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
(PLAINTIFFS)

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA and MEDICAL SERVICE COMMISSION

RESPONDENTS
(DEFENDANTS)

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PART I

STATEMENT OF FACTS

1. Except as follows, these respondents accept the Appellants' Statement of Facts.

The Plaintiffs' Statement of Facts

2. Many of the "facts" alleged by the plaintiffs are recitations of the evidence given by their witnesses rather than facts found by the learned trial judge. In the case of some of the impressionistic statements made by the plaintiffs and their doctors, and in the case of much of the testimony of Dr. Rodda, the evidence was, it was submitted, of dubious weight. While the plaintiffs' description of statements made in evidence is (except as noted below) generally accurate, it is not buttressed by findings of fact by the trial court.

3. With respect to paragraph 8 of the Appellants' Statement of Facts, while Mrs. Warren gave evidence that she was not certain that the nurse who pointed to her heart and then pointed downwards meant that one of the babies' heart rates had gone down, she did conclude that the nurse intended to convey that message.

Reasons for Judgment at Trial, Case on Appeal ("COA") p. 457, ll. 10-14;

4. With respect to paragraph 9 of the Appellants' Statement of Facts, while it is true that Mrs. Warren stated that she and her husband were unable to understand the condition of their babies until two days after their birth, this statement must be taken in context. Mr. Warren did not give any evidence supporting this statement. Mrs. Warren also stated that her mother-in-law attended at the hospital prior to that time, and was able to communicate information to her. Mrs. Warren says, however, that she did not consider the information to be sufficient.

Testimony of Linda Warren, COA p. 29, ll. 28-45

5. With respect to paragraph 11 of the Appellants' Statement of Facts, the evidence with respect to the financial ability of the Warrens to hire an interpreter for the birth of their third child was, at best, equivocal. When Mr. Warren was asked by his own counsel whether he felt that he

could afford to hire an interpreter, his answer was "Well, I don't know. I doubt it", but stated that he would be hiring one in any event. The learned trial judge found that "the evidence that these plaintiffs could not afford to hire interpreters for medical procedures was not very compelling." The Warrens have some disposable income (estimated variously at $100-$300 and at $500.00) left over at the end of each month.

Testimony of John Warren COA p. 20, l. 41 to p. 21, l. 12
Reasons for Judgment at Trial, COA p. 457, ll. 19-21; p. 490, ll 12-15

6. With respect to paragraph 18 of the Appellants' Statement of Facts, the respondents agree that the paragraph accurately reflects the testimony given by Mrs. Eldridge. That plaintiff's feelings of frustration was evident at trial. However, the respondents took issue with idea that "Robin found communication with her doctor very easy and clear with the assistance of an interpreter"; it was evident at trial that even with the aid of an interpreter, Mrs. Eldridge had a great deal of difficulty communicating with hearing people. The learned Trial Judge made no findings of fact with respect to the ease of communications between Mrs. Eldridge and her doctor when she communicated with the aid of an interpreter.

7. With respect to paragraph 20 of the Appellants' Statement of Facts, while the learned trial judge found that Mrs. Eldridge cannot afford to hire an interpreter for every visit to the doctor or hospital, he also found that she can afford to and will hire an interpreter for important medical situations in the future.

Reasons for Judgment at Trial, COA, p. 455, ll. 3-9

8. With respect to the evidence of Dr. Tildesley, and particularly paragraph 26 of the Appellants' Statement of Facts, it must be recognized that this doctor's account of a deterioration in Mrs. Eldridge's condition after interpretation services were withdrawn by the W.I.D. is not reflected in his contemporaneous notes. The trial judge found Dr. Tildesley's attempt to suggest that the absence of interpretation services had caused a deterioration in Mrs. Eldridge's health to be unconvincing.

Exhibit 4, Letter from Dr. Tildesley to Dr. Williams, January 13, 1992 COA p. 341
Exhibit 5 Chart Notes of Dr. Tildesley, COA pp. 343-347

Testimony of Dr. Tildesley, COA, p. 85, l. 45 - p. 87, l. 1; p. 89, l. 44-p. 90, l. 28; p. 95, l. 31- p. 96, l. 23
Reasons for Judgment at Trial, COA p. 456, ll. 14-20.

9. Although Dr. Tildesley did give evidence to the effect that he finds communication by notes to be time-consuming, he has not made attempts to accommodate Mrs. Eldridge by booking longer appointments for her.

Testimony of Dr. Tildesley, COA, p. 96, ll. 24-31 and p. 97, ll. 19-29

10. In view of the fact that neither Dr. Tildesley's contemporaneous notes nor his practice corroborate his testimony as to the difficulties he experienced with Mrs. Eldridge, it is submitted that his testimony must be treated with caution except in cases where it was expressly accepted by the learned trial judge.

11. The evidence attributed to Dr. Tildesley in paragraph 27 of the Appellants' Statement of Facts was, in fact, expressly recanted by him. He did not hire an interpreter for any deaf patient's visits to him. He did, however, on a single occasion, use hospital funds to hire an interpreter for a course attended by a deaf patient.

Testimony of Dr. Tildesley, COA p. 83, ll. 22-47.

12. With respect to paragraph 39 of the Appellants' Statement of Facts, Dr. Rodda did not state that "only a very small number of deaf people have acquired reasonable proficiency in English." While Dr. Rodda was an evasive witness with respect to the ability of deaf persons to learn English symbols for concepts familiar to them, he finally stated that a deaf person, having learned a concept through sign language or through his or her own experience, would have little difficulty learning a symbol for that concept, including an English language symbol. He also stated that there are clinical indications that the average reading comprehension level of deaf people is increasing, partly because of the advent of the Telephone Device for the Deaf ("TDD") and the "insta-caption" system. There is no such thing as written American Sign Language, so deaf people in Canada communicate in writing using English.

