelenting protection of equality rights. See McLachlin, J. in **Miron v. Trudel, supra**, para. 145.

[133] The Supreme Court of Canada has repeatedly held that s. 15(1) applies to unintended discriminatory adverse effects. See **Tétreault-Gadoury v. Canada**, [1991] 2 S.C.R. 22 at pp. 39-41.

[134] In **Vreind, supra**, Cory, J. said at paras. 75 and 76:

> (75)The respondents have argued that because the *IRPA* merely omits any reference to sexual orientation, this "neutral silence" cannot be understood as creating a distinction. They contend that the *IRPA* extends full protection on the grounds contained within it to heterosexuals and homosexuals alike, and therefore there is no distinction and hence no discrimination. It is the respondents' position that if any distinction is made on the basis of sexual orientation that distinction exists because it is present in society and not because of the *IRPA.*
>
> (76)These arguments cannot be accepted. They are based on that "thin and impoverished" notion of equality referred to in *Eldridge* (at para. 73). It has been

> repeatedly held that identical treatment will not always constitute equal treatment (see for example *Andrews, supra*, at p. 164). . . .

[135] In **Eldridge, supra,** La Forest, J. said at para. 64:

> Adverse effects discrimination is especially relevant in the case of disability. The government will rarely single out disabled persons for discriminatory treatment. More common are laws of general application that have a disparate impact on the disabled . . .

[136] Here, the parties disagree on the nature of the distinction drawn.

[137] The appellants view the distinction as one between people who get all medically required services relating to having children on the one hand and those who cannot on the other. The former are the fertile and the latter are the infertile, they say.

[138] The respondents' position is that the line between funded and unfunded services lies between health services that have passed the process required for inclusion in the tariffs and services that have not; only the former are funded. Services for the fertile and the infertile fall, they say, on both sides of the line between funded and unfunded services.

[139] In my opinion, the respondents' position is an oversimplification of the issue presented by the appellants' s. 15(1) **Charter** argument. The trial judge regarded the claim of discrimination as direct, because the exclusion of IVF and ICSI is not facially neutral. At all events, the **Act** and Regulations are, and since the decision to exclude IVF and ICSI does not profess on its face to be made on the ground that the recipients are infertile, I

consider it, too, to be facially neutral. The issue must be addressed with reference to whether, whatever the formal distinction may be, there is distinction in the impact of the policy based on a personal characteristic of the appellants.

[140] The difficulty with the respondents' position that the distinction is simply between medical services which have passed the process for funding and those which have not, is apparent from the following passage in the decision of La Forest, J. in **Tétreault-Gadoury, supra**, at p. 41:

> As in *McKinney, supra,* it was argued here that the policy is not motivated by stereotypical assumptions, but is based upon "administrative, institutional and socio-economic" considerations. In *McKinney*, however, I concluded (at p. 279) that "[t]his is all irrelevant, since as *Andrews v. Law Society of British Columbia* made clear . . . not only does the *Charter* protect from direct or intentional discrimination; it also protects from adverse impact discrimination, which is what is in issue here".

[141] The equality guarantee is a comparative concept. A s. 15(1) analysis must compare the treatment the law accords to one group of individuals with that accorded to another. Generally, the claimant chooses the person, group or groups with whom he or she wishes to be compared.

[142] Here, the appellants characterize themselves as among a group known as the "infertile". The comparative group is the "fertile". In defining the group, the purposes and effect of the policy must be considered. The biological, historical and sociological similarities or dissimilarities are relevant as well. (**Law, supra**, para. 57).

[143] The trial judge made no finding whether or not the infertile was one of the groups

enumerated in s. 15(1) of the **Charter** or an analogous group. There are many causes of infertility. It is not a sharply defined group. For example, Dr. Collins referred to a study showing cases where, without treatment, a number of infertile couples ultimately had children. In a paper, "The Stigma of Involuntary Childlessness", 1983, the author Charlene E. Maill of McMaster University submitted that involuntary childlessness can be conceptualized as a form of disability.

[144] In a report prepared for the New Zealand government (Wayne Gillett and John Peek, *Access to Infertility Services: development of priority criteria* (Wellington, New Zealand, National Advisory Committee on Health and Disability: 1997)), the authors said in their summary (Appendix 1):

> Infertility is a physical disability with nearly always an organic cause. It causes as deep and enduring loss as many chronic illnesses.

[145] On consideration, I do not think it can be seriously disputed that a person unable to have a child has a physical disability. The extent of it and its impact on sufferers in society will be considered later. For now, it is sufficient to point out that 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.

3.2. Section 15 Analysis:

[146] I will now proceed with the three broad enquiries mandated by the Supreme

Court of Canada in **Law, supra**.

3.2.1. First Step: Distinction on the Basis of a Personal Characteristic:

[147] I have already concluded that the trial judge did not err in finding that IVF and ICSI were not shown to be medically necessary within the meaning of the **Act** and Regulations.

[148] So the question is: does the policy developed under the **Act** fail to take into account the appellants' already disadvantaged position resulting in substantially different treatment between the appellants and others based on their infertility? Put another way, was there a distinction - inadvertent or not - by the makers of the policy in the decision to exclude IVF and ICSI based on the personal characteristics of infertility, resulting in substantially different treatment on the basis thereof?

[149] To my mind, the answer is in the affirmative.

[150] Consider for example the broad definition of discrimination in **Andrews v. Law Society of British Columbia**, [1989] 1 S.C.R. 143 at pp. 174-175:

> . . . 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 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.
>
> (emphasis added)

[151] In my opinion, the distinction between procedures medically required and those not medically required is a distinction that is relevant to the values which underlie the health care system. It is made a prerequisite for insurance of a treatment and, if applied consistently to all, and in a manner that meets the criteria of s. 15(1) of the **Charter**, it could be said to be a distinction based on the characteristics of the treatment. This was the way the trial judge expressed his conclusions on the **Charter** issue. However, he did not conduct an inquiry to see whether, in deciding that IVF and ICSI were not medically necessary, a distinction was in effect drawn between the treatment accorded fertile persons and the treatment accorded infertile persons which violated s. 15(1) of the **Charter**.

[152] As Gonthier, J. said in **Miron v. Trudel, supra**, para. 118:

> . . . The fact that legislation is underinclusive, however, does not make it any less discriminatory. Underinclusion is, in many ways, a backhanded way of promoting discrimination . . .

[153] It is important to understand how the Supreme Court of Canada has applied the principle of adverse effect discrimination so as to obligate the state, when it confers benefits, to make sure that the disadvantaged truly share in them. Provision of additional or extended benefits to them may be required. La Forest, J. in **Eldridge, supra**, said at paras. 72 and 73:

> [72] Once it is accepted that effective communication is an indispensable component of the delivery of medical services, it becomes much more difficult to assert that the failure to ensure that deaf persons communicate effectively with their health care providers is not discriminatory. In their effort to persuade this Court otherwise, the respondents and their supporting interveners maintain that s. 15(1) does not oblige governments to implement programs to alleviate disadvantages that exist independently of state action. Adverse effects only arise from benefit

> programs, they aver, when those programs exacerbate the disparities between the group claiming a s. 15(1) violation and the general population. They assert, in other words, that governments should be entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits.
>
> [73] In my view, this position bespeaks a thin and impoverished vision of s. 15(1). It is belied, more importantly, by the thrust of this Court's equality jurisprudence. It has been suggested that s. 15(1) of the *Charter* does not oblige the state to take positive actions, such as provide services to ameliorate the symptoms of systemic or general inequality; see *Thibaudeau, supra*, at para. 37 (*per* L'Heureux-Dubé J.). Whether or not this is true in all cases, and I do not purport to decide the matter here, the question raised in the present case is of a wholly different order. This Court has repeatedly held that once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner . . . In many circumstances, this will require governments to take positive action, for example by extending the scope of a benefit to a previously excluded class of persons; see *Miron, supra, Tétreault-Gadoury, supra*, and *Schachter v. Canada*, [1992] 2 S.C.R. 679, 93 D.L.R. (4th) 1. Moreover, it has been suggested that, in taking this sort of positive action, the government should not be the source of further inequality; *Thibaudeau, supra*, at para. 38 (*per* L'Heureux-Dubé J.).
>
> (emphasis added)

[154] In **Andrews, supra**, at pp. 164-9, McIntyre, J. for the court emphasized that true equality does not necessarily result from identical treatment. Formal distinctions in treatment will be necessary in some contexts in order to accommodate the differences between individuals and thus produce equal treatment in the substantive sense (**Law, supra**, para. 25). Thus, even if a benefit is not needed by some group, as long as it is necessary to enable disadvantaged persons to enjoy a government service, failure to provide it would lead to s. 15(1) **Charter** scrutiny.

[155] In **Eaton v. Brant Board of Education**, [1997] 1 S.C.R. 241, the Supreme Court of Canada held that segregation by provision of special classes for a disadvantaged student rather than integration was protective of equality and therefore did not offend s.15(1) of the **Charter**. At para. 66, Sopinka, J. noted that avoidance of discrimination on

the ground of physical or mental disability may require distinctions to be made to ameliorate the position of people so disabled. Disability, he noted at para. 69, differs from other enumerated grounds because there is individual variation in the group. Special adaptation may be required to provide an equal opportunity to the disabled. In such cases, it is the failure to take into account the true characteristics of a disadvantaged group and not the express drawing of a distinction which violates s. 15(1).

[156] The appellants do not submit that the policy must supply treatments that have not met general acceptance in the community of medical expertise that employs them. They only seek for the infertile medically recommended treatments that will ameliorate their condition, and promote, if not attain, equality with the fertile.

[157] The disadvantages faced by the infertile are ameliorated by the many benefits they enjoy under the policy, not only in common with others, but those aimed at remedying their condition. I have already referred to these. But why must the policy stop where it does? If the decision to deny coverage for a service turned solely on safety or lack or effectiveness, the case would be different. Here, however, we are dealing with what was described by the experts as the treatment of choice, a treatment to which the appellants were referred by their physicians in the course of providing them with insured services.

[158] The appellants point out that benefits under the policy are given regardless of fault and for conditions ranging from trivial to serious. The smoker who develops cancer as a result of the habit is treated without question. The fertile woman who becomes

pregnant gets full services for her pregnancy and childbirth. “Every aspect of having children” is covered by Medicare. She can even elect an abortion, an insured service. Sterilization is also an insured service. The infertile get less. They are denied a treatment which is called by all of the experts the treatment of choice for their problem. If the medically necessary judgment process is done in a way that deprives them of such treatment, are they not in effect excluded from the benefits that would otherwise give them equality with the fertile, or at least a reasonable chance for such equality? What is wrong here, they ask? The policy leaves them out of something. People, like the appellants, are unable to procreate - disabled - are denied key treatments of choice. How do they legitimately feel when confronted with the policy? (**Law, supra**, para. 153).

