

HEALTH CARE AND EQUALITY: IS THERE A CURE?

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I. Introduction

For good or for ill, access to health care has become not only a defining national value, but the dominant social policy concern in Canada.¹ Public support for medicare has remained high, even as other core social programs

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1 Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada - Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at xvi (Chair: Roy Romanow), online: Commission on the Future of Health Care in Canada <<http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html>> [Romanow Commission]; Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Interim Report on the State of the Health Care System in Canada: The Story So Far*, vol. 1 (Ottawa: Senate of Canada, 2002) (Chair: Michael Kirby), online: Parliament of Canada <<http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/rep-e/repintmar01-e.htm>>; Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role: Final Report on the State of the Health Care System in Canada: Recommendations for Reform*, vol. 6 (Ottawa: Senate of Canada, 2002) at 38 (Chair: Michael Kirby), online: Parliament of Canada <<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/repoct02vol6-e.htm>> [Kirby Committee, *Final Report*]; Commission on the Future of Health Care in Canada, *National Values, Institutions and Health Policies: What Do They Imply for Medicare Reform, Discussion Paper No. 5* by Theodore R. Marmor, Kieke G.H. Okma & Stephen R. Latham (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 15-16, online: Commission on the Future of Health Care in Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/5_Marmor_E.pdf>; Conference Board of Canada, *Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results* (Ottawa: Conference Board of Canada, 2000) at 11, online:

have been dismantled,² and Canadians have continued to insist that equal access must be preserved as the system's core and defining feature:

Among the main impetus for Canadian social health reform in the 1960s was the view that health care was a 'basic right' of Canadians and that no citizen, no matter how economically disadvantaged, should ever be denied access to necessary medical health care services. Implicit in the initial expectation was the belief that a national universal health insurance program would help to sever the link between poverty and illness by ... eliminating economic access barriers to health care in this country.³

Conference Board of Canada <<http://www.conferenceboard.ca/documents.asp?rnext=215>>; National Forum on Health, *Canada Health Action: Building on the Legacy – Final Report of the National Forum on Health* (Ottawa: Minister of Public Works and Government Services, 1997) at 10-11, online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/pubs/renewal-renouv/1997-nfoh-fnss-v1/index_e.html> [National Forum on Health, *Final Report*]; National Forum on Health, "Values Working Group Synthesis Report" in *Canada Health Action: Building on the Legacy – Synthesis Reports and Issues Papers* (Ottawa: Minister of Public Works and Government Services, 1997) at 5, online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/pubs/renewal-renouv/1997-nfoh-fnss-v2/legacy_heritage2_e.html> [National Forum on Health, *Synthesis Reports*]; Health Canada, *Canada's Health Care System* (Ottawa: Health Canada, 2005), online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2005-hcs-sss/index_e.html> at 1, 12.

- 2 See generally Shelagh Day & Gwen Brodsky, *Women and the Canada Social Transfer: Securing the Social Union* (Ottawa: Status of Women Canada, 2007), online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/pubspr/0662460909/200703_0662460909_e.pdf>; Janine Brodie & Isabella Bakker, *Canada's Social Policy Regime and Women: An Assessment of the Last Decade* (Ottawa: Status of Women Canada, 2007), online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/pubspr/0662450870/200703_9780662450870_e.pdf>; Armine Yalnizyan, *Canada's Commitment to Equality: A Gender Analysis of the Last Ten Federal Budgets (1995-2004)* (Ottawa: Canadian Feminist Alliance for International Action, 2005), online: FAFIA <<http://www.fafia-afai.org/en/node/207>>.
- 3 David A. Alter, "Are some patients in Canada treated more equally than others? The Orwell prophecy" (2003) 146 *American Heart Journal* 938. See also National Forum on Health Final Report, *supra* note 1 at 11; Lois L. Ross, "Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada"

Successive Canadian governments of all political stripes have affirmed their commitment to the ideal that: “all Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada” and have asserted that this remains an underlying principle of health care reform.⁴ Yet, these same governments appear unwilling or unable to undertake the systemic changes, in relation to both determinants of health and primary care, that a succession of health care reports and studies have argued are necessary to ensure the continued effectiveness and viability of the public system.⁵ Notwithstanding the promise of universality, it is clear that the health needs of certain groups, including Aboriginal people in particular, are not being adequately met.⁶ Even those

in North-South Institute, ed., *The Global Right to Health: Canadian Development Report 2007*, vol. 3 (Ottawa: Renouf Publishing, 2007) at 21, online: North-South Institute <<http://www.nsi-ins.ca/english/publications/cdr/2007/default.asp>>.

- 4 See e.g. First Ministers’ Meeting, *2003 First Ministers’ Accord on Health Care Renewal*, Doc. 800-039 (Ottawa: 2-4 February 2003) at 1, online: Canadian Intergovernmental Conference Secretariat <http://www.scics.gc.ca/pdf/800039004_e.pdf>; First Ministers’ Meeting, *A 10-Year Plan to Strengthen Health Care*, Doc. 800-042 (Ottawa: 13-16 September 2004) at 2, online: Canadian Intergovernmental Conference Secretariat <http://www.scics.gc.ca/confer04_e.html>; Letter from Hon. Stephen Harper, Prime Minister of Canada to the Hon. Ralph Klein, Premier of Alberta (3 April 2006), in which Prime Minister Harper affirms that: “There is no doubt that our governments share the commitment to principles that ensure that Canadians have universal access to medically necessary, timely and quality care based on need and not on an ability to pay” in relation to Premier Klein’s “Third Way” health reform proposals.
- 5 See generally Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007); Colleen M. Flood & Tracey Epps, “Waiting for Health Care: What Role for a Patients’ Bill of Rights?” (2004) 49 McGill L.J. 515 at para. 12; Steven Lewis, “The Potted Road to Romanow: Unrealized Ambitions in Canadian Health Reform” (2003) 66 Sask. L. Rev. 549; Barbara Legowski & Lindsey McKay, *Health Beyond Health Care: Twenty-five Years of Federal Health Policy Development*, (Ottawa: Canadian Policy Research Networks, 2004), online: Canadian Policy Research Networks <<http://www.cprn.org/doc.cfm?doc=131&l=en>>; Nuala P. Kenny, *What Good is Health Care? Reflections on the Canadian Experience* (Ottawa: Canadian Hospital Association Press, 2002).
- 6 See generally Ontario Health Quality Council, *2006 First Yearly Report* (Toronto: Queen’s Printer for Ontario, 2006) at 13-14, online: Ontario Health Quality Council <http://www.ohqc.ca/pdfs/ohqc_report_2006en.pdf> [Ontario Health

Canadians for whom the public system has traditionally worked well fear their continued ability to get the care they need, and especially to obtain it in a timely way, is being seriously eroded.⁷ And, while politicians have proclaimed their support for medicare, governments' commitment to the core principles set out under the *Canada Health Act*⁸ is often belied by their actions, or inaction, in key areas of health policy.⁹ In this context, it is hardly surpris-

Quality Council, *2006 First Yearly Report*]; Paul Caulford & Yasmin Vali, "Providing Health Care to Medically Uninsured Immigrant and Refugees" (2006) 174 *Canadian Medical Association Journal* 1253 at 1253-54, online: CMAJ <<http://www.cmaj.ca/cgi/content/full/174/9/1253>>; Shelley Phipps, *The Impact of Poverty on Health: A Scan of Research Literature*, (Ottawa: Canadian Institute for Health Information, 2003) at 11-12, online: Depository Services Program <<http://dsp-psd.pwgsc.gc.ca/Collection/H118-11-2003-1E.pdf>>; Romanow Commission, *supra* note 1 at 211-31; Royal Commission on Aboriginal Peoples, *Gathering Strength: Report of the Royal Commission on Aboriginal Peoples*, vol. 3 (Ottawa: Supply and Services Canada, 1995) at 247-260, online: Indian and Northern Affairs Canada <http://www.ainc-inac.gc.ca/ch/rcap/sg/si1_e.html#Volume%203> [RCAP, *Gathering Strength*]; Canadian Medical Association, *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada*, (Ottawa: Canadian Medical Association, 1994) [CMA, *Bridging the Gap*].

7 Ross, *supra* note 3 at 23; Micheal M. Rachlis, *Public Solutions to Health Care Wait Lists* (Ottawa: Canadian Centre for Policy Alternatives, 2005), online: Canadian Centre for Policy Alternatives <http://policyalternatives.ca/documents/National_Office_Pubs/2005/Health_Care_Waitlists.pdf>; Flood & Epps, *supra* note 5 at para. 9; Kirby Committee, *Final Report*, *supra* note 1 at 109.

8 *Canada Health Act*, R.S.C. 1985, c. C-6.

9 See e.g. Marie-Claude Prémont, "La garantie d'accès aux services de santé: analyse de la proposition québécoise" (2006) 47 C. de D. 539; Joan M. Gilmour, "Fallout from Chaoulli: Is It Time to Find Cover?" (2006) 44 *Osgoode Hall L. J.* 328; Abby Lippman & Amélie Quesnes-Vallée, "Private Health Insurance for Women? Fall-out from the Chaoulli Decision" (2006) 8:3/4 *Canadian Women's Health Network Magazine* 2, online: The Canadian Women's Health Network <<http://www.cwhn.ca/network-reseau/8-34/8-34pg2.html>>; Greg P. Marchildon, "Private Insurance for Medicare: Policy History and Trajectory in the Four Western Provinces" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care: Access to Justice - The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 428; Commission on the Future of Health Care in Canada, *Strengthening the Foundations: Modernizing the Canada Health Act - Discussion Paper no.13* by Colleen M. Flood & Sujit Choudhry (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 17-19,

ing that access to health care is increasingly being articulated as a *Charter* right and pursued before the courts.¹⁰

When first considering the application of *Charter* equality rights to the health care system in its 1990 decision in *Stoffman v. Vancouver General Hospital*,¹¹ the Supreme Court of Canada characterized health care delivery as a private rather than a public matter. In his majority judgment, Justice La-Forest concluded that: “the provision of a public service, even if it is one as important as health care, is not the kind of function that qualifies as a gov-

online: Commission on the Future of Health Care in Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/13_Flood_E.pdf> [Flood & Choudhry, *Modernizing the Canada Health Act*].

- 10 See e.g. Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007); William Lahey, “Medicare and the Law: Contours of an Evolving Relationship” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3rd ed. (Markham, ON: LexisNexis, 2007) 1 at 50-59; Lorian Hardcastle, “Comment: Clinger c. Centre hospitalier de Chicoutimi” (2006) 14 Health L. Rev. 44; Nola M. Ries, “The Uncertain State of the Law Regarding Health Care and Section 15 of the *Charter*” (2003) 11 Health L.J. 217; Christopher P. Manfredi & Antonia Maioni, “Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada” (2002) 27 J. Health Pol. 211; Commission on the Future of Health Care in Canada, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs? Discussion Paper No. 20* by Donna Greschner (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: Commission on the Future of Health Care in Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/20_Greschner_E.pdf>; Commission on the Future of Health Care in Canada, *The Implications of Section 7 of the Charter for Health Care Spending in Canada - Discussion Paper No. 31* by Martha Jackman (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: Commission on the Future of Health Care in Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/31_Jackman_E.pdf>; Stanley H. Hartt & Patrick J. Monahan, “The *Charter* and Health Care: Guaranteeing Timely Access to Health Care for Canadians” (2002) 164 *Commentary*: C.D. Howe Institute 7, online: C.D. Howe Institute <http://www.cdhowe.org/pdf/commentary_164.pdf>; Joan M. Gilmour, ‘Creeping Privatization in Health Care: Implications for Women as the State Redraws its Role’ in Brenda Cossman & Judy Fudge, eds., *Privatization, Law, and the Challenge to Feminism* (Toronto: University of Toronto Press, 2002) 267 at 298-306.

- 11 [1990] 3 S.C.R. 483, S.C.J. No. 125 [*Stoffman* cited to S.C.R.].

ernment function" within the meaning of the *Charter*.¹² Seven years later, however, in *Eldridge v. British Columbia (Attorney General)*,¹³ both the tone and substance of the Court's approach to health care as a *Charter* equality issue had significantly shifted. In *Eldridge*, the Court rejected the province's argument that the *Charter* was not engaged by the B.C. government's failure to fund, and individual hospitals' failure to provide, medical interpretation services for the Deaf. In his judgment for a unanimous Court, Justice LaForest asserted that: "in providing medically necessary services, hospitals carry out a specific governmental objective ... In recent decades ... health care, including that generally provided by hospitals, has become a keystone tenet of governmental policy."¹⁴ Justice LaForest went on to find that, as a matter of substantive equality, governments "will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services"¹⁵ and in particular, health care services.¹⁶

Seven years after its landmark decision in *Eldridge*, the Supreme Court's judgments in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*¹⁷ and in *Chaoulli v. Québec (Procureur general)*¹⁸ together provide a new indication of the role the Supreme Court sees for the *Charter* and the Canadian courts on the issue of equal access to health care. The *Auton* case revisits the question, first raised in *Eldridge*, of the scope of the right to health care with-

12 *Ibid.* at 516. On that basis, Justice LaForest held that hospitals were private entities to which the *Charter* did not apply. Contrary to the majority view, Justice Wilson argued in her dissenting opinion in *Stoffman, ibid.* at 544, that: "[j]ustification for state involvement in the health care field is not hard to find. Simply put, government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."

13 [1997] 3 S.C.R. 624, S.C.J. No. 86 [*Eldridge* (S.C.C.) cited to S.C.R.].

14 *Ibid.* at para. 50. On that basis, Justice LaForest concluded, at paras 51-52, that hospitals, along with the province's Medical Services Commission which had the power to determine what health services were publicly insured, were subject to *Charter* review in relation to their health care decision-making.

15 *Ibid.* at para. 77.

16 The Court concluded, *ibid.* at para. 80, that sign language interpretation services had to be provided in order to ensure that Deaf persons received equal benefit of the publicly funded health care system.

17 2004 SCC 78 [*Auton* (S.C.C.)], rev'g [2002] B.C.J. No. 2258 (C.A.) [*Auton* (C.A.)]; rev'g [2000] B.C.J. No. 1547 (S.C.) [*Auton no. 2* (S.C.)].

18 2005 SCC 35, rev'g [2002] J.Q. no. 759 (C.A.); rev'g [2000] J.Q. no. 479 (C.S.).

in the existing publicly funded system. The *Chaoulli* case raises, for the first time, the question of whether the *Charter* protects the right to health care *per se*. These decisions are, from both a health and equality rights perspective, profoundly disappointing.¹⁹ In *Auton*, the Supreme Court of Canada reversed the B.C. Supreme Court and Court of Appeal's conclusions that British Columbia's failure to include autism treatment within the provincial medicare system violated section 15 of the *Charter* because the core health care needs of children with autism were not being met. In *Chaoulli*, a majority of the Supreme Court reversed the Quebec Superior Court and Quebec Court of Appeal's decisions that provincial restrictions on private health funding were necessary to safeguard universal access to the public system, and thus were in accordance with Quebec and Canadian *Charter* guarantees.

In the following paper I will focus on the first of these decisions – the one in *Auton* – as it relates to the right to access publicly funded health care under section 15 of the *Charter*.²⁰ I will begin by examining the facts, lower court judgments, and the Supreme Court of Canada's reasoning in *Auton*.