Testimony of Dr. Rodda, COA, p. 167, ll. 9-19; p. 169, ll. 16-32

13. With respect to paragraph 44 of the Appellant's Statement of Facts, the learned trial judge rejected Dr. Rodda's evidence with respect to misdiagnosis of schizophrenia and mental handicaps. The learned trial judge indicated that he was "prepared to conclude" only that "miscommunication or a lack of communication between a deaf person and his or her doctor *could* lead to a misdiagnosis" [emphasis added]

Reasons for Judgment at Trial, COA p. 459, l. 16 - p. 460, l. 8

14. With respect to paragraph 48 of the Appellants' Statement of Facts, the evidence cited with respect to 1989 establishes that the W.I.D. made a request to government for funding that year and that the request was rejected because the request came in the middle of a fiscal year, and there were no funds available for a new program.

15. With respect to paragraph 51 of the Appellants' Statement of Facts, the evidence is that members of the Executive received Mr. van Rheenan's briefing note in advance of the meeting, and would have had an opportunity to review it. The "twenty minute" period referred to in the evidence refers to the time taken at an Executive Committee meeting to come to a decision, not to the time spent by members of the committee reviewing the proposal.

Read-in Discovery Evidence of Peter van Rheenan, COA, p. 104, ll. 16-42

16. With respect to paragraph 52 of the Appellants' Statement of Facts, while it is true that no special research had been conducted prior to the Executive Committee meeting, the members of the Executive Committee were very well aware of the potential demand for interpretive services for non-English speakers.

Testimony of Gary Curtis, COA, p. 282, ll. 21-31

17. With respect to paragraph 55 of the Appellants' Statement of Facts, the report *Closer to Home* does recommend the elimination of barriers, but does not suggest that it is feasible to eliminate "all" barriers.

18. The Appellants' Statement of Facts should be supplemented as follows:

The Plaintiffs

19. The plaintiffs have consciously chosen to be treated by general practitioners who cannot communicate in American Sign Language. Linda Warren previously attended a general practitioner who was able to communicate in American Sign Language, but switched physicians in order to save 15 minutes driving time. She did not consider the extra 15 minute's drive worthwhile. Robin Eldridge's specialist suggested that she attend a general practitioner who could communicate in American Sign Language. Mrs. Eldridge advised her general practitioner that she wished to transfer to a doctor who could communicate in American Sign Language. The doctor agreed that she could do so. Neither Mrs. Eldridge nor her specialist followed up on this matter. She therefore continues to see a general practitioner who does not communicate in American Sign Language.

Testimony of Linda Warren, COA, p. 31, l. 46 - p. 32, l. 2; p. 33, ll. 1-13
Testimony of Robin Eldridge, Transcript, p. 55, l. 35 - p. 58, l. 17

20. The evidence discloses that a lack of funding is not the sole reason why the plaintiffs do not utilize sign language interpreters when they attend doctors or hospitals. There is a shortage of qualified interpreters, and it is often not possible to find an interpreter on short notice. This is the explanation for the failure of the Warrens to have an interpreter present for the birth of their twins, and also for Mrs. Eldridge's failure to contact interpreters when she attends hospital in an emergency. Even when interpreting services were provided free of charge, the Warrens sometimes attended medical appointments without interpreters.

Testimony of Linda Warren, COA, p. 41, ll. 4-39
Testimony of John Warren, COA, p. 19, ll. 19-37; p. 22, ll. 19-28; p. 22, l. 41 - p. 23, l. 6
Testimony of Robin Eldridge, COA, p. 52, ll. 16-34; p. 53, ll. 12-20

21. The plaintiffs have skills in written English. Indeed, they rely on written English to communicate by telephone, through a TDD.

Testimony of John Warren, COA, p. 18, l. 4- p. 19, l. 10 and p. 22, ll. 29-34
Testimony of Linda Warren, COA, p. 27, ll. 30-41
Testimony of Robin Eldridge, COA, p. 46, ll. 11-19; p. 61, ll. 12-22

22. While Dr. Gibb expressed dissatisfaction with note writing, she testified that she is able to give "adequate care to the Warrens."

Testimony of Dr. Victoria Gibb, COA, p. 129, ll. 3-6

The Ministry of Health and the Medical Services Plan

23. The Medical Services Plan ("MSP") does not directly provide medical services. Rather, it pays health care practitioners on a fee for service basis. While MSP covers a very broad range of medical services, there are many services that are not covered at all. These include services by clinical psychologists, occupational therapists, speech therapists, nutritional counsellors, and dentists. There is limited coverage for services provided by dental surgeons, podiatrists, optometrists, chiropractors and physiotherapists. Even some services provided by physicians are not paid for by MSP – for instance, diagnoses done over the telephone. Services ancillary to those provided by health care practitioners are not paid for by MSP.

Reasons for Judgment at Trial, COA p.463, ll. 3-11; p. 485, ll. 15-20
Testimony of Peter van Rheenan, COA, p. 240, l. 44 -p. 241, l. 22
Testimony of Dr. Douglas Schneider, COA, p. 261, ll. 11-33; p. 263, l. 31 - 264, l. 9
Testimony of Dr. Gary Curtis, COA, p. 289, l. 35

24. There are also many other medical and related expenses that are not publicly funded in British Columbia. The Province does not, for example, pay for artificial limbs, hearing aids, wheelchairs, or other medical devices. It provides only limited finding for prescription drugs, and no funding for other medications. The Province does not pay the costs of patients' travel, even when such travel is exclusively for the purpose of obtaining medical services. The evidence is that about 75-80% of health care costs in British Columbia are publicly funded.

Testimony of Peter van Rheenan, COA, p. 240, ll. 2-31
Testimony of Dr. Douglas Schneider, COA, p. 264, ll. 10 - p. 265, l. 19
Testimony of Dr. Gary Curtis, COA, p. 289, ll. 24-42

25. The Ministry of Health does not pay for interpreters, either for people who speak languages other than English or for deaf persons.

Testimony of Peter van Rheenan, COA, p. 241, ll. 23-28
Testimony of Dr. Douglas Schneider, COA, p. 262, ll. 43-47

26. The Ministry of Health receives frequent requests to consider funding new programs. Funding is often denied, primarily because of budgetary considerations.

