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File Number: 29508

IN THE SUPREME COURT OF CANADA
(On Appeal from the Court of Appeal of British Columbia)

B E T W E E N :

THE ATTORNEY GENERAL OF BRITISH COLUMBIA and
THE MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

Appellants
(Respondents
on Cross-Appeal)

and

CONNOR AUTON, an Infant, by his Guardian Ad Litem, MICHELLE AUTON, and the said MICHELLE AUTON, in her personal capacity, MICHELLE TAMIR, an Infant, by her Guardian Ad Litem, SABRINA FREEMAN, and the said SABRINA FREEMAN in her personal capacity, JORDAN LEFAIVRE, an Infant, by his Guardian Ad Litem, LEIGHTON LEFAIVRE in his personal capacity, RUSSELL GORDON PEARCE, an Infant, by his Guardian Ad Litem, JANET GORDON PEARCE, and the said JANET GORDEN PEARCE in her personal capacity

Respondents
(Appellants
on Cross-Appeal)

FACTUM OF THE ATTORNEY GENERAL OF ONTARIO
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Overview of Ontario's Position

1. Health insurance legislation across Canada provides funding for the medically necessary services provided by hospitals and physicians. As a matter of policy, Ontario, like every other province in Canada, does not provide universal or comprehensive funding for the services of any health care professional other than physicians. Ontario, like every other province in Canada, does not provide universal or comprehensive funding for the services of pharmacists, psychologists, opticians, audiologists, nurses, etc. This appeal raises the issue of whether the Charter of Rights and Freedoms requires the expansion of health insurance legislation to include every service, treatment or program which may ameliorate an illness or medical condition. It is Ontario's position that the Charter does not require such an expansion, and that such an interpretation of the Charter would result in a massive expansion of publicly funded health care in Canada that would not be sustainable.

2. It is estimated that in Canada today 70% of health services are publicly funded. Significant components of health care – such as most drugs and home-based health care – are not publicly funded. Whether, and to what extent, public funding should be expanded, and how limited public dollars can be most efficiently and effectively spent, is a complex question of public policy. The polycentricity of these issues is exemplified by the recent Report of the Commission on the Future of Health Care in Canada (*Romanow Commission Report*) and the Senate Report on the State of the Health Care System in Canada (*Kirby Report*) which examined the entire health care system in Canada, and made recommendations for reform. Neither of these reports recommends an expansion of the health care system to include the behavioural interventions at issue in this case.

> Commission on the Future of Health Care in Canada, *Building on Values, The Future of Health Care in Canada Final Report,* November 2002 ("*Romanow Commission Report*")
> Standing Senate Committee on Social Affairs, Science and Technology – *The Health of Canadians – The Federal Role*, Volumes 4 & 5: *Principles and Recommendations for Reform* (*Kirby Report*), 2001, 2002

3. The governments of Canada have established a clear, principled policy to provide universal, comprehensive health insurance only for hospital and physician services[1]. The British Columbia courts have redrawn that boundary by replacing it with a vague standard, without any real consideration of the potential scope, costs and implications of its decision for health care policy at large.

4. The striking feature of this case is that the British Columbia courts have decided to expand the scope of publicly funded health care in the context of an intervention which is neither medical nor delivered by health care professionals. While Lovaas Autism Treatment may be effective for developing skills for many children with autism, and may even result in substantial developmental gains for some children with autism, it is not a medical intervention.

5. The British Columbia Supreme Court concluded that a "medically necessary service" should be defined as "whatever cures or ameliorates illness" (at para.102) and determined that "the primary objective of the medicare legislation . . . is to provide universal health care" (at para. 151). This conclusion confused the principles of "universality" and "comprehensiveness", and represents an unwarranted overstatement of the purpose of health insurance legislation in Canada. By overstating the objective of the law, the British Columbia courts make a violation of s.15 of the Charter and the inability to justify the violation under s.1 a tautological inevitability.

> *Appellants' Record,* Vol. I, pp. 106, 126, Reasons for Judgment, Allan J., Supreme Court of British Columbia

6. In 2000 the Ontario government established an Intensive Early Intervention Program (IEIP) to deliver Intensive Behaviour Intervention (IBI) to children with autism under age 6. IBI, like Lovaas Autism Treatment, is an intensive, early, behavioural intervention for children with autism which uses techniques of applied behaviour analysis (ABA). Since the establishment of the IEIP, the Ontario government has continued to build the capacity of the program in an effort to serve all eligible children. Notwithstanding Ontario's policy decision to publicly fund an IBI program, Ontario intervenes in this case in support of the position of the Attorney General of British

[1] The limited coverage extended to other practitioner services in Ontario is set out at paras.15 to 17.

Columbia because of the serious ramifications of the British Columbia courts' decision on the ability of the provincial governments to allocate finite resources where there is infinite need. As Justice Bastarache recognized in *M. v. H.* "[c]ourts are simply ill-suited to manage holistic policy reform". The lower court's expansion of "health care" coverage effectively invalidated key principles in the current health insurance regime and is such an example of holistic policy reform in the guise of judicial review.

> *Appellants' Appeal Record*, Vol XXIV, p. 4560, 4568 Ex. S to the Affidavit of B. Von Krosigk, (*Ontario Request for Proposals (RFP) for Regional Intensive Early Intervention Program for Children with Autism (Dec. 1999), and Preliminary Program Guidelines)*
> *Appellants' Appeal Record*, Vol. I, pp. 77-78, Reasons for Judgment, Allan J., S.C.B.C., July 26, 2000, para. 28
> *M v. H.*, [1999] 2 S.C.R. 3 at para. 310, (per Bastarache J.)

PART I
STATEMENT OF FACTS

7. The Attorney General of Ontario accepts as correct the facts set out in paragraphs 1-32 of the Appellants' factum. The Attorney General relies on the following additional facts:

A. Provincial Health Insurance

8. Health care is, for the most part, a provincial responsibility. Government policy decisions as to which health care services are to be funded, and under what conditions, limitations and in what amounts, are determined at the provincial level, influenced by the *Canada Health Act* ("*CHA*"), and may vary from province to province. However, as a result of the *CHA*, a significant degree of inter-provincial consistency is maintained with respect to the funding of physician and hospital services.

