Court No. 24896

IN THE SUPREME COURT OF CANADA

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

BETWEEN:

ROBIN SUSAN ELDRIDGE, JOHN HENRY WARREN
and LINDA JANE WARREN

APPELLANTS

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA,
ATTORNEY GENERAL OF CANADA and
MEDICAL SERVICE COMMISSION

RESPONDENTS

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PART I

STATEMENT OF FACTS

APPELLANTS' WITNESSES

John and Linda Warren

1. The Appellants John and Linda Warren are married to each other. At the time of trial John was thirty one years of age and Linda was twenty nine. They have both been profoundly Deaf since birth.

Transcript, Case on Appeal ("COA") p. 25, ll. 18-22, p. 16, ll. 25-43.

2. John's first language is American Sign Language ("ASL"). Although Linda's parents enrolled her in classes to learn how to speak, Linda is not able to speak. Both of them communicate with other Deaf people in ASL. They attempt to communicate with hearing people by way of writing notes in English, unless the hearing person knows ASL. Each lip reads only a very small amount. Both strongly prefer ASL.

Transcript, COA p.25, l.42 - p.26, l.39, p.17, ll. 17-27.

3. John is an ASL Instructor at Vancouver Community College. Linda does not work outside the home. John and Linda's net family income is $20,000.00 per year. Despite their limited income, John uses an interpreter in situations where communication is particularly important, such as civic matters, job interviews and legal problems, and also feels he needs an interpreter for medical appointments.

Transcript, COA p.20, ll. 18-26, p.16, ll. 36-39, p.17, l.35 - p.18, l.3, p.25, ll. 18-22.

4. Linda is the only Deaf person in her family. Aside from one sister, none of Linda's family knows ASL.

Transcript, COA p.26, ll. 17-22.

5. John and Linda are the parents of twin daughters, born May 8, 1990.

Transcript, COA p.17, ll. 11-16, p.20, ll. 11-16.

6. John and Linda planned to have an interpreter present for the birth of their daughters, however, the babies were born two months premature and they were unable to secure an interpreter on such short notice.

Transcript, COA p.19, ll. 19-25.
Trial Court Reasons for Judgment, COA, p.457, 11. 5-7.

7. At the hospital Linda tried to lip read, but mostly she and John attempted to communicate with the doctors and nurses by writing notes. She would sign to John and John would write notes to the medical personnel. The nurses attempted to communicate by means of gestures. Linda and John understood only some of what the staff attempted to communicate to them. There was insufficient time to write everything down. John and Linda found the birth process frightening without an interpreter.

Transcript, COA p.20, ll. 1-10, p.27, ll. 30-47, p.28, ll. 1-7, 31-33, pp.38-40, ll.18-12.
Trial Court Reasons for Judgment, COA, p.457, 11. 8-9.

8. There were complications in the birth. The nurse pointed to her heart and then pointed her thumb downwards. Linda did not understand what she meant, in particular whether the heart rate of Linda or one of the babies had gone down, or whether she was just telling Linda to push hard.

Transcript, COA p.28, ll. 8-30.
Trial Court, Reasons for Judgment, COA, p.457, 11. 10-14.

9. After the babies were born they were taken away and no one explained to Linda why they were being taken away or what their condition was, other than to write a note saying they were "fine". Two days after the birth John and Linda hired an interpreter, and it was only then that they understood the condition of the babies.

Transcript, COA p.28, l. 34 - p.29, l. 27.
Trial Court Reasons for Judgment, COA, p.457, 11. 15-17.

10. Although John's mother came to the hospital to assist, she is not fluent in ASL, she is not as efficient and competent as a professional interpreter would be, and she cannot understand Linda clearly.

Transcript, COA p.19, ll. 37-43, p.29, ll.31-45.

11. At the time of trial John and Linda were expecting another child. While they did not feel they could afford to do so, they were planning to hire an interpreter to attend the birth.

Transcript, COA p.21, ll. 5-16.
Trial Court Reasons for Judgment, COA, p.457, 11. 19-22.

12. Linda generally communicates with her doctor through written means, which she does not find to be very effective because her written English is not good. She does not understand all of her doctor's instructions and sometimes feels that she is missing information.

Transcript, COA p.31, ll. 17-31, p.43, ll. 24-25.

13. On one occasion, Linda took John's mother with her to interpret at a doctor's appointment. She does not feel comfortable taking John's mother because medical appointments are too personal; for example, the doctor might ask Linda if she has a sexual problem. Further, John's mother is not a qualified interpreter, she is not experienced in medical interpreting, she is a family member, and she works and is not always available.

Transcript, COA p.31, ll. 32-45, p.33, 11. 1-22, p.25, ll. 1-27, p.127, ll. 2-21.

Robin Eldridge

14. The Appellant Robin Eldridge was forty-five years old at the time of trial. She and her husband are Deaf. She is a housewife and has never worked outside the home.

Transcript, COA p.44, ll. 15-28.

15. When Robin was young she was taught orally for many years, however she never learned to speak English. Robin was the only member of her family who was Deaf, and she could not communicate with her brothers and sisters. Robin first began to learn sign language when she was about fifteen years old and much prefers it to lip reading.

Transcript, COA p.45, ll. 1-32.

16. Robin suffers from diabetes, Addison's disease and epilepsy. She has also had surgery on her wrist. She sees a specialist for her diabetes, Dr. Tildesley, approximately six times a year and her family doctor approximately fourteen times a year. Neither physician knows ASL.

Transcript, COA p.46, l. 34 - p.47, l. 9.
Trial Court Reasons for Judgment, COA, p.454, ll. 19-29.

17. Prior to the fall of 1990, the Western Institute for the Deaf ("WID") provided interpreter services for medical appointments for Deaf people free of charge to the user, and Robin took advantage of this service.

Transcript, COA p. 21, ll. 29-42, p.47, ll. 17-26.
Trial Court Reasons for Judgment, COA, p.455, ll. 16-23.

18. Robin found communication with her doctor very easy and clear with the assistance of an interpreter, but in the absence of an interpreter she finds that she can not adequately explain how she feels. She finds this experience very difficult and frustrating.

Transcript, COA p.50, ll. 23-35, p.60, l. 41 - p.61, l. 11.

19. Robin has tried writing questions on paper, but the appointments are very brief and the writing is very limited. She writes but the doctor only says "good" or gives very limited answers. While she spent a shorter time with the doctor when an interpreter was present, they were able to say more in a shorter time.

Transcript, COA p.60, ll. 13-25.

20. Robin would like to have an interpreter in the future but cannot afford to pay for one. Like most Deaf people, she and her husband have limited income.

Transcript, COA p.61, ll. 34-41.
Transcript, Reasons for Judgment, COA, p.455, ll. 3-9.

Dr. Tildesley

21. Dr. Tildesley has been Robin's diabetes specialist since approximately 1987.

Transcript, COA p.76, l. 1.

22. Dr. Tildesley found the services of an interpreter to be very helpful in enabling him to be sure that Robin was able to communicate to him the things that she wanted to tell him. Such communication in Dr. Tildesley's opinion is essential:

> Robin has a chronic disease. It is not going to go away...this is a chronic disease which requires subtle changes in therapy. It requires for me to get very important information in a succinct manner from her with regards to her exercise program, her diet, her insulin injections. It's a very time consuming process, getting this information from Robin. It requires a lot of expertise...So, for me to treat her, I have to be sure that we are communicating and communicating accurately and that we both understand one another.

Transcript, COA p.77, ll. 8-36.
Trial Court Reasons for Judgment, COA, p.455, ll. 5-7.

23. An important part of Dr. Tildesley's practice is "social banter":

> My interaction with patients is I try to make an attempt to find out what's going on at home, how work is going, pressures in life, satisfaction with life; to get to know people as people before treating their diseases and that requires banter. It requires questioning. It requires talking about things other than diabetes.

Transcript, COA p.77, ll. 37-47.
Trial Court Reasons for Judgment, COA, p.456, ll. 3-5.

24. When an interpreter was no longer available in the fall of 1990, Dr. Tildesley attempted to communicate with Robin through a combination of lip reading, gestures and passing written notes. He found this frustrating, as the ability to get information back and forth was inhibited and he was less sure of the accuracy of the information communicated. He never felt that a complete job had been done. He was no longer able to engage in the social banter essential to his practice.

Transcript, COA p.79, ll. 13-25, p.97, ll. 16-23.
Trial Court Reasons for Judgment, COA, p. 456, ll. 7-11.

25. Dr. Tildesley finds that in the absence of an interpreter, it is difficult to obtain the information he requires in order to assess Robin's condition, such as her diet, insulin dosage, blood sugar levels and medications. As a result, each visit becomes a matter of solving the immediate problems rather than the more comprehensive approach to Robin's care which he was able to take when an interpreter was present.

Transcript, COA p.80, ll. 19-30.

26. Dr. Tildesley believes that his ability to communicate with Robin has deteriorated since interpreters have not been available and, in part, he attributes an adverse change in the control of her condition to that poorer communication. The cessation of interpreter service has constituted a major change in the delivery of Robin's health care.

Transcript, COA p.79, ll. 37-47, p. 92, ll. 1-7.

27. Dr. Tildesley had a young Deaf patient who was having recurrent hospitalizations because of poor blood glucose control. Due to his concerns about her ability to communicate with her doctors and his conclusion that there was no other way to communicate with her, Dr. Tildesley used monies from a small discretionary fund made up of community donations to hire an interpreter for her visits.

Transcript, COA p.81, l. 20 - p.82, l. 9.

Dr. Gertrude Gibb

28. Dr. Gertrude Gibb, the Warrens' physician, is an expert in family practice. Dr. Gibb communicates with the Warrens mainly through written notes, and finds communication difficult.

Transcript, COA p.118, l. 18 - p.119, l. 32, p.119, l. 43 - p.120, l. 8.

29. Dr. Gibb described the importance of communication with her patients in the following terms:

> I think communication is probably one of the most important things in a relationship between a doctor and her patient. Without good communication, in the first place, I can't get sufficient information to make a correct diagnosis, and

> if I don't make a correct diagnosis, then obviously I can't treat the patient appropriately.
>
> At the other end of the endeavour, once I have decided what I think is the problem and what should be done, I have to communicate that clearly to my patient in a way that they will understand and be able to follow, but also, I have to be able to convince them that it's necessary that they do this.

Transcript, COA p.120, l. 9 - p.121, l. 14.
Trial Court Reasons for Judgment, COA p.458, ll. 3-6.