[159] In my opinion, the appellants belong to the group which may be classed as the infertile who need, but do not get, the full array of services for reproduction. The comparative group is the fertile who need, and do get, the full array of services for reproduction. The policy reinforces the disadvantage of the infertile.

[160] I think that in this way a distinction is drawn, based on their personal characteristic of infertility.

[161] In deciding that the treatments were not medically necessary, the trial judge accepted the evidence of Dr. Collins. The trial judge accepted that these treatments simply did not make their way through the system as treatments deserving coverage. He referred to them as not having been brought forward. Three very telling paragraphs appear in the

opinion of Dr. Collins:

. . .

3. Specific Exclusion of IVF and ICSI Procedures

Why are IVF and ICSI not covered, given that many other infertility treatments are covered by the insurer? Some of these covered treatments have no more evidence for their effectiveness than IVF and ICSI; unfortunately none of the choices, including IVF/ICSI, is effective in all cases. The Canadian health care system has evolved over time and new techniques are usually less likely to be covered, especially if they are costly, as in this case. In part because IVF and ICSI are often reserved for the most difficult infertility cases, they are the most costly treatments. The insurer (MSI) provides a range of options for the treatment of infertility, but there is little evidence on which to base a comparison to determine which treatments have the optimal balance of effectiveness, side-effects and costs.

. . .

These difficult questions clearly cannot be answered by individuals. The Canadian health care system is one of the best in the world, and it has evolved as a result of numerous political, historical and economic circumstances. It appears to have the objective of providing the greatest benefit for the largest number of Canadians at an affordable cost. It is unimaginable that such a plural system could ensure that every individual would have an unlimited right to every known treatment.

Conclusions

The desire to have a child that is biologically related is admirable and deserving of the utmost societal consideration. Of course, infertile couples and their physicians would prefer to make decisions about IVF and ICSI without having to consider the cost. In order to achieve that objective it is necessary to determine whether the public is willing to include IVF and ICSI in its constrained health care system, and to have discussions about the trade-offs that would be needed to ensure that the public health interests were represented. It seems doubtful whether these pre-requisites can be fulfilled by the present action.

(emphasis added)

[162] Dr. Collins, although called by the defence, was an advocate of the infertile. He clearly did not view the exclusion of IVF and ICSI as a violation of their dignity. He testified:

. . . And therefore, I think we need to change our point of view slightly to see that it now becomes a concern of the people, of society. It becomes a concern of politicians . . . And we need to go further as fertility advocates. We need to provide the population, those people who make the decisions, with better evidence than we have to date... the second important thing that we need to do as infertility advocates is to reassure society that unethical things will not take place. . . And the third thing

> . . . is to ensure that the cost issues are well explained and we need to be prepared to accept some of the trade-offs that would be needed because we do have a constrained health care system.

[163] Further on, Dr. Collins, after referring to consideration by the Medical Society of Nova Scotia of the application to M.S.I. respecting IVF, said:

> And they had, they believed - - rightly or wrongly, they felt they had the discretion to dismiss it. So even though the infertility specialists - - and we all agree that it's medically indicated, believe that it is, therefore, medically required, whatever that means, the 99 other physicians for every one infertility physician doesn't see it that way.

[164] I regard this as "mainstream" thinking which fails to make reasonable accommodation for the infertile. See **Eaton v. Brant, supra**, para. 66.

[165] A cost benefit analysis was made by Dr. Collins in terms of difficult cases of infertility and in terms of costly treatment therefor in the context of determining whether the public is willing to include these procedures in its "constrained health care system". This thinking is not consistent with values to be employed in making a s. 15(1) **Charter** analysis, although it is relevant on a s. 1 inquiry.

[166] The cost benefit analysis adopted here is favourable to the majority, the fertile, but not to the infertile. It is true that there are risks to IVF and ICSI, but the evidence makes very clear that there are countless procedures available to all that are risky - far more so than these two. These two procedures are ones that Dr. Collins himself thinks are effective and thinks are worthy of coverage in the system - if only there were enough money. The following is from his cross-examination:

> Q. You agree that ICSI is the standard treatment generally accepted by the community of infertility practitioners for male factor infertility.
>
> A. Yes, I do. I think there's virtually no difference among the medical witnesses at this trial. I believe it levels the playing field.

[167] This answer is in the context of treating one type of infertility as opposed to another, but it is very descriptive of treatment of infertile people generally as opposed to fertile people.

[168] It is the levelling of the playing field that s. 15(1) of the **Charter** is all about.

[169] In **Eldridge, supra**, La Forest, J. said at paras. 77-79:

> [77] This Court has consistently held, then, that discrimination can arise both from the adverse effects of rules of general application as well as from express distinctions flowing from the distribution of benefits. Given this state of affairs, I can think of no principled reason why it should not be possible to establish a claim of discrimination based on the adverse effects of a facially neutral benefit scheme. Section 15(1) expressly states, after all, that 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 . . ." (emphasis added). The provision makes no distinction between laws that impose unequal burdens and those that deny equal benefits. If we accept the concept of adverse effect discrimination, it seems inevitable, at least at the s. 15(1) stage of analysis, that the government will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services. As I will develop below, if there are policy reasons in favour of limiting the government's responsibility to ameliorate disadvantage in the provision of benefits and services, those policies are more appropriately considered in determining whether any violation of s. 15(1) is saved by s. 1 of the *Charter*.
>
> [78] The principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field. . . . Moreover, the principle underlying all of these cases was affirmed in *Haig, supra*, where a majority of this Court wrote, at p. 1041, that "a government may be required to take positive steps to ensure the equality of people or groups who come within the scope of s. 15".
>
> [79] It is also a cornerstone of human rights jurisprudence, of course, that the duty to take positive action to ensure that members of disadvantaged groups benefit equally from services offered to the general public is subject to the principle of reasonable accommodation. The obligation to make reasonable accommodation for

> those adversely affected by a facially neutral policy or rule extends only to the point of "undue hardship"; see *Simpsons-Sears, supra*, and *Central Alberta Dairy Pool, supra*. In my view, in s. 15(1) cases this principle is best addressed as a component of the s. 1 analysis. Reasonable accommodation, in this context, is generally equivalent to the concept of "reasonable limits". It should not be employed to restrict the ambit of s. 15(1).
>
> (emphasis added)

[170] Not every person denied a procedure can successfully mount a **Charter** challenge. If the procedure is judged medically unnecessary by a process that respects s. 15(1) **Charter** values, such a claim would fail. Dr. Collins has shown the thinking that justifies the process that led to the exclusion of IVF and ICSI. Nothing in that process gave recognition to the need to take special measures to ensure that the infertile would benefit equally with the fertile as far as possible under the policy. I have come to the conclusion that the denial of these procedures, on the ground that they are not medically necessary, creates a distinction based on the characteristic of infertility. Probably this distinction was unintentional.

[171] It follows from the foregoing that the distinction drawn by the arbitrary exclusion of IVF and ICSI from the tariffs and from the agreements respecting medical services outside of the Province and the refusal to exercise the Minister's discretionary powers to pay for hospital services outside the Province for these procedures are also distinctions based on personal characteristics resulting in a denial of equal benefit of the policy.

[172] The government has failed to ameliorate the position of the infertile compared with fertile people. They are unequally treated because they are denied a medically

recommended treatment appropriate for them. The fertile on the other hand have no restrictions on access to Medicare for pre-natal treatments and treatments relating to childbirth. “Every aspect is covered”.

[173] The question might be asked whether everybody requiring medical services is disabled, mentally or physically. That need not and cannot be decided here. I do observe though that the Supreme Court in **Law, supra,** pointed out in paras. 44-45 that even where distinctions are made on an enumerated or analogous ground, the indicia of discrimination must also be present before s. 15(1) of the **Charter** is engaged.

3.2.2. Second Step: Enumerated or Analogous Ground:

[174] As to the second step of the inquiry, it is not enough to focus only on the alleged ground of discrimination and determine whether or not it is an enumerated or analogous ground. In some cases a distinction based on such a ground is not discriminatory. The protection of equality rights is concerned with identifying distinctions which are discriminatory.

[175] I have already said that infertile people can be classified as physically disabled. True, the disability Is not obvious to the eye - they need no ramp or seeing eye dog. Nevertheless, they have a personal characteristic - inability to have a child - on the basis of which a distinction can be drawn and has in fact been drawn. We must take a “flexible and nuanced approach”. We must make a comparison of the infertile with the conditions of others in the social and political setting in which this claim arises. As long as the indicia

of discrimination exist when the distinction is drawn - an issue to be explored in taking the third step of the inquiry - there is disability here sufficient to meet the requirements of s.15(1), either as an enumerated or analogous group.

[176] In my opinion, the appellants have passed the first and second steps of the three step inquiry mandated by **Law, supra**.

3.2.3. Third Step: Differential Treatment as Discrimination:

[177] To repeat a part of the passage quoted from paragraph 51 of **Law, supra**, differential treatment is discrimination:

> . . . where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, or otherwise has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society . . .

[178] The Supreme Court of Canada has consistently said that courts should interpret the enumerated rights in a broad and generous fashion, leaving the task of narrowing them to a s. 1 analysis. As McLachlin, J. pointed out in **Miron v. Trudel, supra,** at para. 132, cases where a distinction is made on an enumerated or analogous ground that do not amount to discrimination are rare. See also **Andrews, supra**, per McIntyre, J. pp. 174-175. Faced with a denial of equal benefit on an enumerated or an analogous ground one would be hard pressed to show that the distinction is not discriminatory. Relevance to a legislative goal is a factor to consider, but as La Forest, J. said in **Eldridge, supra**, at para.59, there can be no personal characteristic less relevant to the functional values

underlying the health care system than an individual's physical disability.

[179] As we have seen, the purpose of the equality guarantee provided by s. 15(1) of the **Charter** is the protection of human dignity which is the feeling of self-respect and self-worth. It is harmed by unfair treatment premised upon presumed characteristics unrelated to merit or need. It is harmed when individuals or groups are ignored, devalued or marginalized. It is harmed if it inhibits in those discriminated against the sense that Canadian society is free and democratic as far as they are concerned. How does a person in such a group legitimately feel when confronted with a particular law?

[180] In entering this stage of the inquiry, it is necessary to consider contextual factors which may be relied upon by a claimant to demonstrate that legislation is discriminatory. In **Law, supra**, the Supreme Court of Canada referred to four such contextual factors which might be brought forward by a claimant, but this did not preclude the bringing forward of others. All of the traits, history and circumstances of the infertile must be considered in evaluating whether a reasonable infertile person would find that the policy has the effect of demeaning his or her dignity.