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

9. Section 7 of the *Canada Health Act* provides that in order to qualify for a full cash contribution for a fiscal year from the federal government, the health care insurance plan of a province must satisfy 5 criteria (public administration, comprehensiveness, universality, portability and accessibility) and must not permit user fees or extra billing.

Canada Health Act, *supra*, s. 7

10. Section 9 of the *CHA* states "in order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners [ie. physicians] or dentists [for in-hospital dental surgery], and where the law of the province so permits, similar or additional services rendered by other health care practitioners." The term "insured health services" is defined in section 2 as "hospital services, physician services and surgical-dental services provided to insured persons." Thus, the *CHA* does not require as a condition of federal funding that provinces provide funding for any non-physician health practitioners (i.e. physiotherapists, pharmacists, dentists (except for in-hospital dental surgery), chiropractors, psychologists, audiologists, etc.) outside of hospital. The *CHA* provides no definition of the terms "medically necessary" or "medically required".

Canada Health Act, *supra*, ss.1, 5 and 9

11. In 2000/01, Ontario spent approximately $23.9 billion annually on health care, amounting to approximately 45% of the 2001 Ontario Budget. The major components of health care spending in 2001 were:

- $13 billion for integrated health services provided by hospitals and long-term care facilities;
- $6 billion on Ontario Health Insurance (OHIP);
- $4 billion on other services, including drugs and laboratory costs

Shulman v. Ontario, [2001] O.J. No. 5057 at para. 3 (Ont. S.C.J. Div. Ct.)

12. OHIP is a provincial health care plan available to residents of Ontario and administered by the Ministry of Health and Long-Term Care. Services available through OHIP are provided to insured persons without charge and without regard to pre-existing medical conditions. The services include medically necessary physician services, in-patient and out-patient services provided by public hospitals, limited drug and home care

costs, and limited costs associated with other health care services, as described in further detail below.

Shulman, supra, at para. 2

B. Schedule of Benefits for Physician Services

13. In accordance with the *Health Insurance Act*, every insured person is entitled to payment for prescribed medically necessary services provided by physicians.

Health Insurance Act, R.S.O. 1990, c. E-6, s.11.2(1) para. 2 and s.12(1)

14. Insured services provided by physicians in Ontario are prescribed in a Schedule to Regulation 552 under the *Health Insurance Act*. The Schedule is referred to as the "Schedule of Benefits for Physician Services" ("SOB-PS") The SOB-PS lists a description of the insured service, the amount payable, a code for the service, and any rule or policies applicable to the payment for services. It includes approximately 4,800 insured physician services. The amount payable is not determined by the physician – it is set by the province "to enable the government to maintain some control over its OHIP budget" and physicians are prohibited from charging patients more than the amount set out in the SOB-PS.

Health Insurance Act, s. 17.1, 15(3)
Health Insurance Act Regulations, R.R.O. Reg 552, s. 1, 37.1(1) and (2)
Health Care Accessibility Act, R.S.O. 1990, c.H. 3, s.2(1)
Shulman, supra, at para. 2

C. OHIP Insured Practitioner Services

15. As a matter of policy, Ontario, like every other province in Canada, does not provide universal or comprehensive funding for the services of any health care professional other than physicians. Ontario does not provide universal and comprehensive funding for the services of psychologists, nurses, nurse practitioners, chiropractors, midwives, dieticians, dentists, opticians or pharmacists outside of hospitals.

Shulman, supra, at paras. 2, 17

16. OHIP does, however, provide funding or partial funding for certain practitioner services under very limited conditions. Only the following six health professions receive funding on a fee for service basis under OHIP: dentists, chiropractors, podiatrists, osteopaths, physiotherapists (through Schedule 5 facilities) and optometrists. The limitations imposed on payment for these services vary. For example, only the surgical services of dentists that are required to be rendered in hospital are funded on the basis of a set schedule of fees. The amount payable for a chiropractor's service is only a fraction of the amount that may be charged to the patient by a chiropractor. Only physiotherapy services that are provided in one of 103 prescribed physiotherapy facilities are paid for on a fee for service basis and in accordance with a predetermined and set schedule of fees. Optometrists are paid for only one insured eye examination every 2 years for most adults.

Health Insurance Act, s.11.2(1) paras. 1 and 3
O.Reg. 552, s.16 (dentists), 17 (optometrists), 18 (chiropractors), 19 (osteopaths), 20 (podiatry) and s. 21 (Schedule 5 physiotherapy facilities)

17. There are currently 23 regulated health professions in Ontario as defined in the *Regulated Health Professions Act (RHPA)*. OHIP funding outside hospitals has been provided only to physicians and the 6 others identified above.

Regulated Health Professions Act, S.O. 1991, c. 18, s. 27 and Schedule 1
Health Insurance Act, s.11.2(1) para.2

D. Romanow Commission Report

18. The federal government established the Commission on the Future of Health Care in Canada to examine "the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term sustainability of a universally accessible, publicly funded health system . . .". The Commission's Report "Building on Values, The Future of Health Care in Canada" (the *Romanow Commission Report*) was released in November, 2002, and proposed a number of recommendations regarding health care reform. These recommendations have given rise to much political debate and public discussion.

Romanow Commission Report, supra

19. According to the *Romanow Commission Report*, approximately 70% of health care in Canada is publicly funded. Private services amounted to just over $33 billion in 2001/02, which was 32.4% of total health care expenditures.