30. While some of the questions which Dr. Gibb must ask can be done through writing, the time involved is excessive, and there can be miscommunication and loss of subtleties. Dr. Gibb finds that it takes 2-3 times longer for a visit with the Warrens than a typical patient. She books this extra time for them even though she is not able to bill the Medical Services Plan for taking the additional time necessary. Moreover, she finds that even though she spends a longer period of time, she asks only half the questions she would have asked a hearing person. Dr. Gibb does not know as much about Linda and John, their family arrangements and their medical history, as she does about other patients whom she has seen less often.

Transcript, COA p.121, ll. 35-41, p.122, ll. 16-26, p. 127, ll.22-37, p.128, ll. 1-6.
Trial Court Reasons for Judgment, COA, p. 458, ll. 7-10.

31. Communication is especially important with respect to pre-natal care. Dr. Gibb had a pre-natal visit with Linda Warren, for which she booked extra time. She wrote things down that she thought Linda needed to know. By the end of the visit, they had written ten pages, but she had handled only perhaps one quarter of the information she would usually give her pre-natal patients. She found that she had to take shortcuts. For example, while she normally explains the theory behind an instruction to ensure both understanding and compliance on the part of the patient, she could not do this with Linda.

Transcript, COA p.122, l. 41 - p.124, l. 39.

32. Communication is very important in childbirth. If the doctor can communicate with her patient so that she is able to help with the delivery, complications are less likely to occur and the patient is less likely to have a traumatic birth. At certain stages, for example when

delivering the baby's head, instant communication is necessary to let the woman know when to push and when not to push. The risk of a tear or an episiotomy is greater in cases where the doctor has not been able to maintain good communication and keep the mother calm. It would not be feasible to engage in such communication through writing notes. The doctor has gloves on and possibly a mask and the Deaf mother cannot write notes between contractions. An interpreter would be necessary in order to communicate properly.

Transcript, COA p.124, l. 40 - p.126, l. 30, p.131, ll. 1-12, p.131, l. 31 - p.132, l. 5, p.133, ll. 11-17.
Trial Court Reasons for Judgment, COA, p. 458, ll. 7-10.

33. There are certain medical procedures during which Dr. Gibb cannot write notes to the patient, such as a pelvic examination. Typically, she tells a patient receiving a pelvic exam what she is about to do before she does it, so that the patient does not wince or tighten up. The examination is made more difficult, more painful and less informative if she is not able to communicate with the patient during the examination.

Transcript, COA p.128, ll. 29-47.
Trial Court Reasons for Judgment, COA, p.458, ll. 10-11.

Dr. Michael Rodda

34. Dr. Michael Rodda is qualified as a psycholinguist, and is an expert in psychology specializing in Deafness and language.

Transcript, COA pp. 134-141.

35. On average, 1.2 people per thousand are born Deaf.

Transcript, COA p.142, ll. 9-17.

36. Statistics show that 75% of Deaf children do not have any immediate Deaf relatives. Only very infrequently do families of Deaf children learn ASL.

Transcript, COA p.141, ll. 29-46.

37. There are major differences between a non-English speaking family and a family in which there is a Deaf person. A non-English speaking family is generally a family which communicates

with each other in a common language, whereas the family of a Deaf person lacks communication between parents and their Deaf child or children, as well as between siblings, because of the absence of a common language.

Transcript, COA p.151, l. 44 - p.152, l. 14.

38. Because of their disability, the natural language of Deaf people is necessarily a visual language such as ASL. ASL is different from English in that it uses gestures ordered in space rather than words sequenced in time. Like all languages, ASL has certain advantages and disadvantages, but it is as efficient and effective a language as English. There are very few people who are fluent in ASL outside the Deaf community in North America.

Transcript, COA p.142, ll. 18-30, p.143, ll. 21-26, 38-43.
Trial Court Reasons for Judgment, COA, p.458, ll. 27-28.

39. As a result of their disability, spoken languages such as English can only be learned by the Deaf with great difficulty, if at all, and only as a second language. Further, it is very difficult for the Deaf to acquire proficiency in written English because of the profound structural differences between visual and spoken languages. Consequently, only a very small number of Deaf people have acquired reasonable proficiency in English.

Transcript, COA p.155, ll. 9-26, p.157, l. 45 - p.158, l. 6.

40. There is a great difference between a Deaf child who communicates by means of ASL attempting to learn English, and a non-English speaking hearing person attempting to learn English. The latter case is a transfer from one oral language to another oral language, whereas the former is a transfer from a visual/spatial language to an oral language.

Transcript, COA p.145, ll. 15-35.

41. In the past, educators of the Deaf attempted to teach Deaf children to speak, with tragic results in many cases because of the great difficulty the Deaf typically have in learning to speak. Lip reading is even more difficult to teach than speech. Because of these difficulties, while the

dominant method of instruction was formerly the oral method using lip reading and speech, the dominant method of instruction is now sign language.

Transcript, COA p.142, ll. 35-45, p.143, ll. 1-9.

42. Communication with Deaf people by means of written English is not an effective means of communication, in large part because most Deaf people do not have adequate English language reading and writing skills. The average Deaf person has a grade three reading level on graduation from school. There is a high probability of miscommunication between Deaf and hearing people using written means of communication. Almost all Deaf people have received instruction in English as a first language, and yet only 5% achieve competency in English for some aspects of daily communication.

Transcript, COA p.144, ll. 26-37, p.157, l. 45 - p.158, l. 6, p.172, l. 17 - p.173, l. 9.
Trial Court Reasons for Judgment, COA p. 459, ll. 3-4.

43. The vocabulary of the average Deaf person is restricted in English. It is possible for a Deaf person to know the sign for a term and not know the same word in written or spoken English.

Transcript, COA p.167, ll. 37-42.

44. Clinical studies show that Deaf people have been misdiagnosed as schizophrenic or mentally handicapped. Generally, miscommunication or a lack of communication can lead to a misdiagnosis.

Transcript, COA p. 146, l. 36 - p.147, l. 20.
Trial Court Reasons for Judgment, COA p.460, ll. 4-8.

45. Deaf people are characteristically either unemployed or underemployed in low paying jobs.

Transcript, COA p.158, l. 33 - p.159, l. 7.

46. In Alberta and Manitoba the provincial governments fund medical interpretation.

Transcript, COA p. 147, l. 36 - p.148, l. 12.
Trial Court Reasons for Judgment, COA. p.459, ll. 10-14.

Janet Johanson

47. In Seattle, Washington, the Community Service Centre for the Deaf and Hard of Hearing provides interpretation for medical services. The cost for interpreting for hospitals is about $230,000 a year and, for doctors, is about $5,000 a year. Patients do not pay for this service. These services are required and must be paid for by the service provider under the *Rehabilitation Act* and the *Americans with Disabilities Act*. There is an emergency response system in place under which it takes approximately 30 minutes for an interpreter to be provided.

Transcript, COA p.216, l. 17 - p.219, l. 41.
Trial Court Reasons for Judgment, COA, p. 460, ll. 10-22.

RESPONDENTS' WITNESSES

Peter Van Rheenen

48. In 1990, the Western Institute for the Deaf ("WID") indicated to the Ministry of Health (the "Ministry") that it could not continue to provide interpreter services for Deaf persons attending hospitals and medical appointments with physicians, and again requested funding, having made an earlier request in 1989 which had been rejected out of hand.

Transcript, COA p.63, ll. 11-19, p.71, ll. 17-21, p. 235, ll. 39-49, p.235, ll. 33-38.
COA, Exhibit 3, pp. 306-308.

49. In response, Dr. Van Rheenen, Executive Director of the Family Health Division of the Ministry of Health, prepared a briefing note for the Ministry Executive Committee. The briefing note explains that WID had contracts with the Government to provide interpreters for the Ministry of Social Services and Housing for Family and Child Service investigations and counseling, the Ministry of Education for Jericho Hill School, the Ministry of the Attorney General for interpreters in the courts, and the Ministry of Advanced Education, Training and Technology for interpreters for vocational training and assessment and job placement. WID requested similar funding for provision of interpreter services in the medical setting, suggesting that such interpreter services be covered as insured benefits under the Medical Services Plan.

Transcript, COA p. 245, ll. 2-22, 41-43.
COA, Exhibit 3, pp. 306-308.

50. The briefing note highlights how in the preceding calendar year, WID had provided close to 800 hours of interpreter services in Victoria and the Lower Mainland for over 400 clients, out of an estimated population of the Deaf and hard of hearing in B.C. of between four and five thousand. The options discussed in the briefing note are (1) no funding, (2) blanket coverage for all interpreter services for medical appointments, the potential cost of which, if every eligible person were to take advantage of the service, would be approximately $150,000, (3) providing a limited grant to maintain the then current WID service at an estimated cost of $35,000 for the remaining nine months of the 1990-91 fiscal year, with a province wide plan to be developed in that period, and (4) developing a user pay program. Dr. Van Rheenen recommended the third option, which was that the Ministry:

> make a small commitment to initiating a program this fiscal year, with a view that it will be included for longer term implementation as part of the 1991-92 budget process. Not recognizing this as a need, and given the financial position of the Society providing this service, is sure to lead to significant backlash and allegations of placing individuals, who are already vulnerable, at further risk.

Transcript, COA p.245, ll. 2-22, 41-43.
COA, Exhibit 3, pp. 306-308.

51. The Executive Committee spent only twenty minutes reviewing Dr. Van Rheenen's briefing note before making its decision to refuse funding. Its stated reasons were the financial resources available within the Ministry and the fear of setting a precedent for the funding of language translation services for non-English speakers.

Transcript, COA p.104, ll. 16-20, p. 104, l. 32 - p.105, l. 18, p.106, ll. 9-20, p.246, ll. 3-14, p.282, ll. 2-45.
Trial Court Reasons for Judgment, COA, p.464, ll. 6-18.

52. Prior to this meeting of the Executive Committee, there had been no research into the question of whether a precedent might be set with respect to the provision of interpreting services for non-English speakers or the cost of providing such services.

Transcript, COA p.107, ll. 31-38.

53. The Ministry's global budget is approximately $6 billion, and it has been increasing by 10% per year.

Trial Court Reasons for Judgment, COA p.462, ll. 6-8.

Dr. Douglas Schneider

54. No one within the Medical Services Plan has ever done a study of sign language interpretation services for the Deaf.

Transcript, COA p.267, l. 46 - p.268, l. 1.