[181] The focus of the appellants' case is on the first factor - pre-existing disadvantage - and that is the principal one for our consideration here. I will comment to a lesser degree on the others.

3.2.3.1. Pre-existing Disadvantage:

[182] The appellants refer to literature which shows that the commitment to parenthood in western civilization reflects a Judeo-Christian tradition which views children as blessings from heaven and barrenness as a curse or punishment. See Genesis 17:15-16; Luke 1:5-24. Like leprosy and epilepsy, they say, infertility bears an ancient social stigma. They say that the material shows the bigotry, ignorance and medieval thinking that they say have typified views of infertility and opposition to treatment of the infertile.

[183] While neither appellant testified to any disadvantage suffered by them as infertile persons, the material shows that in various cultures and at various times, infertility - particularly in the female - has been regarded as a disadvantage - an unworthy state, the object of derision, banishment and disgrace. More recent writings in Canada and the United States however have shown a concern, a sympathy and support for the infertile among knowledgeable people. The low esteem in which they have been held in some places in the past has not appeared to have spilled massively over in modern day Canada. However, as McLachlin, J. said in **Miron v. Trudel, supra**, of common-law couples, notwithstanding improved attitudes, the historical disadvantage cannot be denied. The literature includes studies that show, as one would expect, that infertile persons perceive themselves in a negative light.

[184] The Royal Commission on New Reproductive Technologies, 1993, Volume 1, p. 171 paints a picture of infertility:

> Having children links generations within families and helps to ensure continuation of one's name, values, and genes. The Commission heard from childless couples who spoke eloquently about feeling cut off from the future. The effects of childlessness

> are felt strongly at all stages of life, not just during the childbearing years.
>
> Given these attitudes toward having children, the inability to have children cannot be dismissed as inconsequential. For many people, the experience of not being able to have children triggers complex and powerful emotions. There is often a loss of self-esteem mixed with feelings of grief, anger, and sometimes guilt about the source of the infertility. Many also experience a sense of isolation from family members and friends. People told us that infertility is not something that is easy to deal with and move on from, because having children is so firmly embedded in the everyday social and family interactions in which most of us take part. As friends and siblings go through life, milestones in their children's lives - school events, graduations, weddings, the birth of grandchildren - continuously remind those without children of their childlessness. Coming to terms with the inability to have children is not something that can be dealt with once and then left behind.
>
> A psychologist who counsels couples who are infertile explained to the Commission:
>
> > One thing that I've learned through my work is that it is almost impossible to understand what it is like to be infertile, to grasp the profound impact of infertility, unless you personally have been in the position of wanting to conceive a child and have been unable to do so . . . I have, since having worked with several hundred infertile couples, learned that loss of control, deteriorating relationships, increases in sick leave, inability to make career changes because of separation from the infertility clinic, lost friendships, depression, and marked deterioration in self-esteem are the hallmarks of the infertility experience. (P. Gervaize, Reproductive Health Psychologist, Public Hearings Transcripts, Ottawa, Ontario, September 18, 1990.)

[185] Infertility has been equated to frigidity. See Volume 8, **Journal of the American Society for the Study of Fertility** (1957), pp. 200-204.

[186] The perception of the inadequacy of the infertile is referred to in the judgment of the Ontario Court of Appeal in **Re Schafer, et al.** (1997), 149 D.L.R. (4th) 705 at paras. 26, 27, and 50.

[187] A scathing attack on the practice of artificial insemination was made in an article in 1956 **C.B.R.,** 1, by the Dean of the Manitoba Law School.

[188] In **The Stigma of Involuntary Childlessness, supra**, revised 1986, the author Charlene Maill said at p. 271:

> . . . Nearly all of the respondents characterized infertility as something negative, as representing some sort of failure, or an inability to work normally. In addition, women experiencing or sharing infertility regarded it as a discreditable attribute - that is, most were concerned that an awareness of problems with fertility would cause others to view them in a new and damaging light . . .

[189] Some of the reproductive technologies which are sought out by the infertile have met with disapproval or scepticism by various writers. They have been referred to as "morally illicit" by leading religious leaders.

[190] Dr. Grantmyre said that it seemed that infertile couples have been victimized by our society. Their treatments are perceived as experimental and extremely costly. He said infertile couples often harbour feelings of embarrassment or inadequacy and are rarely outspoken about their problem, its treatment, or who pays the bill.

[191] Dr. Collins agreed that infertility leaves its victims scarred and vulnerable. He said that it is a very burdensome affliction. He agreed it has a serious impact on the mental and social well-being of couples and may result in detrimental social consequences such as divorce or ostracism.

[192] It is true that the infertile do not appear to suffer consequences of their disability to the same extent as pictured by La Forest, J. in **Eldridge, supra,** at para. 56

> It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction

> and advancement, subjected to invidious stereotyping and relegated to institutions; see generally M. David Lepofsky, "A Report Card on the *Charter's* Guarantee of Equality to Persons with Disabilities after 10 Years: What Progress? What Prospects?" (1997), 7 N.J.C.L. 263. This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able-bodied norms; see Sandra A. Goundry and Yvonne Peters, *Litigating for Disability Equality Rights: The Promises and the Pitfalls* (Winnipeg: Canadian Disability Rights Council, 1994), at pp. 5-6. One consequence of these attitudes is the persistent social and economic disadvantage faced by the disabled. Statistics indicate that persons with disabilities, in comparison to non-disabled persons, have less education, are more likely to be outside the labour force, face much higher unemployment rates, and are concentrated at the lower end of the pay scale when employed; see Minister of Human Resources Development, *Persons with Disabilities: A Supplementary Paper* (Ottawa: Minister of Human Resources Development, 1994), at pp. 3-4, and Statistics Canada, *A Portrait of Persons with Disabilities* (Ottawa: Statistics Canada, 1995), at pp. 46-49.

[193] I do not take this to be an exclusive description of disability for the purposes of s. 15(1) of the **Charter**.

[194] It is true, however, that the infertile have been shown to suffer pre-existing disadvantage, vulnerability, stereotyping and prejudice. They have been, and seen themselves portrayed as, having undesirable traits or lacking those traits which are regarded as worthy.

[195] Nor is it even necessary "in order to establish an affront to human dignity" to show that the claimant's group is the subject of a stereotypical stigmatization. In **Law, supra**, at para. 64, after describing what is a stereotype and why it gives rise to disadvantage, the court continued:

> . . . However, proof of the existence of a stereotype in society regarding a particular person or group is not an indispensable element of a successful claim under s. 15(1).

> Such a restriction would unduly constrain discrimination analysis, when there is more than one way to demonstrate a violation of human dignity. I emphasize, then, that any demonstration by a claimant that a legislative provision or other state action has the effect of perpetuating or promoting the view that an individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society (whether or not it involves a demonstration that the provision or other state action corroborates or exacerbates an existing prejudicial stereotype), will suffice to establish an infringement of s. 15(1).

[196] These are strong words with wide implications.

[197] The court in **Law, supra**, also said at para. 65 that it is not necessary in order to establish an affront to human dignity to show historic disadvantage. A number of any of the more disadvantaged groups in society will, in appropriate cases, succeed in a s. 15(1) claim. To repeat a portion of the quotation from para. 51 of **Law, supra**:

> . . . or otherwise has the effect of perpetuating or promoting the view that the individual is less capable or less worthy . . . (emphasis added)

[198] Thus, even if the infertile are less stigmatized than, for example, gays and lesbians, what must be considered is the effect of the law drawing a distinction based on their characteristics. Cory, J. and Iacobucci, J. in **Vriend, supra**, said at para. 102:

> [102] Perhaps most important is the psychological harm which may ensue from this state of affairs. Fear of discrimination will logically lead to concealment of true identity and this must be harmful to personal confidence and self-esteem. Compounding that effect is the implicit message conveyed by the exclusion, that gays and lesbians, unlike other individuals, are not worthy of protection. This is clearly an example of a distinction which demeans the individual and strengthens and perpetuates the view that gays and lesbians are less worthy of protection as individuals in Canada's society. The potential harm to the dignity and perceived worth of gay and lesbian individuals constitutes a particularly cruel form of discrimination.
>
> (emphasis added)

[199] In short, infertile people are vulnerable.

[200] When the question posed in **Law, supra**, is asked: 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 in the policy and the exclusion of IVF and ICSI from the policy? What of their human dignity? Of their self-worth? The answer becomes clear.

[201] As McIntyre, J. said in **Andrews, supra**, a distinction based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, whereas a distinction based on an individual's merits and capacities will rarely be so classed.

[202] 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.

3.2.3.2. Relationship Between Grounds and the Claimant's Characteristics or Circumstances:

[203] The fact that the legislation may achieve a valid social purpose for one group, does not save the legislation where its effect upon another group conflicts with the purpose of the s. 15(1) guarantee. The focus here, we are told, must remain upon the central question whether, viewed from the perspective of the claimant, the differential treatment imposed by the legislation has the effect of violating human dignity. The mere fact the legislation has to some degree taken into account the actual situation of persons like the

claimant will not necessarily defeat a s. 15(1) claim. The policy takes into account the infertile by providing a number of services. However, the distinction which results from the exclusion of IVF and ICSI from coverage under the policy is significant. In 1993, the Royal Commission on New Reproductive Technologies recommended that IVF for bilateral fallopian tube blockage be an insured service under provincial medical care programs. I have referred to the evidence which indicates the ever growing importance of IVF and ICSI in overcoming the affliction of childlessness.

[204] The policy denies to the infertile a major component of the array of services available to ameliorate their condition. They are, to paraphrase the court in **Vriend, supra**, at para. 77 still denied a treatment which "may be the most significant for them". These two procedures are the ones holding out the only real hope of having a child for those with severe tubal disease or those with male factor infertility. It is not necessary to show that all persons in the class of infertile have been discriminated against on a prohibited ground. See **Gibbs v. Battleford District Co-op** (1996), 140 D.L.R. (4th) 1 (S.C.C.) where the court said at p. 13:

> . . . in order to find discrimination on the basis of disability, it is not necessary that all disabled persons be mistreated equally. The case law has consistently held that it is not fatal to a finding of discrimination based on a prohibited ground that not all persons bearing the relevant characteristics have been discriminated against.

3.2.3.3. Ameliorative Purpose or Effects:

[205] The policy does offer services directed towards ameliorating the condition of the infertile. It is, however, underinclusive because it excludes the infertile from access to

payment for IVF and ICSI.

3.2.3.4. Nature of the Interest Affected:

[206] The denial of funding for IVF and ICSI for the infertile is a denial of access to major components for them of Medicare - a cornerstone of social programs in Canada.