Romanow Commission Report, *supra* at pp. 5, 27

20. The *Romanow Commission Report* recognized that the "principle of comprehensiveness" in the *Canada Health Act* "has been limited to 'insured medical services' defined as medically necessary hospital and physician services (including dental surgery services performed in hospitals)". The Report recognized that it is not financially possible for government to fund all health services:

> This gap exists in the first place because of **the impossibility of the public purse covering all health services immediately. Financial probity requires that services be added as fiscal resources permit.** Public coverage in Canada began with hospitals in the 1950s and physician services in the 1960s. Each new step has been preceded by much discussion concerning the public resources required to fund such services. (emphasis added)[2]

Romanow Commission Report, *supra* at pp.62, 63

21. Accordingly, the *Romanow Commission Report* proposed that "the definition of comprehensive (and of services insured under provincial plans) should continue to evolve to improve the continuum of care" with the important caveat that evolution should occur "as financial resources permit" (p. 62). Although Romanow thought that the *Canada Health Act* should eventually be expanded to include all home care services, he recognized "the significant costs that would be involved in including all home care services under the *Canada Health Act*" (p. 172). Accordingly, Romanow limited his recommendation to the immediate inclusion of medically necessary home care services in the areas of home mental health case management and intervention, post acute home care

[2] Romanow made similar conclusions with regard to the potential coverage of prescription drugs. He said "Given the expanding role of prescription drugs in Canada's health care system, a strong case can be made that prescription drugs are just as medically necessary as hospital or physician services . . . . However, the immediate integration of all prescription drugs into a revised *Canada Health Act* has significant implications, not the least of which would be substantial costs" (emphasis added) (at p. 190)

and home palliative care (recommendation #34). None of these services would encompass the Lovaas Autism Treatment sought by the Respondents in this case.

Romanow Commission Report, *supra* at pp. 62-63, 172, 179

E. Ontario's Intensive Early Intervention Program for Children with Autism

22. In the spring of 1999, the Ontario government announced funding for a new program for intensive early intervention services for young children (to age 6) with autism. This program (the IEIP) is based on research which indicates that with intensive behavioural intervention (IBI), children with autism can make a significant gains in their early years. This research indicates that to achieve these results, services must:

i) begin early (before age 5),
ii) be intensive (20-40 hours per week) and
iii) be provided by well trained therapists.

*Appellants' Appeal Record,*Vol. XXIV, pp. 4533. 4543-5. 4547, 4560-4576

23. IBI is not provided by physicians or in hospitals. It is provided by instructor-therapists who are generally community college or university undergraduates in a related field. They are supervised by a senior therapist who has or is working towards a master's level graduate degree in psychology or related field. The senior therapist, in turn, is supervised by a psychologist. Neither IBI instructor-therapists nor senior therapists are regulated health care professionals in Ontario, and there is no legislation regulating their professional qualifications anywhere in Canada.[3] Since IBI is relatively new, there is a shortage of trained therapists available to provide IBI and of psychologists to supervise.

Appellants' Appeal Record, Vol. XXIV, pp. 4545, 4572 – 4573

24. While the exact numbers of children with autism in Ontario is not known, it was estimated that between 1 and 2 per 1000 would qualify for the IEIP. Given a total

[3] The IBI therapists in the studies relied upon by the Respondents were "undergraduate and graduate students earning course credit" or "teacher aides working in the public school". *Appellants Appeal Record*, Vol. X, p.1750, Ex. E to the Affidavit of Tristam H. Smith. The Respondent's expert indicated that guidelines for qualifications for directors of ABA programs for children with autism indicate "that directors should have a masters or doctoral degree with a specialty in behaviour analysis"**.** *Appellants Appeal Record,* Vol. XI, p.1986-7, Ex. A to the Affidavit of Tristam H. Smith (emphasis added)

population of 607,302 children between ages 2-5, this would mean approximately 600-1,200 children (or approximately 150-300 children per age cohort) would be eligible for the IEIP. Given the intensive nature of this program (1:1 therapy for 20-40 hours per week) this program would require at least one full-time therapist per child.

Appellants' Appeal Record, Vol. XXIV, pp. 4547, 4557, 4568, 4570

25. In establishing the IEIP, the government of Ontario was faced with several significant policy issues relating to design, capacity building, and implementation of this new program. These issues included:

i) Given the shortage of trained therapists, the recruitment and training of staff to serve as instructor therapists and senior therapists to develop the capacity to deliver services in regions across the province.

ii) Given the shortage of qualified psychologists, the recruitment of qualified psychologists to act as Clinical Directors to monitor the IBI program as well as oversee the assessment of individual service plans.

iii) The establishment of standards and qualifications for therapists (none previously existed in Canada). In the context of pressure to provide these services, there was a possibility of poorly trained and unsupervised therapists exploiting families financially and otherwise.

iv) The choice of funding models – direct funding to families to permit families to hire their own service providers, or the establishment of public agencies to hire service providers and provide services to families, or some combination of these models.

v) Prioritization of services or funding if program capacity were insufficient to meet the full demand. This was a particularly important issue given evidence that IBI is most effective if commenced as early as possible after diagnosis, and preferably before age 5.

vi) Given the uncertainties in the research literature, the establishment of criteria for eligibility, discharge, intensity (number of hours per week) and duration (length of service).

Appellants' Appeal Record, Vol. XXIV, pp. 4561-4563, 4568-4570, 4571-4572, 4581
Appellants' Appeal Record, Vol. XVII, pp. 3111-3112, 3113, Ex.B to the Affidavit of Frank Gresham
Appellants' Appeal Record, Vol. X, p.1733, Ex. C to the Affidavit of Tristam H. Smith
Appellants' Appeal Record, Vol. X, pp. 1681-1682, Ex. C to the Affidavit of Sabrina Freeman
Appellants' Appeal Record, Vol. X, p. 1717, Ex. A to the Affidavit of Tristam H. Smith

26. In addition, the government had to establish a budget for this new program, and weigh each of the policy issues listed above against the reality that every government program has a finite budget which limits the scope and capacity of the program. Every government program, be it health, education or social services, could undoubtedly be improved or expanded if it had additional funding – but governments have finite resources and this necessarily influences the parameters of the final policy. There are no government programs with unlimited budgets.