Dr. Gary Curtis

55. The Report of the British Columbia Royal Commission on Health Care and Costs, entitled *Closer to Home*, discussed the difficulties experienced by the disabled in accessing health care in the following terms:

> The problems discussed here weigh upon the lives of many other British Columbians with chronic disabling conditions that cannot be cured. When these people need access to the health care system, special efforts may be needed for them to have the same benefits that other people enjoy. For instance, we have been told that:
>
> - Extra time should be allowed for health care workers to understand and help the mentally handicapped.
> - The deaf may need translators.
> - The blind may need instructions in braille or on tape.

The Report also considered problems relating to accessibility, including the difficulty which some people have accessing services because of physical or mental disabilities. The Commission recommended that all such barriers be eliminated.

Transcript, COA p.295, ll. 9-24, p.296, ll. 7-45, p.297, ll. 1-19.
Trial Court Reasons for Judgment, COA, p.465, ll. 7-14.

56. In response to *Closer to Home*, the Ministry has not made any specific changes with respect to the provision of interpreter services for the Deaf, nor is it otherwise addressing issues related to barriers to access to medical services for the Deaf.

Transcript, COA p. 297, ll. 25-39, p.299, ll. 11-24.

PART II

ERRORS IN JUDGMENT

57. A. The Court of Appeal erred in law in holding that the Legislature of British Columbia did not violate s. 15(1) of the *Canadian Charter of Rights and Freedoms* in failing to provide interpreters for Deaf people while receiving medical services under the *Medical and Health Care Services Act* and *Hospital Insurance Act*.

B. If the failure to provide interpreters violates s. 15(1) of the *Charter*, this appeal also raises the issue of whether the unequal treatment accorded the Deaf is a reasonable limit which is demonstrably justified pursuant to s. 1 of the *Charter*.

PART III

ARGUMENT

A. Does the Provincial Legislature's failure to provide interpreters to Deaf people while receiving medical services violate s. 15(1) of the *Charter*?

58. It is submitted that the Government's failure to provide interpreting services to Deaf people as part of the publicly funded scheme for the provision of medical care violates the right, guaranteed by s. 15(1) of the *Charter,* to equal benefit of the law without discrimination based on physical disability.

59. The Appellants' submissions may be summarized as follows:

(1) The Government may be under no constitutional obligation to provide publicly funded medical services. However, if the Government chooses to provide any publicly funded medical services, then these services are a benefit of the law, which s. 15(1) of the *Charter* requires to be made available without discrimination, and in particular without discrimination based on physical disability.

(2) As a result of the Government's failure to provide interpreters to Deaf people receiving publicly funded medical services, Deaf people receive significantly inferior, and hence unequal, medical services because their physical disability fundamentally impairs their ability to communicate with physicians and other health care providers without the aid of an interpreter.

(3) To receive the equal benefit of publicly funded medical services without discrimination based on physical disability as required by s. 15(1) of the *Charter*, the Deaf must be provided with interpreters as an integral component of the publicly funded medical services to which they are currently legally entitled.

(1) Application of the *Charter*

60. The Legislature of British Columbia has enacted legislation which provides for public funding of a wide range of medical services for residents of British Columbia. The Medical Services Plan is established under the *Medical and Health Care Services Act*, S.B.C. 1992, c. 76. In general, the medical services funded under the Plan include all medically required services recognized by the Medical Services Commission and any services set out in regulations made by the Lieutenant Governor in Council. The relevant provisions of the *Medical and Health Care Services Act* are ss. 1, 2, 6 (1) & (2), and 8(1), which are set out in the Appendix.

61. Hospital services are provided pursuant to the *Hospital Insurance Act*, R.S.B.C. 1979, c. 180. Section 3 of the *Act* provides that "subject to this *Act* and the *Regulations*, every qualified person or beneficiary is entitled to receive the general hospital services provided under this *Act*". Section 5(1) of the *Act* sets out the "general hospital services provided under this *Act*". The services generally include all accommodation, diagnostic and therapeutic services necessary for persons suffering acute illness or injury or chronic illness or disability. The relevant provisions of the *Hospital Insurance Act* are set out in the Appendix.

62. Clearly, both the *Medical and Health Care Services Act* and the *Hospital Insurance Act*, are statutes enacted by the British Columbia Legislature, and are subject to review pursuant to s. 32 of the *Charter*.

63. Further, in our respectful submission, both pieces of legislation provide for benefits which are a "benefit of the law" within the meaning of s. 15 of the *Charter*, such that any discrimination in their application would be subject to *Charter* review.

64. In the Courts below, the Respondent conceded and the Courts accepted these propositions with respect to the *Medical and Health Care Services Act*. The *Hospital Insurance Act*, however, was held to stand on a different footing. The majority in the Court of Appeal held that

the failure to provide interpreters to the Deaf receiving hospital services was not subject to the *Charter*. They did so on the basis that the *Hospital Insurance Act* grants individual hospitals a measure of discretion in the specific services they provide, and, following this Court's decision in *Stoffman v. Vancouver General Hospital,* hospitals are not part of government for the purposes of s. 32 of the *Charter*.

Court of Appeal Reasons for Decision, COA, pp. 510 - 512.
Stoffman v. Vancouver General Hospital, [1990] 3 S.C.R. 483.

65. It is respectfully submitted that in reaching this conclusion, the Courts below misapprehended both the Appellants' argument and this Court's decision in *Stoffman v. Vancouver General Hospital*. The fact that hospitals are not part of government for the purposes of the *Charter* does not render the *Hospital Insurance Act* immune from *Charter* review; that *Act* is clearly subject to *Charter* scrutiny.

McKinney v. University of Guelph, [1990] 3 S.C.R. 229 at pp. 264-65, 276-77.
Dianne Pothier, "M'Aider, Mayday: Section 15 of the *Charter* in Distress" (1996) 6 N.J.C.L. 295 at pp.334-35.
Dianne Pothier, "The Sounds of Silence: *Charter* Application When the Legislature Declines to Speak" (1996) 7:4 Constitutional Forum 113 at pp. 116-17.

66. Just as the *Medical and Health Care Services Act* fails to include medical interpreter services for the Deaf as a necessary component of all medical services provided under the *Act*, so too the *Hospital Insurance Act* fails to include medical interpreter services as a component of the medical services provided to Deaf persons under that *Act*. The failure to provide medical interpreter services in the *Hospital Insurance Act* is therefore similarly subject to *Charter* review.

67. The central and overarching purpose of the *Hospital Insurance Act* is to provide a complete range of publicly funded hospital services to qualified persons in British Columbia. To accomplish this purpose, the Legislature has, in s. 3 of the *Act*, granted an entitlement to all qualified persons to receive the general hospital services provided under the *Act*. The broad range of services to which qualified persons are entitled is set out in s. 5 of the *Act*. It is

therefore clear, that while the *Act* does not require each individual hospital to provide the full range of hospital services, the purpose and effect of the *Act* is to create an entitlement to all hospital services through the combined resources of all hospitals in the Province. The hospitals are merely agents through which the Legislature accomplishes this objective. As LaForest J. stated in *McKinney v. University of Guelph*, in describing this Court's decision in *Slaight Communications Inc. v. Davidson*:

> The arbitrator was, therefore, part of the governmental administrative machinery for effecting the specific purpose of the statute. It would be strange if the legislature and the government could evade their *Charter* responsibility by appointing a person to carry out the purposes of the statute.
>
> *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038.
> *McKinney v. University of Guelph, supra*, at p. 265.

68. The Legislature, therefore, upon defining the central purpose of the statute as an entitlement to a range of medical services, cannot evade its responsibilities under the *Charter* to provide those services without discrimination by appointing the hospitals to carry out the purpose of the statute.

> *Douglas/Kwantlan Faculty Association v. Douglas College*, [1990] 3 S.C.R. 570.
> *McKinney v. University of Guelph, supra.*

(2) Is the failure of the Government to provide interpreters for the Deaf receiving publicly funded medical services a denial of equal benefit of the law under s. 15(1)?

(a) Equality under s. 15(1) may require different treatment of individuals

69. Section 15(1) of the *Charter* guarantees every individual equality before and under the law, as well as equal protection and equal benefit of the law without discrimination. As stated by McIntyre J. in *Andrews v. Law Society of British Columbia*:

> To approach the ideal of full equality before and under the law - and in human affairs an approach is all that can be expected - the main

> consideration must be the impact of the law on the individual or the group concerned. Recognizing that there will always be an infinite variety of personal characteristics, capacities, entitlements and merits among those subject to a law, there must be accorded, as nearly as may be possible, an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another. In other words, the admittedly unattainable ideal should be the law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another. (emphasis added)
>
> *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 at p. 165.

70. In assessing whether individuals have been accorded equal benefit of the law, the similarly situated test has been unequivocally rejected by the Supreme Court of Canada. The attainment of substantive, and not merely formal equality, is the purpose of s.15 of the *Charter*. As McIntyre J. stated in *Andrews*:

> It must be recognized at once, however, that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality. (emphasis added)
>
> *Andrews*, *supra*, at p.164.

71. In *Andrews*, McIntyre J. adopted the reasoning of Dickson J. (as he then was) in *R. v. Big M. Drug Mart Ltd.* that "the equality necessary to support religious freedom does not require identical treatment of all religions. In fact, the interests of true equality may well require differentiation in treatment". (emphasis added)

Andrews, supra, at p. 165.
R. v. Big M. Drug Mart Ltd., [1985] 1 S.C.R. 295 at p.347.

72. What is at issue in a s. 15(1) analysis is ultimately not whether there is differentiation between individuals or classes, but rather, whether the differentiation leads to discrimination or is actually necessary in order to avoid discrimination. Wilson J. in *R. v. Turpin*, clarified this point as follows:

> In determining whether there is discrimination on grounds relating to the personal characteristics of the individual or group, it is important to look not only at the

impugned legislation which has created a distinction that violates the right to equality but also the larger social, political and legal context. McIntyre J. emphasized in *Andrews* (at p. 167):

> For, as has been said, a bad law will not be saved merely because it operates equally upon those to whom it has application. Nor will a law necessarily be bad because it makes distinctions.