19 While the *Auton* decision has been heavily criticized by parents of autistic children and their supporters, as well as within the equality community generally, it must be noted that Michelle Dawson, an autistic woman who intervened before the Supreme Court of Canada in the case, takes a profoundly different view of the ethical and equality rights issues raised by the claim that intensive autism treatment should be provided as a matter of *Charter* right. As she summarized the *Auton* claim: "This Court is being asked to endorse a treatment of disability which denies the autistic population ... the very human dignity which the *Charter* is supposed to protect. It makes the assumption that autistic individuals can only be fulfilled (and in fact can only be 'human') if they are moulded to meet society's expectation of what is 'normal'. It is difficult to imagine this being tolerated in any other setting." See generally: *Auton* (S.C.C.), *Factum of the Intervener, Michelle Dawson* at paras 40-41, online: Michelle Dawson <http://www.sentex.net/~nexus23/naa_fac.html>; Michelle Dawson, "The Many Varieties of Being Written Off: An Argument About Autism as Catastrophe," online: Michelle Dawson <http://www.sentex.net/~nexus23/naa_wro.html>; Michelle Dawson, "An Autistic Victory: The True Meaning of the *Auton* Decision," online: Michelle Dawson <http://www.sentex.net/~nexus23/naa_vic.html>; and see the discussion at notes 180-185, *infra*.

20 For my commentary on the *Chaoulli* case, see Martha Jackman, "'The Last Line of Defence for [Which?] Citizens': Accountability, Equality and the Right to Health in *Chaoulli*" (2006) 44 *Osgoode Hall L.J.* 349; Martha Jackman, "Misdiagnosis or Cure? *Charter* Review of the Health Care System" in Colleen M. Flood,

I will go on to assess the implications of the decision for future equality based claims to publicly funded health care in Canada. In particular, I will consider what access-related claims remain susceptible to section 15 review, and what claims appear to be foreclosed following the *Auton* decision. I will suggest that, if the Supreme Court maintains the formal approach to equality it adopted in *Auton*, the health care rights and needs of many disadvantaged Canadians will fail to receive the *Charter* scrutiny and protection they deserve. I will conclude that, given the pre-eminence of equal access to health care as a core value within Canadian society, this cannot be what the *Charter's* promise of "equal protection and equal benefit of the law" means in the health care context.

II. The *Auton* case

The *Auton* case was brought by the parents of four autistic children after they failed to obtain funding for Lovaas intensive behavioural autism treatment from the B.C. ministries of Health, Education and Children and Families. The parent petitioners alleged that the province's refusal to fund their children's autism treatment violated sections 7 and 15 of the *Charter*, and they sought an order requiring the province to pay for the past and future costs of such treatment.

1. The Trial Court Decision in *Auton*

At trial,²¹ Justice Allan characterized the issue raised by the case as "primarily a health issue" and she focussed her analysis on the argument that autism treatment had to be provided by the Ministry of Health as an insured benefit under the provincial medicare scheme.²² Justice Allan began her analysis by describing the characteristics of autism and the nature of Lovaas, or intensive behavioural, autism treatment. She noted the high cost of the treatment – between \$45,000 and \$65,000 annually per child – and she suggested that autism would have severe adverse consequences for the

ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 58.

21 Justice Allan had earlier rejected an application to certify the proceedings as a class action: [1999] B.C.J. No. 718 (S.C.). She dealt with the remedial issues in a subsequent judgment: [2001] B.C.J. No. 215 (S.C.) [*Auton no. 3* (S.C.)].

22 *Auton no. 2* (S.C.), *supra* note 17 at para. 88.

lives of children left untreated.²³ She next reviewed the parent petitioners' own accounts of the behavioural gains made by their children as a result of receiving Lovaas treatment and the supporting medical evidence relating to its benefits.²⁴ Justice Allan then considered the province's evidence relating to the unproven and experimental nature of the treatment.²⁵ On the evidence presented, Justice Allan concluded that early diagnosis and treatment of autism are essential; that "current research has established, with some certainty, the efficacy of early intervention in assisting many children to achieve significant social and education gains"; and that intensive behavioural therapies are the "treatment of choice."²⁶

Having set out the relevant provisions of the *Canada Health Act*²⁷ and B.C.'s *Medicare Protection Act*,²⁸ Justice Allan rejected the province's argument that "medically necessary services" in B.C. were restricted to services delivered by "health care practitioners" currently recognized under the provincial health insurance regime, a category which did not include therapists providing autism treatment. Instead Justice Allan accepted the petitioners' claim that "medical treatment is whatever cures or ameliorates illness", and that autism treatment was therefore a medically necessary service within the meaning of the province's *Medicare Protection Act*.²⁹ As she summarized it: "Canadians are entitled to expect medical treatment for their physical and mental diseases ... I conclude that the legislative framework does not preclude the delivery of early intensive ABA treatment to autistic children, where appropriate, within B.C.'s medicare scheme."³⁰

23 *Ibid.* at para. 11.

24 This evidence included a petition obtained by FEAT B.C., signed by 63 psychiatrists endorsing Lovaas therapy as a necessary medical treatment for autism; *ibid.* at paras 22-29.

25 *Ibid.* at paras. 30-50.

26 *Ibid.* at paras 51-52; for a critique of the evidence presented in the *Auton* case, see Dawson, "The Many Varieties of Being Written Off," *supra* note 19.

27 *Supra* note 8.

28 R.S.B.C. 1996, c. 286. The relevant provisions of the *Canada Health Act* and the *Medicare Protection Act* are set out in Appendix A to the Supreme Court's decision in *Auton* (S.C.C.), *supra* note 17.

29 *Auton no. 2* (S.C.), *supra* note 17 at para. 102.

30 *Ibid.* at para. 109.

Deeming it unnecessary to address the petitioners' section 7 arguments,³¹ Justice Allan proceeded to consider their equality claim. In light of the Supreme Court's section 15 case law, Justice Allen agreed that the province's failure to fund intensive behavioural autism treatment was discriminatory. As she put it:

Having created a universal medicare system of health benefits, the government is prohibited from conferring those benefits in a discriminatory manner. In the case of children with autism, their primary health care need is, where indicated, intensive behavioural intervention. In failing to make appropriate accommodation for their health care needs, the Crown has discriminated against them. It is not that medicare legislation that is discriminatory or defective but the Crown's overly narrow interpretation of it.³²

Justice Allan rejected the province's argument that the appropriate comparison for section 15 purposes was to other groups of children with disabilities, whose medical needs were likewise not always or fully met. She emphasized that the relevant comparator groups in the case were non-autistic children or adults with mental disabilities. In her view: "In comparison to both [groups] ... the infant petitioners are subject to differential treatment based on the enumerated ground of mental disability. Indeed as children and mentally disabled, they are doubly vulnerable."³³ Justice Allan also rejected the province's attempt to distinguish the Supreme Court's decision in the *Eldridge* case³⁴ on the basis that the Deaf claimants in that case had been denied access to "core medical services" because of their deafness.³⁵ She pointed out that, for children with autism, autism treatment is the core medical need which is not being met by the universal health insurance system.³⁶ In her view: "the only accommodation possible is funding for effective treatment."³⁷

31 *Ibid.* at para. 111.

32 *Ibid.* at para. 126.

33 *Ibid.* at para. 129.

34 *Supra* note 13.

35 *Auton no. 2* (S.C.), *supra* note 17 at para. 133.

36 *Ibid.* at para. 135.

37 *Ibid.* at para. 139.

In light of her findings under section 15, Justice Allan turned to section 1 of the *Charter*. She acknowledged that: “The Crown is entitled to judicial deference in performing its difficult task of making policy choices and allocating finite resources among myriad vulnerable groups.”³⁸ However, Justice Allan questioned whether the cost of providing effective autism treatment “might well be more than offset by the savings achieved by assisting autistic children to develop their educational and societal potential rather than dooming them to a life of isolation and institutionalization.”³⁹ She concluded that exclusion of treatment for autistic children undermined the objectives of the universal health care system; and that, as in *Eldridge*, a remedy could be fashioned “without the wholesale destruction of the government’s medicare system.”⁴⁰

2. The Court of Appeal Decision in *Auton*

In her judgment for the B.C. Court of Appeal, Justice Saunders agreed with Justice Allan that the appropriate comparator group for purposes of section 15 analysis in the case was not, as the province alleged, others whose health care needs are not entirely funded by the provincial medicare regime, but rather non-autistic children or adults with mental disabilities.⁴¹ In her view:

There is no doubt that not all refusals to treat a health care problem will be seen as discrimination. The complaint here, however, is in the context of a severe condition which, untreated, will very likely lead to an adult life of isolation and institutionalization ... It is also in the context of a treatment method which holds a realistic prospect of substantial improvement in communication and behavioural skills,

38 *Ibid.* at para. 143.

39 *Ibid.* at para. 147.

40 *Ibid.* at paras 150-151. In her subsequent judgment on the issue of remedy, in *Auton no. 3* (S.C.), *supra* note 21 at para. 65, Justice Allan rejected the petitioners’ request for a mandamus and instead issued a declaratory order that the Crown’s failure to provide the infant petitioners with effective autism treatment violated their rights under section 15(1) of the *Charter*. She also granted each of the petitioners \$20,000 in monetary damages and agreed to maintain a “limited supervisory role” in the case, allowing the petitioners the possibility of renewing their application for a mandatory order if the government failed to implement a timely and effective early intensive autism program; *ibid.* at paras 47, 64.

41 *Auton* (C.A.), *supra* note 17 at paras 30-33.

no alternate treatment program offered, and the certain knowledge that other serious, and indeed less serious, conditions are treated by state funded therapies.⁴²

On that basis, Justice Saunders upheld Justice Allan's decision that B.C.'s failure to provide intensive behavioural autism treatment within the provincial medicare system violated section 15 of the *Charter*.⁴³ On the question of whether the violation of the petitioners' equality rights could not be justified under section 1, Justice Saunders concluded that the spending required was not so "extraordinary" as to justify the government's failure to include autism treatment under medicare and she rejected the argument that a decision in favour of the petitioners would "open Pandora's Box." While acknowledging that the issue of whether the *Charter* imposes positive obligations on governments to ameliorate pre-existing disadvantage remains an open one, she characterized the *Auton* case as one of discriminatory under-inclusion which, in her view, could not be saved under section 1.⁴⁴

Justice Saunders briefly reviewed and rejected the petitioners' argument that the failure to fund autism treatment also violated section 7 of the *Charter*. She found that a deprivation of the right to life or to security of the person had not been proven, and that "the underinclusiveness of the health system, even as it relates to children, would not violate a principle of fundamental justice."⁴⁵ In terms of remedy, Justice Saunders held that the infant petitioners were entitled to government funding of the treatment they had been receiving, from the time of the trial court decision until the treatment was deemed by the child's physicians to no longer be of benefit.⁴⁶ Justice Saunders also affirmed the continuing jurisdiction of the Superior Court to address any disputes which might arise between the parties in relation to the order of Lovaas treatment for the infant petitioners.⁴⁷

42 *Ibid.* at para. 49.

43 *Ibid.* at paras. 51-52.

44 *Ibid.*

45 *Ibid.* at para. 73.

46 *Ibid.* at para. 92.

47 *Ibid.* at para. 100.

3. The Supreme Court of Canada Decision in *Auton*

The Supreme Court of Canada granted B.C.'s appeal in a unanimous judgment by Chief Justice McLachlin.⁴⁸ The petitioners' claim foundered on the Court's approach to section 15 and in particular, on the interpretation and emphasis the Court placed on the questions: first, whether the *Auton* claim was for a benefit "provided for by the law", and; second, whether the appropriate comparator group had been selected in the case.

On the first question, of whether the benefit claimed in the case was one "provided for by the law", the Chief Justice characterized the petitioners' argument as a demand for provincial funding "for all medically required treatment."⁴⁹ In response she noted that the health care scheme established under B.C.'s *Medicare Protection Act*, within the broader framework of the *Canada Health Act*, did not ensure funding for all medically required services. As she explained: "the legislative scheme does not promise that any Canadian will receive funding for all medically required treatment. All that is conferred is core funding for services provided by medical practitioners, with funding for non-core services left to the Province's discretion."⁵⁰ Thus, the Chief Justice found, the benefit claimed by the petitioners: funding for intensive behavioural autism treatment, was not "provided for by the law" within the meaning of section 15 of the *Charter*.⁵¹

Further, because those providing autism treatment were not recognized as "health care practitioners" under the *Medicare Protection Act*, B.C.'s Medicare Services Commission did not, the Chief Justice affirmed, have the power to order funding for autism treatment.⁵² The Chief Justice distinguished the petitioners' claim for autism treatment from the claim for medical interpretation services for the Deaf, accepted by the Court in *Eldridge*, on the following grounds:

In *Eldridge*, this Court held that the Province was obliged to provide translators to the deaf so that they could have equal access to core benefits accorded to everyone under the B.C. medicare scheme ... *Eldridge* was concerned with unequal access to a benefit that the law

48 *Auton* (S.C.C.), *supra* note 17.

49 *Ibid.* at para. 30.

50 *Ibid.* at para. 35.

51 *Ibid.*

52 *Ibid.* at para. 37.

conferred and with applying a benefit-granting law in a non-discriminatory fashion. By contrast, this case is concerned with access to a benefit that the law has not conferred.⁵³

On the question of whether the medicare regime as a whole was discriminatory in providing non-core services to some groups, while denying funding for intensive behavioural therapy to autistic children, the Chief Justice held that it was not. As she explained: "This Court has repeatedly held that the legislature is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory way."⁵⁴ In her assessment, the system created by the B.C. *Medicare Protection Act* and the *Canada Health Act* was "by its very terms, a partial health plan", and the exclusion of particular non-core services could not be seen as an adverse distinction, but rather was an "anticipated feature" of the legislation.⁵⁵ As she argued:

The correctness of this conclusion may be tested by considering the consequences to the legislative scheme of obliging provinces to provide non-core medical services required by disabled persons and people associated with other enumerated and analogous grounds, like gender and age. Subject to a finding of no discrimination at the third step [of the *Law* analysis], a class of people legally entitled to non-core benefits would be created. This would effectively amend the medicare scheme and extend benefits beyond what it envisions – core physician-provided benefits plus non-core benefits at the discretion of the province.⁵⁶

While noting that her finding on the nature of the benefit claimed was sufficient to resolve the case, the Chief Justice went on to consider the second section 15-related issue of the appropriate comparator group in the case.⁵⁷ The Chief Justice rejected the petitioners' suggestion that the infant petitioners' situation should be compared to that of non-disabled children or

53 *Ibid.* at para. 38.

54 *Ibid.* at para. 41.

55 *Ibid.* at para. 43.

56 *Ibid.* at para. 44.