Appellants' Appeal Record, Vol. XXIV, pp. 4557

Brown v. British Columbia (1994), 112 D.L.R. (4th) 1, at p. 15:
True policy decisions involve social, political and economic factors. In such decisions, the authority attempts to strike a balance between efficiency and thrift, in the context of planning and predetermining the boundaries of its undertakings and of their actual performance. True policy decisions will usually be dictated by financial, economic, social and political factors or constraints.

M. v. H., supra, at para. 329, (per Bastarache, J.):
The reasons for limitation do not always flow logically from the reasons for inclusion. For example, the scope of many acts granting financial benefits are circumscribed by a government's need to operate within fiscal constraints. Such a concern is usually totally separate and distinct from the reasons for granting a benefit in the first place.

27. These policy issues are not unique to the establishment of the IEIP. These factors are part of every health care, social services and education policy decision made by government. The *Romanow Commission Report* recognized these concerns in the context of health care (p.9):

The ability of health services to meet health needs is affected by the following factors:
- Limited fiscal resources to address the range of health needs;

- Limited physical resources, equipment and new technologies;
- Imbalance in the supply, distribution and scopes of practice of health care providers;
- Demographic, societal, and technological changes that make some services (e.g. prescription drugs and home care) more important than they were in the past; and
- Canadians' growing expectations that an increasing range of treatments will be provided within the public system.

Romanow Commission Report, supra at pp. 6, 9

28. The choice of funding models referred to at para. 25(iv) above raises the issue of public versus private sector service delivery and the relative efficiencies and benefits of each. The *Romanow Commission Report* recognized that "one of the most contentious issues facing Canadians is the extent to which the private sector should be involved in delivering health care services"(p.6).

Romanow Commission Report, supra at pp. 6, 9

29. Limited capacity results in waiting lists and the need to prioritize within a program. The *Romanow Commission Report* dealt extensively with issues relating to existing wait lists in health care and to the reduction and management of wait lists. These issues also raise complex policy questions, and waiting lists cannot be eliminated by judicial declaration.

Romanow Commission Report, supra at pp. 137, 157

30. Ontario's IEIP is not funded as an insured health service under the *Health Insurance Act*. It is a social service funded under the *Child and Family Services Act*. Services are generally provided by regional programs which are transfer payment agencies. The regional programs hire and train therapists and provide services directly to children. Families have an option of receiving direct funding from the regional programs to purchase their own services from private providers. Services are provided in the child's home, or in segregated centre-based programs.

Appellants' Appeal Record, Vol. XXIV, pp. 4545, 4570-4571

31. The IEIP was intended to address a gap in services by providing funding to build province-wide capacity to deliver high quality IBI services, integrated with existing service delivery programs. Ontario's IEIP is intended to provide IBI for children with autism or a disorder which would be considered toward the severe end of the Autism Spectrum Disorder. The services are primarily intended for children up to and including the age of 5, however children with autism who are between 5 and 6 years old when they enter the program are eligible to receive 12 months of service to help them make the transition to school-based programs. The transition to school based programs itself raises complex policy issues which are not before this Court.

Appellants' Appeal Record, Vol. XXIV, pp. 4561, 4564

32. The IEIP Guidelines make it clear that IBI is not a medical intervention. IBI services must use "systematic behavioural teaching methods to build up skills (including, when appropriate, discrete trial teaching in one-to-one structured programming using techniques of applied behaviour analysis such as positive reinforcement, task analysis, modeling, and prompting)" and other systematic methods "such as small group instruction, activity based learning, and capitalize on naturalistic teaching opportunities" and should include "planning for generalization, independence, and flexibility in children's behaviour and skills as well as teaching functional, relevant skills they will need in natural settings". IBI services should "use a curriculum which is comprehensive in scope (i.e., it provides teaching in all areas including social, play, cognitive, language, self-help, and so on) and is developmental in sequence" and uses "an ethically sound, positive programming approach to treat any serious problematic behaviours".

Appellants' Appeal Record, Vol. XXIV, pp. 4568-9

33. The number of hours of intensive behavioural intervention shown by research to be effective ranges from 20 to 40 hours per week in different studies. Within this range, the limited research available does not demonstrate any clear relationship between the amount of intervention and the child's outcome. Similarly, research studies documenting good outcomes for children involved in intensive early behavioural intervention have

typically been based on programs which lasted one to two years, with the most compelling long-term outcome data from programs that lasted two years or longer.

> *Appellants' Appeal Record,* Vol. XXIV, pp. 4570-4571
> *Appellants' Appeal Record,* Vol. XI, p. 1986, Ex. A to the Affidavit of Tristam H. Smith

34. These research studies are based on small, tightly controlled university-based programs where staff are highly trained. It is a significant challenge for any jurisdiction to attempt to create a province wide program for 600-1,200 children and maintain the quality control of the small university-based research programs. The time and resources necessary for any province to introduce and build the capacity of such a new public program should not be ignored nor underestimated.

> *Appellants' Appeal Record,* Vol. X, p. 1722, Ex. C. to the Affidavit of Tristam H. Smith
> *Appellants' Appeal Record,* Vol. IX, pp. 1627 – 1643, Ex. C to the Affidavit of Philip S. Strain

35. The age limit in Ontario's IEIP is the subject of several legal proceedings and has been considered in the context of several interlocutory injunctions.

> *Clough v. Ontario*, [2003], O.J. No. 1074
> *Lowrey v. Ontario* (2003), 64 O.R. (3d) 222 (leave to appeal refused [2003] O.J. No. 2009)
> *Burrows v. Ontario* (unreported, Oct. 20, 2003, Backhouse J.)
> *Burrows v. Ontario* (leave to appeal granted, Epstein J., Jan. 5. 2004, unreported)
> *Juravsky v. Ontario* (unreported, Dec. 1, 2003, Sachs J.)
> *Wynberg v. Ontario* (unreported, March 12, 2004, Kiteley J.)