3.2.3.5. Summary of the Third Step:

[207] I have identified what I consider the relevant contextual factors in this discrimination claim. They may be better appreciated by comparing the position of the infertile under the policy with others against whom a distinction was drawn based on an enumerated or analogous ground, but where the indicia of discrimination were found by the Supreme Court of Canada to be absent; the males under s. 146(1) of the **Criminal Code** (**R. v. Nguyen,** [1990] 2 S.C.R. 906); those accused of murder who, because of Province of residence, could not elect trial by judge alone (**R. v. Turpin**, [1989] 1 S.C.R. 1296); the male prisoner who complained of cross-gender searches (**Weatherall v. Canada (Attorney General)**, [1993] 2 S.C.R. 872); the abled bodied childless 30 year old widow who did not get the pension benefits (**Law, supra**).

[208] Considering the purpose of the equality guarantee, the contextual factors and the generous approach towards claimants which has been mandated by the Supreme Court of Canada, I am satisfied that the distinction drawn here with respect to the exclusion by the policy of IVF and ICSI - albeit unintentional - is discrimination.

3.3. Section 1 Analysis:

[209] I must next make an analysis under s. 1 of the **Charter** to determine whether the exclusion of IVF and ICSI by the policy can be justified by the respondents.

[210] I reject the appellants' submission that the government action of which they now complain is not "prescribed by law" but by a mere policy. I have already determined that the policy created under the **Act** and the Regulations is law for the purposes of s. 15(1) of the **Charter** and thus subject to scrutiny. By the same "law", it is open to the respondents to justify reasonable limits imposed by the policy on s. 15(1) **Charter** rights.

[211] To successfully invoke s. 1 of the **Charter**, a party must show that the objective of the impugned law is of sufficient importance to justify limiting a **Charter** right, and that the means chosen are reasonable and demonstrably justified.

[212] The following is a concise statement of the so-called **Oakes** test by Iacobucci, J. in **Egan,** [1995] 2 S.C.R. 513, at para. 182:

> First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislative end must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the rights violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the **Charter** guarantee; and (3) there must be a proportionality between the effect of the measure and its objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right. In all s. 1 cases the burden of proof is with the government to show on a balance of probabilities that the violation is justifiable.

[213] The test must be applied with flexibility in the balancing of competing interests

between the rights created on the one hand and the need for governmental modification of them on the other.

[214] In **Eldridge, supra**, La Forest, J. said at para. 85:

> 85 This Court has recently confirmed that the application of the *Oakes* test requires close attention to the context in which the impugned legislation operates; see *Ross v. New Brunswick District No. 15 Board of Education*, [1996] 1 S.C.R. 825, 133 D.L.R. (4th) 1, at para. 78. The Court has also held that where the legislation under consideration involves the balancing of competing interests and matters of social policy, the *Oakes* test should be applied flexibly, and not formally or mechanistically; see *R. v. Keegstra*, [1990] 3 S.C.R. 697, at p. 737, *McKinney, supra*, *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927, at pp. 999-1000, 58 D.L.R. (4th) 577, *Cotroni*, *supra*, at p. 1489, *Committee for the Commonwealth of Canada v. Canada*, [1991] 1 S.C.R. 139, at p. 222, 77 D.L.R. (4th) 385 (*per* L'Heureux-Dube J.), *Egan, supra*, at para. 29 (*per* La Forest J.) and at paras. 105-106 (*per* Sopinka J.), and *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 63, 127 D.L.R. (4th) 1 (*per* La Forest J.) and at paras. 127-138 (*per* McLachlin J.). It is also clear that while financial considerations alone may not justify *Charter* infringements (*Schachter, supra*, at p. 709), governments must be afforded wide latitude to determine the proper distribution of resources in society; see *McKinney*, *supra,* at p. 288, and *Egan*, *supra,* at para. 104 (*per* Sopinka J.). This is especially true where Parliament, in providing specific social benefits, has to choose between disadvantaged groups; see *Egan*, *supra*, at paras. 105-110 (*per* Sopinka J.) . . .
>
> (emphasis added)

[215] La Forest, J. notes that it is unnecessary to decide whether in the social benefits context a different approach should be taken where the choice is between the needs of the general population and those of the disadvantaged group. Governments must demonstrate that their actions infringe the rights at issue no more than reasonably necessary to attain these goals. In **McKinney v. University of Guelph**, [1990] 3 S.C.R. 229 at p. 317 La Forest, J. said:

> In looking at this type of issue, it is important to remember that a Legislature should not be obliged to deal with all aspects of a problem at once. It must surely be permitted to take incremental measures. It must be given reasonable leeway to deal with problems one step at a time, to balance possible inequalities under the law against other inequalities resulting from the adoption of a course of action, and to take account of the difficulties, whether social, economic or budgetary, that would arise if it attempted to deal with social and economic problems in their entirety, assuming such problems can ever be perceived in their entirety.
>
> (emphasis added)

[216] In **Egan v. Canada**, **supra**, Sopinka, J. at para. 104 added a caution:

> 104 I agree with the respondent the Attorney General of Canada that government must be accorded some flexibility in extending social benefits and does not have to be pro-active in recognizing new social relationships. It is not realistic for the Court to assume that there are unlimited funds to address the needs of all. A judicial approach on this basis would tend to make a government reluctant to create any new social benefit schemes because their limits would depend on an accurate prediction of the outcome of court proceedings under s.15(1) of the *Charter*.

[217] On the other hand, the leeway granted is not infinite and the government must show a reasonable basis for concluding that it has complied with the requirement of minimal impairment in seeking to attain the objectives. The burden of persuasion is on the government in a s. 1 analysis.

[218] I would characterize the objective of the policy here as being to provide the best possible health care coverage to Nova Scotians in the context of limited financial resources. I take judicial notice that these limits have been a major concern for some years. There was evidence in the record as well respecting them. They have threatened, in the minds of most people, the very foundation of health care. It is the general perception that it will take a great deal of effort to make do with what we have. The respondents also emphasize that the objective of the non-funding of IVF and ICSI includes the controlling of health care costs and the protection of those receiving the procedures from the potential harms of treatments not adequately proven safe. I would take these to be components of the objective as I have stated it.

[219] Catherine Hampton, Executive Director of Strategic Planning and Policy Development of the Department of Health testified that federal cutbacks to health care in

the Province have reduced the federal government's cost-sharing of health programs, which were originally 50%, to about 39% - 40%. The decline in federal contributions to the health program in 1996-7 was $74.6 million. In 1997-8 it was $131 million. The projected decline for 1998-9 is $113.7 million, for a total of $319.3 million over three years.

[220] Over the same period of time, actual expenditures for health care in the Province have gone up. In 1996-7, it increased by $61.2 million. In 1997-8, it increased by $132.4 million and the projected increase for 1998-9 is $36.5 million. Thus, while federal contributions declined by $319.3 million over three years, the provincial contribution to health care has increased by $230.1 million.

[221] Health care expenditures in the Province increased from 36% to 39% of the total budget over the three year period in question. We were not given the total health care budget or the total budget, nor were we provided with any breakdown of health care costs showing what was paid for hospital and medical services as opposed to other services. I have examined the **Appropriations Acts** for the years 1996, 1997 and 1998 (S.N.S., 1996, c.4; S.N.S., 1997, c.1; S.N.S., 1998, c.1) showing the amounts of money voted by the House of Assembly to the Department for each of the fiscal years ending March 31, 1997, 1998 and 1999 to be $1,162,179,000, $1,286,097,000 and $1,455,102,000 respectively.

[222] Ms. Hampton referred to these developments as having resulted in obvious and very compelling pressures imposed on the Department's budget.

[223] The pressures on the budget of the Department of Health are, as noted by Ms. Hampton, “quite extreme”. The health needs of an aging population in Nova Scotia, together with the requests for funding of new programs, places a substantial burden on the public purse. The evidence discloses that the priorities for the expenditure of available dollars is continually reviewed. The review has resulted in the recent approval of new home care programs, implementation of new emergency health programs, construction of three replacement hospitals, substantial renovations to an existing hospital, and an enlargement of the cancer treatment program at the Cape Breton Regional Hospital.

[224] There have, of course, been programs which, although meritorious, have not been approved by the Strategic Planning Department, simply because of the lack of funds.

[225] The coverage for Nova Scotians is not determined in a vacuum.

[226] Ms. Hampton testified:

> [T]he Nova Scotia program compares quite generously when contrasted with other provincial health programs. Periodically we do undertake an assessment of the range and types of coverage undertaken by other provinces as compared with Nova Scotia. And in a number of notable examples, probably the most apparent at the moment being the Pharmacare program. We certainly have much more generous [coverage] than, I believe, all of the Atlantic provinces and most of the western provinces as well.

[227] The estimated cost of IVF and ICSI in Nova Scotia was addressed in the evidence. Dr. Collins estimated in his report that the cost of insuring the procedures would be 1.6 million dollars annually, not including drugs. This was based on data from a report

from the Department's, Section of Health Economics. On cross-examination, making certain assumptions, his estimate was reduced to about $800,000. The trial judge made no finding on the cost. There are a number of variables in arriving at any estimate, not the least of which are the degree of utilization if the service were introduced, the savings of the cost of other treatments no longer pursued, and savings arising out of increased effectiveness of the treatments over time.

[228] The best we can do in these circumstances, keeping in mind the burden on the respondents, is to arrive at an approximate figure for costs which I would estimate to be in the order of a million dollars annually.

[229] Costs, risks and survival rates were canvassed in the evidence with respect to IVF and ICSI and other procedures as well.

[230] As I mentioned, the present cost of a cycle of IVF at the I.W.K. Grace Hospital is about $2,900.00, not including drugs. It is estimated that ICSI would add from $500.00 to $700.00 per cycle to the cost.

[231] With IVF and ICSI the success rate varies with the age of the female, reducing with advancing age. At the Calgary Clinic, the take home baby rate exceeded 50% in women under 34; it was 20% in the over 39 age group. The further couples pass through the stages of the treatment, the greater become their chances of success. The live birth delivery rate per cycle is just that. It is common for couples to undergo two to three cycles,

as did the appellants. The cumulative success ratios are higher. Dr. Collins said that with two cycles it is almost double one cycle.

[232] Dr. Collins discussed on cross-examination the evaluation of a medical procedure in terms of cost for every year of life it gains. Dr. Collins had difficulty translating this to fertility treatments because yet another life becomes part of the equation. Looked at in this way, he agreed that $145.00 a year would represent the cost of IVF and ICSI . Cardiac artery bypass grafting costs $50,000 for each year of life gained; AIDS treatment costs about $8,000 for each year of life gained.

[233] There was evidence of the cost of a number of procedures such as: heart transplant at $75,000; heart and lung transplant at $111,000; liver transplant at $82,400; bone marrow transplant at $80,400. Tubal surgery runs from $4,000 - $6,000, as we have seen. These treatments are routinely provided as insured services.