57 *Ibid.* at para. 47.

of adults with mental disabilities, whose health care needs were being met. Rather, she argued, the appropriate comparator was: “a non-disabled person or a person suffering a disability other than a mental disability (here autism) seeking or receiving funding for a non-core therapy important for his or her present and future health, which is emergent and only recently becoming recognized as medically required.”⁵⁸ The petitioners’ error, and that of the courts below, the Chief Justice underscored, was having left “the recent and emergent nature of ABA/IBI therapy out of the equation.”⁵⁹

On the question of differential treatment between the relevant groups, the Chief Justice found that there was no evidence that the provincial government’s approach to intensive behavioural autism treatment was any different from its approach to other comparable, novel therapies for non-disabled persons or persons with different types of disabilities.⁶⁰ In fact, the Chief Justice pointed out, the province had put in place a range of autism programs, if not Lovaas treatment *per se*. The Chief Justice attributed the province’s delay in funding such programs to the transfer of responsibility for child and youth mental health from the Ministry of Health to the Ministry of Children and Families; to financial concerns and competing claims on insufficient resources; and to the “emergent nature of the recognition that ABA/IBI therapy was appropriate and medically required.”⁶¹ Absent any evidence of differential treatment in the government’s response to intensive autism treatment relative to other emergent therapies, the Chief Justice concluded, the petitioners’ claim of discrimination failed.⁶²

On the issue of whether B.C.’s lack of funding for intensive autism treatment violated section 7 of the *Charter*, the Chief Justice agreed with the Court of Appeal that the petitioners had not identified what principle of fundamental justice had been breached, nor had they argued that the province’s medicare regime was arbitrary, or failed to meet other procedural requirements under section 7. In the Chief Justice’s view: “To accede to the petitioners’ s. 7 claim would take us beyond the parameters discussed by this Court in *R. v. Malmo-Levine* and *Canadian Foundation for Children, Youth and the Law*

58 *Ibid.* at para. 55.

59 *Ibid.* at para. 56.

60 *Ibid.* at para. 58.

61 *Ibid.* at para. 60.

62 *Ibid.* at para. 62.

v. Canada (Attorney General). The record before us does not support taking this step.⁶³ On that additional ground, the Chief Justice held that B.C.'s failure to fund autism treatment did not infringe the *Charter*.⁶⁴

III. The Right to Publicly Funded Care Following *Auton*

The Supreme Court's reasoning and conclusions in *Auton* have significant implications for future *Charter*-based claims to publicly funded health care. As will be described below, the Chief Justice's decision for the Court, while recognizing equality rights in relation to existing provincially insured medical and hospital services, seriously limits the potential scope of *Charter* scrutiny of government decision-making in relation to the broader contours of the publicly funded system. Chief Justice McLachlin effectively suggests in *Auton* that government choices around what types of health care services should be included within the public system, and what types of services need not be, are immune from section 15 review as matters for the legislature and not the courts, notwithstanding the systemically adverse impact such choices may have on particular disadvantaged groups.

1. "Universality" versus "Comprehensiveness"

As Chief Justice McLachlin notes at the outset of her judgment in *Auton*, the framework for the publicly funded health care system is provided by the *Canada Health Act (CHA)*, which sets out the conditions provincial health and hospital insurance plans must satisfy in order to be eligible for federal funding. In particular, provincial medicare regimes must be "universal" and "comprehensive."⁶⁵ To meet the "universality" requirement under section 10 of the *CHA*, a provincial medicare plan must entitle all qualified residents of the province to receive the "insured health services" provided under the plan "on uniform terms and conditions."⁶⁶ To meet the "comprehensiveness" requirement under section 9 of the *CHA*, provincial funding must be avail-

63 *Ibid.* at para. 66.

64 *Ibid.* at para. 69.

65 The other conditions under the *Canada Health Act* are "public administration," "portability" and "accessibility." See generally Flood & Choudhry, *Modernizing the Canada Health Act*, *supra* note 9.

66 *Supra* note 8, s. 10.

able for all “insured health services” provided by hospitals, physicians or dentists and “where the law of the province so permits”, similar or additional services rendered by other health care practitioners.⁶⁷

Under section 2 of the *CHA*, “Insured health services” are defined as “physician services” and “surgical-dental services” that are “medically required” and as “hospital services” that are “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.” No more explicit definition and no specific criteria are set out under the *CHA* for determining whether or when a particular health service is considered “medically necessary” or “medically required”, so that it must be included and funded under a provincial medicare plan. As Dr. Nuala Kenny explains: “No criteria for determining medical necessity are provided. Medical necessity is what doctors decide needs to be done or what doctors actually do.”⁶⁸ While medical necessity is not defined under the *CHA*,⁶⁹ in practice, the list of insured health and hospital services in a province is negotiated between the provincial governments and their respective provincial medical associations.⁷⁰ As Colleen Flood and Sujit Choudhry describe it:

The decision process has been primarily a one-way highway, with new services being added to the list that is publicly funded and few removed. More recently, there has been some movement in the opposite direction. Increasingly, provincial governments are “delisting” certain services on the grounds they are not “medically necessary” or “medically required.” As with the decision to publicly fund a ser-

67 *Ibid.*, s. 9.

68 Kenny, *supra* note 5 at 62.

69 For a discussion of the difficulties in providing such a definition, see Glenn Griener, “Defining Medical Necessity: Challenges and Implications” (2002) 10 *Health L. Rev.* 6; Timothy A. Caulfield, “Wishful Thinking: Defining ‘Medically Necessary’ in Canada” (1996) 4 *Health L.J.* 63; Sujit Choudhry, “The Enforcement of the Canada Health Act” (1996) 41 *McGill L.J.* 461 at 491-94. For an examination of this issue in the specific context of the *Auton* case see Claire Bond, “Section 15 of the Charter and the Allocation of Resources in Health Care: A Comment on *Auton v. British Columbia*” (2005) 13 *Health L.J.* 253 at 258-263; and Ries, *supra* note 10 at 220-224.

70 See generally Colleen M. Flood, Mark Stabile & Carolyn Tuohy, “What Is In and Out of Medicare? Who Decides?” in Colleen M. Flood, ed., *Just Medicare: What’s In, What’s Out, How We Decide* (Toronto: University of Toronto Press, 2006) 15.

vice, the decision to delist is made jointly by provincial governments and medical associations.⁷¹

In *Auton*, Chief Justice McLachlin located the distinction she drew between “core” and “non-core” services in the *CHA*’s “comprehensiveness” criterion, as implemented under B.C.’s *Medicare Protection Act*. In her analysis, “core services” are those delivered by hospitals and physicians, which B.C. is required by the *CHA* to fund, while “non-core services” are the “broader assortment of health care services” whose funding remains at the province’s discretion. In terms of the *Charter*, as discussed above, Chief Justice McLachlin held that section 15 review was limited to claims of discrimination relating to core services, or to non-core services already being funded under provincial medicare legislation. Since, in B.C., intensive behavioural autism treatment was not such a service, the Chief Justice dismissed the petitioners’ *Charter* claim. As she framed it: “the issue before us is not what the public health system should provide, which is a matter for Parliament and the legislature.”⁷²

In light of the Chief Justice’s reasoning, “universality” claims remain susceptible to *Charter* review following the *Auton* decision, while “comprehensiveness” claims arguably do not. In other words, *Auton* leaves open the possibility of judicial scrutiny of a province’s failure to guarantee equal access to those health and hospital services that are already insured under the province’s medicare plan, without discrimination on disability or other grounds. Section 15 review remains available in relation to the “core services” which the province is, according to Chief Justice McLachlin’s reading of the *CHA*, required to fund, as well as those “non-core services” it has opted to fund. In contrast, decisions relating to the comprehensiveness of the system, that is, in relation to the specific range of services that a province has chosen to include within the medicare system, are not subject to similar *Charter* scrutiny. In particular, provincial decisions to delay or to refuse funding for “non-core services”, such as the intensive autism treatment at issue in *Auton*, are not, according to the Chief Justice’s reasoning in *Auton*, susceptible to section 15 review. In other words, while the Chief Justice concludes that everyone must be treated the same once a government chooses to fund

71 Flood & Choudhry, *Modernizing the Canada Health Act*, *supra*, note 9 at 8. See also Lahey, *supra* note 10 at 37-42; Flood, Stabile & Tuohy, *ibid.* at 16-17.

72 *Auton* (S.C.C.), *supra* note 17 at para. 2.

a particular service, she maintains that the initial choice of what to fund is itself not open to section 15 scrutiny.

A potential example of a “universality” claim that would fit within the *Auton* framework is the abortion access issue raised most recently in the *Jane Doe 1 v. Manitoba*⁷³ case. The plaintiffs in the case, Jane Doe 1 and Jane Doe 2, sought an order for summary judgment against the province of Manitoba, on the argument that the provincial medicare plan’s failure to fund therapeutic abortions performed outside a hospital violated sections 7 and 15 of the *Charter*. Seeking to terminate their pregnancies, Jane Doe 1 and Jane Doe 2 were advised that the waiting time for a hospital abortion would be six to eight weeks and would require a series of up to three appointments prior to the abortion being performed. Notwithstanding the fact that they would have to pay for the procedure out of their own pockets, because Manitoba’s health insurance legislation only funded hospital abortions, both women chose instead to obtain abortions at the Morgentaler Clinic in Winnipeg. They made this decision because of the emotional and physical health risks associated with the delay provincially funded hospital abortions would have entailed.⁷⁴

The plaintiffs argued that, by subjecting pregnant women to the physical risk and psychological harm caused by delays in access to publicly funded hospital abortions, Manitoba’s medicare legislation violated their rights to liberty and security of the person under section 7 of the *Charter* and to sex equality under section 15.⁷⁵ As Justice Oliphant described the plaintiffs’ section 15 claim:

... any legislated restrictions on women’s ability to access abortion services uniquely affects women as opposed to the general population ... the impugned legislation here has the effect of preventing women from having reasonable access to publicly-funded therapeutic abortions and ... “imposes an unfair burden on women by forcing them to pay for medical services to be received in a safe and timely fashion as distinct from the rest of the population.”⁷⁶

73 [2004] M.J. No. 456 (Q.B.) [*Jane Doe 1* (Q.B.)], rev’d [2005] M.J. No. 335 (C.A.) [*Jane Doe 1* (C.A.)], leave to appeal to S.C.C. refused [2005] S.C.C.A. No. 513.

74 *Jane Doe 1* (Q.B.), *ibid.* at paras. 5-15.

75 *Ibid.* at paras. 32-35.

76 *Ibid.* at para. 36.

Rejecting the province's argument that the plaintiffs had failed to adduce sufficient evidence in support of their *Charter* claim,⁷⁷ Justice Oliphant found that it was clear that undergoing a publicly funded hospital abortion would have resulted in serious delay – a delay not encountered at the Morgentaler Clinic.⁷⁸ Justice Oliphant agreed with the plaintiffs that the situation was similar to the one at issue in the 1988 *R. v. Morgentaler*⁷⁹ case in terms of the physical and psychological risks entailed for women seeking publicly funded abortions. In Justice Oliphant's view: "Because of the impugned legislation, a woman who wishes to have a safe therapeutic abortion without having to undergo the physical risks and psychological harm associated with delay cannot rely upon the state to pay for that abortion. Rather, she must pay for same out of her pocket."⁸⁰ Justice Oliphant concluded that delays in accessing publicly funded abortions infringed women's rights to security of the person under section 7; to freedom of conscience under section 2(a); and to equality under section 15 of the *Charter*.⁸¹ He also found that provincial limits on abortion funding were arbitrary and irrational, and could not be justified under section 1 of the *Charter*.⁸²

As decided by Justice Oliphant, the *Jane Doe 1* case is primarily one of excessive waiting times, akin to the claim put forward by the appellants and accepted by the majority of the Court in the *Chaoulli* case.⁸³ In reality, however, as the Canadian Abortion Rights Action League (CARAL) and its

77 On appeal, the Manitoba Court of Appeal disagreed with Justice Oliphant on this point, and granted the Province's appeal from his summary judgment in favour of the plaintiffs. The Court of Appeal held that, in view of the complexity and importance of the *Charter* issues raised in the case, the evidence before the Court on the motion was insufficient, and a full trial was needed. See *Jane Doe 1* (C.A.), *supra* note 73 at para. 29.

78 *Jane Doe 1* (Q.B.), *supra* note 73 at para. 69.

79 [1988] 1 S.C.R. 30, S.C.J. No. 1.

80 *Jane Doe 1* (Q.B.), *supra* note 73 at para. 75.

81 *Ibid.* at paras. 78-79.

82 *Ibid.* at paras. 85-86. Following the *Jane Doe 1* decision the Manitoba government agreed to pay for abortions performed at provincially-approved private clinics. In the spring of 2007 an expanded provincially funded Women's Health Clinic took over provision of abortion services in Winnipeg; see Jen Skerritt, "Clinic for Women to Open" *Winnipeg Free Press* (26 March 2007) B2.

83 *Supra* note 18.

successor Canadians for Choice have amply documented,⁸⁴ the real problem in the therapeutic abortion context in Canada remains one of discriminatory barriers, both direct and systemic, to women's access to a medically necessary health service. In 2003 CARAL reported that less than one fifth of Canadian hospitals provide therapeutic abortions, with no hospitals in Nunavut or in Prince Edward Island doing so.⁸⁵ Even where hospital abortions were available, numerous barriers were found to exist. Referral procedures, such as New Brunswick's requirement that an abortion be approved by two doctors;⁸⁶ hospital gestational limits and waiting times; lack of, or inaccurate, information about the availability of abortion services; and outright denials of service based on the personal beliefs of hospital staff and physicians, all limit access to abortion.⁸⁷ As the CARAL report concluded: "since the decriminalization of abortion 15 years ago, abortion providers and the women they serve have become demonized by the anti-choice movement and abortion has remained politicized and marginalized within our health care system ... nowhere is this more evident than when a woman tries to obtain an abortion from a hospital in or near her community."⁸⁸

In their 2006 update of the CARAL report, Canadians for Choice found that the situation for women attempting to obtain hospital abortions had further deteriorated.⁸⁹ By 2006, only 15.9% or one in six Canadian hospi-

84 Canadian Abortion Rights Action League (CARAL), *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion* (Ottawa: CARAL, 2003). See also Childbirth by Choice Trust, *Abortion in Canada Today: The Situation Province-by-Province* (Toronto: Childbirth by Choice Trust, July 2006); Canadians for Choice, *Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals* (Ottawa: Canadians for Choice, 2006); Sanda Rodgers & Jocelyn Downie, "Abortion: Ensuring Access" (2006) 175 *Canadian Medical Association Journal* 9.

85 CARAL, *ibid.* at 3.

86 In May, 2006, the Dr. Everett Chalmers Hospital in Fredericton, the last major provider of publicly funded hospital abortions in New Brunswick, announced that it would shortly stop offering the service, due to "physician-resource issues;" see Chris Morris, "N.B. to Seek New Ways to Offer Abortions" *The Globe and Mail* (19 May 2006) A9.

87 CARAL, *supra* note 84 at 3-4.

88 *Ibid.* at 5.