PART II

ISSUES ON APPEAL

36. The Attorney General of Ontario's position is that the definitions of "benefits" and "health care practitioners" in s.1 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286, and ss. 17-29 of the M*edical and Health Care Services Regulation*, B.C. Reg. 426/97 do not infringe either s.15 or s.7 of the Charter. The Attorney General of Ontario's submissions will be restricted to Charter s. 15.

37. In the alternative, any infringement is justified under Charter s.1.

38. The Attorney General of Ontario also supports the position of the Attorney General of British Columbia with respect to the remedial issues raised in this appeal.

PART III
ARGUMENT

i) Charter s. 15 Overview

39. Section 15 of the Charter authorizes courts to invalidate discriminatory limitations on existing government programs, and to ensure that all individuals have access to existing programs without barriers based on enumerated or analogous grounds of discrimination. It does not authorize courts to create entirely new government programs.

40. Section 15 may require the expenditure of public funds to ensure that protected groups have equal access to existing medical programs. For example, in *Eldridge v. British Columbia (Attorney General),* this Court held that the province must pay for sign language interpretation in hospitals since it was necessary to ensure "effective communication" between deaf persons and their doctors, without which deaf persons would have no meaningful access to existing medical services. However, the holding in *Eldridge* is based on the finding that effective communication is integral to the provision of medical services. The Court specifically stated that its decision would not lead to governments being forced "to spend precious health care dollars accommodating the needs of myriad disadvantaged persons" and noted that having the government provide disabled persons with **"a discrete service or product, such as hearing aids, that will help alleviate their general disadvantage"** was not at issue –

> [The] claim is not for a benefit that the government, in the exercise of its discretion to allocate resources to address various social problems, has chosen not to provide. **On the contrary, they ask only for equal access to services that are available to all.**
>
> *Eldridge v. British Columbia (Attorney General],* [1997] 3 S.C.R. 624 at para. 91-2
> *Adler, supra* at p. 649

ii) IBI is not a Medical or Health Care Service

41. Unlike *Eldridge*, this case does not involve determining whether special accommodation is necessary to ensure that children with autism can benefit equally from existing medical services. This case seeks to require government to fund an entirely new service that is outside the parameters of the kinds of services funded by the existing health care system.

42. It is submitted that the courts below erred in finding that IBI is a "medically necessary" service. IBI services are more properly characterized as a non-medical intervention which uses psychological principles (operant conditioning and behaviour modification) to build skills and promote joint attention, social interaction and intentional communication. The Respondent's expert (Tristam H. Smith) states that IBI emphasizes "the implementation of experimentally validated teaching approaches" (p. 1750 of Appellants' Record) and "empirically supported teaching approaches". (p.1986 of Appellants' Record). As indicated above, IBI is not provided by physicians or in hospitals, and IBI instructor-therapists are not regulated health care professionals.

> *Appellants' Record,*Vol. XVII, pp. 3099. 3115-3116, 3125, Ex. C to the Affidavit of Frank Gresham
> *Appellants' Record,* Vol. IX, pp.1634 – 1638, Ex. C to the Affidavit of Phillip S. Strain
> *Appellants' Record,* Vol. X, p. 1714, 1730, 1750, Exs. A, C and E to the Affidavit of Tristam H. Smith
> *Appellants' Record,* Vol. XI, p. 1986, Ex. A to the Affidavit of Tristam H. Smith
> See also paras 23 and 32, *supra*

43. The determination of whether IBI is actually a medical, educational or social service must be made before a proper comparator group can be identified and is thus critical to the s.15 analysis. Greschner and Lewis emphasize the importance of this point as follows:

> To illustrate, if IBI is seen as medical treatment, then the petitioner's claim for funding is compared against the funding given to other patients. The health care system is by common understanding Canada's most valued social program and as a consequence is very generously funded…By

> contrast, if the service is classified as educational, then the plaintiffs' treatment is compared to that of other pupils. Public education is not quite so richly endowed. It is only universal for people between the ages of five and nineteen; teachers are employees, not paid on a fee-for-service basis; and a host of educational programs that would dramatically benefit children are offered sporadically, if at all. An even smaller share of public resources is usually directed toward social services; moreover, its standards for entitlement are much stiffer, and the range of competing needs is even more basic…
>
> D. Greschner and S. Lewis, "Auton and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82 Can. B.R. 501 at 517
> *Granovsky v. Canada, [2000] 1 S.C.R. 703, at p. 729 – 730*

44. This is not a case like *Nova Scotia v. Martin* or *Vriend v. Alberta*, where the government established a benefit program, but excluded a group of persons identified by enumerated or analogous grounds from the benefit provided by that program. The plaintiffs in this case are not seeking access to medically necessary physician or hospital services. They seek a "discrete service or product" – in this case the services of an IBI therapist – "that will help alleviate their general disadvantage".

> *Eldridge, supra at 91-2*
> *Nova Scotia (Workers' Compensation Board) v. Martin, [2003] S.C.J. no. 54*
> *Vriend v. Alberta, [1998] 1 S.C.R. 493*

45. The establishment of such a discrete service directed at helping children with autism would qualify as an affirmative action program within the meaning of Charter s.15(2). Indeed, Ontario's IEIP for pre-school children with autism is an example of a special program which has no parallel or "comparator" in either the health care or education sector. As indicated at para. 30, supra, it is Ontario's position that the IEIP is a social service directed at pre-school age children.

> *Lovelace v. Ontario,* [2000] 1 S.C.R. 950

46. Even if autism is a "medical condition", this does not mean that every service required by children with autism is therefore a "medical service". Many developmental disabilities are the result of an underlying medical condition. This does not mean that every service directed at ameliorating such a condition is a medical service.