[234] The 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.

[235] Here, it is the administrators of the policy who have drawn the line that excludes IVF and ICSI from the category of insured services. As well, they have found it necessary to curtail or eliminate coverage for procedures that they had previously considered medically necessary and hence worthy of coverage. In the face of the tremendous

pressures upon them, they must be “accorded some flexibility” in apportioning social benefits among the vast number of competing procedures and the conditions of patients that call for them.

[236] The policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second guess them, except in clear cases of failure on their part to properly balance the **Charter** rights of individuals against the overall pressing objective of the scheme under the **Act**.

[237] To use the words of Sopinka, J. in **Egan, supra**, “it would be unrealistic” for this Court to assume that there are unlimited funds to address the needs of all. We must necessarily show considerable deference to the decision makers in this exercise.

[238] What we have here is a policy made and changed by its administrators on an ongoing basis, not a specific piece of legislation which is of a more lasting character. In measuring any particular exclusion against the overall objective of the policy as I have stated it, it should not, to paraphrase the words of Sopinka, J. in **Egan, supra**, at para. 106, be judged on the basis that the choice has been made for all time. At para. 111, he said:

> . . . I am not prepared to say that by its inaction to date the government has disentitled itself to rely on s. 1 of the *Charter*.

[239] In my opinion, the evidence of Dr. Collins has captured the true nature of how

the policy works and must be allowed to work. While hoping that IVF and ICSI would soon become insured procedures, he recognized that in the development of the policy the responsible decision makers must make trade offs in a constrained health care system. Having regard to the costs, the limited success rate and the risks, they are not yet ready for acceptance as insured services. Dr. Collins said:

> . . . It is unimaginable that such a plural system could ensure that every individual would have an unlimited right to every known treatment.

[240] The trial judge accepted this reasoning.

[241] The present position of IVF and ICSI under the policy obviously does not have to be the solution for all time. Dr. Collins and the trial judge recognized this approach as a reasonable one.

[242] I have concluded that the respondents have met the burden which lies upon them.

[243] The violation of the appellants' rights is rationally connected to the aim of the **Act** and the policy developed under it. IVF and ICSI, although recommended in appropriate cases by the experts who testified at the trial, have not yet passed the process of peer review set up under the policy. That is a process developed to evaluate the safety and efficiency of procedures in the context of the limited funding available.

[244] The violation minimally impairs the appellants' **Charter** guarantee because unlike

the failure of funding in **Eldridge, supra**, it denies to the infertile funding for only two procedures, leaving them not only the full panoply of medical services available to all, but a number of specific procedures available for their condition.

[245] There is proportionality between the effect of the exclusion of these procedures and the objective. Overall, the exclusion is minimal in relation to all of the available benefits. The exclusion may work some hardship, but it does not work "undue hardship": **Eldridge, supra**, para. 79. The funding that would otherwise be used for these procedures is available for other projects and procedures. Moreover, the decision makers have also excluded and must necessarily exclude other procedures, which could result in a **Charter** challenge by those deprived of funded access to them.

4. DISPOSITION:

[246] In the result, I would dismiss the appeal. In view of the respondents' position taken with respect to costs, I would award them none.

Chipman, J.A.

Concurred in:

Pugsley, J.A.

BATEMAN, J.A.: (Concurring by Separate Reasons)

1. INTRODUCTION:

[247] While I am in agreement with the result reached by my colleague on the first and second grounds of appeal, I do not agree with his analysis of the **Charter** issue. It is my view that the appellants are not, by reason of the male appellant's infertility, disabled nor is the denial of funding for the medical procedures discriminatory. Accordingly, it is unnecessary to resort to s.1.

[248] This appeal raises the question of when, in the context of the **Health Services and Insurance Act**, R.S.N.S., 1989, c. 20, a distinction which results in the denial of a benefit to an individual or group may be made without offending s.15(1) of the **Charter**.

[249] Section 15 was recognized by Iacobucci J. in **Law v. Canada (Minister of Employment and Immigration)**, [1999] 3 S.C.R. 497; [1999] S.C.J. No. 12, as the **Charter's** “most conceptually difficult provision”:

> 15(1) 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.

[250] It is not every distinction on an enumerated or analogous ground which violates s.15(1). In **R. v. Hess; R. v. Nguyen**, [1990] 2 S.C.R. 906; [1990] S.C.J. No. 91; 906, both appellants were charged with sexual intercourse with a female person under the age of 14

years under s. 146(1) of the **Criminal Code**, R.S.C., 1970, c.C-34. The appeal to the Supreme Court of Canada was to determine whether s. 146(1) of the **Code** infringed s. 7 or 15 of the **Charter**; and, if so, whether the infringement was justified under s. 1. Section 146(1) provides:

> 146(1) Every male person who has sexual intercourse with a female person who
> (a) is not his wife, and
> (b) is under the age of fourteen years,
> whether or not he believes that she is fourteen years of age or more, is guilty of an indictable offence and is liable to imprisonment for life.

[251] In **Nguyen** the appellants argued that s. 146 violated the **Charter** by discriminating on the basis of sex because only a male could be convicted of the offence. Justice Wilson, writing for the majority of the Court, found that the provision did not run afoul of s. 15(1) and in so doing said:

> In *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, McIntyre, J. stressed that it was not every difference in treatment that would result in inequality and that it was not every distinction or differentiation in treatment that would give rise to discrimination and so violate the equality guarantee in s. 15(1) of the *Charter*. Similarly, in *R. v. Turpin*, [1989] 1 S.C.R. 1296, at p. 1332, I observed that in determining whether there was an infringement of s. 15(1) of the *Charter* it was important to look not only at the impugned legislation which had created the challenged distinction but also at the larger social, political and legal context because "[i]f the larger context is not examined, the s. 15 analysis may become a mechanical and sterile categorization process conducted entirely within the four corners of the impugned legislation" (p. 1332). In other words, we must not assume that simply because a provision addresses a group that is defined by reference to a characteristic that is enumerated in s. 15(1) of the *Charter* we are automatically faced with an infringement of s. 15(1). There must also be a denial of an equality right that results in discrimination. [Emphasis added]

[252] As stated by my colleague, the Supreme Court of Canada, in **Law**, **supra**, after reviewing the development of the jurisprudence, postulates a three step analysis of a s.15(1) claim (at para 88):

> A. 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?
>
> B. Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds?
>
> and
>
> C. Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?
>
> (emphasis added)

[253] In recognition of the varied circumstances in which a s.15(1) claim can arise, Iacobucci J. cautioned in **Law**, **supra**, however, that a claim is not to be decided by a "formalistic or mechanical approach":

> [88] . . . It is inappropriate to attempt to confine analysis under s. 15(1) of the *Charter* to a fixed and limited formula. A purposive and contextual approach to discrimination analysis is to be preferred, in order to permit the realization of the strong remedial purpose of the equality guarantee, and to avoid the pitfalls of a formalistic or mechanical approach.

[254] While Iacobucci J. endorsed the three part test in **Law**, **supra,** he acknowledged that a court may assess a s.15(1) claim using a different route:

> [87] . . . I have continued this Court's practice of articulating s. 15(1) analysis as having the three distinct elements which have been reviewed in these reasons. At the same time, I do not disagree with the idea that the concept of substantive inequality *could* be defined in terms of its discriminatory purpose or effect, nor do I mean to suggest that a court which articulated its analysis using a different structure would err in law simply by doing that, provided it addressed itself properly and thoroughly to the purpose of s. 15(1) and the relevant contextual factors. [Emphasis added]

2. ANALYSIS:

2.1. Equal Benefit of the Law:

[255] The appellants characterize their claim as a denial of “equal benefit of the law”. The respondents accept that the policy not to fund IVF results in the denial of a benefit, in particular, funding of the IVF procedure. I would agree. “Equal benefit of the law” is interpreted broadly. In **Andrews v. The Law Society of British Columbia**, [1989] 1 S.C.R. 143, the Court recognized that facially neutral laws may be discriminatory. As McIntyre J. commented at p. 164: ". . . every difference in treatment between individuals under the law will not necessarily result in inequality and . . . identical treatment may frequently produce serious inequality". The latter is recognized as “adverse effect” discrimination. In the context of this case, it is not sufficient, say the appellants, that they have access to all of the funded health services generally available. They are entitled to different treatment taking into account their special needs (infertility), in order to bring about true equality. The policy not to fund IVF fails to extend to them a benefit required to ameliorate their disadvantaged position in society.

[256] While the differential treatment here is not expressly “on the basis of a personal characteristic”, I accept that the policy not to fund IVF “adversely effects” the appellants due to their “personal characteristic” of infertility. In this regard, I would differ with Chief Justice Kennedy, who, while finding no violation of s.15(1), characterized the alleged discriminatory effect as “direct”.

[257] I would agree with the Chief Justice, however, that the alleged denial of benefit

here - the unavailability of funding for this medical procedure - should be narrowly construed. In this regard he said:

> [136] The plaintiffs claim a denial of equal benefit under the law. They claim that the defendants' "policy" singles out infertile persons, treats them differently than fertile persons, that it denies them comprehensive medical coverage (funding for IVF and ICSI) which effectively prevents those suffering from male factor infertility, the opportunity to have children.
>
> [137] The defendants agree that there is denial of benefit under the law herein. The defendants though, argue that the denial should be restricted to the refusal to provide funding to cover this treatment. To the extent that the plaintiffs further characterize the denial as preventing them from being parents, the defendants take issue.
>
> [138] The defendants have argued that the refusal of the Province to provide funding for IVF and ICSI has not prevented the plaintiffs from accessing the process, nor are they prevented from parenting by other means, such as donor insemination or adoption.
>
> [139] I agree with the defendants that the denial that the government by this policy, is making herein, is a denial of funding for specific medical treatment and should not be characterized as broader than that.

2.2. Enumerated or Analogous Ground:

[258] While a distinction is drawn by the IVF policy, I am unable to agree with the appellants' submission that the differential treatment is based upon an enumerated or analogous ground.