Reasons for Judgment at Trial, COA p. 462, ll. 19-21
Testimony of Peter van Rheenan, COA, p. 239, l. 25 - p. 240, l. 1; p. 241, l. 34 - p. 242, l. 1

27. Growth in the Province's health care budget is a serious concern. At the time of trial, it was growing at about 10% per year – higher than the general increase in the provincial budget, higher than the increase in G.D.P. and higher than the general rate of inflation. One response to this concern was the appointment of a Royal Commission on Health Care and Costs. The Royal Commission recognized that increased growth in health care costs would result in three unattractive options: deficit financing, increased taxation, or the withdrawal of resources from other public programs. It warned that "in the longer run, the strain of competing priorities public and private could very well lead to the collapse of the Canadian Medicare System itself."

Reasons for Judgment at Trial, COA p. 462, ll. 6-8; p. 464, l. 22 - p. 465, l. 5
Testimony of Dr. Gary Curtis, COA, p. 278, ll. 29-32; p. 280, l. 45 - p. 281, l. 13; p. 284, l. 12 - p. 285, l. 9; p. 287, l. 32 - p. 288, l. 32
Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA p. 640

Hospitals

28. Hospitals in British Columbia are funded by the Ministry of Health through "global budgets" *i.e.* they are given a large lump sum, which, for the most part, they are free to allocate as they see fit. Hospitals are completely free to use government funds to pay for interpreter services if they wish to do so.

Testimony of Dr. Gary Curtis, Transcript, p. 274, ll. 3-25

29. Hospitals are rarely ordered by government to provide specific services. In those rare instances, they are generally required to fund the service out of their global budgets. The government does provide some funding allocated to specific programs, such as heart transplantation, but this is infrequent..

Testimony of Gary Curtis, COA, p. 293, ll. 15-47

PART II

ISSUES ON APPEAL

30. The "Errors in Judgment" alleged in Part II of the Appellants' Factum speak of an alleged duty on the Province to "provide interpreters for deaf people while receiving medical services". With respect, this is a misstatement of the issue. This case is not about the provision of interpreters, but about whether the Province is required to pay for the services of interpreters under certain insurance schemes. A correct statement of the issues is conveniently encompassed within the Constitutional Questions stated by the Honourable Chief Justice of this Court on December 12, 1996.

31. The respondents frame the issues as follows:

A. Does the plaintiffs' challenge to the *Hospital Insurance Act* raise an issue that engages the *Canadian Charter of Rights and Freedoms*?

B. If so, does the failure of the Province to compel hospitals to provide medical interpreting services free of charge to deaf patients infringe section 15 of the *Charter*

C. Does the failure of the Province to include medical interpreting services for the deaf as a benefit under the *Medicare Protection Act* infringe section 15 of the *Charter*?

D. If there is an infringement of section 15 of the Charter, is the infringement demonstrably justified in a free and democratic society pursuant to s. 1 of the *Charter*?

E. If there is a finding of a *Charter* violation, what is the appropriate remedy?

PART III
ARGUMENT

32. The plaintiffs' claim is an attempt to use section 15 of the *Canadian Charter of Rights and Freedoms* to compel the government of British Columbia to implement a new program that is neither analogous to existing programs nor related to any form of discrimination having its foundation in law. They invite this Honourable Court to put itself in the invidious position of dictating, on a piecemeal basis and without the advantages available to the legislative and executive branch of government, what policies best meet social needs. The invitation to interpret section 15 as requiring governments to remedy all pre-existing inequalities whenever they enter a field is, it is submitted, not only beyond the proper scope of judicial power, but also, in the long run, calculated to ensure that governments do not implement broad social programs for fear of opening a fiscal Pandora's box.

A. Application of the *Charter*

The Impugned Legislation

33. The plaintiffs' challenge is to two separate pieces of legislation setting up medical insurance schemes in the Province: the *Hospital Insurance Act*, R.S.B.C. 1979, c. 180 and the *Medicare Protection Act*, S.B.C. 1992, c. 76. The title of the latter Act was changed by the *Medical and Health Care Services Amendment Act, 1995*, S.B.C. 1995 c. 52. Its former title was the "*Medical and Health Care Services Act*", and it is referred to by its former appellation in the judgments below.

34. There is no doubt, as stated at paragraph 62 of the plaintiffs' factum, that the *Charter* applies to the impugned legislation. However, the *Charter* does not apply to the activities of private parties, such as individual doctors or hospitals. This is of some moment, as the plaintiffs' argument frequently suggests that the Province is under a duty to "provide interpreters for deaf people", and discusses "services provided under the Act". The Province does not provide medical or other services under either statute. Such services are provided by private actors.

35. Under the *Medicare Protection Act*, the Province makes payments to doctors (and certain other primary health care professionals) for specified services. The legislation contains no provision for making payments to sign language interpreters for services rendered in connection with medical appointments. The failure to include such services as insured services under the *Act* is clearly amenable to *Charter* scrutiny.

36. Under the *Hospital Insurance Act*, the Province does not (insofar as it is relevant) provide funding for specific procedures or medical services. Instead, the statute requires hospitals to provide general hospital services without charge to beneficiaries. In return, the Province provides lump sum funding for hospital operations. While the Lieutenant Governor in Council is empowered under the *Hospital Insurance Act* to require hospitals to provide particular services, that power has been used very sparingly. For the most part, the services provided by a hospital are within its discretion, and the Minister of Health funds hospitals by paying a portion of their overall operating costs.

Hospital Insurance Act, ss. 9 and 10
Hospital Insurance Act Regulations, B.C. Reg. 25/61, s. 5.1
Testimony of Dr. Gary Curtis, Transcript, p. 274, ll. 3-25; p. 293, ll. 15-47
Judgment of the Court of Appeal, COA p. 507, l. 22 - p. 511, l. 40

37. The question with respect to the *Hospital Insurance Act*, therefore, cannot be whether or not the Province is required to fund sign language interpretation; the mechanisms of the *Act* do not call for separate funding of different services or procedures. The only question amenable to *Charter* scrutiny with respect to the *Hospital Insurance Act* is whether the Province is required to force hospitals to provide sign language interpreting services for the deaf.

38. The constitutional issues in relation to the two statutes are, therefore, markedly different. While it will be argued that the claim with respect to the *Medicare Protection Act* must fail, the issues surrounding that statute are more complex, and require more detailed analysis than the issues surrounding the *Hospital Insurance Act*. A straightforward application of the principles in *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 dictates that the claim with respect to the *Hospital Insurance Act* must fail.