89 Canadians for Choice, *supra* note 84 at 1-3.

tals were providing abortion services, with most of these located in urban areas within close proximity of the U.S. border.⁹⁰ The percentage of hospitals providing abortion services ranged from a high of 100% in Nunavut (1/1 hospital) to a low of 6% in Alberta (6/100 hospitals); 4% in Manitoba (2/52 hospitals); 4% in New Brunswick (1/28 hospitals) and no abortion services at all in Prince Edward Island.⁹¹ The process for obtaining an abortion; wait-times (some as long as 6 weeks)⁹²; gestational limits (ranging from 10-22 weeks); and the availability of counselling services, continue to vary greatly between provinces/territories and even from hospital to hospital.⁹³ The Canadians for Choice report also found that uninformed and anti-choice hospital staff members and health care professionals create additional barriers for women seeking abortions.⁹⁴ As the report concludes: "People often think that because abortion was legalized in 1988, it is easy for a woman to access the procedure. Such thoughts are far from the truth."⁹⁵

At issue in the *Jane Doe 1* case in Manitoba, as in many other Canadian provinces, is governments' failure, intentional or not, to adequately provide and fund a "core" medically necessary reproductive health service, delivered by physicians in hospitals, but used only by women. Failure to provide and adequately fund timely therapeutic abortion services under provincial medicare legislation represents a clear violation of the *CHA's* universality requirement and, in keeping with Chief Justice McLachlin's analysis in the *Auton* case, a clear breach of *Charter* equality guarantees.⁹⁶ The *Jane Doe 1*

90 *Ibid.* at 15.

91 *Ibid.* at 2.

92 For recent media accounts of the various factors contributing to excessive delays in access to abortion in the city of Ottawa, see Jenn Gearey, "Why women face agonizing waits for abortions in Ottawa" *The Ottawa Citizen* (24 September 2007) A1; Rebecca Dube, "Abortion wait times in Ottawa hit six weeks" *Globe and Mail* (1 October 2007), online: *Globe and Mail* <<http://www.theglobeandmail.com/servlet/story/RTGAM.20071001.wlabortion01/BNStory/lifeMain/home>>.

93 Canadians for Choice, *supra* note 84 at 15-16.

94 *Ibid.* at 42-45.

95 *Ibid.* at 4.

96 For an in-depth analysis of *Charter* and *CHA* issues raised in the abortion context, see Sanda Rodgers, "Abortion Denied: Bearing the Limits of Law" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 107; Sanda Rodgers, "Misconceptions: Equality and Reproductive Autonomy in the Supreme Court of Canada" in Sheila McIntyre

case is not as the Chief Justice characterized the *Auton* situation “concerned with access to a benefit the law has not conferred.”⁹⁷ Rather, as the Chief Justice argued in reference to *Eldridge*, the *Jane Doe 1* case is “concerned with unequal access to a benefit that the law conferred and with applying a benefit-granting law in a non-discriminatory fashion.”⁹⁸ As Sanda Rodgers has summarized the abortion situation: “Discriminatory delivery of medically necessary health services needed only by women is clear sex discrimination.”⁹⁹ The *Jane Doe 1* case in Manitoba, and the lack of equal access to publicly funded therapeutic abortion services in other provinces, is thus directly amenable to a successful section 15 *Charter* challenge in accordance with the Supreme Court’s reasoning in *Auton*.

Conversely, as suggested above, Chief Justice McLachlin’s analysis in the *Auton* case appears to preclude *Charter*-based claims relating to “non-core” services or, in the language of the *CHA*, claims relating to the comprehensiveness rather than the universality of the medicare system. The Ontario Superior Court decision in *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*¹⁰⁰ provides an example of one such case. The applicants in *Shulman* challenged the Ontario government’s 2001 decision to restrict provincial funding of diagnostic hearing tests performed by audiologists operating independently of physicians, and to delist hearing aid evaluations altogether, under the Ontario Health Insurance Plan (OHIP).¹⁰¹ The applicants alleged that these changes, and particularly the loss of health insurance coverage for hearing aid evaluations which had been included under OHIP since 1978, violated section 15 of the *Charter* because of their

& Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: Butterworths, 2006) 271; Erin Nelson, “Regulating Reproduction” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3rd ed. (Markham: ON, 2007) 367 at 368-373.

97 *Auton* (S.C.C.), *supra* note 17 at para. 38.

98 *Ibid.*

99 Rodgers, *supra* note 96 at 121.

100 [2001] O.J. No. 5057 (S.C.J.).

101 See generally: Jennifer Campbell, “Audiologists fight hearing aid rule: Ontario forces them to work under MDs to be able to bill OHIP, or bill their patients,” *The Ottawa Citizen* (29 August 2001) A5; Vanessa Lu, “More cuts coming to medical procedures: Ontario to delist more health-care services to save another \$29 million,” *Toronto Star* (2 February 2002) H04; Sharon Lindores, “Health minister has to listen,” *Kingston Whig-Standard* (16 August 2001) 6.

adverse effect on the health and well-being of the hearing impaired, many of whom are also poor.¹⁰²

Justice Pardu rejected the applicants' claim in relation to changes affecting diagnostic hearing tests on the basis that such tests remained eligible for provincial funding so long as they were supervised by a physician.¹⁰³ In the case of hearing aid evaluations, he found that: "in delisting hearing aid evaluations and re-evaluations the hearing impaired are treated no differently from others who must pay for medications, maintenance of their prosthetic devices, wheelchairs or eyeglasses."¹⁰⁴ In Justice Pardu's view, this was not a situation like in *Eldridge*, where "additional services must be provided so that a group can access medical services available to all."¹⁰⁵ In similar terms to the Chief Justice's argument on this point in *Auton*, Justice Pardu expressed concern about the broader implications of allowing the applicants' section 15 claim:

The Applicants argue that the purpose of the Health Insurance Act is to promote the health and wellbeing of insured persons and to the extent that services are cut, or not made available to disabled persons, the purpose of the act is violated. Adopting this mode of analysis would require that OHIP fund all health enhancing services for the disabled including drug expenses, prosthetic devices, psychological services, the services of dieticians and [a] host of medical services not now insured.¹⁰⁶

Rejecting this approach, Justice Pardu concluded that, inasmuch as hearing impaired persons continue to receive provincially insured medically necessary physician services under the Ontario medicare regime, the impugned

102 In a 2005 study of supports and services for persons with disabilities, the Canadian Council on Social Development found that, in terms of assistive aids and devices, the greatest unmet need was for hearing-related aids and devices, because they were "too expensive" and "not covered by insurance." See Canadian Council on Social Development, *Information Sheet, No. 17, 2005, Supports and Services for Persons with Disabilities in Canada: Requirements and Gaps*, online: Canadian Council on Social Development <<http://www.ccsd.ca/drip/research/drip17/drip17.pdf>>.

103 *Supra* note 100 at para. 29.

104 *Ibid.* at para. 31.

105 *Ibid.* at para. 32.

106 *Ibid.* at para. 39.

amendments were not discriminatory within the meaning of section 15. As Justice Pardu concluded: “A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a health-care system by the judiciary.”¹⁰⁷ Like Chief Justice McLachlin in the *Auton* case, Justice Pardu found that section 15 of the *Charter* required only that everyone have equal access to the same range of insured medical services. The adverse impact on a disadvantaged group of the province’s failure to provide non-insured health services was not, in his view, a matter for section 15 review.

2. Categorizing Existing Inequalities in Access to Care

Some of the most significant health care issues facing disadvantaged groups in Canada do relate to equal access to acute health care services and to the “universality” of the publicly funded system. As the Ontario Health Quality Council stated in its *2006 First Yearly Report*:

Despite over 30 years of universal coverage for physician and hospital services in Ontario, access to these services is not equally available to all who need them. In Ontario, heart attack victims who are wealthier and better educated are more likely to receive specialized investigations, rehabilitation, and specialist follow up. Wealthier Ontarians are also more likely to get rehabilitation after a stroke, get preventative care such as screening tests for colorectal cancer and have more hip and knee replacements, cancer surgery (in total) and MRI scans, even though lower income Ontarians tend to be sicker than wealthier ones. Higher-income Ontarians get to hospital faster when they have chest pain. Better educated Ontarians are more likely to get care for depression.¹⁰⁸

The Romanow Commission also reported that “Canadians’ access to specialists appears to be easier for people with higher incomes.”¹⁰⁹ Recent medi-

107 *Ibid.* at para. 43.

108 Ontario Health Quality Council, *2006 First Yearly Report*, *supra* note 6 at 13. See also Nancy M. Baxter, “Equal for Whom? Addressing disparities in the Canadian medical system must become a national priority” (2007) 177:12 *Canadian Medical Association Journal* 1522.

109 Romanow Commission, *supra* note 1 at 14.

cal research makes it clear that, even within the publicly funded system, the poor have unequal access to care.¹¹⁰ As one commentator puts it:

Whereas the underlying reasons for socioeconomic treatment disparities remain unclear, these studies, when taken together, challenge the egalitarian principles of Canada's health care system, especially when considering that those patients who are most socially disadvantaged are also often the individuals with poorest health status and outcomes.¹¹¹

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- 110 Alter, *supra* note 3; Richard H. Glazier *et al.*, "Primary Care in Disadvantaged Populations" in Ontario Institute for Clinical Evaluative Services, ed., *Primary Care in Ontario* (Toronto: Institute for Clinical Evaluative Sciences, 2000) 120; Jeremiah Hurley & Michel Grignon, "Income and equity of access to physician services" (2006) 174 *Canadian Medical Association Journal* 187; Moira K. Kapral *et al.*, "Effect of Socioeconomic Status on Treatment and Mortality After Stroke" (2002) 33 *Stroke* 268 at 271-72; Anne Rhodes *et al.*, "Depression and mental health visits to physicians – a prospective records based study" (2006) 62 *Social Science & Medicine* 828; Leah S. Steele, Richard H. Glazier & Elizabeth Lin, "Inequity in Mental Health Care Under Canadian Universal Health Coverage" (2006) 57 *Psychiatric Services* 317; Laura M. Woods, B. Rachet & M.P. Coleman, "Origins of socio-economic inequalities in cancer survival: a review" (2006) 17 *Annals of Oncology* 5; David A. Alter *et al.*, "Socioeconomic Status, Service Patterns, and Perceptions of Care Among Survivors of Acute Myocardial Infarction in Canada" (2004) 291 *Journal of the American Medical Association* 1100; Ruth Croxford, J. Friedberg & Peter C. Coyte, "Socio-economic status and surgery in children: myringotomies and tonsillectomies in Ontario, Canada, 1996-2000" (2004) 93 *Acta Paediatr* 1245; Louise Pilote *et al.*, "Universal health insurance coverage does not eliminate inequities in access to cardiac procedures after acute myocardial infarction" (2003) 146 *American Heart Journal* 1030; Sheryl Dunlop, Peter C. Coyte & Warren McIsaac, "Socio-economic status and the utilisation of physicians' services: results from the Canadian National Population Health Survey" (2000) 51 *Social Science & Medicine* 123; Leah S. Steele *et al.*, "Education Level, Income Level and Mental Health Services Use in Canada: Associations and Policy Implications" (2007) 3 *Healthcare Policy* 96.
- 111 Alter, *supra* note 3 at 939; Dennis Raphael, "Poverty and Health: Implications for Health and Quality of Life" in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 319; Dennis Raphael, "From Increased Poverty to Societal Disintegration: How Economic Inequality Affects the Health of Individuals and Communities" in Pat Armstrong, Hugh Armstrong & David Coburn, eds., *Unhealthy Times: Political*

In a comprehensive review of disability related supports and services in Canada, the Canadian Council on Social Development likewise found that people with disabilities do not enjoy equal access to publicly funded primary care.¹¹² The CCSD concluded: "The greater likelihood of persons with disabilities having poorer health is ... accompanied by a greater likelihood of requiring health care, but not receiving it."¹¹³ A recent *CMAJ* guest editorial noted that while privatisation and wait times have been the focus of most recent health care debates in Canada, for patients with disabilities the issue remains one of basic access to medically necessary care:

[P]eople with disabilities do not receive the same level of primary and preventive care as others do. Routine interventions such as a Pap smear or prostate exam are not consistently provided to them. Even more disturbing, people with disabilities are 4 times as likely as able-bodied people to report an inability to obtain required medical care when it is needed.¹¹⁴

Persistent inequalities in access by Aboriginal people, and by Aboriginal women in particular,¹¹⁵ to health and health care services have also

Economy Perspectives on Health and Care in Canada (Toronto: Oxford University Press, 2001) 223.

112 Canadian Council on Disabilities, *Disability Information Sheet No. 9, 2003, The Health and Well-being of Persons With Disabilities* (Ottawa: Canadian Council on Social Development, 2003), online: <<http://www.ccsd.ca/drip/research/dis9/index.htm>> ; Queen's University Centre for Health Services and Policy Research, *Fact Sheet: Primary Care for People With Disabilities* (Kingston, ON: Queen's University Press, 2003), online: <<http://chspr.queensu.ca/downloads/Reports/brochure%20for%20fam%20docs.pdf>>; Office for Disability Issues, *Advancing the Inclusion of Persons With Disabilities 2004: A Government of Canada Report* (Ottawa: Social Development Canada, 2004) at 80-81; Shirley Masuda, *The Impact of Block Funding on Women With Disabilities* (Ottawa: Status of Women Canada, 1998) at 21-23; H el ene Ouellette-Kuntz *et al.*, "Addressing Health Disparities Through Promoting Equity for Individuals with Intellectual Disability" (2005) 96 *Canadian Journal of Public Health* S8 at S15.

113 Canadian Council on Disabilities, *ibid.* at 2-3.

114 Meredith B. Marks & Robert Teasell, *Guest Editorial, More than ramps: accessible health care for people with disabilities* (2006) 175 *Canadian Medical Association Journal* 329, online: <<http://www.cmaj.ca/cgi/content/full/175/4/329>>.

115 Yvonne Boyer, *First Nations, M etis and Inuit Women's Health, Discussion Paper Series*

been well-documented.¹¹⁶ The Ontario Health Quality Council summarizes the situation in Ontario: “Aboriginal Ontarians have, on average, more health problems, but have less access to care.”¹¹⁷ Like for other residents

in Aboriginal Health: Legal Issues, No. 4 (Ottawa/Saskatoon: National Aboriginal Health Organization/Native Law Centre, University of Saskatchewan, 2006) at 19-20; Canadian Population Health Initiative, *Women’s Health Surveillance Report: A Multi-dimensional Look at the Health of Canadian Women* (Ottawa: Canadian Institute for Health Information, 2003) at 68, online: Canadian Population Health Initiative <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_29_E&cw_topic=29&cw_rel=AR_342_E>; Pat Armstrong, “Health Care Reform as if Women Mattered” in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 257 at 258-259.