> Accordingly, it is only by examining the larger context that a court can determine whether differential treatment results in inequality or whether, contrariwise, it would be identical treatment which would in the particular context result in inequality or foster disadvantage. A finding that there is discrimination will, I think, in most but perhaps not all cases, necessarily entail a search for disadvantage that exists apart from and independent of the particular legal distinction being challenged. (emphasis added)

R. v. Turpin, [1989] 1 S.C.R. 1296, at pp. 1331-32.
See also: *Andrews, supra*, at p. 174.

73. The legislation need not be motivated by a desire to disadvantage or deprive an individual or group of a benefit in order to violate s. 15(1). It is sufficient if the effect of the legislation is to deprive an individual or a group of a benefit available to others, in this case, the full benefit of publicly funded medical services.

Andrews, supra, at pp. 173-74.
Rodriguez v. R., [1993] 3 S.C.R. 519 at pp. 544-49 (per Lamer C.J.C.).
Knodel v. B.C. (Medical Services Commission) (1991), 58 B.C.L.R. 356 (S.C.).
Ontario (Human Rights Commission) v. Simpsons - Sears Ltd., [1985] 2 S.C.R. 536, at p. 547.

74. Legislation which is neutral on its face may be discriminatory if it has a discriminatory impact on persons, such as the Deaf, who are already clearly disadvantaged. The fact that no one, whether Deaf or hearing, is entitled under the current legislation in British Columbia to a sign language interpreter for medical services does not mean that Deaf people are not thereby discriminated against. This is a case of a neutral rule which has a discriminatory impact, as a result of which Deaf persons do not enjoy equal access to medical services. Such adverse effect discrimination is clearly encompassed within s. 15 of the *Charter*.

Rodriguez, supra, at pp. 550-51.
Symes v. Canada, [1993] 4 S.C.R. 695 at pp. 754 - 56.

75. It is respectfully submitted that the learned trial judge and the majority in the Court of Appeal failed to appreciate the unequivocal statements of this Honourable Court that equality may require differentiation in treatment. This is apparent in the reasons of Hollinrake J.A., which attribute the inequality experienced by the Deaf exclusively to their disability, a source outside of the law, rather than to a legislative failure to accord the Deaf the differential treatment they require in light of their constitutional entitlement to equal benefit of the law:

> In the absence of the legislation those deaf people requiring translators would be required to pay their doctors in addition to translators in order to receive what they say are equivalent medical services to the hearing. Hearing people in the absence of the legislation would be in the similar position of having the responsibility of making payment to their doctors. The legislation removes the responsibility of both the hearing and the deaf to make payment to their doctors. This is the impact of the legislation on both the deaf and the hearing. Therefore, the effect of the legislation is that the deaf remain responsible for the payment of translators in order to receive equivalent medical services as those with hearing, as they would be in the absence of the legislation. <u>This inequality exists independently of the legislation and cannot be said in any way to be an effect of the legislation. Both purposively and effectively the legislation provides its benefit of making payment for medical services equally to the hearing and the deaf</u>. (emphasis added)
>
> Court of Appeal Reasons for Decision, COA, p. 519, l. 20 - p. 520, l. 2.

76. With respect, the Appellants submit that in this passage the Court of Appeal repeated the erroneous reasoning of *Bliss v. Attorney General of Canada*, which has been resoundingly rejected by this Court. In both cases, inequality has been legally justified as "not created by legislation but by nature". To adopt such an approach is not only inconsistent with this Court's jurisprudence; it also renders nugatory the *Charter*'s guarantee of equal benefit of law, particularly for the disabled. Were the Court of Appeal's reasoning to be accepted, the disabled could <u>never</u> succeed in a claim of discrimination: their "inequality [always] exists independently of the legislation."

Reasons for Decision of Lambert JA. in dissent, COA, pp. 528-29.
Bliss v. Attorney General of Canada, [1979] 1 S.C.R. 183 at p. 190.
Brooks v. Canada Safeway Ltd., [1989] 1 S.C.R. 1219 at pp. 1243-44.
Andrews, supra, at pp. 167-70.

Miron v. Trudel, [1995] 2 S.C.R. 418 at pp. 443 - 44 (per Gonthier J.).
Pothier, "M'Aider, Mayday: Section 15 of the *Charter* in Distress", *supra*, at pp. 333-34, 337-39.
Judith Keane, "Discrimination in the Provision of Government Services and S. 15 of the *Charter*: Making the Best of the Judgments in *Egan*, *Thibaudeau*, and *Miron*", (1995) 11 J. Law & Soc. Pol'y 108 at pp. 136 141.

77. While this Court has repeatedly recognized in principle that equality may necessitate differentiation in treatment, few *Charter* cases have raised the issue directly. However, there have been numerous human rights cases in which apparently neutral rules have been found to be discriminatory and in which the rule maker or service-provider has been required to provide different treatment to a person or group in order to ensure equal access to a benefit available to all.

78. Adjudicators at all levels have been careful to keep to the forefront the purpose of a guarantee of freedom from discrimination on the basis of disability:

> The purpose of such legislation is again to guarantee, *inter alia*, to disabled persons that they will not be excluded by society and that they enjoy a real and not simply hypothetical, right to equal opportunity with other individuals to make for themselves the lives that they are able and wish to have through their fullest possible integration into and participation in society.
>
> *Robinson v. Canada (Armed Forces)* (1992), 15 C.H.R.R. D/95 at D/121 (C.H.R.T.).

79. This purposive approach is exemplified by the decision of the British Columbia Human Rights Council in *Howard v. University of British Columbia,* in which it was held that U.B.C. was obligated to provide the Deaf complainant with a qualified sign language interpreter so that he could participate in U.B.C.'s education programs. The Human Rights Council held that the complaint was not about ancillary or discretionary services; it was about access to education itself. It was no answer that the University did not provide interpreters or funding for them, as that was the very omission complained of. The Human Rights Council held that "without interpreters the complainant did not have meaningful access to the service".

Howard v. University of British Columbia (1993), 18 C.H.R.R. D/353 at D/358.
See also: *Woolverton v. B.C. Transit* (1994), 19 C.H.R.R. D/200 (B.C.H.R.C.).
Youth Bowling Council of Ontario v. McLeod (1991), 14 C.H.R.R. D/120 (Ont. Div. Ct.).
Atlantic Shopping Centres v. Newfoundland (Attorney General) (1988), 9 C.H.R.R. D/4836 (Nfld. T.D.).

80. Likewise, the Saskatchewan Court of Appeal has held that the failure of a movie theatre to provide places in its theatre in which a person in a wheelchair could view the movie discriminated against wheelchair users. While precisely the same physical arrangements were provided to all members of the public, namely a seat in which to view the movie, the consequences of those arrangements for persons in a wheelchair were discriminatory and accordingly unlawful.

Huck v. Canadian Odeon Theatres Ltd. (1985), 18 D.L.R. (4th) 93 (Sask. C.A.).
Rodriguez, supra, at pp. 551-52.

81. In each of these human rights cases it was recognized that the failure to provide the disabled with the accommodation they require in order to enjoy the equal benefit of a service or other opportunity denies them substantive equality. Thus differential treatment may be necessary in order to achieve equality. As this Court has recognized in principle ever since *Andrews*, the same reasoning applies under the *Charter*: in some circumstances, such as the case on appeal, government must provide appropriate assistance to ensure the disabled have equal benefit of laws applicable to all. As Lamer C.J.C. said in *Rodriguez*, it would be absurd to suggest that "there is no discrimination where persons with disabilities receive the same treatment as the general public."

Rodriguez, supra, at pp. 550-51.
Pothier, "M'Aider, Mayday: Section 15 of the *Charter* in Distress", *supra*, at pp. 303, 337-38.

82. The American experience in this area is also instructive, particularly given the breadth of American jurisprudence dealing specifically with the provision of interpreters for the Deaf.

83. The *Americans with Disabilities Act of 1990* ("*ADA*"), was enacted pursuant to Congress' power to enforce the equality guarantees of the Fourteenth Amendment. Title II of the *ADA* provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services... of a public entity, or be subjected to discrimination by any such entity". Title III to the *ADA* prohibits discrimination on the basis of disability by public accommodations.

Americans with Disabilities Act of 1990 (42 U.S.C. 12101).
Burgdorf, "Equal Members of the Community: the Public Accommodation Provisions of the Americans with Disabilities Act" (1991) 64 Temple L.Rev. 551.

84. The *Regulations* to the *ADA* specifically provide that public accommodations include, *inter alia,* hospitals and the professional offices of health care providers. Further, the *Regulations* require that public entities and public accommodations reasonably modify their policies, practices and procedures so as to ensure that disabled individuals receive equal benefits therefrom, and also provide that such reasonable modifications include the provision of qualified interpreters and other auxiliary aids for the Deaf.

Regulations (28 C.F.R. 35.101 *et seq*).

85. At least one American court has specifically held that the *ADA* requires the provision of qualified sign language interpreters free of charge to Deaf persons in hospitals (*Aikens v. St. Helene Hospital).* As well, the courts have held that the failure of a medical clinic to provide sign language interpreters for Deaf patients and the decision of a doctor to cease treating a Deaf patient due to the cost of interpreter services are actionable under the *ADA*, and that injunctive relief is available to enforce rights under the *ADT.*

Aikens v. St. Helena Hospital, 843 F. Supp. 1329 (N.D. Cal. 1994).
See also: *People by Vacco v. Mid Hudson Medical Group, P.C.*, 877 F. Supp. 143 (S.D.N.Y. 1995).
Mayberry v. Von Valtier, 843 F. Supp. 1160 (E.D. Mich. 1994).

86. American courts have also held that prison authorities are required to provide qualified interpreters to Deaf inmates and that universities and colleges must supply and pay for qualified interpreters to assist Deaf students in their classes.

Bonner v. Lewis, 857 F. 2nd 599 (9th Cir. 1988).
Bonner v. Arizona Department of Corrections, 714 F. Supp. 420 (D. Ariz. 1989).
Duffy v. Riveland, 98 F. 3d 447 (9th Cir. 1996).
Greater Los Angeles Council on Deafness Inc. v. Zolin, et al, 812 F. 2nd 1103 (9th Cir. 1987).
Camenisch v. University of Texas, 616 F. 2nd 127 (5th Cir. 1980).
Crawford v. University of North Carolina, 440 F. Supp. 1047 (N.C. Div., 1977).
Barnes v. Converse College, 436 F. Supp. 635 (S.C. Div. 1977).
Jones v. Illinois Department of Rehabilitation Services and Illinois Institute of Technology, 689 F. 2nd 724 (7th Cir. 1982).