The *Stoffman* case and the Challenge to the *Hospital Insurance Act*

39. In the present case, the plaintiffs postulate that "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". From this postulate, they go on to state that "the hospitals are merely agents through which the Legislature accomplishes this objective." In both of these statements, the plaintiffs are in error.

40. The plain purpose of the *Hospital Insurance Act* is to ensure that hospitals are financed without setting up financial barriers that prevent people from using them. Hospitals existed long before the statute, and have historically provided a full range of medical services. Nothing in the *Hospital Insurance Act* suggests that it was designed to enhance or ensure that hospitals provide particular medical services. The statute is plainly directed only at the manner in which hospitals are funded.

41. It has also been conclusively determined that hospitals are not "agents of government through which public objectives are accomplished." This suggestion is precisely the argument rejected by a majority of this Honourable Court in *Stoffman*:

> The question [is] whether the Vancouver General is part of what McIntyre J. [in *R.W.D.S.U. v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573] designated the "administrative branch" of government.
>
> This question cannot be answered by simply pointing out that the provision of health care and hospital services is an important part of the legislative mandate of provincial governments, and that the Vancouver General was incorporated for the express purpose of providing such care and services. If that was by itself sufficient to bring hospitals and all other bodies and individuals concerned with the provision of health care or hospital services within the reach of the Charter, a wide range of institutions and organizations commonly regarded as part of the private sector, from airlines, railways, and banks, to trade unions, symphonies and other cultural organizations, would also come under the Charter. For each of these entities, along with many others, are concerned with the provision of a service which is an important part of the legislative mandate of one or the other level of government.

The court concluded that hospitals were not part of the "administrative branch" of government. The government does not control the day to day policy decisions undertaken by hospitals.

Stoffman v. Vancouver General Hospital, *supra* at 511
Regina v. Dersch, [1993] 3 S.C.R. 768

42. The Lieutenant Governor in Council has the power to compel hospitals to provide particular services as a condition of funding under the *Hospital Insurance Act*. The mere fact that a government *can* control the policies of a hospital, however, is not sufficient to allow the court to compel a government to do so. Subject only to the division of powers and the limits of the *Charter*, governments *can* legislate in respect of all manner of things. The mere fact that a government can regulate a matter cannot be sufficient to apply the *Charter* to private relations.

McKinney v. University of Guelph, [1990] 3 S.C.R. 229
Stoffman v. Vancouver General Hospital, *supra*

43. The plaintiffs' argument with respect to the *Hospital Insurance Act* is that the government ought, as a condition of funding hospitals, to require them to provide sign language interpreting services to deaf patients. As found in *Stoffman*, and as is evident from the *Act* and the regulations, the government of British Columbia treats hospitals as autonomous with regard to their day-to-day operations. The regulation called for by the plaintiffs, while it would be *intra vires*, would be completely out of keeping with the regime that exists.

44. Just as the power to control hospitals' internal policies, either by rejecting their bylaws or by restricting funding, was insufficient to found *Charter* application in *Stoffman*, the regulatory power of the Province to act in this case must be insufficient to bring the decision whether or not hospitals will provide sign language interpretation within *Charter* scrutiny.

45. This does not mean that the plaintiffs are without a remedy if they are able to show that the failure of hospitals to provide sign language interpretation is discriminatory. Their remedy, however, would lie against the hospitals under Provincial human rights legislation, not against the government under the *Charter*.

B. Does the *Hospital Insurance Act* Infringe Section 15?

46. If, contrary to these submissions, this Honourable Court finds that the challenge to the *Hospital Insurance Act* raises an issue amenable to Charter scrutiny, it is submitted that, for the same reasons expressed below in regard to the *Medicare Protection Act*, the legislation cannot be found to be "discriminatory".

C. Does the *Medicare Protection Act* Infringe Section 15?

The Approach to Section 15

47. While there have been important disagreements among the members of this Honourable Court on the interpretation of section 15 – particularly with respect to the issue of whether the "relevance" of a legislative distinction is a matter to be considered in the section 15 analysis – there has also developed a broad consensus as to the general approach to be adopted.

48. In *Regina v. Swain*, the Lamer C.J., speaking for a majority of the Court on this issue, adopted a three-stage inquiry:

> The Court must first determine whether the claimant has shown that one of the four basic equality rights has been denied (*i.e.*, equality before the law, equality under the law, equal protection of the law and equal benefit of the law). This inquiry will focus largely on whether the law has drawn a distinction (intentionally or otherwise) between the claimant and others, based on personal characteristics. Next, the Court must determine whether the denial can be said to result in "discrimination". This second inquiry will focus largely on whether the differential treatment has the effect of imposing a burden, obligation or disadvantage not imposed upon others or of withholding or limiting access to opportunities, benefits and advantages available to others. Further, the Court must consider whether the personal characteristic in question falls within the grounds enumerated in the section or within an analogous ground, so as to ensure that the claim fits within the overall purpose of remedying or preventing discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society.
>
> *Regina v. Swain*, [1991] 1 S.C.R. 933 at 940-1

49. A similar inquiry was undertaken by Iacobucci J., for the majority in *Symes*:

> First, it must be determined whether [the impugned law] establishes an inequality: does [the impugned law] draw a distinction (intentionally or otherwise) between the appellant and others, based upon a personal characteristic? Second, if an inequality is found, it must be determined whether the inequality results in discrimination: does the distinction drawn by [the impugned law] have the effect of imposing a burden, obligation or disadvantage not imposed upon others or of withholding or limiting access to opportunities, benefits and advantages available to others? Finally, assuming that both an inequality and discrimination can be found, it must be determined whether the personal characteristic at issue constitutes either an enumerated or analogous ground for the purposes of s. 15(1) of the Charter.
>
> *Symes v. Canada*, [1993] 4 S.C.R. 695 at 761

50. This general approach to section 15 was adopted in the analyses of this Honourable Court in the 1995 trilogy of s. 15 cases, and was followed in the recent case of *Eaton v. Brant County Board of Education*.

> *Miron v. Trudel*, [1995] 2 S.C.R. 418
> *Egan v. Canada*, [1995] 2 S.C.R. 513
> *Thibaudeau v. Canada*, [1995] 2 S.C.R. 627
> *Eaton v. Brant County Board of Education* (February 6, 1997), not yet reported, S.C.C. No. 24668.