[259] The principle which informs the s.15(1) analysis is the “purpose” of the equality guarantee. Iacobucci J. said in **Law**, **supra**:

> [41] . . .the existence of a conflict between an impugned law and the purpose of s. 15(1) is essential in order to found a discrimination claim. This principle holds true with respect to each element of a discrimination claim. The determination of whether legislation fails to take into account existing disadvantage, or whether a claimant falls within one or more of the enumerated and analogous grounds, or whether differential treatment may be said to constitute discrimination within the meaning of s. 15(1), must all be undertaken in a purposive and contextual manner.
>
> [42] What is the purpose of the s. 15(1) equality guarantee? There is great

> continuity in the jurisprudence of this Court on this issue. In *Andrews*, *supra*, all judges who wrote advanced largely the same view. McIntyre J. stated, at p. 171, that the purpose of s. 15 is to promote "a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration". The provision is a guarantee against the evil of oppression, he explained at pp. 180-81, designed to remedy the imposition of unfair limitations upon opportunities, particularly for those persons or groups who have been subject to historical disadvantage, prejudice, and stereotyping.
>
> [48] . . . Similarly, in *Miron*, *supra,* at para. 131, McLachlin J. stated the overarching purpose of s. 15(1) as being "to prevent the violation of human dignity and freedom by imposing limitations, disadvantages or burdens through the stereotypical application of presumed group characteristics rather than on the basis of merit, capacity, or circumstance".
>
> [51] All of these statements share several key elements. 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. Legislation which effects differential treatment between individuals or groups will violate this fundamental purpose where those who are subject to differential treatment fall within one or more enumerated or analogous grounds, **and** where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, **or otherwise has the effect** of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society. Alternatively, differential treatment will not likely constitute discrimination within the purpose of s. 15(1) where it does not violate the human dignity or freedom of a person or group in this way, and in particular where the differential treatment also assists in ameliorating the position of the disadvantaged within Canadian society.
> [Emphasis added]

[260] Earlier, Wilson J., in **R. v. Turpin**, [1989] 1 S.C.R. 1333; [1989] S.C.J. No. 47, said that the purpose of s.15 was to remedy or prevent “discrimination against groups suffering social, political and legal disadvantage in our society”.

[261] Iacobucci J. in **Law**, **supra**, confirmed the view of McIntyre J. in **Andrews**, **supra**, that in deciding whether a claimant fits within an enumerated or analogous ground, a substantive analysis was a proper part of the inquiry:

> [81] There is nothing new in requiring a *Charter* claimant to establish that his or her right has been infringed in a manner which brings into play the purpose of the right in question. Both the principle that *Charter* rights are to be interpreted purposively, and the principle that the *Charter* claimant bears the onus of establishing an infringement of his or her right before the onus shifts to the state to justify the infringement, are fundamental and well established: see *Hunter v. Southam*, *supra*; *Big M*, *supra*; *R. v. Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200; *R. v. Edwards Books and Art Ltd*., [1986] 2 S.C.R. 713, 35 D.L.R. (4th) 1. In *Andrews*, *supra*, McIntyre J. specifically rejected an approach to analysis under s. 15(1) which would have seen the mere drawing of a legislative distinction as an infringement of the provision, noting that such a formalistic approach to the equality guarantee did not accord with its purpose. He also rejected an approach which would have seen issues of reasonableness and justification dealt with under s. 15 rather than under s. 1. In preferring the "enumerated and analogous grounds" approach to s. 15(1), McIntyre J. emphasized that this approach struck the appropriate balance between the claimant and the state, stating, at p. 178: "It must be admitted at once that the relationship between these two sections [s. 15 and s. 1] may well be difficult to determine on a wholly satisfactory basis. It is, however, important to keep them analytically distinct if for no other reason than the different attribution of the burden of proof. It is for the citizen to establish that his or her *Charter* right has been infringed and for the state to justify the infringement."
> [Emphasis added]

[262] Under the purposive and contextual approach mandated in **Law**, one must determine whether the appellants are, as they submit, among the “disabled” as that term is used in s.15(1). In **Eaton v. Brant Board of Education,** [1997] 1 S.C.R. 241; [1996] S.C.J. No. 98 Sopinka J. said of disability as a ground:

> [66] The principles that not every distinction on a prohibited ground will constitute discrimination and that, in general, distinctions based on presumed rather than actual characteristics are the hallmarks of discrimination have particular significance when applied to physical and mental disability. Avoidance of discrimination on this ground will frequently require distinctions to be made taking into account the actual personal characteristics of disabled persons. In *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R.143, at p. 169, McIntyre J. stated that the "accommodation of differences . . . is the true essence of equality". This emphasizes that the purpose of s. 15(1) of the *Charter* is not only to prevent discrimination by the attribution of stereotypical characteristics to individuals, but also to ameliorate the position of groups within Canadian society who have suffered disadvantage by exclusion from mainstream society as has been the case with disabled persons.
>
> [67] The principal object of certain of the prohibited grounds is the elimination of discrimination by the attribution of untrue characteristics based on stereotypical attitudes relating to immutable conditions such as race or sex. In the case of disability, this is one of the objectives. The other equally important objective seeks to take into account the true characteristics of this group which act as headwinds to the enjoyment of society's benefits and to accommodate them. Exclusion from the mainstream of society results from the construction of a society based solely on

> "mainstream" attributes to which disabled persons will never be able to gain access. Whether it is the impossibility of success at a written test for a blind person, or the need for ramp access to a library, the discrimination does not lie in the attribution of untrue characteristics to the disabled individual. The blind person cannot see and the person in a wheelchair needs a ramp. Rather, it is the failure to make reasonable accommodation, to fine-tune society so that its structures and assumptions do not result in the relegation and banishment of disabled persons from participation, which results in discrimination against them. The discrimination inquiry which uses "the attribution of stereotypical characteristics" reasoning as commonly understood is simply inappropriate here. It may be seen rather as a case of reverse stereotyping which, by not allowing for the condition of a disabled individual, ignores his or her disability and forces the individual to sink or swim within the mainstream environment. It is recognition of the actual characteristics, and reasonable accommodation of these characteristics which is the central purpose of s. 15(1) in relation to disability.
>
> . . .
>
> [69] It follows that disability, as a prohibited ground, differs from other enumerated grounds such as race or sex because there is no individual variation with respect to these grounds. However, with respect to disability, this ground means vastly different things depending upon the individual and the context. . . .
> [Emphasis added]

[263] Disabled persons have historically been denied access to education, employment, shelter, and other basic amenities of life through the inappropriate attribution of stereotypes and generalizations of inability. Similarly, they have been denied such access through the construction of a society which requires that disabled, in order to fully participate, be free of their limitations. This results in a marginalization of the disabled unwarranted by their personal characteristics. As recognized in the passage above, not allowing for the condition of a disabled individual forces that person to “sink or swim within the mainstream environment.” In the result, stereotypes are reinforced. As Gonthier J. said in **Miron v. Trudel**, [1995] 2 S.C.R. 418, [1995] S.C.J. No. 44 (at para 24) an enumerated or analogous ground is identified as “one that is commonly used to make distinctions which have little or no rational connection with the subject-matter, generally reflecting a stereotype”.

[264] Similarly in **Eldridge,** [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86 La Forest J. wrote:

> [56] It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions; see generally M. David Lepofsky, "A Report Card on the *Charter's* Guarantee of Equality to Persons with Disabilities after 10 Years -- What Progress? What Prospects?" (1997), 7 *(N.J.C.L.)* 263. This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able-bodied norms; see Sandra A. Goundry and Yvonne Peters, *Litigating for Disability Equality Rights: The Promises and the Pitfalls* (Winnipeg: Canadian Disability Rights Council, 1994), at pp. 5-6. One consequence of these attitudes is the persistent social and economic disadvantage faced by the disabled. Statistics indicate that persons with disabilities, in comparison to non-disabled persons, have less education, are more likely to be outside the labour force, face much higher unemployment rates, and are concentrated at the lower end of the pay scale when employed; see Minister of Human Resources *Development, Persons with Disabilities: A Supplementary Paper* (Ottawa: Minister of Human Resources Development, 1994), at pp. 3-4, and Statistics Canada, *A Portrait of Persons with Disabilities* (Ottawa: Statistics Canada, 1995), at pp. 46-49.
>
> [para57] Deaf persons have not escaped this general predicament. Although many of them resist the notion that deafness is an impairment and identify themselves as members of a distinct community with its own language and culture, this does not justify their compelled exclusion from the opportunities and services designed for and otherwise available to the hearing population. For many hearing persons, the dominant perception of deafness is one of silence. This perception has perpetuated ignorance of the needs of deaf persons and has resulted in a society that is for the most part organized as though everyone can hear; see generally Oliver Sacks, *Seeing Voices: A Journey Into the World of the Deaf* (Los Angeles: University of California Press, 1989). Not surprisingly, therefore, the disadvantage experienced by deaf persons derives largely from barriers to communication with the hearing population.
> [Emphasis added]

[265] The appellant Cameron suffers from male factor infertility with markedly reduced prospects of conceiving a child. In some contexts this dysfunction would be viewed as a “disability”. In my view, however, it does not fall within the meaning of “disability” for which protection is afforded by s.15(1). I am not satisfied, on the evidence, that the appellants

(or their like group), by reason of infertility, are excluded from mainstream society in the way contemplated in the passages above. This is not to trivialize the heartbreak that the appellants have clearly suffered in their inability to conceive a child. In their subjective view, this inability has indeed marginalized them and denied to them a fundamental advantage enjoyed by those who do not suffer from this condition.

[266] Nor can a realistic argument be advanced that infertility, if not within the enumerated ground of "disability", constitutes an analogous ground. The determination of whether a characteristic forms an analogous ground depends upon the factual context of the case. In **R. v. Turpin**, **supra**, the appellants were charged with first degree murder in Ontario. Their pre-trial motion for trial by judge alone was denied. Except in Alberta, an accused charged with murder must, under ss. 427, 429 and 430 of the **Criminal Code**, be tried by a judge and jury. The trial judge granted the motion holding, *inter alia*, ss. 427, 428 and 429 of the **Criminal Code** violated s.15(1) of the **Charter** because s.430 gave individuals charged with the same offence in Alberta an election to be tried by a judge alone, an option not available to those charged with the same offence in other provinces. Among the issues to be decided when the matter reached the Supreme Court of Canada was whether the denial of the right to be tried by judge alone in other than Alberta violated appellants' equality rights under s.15(1) of the **Charter**. Wilson J., for the Court, found that "province of residence" in that case did not qualify as an analogous ground, but that it might in another context:

> . . .Differentiating for mode of trial purposes between those accused of s. 427 offences in Alberta and those accused of the same offences elsewhere in Canada would not, in my view, advance the purposes of s. 15 in remedying or

> preventing discrimination against groups suffering social, political and legal disadvantage in our society. A search for indicia of discrimination such as stereotyping, historical disadvantage or vulnerability to political and social prejudice would be fruitless in this case because what we are comparing is the position of those accused of the offences listed in s. 427 in the rest of Canada to the position of those accused of the offences listed in s. 427 in Alberta. To recognize the claims of the appellants under s. 15 of the *Charter* would, in my respectful view, "overshoot the actual purpose of the right or freedom in question": see *R. v. Big M Drug Mart Ltd*., at p. 344.
>
> I would not wish to suggest that a person's province of residence or place of trial could not in some circumstances be a personal characteristic of the individual or group capable of constituting a ground of discrimination. I simply say that it is not so here. ...
> [Emphasis added]