- 116 RCAP, *Gathering Strength*, *supra* note 6; National Aboriginal Health Organization, *First Nations Regional Longitudinal Health Survey (RHS) 2002/03: The People’s Report* (Ottawa: National Aboriginal Health Organization, 2005), online: <<http://rhs-ers.ca/english/>>; Harvard Project on American Indian Economic Development, *Review of the First Nations Regional Longitudinal Health Survey (RHS) 2002/2003* (Cambridge, MA: Harvard Project on American Indian Economic Development, 2006) at 1-2, online: <<http://www.ksg.harvard.edu/hpaid/pubs/documents/ReviewoftheRHS.pdf>>. See also Romanow Commission, *supra* note 1; National Forum on Health, *Final Report*, *supra* note 1 at 16; James B. Waldram, D. Ann Herring & T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*, 2nd ed. (Toronto: University of Toronto Press, 2006); Angela Campbell, “Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care” (2002) 10 Health L.J. 147; Yvonne Boyer, “Discussion Document for the Aboriginal Dialogue: Self Determination as a Social Determinant of Health” in Canadian Reference Group WHO Commission – Social Determinants of Health, *Aboriginal Dialogue Proceedings* (Vancouver: Raincoast Ventures, 2006) Appendix 1 at 7-10; Naomi Adelson, “The Embodiment of Inequity: Health Disparities in Aboriginal Canada” (2005) 96 Canadian Journal of Public Health S45; Constance Macintosh, “Jurisdictional Roulette: Constitutional and Structural Barriers to Aboriginal Access to Health” in Colleen Flood, ed., *Just Medicare: What’s In, What’s Out, How We Decide* (Toronto: University of Toronto Press, 2006) 193 at 194; National Council of Welfare, *First Nations, Métis and Inuit Children and Youth: Time to Act* (Ottawa: National Council on Welfare, 2007) at 61-72.
- 117 Ontario Health Quality Council, *2006 First Yearly Report*, *supra* note 6 at 13; Marcello Tonelli *et al.*, “Death and renal transplantation among Aboriginal people undergoing dialysis” (2004) 171:6 Canadian Medical Association Journal 577.

of rural and remote areas,¹¹⁸ inequalities in primary and advanced care are exacerbated for Aboriginal people living in isolated communities, who report difficulty in accessing family doctors, paediatricians, ophthalmologists and obstetricians/gynaecologists, among other services.¹¹⁹ The final report of the Royal Commission on Aboriginal Peoples describes the situation for Aboriginal people receiving federally funded health care services on-reserve:

Many of the community health facilities were constructed in the 1970s or earlier ... In addition to requiring general renovation to meet contemporary standards, older facilities are crowded and unable to provide an expanded range of healing programs ... efforts to achieve a holistic approach to healing are frustrated by fragmented delivery structures and inappropriately trained personnel ...¹²⁰

The Commission points out that barriers are even greater for Aboriginal people living off-reserve, whether in cities or rural areas, who do not benefit from federally funded health services: "Aboriginal people who do not live in communities that receive federally funded services tend to be served inadequately, sometimes to a severe extent."¹²¹ As the Romanow Commission

118 See generally Romanow Commission, *supra* note 1 at 162-63; Jude Kornelson & Stefan Grzybowski, *Rural Women's Experiences of Maternity Care: Implications for Policy and Practice* (Ottawa: Status of Women Canada, 2005), online: Status of Women Canada

<http://www.swc-cfc.gc.ca/pubs/pubspr/0662407997/inde_e.html>.

119 National Aboriginal Health Organization, *National Aboriginal Health Organization's Public Opinion Poll on Aboriginal Health and Health Care in Canada - Summary of Findings* (Ottawa: National Aboriginal Health Organization, 2003) at 6, online: National Aboriginal Health Organization <http://www.naho.ca/firstnations/english/documents/research/FNC_SummaryofNAHOPoll.pdf> [NAHO, *Public Opinion Poll*]; Zhong-Cheng Luo *et al.*, "Infant mortality among First Nations versus non-First Nations in British Columbia: temporal trends in rural versus urban areas, 1981-2000" (2004) 33 *International Journal of Epidemiology* 1252 at 1256-1258; Office for Disability Issues, *supra* note 112 at 83-84.

120 RCAP, *Gathering Strength*, *supra* note 6 at 248; see also Campbell, *supra* note 116; Jeff Reading, "The Quest to Improve Aboriginal Health" (2006) 174:9 *Canadian Medical Association Journal* 1233.

121 RCAP, *Gathering Strength*, *ibid.* at 249. See also Yvonne Boyer, *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation, Discussion Paper Series*

concluded in its final report: "In spite of ... various studies and a number of initiatives underway in every province and territory, the fact remains that there are deep and continuing disparities between Aboriginal and non-Aboriginal Canadians in both their overall health and in their ability to access health care services."¹²²

Like the discriminatory barriers to abortion services at issue in the *Jane Doe I* case, unequal access by Aboriginal, low income and other disadvantaged groups to existing publicly funded health care services violates the *Canada Health Act* principle of universality. These inequalities are clearly amenable to section 15 challenges under the analytical framework set out in the *Auton* case. However, many health care issues of equal or greater concern to Aboriginal people and other disadvantaged groups are more difficult to categorize. For example, in a background paper to its brief to the Royal Commission on Aboriginal Peoples, the Canadian Medical Association (CMA) identifies interpretation services and traditional medicine as two areas in which publicly funded health programs and services are seriously lacking.¹²³ In the case of medical interpretation services, the CMA observes:

[Many] Aboriginal peoples whose first language is not English, access health services from rural and remote communities. These individuals are vulnerable on several fronts. At the same time that they must confront an illness and travel often large distances to unfamiliar (and hostile) settings, language is a further barrier. The use of Aboriginal interpreters is essential to provision of services in these circumstances.¹²⁴

Although many Aboriginal patients from remote areas require interpretation services, such services are only sporadically available across the coun-

in Aboriginal Health: Legal Issues, No. 2 (Ottawa/Saskatoon: National Aboriginal Health Organization/Native Law Centre, University of Saskatchewan, 2004) at 8; Adelson, *supra* note 116 at 558; Macintosh, *supra* note 116 at 208; Janesca Kydd, "The Rural Aboriginal Health Gap: The Romanow Solutions?" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 216; National Council of Welfare, *supra* note 116 at 70.

122 Romanow Commission, *supra* note 1 at 211; Macintosh, *supra* note 116 at 193.

123 CMA, *Bridging the Gap*, *supra* note 6 at 53-54.

124 *Ibid.* at 53.

try. While the federal government provides some interpretation services for northern communities and patients requiring tertiary care in urban hospitals, a 2001 Health Canada study examining the impact of language barriers on access to health care found that a significant proportion of Aboriginal people in Western cities “may lack the functional language capability to communicate in an official language during encounters with the health care system” and that providing interpretation services to this population has not been seen as a priority.¹²⁵

The CMA also underscores the importance, from an Aboriginal perspective, of access to traditional medicine and healing, including to Aboriginal herbalists and to healing by ceremonial means. Here the CMA explains: “There has been very little interaction between western and Aboriginal traditional healers. Historically, the efforts of Aboriginal healers have been suppressed ... Many case studies have been published that describe resistance by western caregivers to allowing the incorporation of traditional healers into the health care system.”¹²⁶ As with interpretation services, public funding for access to traditional medicine is also limited, particularly for Aboriginal people living off-reserve.¹²⁷

The inadequacy, or absence, of public funding for interpretation services and non-traditional medicine may have a similar adverse impact on the members of new immigrant communities, whose lack of English or French language fluency or familiarity with conventional western medicine also creates systemic barriers to publicly funded care.¹²⁸ The above-cited Health Canada

125 Sarah Bowen, *Language Barriers in Access to Health Care* (Ottawa: Health Canada, 2001) at 15.

126 CMA, *Bridging the Gap*, *supra* note 6 at 53-54; Adelson, *supra* note 116 at S58; National Council of Welfare, *supra* note 116 at 68-69.

127 In a 2002 survey, the National Aboriginal Health Organization found that while 51 percent of First Nations respondents had made use of traditional healers and medicines, 68 percent said they would seek such care more often if it were available through their local health centre and 62 percent said they would make greater use of traditional care if it were covered by the health care system; NAHO, *Public Opinion Poll*, *supra* note 119 at 13-15.

128 Anita J. Gagnon, *Responsiveness of the Canadian Health Care System Towards Newcomers - Discussion Paper No. 40* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: Commission on the Future of Health Care in Canada <<http://www.hc-sc.gc.ca/english/care/romanow/hcc0426.html>>; Richard A. Haigh, “Reconstructing Paradise: Canada’s Health Care System,

study on language barriers within the health care system summarized the situation for refugee and new immigrant communities: "Language barriers have been demonstrated to have adverse effects on access to health care, quality of care ... and most importantly, on patient health outcomes. In spite of universal health coverage, patients who lack proficiency in English or French may not have access to the same quality of care as other Canadians."¹²⁹ In its review of the Ontario health care system, the Ontario Health Quality Council concluded that, in order to address access barriers facing new immigrants in the health care context: "The most essential service that can be offered to immigrants is translation."¹³⁰ Language barriers have also been identified as a serious access to health issue for official minority language communities in many parts of Canada.¹³¹

In light of the Supreme Court's reasoning in *Eldridge*, it may be possible to characterize Aboriginal and other language interpretation services as akin to medical interpretation services for the Deaf, and therefore as mat-

Alternative Medicine and the *Charter of Rights*" (1999) 7 Health L.J. 141; Glazier, *supra* note 110 at 135. It is also notable that people with disabilities are one and a half times more likely to seek alternative care than persons without disabilities; see Canadian Council on Social Development, *Disability Information Sheet No. 13, 2004, Persons with Disabilities and their Contact with Medical Professionals and Alternative Health Care Providers* at 3, online: Canadian Council on Social Development <<http://www.ccsd.ca/drip/research/drip13/drip13.pdf>>.

129 Bowen, *supra* note 125 at 100. See also Gagnon, *ibid.* at 9, 16; Marian MacKinnon, "Affirming Immigrant Women's Health Practices in Prince Edward Island" (2001) 2:2 *Centres of Excellence for Women's Health Research Bulletin* 19 at 20.

130 Ontario Health Quality Council, *2006 First Yearly Report*, *supra* note 6 at 14; Zheng Wu, Margaret J. Penning & Christoph M. Schimmele, "Immigrant Status and Unmet Health Care Needs" (2005) 96 *Canadian Journal of Public Health* 369 at 373; Sannie Tang, "Interpreter Services in Healthcare: Policy Recommendations for Healthcare Agencies" (1999) 29 *Journal of Nursing Administration* 23.

131 See for example Fédération des francophones de la Colombie-Britannique, *Needs and Priorities Regarding Access to Health Services in French in British Columbia: What Do Francophones Think? Final Report* (Ottawa: Health Canada, 2002); Fédération des communautés francophones et acadienne du Canada, *Pour un meilleur accès à des services de santé en français* (Ottawa: Fédération des communautés francophones et acadienne du Canada, 2001); Bowen, *supra* note 125 at 15; Dave Rogers, "Ontario francophones lack 'equitable' health care : minister" *The Ottawa Citizen* (27 November 2007) B2.

ters of “universality” rather than “comprehensiveness” within the framework of the *Canada Health Act*. Such services would therefore be entitled to funding, in accordance with Chief Justice McLachlin’s analysis in the *Auton* case. To the extent that certain alternative or “non-core” therapies are already funded within the public system, there may also be some basis for challenging the failure to fund other traditional or alternative forms of medicine and healing, where lack of funding can be shown to have a discriminatory impact on race, ethnic origin, or other prohibited grounds. In *Auton*, the Chief Justice suggested that, to succeed in such a section 15 claim, it would have to be shown that the government’s approach to the alternative treatment at issue differed from its approach to other “comparable, novel therapies” eligible for provincial medicare funding.¹³² Colleen Flood, Mark Stabile and Carolyn Tuohy’s recent assessment of the significant procedural and substantive defects in the existing structures and principles for deciding which medicare services do or do not receive public funding suggests that such a case may, in some instances, be possible to construct.¹³³

It remains, however, that a number of the issues of most pressing concern to disadvantaged groups in Canada relate squarely to the comprehensiveness, rather than the universality, of the publicly funded system. As William Lahey has pointed out, the medicare system is designed primarily to meet the episodic or acute health care needs of the otherwise healthy.¹³⁴ Thus, for example, the medicare system places a priority on physical over mental health and on physical over mental health care services. Notwithstanding the profound impact of mental health on overall health and well-being at both the individual and community levels, mental health services are not included within the current framework of the *Canada Health Act*, and existing federal and provincial funding and programs have long been criticised as both fragmented and inadequate.¹³⁵ In the words of the Romanow

132 *Auton* (S.C.C.), *supra* note 17 at para. 62.

133 *Supra* note 70 at 16-23.

134 Lahey, *supra* note 10 at 79-80; and see the discussion at note 169, *infra*.

135 Romanow Commission, *supra* note 1 at 178; Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa: Senate of Canada, 2006) (Chair: Michael Kirby), online: Parliament of Canada <<http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm>>; Public Health Agency of Canada *et al.*, *The Human Face of Mental Health and Men-*

Commission: "Mental health has often been described as one of the 'orphan children' of medicare."¹³⁶ Given the historical and continuing legacy of colonialism, the inadequacy of mental health-related funding and programs has particularly adverse effects in Aboriginal communities.¹³⁷ The gendered impact of lack of public funding in this area is also evident.¹³⁸

Aside from mental health services, the Canadian medicare system also excludes most dental care, an aspect of health care which is particularly critical for children and adolescents.¹³⁹ While middle and upper-middle in-

tal Illness in Canada 2006 (Ottawa: Minister of Public Works and Government Services Canada, 2006), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/human-humain06/index.html>>; Laura Eggertson, "Children's mental health services neglected: Kirby" (2005) 173 Canadian Medical Association Journal 471; Keith S. Dobson, "A National Imperative: Public Funding of Psychological Services" (2002) 43:3 Canadian Psychology 65.

136 Romanow Commission, *supra* note 1 at 178.

137 Public Health Agency of Canada, *supra* note 135 at 169, 174; J. Kevin Barlow, *Examining HIV/AIDS Among the Aboriginal Population in Canada in the Post-Residential School Era* (Ottawa: Aboriginal Healing Foundation, 2003), online: Aboriginal Healing Foundation <<http://www.ahf.ca/publications/research-series>>; Craig Jones, "Fixing to Sue: Is There a Legal Duty to Establish Safe Injection Facilities in British Columbia" (2002) 35 U.B.C. L.Rev. 393 at para. 90; CMA, *Bridging the Gap*, *supra* note 6 at 53; Daniel Salée, "Quality of Life of Aboriginal People in Canada: An Analysis of Current Research" (2006) 12:6 Choices 4 at 17; Kwasi Kafele, "Racial Discrimination and Mental Health: Racialized and Aboriginal Communities" (December 2004), online: Ontario Human Rights Commission: <<http://www.ohrc.on.ca/en/issues/racism/racepolicydialogue/kk/pdf>>.

138 Office for Disability Issues, *supra* note 112 at 77; Marina Morrow & Monika Chappell, *Hearing Women's Voices: Mental Health Care for Women* (Vancouver: British Columbia Centre of Excellence for Women's Health, 1999), online: British Columbia Centre of Excellence for Women's Health <<http://www.bccewh.bc.ca/publications-resources/documents/hearingvoices.pdf>>; Status of Women Canada, *Mental Health Promotion Among Newcomer Female Youth: Post-Migration Experiences and Self-Esteem* by Nazilla Khanlou *et al.* (Ottawa: Status of Women Canada, 2002) at 53; Canadian Population Health Initiative, *supra* note 115 at 39.