51. This case raises an issue on the first stage of the section 15 inquiry. The respondents contend that the legislation in issue does not draw, either on its face or when considered in a broader social context, a distinction based on a personal characteristic.

Do the Impugned Laws Draw a Distinction?

a) Overview of the Legislation

52. The first stage of the inquiry under section 15 involves an assessment of whether or not the impugned law draws a distinction between the claimant and others. In order to answer this question, it is important to have a clear understanding of the insurance scheme in issue. In particular, the nature of the benefits conferred on beneficiaries must be understood, as must the degree of governmental regulation of medical care encompassed in the legislative scheme. It is submitted that the plaintiffs commit a fundamental error in their analysis by failing to closely

examine (and in some cases simply misapprehending the nature of) the statutory insurance scheme.

53. The *Medicare Protection Act* forms the basis for public health insurance in British Columbia. The *Act* does not restrict the forms of medical and ancillary services that are available to the plaintiffs, nor does it set up government health care services. Rather, it creates arrangements whereby certain medical expenses are borne by a publicly funded insurance plan.

54. The *Act* establishes MSP. Beneficiaries enrolled under MSP are entitled to receive specified benefits. These benefits consist of direct payments by MSP to specified health care professionals in respect of specified medical services. In particular, MSP covers:

a) payments to physicians in respect of any medically required services, except those services specifically exempted by the Medical Services Commission;

b) limited payments to chiropractors, dentists, massage practitioners, naturopaths, optometrists, physiotherapists, and podiatrists in respect of a limited category of necessary health services performed by them;

c) payments to diagnostic facilities (which must be supervised by physicians) that have been approved in respect of diagnostic procedures carried out under the orders of certain of the above-listed professionals.

Medicare Protection Act, ss. 1 (definitions of "approved diagnostic facility", "benefits", "health care practitioner", "medical practitioner") and 12

55. Under section 21 of the *Act*, the Medical Services Commission establishes fee schedules for the various medical services provided by the medical and health professionals who are entitled to enroll under the *Act*. Practitioners who enroll under the *Act* are not permitted to charge beneficiaries more than the amounts set out in the applicable fee schedule.

Medicare Protection Act, ss. 21, and part 3.1 ("Limits on Billing")

56. MSP is a "universal" health care plan in the sense that all residents of the Province are eligible to enroll as beneficiaries. Its coverage is broad – it covers most medically necessary services performed by physicians, and some services performed by members of other self-governing health professions. MSP does not, however, purport to be "comprehensive" either in

terms of the types of health care that are covered or the professions entitled to be paid under the plan.

57. At paragraph 60 of their factum, the plaintiffs' characterize the *Medicare Protection Act* as follows:

> In general, the medical services funded under the Plan include all medically required services recognized by the Medical Services Commission ....

This is potentially misleading. While most medically required services performed directly by physicians are funded by MSP, other health care services are either funded to a limited extent, or not funded at all. No services performed by persons who are not health care professionals are funded.

58. The learned trial judge correctly characterized the situation as follows:

> The *Act* provides for payment of a fairly comprehensive list of medical services but it does not purport to be an exhaustive list and it does not cover any ancillary services. The *Act* authorizes payment for medically required services rendered by a medical practitioner and medically required services that are prescribed in the regulations under the *Act*.
>
> Reasons for Judgment at Trial, COA 484, ll. 14-20

59. On the face of it, MSP does not differentiate in any way between deaf persons and others. All beneficiaries receive funding in respect of charges made by physicians, and in respect of charges made for specified medical procedures undertaken by certain other health professionals who provide therapy that is an alternative to therapy provided by physicians. No person receives funding under MSP for services that are not performed by medical personnel, no matter how important those services might be to health care. The evidence does not suggest that deaf people use less of the covered services than their hearing counterparts, or that the government contributes less in respect of deaf people. On the contrary, such evidence as exists shows the plaintiffs to be rather heavy users of the system.

60. Indeed, the plaintiffs do not suggest that the statute directly discriminates against them; they acknowledge that, at least on the face of the legislation, they receive benefits that are

identical to those received by other members of the public. Rather, they allege that this is a case of "adverse impact discrimination". In order to evaluate that claim, it is necessary to consider the nature of such discrimination and its relation to section 15 of the *Charter*.

b) Adverse Impact Discrimination

61. The phrase "adverse impact discrimination" is often used in both human rights and *Charter* jurisprudence as if it had a well-defined meaning. In fact, it is used in a number of different senses. At its broadest, the phrase encompasses all situations in which discrimination is not malicious. For instance, in *McKinney v. University of Guelph* and *Tétreault-Gadoury v. Canada*, this Honourable Court described statutes that clearly and directly accorded disadvantageous treatment to older people as "adverse impact discrimination".

McKinney v. University of Guelph, supra at 279
Tétreault-Gadoury v. Canada, [1991] 2 S.C.R. 22 at 41

62. While this broad definition of "adverse impact discrimination" may serve a purpose in human rights law (where cases of deliberate discrimination are not infrequent), it is of limited utility in *Charter* litigation. Governments rarely engage in discrimination "motivated by an intentional desire to obstruct someone's potential"; where discrimination occurs it is generally "the accidental by-product of innocently motivated practices." Further, there is nothing novel in the idea that the *Charter* is aimed at the effects of governmental action as well as at its purposes.

Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143 at 174
Regina v. Big M Drug Mart, [1985] 1 S.C.R. 295

63. In the human rights context, there is also a second meaning of "adverse impact discrimination". It can describe a practice that, on its face, discriminates on the basis of a personal characteristic that is not prohibited by law. The personal characteristic, however, may occur more prevalently among members of a group that is enumerated.

64. For example, height and weight requirements for employment in police forces constitute "adverse impact discrimination" against women. On their face, such requirements constitute direct discrimination against short and lightweight people, but human rights legislation does not

outlaw discrimination on the basis of size. Accordingly, such cases are analysed as "adverse impact discrimination" on the basis of the sex, which is an outlawed ground of discrimination.