47. For example, the mere fact that a physician or psychologist may recommend a full time educational assistant for a special needs child does not transform the educational assistant into a "medically necessary" health care service. The British Columbia Court of Appeal's analysis and remedial order are based on the premise that any service or program recommended by a physician or psychologist qualifies as a "health" service even if the recommended service is not provided by a health care practitioner.

iii) Purpose of Health Insurance Legislation

48. The lower Courts erred in finding that the primary purpose of the British Columbia medicare legislation was to provide "universal" health care, and appear to have confused the concepts of universality and comprehensiveness as defined by the *Canada Health Act*. As a general proposition, the primary objective of provincial health care legislation is to provide medically necessary hospital and physician services to all residents in accordance with the requirements of the *Canada Health Act*. While some additional health care services may receive partial funding, the objective of health care legislation has never been to fund all health services. This is apparent from the statutory scheme taken as a whole and viewed in the context of the requirements of the *Canada Health Act* and the history of health insurance legislation in Canada. This is also apparent from the limited coverage for non-physician practitioner services provided in every province. By overstating the legislative objective, the Courts made a violation of s. 15 a tautological inevitability.

49. Both academic commentaries and courts have recognized this point. Greschner and Lewis note:

> The [*Auton*] judgments appear confused about which principle of the *CHA* and complementary provincial legislation was at play in the litigation…The Court of Appeal … describes the issue as the failure to provide treatment "in the context of a universal program". But this litigation does not engage the principle of universality. Under s.10 of the CHA, universality means that 100% of qualified provincial residents are entitled to receive insured health services. British Columbia's program

> meets this criterion, as its counsel pointed out in noting that 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. To put the matter another way, the case is about seeking a bigger share of the resource pie; it does not engage basic questions of citizenship, the fundamental value captured by the principle of universality…
>
> The principle of comprehensiveness has never meant coverage for every treatment or service that improves health. Since at least passage of the CHA, many beneficial and highly effective health services, such as prescription drugs have not been insured…Unless publicly funded health care has an unlimited budget, 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. In Canada, comprehensiveness, which means insured health services, has been generally demarcated in the CHA as medically necessary services that are delivered in a hospital by a physician.
>
> Greschner and Lewis, *supra* at 514-515

50. In *Shulman*, the Divisional Court of the Ontario Superior Court recognized this principle in dismissing a s.15 challenge to the Ontario government's decision to stop insuring the costs of hearing aid evaluations (which is not a physician service) and to attach conditions to the terms of payment to physicians for diagnostic hearing tests:

> The primary purpose of the Health Insurance Act is to ensure hospital and medically necessary physician services. The purpose of the SOB-PS is to define the vast array of medically necessary services and to set fair and reasonable compensation for these services, keeping in mind the budgetary restrictions affecting the government…
>
> 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 host of medical services not now insured.
>
> In the context of assessing whether the SOB-PS is discriminatory, the purpose must be defined more narrowly.

Shulman, supra, at paras. 26, 39, 40

iv) Exclusion of Non-physician Practitioner Services is Not Discriminatory

51. While IBI is delivered by instructor-therapists, it is generally "supervised" by a psychologist (PhD. or Masters level). Psychologists are not publicly funded health care professionals under provincial health insurance legislation (unless their services are provided in hospitals). However, as indicated at paras. 15-17, supra, psychologists are only one example of 16 regulated health professions that are not publicly funded. These health professions provide services to individuals with a wide range of illnesses and medical conditions. While health insurance legislation in Canada does draw a distinction between physicians and other health care professionals, it is submitted that restricting fee for service payments to physicians does not discriminate in the substantive sense.

52. The funding of physician, but not psychologist, services does not withhold benefits in a "manner which reflects the stereotypical application of presumed group or personal characteristics" of children with autism or have "the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being". The structure of the publicly funded Canadian health care system is based on a myriad of complex policy determinations which have evolved since the first funding of hospital services in the 1950's. The exclusion of psychologist services (among other health care professional services), when seen in the context of the Canadian health care system, cannot be viewed as discrimination as that term has been interpreted by this Court.

Law v. Canada (Minister of Employment and Immigration), [1999] 1 S.C.R. 497 *at para. 99*

53. Even if psychologist services were funded as an insured service, the services of IBI instructor-therapists and senior-therapists would not meet the delegation and supervision requirements which apply to physicians. While physicians can charge OHIP for some services delegated to a qualified health care employee, these services must meet

specific delegation and supervision requirements. The services provided by instructor-therapists do not meet these requirements because they are not members of a regulated health profession, do not perform IBI under the "direct supervision" of psychologists, are not employed by psychologists and the IBI services are not performed in the psychologist's office.

Shulman, supra at para. 7

54. Requiring the public payment of IBI services in such circumstances would not simply extend existing programs to an excluded group, it would require the establishment of a completely new service or program. This program would include the funding of psychologist services and the funding of individuals who are not health care professionals or a change to the delegation and supervision requirements. While the establishment of such a new program may prove to be good public policy, nothing in the s.15 jurisprudence suggests a positive obligation on the state to establish a new program.

Eldridge, supra at para. 69

55. The extent to which publicly funded health care should be expanded to provide comprehensive funding for the services of health care professionals other than physicians is a complex question of resource allocation that cannot be determined by considering specific claims for new services and programs in isolation.

56. The Romanow Commission had the benefit of hearing from a myriad of potential beneficiaries, each with a legitimate, even compelling, argument for a greater share of limited health care resources. Legislatures must consider all of these claims in determining whether to expand health care and the proper prioritization of any such expansion. In contrast, the Courts are presented with only one potential beneficiary or group of beneficiaries, and cannot therefore make principled prioritization decisions. Whether to adopt the recommendations of the *Romanow Commission Report*, whether to expand the scope of publicly funded health care, and, if it is to be expanded, where to expand first, are complex economic and social policy decisions which require "holistic policy reform", not case by case adjudication. Greschner and Lewis note:

> …government departments are better equipped than courts to manage complex programs and use resources effectively. They may not always make the best use of available data and expertise, but they have far more of it than judges do, and more practice at using it. Moreover, they have the major advantage of perspective: they not only can, but must, look at the entire system. In the context of health care, they must consider the needs of all patients, compare the sometimes incommensurable, and make often tragic trade-offs. In contrast, courts run a higher risk of telescopic vision: focussing on the case before them magnifies that case, and removes other needs and problems from their field of vision.
>
> *Greschner and Lewis, supra,* at 507-508
>
> *Egan v. Canada,* [1995] 2 S.C.R. 513 at para 104 (per Sopinka J.):
> It is not realistic for the Court to assume that there are unlimited funds to address the needs of all.
>
> *R. v. Askov,* [1990] 2 S.C.R. 1199 at para 55:
> Wise political decisions will be required with regard to the allocation of scarce funds. Due deference will have to be given to those political decisions, as the provisions of courtroom facilities and Crown attorneys must, for example, be balanced against the provision of health care and highways.
>
> *Eldridge v. British Columbia,* [1997] 3 S.C.R. 624 at para. 85:
> It is also clear that while financial considerations alone may not justify *Charter* infringements,…governments must be afforded wide latitude to determine the proper distribution of resources in society; …This is especially true where Parliament, in providing specific social benefits, has to choose between disadvantaged groups

57. The Courts below do not appear to consider how the extension of phrases like "benefits" and "health care practitioners" to IBI services and IBI instructor-therapists will affect other contexts like pharmacare, homecare and practitioner services. Every publicly funded benefits program must have limits – the benefits offered must be limited, the eligible beneficiaries must be limited, and, regardless of how deserving the cause may be, the program must have a limited budget. The fact that comprehensive health care funding in Canada is limited to physician and hospital services reflects the prioritization of these services for all Canadians, and does not give rise to an infringement of Charter s. 15.

> *M. v. H.*, supra, at para. 311 (per Bastarache, J.):
> "The courts are not called upon to substitute judicial opinions for legislative ones as to the place at which to draw a precise line." These words are even

> more apposite in the context of legislation implicating a chain of interconnecting interests of which a court can only be dimly aware in any one case brought before it.
>
> P. Hogg, *Constitutional Law of Canada, Loose-leaf ed*. (Toronto: Carswell, 1997) at 35-28:
> the right to equal benefit of the law can hardly be defined without regard for the claims on resources of policies and programmes that compete with a challenged program

58. If IBI were actually a health service, and if all health services but IBI were funded, then this appeal would be more like *Vriend*, where the exclusion of one group from an otherwise comprehensive code was held to be discriminatory under Charter s. 15. In contrast, publicly funded health care in Canada is not comprehensive - no one in Canada receives funding for all health care needs. Seen in the context of the other limits on health care – including limited funding for "medically necessary" prescription drugs, home care, and practitioner services - the impugned provisions of the legislation at issue do not reinforce disadvantages or perpetuate a stereotype of autistic individuals. Viewed in the context of the entire health insurance system the impugned legislative provisions are not based on any assumptions or stereotypes, and do not infringe Charter s. 15.

Gosselin v. Quebec (Attorney General), [2002] S.C.J. No. 85, paras. 26-27

v. Remedy

59. The remedial order of the Court of Appeal establishes a fully publicly funded IBI program for the infant Petitioners which is without parallel in the publicly funded health, social service or education system. There is simply no other publicly funded service in which the service provider determines the amount the government will pay for the service. The Attorney General of Ontario adopts the concerns raised by the Attorney General of British Columbia at paras. 104 – 114 of its factum, and raises the following additional concerns.

60. This Court has established a general rule that there is no individual remedy under s. 24(1) of the *Charter* where the Court grants a declaration pursuant to s. 52(1) of the *Constitution Act, 1982*, as long as government has acted in good faith and without

abusing its power. This general rule was established in *Schachter* v. *Canada* and reaffirmed in *Mackin v. New Brunswick* as follows –

> According to the general rule of public law, absent conduct that is clearly wrong, in bad faith or an abuse of power, the courts will not award damages for the harm suffered as a result of the mere enactment or application of a law that is subsequently declared to be unconstitutional.
>
> *Mackin v. New Brunswick (Minister of Finance),* [2002] 1 S.C.R. 405 at para. 78
> *Schachter* v. *Canada,* [1992] 2 S.C.R. 679 at 720

61. It is submitted that there are three reasons for the general rule against damages where declaratory relief is provided, all of which apply to this appeal. The first is that the enactment of legislation subsequently declared to be invalid does not establish fault on the part of the government on which an action in tort could lie. This principle, as articulated in *Welbridge Holdings Ltd.* v. *Greater Winnipeg*, confirms that policy decisions by government are immune from claims in negligence where the government has acted unconstitutionally -

> In exercising [a discretionary legislative] authority, a municipality [no less than a provincial Legislature or the Parliament of Canada] may act beyond its powers in the ultimate view of a Court, albeit it acted on the advice of counsel. It would be incredible to say in such circumstances that it owed a duty of care giving rise to liability in damages for its breach. "Invalidity is not the test of fault and it should not be the test of liability" - see Davis, *3 Administrative Law Treatise*, 1958, at p. 487. [per Laskin J. at 969] [emphasis added]
>
> *Welbridge Holdings Ltd.* v. *Greater Winnipeg,* [1971] S.C.R. 957 at 969
> *Guimond* v. *Quebec (Attorney General),* [1996] 3 S.C.R. 347 at para. 13

62. A second basis for restricting the availability of damages where legislation is declared invalid is that the threat of liability for damages would have the effect of hampering government decision-making. A primary role of government and the legislatures is to advance society through the creation of new policies and programs. As courts themselves often disagree on what is constitutional and what is not, it is impossible in some circumstances for a government to know whether a particular law or program would withstand a constitutional challenge. Making governments liable for damages

risks interfering with effective governance by deterring governments from creating new social benefit schemes.

> *Mackin, supra* at para. 79
> *Welbridge Holdings Ltd, supra* at 969
> *Egan v. Canada*, [1995] 2 S.C.R. 513 at para 104 (per Sopinka):
> It is not realistic for the Court to assume that there are unlimited funds to address the needs of all. A judicial approach on this basis would tend to make a government reluctant to create any new social benefit schemes because their limits would depend on an accurate prediction of the outcome of court proceedings under s. 15(1) of the *Charter*.