139 Pursuant to section 2 of the *Canada Health Act*, "medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure" are defined as "insured health services" that are eligible for medicare funding. Dental care is provided

come families may be able to pay for visits to the dentist directly out of pocket, and are also more likely to have private health insurance coverage that includes dental care, many low income individuals and families are unable to afford proper dental care for themselves or their children.¹⁴⁰ Studies show that the highest-income Canadians are almost three times as likely to visit a dentist relative to the lowest income Canadians;¹⁴¹ that both the probability of receiving dental care and the amount of care received increases with dental insurance, household income and level of education;¹⁴² and that disparities in access to oral health care in Canada are increasing, rather than decreasing.¹⁴³ As the author of a recent study on access to dental health by low-income families in Eastern Ontario concludes:

to social assistance recipients and to children in some provinces. See online: Canadian Association of Public Health Dentistry <<http://www.caphd-acsdp.org/Programs.html>>. In Quebec, for example, children under the age of 10 also receive publicly funded dental care, although dentists in that province have recently threatened to pull out of the plan unless the provincial government increases their fees; see André Picard, "Quebec dentists step up fight against government" *The Globe and Mail* (26 November 2007), online: *Globe and Mail* <<http://www.theglobeandmail.com/servlet/story/RTGAM.20071126.wteeth26/BNStory/National/>>.

140 William H. Ryding, "The 2-Tier Dental Health Care System" (2006) 72 *Journal of the Canadian Dental Association* 47 at 48; Robert J. Schroth *et al.*, "Prevalence of Caries Among Preschool-Aged Children in a Northern Manitoba Community" (2005) 71 *Journal of the Canadian Dental Association* 27; Taimur Bhatti, Zeeshan Rana & Paul Grootendorst, "Dental Insurance, Income and the Use of Dental Care in Canada" (2007) 73 *Journal of the Canadian Dental Association* 57 at 57; Ruth Armstrong, "Access and Care: Towards a National Oral Health Strategy – Report of the Symposium" (2005) 71 *Journal of the Canadian Dental Association* 19; Stephen Birch & Rob Anderson, "Financing and Delivering Oral Health Care: What Can We Learn from Other Countries?" (2005) 71 *Journal of the Canadian Dental Association* 243; James L. Leake, "Why Do We Need an Oral Health Care Policy in Canada?" (2006) *Journal of the Canadian Dental Association* 317.

141 Bhatti, Rana & Grootenedorst, *ibid.* at 57.

142 *Ibid.*; Armstrong, *supra* note 140; Birch & Anderson, *supra* note 140; Leake, *supra* note 140.

143 Leake, *ibid.* at 317. In terms of the mix of public and private dental care funding in Canada, another study concludes that: "Per capita public funding is low by international standards and, in contrast to other countries, is diminishing as a

... keeping oral health care out of the universal health care system has created a 2-tier oral health care system to which wealthy people and employed individuals with dental benefits have easy access but which presents barriers to care for others in our community, most notably the unemployed, the working poor, single-parent families, members of First Nations communities, recent immigrants and elderly people ... Regrettably, dentistry is an example of the 'inverse care law,' whereby those with the greatest need of services tend to be those with the least ability to pay for them.¹⁴⁴

Another serious gap in the current medicare system relates to access to pharmaceuticals. In examining this issue, the Romanow Commission concluded that "Canada has a fragmented system of drug coverage across the country. To a very large extent, people's income, the kind of job they have, and where they live determine what type of access they have to prescription drugs."¹⁴⁵ While social assistance recipients and the elderly receive varying levels of drug coverage from province to province, pharmaceuticals are automatically provided only to those being treated in hospital, with a correspondingly adverse impact on those with chronic physical and mental illnesses and disabilities, as well as on low income people generally.¹⁴⁶

proportion of total expenditures. The impact of this trend is heavily concentrated on the less prosperous members of the population." See Birch & Anderson, *supra* note 140 at 243c.

144 Ryding, *supra* note 140 at 48; see also Birch & Anderson, *ibid.* at 243; Patricia Main, James Leake & David Burman, "Oral Health Care in Canada – A View from the Trenches" (2006) 72 *Journal of the Canadian Dental Association* 319 at 319c.

145 Romanow Commission, *supra* note 1 at 194; Virginie Demers *et. al.*, "Comparison of provincial prescription drug plans and the impact on patients' annual drug expenditures" (2008) 178 *Canadian Medical Association Journal* 405; Canadian Health Coalition, *More for Less: A National Pharmacare Strategy* (Ottawa: Canadian Health Coalition, 2006) at 11-12; National Forum on Health, *Synthesis Reports*, *supra* note 1 at 3-4; Greg Marchildon, "Federal Pharmacare: Prescription for an Ailing Federation?" in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 268 at 278-279.

146 Canadian Centre for Policy Alternatives, *A National Pharmacare Plan: Combining Efficiency and Equity* by Joel Lexchin (Ottawa: Canadian Centre for Policy Alternatives, 2001) at i, 5-6, 10; Steve Morgan *et al.*, "Income-Based Drug Coverage in British Columbia: Lessons for BC and the Rest of Canada" (2006) 2:2

A 2003 Canadian Council on Social Development report on medication use among people with disabilities found, for example, that 19% of working-age women with disabilities were unable to get the medication they needed because they could not afford it, and one-quarter of women under age 65 with severe or very severe disabilities were unable to get their required medication due to cost.¹⁴⁷ Various studies on the impact of poverty on women's health have also found that women on social assistance and other low-income women are often unable to obtain public coverage for medications or to afford dispensing fees for medically necessary prescription drugs for themselves and their families.¹⁴⁸ As Jeremiah Hurley and Michel Grignon explain, variations in access to prescription drugs in turn compound other inequities within the health care system:

Utilization of physician services depends in part on the demand for complementary services – for instance, the demand for prescription drugs. The demand for prescription drugs depends in part on drug insurance coverage. Because drug insurance in Canada is often linked to employment, higher-income Canadians are more likely to have drug insurance, which in turn induces them to utilize more physician services. Hence, private financing for many complementary health care services in Canada can exert an important influence on the utilization of publicly insured services.¹⁴⁹

Home care, including palliative care and other services that allow individuals with acute or chronic health needs to remain at home, instead of being treated in hospitals or long term care facilities, also falls outside the medicare system. The results have been described as follows:

Healthcare Policy 115; Glazier, *supra* note 110 at 135; Mindelle Jacobs, "Drug dilemma: poor often have to choose between food and filling prescriptions," online: Health Sciences Association of Alberta <http://www.hsaa.ca/index_html/drug_dilemma>.

147 Canadian Council on Social Development, *Disability Information Sheet: Number 11, 2003: Persons with Disabilities and Medication Use*, online: <<http://www.ccsd.ca/drip/research/dis11/index.htm>>; see also Masuda, *supra* note 112 at 24.

148 See e.g. Mildred Kerr *et al.*, "Don't We Count as People? Saskatchewan Social Welfare Policy and Women's Health" (2005) 4:2 *Centres of Excellence for Women's Health Research Bulletin* 25 at 26-27; Chrystal Ocean, *Policies of Exclusion, Poverty and Health: Stories from the Front* (Duncan, B.C.: WISE Society, 2005).

149 Hurley & Grignon, *supra* note 110 at 187.

Because of home care's exclusion from the *Canada Health Act*, there are different standards, eligibility requirements, administrative mechanisms and costs in each province and territory. Home care legislation varies, and there is no minimum definition of 'comprehensiveness' when it comes to the variety of health and social services that fall under home care ... Each province and territory provides a different 'bundle' of such services. What is consistent, however, is that services are being stretched to their limits, waiting lists are growing and eligibility requirements for services are becoming more restrictive.¹⁵⁰

The gendered effects of the failure to include home care within the public system, both on women who need home care services and on women who provide such care, informally or as paid workers, have been well documented.¹⁵¹ So too has the adverse impact of the existing patchwork

- 150 Status of Women Canada, *Trade Agreements, Home Care and Women's Health* by Olena Hankivsky *et al.* (Ottawa: Status of Women Canada, 2004) at 13, online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/pubspr/0662360565/200403_0662360565_e.pdf>; Susan Duncan & Linda Reutter, "A critical policy analysis of an emerging agenda for home care in one Canadian province" (2006) 14:3 *Health and Social Care in the Community* 242; Judith Shamian, "Home and Community Care in Canada: The Unfinished Policy" in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 291.
- 151 Armstrong, *supra* note 115 at 260; Canadian Council on Social Development (CCSD), *Supports and Services for Adults and Children Aged 5-14 With Disabilities in Canada: An Analysis of Data on Needs and Gaps* by Gail Fawcett *et. al* (Ottawa: Canadian Council on Social Development, 2004) at 34, online: CCSD <http://www.socialunion.gc.ca/pwd/_GAPS_Report_Eng_rev.pdf>; Status of Women Canada, *The Changing Nature of Home Care and its Impact on Women's Vulnerability to Poverty* by Marika Morris *et al.* (Ottawa: Status of Women Canada, 1999), online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/pubspr/0662280857/index_e.html>; Jane Aronson, "Missing Voices in Long-term Care Policy Making: Elderly Women and Women with Disabilities Receiving Home Care" (2000) 1:1 *Centres of Excellence for Women's Health Research Bulletin* 14, online: Canadian Women's Health Network <<http://www.cewh-cesf.ca/bulletin/v1n1/page9.html>>; Status of Women Canada, *Who Will be Responsible for Providing Care? The Impact of the Shift to Ambulatory Care and of Social Economy Policies on Quebec Women* by Denyse Côté *et al.* (Ottawa: Status of Women Canada, 1998), online: Status of Women Canada <http://www.swc-cfc.gc.ca/pubs/pubspr/0662672895/200305_

and chronic under-funding of home care services on people with disabilities.¹⁵² The Romanow Commission has also underscored the severe negative consequences of the lack of adequate, publicly funded home care services on people with mental illnesses:

Recent history has shown that the trend to treating people with mental illnesses in their own communities rather than in institutions has not been accompanied by sufficient resources. Many mental health patients were discharged with insufficient resources and networks to support their ability to live at home. Often, to be eligible for home care, a person had to have a physical disability or difficulties with activities of daily living. These requirements preclude many people with mental illnesses from accessing necessary home care and support.¹⁵³

In all of the above-described areas: home care, prescription drugs, dental services, and mental health, the primary problem is not one of lack of universality but rather lack of comprehensiveness of the current publicly funded health care system. Aboriginal people, people with disabilities, people living in poverty, and women particularly in each of these groups, experience inequalities in access to medically necessary care, not because governments are violating the principle of universality within the meaning of the *Canada Health Act*. Health care inequality arises from the fact that many of the services that are required to restore, protect or to maintain basic physical and mental health are considered 'non-core' services that are either partially or entirely excluded from the medicare system. As a result, in spite of the stated objectives of the *Canada Health Act* and our collective aspirations vis-à-vis the

0662672895_20_e.html>; Erika Haug & Shelley Thomas Prokop, "Aboriginal Women and Home Care in Saskatchewan" (2004) 3 Canadian Centre for Policy Alternatives: Saskatchewan Notes 1.

152 Marks & Teasell, *supra* note 114; Canadian Council on Social Development, *supra* note 102 at 6-8; Kari Krogh & Jon Johnson, "A Life Without Living: Challenging Medical and Economic Reductions in Home Support Policy for People with Disabilities" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: University of British Columbia Press, 2006) at 151; Masuda, *supra* note 112 at 13-16; CCSD, *ibid.* at 33.

153 Romanow Commission, *supra* note 1 at 179.

health care system, access to health care remains in many cases “a privilege of status or wealth.”¹⁵⁴

3. Formal or Substantive Equality within the Health Care System?

This systemic source of inequality within the health care system is reinforced rather than confronted by the Supreme Court’s decision in *Auton*. As outlined earlier, Chief Justice McLachlin’s judgment suggests that the *Canada Health Act* and provincial health and hospital insurance laws are immune from *Charter* equality rights scrutiny when it comes to the particular funding choices that were made when the medicare system was first put in place, and the systemic impact that these decisions continue to have for individuals and disadvantaged groups. According to the Chief Justice, the exclusion of particular ‘non-core’ health care services does not amount to discrimination within the meaning of section 15, because this was how the medicare regime was originally intended to be structured. In her words:

The legislative scheme in the case at bar, namely the CHA and the MPA, does not have as its purpose the meeting of all medical needs. As discussed above, its only promise is to provide full funding for core services, defined as physician-delivered services It is, by its very terms, a partial health plan. It follows that exclusion of particular non-core services cannot without more be viewed as an adverse distinction based on an enumerated ground. Rather, it is an anticipated feature of the legislative scheme.¹⁵⁵

Thus it would seem that, following *Auton*, federal and provincial governments’ decisions to fund physician and hospital services while failing to provide public funding for other services which are arguably of equal or greater medical necessity to particular disadvantaged groups are not subject to section 15 review. In particular, lack of public funding for pharmacare, mental health care, and the other services described above that fall outside the existing framework of the *Canada Health Act* although they are matters of absolute medical necessity for many disadvantaged individuals and groups, cannot, according to the Chief Justice’s analysis in *Auton*, be successfully

154 *Ibid.* at xvii-xix; National Forum on Health, *Final Report*, *supra* note 1 at 12-14, 20-23.

155 *Auton* (S.C.C.), *supra* note 17 at para. 43.

challenged because they relate to the comprehensiveness rather than the universality of the system.

The financial and institutional implications of *Charter* challenges to the scope of the publicly funded health care system clearly raise important issues and legitimate concerns.¹⁵⁶ However, it remains that the distinction drawn by the Chief Justice in *Auton*, between “core” and “non-core” services or, as outlined above, between the “universality” and “comprehensiveness” of the system, reflects a formal approach to equality¹⁵⁷ that the Supreme Court has, until now, squarely rejected. For example, in his trial decision in the *Eldridge* case,¹⁵⁸ ultimately reversed by the Supreme Court of Canada on appeal, Jus-

156 See Donna Greschner, “*Charter* Challenges and Evidence-Based Decision-Making in the Health Care System: Towards a Symbiotic Relationship” in Colleen M. Flood, ed., *Just Medicare: What’s In, What’s Out, How We Decide* (Toronto: University of Toronto Press, 2006) 42; Marchildon, *supra* note 9; Bond, *supra* note 69 at 267-269; Maryth Yachnin, “False Promises: The *Charter*, *Chaoulli* and Collective Choices,” online: University of Toronto Health Law and Policy Group <http://www.law.utoronto.ca/healthlaw/docs/student_Yachnin-Rights.pdf>; Donna Greschner & Steven Lewis, “*Auton* and Evidence-Based Decision-Making: Medicare in the Courts” (2003) 82 Can. Bar Rev. 501; Manfredi & Maioni; *supra* note 10; B. von Tigerstrom, “Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*” (1999) 11 Const. Forum Const. 30.

157 Margot Young provides the following definition of formal, versus substantive, equality as these concepts have been understood within the context of section 15: “By formal equality, I mean an understanding of equal treatment as requiring simply the same treatment – that individuals are treated identically with no eye to the different contextual (social, historical, economic, or cultural) factors that distinguish each individual and that may mean that the effect of such ‘equal’ treatment will vary across individuals. An approach characterized, conversely, by an insistence on a substantively equal outcome will look to contextual factors, to how the treatment in question affects each individual in light of pre-existing individual and group characteristics, circumstances, and history. Under a substantive approach, equality may very well demand different treatment; equality in substance is determined by an assessment of the effects and outcome of the treatment in question.” See Margot Young, “Why Rights Now? Law and Desperation” in Margot Young *et al.*, eds., *Poverty: Rights, Social Citizenship, and Legal Activism* (Vancouver: University of British Columbia Press 2007) 317 at 319-20.