65. The use of "adverse impact discrimination" in this context carries with it an irony. Because human rights tribunals are forced into using "sex" as a substitute for the real basis of discrimination ("size"), the law itself discriminates by affording a remedy to one sex, but not to the other. As an individual, a male of slight build suffers the same sort of discrimination as a woman of average build, yet he is unable to make a claim under the human rights legislation, since his own legally protected rights are not infringed.

66. The categories of unlawful discrimination under section 15 are not closed, so this difficulty does not arise; courts are able to deal directly with the ground upon which discrimination is based.

67. There remains a final interpretation of "adverse impact discrimination" which can be applied more usefully in a *Charter* analysis. This is the type of discrimination identified by this court in *Ontario Human Rights Commission and O'Malley v. Simpsons-Sears*. That case concerned a rule adopted by the employer requiring the employee to work on Friday evenings and Saturdays. This rule was found to discriminate, contrary to the *Ontario Human Rights Code*. McIntyre J., for the court said:

> It will be seen at once that the problem confronting the Court involves consideration of unintentional discrimination on the part of the employer and as well the concept of adverse effect discrimination.
>
> ...
>
> A distinction must be made between what I would describe as direct discrimination and the concept already referred to as adverse effect discrimination in connection with employment. Direct discrimination occurs in this connection where an employer adopts a practice or rule which on its face discriminates on a prohibited ground.... On the other hand, there is the concept of adverse effect discrimination. It arises where an employer for genuine business reasons adopts a rule or standard which is on its face neutral, and which will apply equally to all employees, but which has a discriminatory effect upon a prohibited ground on one employee or group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other

> members of the work force. For essentially the same reasons that led to the conclusion that an intent to discriminate was not required as an element of discrimination contravening the Code I am of the opinion that this Court may consider adverse effect discrimination as described in these reasons a contradiction of the terms of the Code.
>
> *Ontario Human Rights Commission and O'Malley v. Simpsons-Sears*, [1985] 2 S.C.R. 536 at 546 and 551

68. Cory J., in *Egan v. Canada*, considered that it was discrimination of this nature that is properly described as "adverse effect discrimination."

> Direct discrimination involves a law, rule or practice which on its face discriminates on a prohibited ground. Adverse effect discrimination occurs when a law, rule or practice is facially neutral but has a disproportionate impact on a group because of a particular characteristic of that group.
>
> *Egan v. Canada, supra*, at 586-87

69. It is in this sense that the legislation in issue has been described by the plaintiffs as exemplifying "adverse impact discrimination." The question that must be asked, therefore, is how we can determine whether the impugned legislation is a source of adverse impact discrimination.

c) The Role of Human Rights Tribunal Decisions in the Section 15 Analysis

70. In the absence of *Charter* cases dealing with adverse impact discrimination, the plaintiffs turn to human rights legislation for guidance. It must be remembered, however, that the language and focus of human rights legislation differ, at least subtly, from those of section 15. Human rights jurisprudence, while helpful, cannot be imported wholesale into s. 15 of the *Charter*.

> *Andrews* v. *Law Society of B.C., supra*, at 175

71. Further, not every pronouncement of a human rights tribunal is useful in interpreting section 15 of the *Charter*. Such tribunals have limited expertise, and are not generally entitled to deference on issues of law; *a fortiori*, the courts will not necessarily find their pronouncements helpful, particularly on individual fact patterns.

> *A.G. Canada v. Mossop* [1993] 1 S.C.R. 554

72. Indeed, if all of the human rights jurisprudence cited by the plaintiffs were compelling, it might well prove that doctors and hospitals are required, at their own expense, to provide the plaintiffs with sign language interpretation. If that were correct, the source of the alleged discrimination would not be a lack of government funding, but rather the failure of private parties to fulfil their obligations under human rights legislation.

d) When Does a Law have an Adverse Impact?

73. The plaintiffs concentrate their argument on demonstrating that they are disadvantaged when compared to hearing people. Even without fully accepting all of the allegations of the plaintiffs, it is obvious that deaf persons are disadvantaged when they must communicate in a hearing world. This disadvantage will present itself during attempts to communicate with physicians who are not fluent in American Sign Language.

74. A violation of section 15 is not made out merely by establishing that a group suffers disadvantages *vis-à-vis* the majority. Section 15 is engaged only if the disadvantage stems from a denial of "equal benefit of the law".

> Section 15(1) of the Charter provides for every individual a guarantee of equality before and under the law, as well as the equal protection and equal benefit of the law without discrimination. This is not a general guarantee of equality; it does not provide for equality between individuals or groups within society in a general or abstract sense, nor does it impose on individuals or groups an obligation to accord equal treatment to others. It is concerned with the application of the law.
>
> *Andrews v. Law Society of British Columbia,* [1989] 1 S.C.R. 143 at 174

75. In the case at bar, the majority of the Court of Appeal held that any inequality suffered by the plaintiffs was independent of the law and could not be said to be an effect of the legislation. The plaintiffs, at paragraph 76 of their argument chastise the majority, suggesting that it "repeated the erroneous reasoning of *Bliss v. Attorney General of Canada* [in which] inequality [was] legally justified as 'not created by legislation but by nature'."

76. In the same paragraph, the plaintiffs say that requiring inequality to be a product of law "renders nugatory the *Charter*'s guarantee of equal benefit of law, particularly for the disabled." They state: "Were the Court of Appeal's reasoning to be accepted, the disabled could never succeed in a claim of discrimination: their inequality always exists independently of the legislation."

77. The plaintiffs suggest that any requirement that inequality be founded in law will effectively nullify rights under section 15. The result of the plaintiffs' argument is that by entering a field, the government is required not only to act without discrimination, but also to redress pre-existing inequalities. According to their argument, the government violates its section 15 duties if those who suffered disadvantage prior to government intervention continue to suffer any disadvantage after such intervention. Even if the relative disadvantage of a group is reduced by the government intervention, they contend, the requirements of section 15 are not satisfied.

78. While the elimination of all social disadvantage is a laudable goal, it is realistically unattainable. In complex areas such as health care spending, demands are, for all practical intents, limitless. Every allocation of resources can be criticised as favouring one group over another. If the plaintiffs' argument were accepted, a government's choices would effectively be limited: do nothing or do everything. One cannot imagine a greater disincentive for governments to enter into fields of social welfare.