87. It is clear from these decisions that under American law, publicly provided sign language interpreting services are required to guarantee Deaf persons equal access to benefits.

(b) What is the effect on Deaf Persons of the denial of interpreters for publicly funded medical services?

88. Section 2(2) of the *Act* states that "the function of the Medical Service Commission is to facilitate, in the manner provided for in this Act, reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan."

89. The effect of the refusal on the part of the Government to provide interpreters as part of funded medical services is to deny Deaf persons a comparable quality of medical services to that enjoyed by hearing persons. Communication is fundamental to both the diagnostic and therapeutic aspects of medicine. In the absence of adequate communication between health care provider and patient, the medical service cannot be said to have fully been provided.

90. In this connection it is important to recognize that interpreting services for the Deaf are not merely ancillary to the medical service which they seek. Communication is an integral part of the medical service itself, and a part of that service which is provided free of charge to the hearing community under the terms of the Medical Services Plan and other relevant legislation.

Reasons for Decision of Lambert JA. in dissent, COA, p. 528.

91. For the Deaf, the assistance of an interpreter is not merely an option which an individual might desire, like a private hospital room or cosmetic surgery, but is fundamentally necessary in order for the Deaf to receive medical services of equivalent quality and nature to those provided to the remainder of society.

92. The Deaf are not analogous to non-English speaking hearing persons by virtue of their physical disability. The Deaf as a group confront qualitatively different obstacles, and experience greater difficulty in attempting to learn English, whether in spoken or written form, than any group of hearing non-English speakers. The average Deaf person has a grade three reading level on graduation from school, which is not sufficient to permit even minimal communication by way of written notes with a physician.

Transcript, COA p.142, ll. 35-45, p.143, ll. 1-9, p.144, l. 26- p. 145, l.35, p.157, l. 45-p.158, l. 6, p. 172, l. 17-p.173, l. 9.
Trial Court Reasons for Judgment, COA p.459, ll. 3-4.
C. King, *Reading and Deafness* (San Diego: College-Hill Press, 1985) at p. 57-59.
O. Sacks, *Seeing Voices* (Berkeley: University of California Press, 1989) at pp. 28-29.

93. The direct result of the physical reality of being unable to hear is that Deaf people are at a great disadvantage in ever being able to communicate directly with the hearing world. This point is demonstrated by the Appellants in the present case, all of whom have minimal, if any, lip-reading skills, and who are able to communicate, if at all, with their hearing physicians only by means of written notes, which both they and their physicians find to be wholly unsatisfactory.

Transcript, COA p.17, ll. 17-27, p.25, l. 42 -p.26, l.39, p.31, ll. 17-31, p.43, ll. 24-25, p.45, ll. 1-14, p.50, ll. 23-35.

94. All of the expert evidence in the case at bar demonstrated that communication is extremely important in the medical setting and that a failure in communication may result in mis-diagnosis, complications, or a failure on the part of a patient to follow the doctor's directions.

Transcript, COA p.79, ll. 13-25, p.120, ll. 9-23, p.131, ll. 1-12, p.131, l. 31- p.132, l. 5, p.128, ll. 29-47, p.146, l. 36- p.147, l. 20.

Trial Court Reasons for Judgment, COA p. 460, ll. 4-8.

95. Family members or other non-professional interpreters are not an adequate alternative for the Deaf. Seventy-five percent of Deaf children do not have any immediate Deaf relatives and it is very infrequent that families of Deaf children learn ASL. Those family members who learn to sign may not have adequate knowledge to serve as interpreters, as in the case of John Warren's mother.

Transcript, COA p.141, ll. 29-46.
Transcript, COA p.19, ll. 37-43, p.29, ll. 31-45, p.31, ll. 32-45, p.33, ll. 22-35.

96. Even where family members can interpret, their presence in a medical setting can cause many problems. Their skills in English or ASL may be unsophisticated, particularly in dealing with technical medical language. Patients may be reluctant to disclose personal information in the presence of family members. Family members may fail or choose not to interpret accurately. Using a family member in the role of interpreter may harm the family structures which must continue to exist outside of the narrow context of the medical appointment.

Linda Haffner, "Cross Cultural Medicine, a Decade Later: Translation is Not Enough, Interpreting in a Medical Setting" (Sept. 1992) 157 *West. J. Med.* 255 at pp. 256-257.

97. Issues of informed consent may also arise. In the absence of a properly qualified interpreter, a patient may not fully understand a procedure and therefore not be able to give informed consent.

Reasons for Decision of Lambert JA., in dissent, COA p. 527.
Hopp v. Lepp, [1980] 2 S.C.R. 192.
Reibl v. Hughes, [1980] 2 S.C.R. 880.

98. The difficulties associated with a Deaf person attempting to communicate with the physician in written English may be particularly acute in situations where communication is the diagnostic and therapeutic instrument.

K.W. Bamford, "Bilingual Issues in Mental Health Assessment and Treatment"

(Nov. 1991) 13:4 Hispanic Journal of Behavioral Sciences 377 at p.380.
Transcript, COA p. 77, 11. 37-47.
Trial Court Reasons for Judgment, COA, p. 456, 11. 3-5.

99. For all of these reasons, a Deaf person attending a physician or a hospital or other medical practitioner without an interpreter simply does not receive the medical care which a hearing person does. This is not a case of a merely ancillary service or a non-medically required service; communication is an integral component of the medical service itself and a failure on the part of the Government to provide the Deaf with reasonably equivalent means of communication means that the Deaf are not receiving equal benefit of publicly funded medical services in this Province.

(c) Conclusion

100. It is important to note that the case on appeal is not one in which different results may flow depending on which of the three differing approaches to s. 15 of the *Charter* employed in *Miron v. Trudel*, *Egan v. Canada* and *Thibaudeau v. Canada* is adopted. In some circumstances, the choice of analytical approach taken to s. 15 may result in different conclusions with respect to whether an equality right has been infringed. In the present case, however, all three approaches lead to the same conclusion: the failure to provide sign language services to Deaf people while receiving medical services results in a denial of equal benefit of the law.

Miron v. Trudel, *supra*.
Egan v. Canada, [1995] 2 S.C.R. 513.
Thibaudeau v. Canada, [1995] 2 S.C.R. 627.

101. The most restrictive of these approaches to s. 15 is that adopted by Lamer C.J.C., LaForest, Gonthier and Major JJ. Under this approach, in order to establish discrimination under s. 15, the complainant must prove that the distinction in issue is based on a personal characteristic irrelevant to the functional values underlying the legislation.

102. Applying this approach, the personal characteristic in issue in the case on appeal, deafness, is clearly not relevant to the functional values underlying the *Medical and Health Care Services Act* and *Hospital Insurance Act*. The functional values underlying these statutes concern the promotion of health and prevention and treatment of illness and disease, and the realization of those values through the creation of a scheme of publicly funded health care. There could be no personal characteristic less relevant to these values than an individual's disability.

103. Finally, in addressing the question of whether there is a violation of s. 15(1), it is important to keep in mind the purpose of s. 15(1), as enunciated by the Supreme Court of Canada. That purpose is to eliminate discrimination in order to ensure that the disadvantaged have equal access to and participation in Canadian society including the benefits and advantages available by virtue of law. The Deaf belong to an enumerated group under s. 15(1), a group which traditionally has been isolated and disadvantaged from participation in Canadian society. Medical services are a benefit which, since the introduction of the Medicare program in the 1960s, Canadians and our governments have asserted is vital and must be equally available to all. The exclusion of the Deaf in British Columbia from full access to these benefits as a result of the Government's refusal to provide interpreters is the very sort of discrimination which s. 15(1) was designed to avoid.

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

B. Is the violation of s. 15(1) a reasonable limit pursuant to s. 1?

104. It is submitted that the violation of the Appellants' s. 15(1) rights through the unequal provision of medical services to the Deaf by the Government is not a reasonable limit which is demonstrably justified under s. 1.

105. The Supreme Court of Canada has repeatedly affirmed that *R. v. Oakes* correctly set out the analytical framework to be followed in determining whether a law constitutes a reasonable

limit on a *Charter* right. A succinct restatement of that framework can be found in the judgment of Iacobucci J. in *Egan, supra*:

> First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislative end must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the rights violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the *Charter* guarantee; and (3) there must be proportionality between the effect of the measure and it objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right. In all s. 1 cases the burden of proof is on the government to show on a balance of probabilities that the violation is justifiable.
>
> *Egan, supra*, at p. 605.

106. While the *Oakes* framework has been consistently employed by the Court, Sopinka J. in *Egan* adopted a distinctive approach. That approach is, however, clearly inapplicable to this case. In holding that the federal Government should be given time to extend benefits to same sex couples, Sopinka J. relied heavily on the fact that: (a) it is only in recent years that society, and with it governments and the courts, have begun to recognize sexual orientation as an analogous ground of discrimination under the *Charter*, and (b) the Legislature was moving consistently and incrementally to redress inequalities in this area.

> *Egan, supra*, at p. 576.

107. The same can not be said of the disabled, and the Deaf in particular. Acceptance and accommodation of the disabled and their right to equal treatment in our society is neither a newly emerging social norm nor a controversial one. Unlike sexual orientation, disability is a ground enumerated in the *Charter*. As such, governments have had ample time to make the legislative amendments necessary to ensure conformity with the *Charter's* demands. Indeed, it was for that very reason that the coming into force of s. 15 of the *Charter* was delayed three years, until April 17, 1985. Despite that fact, no legislation has been introduced to redress the inequality in the provision of medical services to the Deaf, even on an incremental basis.

(1) Is there a pressing and substantial Government objective?

108. The initial task of defining the objective of the legislation under review is never self-evident. The more broadly the objective is defined, the more readily it may be upheld as pressing and substantial. The difficulties associated with this process may be particularly acute where, as here, the *Charter* violation is the result of a failure on the part of government to take the legislative steps necessary to ensure that equal benefit of the law has been obtained.

109. The objective of the complete legislative scheme in issue is, as indicated in the preamble to the *Medical and Health Care Services Act*, to provide reasonable access to quality medical care to all British Columbians. But is it this, obviously unassailable, objective which is to be assessed, or is it the Government's objective in refusing to fund sign language interpretation services for Deaf persons receiving medical services under that *Act* and the *Hospital Insurance Act*?