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

tice Tysoe's description of the scope and objectives of the provincial medicare system is very similar to the one adopted by the Chief Justice in *Auton*. As Justice Tysoe explained it:

The [B.C. *Medical and Health Care Services*] Act provides for payment of a fairly comprehensive list of medical services but it does not purport to be an exhaustive list and it does not cover any ancillary services. The Act authorizes payment for medically required services rendered by a medical practitioner and medically required services that are prescribed in the regulations to the Act. Interpreting services are not medically required services. Even if they could be classified as medically required services, they are not rendered by medical or health care practitioners.¹⁵⁹

In Justice Tysoe's view, medically required services funded under B.C.'s medicare legislation were provided to Deaf and non-deaf persons alike, "with no differentiation between them." In contrast, "ancillary services", including interpretation and other services delivered by non-health care practitioners, were not. Thus, Justice Tysoe concluded, the province's refusal to fund medical interpretation services was not discriminatory within the meaning of section 15.¹⁶⁰ A majority of the B.C. Court of Appeal agreed with Justice Tysoe, dismissing the appellants' claim on the grounds that: "The legislation removes the responsibility of both the hearing and the deaf to make payment to their doctors ... Both purposively and effectively the legislation provides its benefit equally to the hearing and the deaf."¹⁶¹

Writing for a unanimous Supreme Court in *Eldridge*, Justice LaForest rejected the lower courts' narrow reading of section 15 and the obligations it imposes on governments in the health care context. On the preliminary issue of the application of the *Charter*, Justice LaForest found that B.C.'s medicare legislation was drafted permissively, neither requiring nor prohibiting the provision of interpretation services. Because the power to decide what services should be funded was delegated by the *Medical and Health Care Services Act* to B.C.'s Medical Services Board, and by the province's *Hospital Insurance Act* to individual hospitals, Justice LaForest held that it was the ac-

159 *Ibid.* at 87.

160 *Ibid.*

161 *Eldridge v. British Columbia (Attorney General)*, (1995), 125 D.L.R. (4th) 323, [1995] B.C.J. No. 1168 at 339 [*Eldridge*, B.C.C.A. cited to D.L.R.].

tions of these entities that gave rise to the appellants' equality rights claim.¹⁶² Contrary to Chief Justice McLachlin's subsequent finding in *Auton*, Justice LaForest did not see the failure to explicitly include interpretation services under B.C.'s medicare legislation as in any way determinative of the equality issues raised in the case. Rather, he found that the choice whether or not to fund interpretation services remained an issue under section 15, whether the decision was made by the legislature itself, or by its delegates within the health care system.

Justice LaForest acknowledged that, on its face, the provincial medicare regime applied equally to the Deaf and the hearing: all were entitled to receive certain medical services free of charge. Justice LaForest reiterated, however, that section 15 provides a remedy not only against direct discrimination, but also against the adverse effects of facially neutral laws or government policies. Thus, Justice LaForest identified the inequality in *Eldridge* as the failure to ensure that the Deaf receive the same level and quality of care as the hearing population.¹⁶³ Contrary to the trial and Court of Appeal's analysis, Justice LaForest emphasized that this was not simply a case of lack of funding for a non-core service not delivered by medical practitioners. Rather, by refusing to recognize interpretation services as eligible for provincial funding, the B.C. medicare system was not meeting the primary health care needs of Deaf residents of the province.¹⁶⁴

In rejecting the lower courts' conclusion that access to an identical range of insured medical services was tantamount to equal treatment in the health care context, Justice LaForest also challenged the province's argument that section 15 could only be invoked to challenge discrimination within existing health care programs, and could not be read to impose any obligations on governments' in their choice to provide those programs at the outset. As Justice LaForest addressed the B.C. government's position on this point:

[T]he respondents ... 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 groups claiming a s. 15(1) violation and the general population. They assert, in other words, that governments should be

162 *Eldridge* (S.C.C.), *supra* note 13 at paras. 51-52.

163 *Ibid.* at para. 71.

164 *Ibid.* at para. 76.

entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantages of those benefits. 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.¹⁶⁵

Contrary to Justice McLachlin's approach in *Auton*, Justice LaForest did not accept the characterization of interpretation services as "ancillary", or "non-core" services, as the end of the section 15 analysis. Nor did he agree that providing access to an identical range of medical services was the extent of the province's equality rights obligations in relation to the medicare system. Rather, Justice LaForest focussed on the systemic impact of the province's choice not to fund interpretation services on Deaf patients' access to publicly funded care that met their health care needs and, consequently, on their ability to benefit equally from the publicly funded health care system.

Similarly, in his decision for the Court in *Vriend v. Alberta*,¹⁶⁶ Justice Cory rejected the Alberta government's argument that failure to include sexual orientation under that province's human rights law was a form of government inaction that was not subject to the application of the *Charter*. Justice Cory insisted that the Alberta legislation had to be examined under section 15 to assess what impact the lack of state protection against discrimination based on sexual orientation had on gays and lesbians living in the province.¹⁶⁷ It was not an answer, according to Justice Cory, to say that gays and lesbians enjoyed the same protection from discrimination based on sex, religion, or other grounds, as did other Albertans. Rather gays and lesbians failed to receive protection against the form of discrimination they were most likely to suffer. Alberta's human rights legislation did not violate section 15 simply because the legislature intentionally excluded a group they didn't like. The legislation was discriminatory because of the systemic effects of the failure to protect the human rights of gays and lesbians under a provincial regime designed to do just that.¹⁶⁸

165 *Ibid.* at paras. 72-73.

166 *Vriend v. Alberta*, [1998] 1 S.C.R. 493, [1998] S.C.J. No. 29 at paras. 86-87 [*Vriend* cited to S.C.R.].

167 *Ibid.*

168 *Ibid.* See generally Bruce Porter, "Expectations of Equality" in Sheila McIntyre & Sandra Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto; Butterworths, 2006) 23; R. Douglas Elliott & Jason

As the Women's Legal Education and Action Fund (LEAF) and the Disabled Women's Network Canada (DAWN) argued in their joint intervention before the Supreme Court in the *Auton* case, the distinction between "core" and "non-core" services, or between those "medically insured" services that are government funded and those that are not, because they are not provided by physicians or hospitals, is based upon an inherently discriminatory understanding of health and health care.¹⁶⁹ LEAF/DAWN referred to William Lahey's description of this underlying bias within the existing publicly funded system. Professor Lahey explains:

[T]he legal compartmentalization of our health care system obscures the nature of the premises and assumptions on which we implicitly rely when we make choices about (for example) funding for treatments that are outside the scope of medicare. These include a premise that medicine is generally superior to other responses to illness, suffering and disability, that curing is more important than caring (as well as prevention), that dealing with the episodic illness of the

J. Tan, "Unequal Benefits or Unequal Persons? Social Benefit Programs and the *Charter*" (2006) 19 N.J.C.L. 285 at 300-302; Donna Greschner, "Does *Law* Advance the Cause of Equality?" (2001) 27 *Queen's L.J.* 299; Martha Jackman, "'Giving Real Effect to Equality: *Eldridge v. British Columbia (Attorney General)* and *Vriend v. Alberta*" (1998) 4 *Rev. Const. Stud.* 352; Bruce Porter, "Beyond *Andrews*: Substantive Equality and Positive Obligations After *Eldridge* and *Vriend*" (1998) 9 *Const. Forum Const.* 71; Fay Faraday, Margaret Denike & M. Kate Stephenson, eds., *Making Equality Rights Real: Securing Substantive Equality Under the Charter* (Toronto: Irwin Law, 2006).

169 *Auton (Guardian ad litem of) v. British Columbia (Attorney General)* 2004 SCC 78 (Factum of the Intervener, LEAF/DAWN at paras 24-27), online: Women's Legal Education and Action Fund <<http://www.leaf.ca/legal/briefs/2004-auton.html#target>> [Factum of LEAF/DAWN]; see also Dianne Pothier, "Appendix: Legal Developments in the Supreme Court of Canada Regarding Disability" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: University of British Columbia Press, 2006) 305 at 310-312; Fiona Sampson, "The *Law* Test for Discrimination" in Fay Faraday, Margaret Denike & M. Kate Stephenson, eds., *Making Equality Rights Real: Securing Substantive Equality Under the Charter* (Toronto: Irwin Law, 2006), 245 at 262-63; Natasha Bakht, "Furthering an Economic/Social Right to Healthcare: The Failure of *Auton v. British Columbia*" (2005) 4 *J.L. and Equality* 241.

healthy is more important than dealing with chronic illness and disability, and that physical health takes priority over other dimensions of health, including mental health. Seen in this broader light, the *Auton* case is a manifestation of a decision-making dynamic that cuts across the Canadian health care system.¹⁷⁰

The Supreme Court's approach to section 15 in *Auton* is directly at odds with its insistence, in *Andrews* and subsequent judgments, that section 15 is not primarily concerned about discriminatory purposes, but rather about discriminatory effects.¹⁷¹ The medicare system was set up and has been maintained in a way that gives priority to certain health care needs over others, and this priority has and continues to skew the system in very specific ways. The fact that everyone benefits from public funding of hospital and physician services does not remove from the fact that excluding other types of medically necessary care from the public health insurance system has a systemically adverse impact on certain disadvantaged groups, people living

170 William Lahey, "The Legal Framework of Canada's Health Care System" in Jocelyn Downie, Karen McEwen & William MacInnis, eds., *Dental Law in Canada* (Toronto: LexisNexis, 2004) 29 at 79-80, cited in Factum of LEAF/DAWN, *ibid.* at para. 25. See also Catherine Frazee, Joan Gilmore & Roxanne Mykitiuk, "Now You See Her, Now You Don't: How Law Shapes Disabled Women's Experience of Exposure, Surveillance, and Assessment in the Clinical Encounter" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: University of British Columbia Press, 2006) 223 at 223-24; Peter Carver, "Disability and the Allocation of Health Care Resources: The Case of Connor Auton" (2001) 12 *Health News Today* 6, online: University of Alberta <<http://www.ualberta.ca/~bioethic/HETVol12No1/page6.html>>; Richard Devlin & Dianne Pothier, "Dis-citizenship" in Law Commission of Canada, ed., *Law and Citizenship* (Vancouver: University of British Columbia Press, 2006) 144 at 159-163.

171 See Bakht, "The Failure of *Auton*", *supra* note 169; Sampson, *supra* note 169; Dianne Pothier, "Equality as a Comparative Concept: Mirror, Mirror, on the Wall, What's the Fairest of Them All?" in Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: Butterworths, 2006) at 146-48; Fay Faraday, "Developments in Social and Economic Rights Access to Social Programs: Substantive Equality Under the Charter of Rights" (2006) 21 *N.J.C.L.* 11; Daphne Gilbert & Diana Majury, "Critical Comparisons: The Supreme Court of Canada Doooms Section 15" (2006) *Windsor Y.B. Access Just.* 111.

in poverty in particular. Thus, in the context of the *Auton* case, as Justice La-Forest recognized in relation to the health care needs of the Deaf in *Eldridge*, the fact that autistic children have the same access to physician and hospital services as non-autistic children, or that non-autistic children are likewise ineligible for autism-related health services, cannot be the end of the equality rights analysis.¹⁷²

Nor, despite the Chief Justice's assertion to this effect in *Auton*, can it be true from a substantive equality perspective, that broader government choices about how the health care system is structured, or around what type of health care services will be funded or not, are *a priori* immune from section 15 review. As the Court's decisions in both *Eldridge*¹⁷³ and in *Vriend*¹⁷⁴ make clear, the government's choice of what "benefit of the law" to provide and what benefits to withhold falls squarely within the ambit of section 15. This is the case whether that choice is made – overtly or by omission – by the legislature itself, such as occurred in *Vriend*, or by legislative delegates, as was the situation in *Eldridge*. And, as these judgments also underscore, choices that result from discounting of, or wilful blindness to, the needs of disadvantaged groups are as objectionable as more overtly discriminatory government action.¹⁷⁵ Thus, in the health care context, as LEAF and DAWN affirm in their intervention in *Auton*: "Substantive equality requires an assessment of what "comprehensiveness" includes within insured services to determine if the most pressing health services needs of marginalized segments of the population are disproportionately not met, so as to amount to discrimination."¹⁷⁶

172 See generally Pothier, *ibid.*; Margot Young, "Blissed Out: Section 15 at Twenty" in Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: Butterworths, 2006) at 45; David Schneiderman, "Universality vs. Particularity: Litigating Middle Class Values Under Section 15" in Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: Butterworths, 2006) 367 at 371.

173 *Eldridge* (S.C.C.), *supra* note 13.

174 *Vriend*, *supra* note 166.

175 See Porter, "Beyond *Andrews*" *supra* note 168.

176 Factum of LEAF/DAWN, *supra* note 169 at para. 28; Pauline Rosenbaum & Ena Chadha, "Reconstructing Disability: Integrating Disability Theory Into Section 15" in Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: Butterworths, 2006) at 343.

IV. Conclusion

Like the National Forum on Health before it, the Romanow Commission concluded in its final report that: "We ... need to renovate our concept of medicare and adapt it to today's realities. In the early days, medicare could be summarized in two words: hospitals and doctors. That was fine for the time, but it is not sufficient for the 21st century."¹⁷⁷ In a 2002 discussion paper prepared for the Commission, Colleen Flood and Sujit Choudhry highlight the irrationalities created by the disproportionate focus on physician and hospital based services under the current medicare system, alongside other funding choices (or choices not to fund) in areas such as pharmaceuticals:

By giving primacy to 'medically necessary' hospital services and 'medically required' physician services, the [Canada Health] Act skews public financing toward those services ... The core value that lies behind the criterion of comprehensiveness is that people should have access to needed services. Most Canadians would probably agree that it is more important for people with diabetes to get insulin than an annual general checkup, but the CHA does not currently reflect that value because it requires full public funding of the latter (if medically required) but not the former. Moreover, those people who have private insurance for prescription drugs are more likely (all other things being equal) to use more publicly funded physician services.¹⁷⁸

177 Romanow Commission, *supra* note 1 at xvii; National Forum on Health, *Final Report*, *supra* note 1 at 12-14; Michael Rachlis, "Completing the Vision: Achieving the Second Stage of Medicare" in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 221; Monique Bégin, "It's About Equity and Going Upstream: Health For All" in Bruce Campbell & Greg Marchildon, eds., *Medicare: Facts, Myths, Problems and Promise* (Toronto: James Lorimer, 2007) 305.

178 Flood & Choudhry, *Modernizing the Canada Health Act*, *supra* note 9 at 10-11. See also Hurley & Grignon, *supra* note 110 at 187; Colleen M. Flood & Michelle Zimmerman, "Judicious Choices: Health Care Resource Decisions and the Supreme Court of Canada" in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 25 at 28-29.