79. Fortunately, this "all or nothing" approach is neither compelled by nor consistent with section 15 of the *Charter*. Section 15 is deliberately structured to allow for, but not require programs that redress natural or historical imbalances. Section 15(1) ensures that no law which confers opportunities, benefits or advantages does so in a way that excludes members of enumerated or analogous groups from its benefits. Section 15(2) provides that, where it wishes to do so, a government may enact legislation for the specific purpose of enhancing the position of enumerated and analogous groups. Governments may, provided they do not act in a discriminatory manner, limit their intervention without running afoul of s. 15 of the *Charter*. As Rowles J. (as she then was) said:

> The state is not required to remedy all aspects of a particular mischief or none at all. The state in the regulation of the economy and taxing of its subjects is free to remedy parts of a mischief or to recognize degrees of evil and to strike at the harm where is thinks it most acute.
>
> *Knodel* v. *British Columbia* (1991), 58 B.C.L.R.(2d) 356 at 385 (SC)

80. The plaintiffs create a false dichotomy when they suggest that any consideration of pre-existing inequality will render *Charter* protection for the disabled meaningless. Inequalities that exist independently of legislation are not *ipso facto* outside the scope of section 15. Nonetheless, governmental action must be "discriminatory" before the existence of such inequalities can be said to engage the *Charter*. The legislative scheme must actually have an adverse impact on the group claiming that its rights are infringed before it can succeed under section 15.

81. The test to determine whether legislation embodies "adverse impact discrimination" is not appreciably different from the test that applies to direct discrimination. An adverse impact occurs where a law "has the effect of imposing burdens, obligations, or disadvantages ... not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society."

Andrews v. Law Society of British Columbia, supra, at 174

82. In the case of legislation that prohibits activities or imposes burdens, adverse impacts will generally be manifest, and the question will be whether they fall inequitably on an enumerated or analogous group. There are obvious cases in which a rule will have an adverse impact. The height and weight requirements for employment with police forces described earlier, for example, will limit the opportunities of women to obtain employment. While it is true that a person's height and weight exist independently of the rule, it is the rule itself that limits opportunities.

83. Benefit-conferring laws will normally not impose burdens of this sort. They may, however, nonetheless exemplify "adverse impact discrimination". It is submitted that the impact of such legislation can only meaningfully be said to be "adverse" where it exacerbates the disparities between the group claiming that its rights have been infringed and the majority. Where

this gap is widened, the legislation can properly be said to make a distinction that "limits access to opportunities, benefits and advantages available to others."

84. In *Bliss v. A.G. Canada*, [1979] 1 S.C.R. 183, the impugned law conferred benefits on the general working population, but limited the availability of these benefits for pregnant women. It is true that this Honourable Court, in *Bliss*, stated that the disparity was one "not created by legislation but by nature". In overruling *Bliss*, however, this Honourable Court did not hold that the question of whether a disparity is created by law is irrelevant. Rather, it found that the disparity in *Bliss* was, when properly analyzed, a disparity created by law:

> It is difficult to accept that the inequality to which Stella Bliss was subject was created by nature and therefore was no discrimination; the better view, I now venture to think, is that the inequality was created by legislation, more particularly the *Unemployment Insurance Act, 1971*.
>
> *Brooks v. Canada Safeway*, [1989] 1 S.C.R. 1219 at 1244

85. The necessity of finding law to be the source of inequality in order to invoke section 15 was reiterated by Iacobucci J., speaking for the majority in *Symes*:

> If the adverse effects analysis is to be coherent, it must not assume that a statutory provision has an effect which is not proved. We must take care to distinguish between effects which are wholly caused, or are contributed to, by an impugned provision, and those which exist independently of such a provision.
>
> *Symes v. Canada*, [1993] 4 S.C.R. 695 at 746

86. Both *Bliss* and *Brooks* concerned benefit plans that were less advantageous to pregnant women than to other people. In both cases, this Court was dealing with a comprehensive scheme that singled out pregnant women for inferior treatment. It is little wonder that in such cases, the treatment is seen as discriminatory. While pregnancy itself was not a creation of the legislation, the disparity between women and men was exacerbated by denying a class of women benefits that were completely analogous to those available to other people.

87. Requiring that discrimination find its foundation in law before finding a violation of section 15, then, does not render the *Charter* right nugatory. What the plaintiffs must show, however, is

that MSP is discriminatory in its allocation of benefits. It is not sufficient for the plaintiffs to demonstrate that they suffer disadvantages in society. They must show that the legislative scheme itself treats them disadvantageously.

e) Does the Medical Services Plan Treat the Plaintiffs Disadvantageously

88. As in *Brooks v. Canada Safeway*, therefore, the appropriate question in this case is whether the legislation withholds benefits and advantages from deaf people.

89. As this Court has said on a number of occasions, the question of whether benefits and advantages are withheld cannot be determined by applying the mechanical "similarly situated test". In *Bliss*, for instance, it should have been no answer to the complainants' claims that all people were denied benefits during certain stages of pregnancy. Similarly, it is no answer in this case to say that sign language interpretation services are denied to everyone.

> *Andrews v. Law Society of British Columbia, supra,* at 167-68
> *Brooks v. Canada Safeway, supra*, at 1245-46

90. This does not mean, however, that the benefits provided to different groups under the *Act* need not be compared.

> The fact that a comparison must be made does not mean that courts will be returning to the similarly situated test, as suggested by the respondent. Rather, making the comparison recognizes that discrimination cannot be identified in a vacuum.
> *Egan v. Canada, supra*, per Corey J. at 662

In *Brooks*, for instance, the court emphasized the comparative approach to discrimination. At 1236, this court noted the marked inequality evident in the plan:

> In my view, it is beyond dispute that pregnant employees receive significantly less favourable treatment under the Safeway plan than other employees.... The plan singles out pregnancy for disadvantageous treatment, in comparison with any other health reason which may prevent an employee from reporting to work. With the sole exception of pregnancy, eligibility for compensation is available on broad and general terms. It is indeed generous, save in respect of pregnant women.... No restrictions are placed on disability, with the solitary exception of pregnancy. It is difficult to conclude otherwise than that, as a

result of the unfavourable treatment accorded to pregnancy *vis-à-vis* all other medical conditions, the Safeway plan discriminates on the basis of pregnancy.