110. In our respectful submission, it is the Government's objective in refusing to provide funding for medical sign language interpreters that is relevant to the s. 1 inquiry. It was the failure to include such services under the Medical Services Plan which, in the Appellants' submission, led to a violation of s. 15. Logically, therefore, it is that omission which must be justified as pressing and substantial, not the laudatory objectives of the legislation from which such services were excluded.

Pothier, "M'Aider, Mayday: Section 15 of the *Charter* in Distress", *supra*, at pp. 311 - 14.

111. The evidence at trial clearly indicated that the Government sought to achieve two objectives by excluding interpreting services for the Deaf from publicly funded medical services:

(1) The reduction of the cost of medical services; and

(2) The avoidance of a precedent that would lead to requests from ethnic communities for interpreting services where language barriers might be a factor.

Transcript, COA p.104, ll. 16-20, l. 32 - p.105, l. 18,
p.106, ll. 9-20, p.246, ll. 3-14, p.282, ll. 2-45.
Trial Court Reasons for Judgment, COA, p.464, ll. 6-18.

112. It is submitted that neither of the objectives is sufficiently important to warrant overriding the Appellants' rights under s. 15 of the *Charter*. With respect to the objective of reducing costs, as Lamer C.J.C., speaking for the majority of the Court, stated in *Schachter*:

> This court has held, and rightly so, that budgetary considerations cannot be used to justify a violation under s.1.

Schachter v. Canada, [1992] 2 S.C.R. 679 at p. 709.

113. While governments legitimately consider finances in making legislative choices, financial considerations alone cannot be sufficiently pressing and substantial to justify the violation of constitutional rights. That is because "it is inherent in the nature of constitutional rights that they must receive a higher priority in the distribution of available Government funds than policies or programs that do not enjoy that status". Unless all Government funds are currently committed to programs necessary to maintain the constitutional rights of other individuals, the cost of a program cannot of itself be of sufficient importance to warrant overriding a constitutional right if that program is necessary to preserve constitutional rights.

Weinrib, "The Supreme Court of Canada and Section 1
of the Charter" (1988) 10 S.Ct. L.R. 469 at p. 486.

114. With respect to the Government's second objective, it seems to consist of two distinct goals: first, to avoid the political inconvenience or embarrassment of receiving requests from ethnic communities for interpreting services if sign language interpreting services for the Deaf are funded; and second, to avoid taking any steps which might encourage other groups to assert constitutional or other claims against the Government for funding for interpreting services.

115. The first of these goals clearly does not warrant overriding a *Charter* right. Governments cannot avoid the rigors and stresses inherent in the democratic process by violating a constitutional right. If this were a valid goal, a great number of constitutional rights could be violated in the interest of creating a more docile citizenry. Likewise, governments cannot justify violating individual rights in order to deter other groups from pursuing what may or may not be legitimate constitutional claims. In this case, the goal of deterring various non-English language groups from pursuing other constitutional claims against the Government, whether meritorious or not, cannot warrant violating the constitutional rights of the Deaf.

116. Further, and in any event, it is by no means clear that non-English speaking groups would stand in an analogous position to the Deaf in making such a claim. The qualitatively different obstacles faced by the Deaf by virtue of their disability in attempting to communicate in any spoken language were established at trial. Moreover, if the extent of the financial burden to be imposed on government in order to ensure compliance with the *Charter* is relevant at any stage of the analysis prior to remedy, then the weight of that financial burden may also be different in a s. 1 analysis respecting the *Charter* claims of hearing non-English speakers. The outcome of such a potential claim cannot be predicted in advance. Certainly the possibility that such a claim might be made, let alone that it could succeed, cannot justify the constitutional infringement of the rights of the Deaf.

Transcript, COA p.142, ll. 35-45, p.143, ll. 1-9, p.145, ll. 15-35, p.155, ll. 9-26, p.157, l. 45 - p.158, l. 6.

(2) Rational Connection

117. Even if budgetary considerations could be a pressing and substantial objective warranting overriding the constitutional rights of the Deaf, the Government has not discharged its onus to show that there is a net cost to the health care budget, let alone the entire Provincial budget, associated with the provision of interpreting services for the Deaf.

118. The evidence indicates that the maximum cost of a complete sign language interpretation service would be approximately $150,000.00 per year. There is also considerable evidence, however, that the failure to provide interpretation services increases costs to the provincial health care budget under the Medical Services Plan. It has been established that poor communication between doctor and patient, as may occur in the absence of an interpreter, increases the probability of mis-diagnosis and complications in treatment and impedes efforts to minimize future illness through advice and instruction in preventative medicine. Further, the evidence indicates that less is achieved in visits to the physician when an interpreter is not present. This will lead inevitably to Deaf patients having to visit their physicians more frequently in order to obtain anything approaching the same medical care which hearing persons receive in fewer visits. The inevitable result of mis-diagnoses, complications, poor preventative medicine and increasingly frequent visits can only be significantly higher cost to the publicly funded medical services program. The Government has not submitted any studies showing the total financial cost, let alone human cost, of the Deaf receiving inferior health care. Given the high cost of medical services, however, it is likely these costs would exceed the approximately $150,000.00 which the Government appears to save by withholding interpreting services from the Deaf.

119. The Government has therefore failed to discharge its burden of showing that the violation of the rights of the Deaf actually result in a cost saving. Hence, the Government has failed to show any rational connection between the refusal to provide interpretive services and reducing Government costs.

Egan, supra, at pp. 608 - 11 (per Iacobucci J.).

120. With respect to the second objective, although both Alberta and Manitoba provide interpreting services to the Deaf, there is no evidence that in either province non-English language groups have pursued constitutional claims for publicly funded interpretation services, nor that the government has granted these services as a matter of government policy. There is, therefore, no demonstrated rational connection between denying the constitutional rights of the Deaf and the objective of avoiding claims by non-English language groups.

(3) Minimal Impairment

121. In *Keegstra*, Dickson, C.J.C. stated that minimal impairment requires that the means adopted by the Legislature "should be carefully tailored so as to minimize impairment" of the fundamental right in issue.

R. v. Keegstra, [1990] 3 S.C.R. 697 at p. 771.

122. Courts will not hold government to a standard of perfection in determining the means by which it may attempt to achieve its valid legislative objectives. At the same time, the leeway to be granted is not infinite: government must demonstrate that its actions infringe the rights in question no more than is reasonably necessary to achieve its goals. Thus, the Court has cautioned that:

> It should go without saying, however, that the deference that will be accorded to the government when legislating in these matters does not give them an unrestricted licence to disregard an individual's *Charter* rights. Where the government cannot show that it had a reasonable basis for concluding that it had complied with the requirement of minimal impairment in seeking to obtain its objectives, the legislation will be struck down.
>
> *Tétreault-Gadoury v. Canada (E.I.C.)*, [1991] 2 S.C.R. 22 at p. 44 (per LaForest J.).

123. For the reasons stated above with respect to the lack of a rational connection, the Government has failed to discharge the onus of demonstrating that the failure to provide interpreting services to the Deaf is so carefully tailored to the objectives sought as to minimize the impairment of the constitutional rights of the Deaf. In this connection, it is important to emphasize that the maximum cost sought to be saved by violating the rights of the Deaf is only $150,000.00, or approximately 0.0025% of the Provincial health care budget at the time of trial. The Government could readily minimize the impairment of the fundamental rights of the Deaf without incurring any additional cost by taking the sum from any other program which is not necessary to preserve constitutional rights. In this way, the Government would achieve its objective of reducing costs without impairing the constitutional rights of the Deaf. The presence

of such alternatives strongly suggests that the Government's failure to provide the necessary services does not satisfy the minimal impairment test.

Miron, supra, at pp. 504 - 08.

124. In assessing whether the Government has established that its failure to provide medical interpreting services for the Deaf minimally impairs their right to equality, it must be kept in mind that the Government has failed to provide <u>any</u> medical sign language interpreter services whatsoever. If the Government had made <u>some</u> provision for such services, it might be able to argue that it had addressed the Deaf's concerns in a reasonable way. As it is, there is a complete denial of the benefit in issue, which cannot be said to impair minimally the Deaf's right to equality.

Tétreault-Gadoury, supra, at p. 47.

(4) Effects

125. Under this branch of the s. 1 analysis, the question to be addressed is whether the denial of interpreters so severely trenches on individual or group rights that the salutary effects of the denial are outweighed by the deleterious effects of the abridgement of rights.

Dagenais v. CBC, [1994] 3 S.C.R. 835 at pp. 888-889.

126. The nature of this analytical balancing was described in more detail by McLachlin J., in *Keegstra*, as follows:

> The analysis is essentially a cost-benefit analysis. On the one hand, how significant is the infringement of the fundamental right or freedom in question? On the other hand, how significant is the benefit conferred by the impugned legislation?

Keegstra, supra, at p. 863.

127. When this analysis is performed, it is clear that the refusal to provide interpreting services for the Deaf cannot be justified. The objectives proffered by the Government are not

particularly pressing or substantial. Further, the evidence indicates that, to the extent there is any rational connection between the violation of the constitutional rights of the Deaf and the Government's objectives, the connection is a very weak one. There is no reason to believe that there is any net saving in refusing to provide the interpreting service nor is there any reason to believe that providing the service will encourage other groups to press successfully for additional funding. Finally, the total cost of the program when measured against the health care budget or the entire Provincial Budget, is negligible. On the other hand, the refusal to fund interpreting services for the Deaf has a profound effect upon the fundamental rights of these individuals. The evidence has clearly demonstrated that without interpreters, the Deaf receive medical services which in both nature and quality are inferior to those received by other residents of British Columbia. Given the central place of good health in the quality of life of all persons in our society, the provision of inferior medical services to the Deaf must necessarily diminish the overall quality of their lives. When the profound effect of the violation of the constitutional rights of the Deaf are placed in balance against the benefit of the Government's refusal of interpreting services to the Deaf, it is clear that those benefits do not outweigh the abridgement of the rights.

128. In the Appellants' submission, the violation of the constitutional rights of the Deaf is clearly not a reasonable limit which is demonstrably justified under s. 1.

C. Remedy

129. This is an appropriate case in which to grant the remedy of "reading in" the benefit which has been unconstitutionally withheld from the Appellants. No other remedy will meet the objective of providing the Appellants with adequate redress for the violation of their right to equality while at the same time preserving the beneficial legislative scheme which the Provincial Government has put in place for the provision of publicly funded medical services. In *Schachter*, Chief Justice Lamer provided the following guidelines as to when reading in will be the appropriate remedy for a violation of constitutional rights:

A. The legislative objective is obvious, or it is revealed through the evidence offered pursuant to the failed s.1 argument, and severance or reading in would further that objective or constitute a lesser interference with that objective than would striking down;

B. The choice of means used by the legislature to further that objective is not so unequivocal that severance/reading in would constitute an unacceptable intrusion into the legislative domain; and

C. Severance or reading in would not involve an intrusion into legislative budgetary decisions so substantial as to change the nature of the legislative scheme in question.