The Supreme Court's decision in *Auton* validates and further reinforces the emphasis placed on access to provincially insured physician and hospital services as the central, if not the sole concern, of the publicly funded system. It can be argued that this focus on the *Canada Health Act* guarantee of universality has in turn allowed the even narrower issue of waiting times for care, and the claim that further expansion of private funding and insurance can solve the problem, to dominate the Canadian health care agenda.¹⁷⁹ The *Auton* case tells us that the *Charter* speaks only to the formal equality of the medicare system, or to questions of equal access for those who are already in a publicly funded health care queue. What the decision appears to reject is the idea that section 15 has anything to say to systemic barriers to care or to any notion of substantive equality of access, much less of health outcomes, for people living in poverty, people with mental illnesses, or others seeking health care services for which no public queue exists.

In assessing the ultimate impact of the *Auton* decision, it must be noted that Michelle Dawson, an autistic woman who intervened before the Supreme Court of Canada in the case, takes a different view of the *Charter* issues at stake and the significance of the Supreme Court's ruling that section 15 does not require government funding of autism treatment.¹⁸⁰ At the outset of her factum, Ms. Dawson provides the following overview of the arguments put forward by the parties and accepted by the lower courts in the case:

The judgments in the courts below, accepting the submissions of the two parties before them, present a unified view of untreated autistic individuals, who are described as hopeless, unable to communicate and to learn, and expensively doomed to isolation and institutionalization. Autistic individuals have in consequence been judged by the courts below to require 'medically necessary' early intensive behaviour intervention ... Under this treatment, success is considered to be achieved when the individuals lose their autistic nature

179 Martha Jackman, "Misdiagnosis or Cure? *Charter* Review of the Health Care System" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 65; see generally Kenny *supra* note 5.

180 See generally *Auton* (S.C.C.), *Factum of the Intervener, Michelle Dawson*, *supra* note 19; Dawson, "The Many Varieties," *supra* note 19; Dawson, "An Autistic Victory," *supra* note 19.

and traits, and become, or appear to become, indistinguishable from non-autistic Canadians. The *Charter* does not exist to promote these stereotypes and prejudices ...¹⁸¹

In her subsequent evaluation of the Supreme Court's decision in *Auton*, Ms. Dawson underscores the fact that, while the Court made significant errors in reviewing the evidence presented by the parties and accepted by the trial judge in *Auton*, Chief Justice McLachlin did identify ABA/IBI as an 'emergent', 'novel' and 'controversial' treatment.¹⁸² As the Chief Justice noted it in her judgment: "Applied Behavioural Analysis ... therapy is not uncontroversial. Objections range from its reliance in its early years on crude and arguably painful stimuli, to its goal of changing the child's mind and personality. Indeed one of the interveners in this appeal, herself an autistic person, argues against the therapy."¹⁸³ In contrast to *Auton's* many critics, Ms. Dawson characterizes the Supreme Court's rejection of the petitioners' claim that intensive behavioural autism treatment must be provided as a matter of *Charter* right as a "singular unprecedented victory" for autistics in particular, and for people with disabilities generally.¹⁸⁴ As she concludes: "We are protected when caution is shown in examining promises that unwanted differences, and unwanted people, can be altered, restricted, or eliminated to the great benefit of society as a whole."¹⁸⁵

In a 2003 case comment on the lower court rulings in *Auton*, Donna Greschner and Steven Lewis are also highly critical of both the evidence and the lower courts' reasoning in the case.¹⁸⁶ Professors Greschner and Lewis note that, rather than relying on independent scientific studies of intensive autism treatment, the only apparent basis for the trial judge's finding that the treatment improved the condition of the four infant petitioners receiving it was anecdotal evidence contained in affidavits provided by their parents, who were themselves parties to the litigation.¹⁸⁷ The trial judge did not assess the effectiveness rate of intensive autism treatment generally, nor did she compare the effectiveness of intensive autism treatment to other possible

181 *Auton* (S.C.C.), *Factum of the Intervener, Michelle Dawson, ibid.* at paras 3-5.

182 Greschner & Lewis, *supra* note 156 at 515.

183 *Auton* (S.C.C.), *supra* note 17 at para. 5.

184 Dawson, "An Autistic Victory", *supra* note 19 at para. 120.

185 *Ibid.* at para. 67.

186 Greschner & Lewis, *supra* note 156 at 501.

187 *Ibid.* at 517-518. See also Dawson, "An Autistic Victory", *supra* note 19.

therapies, pointing simply to the fact that the treatment was being funded in other provinces.¹⁸⁸ As Professors Greschner and Lewis assert:

If the objective is a better health care system for everyone, courts should not blithely accept the mere fact of funding programs in other provinces as conclusive evidence that a treatment is cost-effective. Many programs are introduced for various political reasons, and their effectiveness may not withstand close scrutiny. Indeed, according to one Canadian expert ... treatment for autism falls into this category.¹⁸⁹

Professors Greschner and Lewis are also critical of the lower courts' legal analysis in *Auton*. In arguing that the trial and appellate courts failed to properly appreciate the scope and limits of the publicly funded system, and thereby erred in applying section 15 to the facts of the case, they draw the same distinction between the *Canada Health Act* principles of universality and comprehensiveness as does Chief Justice McLachlin in her subsequent judgment in *Auton*. In their view:

... this litigation does not engage the principle of universality ... British Columbia's program meets this criterion, as ... children with autism are entitled to all insured services in the same manner as other residents. Rather, since the plaintiffs were asking for IBI to be funded by the government, thus in effect seeking expansion of insured health services, they were invoking the principle of comprehensiveness...if the courts had viewed the litigation through the lens of comprehensiveness, they would have seen the petitioners, not standing alone outside of medicare's protection, but jostling with numerous other groups of patients pressing for expansion of insured services.¹⁹⁰

As the preceding section of the paper details, problems relating to the universality of the medicare system, such as variations in access to medical specialists based on socio-economic status; barriers to care faced by Aborigi-

188 Greschner & Lewis, *ibid.* at 518-519.

189 *Ibid.* at 519. For a discussion of this aspect of the *Auton* decision, see Christopher P. Manfredi & Antonia Maioni, "Reversal of Fortune: Litigating Health Care Reform in *Auton v. British Columbia*" (2005) 29 Sup. Ct. L. Rev. (2d) 111.

190 Greschner & Lewis, *ibid.* at 514-515.

nal people living on and off-reserve; and the discriminatory restrictions on abortion services that persist, have indeed gotten worse in the twenty-years since the *Mortgentaler* decision. This raises serious legal and health policy issues that must be addressed. However, it is also clear that systemic gaps in the comprehensiveness of the health care system, especially for people living in poverty who cannot afford, and for people with disabilities who cannot obtain, private insurance or care, raise equally significant concerns. Professors Greschner and Lewis are correct to insist that, given the complexity of the issues engaged and the potentially negative impact of judicial decisions on the publicly funded health care system, *Charter* review in this area must be evidence-based, under section 15 as well as under section 1.¹⁹¹ It is difficult to dispute their conclusion that *Auton* represents a signal failure in this regard, this quite apart from the more fundamental questions raised by Michelle Dawson about how the evidence around autism as a 'condition' to be 'treated' and 'cured' was dealt with by the courts at every level in the *Auton* case.¹⁹²

191 Professors Greschner and Lewis propose the following criteria in this regard: "When courts approach claims for expanding the scope of insured health services, their findings of discrimination need to incorporate more clearly several vital aspects about medical treatments. In deciding to fund treatments, officials in the health system apply, or should apply, three tests: a) is there a need?; b) is the need addressable by therapies that are known to be within the usual bounds of effectiveness?; and c) is the cost of those therapies acceptable?" *Ibid.* at 521; see also Keith Syrett, "Priority Setting and Public Law: Potential Realised or Unfulfilled?" (2006) 7 *Medical Law International* 265; Greschner, *supra* note 156 at 42; Charles J. Wright, "Different Interpretations of 'Evidence' and Implications for the Canadian Health Care System" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 220; but see Pat Armstrong, "Evidence-Based Health-Care Reform: Women's Issues" in Pat Armstrong, Hugh Armstrong & David Coburn, eds., *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada* (Toronto: Oxford University Press, 2001) 121.

192 Dawson, "An Autistic Victory", *supra* note 19. In considering the broader implications of the *Auton* case from a disability rights perspective, Peter Carver has suggested that the way the case was framed illustrates the particular difficulty of understanding what discrimination based on disability means in the health care context. As Professor Carver explains:

A major contribution of the social model of disability is to stress the human rights dimension of the allocation of public goods and opportuni-

Whatever the distinct challenges presented by the facts of the *Auton* case, however, it remains that the distinction the Chief Justice draws in *Auton*, between the universality and the comprehensiveness of the health care system, is neither defensible as a matter of *Charter* equality analysis nor, as I have attempted to demonstrate above, convincing as a matter of health policy. Why should the fact that ‘non-core’ services are excluded from public funding by design preclude a finding that this ‘anticipated feature’ of the system is discriminatory based on disability, poverty, gender or other grounds. And, even if it is true that “every medicare system must have a method of distinguishing between those health services provided at public expense, and those that it leaves to an individual’s own resources to finance,”¹⁹³ what justification is there for drawing the line where it is beyond the fact that this is what Canadian governments agreed to when the medicare system was first put in place?

As I have argued above, only by limiting the scope of the *Charter*’s equality guarantee to one that “persons who are similarly situated be similarly treated”¹⁹⁴ can the rationale for the current funding choices under the Canadian medicare system be considered legitimate and constitutionally acceptable under section 15: a distinction between the services and providers that

ties. Recognizing quality health care as a public good of great value in Canada, social model theory would insist that it be distributed fairly and without discrimination based on disability. With a claim of discrimination going to the availability of treatment for disability, however, things get more complicated. The purported value of the therapy takes centre stage. Medicine’s proper concern with alleviating the impairments of disability (also the concern, of course, of families with disabilities) seems to overtake what the social model views as the proper concern of human rights law – respect for the equal worth of the person with a disability.

See Carver, *supra* note 170; see also Devlin & Pothier, *supra* note 170; Margot Finley, “Limiting Section 15(1) in the Health Care Context: The Impact of *Auton v. British Columbia*” (2005) 63 U.T. Fac. L. Rev. 213 at 233-36; Ena Chadha & C. Tess Sheldon, “Promoting Equality: Economic and Social Rights for Persons With Disabilities Under Section 15” (2004) 16 N.J.C.L. 27 .

193 Greschner & Lewis, *supra* note 156 at 515.

194 *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, 56 D.L.R. (4th) 1 at 161 [*Andrews* cited to S.C.R.], per McIntyre J., citing McLachlin J.A.’s judgment for the Court of Appeal in *Andrews v. Law Society of British Columbia* (1986), 27 D.L.R. (4th) 600 (B.C.C.A.) at 605.

have always been “in” and those that have not.¹⁹⁵ In justifying her decision in *Auton*, Chief Justice McLachlin questioned the “consequences to the legislative scheme of obliging provinces to provide non-core medical services required by disabled persons and people associated with other enumerated and analogous grounds, like gender and age.”¹⁹⁶ As Colleen Flood and Michelle Zimmerman have argued, if the Supreme Court was indeed preoccupied by the financial or health policy implications of a substantive equality rights analysis on the specific facts of the *Auton* case, or by the broader issues of institutional competence or legitimacy that are raised by *Charter* review in this area, these concerns could and should have been addressed directly by the Court, under section 1.¹⁹⁷

In its landmark 1964 report¹⁹⁸ the Royal Commission on Health Services recommended that a national medicare system be put in place in Canada that would include public funding not only for medical services, but for dental care,¹⁹⁹ prescription drugs, optical services,²⁰⁰ prosthetics, and home care.²⁰¹

195 Flood, Stabile & Tuohy, *supra* note 70; Carolyn Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (New York: Oxford University Press, 1999).

196 *Auton* (S.C.C.), *supra* note 17 at para. 56.

197 Colleen M. Flood & Michelle Zimmerman, “Judicious Choices: Health Care Resource Decisions and the Supreme Court of Canada” in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 25 at 45-51. See also Commission on the Future of Health Care in Canada *Implications*, *supra* note 10 at 17-19; Commission on the Future of Health Care in Canada, *How*, *supra* note 10 at 14-16; Christopher Brecht & Adam Dodek, “The Increasing Irrelevance of Section 1 of the Charter” (2001) 14 Sup. Ct. L. Rev 175; Jane Bailey & Carissima Mathen, “Constitutional Advancement and Women’s E-Quality: Responding to Challenges and Seizing Opportunities” (2005) 30 Queen’s L.J. 660.

198 *Royal Commission on Health Services*, vols. I and II (Ottawa: Queen’s Printer, 1964-1965) [Hall Commission].

199 The Hall Commission recommended that dental services be funded for children, expectant mothers, and social assistance recipients. *Ibid.* at 19.

200 The Hall Commission recommended that optical services be funded for children and social assistance recipients. *Ibid.*

201 The Hall Commission further recommended that the order of priority and timing of the introduction of these health services would be determined by each province; see generally Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and*

Over forty years later, the full promise of medicare as it was envisioned by Tommy Douglas and Emmett Hall remains unfulfilled.²⁰² As the Romanow Commission and other health policy experts have long argued, the continuing under-inclusiveness of medicare in areas such as mental health, prescription drugs and long term care needs to be scrutinized because it compromises the overall effectiveness of the health care system. More importantly however, the lack of comprehensiveness of medicare must be challenged because it undermines the *Charter's* promise of substantive rather than merely formal equality – this in the context of the one social program that Canadians continue to define as a “right of citizenship.”²⁰³

Dr. Nuala Kenny has warned that: “The goal of equity in health care requires that we think carefully about more than just getting more money into acute care. It requires a reflection on the implications of the rising social inequity in Canadian society and its implications for health and well-being.”²⁰⁴ In the *Chaoulli* case, a majority of the Supreme Court of Canada showed a singular lack of regard for the implications of its conception of the *Charter* right to health for those who live that inequality every day: individuals and families who lack the “resources to finance”²⁰⁵ private care.²⁰⁶ Unfortunately, insofar as the systemically discriminatory impacts of current gaps within the publicly funded health care system are concerned, adherence to the vision of equality accepted by the Court in *Auton* is unlikely to provide a much needed cure.

Their Outcomes, 2^d ed. (Kingston/Montreal: McGill-Queen’s University Press, 1987) at 344-347.

202 Rachlis, *supra* note 177; Ann Silversides, *Conversations With Champions of Medicare* (Ottawa: Canadian Federation of Nurses Unions, 2007) at 25-32, 49-56, 94-96.

203 Romanow Commission, *supra* note 1 at xvi.

204 Kenny, *supra* note 5 at 182; Commission on the Future of Health Care in Canada, *Discussion Paper No. 3: Creating a More Democratic Health System: A Critical Review of Constraints and a New Approach to Health Restructuring* by Stephen Tomblin (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/3_Tomblin_E.pdf>.

205 Greschner & Lewis, *supra* note 156 at 515.

206 Jackman, “The Last Line,” *supra* note 20; Andrew Petter, “Wealthcare: The Politics of the Charter Revisited” in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access To Care: Access To Justice – The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 116.