63. A related concern is the potentially vast scale of liability that a government would face if it were liable for damages to all persons affected by unconstitutional laws. Exposing government to this level of financial burden would have the effect of redirecting the expenditure of public funds away from the restructuring and development of public programs and institutions toward private individual redress for past acts of government. As Professor Hogg states –

> If a duty at the planning level was made in breach of procedural requirements, or in bad faith, or for an improper purpose, such a decision would be held to be invalid by a Court. But it does not follow that damages should be available to a person injured by the decision. An award of damages would involve the court moving beyond the infirmity of the actual decision and deciding what the "correct" decision should have been. As well, an award of damages at the planning level would often expose the public authority to a multiplicity of lawsuits and intolerable financial burdens. These seem to be the reasons why no common law duty of care arises at the planning level - even an invalid decision at the planning level does not provide a cause of action in negligence.
>
> Peter Hogg and Patrick Monahan, *Liability of the Crown* (3rd ed.) at p. 165
> Pilkington, "Monetary Redress for *Charter* Infringement" in R.J. Sharpe ed., *Charter Litigation* (Toronto: Butterworths) at pp. 307, 310
> *Gosselin, supra* at para. 297 (per Bastarache, J.)

64. A third rationale for restricting the availability of compensatory damages for invalid legislation is the impossibility of accurately quantifying such damages. This is primarily because assessing the loss attributable to an unconstitutional law involves speculation as to what the government would have done had it known that it could not proceed in the way it did. This Court has recognized, in the context of "reading in" to

cure legislation of a constitutional defect, that it is not the function of the courts to guess what constitutionally valid form of law the legislature would have passed.

> *M.* v. *H.*, [1999] 2 S.C.R. 3 at para. 142
> S*chachter* v. *Canada*, *supra* at 707

65. In the context of this case, there is a fourth factor restricting the availability of a s.24(1) damages remedy – the need for the government to act equitably. When government establishes a funding or benefits program, like the IEIP, there is an obligation to establish a program that is generally available to all eligible beneficiaries. It would be improper, for example, for government to provide IBI funding to only those children who bring court proceedings, or to give special preference or priority to children who bring court proceedings. If IBI is to be publicly funded, such services or funding must be available to all eligible children with autism on the basis of objective and fair criteria.

66. The remedial order of the Court of Appeal effectively gives preference or priority to the Petitioners over all other children with autism. The Court does not grant a declaration that would permit all children with autism to access its newly created benefit, no doubt recognizing that the extension of such an unlimited benefit to all children with autism would not be financially sustainable. While it may be understandable that a Court might want to provide special treatment for the Petitioners, the Court has no way to determine whether the Petitioners should be given priority over all other children with autism who are not before the Court. In fashioning this remedy, the Court did not consider any of the policy issues set out at paras. 25 - 27, above.

> Greschner and Lewis, *supra*, at. 526-527:
>
> > It is remarkable that the court ignored the age limit on IBI for these four plaintiffs. Given that trained therapists are a scarce resource, its order means that the four plaintiffs are at the front of the line for treatment, and receive it well past the time allotted for other children with ASD, even if those other children would benefit more than the four plaintiffs. Surely such an untoward result would need compelling justification, but the Court does not give any cogent reason for favouring these four plaintiffs.
> >
> > The Court's failure to address the likely 'wait time' problem with order LAT for four children well past the critical treatment age is not a trivial

> point. Health care personnel are frequently in short supply, especially in specialized fields. This is one cause of longer-than-desirable wait times; trained personnel are a scarce resource, and there must be a method of allocating them. With IBI, how to allocate trained therapists among children with ASD is a central question. Requiring funding IBI for children older than six will have, at least in the short term, a potentially disastrous effect on IBI for younger children. Generally, unless the supply of trained therapists meets or exceeds the demand, any extension of the right to fully funded IBI is a reallocation of the service

67. There is a real difficulty if courts grant to the plaintiffs under s.24(1) a remedy or benefit which the government cannot provide or sustain on a general basis. This difficulty arises from the reality that all potential beneficiaries (in this case children with autism) will expect to receive equal treatment or benefit from the government. A court cannot ignore the fact that a s.24(1) remedy will have significant policy implications for the government's response to the Court's decision, and therefore for all those who are not before the court. If these four Petitioners were in fact the only children with autism in the province, the policy response to any constitutional entitlement would be as easy as the Court of Appeal's s.24(1) remedy. The reality, however, is much more complex (see paras 25 - 27, supra). Assuming that there is an infringement of the *Charter*, the issues raised by this case can only be addressed by macro-allocation decisions by government, and cannot, and should not, be settled on a case by case basis.

> *Manitoba (Attorney General) v. Metropolitan Stores,* [1987] 1 S.C.R. 110 at 146 - 147
> *M. v. H., supra at paras. 139, 147*
> *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145 at 168-169
> *Miron v. Trudel,* [1995] 2 S.C.R. 418 at para. 179

68. Accordingly, the Attorney General of Ontario supports the position of British Columbia (at para. 109 of its Factum) that if there is an infringement of the Charter, the proper remedy in this kind of case is a suspended declaration under s. 52 of the Constitution Act, 1982, to permit the government to establish a program that considers the policy issues set out at paras. 25 - 27, above. In this context, a s.24(1) remedy is particularly inappropriate unless the Court can provide reasons for giving these Petitioners priority over all other children with autism in the province.

PART IV

NATURE OF ORDER REQUESTED

69. The Attorney General of Ontario requests that this appeal be allowed and that Constitutional Questions #1 and #3 be answered in the negative, or, alternatively, if Constitutional Questions #1 and #3 are answered in the positive that Question #2 be answered in the positive.

ALL OF WHICH IS RESPECTFULLY SUBMITTED ON March 15, 2004

_____

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_____

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