Schachter, supra, at p.718.

130. The legislative objective of the scheme by which the public receives funded medical services in the Province of British Columbia is obviously to ensure that all residents of the Province receive the medical care which they need. Reading in the provision of interpreters for the Deaf as part of this scheme would further that objective, and would clearly constitute a lesser interference with that worthy objective than would striking down the legislation in its entirety.

131. Given the global size of the health care budget of 6 billion dollars, and the fact that the provision of this service on an annual basis would cost only $150,000,00, or 0.0025% of the health care budget, reading in a requirement to provide interpreters for the Deaf would not involve an intrusion into legislative budgetary decisions so substantial as to change the nature of the legislative scheme in question. As was stated by Chief Justice Lamer in *Schachter,* any remedy granted by a court will have budgetary repercussions, and the question is not whether the remedial choice of reading in would have an impact on budgetary policy, but rather whether it would be an inappropriate impact. Given the percentage of the global budget which this expenditure would represent, it cannot be argued that this would be an inappropriate intrusion into the budgetary scheme. This is a situation like *Knodel, supra,* and *Tétreault-Gadoury*, *supra,* in which the group that will receive the benefit, in this case the Deaf, is much smaller than the group already receiving the benefit, the hearing, and accordingly, a reading in remedy is

constitutionally appropriate. As in *Miron*, "to deny such persons a remedy would be to perpetuate the effects of a discrimination which the Court has found to violate the *Charter*."

Schachter, supra, at pp. 709-12.
Knodel, supra, at pp. 388-92.
Miron, supra, at pp. 508-10 (per McLachlin J.).

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PART IV

NATURE OF THE ORDER SOUGHT

132. The Appellants ask that the appeal be allowed and that the decision of the Court of Appeal be overturned. Further, the Appellants ask the Court for the following:

(a) A declaration that the continuing failure of the Government to provide interpreters to the Deaf for publicly funded medical services in the Province of British Columbia is contrary to s.15(1) of the *Charter* and is not a reasonable limit pursuant to s.1 of the *Charter*;

(b) A requirement that interpreters be provided to the Deaf by the Government for all medical services funded by the Government, be read into the *Medical and Health Care Services Act and Regulations*, the *Hospital Insurance Act and Regulations*, and any other legislation pursuant to which such medical services are provided by the Government;

(c) Costs; and

(d) Such further and other relief as this honourable Court deems just.

All of which is respectfully submitted on behalf of the Appellants, John Warren, Linda Warren and Robin Eldridge.

Dated November 14, 1996, at Vancouver, British Columbia.

Lindsay M. Lyster

Robert W. Grant

Andrea L. Zwack

Nitya Iyer

NOTICE TO THE RESPONDENTS: Pursuant to subsection 44(1) of the *Rules of the Supreme Court of Canada*, this appeal will be inscribed by the registrar for hearing after the respondent's factum has been filed or on the expiration of the time period set out in paragraph 38(3)(b) of the said Rules, as the case may be.

CHAPTER C-6

An Act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services

Preamble

WHEREAS the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada aux services de santé assurés pris en charge par les régimes provinciaux d'assurance-santé et les montants payables par le Canada pour les programmes de services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélio-

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

ration de la santé et du bien-être des Canadiens;

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*. 1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé*. 1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" «*loi...*»

"Act of 1977" means the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*;

"cash contribution" «*contribution pécuniaire*»

"cash contribution" means the amount of the established programs cash contribution referred to in paragraph 13(1)(*b*) of the Act of 1977 that is allocated by the Minister of Finance under section 19 of that Act in respect of the insured health services program of a province;

"contribution" «*contribution*»

"contribution" means the established programs financing contribution referred to in paragraphs 13(1)(*a*) and (*b*) of the Act of 1977 that may be provided to a province in respect of the insured health services program of the province;

"dentist" «*dentiste*»

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" «*services complémentaires...*»

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" «*surfacturation*»

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

«assuré» «*assuré*» "*insured person*"

«assuré» Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la *Loi sur les pénitenciers*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

«contribution» «*contribution*» "*contribution*"

«contribution» La contribution pour le financement des programmes établis visée aux alinéas 13(1)*a*) et *b*) de la loi de 1977 qui peut être versée à une province pour son programme de services de santé assurés.

«contribution pécuniaire» «*contribution pécuniaire*» "*cash...*"

«contribution pécuniaire» La fraction de la contribution pour le financement des programmes établis visée à l'alinéa 13(1)*b*) de la loi de 1977 qui est payable comptant et affectée par le ministre des Finances en vertu de l'article 19 de cette loi au programme de services de santé assurés d'une province.

«dentiste» «*dentiste*» "*dentist*"

«dentiste» Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

«frais modérateurs» «*frais modérateurs*» "*user...*"

«frais modérateurs» Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non paya-

be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime...»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel...»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *«services hospitaliers»*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *«services de santé...»*

"insured health services" means hospital services, physician services and surgical-dental

bles, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

«habitant» *"resident"*

«habitant» Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

«hôpital» *"hospital"*

«hôpital» Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

«loi de 1977» *"Act..."*

«loi de 1977» *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces et sur les contributions fédérales en matière d'enseignement postsecondaire et de santé.*

«médecin» *"medical..."*

«médecin» Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

«ministre» *"Minister"*

«ministre» Le ministre de la Santé nationale et du Bien-être social.

«professionnel de la santé» *"health care practitioner"*

«professionnel de la santé» Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

«régime d'assurance-santé» *"health care insurance..."*

«régime d'assurance-santé» Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

«services complémentaires de santé» *"extended..."*

«services complémentaires de santé» Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" «*assuré*»

"insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" «*médecin*»

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" «*ministre*»

"Minister" means the Minister of National Health and Welfare;

"physician services" «*services médicaux*»

"physician services" means any medically required services rendered by medical practitioners;

"resident" «*habitant*»

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" «*services de chirurgie...*»

"surgical-dental services" means any 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 procedures;

"user charge" «*frais...*»

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing. 1984, c. 6, ss. 2, 33.

«services de chirurgie dentaire» «*services de chirurgie dentaire*» "*surgical-dental...*"

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

«services de santé assurés» «*services de santé assurés*» "*insured health...*"

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

«services hospitaliers» «*services hospitaliers*» "*hospital services*"

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

«services médicaux» «*services médicaux*» "*physician...*"

«services médicaux» Services médicalement nécessaires fournis par un médecin.

«surfacturation» «*surfacturation*» "*extra-billing*"

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime

provincial d'assurance-santé. 1984, ch. 6, art. 2 et 33.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. 1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre. 1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law. 1984, c. 6, s. 4.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir des conditions d'octroi et de versement du plein montant prévu à la loi de 1977 à l'égard des services de santé assurés et des services complémentaires de santé fournis en vertu de la loi d'une province. 1984, ch. 6, art. 4.

CASH CONTRIBUTIONS AND PAYMENTS

Cash contribution

5. Subject to this Act, as part of the contribution provided by Canada to each province, a full cash contribution is payable under the Act of 1977 for each fiscal year in respect of the cost of insured health services provided under a health care insurance plan of the province. 1984, c. 6, s. 5.

CONTRIBUTIONS PÉCUNIAIRES ET VERSEMENTS

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse pour chaque exercice, en vertu de la loi de 1977, comme fraction de sa contribution à chaque province, une pleine contribution pécuniaire à l'égard du coût des services de santé assurés fournis au titre d'un régime d'assurance-santé de la province. 1984, ch. 6, art. 5.

Amount payable for extended health care services

6. In addition to the cash contribution referred to in section 5, a full amount is payable by Canada to each province under section 23 of the Act of 1977 for each fiscal year in respect of the extended health care services program if the province complies with the conditions set out in section 13 of this Act. 1984, c. 6, s. 6.

Versement pour les services complémentaires de santé

6. En plus de la contribution pécuniaire visée à l'article 5, le Canada verse un plein montant à chaque province, pour chaque exercice, à l'égard du programme de services complémentaires de santé en vertu de l'article 23 de la loi de 1977, si la province se conforme aux conditions prévues à l'article 13 de la présente loi. 1984, ch. 6, art. 6.

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility. 1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité. 1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof. 1984, c. 6, s. 8.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard. 1984, ch. 6, art. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners. 1984, c. 6, s. 9.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé. 1984, ch. 6, art. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions. 1984, c. 6, s. 10.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes. 1984, ch. 6, art. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period,

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois

in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay. 1984, c. 6, s. 11.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), «services de santé assurés facultatifs» s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai. 1984, ch. 6, art. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(*c*) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (*a*), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province. 1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTIONS OR PAYMENTS

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5 or payment of the full amount referred to in section 6 for a fiscal year, the government of the province

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c*) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a*), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b*), sauf par une loi de la province. 1984, ch. 6, art. 12.

CONDITIONS DE VERSEMENT

Obligations de la province

13. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 ou du plein montant visé à l'article 6 est assujetti à l'obligation pour le gouvernement de la province :

HOSPITAL INSURANCE ACT

CHAPTER 180

Interpretation

1. In this Act

"beneficiary" or "qualified person" means a resident or a dependent of a resident who is eligible for benefits in accordance with the regulations;

"benefits" means the general hospital services authorized under this Act, and for an agreement made under section 19 of this Act with Canada under the *Hospital Insurance and Diagnostic Services Act* (Canada) means "insured services" as specified in such an agreement;

"hospital" means, except in sections 25 and 29 (a),

(a) a hospital as defined by either section 1 of the *Hospital Act* that has been designated under this Act by the Lieutenant Governor in Council as a hospital required to furnish the general hospital services provided under this Act;

(b) a private hospital as defined by section 5 of the *Hospital Act* with which the Province has entered into an agreement requiring the hospital to furnish the general hospital services provided under this Act;

(c) a hospital owned and operated by Canada that has been designated under this Act a "federal hospital";

(d) an agency or establishment which provides a service to hospitals or a health service and which has been designated as a "hospital facility" by the Lieutenant Governor in Council; or

(e) an establishment in which out patient services are available and which has been designated a diagnostic and treatment centre by the Lieutenant Governor in Council for providing out patient benefits to beneficiaries in accordance with this Act and the regulations;

"resident" means a person who has made his home in British Columbia and is ordinarily present in it, but does not include a tourist, a transient or a visitor to the Province.