[267] Iacobucci J. said in **Law**, **supra**:

> [93] . . . Where a party brings a discrimination claim on the basis of a newly postulated analogous ground, or on the basis of a combination of different grounds, this part of the discrimination inquiry must focus upon the issue of whether and why a ground or confluence of grounds is analogous to those listed in s. 15(1). This determination is made on the basis of a complete analysis of the purpose of s. 15(1), the nature and situation of the individual or group at issue, and the social, political and legal history of Canadian society's treatment of the group. A ground or grounds will not be considered analogous under s. 15(1) unless it can be shown that differential treatment premised on the ground or grounds has the potential to bring into play human dignity: see *Egan*, *supra*, at para. 52, *per* L'Heureux-Dubé J. If the court determines that recognition of a ground or confluence of grounds as analogous would serve to advance the fundamental purpose of s. 15(1), the ground or grounds will then be so recognized: see, e.g., *Turpin*, *supra*, at pp. 1331-33.
> [Emphasis added]

[268] To put the appellants' claim in context one must consider the impugned statute - the **Health Services and Insurance Act**, R.S.N.S., 1989, c. 20. The purpose of health care legislation is “the promotion of health and the prevention and treatment of illness and disease” (per La Forest J., **Eldridge**, **supra**, at para 59). 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 treatment or procedures will be funded but also which of the array of alternative procedures or treatments for the same ailment will receive funding. To create an analogous ground in the broad sense suggested by the appellants would unreasonably expand the ambit of s.15(1) - it would overshoot the purpose of the equality guarantee. When a procedure or treatment is not funded some person or group will inevitably suffer disadvantage. Every such decision would conceivably be a distinction based upon a new analogous ground or, in the appellants' submission, a “disability”.

[269] The appellants having failed to satisfy the second branch of the three part test in **Law**, the inquiry ends. They have not established an infringement of s.15(1) in that they have not been subject to differential treatment based upon an enumerated or analogous ground.

2.3. Discrimination:

[270] I have found that the appellants’ infertility is not an enumerated (or analogous) ground. Had I been satisfied that the appellants are among the disabled within s.15(1), they would, nevertheless in my opinion, have failed to establish that the benefit was denied in a discriminatory fashion. It is not sufficient, for the claimant to show simply that a distinction is drawn on an enumerated or analogous ground. Wilson J. said in **Turpin**, **supra**, at p. 1330:

> . . . Differential treatment is permitted under s. 15 provided it is "without discrimination". As McIntyre J. stated in *Andrews* (at p. 182):

> A complainant under s. 15(1) must show not only that he or she is not receiving equal treatment before and under the law or that the law has a differential impact on him or her in the protection or benefit accorded by law but, in addition, must show that the legislative impact of the law is discriminatory.
>
> The internal qualification in s. 15 that the differential treatment be "without discrimination" is determinative of whether or not there has been a violation of the section. It is only when one of the four equality rights has been denied with discrimination that the values protected by s. 15 are threatened and the court's legitimate role as the protector of such values comes into play.

[271] This approach was recently re-stated by Iacobucci J. in **Law**, **supra**:

> [27] Importantly, McIntyre J. [in *Andrews*] explained that the determination of whether a distinction in treatment imposes a burden or withholds a benefit so as to constitute "discrimination" within the meaning of s. 15(1) is to be undertaken in a purposive way. As he stated, at pp. 180-81, "[t]he words 'without discrimination' require more than a mere finding of distinction between the treatment of groups or individuals". Moreover, "in assessing whether a complainant's rights have been infringed under s. 15(1), it is not enough to focus only on the alleged ground of discrimination and decide whether or not it is an enumerated or analogous ground" (p. 182). Rather, "a role must be assigned to s. 15(1) which goes beyond the mere recognition of a legal distinction" on such a ground. The protection of equality rights is concerned with distinctions which are truly discriminatory. A discriminatory burden or denial of a benefit, McIntyre J. stated, is to be understood in a substantive sense and in the context of the historical development of Canadian anti-discrimination law, notably the human rights codes: "The words 'without discrimination'...are a form of qualifier built into s. 15 itself and limit those distinctions which are forbidden by the section to those which involve prejudice or disadvantage" (pp. 180-81). [Emphasis added]

[272] In determining whether “discrimination” has been established, the s.15(1) claim must be analyzed substantively. Iacobucci J. continued in **Law**:

> [38] In the same way, the jurisprudence of the Court has affirmed and clarified McIntyre J.'s emphasis in *Andrews* upon the necessity of establishing discrimination in a substantive or purposive sense, beyond mere proof of a distinction on enumerated or analogous grounds . . . In *Miron*, *supra*, at para. 132, McLachlin J. confirmed that "distinctions made on enumerated or analogous grounds may prove to be, upon examination, non-discriminatory". She explained that a distinction "may be found not to engage the purpose of the *Charter* guarantee", or it may "not have the effect of imposing a real disadvantage in the social and political context of the claim". [Emphasis added]

[273] Thus, contextual factors are central, not only to the analysis under the "enumerated ground" inquiry, but also in determining whether the differential treatment is discriminatory:

> [86] . . . To take the adverse effects discrimination example again, there may be cases where a law which applies identically to all fails to take into account the claimant's different traits or circumstances, yet does not infringe the claimant's human dignity in so doing. In such cases, there could be said to be substantively differential treatment between the claimant and others, because the law has a meaningfully different effect upon the claimant, without there being discrimination for the purpose of s. 15(1). . . . I believe it is easier and more effective for a court to apply an approach which distinguishes conceptually between differential treatment, on the one hand, and the discriminatory quality of that differential treatment, on the other.

[274] What is discriminatory treatment? Iacobucci J. acknowledged that state action corroborating or exacerbating an existing prejudicial stereotype, while a hallmark of discrimination, is not essential to a successful claim under s.15(1):

> [64] . . . A stereotype may be described as a misconception whereby a person or, more often, a group is unfairly portrayed as possessing undesirable traits, or traits which the group, or at least some of its members, do not possess. In my view, probably the most prevalent reason that a given legislative provision may be found to infringe s. 15(1) is that it reflects and reinforces existing inaccurate understandings of the merits, capabilities and worth of a particular person or group within Canadian society, resulting in further stigmatization of that person or the members of the group or otherwise in their unfair treatment. This view accords with the emphasis placed by this Court ever since *Andrews*, *supra*, upon the role of s. 15(1) in overcoming prejudicial stereotypes in society. However, proof of the existence of a stereotype in society regarding a particular person or group is not an indispensable element of a successful claim under s. 15(1). Such a restriction would unduly constrain discrimination analysis, when there is more than one way to demonstrate a violation of human dignity. I emphasize, then, that <u>any demonstration by a claimant that a legislative provision or other state action has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society</u> (whether or not it involves a demonstration that the provision or other state action corroborates or exacerbates an existing prejudicial stereotype), <u>will suffice to establish an infringement of s. 15(1)</u>. [Emphasis added]

[275] Discrimination thus has at its root prejudice, stereotyping or devaluation of the group or individual in society's eyes. In assessing the claim:

> [60] . . . a court must be satisfied that the claimant's assertion that differential treatment imposed by the legislation demeans his or her dignity is supported by an objective assessment of the situation. All of that individual's or that group's traits, history, and circumstances must be considered in evaluating whether a reasonable person in circumstances similar to those of the claimant would find that the legislation which imposes differential treatment has the effect of demeaning his or her dignity. (*Law, supra*) [Emphasis added]

[276] In **Law**, **supra**, the 30-year-old appellant was denied survivor's benefits under the Canadian Pension Plan (CPP). The CPP gradually reduces the survivor's pension for able-bodied surviving spouses without dependent children who are between the ages of 35 and 45 so that the threshold age to receive benefits is age 35. The appellant unsuccessfully appealed first to the Minister of National Health and Welfare and then to the Pension Plan Review Tribunal, arguing that the age distinction discriminated against her on the basis of age contrary to s.15(1) of the **Charter**. A further appeal was made to the Pension Appeals Board, which, in a trial *de novo*, concluded that the impugned age distinctions did not violate the appellant's equality rights. The majority of the Board also found that, even if the distinctions did infringe s.15(1) of the **Charter**, they could be justified under s. 1. A subsequent appeal to the Federal Court of Appeal was dismissed largely for the reasons of the Pension Appeals Board. A final appeal to the SCC was dismissed. It was held, Iacobucci J. writing for a unanimous Court, that neither the purpose nor the effect of the CPP provisions violated the appellant's dignity so as to constitute discrimination within s.15(1). Accordingly, justification of the distinction on the enumerated ground under s.1 was unnecessary.

[277] 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. At the center of such a complaint is diminution of the individual in society's eyes.

[278] In analysing the "dignity" issue in **Law**, **supra,** Iacobucci J, posed the following questions:

> [99] The questions, to take up the dignity-related concerns discussed above, may be put in the following terms. Do the impugned CPP provisions, in purpose or effect, violate essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice? Does the law, in purpose or effect, conform to a society in which all persons enjoy equal recognition as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect, and consideration? Does the law, in purpose or effect, perpetuate the view that people under 45 are less capable or less worthy of recognition or value as human beings or as members of Canadian society?

[279] Notwithstanding Ms. Law's sincere assertion that her dignity had suffered, the Court held that denial of the spousal pension on the basis of age - an express denial of a benefit on an enumerated ground:

> [107] . . . does not reflect a view of the appellant that suggests she is undeserving or less worthy as a person, only that the distribution of the benefit to her will be delayed until she is at a different point in her life cycle, when she reaches retirement age.
>
> [108] In these circumstances, recalling the purposes of s. 15(1), I am at a loss to locate any violation of human dignity. The impugned distinctions in the present case do not stigmatize young persons, nor can they be said to perpetuate the view that surviving spouses under age 45 are less deserving of concern, respect or consideration than any others. Nor do they withhold a government benefit on the basis of stereotypical assumptions about the demographic group of which the appellant happens to be a member. I must conclude that, when considered in the social, political, and legal context of the claim, the age distinctions in ss. 44(1)(*d*) and 58 of the CPP are not discriminatory.

[280] Similarly, 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. As I have said above, it is an inevitable consequence of the administration of health care that choices are made among procedures and treatments offered.

[281] This is not to ignore the policy's adverse effect upon the appellants, but to consider the decision not to fund the procedure in the context of health care legislation and its administration. In **Eldridge**, **supra**, the deaf were not provided with paid interpreters for medical services thereby depriving them of the services received by hearing persons. The unanimous Court held that the distinction was:

> [59] . . . based upon a personal characteristic that is irrelevant to the functional values underlying the health care system. Those values consist of the promotion of health and the prevention and treatment of illness and disease, and the realization of those values through the vehicle of a publicly funded health care system.