RS1960-180-2; 1974-106-Sch.; 1975-28-1; 1985-9-9; 1987-59-6; 1990-51-19.

Residence regulations

2. The Lieutenant Governor in Council may, by regulation, make provisions necessary for determining whether a person has made his home in British Columbia and is ordinarily present in it and for determining the conditions under which a person ceases to be a resident of the Province.

RS1960-180-3; 1983-10-24, effective October 26, 1983 (B.C. Reg. 393/83).

Beneficiaries

3. (1) Subject to this Act and the regulations, every qualified person or beneficiary is entitled to receive the general hospital services provided under this Act.

(2) In determining who shall be a beneficiary in accordance with this section, the decision of the minister is final.

RS1960-180-4; 1974-106-Sch.

Benefits for beneficiaries only

4. No person other than a qualified person is entitled to the benefits provided by this Act.

RS1960-180-5.

Benefits

5. (1) The general hospital services provided under this Act are

(a) for qualified persons requiring treatment for acute illness or injury: the public ward accommodation, necessary operating and case room facilities, diagnostic or therapeutic Xray and laboratory procedures, anaesthetics, prescriptions, drugs, dressings, cast materials and other services prescribed by regulation;

(b) for qualified persons requiring active treatment for chronic illness or disability: the public ward accommodation, physiotherapy and occupational therapy, minor operating room and diagnostic Xray and laboratory services, prescriptions, drugs, dressings, cast materials and other services prescribed by regulation; and

(c) for qualified persons requiring treatment or diagnostic services as out patients: the out patient treatment or diagnostic services prescribed by regulation and, for this paragraph, the regulations may authorize the minister to define categories of out patient care and specify the treatment or diagnostic services to be provided for those categories;

but do not include

(d) transportation to or from hospital,

(e) services or treatment that the minister, or a person designated by him, determines, on a review of the medical evidence, the qualified person does not require, or

(f) services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council.

(2) No person is entitled to receive any of the benefits under this Act unless

(a) it has been certified in the manner provided in the regulations that he requires the services; and

(b) he proves to the satisfaction of the minister that he is a beneficiary by making an application for benefits in the manner and form specified by the minister on being admitted to hospital; and if the person requiring admission to a hospital is unable to make an application, or if he is a dependent, it shall be made on his behalf by a member of his family or some other person having knowledge of the facts required to be stated in an application.

(3) If a person does not obtain certification as provided in subsection (2), he shall have no claim against the hospital insurance fund for general hospital services provided to him.

(4) Subject to the approval of the Lieutenant Governor in Council, the right of a beneficiary to receive the benefits under this Act may be made subject to the payment by or on behalf of the beneficiary of a portion of the cost of providing any treatment or services rendered to the beneficiary by a hospital, and the Province shall pay, on behalf of any person who is certified by the Minister of Human Resources to be a person entitled to health services, a charge levied under this subsection against that person.

RS1960-180-6; 1974-106-Sch.; 1975-28-2; 1983-10-21, effective October 26, 1983 (B.C. Reg. 393/83); *{amended 1985-9-10, not in force, amendment not included}*; 1987-59-7.

Payment for organ donor not a beneficiary

6. Notwithstanding anything in this Act, where a beneficiary requires an organ transplant from a donor who is not a beneficiary, the cost of diagnosis, services and

Certified correct as passed Third Reading on the 3rd day of July 1992
Ian D. Izard, Law Clerk

MINISTER OF HEALTH AND
MINISTER RESPONSIBLE FOR SENIORS

BILL 71 – 1992

(Chapter 76)

MEDICAL AND HEALTH CARE SERVICES ACT

Contents

(d) the *Naturopaths Act*, for a naturopathic physician,

(e) the *Optometrists Act*, for an optometrist,

(f) the *Physiotherapists Act*, for a massage practitioner or physiotherapist,

(g) the *Podiatrists Act*, for a podiatrist, or

(h) the governing Act, bylaws or rules, for a member of a health care profession or occupation prescribed for the purposes of paragraph (h) of the definition of "health care practitioner";

"appropriation" means an appropriation as defined in the *Financial Administration Act*;

"approved diagnostic facility" means a diagnostic facility approved under section 28;

"beneficiary" means a resident who is enrolled in accordance with section 6, and includes that resident's spouse or child who is a resident and has been enrolled under section 6;

"benefits" means

(a) medically required services rendered by a medical practitioner who is enrolled under section 12, unless the services are determined under section 4 by the commission not to be benefits,

(b) required services prescribed as benefits under section 45 and rendered by a health care practitioner who is enrolled under section 12, or

(c) medically required services performed in accordance with protocols agreed to by the commission, or on order of the referring practitioner, who is a member of a prescribed category of practitioner, in an approved diagnostic facility by, or under the supervision of, a medical practitioner who has been enrolled under section 12, unless the services are determined under section 4 by the commission not to be benefits;

"board" means the Medical and Health Care Services Appeal Board established under section 35;

"chair", other than in Part 7 or with reference to a subcommittee, means the individual who is appointed under section 2 to chair the commission;

"child" means a person who

(a) is a child of a beneficiary or a person in respect of whom a beneficiary stands in the place of a parent and who

(7) The commission may sue or be sued in its own name or in the name of the Crown in right of the Province in any civil action respecting the commission or a subcommittee, but any proceeding by or against the commission is binding on the Crown in right of the Province, and the *Crown Proceeding Act* applies accordingly.

1992-76-2.

Repeal and replacement of section 2

2.1 Section 2 is repealed and the following substituted:

Commission and Medical Services Plan

2. (1) The Medical Services Commission is continued consisting of 9 members appointed by the Lieutenant Governor in Council as follows:

(a) 3 members appointed from among 3 or more persons nominated by the British Columbia Medical Association;

(b) 3 members appointed on the joint recommendation of the minister and the British Columbia Medical Association to represent beneficiaries;

(c) 3 members appointed to represent the government

and the commission reports to the minister.

(2) The Medical Services Plan established under the former Act is continued and the function of the commission is to facilitate, in the manner provided for in this Act, reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan.

(3) The Lieutenant Governor in Council must designate a member of the commission appointed under subsection (1) (c) as its chair and may designate another member of the commission as its deputy chair.

(4) The chair of the commission shall call a meeting at least once every 2 months and, by giving written notice to the chair, 3 or more members of the commission can require the chair to call a meeting.

(5) In the event that a member of the commission is absent for more than 3 consecutive meetings of the commission, the member ceases to be a member of the commission.

(6) Notwithstanding subsection (5) the commission may waive this requirement with the agreement of a majority of the commission.

(7) Each member of the commission shall have one vote.

(8) Decisions of the commission shall be upon the agreement of the majority of members present at a meeting.

(9) If the commission is not meeting, the chair may exercise a power, duty and function that the commission may exercise unless the commission has directed that the chair is not to exercise the power, duty or function.

(t) exercise other powers or functions that are authorized by the regulations or the minister.

(2) The commission must not act under subsection (1) in a manner that does not satisfy the criteria described in section 7 of the *Canada Health Act* (Canada).

(3) The commission has, for the purposes of conducting hearings under this Act, the powers, privileges and protections of a commissioner under sections 12, 15 and 16 of the *Inquiry Act*.

(4) The *Financial Administration Act* applies to the commission as though the commission were a division of the ministry that is administered by the minister.

(5) The commission must prepare and file with the minister as soon as practicable each year a report for the fiscal year ending March 31 in that year respecting the work of the commission and its subcommittees, and the minister must lay the report before the Legislative Assembly as soon as is practicable.

1992-76-4.

Power to delegate

5. The commission may delegate any of the commission's or chair's powers or duties other than the commission's power under section 10 (2), 14 (2), 19 to 21, 28 (4) or 32 (1) to a person named by the commission.

1992-76-5.

PART 2

BENEFICIARIES

Eligibility and enrollment of beneficiaries

6. (1) A resident who wishes to be enrolled as a beneficiary on his or her own behalf, or on behalf of his or her spouse or children, must apply to the commission in the manner required by the commission.

(2) The commission must, after determining that the applicant, the spouse of the applicant and each of the applicant's children named in the application are residents, enroll as beneficiaries those covered by the application who are residents, effective not more than 3 months after receipt of the application.

(3) The commission may, at the time of enrollment under subsection (2), or at any other time, enroll as a beneficiary a spouse or a child of a beneficiary after the commission determines that the spouse or child is a resident.

(4) An enrollment under subsection (2) or (3) may be made effective on a date preceding the date of application for enrollment.

(5) A beneficiary enrolled under subsection (2) or (3) must pay to the commission the applicable premiums.

(6) Every person who was an insured person under the former Act immediately before this Act came into force is a beneficiary under this Act until he or she ceases to be a beneficiary in accordance with this Act or the regulations.

(7) The commission may cancel the enrollment of a beneficiary if the commission determines that the beneficiary no longer is a resident.

(8) If a person paid premiums for a period after which cancellation of that person's enrollment as a beneficiary took effect, the commission must, if practicable, refund the amount of those premiums to the person who paid them.

1992-76-6.

Premiums

7. (1) The Lieutenant Governor in Council may prescribe premium rates for beneficiaries.

(2) The rates may be different for different categories of beneficiaries, as defined in the regulations, and the regulations may provide that, in respect of a category of beneficiaries as defined in the regulations, no premiums are payable.

(3) A premium that has not been paid during any period in which a beneficiary has been enrolled may be recovered by the commission as a debt owing to the commission.

1992-76-7.

Payments for benefits and cancellation or extension of enrollment

8. (1) A beneficiary is, subject to sections 9 (1), 10, 13 and 14, entitled to have payment made for a benefit that he or she has received, in accordance with amounts in a payment schedule, less any applicable patient visit charge.

(2) The commission may cancel the enrollment of a beneficiary who has failed to pay premiums

(a) within the time required by the commission, or

(b) within any extension of time that may be given by the commission.

(3) An extension under subsection (2) (b) may be given after the time under subsection (2) (a) has expired.

(4) A beneficiary whose enrollment is cancelled under subsection (2) may, with the consent of the commission, be reinstated on payment of the arrears owing at the time of the reinstatement.