[282] The denial of interpretive services amounted to a structuring of society in a way which fails to "take into account the true characteristics of this group which act as headwinds to the enjoyment of society's benefits and to accommodate them". (per Sopinka J. in **Eaton**,**supra,** at para 67, above)

[283] Here, the impugned policy does not deny all treatment to the infertile - indeed, many procedures are funded as are set out in the decision of my colleague. There may be

legitimate dispute as to the wisdom of the choices made in this regard. We cannot, however, hold the government to a standard of perfection. As Iacobucci J. wrote in **Law**, **supra**:

> [105] In referring to the existence of a correspondence between a legislative distinction in treatment and the actual situation of different individuals or groups, I do not wish to imply that legislation must always correspond perfectly with social reality in order to comply with s. 15(1) of the *Charter*. The determination of whether a legislative provision infringes a claimant's dignity must in every case be considered in the full context of the claim. . . .
>
> [106] Under these circumstances, the fact that the legislation is premised upon informed statistical generalizations which may not correspond perfectly with the long-term financial need of all surviving spouses does not affect the ultimate conclusion that the legislation is consonant with the human dignity and freedom of the appellant. Parliament is entitled, under these limited circumstances at least, to premise remedial legislation upon informed generalizations without running afoul of s. 15(1) of the *Charter* and being required to justify its position under s. 1. ...

[284] Here, the Chief Justice's findings at trial are deserving of deference. Having heard the evidence he said:

> [154] There is convincing evidence that shows, and I find, that the non-funding of IVF and therefore ICSI, is based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking the funding, the infertile.
>
> [155] The non-funding of IVF and ICSI is, I find, based on the failure of these medical treatments to come within criteria necessary before a medical procedure is funded. <u>They have not been brought forward by the profession for consideration under the process agreed to by the doctors and the government Dr. William Wrixon, the specialist who oversees the provision of IVF at the I.W.K. Grace Health Centre, testified that, about eight years ago, a request that IVF be added to the "fees structure" was made to the Medical Society, but it was not taken to the government because the procedure was considered "too new"</u>.
> [Emphasis added]

[285] This conclusion is relevant to whether or not equal protection has been denied in a discriminatory manner. The refusal to fund the procedure in these circumstances would not, in my opinion, promote the view that the infertile are less capable or less worthy of value. In effect the Chief Justice found that the denial of the funding was not

"discriminatory". This is not to suggest that policies excluding funding for certain treatments or procedures could never be discriminatory. If, for example, it was the government's policy not to fund any medical services for the infertile (assuming them to be "disabled"), without regard to the nature of the service, it is likely that such a policy would be seen to promote the view that such persons were less worthy of recognition or value as a human being or as a member of Canadian society. Such would likely be the case, as well, with a policy that denied all medical treatment specific to gays or lesbians or all treatments which only women required. Regardless of the language of such policy, if its existence led inevitably to the conclusion that its effect was to send a message that these persons or groups were less worthy of recognition it would likely not withstand the s.15(1) scrutiny and require justification under s.1.

[286] In my view the Courts must, in conducting the s.15(1) inquiry, exercise caution and restraint. As La Forest, J. wrote in **Andrews**, **supra**, at page 194:

> . . . I am convinced that it was never intended in enacting s. 15 that it become a tool for the wholesale subjection to judicial scrutiny of variegated legislative choices in no way infringing on values fundamental to a free and democratic society. Like my colleague, I am not prepared to accept that all legislative classifications must be rationally supportable before the courts. Much economic and social policy-making is simply beyond the institutional competence of the courts: their role is to protect against incursions on fundamental values, not to second guess policy decisions.
>
> I realize that it is no easy task to distinguish between what is fundamental and what is not and that in this context this may demand consideration of abstruse theories of equality. For example, there may well be legislative or governmental differentiation between individuals or groups that is so grossly unfair to an individual or group and so devoid of any rational relationship to a legitimate state purpose as to offend against the principle of equality before and under the law as to merit intervention pursuant to s. 15. For these reasons I would think it better at this stage of *Charter* development to leave the question open. I am aware that in the United States, where Holmes J. has referred to the equal protection clause there as the "last resort of constitutional arguments" (*Buck v. Bell*, 274 U.S. 200 (1927), at p. 208), the courts have been extremely reluctant to interfere with legislative judgment. Still, as

> I stated, there may be cases where it is indeed the last constitutional resort to protect the individual from fundamental unfairness. Assuming there is room under s. 15 for judicial intervention beyond the traditionally established and analogous policies against discrimination discussed by my colleague, it bears repeating that considerations of institutional functions and resources should make courts extremely wary about questioning legislative and governmental choices in such areas.

[287] In summary, it is my view that Chief Justice Kennedy did not err when he found that the policy denying funding for IVF treatment was not discriminatory. In this regard he said (decision reported as **Cameron v. Nova Scotia (Attorney General)** at (1999), 172 N.S.R. (2d) 227); [1999] N.S.J. No. 33:

> [136] The plaintiffs claim a denial of equal benefit under the law. They claim that the defendants' "policy" singles out infertile persons, treats them differently than fertile persons, that it denies them comprehensive medical coverage (funding for IVF and ICSI) which effectively prevents those suffering from male factor infertility, the opportunity to have children.
>
> [137] The defendants agree that there is denial of benefit under the law herein. The defendants though, argue that the denial should be restricted to the refusal to provide funding to cover this treatment. To the extent that the plaintiffs further characterize the denial as preventing them from being parents, the defendants take issue.
>
> [138] The defendants have argued that the refusal of the Province to provide funding for IVF and ICSI has not prevented the plaintiffs from accessing the process, nor are they prevented from parenting by other means, such as donor insemination or adoption.
>
> [139] I agree with the defendants that the denial that the government by this policy, is making herein, is a denial of funding for specific medical treatment and should not be characterized as broader than that.
>
> [140] There is also the question as to the exact nature of the distinction that the government policy, the law, draws.
>
> [141] The distinction is between funded and unfunded medical services that is basic, but for the plaintiffs to ultimately succeed in this claim, they must, and do, argue that the distinction is between the funded services provided to the fertile and the unfunded services denied the infertile based on personal characteristics.
>
> [142] The reality though, is not so clear cut. In fact, there are numerous individual services denied the fertile as well as the infertile (eg. electrolysis) and many medical services funded for the infertile such as diagnostic procedures.
>
> [143] I am satisfied that the distinction that the policy draws is between medical health services that have passed the process for inclusion as those funded and

medical health services that have not and go unfunded.

[144] The distinction, I find, contrasts those people who wish to access funded services and those who wish to access unfunded services. In the case of IVF and ICSI, the infertile are in the latter group. The only people who want or need to access these procedures are the infertile.

[145] The question then is, does this distinction that results in this denial of these services to the infertile constitute discrimination?

[146] There are two kinds of possible discrimination under s. 15(1), direct and adverse effects discrimination.

[147] In *Egan v. Canada* (1995), [1995] 2 S.C.R. 513; 182 N.R. 161; 12 R.F.L. (4th) 201;124 D.L.R. (4th) 609 (S.C.C.) at p. 663 Cory, J. wrote:

> Direct discrimination involves a law, rule or practice which on its face discriminates on a prohibited ground. Adverse effect discrimination occurs when a law, rule or practice is facially neutral but has a disproportionate impact on a group because of a particular characteristic of that group.

[148] If there is discrimination in this matter, it is "direct". The decision to exclude IVF and thus ICSI from funding is not facially neutral. It is clear that the decision will impact the infertile.

[149] The plaintiffs claim that it is discrimination based on disability. They argue that infertility is the impairment of a natural human function similar to an impairment of hearing or eyesight.

[150] In the alternative, if the infertile are not disabled, argue the plaintiffs, then they are an analogous group as surely as are "separated or divorced custodial parents" found by McLachlin, J. to be a "discrete and insullar" minority in *Thibaudeau v. Canada (1995)*, [1995] 2 S.C.R. 627; 182 N.R.1; 124 D.L.R. (4th) 449, at p. 518 D.L.R.and unmarried couples who suffer "social disadvantage and prejudice" and "social ostracism" as McLachlin, J. stated in *Miron v. Trudel (1995)*, [1995] 2 S.C.R. 418; 181 N.R. 253; 81 O.A.C. 253; 124 D.L.R. (4th) 693 at p. 749 D.L.R.

[151] In support, the plaintiffs have produced evidence that speaks to the severe personal crisis, emotional stress and social isolation experienced by infertile couples. I am satisfied that this is often true.

[152] The plaintiffs argue that whether the infertile are classed as disabled or an analogous group, they must receive s. 15(1) protection against the defendants' policy. In the light of the comprehensiveness of medicare, the policy exercised by the Nova Scotia Government, the plaintiffs submit, signals to the infertile that their medical treatment is less important than the medical treatment made available to others.

[153] It is not necessary for this Court, in this case, to classify the infertile as disabled or an analogous group or neither.

[154] <u>There is convincing evidence that shows, and I find, that the non-funding of IVF and therefore ICSI, is based on the nature of the treatment being sought, rather</u>

> than the personal characteristics of those persons seeking the funding, the infertile.
>
> [155] The non-funding of IVF and ICSI is, I find, based on the failure of these medical treatments to come within criteria necessary before a medical procedure is funded. They have not been brought forward by the profession for consideration under the process agreed to by the doctors and the government. Dr. William Wrixon, the specialist who oversees the provision of IVF at the I.W.K. Grace Health Centre, testified that, about eight years ago, a request that IVF be added to the "fees structure" was made to the Medical Society, but it was not taken to the government because the procedure was considered "too new".
>
> [156] That is why the procedures are not covered. They are not covered because of reasonable government policy made in compliance with provincial law. They are not covered because the medical profession in this Province has not sought to have them covered.
>
> [157] I find that the reality that these medical processes are accessed only by the infertile is not the reason for their exclusion from insurance coverage, not the reason for the distinction drawn in law.
>
> [158] There is no discrimination against the plaintiffs shown. There is no breach of s. 15 of the *Charter*. The plaintiffs claim based on that section fails.
> [Emphasis added]

[288] The Chief Justice found that the decision not to fund IVF/ICSI created a distinction but that the distinction was not “discriminatory”. I would agree. While his analysis did not and could not have mirrored the approach subsequently developed in **Law**, **supra**, that in itself is not an error of law, as was recognized by Iacobucci J.

3. DISPOSITION:

[289] Accordingly, in my view, the appellants cannot succeed on this appeal. They have neither brought themselves within an enumerated nor analogous ground, nor demonstrated that they have been denied equal benefit of the law in a way that discriminates as contemplated by s.15(1).

[290] I would dismiss the appeal, but in the circumstances, without costs.

Bateman, J.A.