91. It is important to ensure that, in looking for appropriate comparisons, one searches for fair analogues in the legislative scheme. If one searches for too close a comparison, the equality inquiry can collapse into just the sort of mechanical "similarly situated" test which this court has rejected. On the other hand, if one stretches comparisons in order to discover inequality where none exists, then the test degenerates into the sort of "all or nothing" approach which, it is contended, is the essence of the plaintiffs' argument.

92. In this case, the evidence permits us to examine the insurance scheme to find appropriate comparisons – we are not faced with having to choose between the "similarly situated approach" ("no one gets sign language interpreters") and the "all or nothing approach" ("the Province pays for some health care, therefore it has to address all disadvantages in respect of health care").

93. While the deaf are unique in their need for sign language interpreters, many other people face financial or other burdens in accessing medical care. The most obvious analogies are people who cannot communicate in English (who face the burden of paying for interpreters) and people who have to travel long distances in order to get appropriate medical services (who must pay their own transportation costs). These costs are not imposed on people by MSP; it is "deficient" only in that it does not provide payment for these or analogous services.

94. The evidence in this case is that about 25% of health care costs are privately funded. Among the areas where private funding is most prevalent are dentistry, medications and pharmaceuticals, medical appliances, clinical psychology, and home and continuing care.

Testimony of Dr. Gary Curtis, COA, p. 289, ll. 24-42

95. In deciding whether or not the benefits provided by a health care insurance scheme are discriminatory, the true character of the plan must be determined. MSP is a scheme for covering the professional fees of physicians and certain other health care professionals who provide analogous therapies. It is not a general plan covering all health care costs. Indeed, when the

Ministry of Health considered whether it would fund medical sign language interpretation, the public official who recommended that the government provide funding noted that MSP was not really an appropriate vehicle under which to provide it.

> *Gibbs v. Battlefords and District Co-operative Ltd.* (October 31, 1996), not yet reported, S.C.C. No. 24342 at paras. 38 - 39
> Exhibit 3, Tab 1, Briefing Note prepared for Ministry Executive Committee, COA p. 307

96. MSP not a scheme in which some people are completely covered and others are not. Rather, it is a system in which a broad level of coverage is provided to all, but all are also subject to having to pay for services that are not within that broad range. This is not discriminatory. It is an example of what Rowles J. described as the state exercising its discretion to "remedy parts of a mischief [and to] recognize degrees of evil and strike at the harm where it thinks it is most acute."

> *Knodel* v. *British Columbia*, supra, at 385

97. In the case at bar, the learned trial judge held that the failure to pay for interpreters was not discriminatory. He found the services of interpreters not to be "medically required services", but rather ancillary services:

> Interpreting services are not medically required services. Even if they could be classified as medically required services, they are not rendered by medical or health care practitioners.
>
> An interpreting service is a service which is ancillary to the provision of medically required services, much the same as transportation services to the doctor's office or the hospital is an ancillary service. The *Medical and Health Care Services Act* does not authorize payment of any ancillary service.
>
> Reasons for Judgment at Trial, COA 484, ll. 20-29

98. The plaintiffs have not alleged a palpable and overriding error in the finding that interpreting services are not medically required. It is clear, in any event, that there was evidence supports this finding. However, the plaintiffs do take issue with the trial judge's characterization of interpreting services as "ancillary". In doing so, at paragraph 91 of their factum, they contrast interpreting services with such luxuries as private hospital rooms and cosmetic surgery. By

equating "ancillary" services with trivial or luxury items, the plaintiffs misapprehend the reasons of the learned trial judge.

99. The fact that American Sign Language interpretation may be very beneficial to the medical treatment of deaf persons does not make it analogous to the primary health care services covered by MSP. Many items of care that are crucial to successful treatment are not paid for under MSP. Pharmaceuticals, counselling, transportation, dental care, and diet may be essential to proper medical care; this does not mean that they must be categorized as "medically required services" rather than as "ancillary services".

100. This is not a case in which the plaintiffs are, by virtue of a disability, effectively denied a benefit available to others. After a full review of the evidence, the majority of the Court of Appeal in this case stated:

> In my opinion the evidence before us falls far short of establishing that because of their hearing impairment, for all practical purposes, the deaf are denied the medical services available to the hearing.

Indeed, the evidence, read as a whole, demonstrates that the plaintiffs suffer some frustration when they attend medical appointments without interpreters, but they nonetheless receive adequate and appropriate medical treatment.

> Judgment of the Court of Appeal, per Hollinrake, J.A. (Cumming J.A. concurring), COA, p. 514, ll. 16-22.

101. No relevant distinction can be drawn between the services of sign language interpreters and many other services and supplies that are not covered by MSP. The legislation is consistent and non-discriminatory in choosing between services that are funded and those that are not. It does not widen the gap between the deaf and the hearing population.

102. Accordingly, the plaintiffs cannot show that they are denied benefits analogous to those generally covered by MSP. MSP does not discriminate against them.

D. If there is an Infringement, is it saved by Section 1?

103. In determining whether a law that infringes a provision of the *Charter* is saved by section 1, this Honourable Court has emphasized that the *Oakes* test "must take into account both the nature of the infringed right and the specific values the state relies on to justify the infringement. This involves a close attention to context."

> *Ross v. School New Brunswick School District No. 15*, [1996] 1 S.C.R. 825 at 872

104. The relevant context in this case includes the state of health care and costs in British Columbia. We are fortunate in that a study on this very issue was conducted by a royal commission which reported in 1991. The Royal Commission on Health Care and Costs was established to address the concerns related to growth in costs in British Columbia's health care sector. The Commission took eighteen months to study and report on health care and costs in the Province. In its compendious review of our health care system, the Commission concluded that while the system was quite possibly the best in the world, it suffered from a number of identifiable deficiencies. Although the Commission did not single out any particular issue as being more problematic than all others, it clearly identified the clash of expectations for services with the reality of limited funding as being the major threat to health care:

> From the beginning of this commission we have assumed that any report calling for a major commitment of new money to the health care system would be unacceptable, and therefore unhelpful, to the people and the government of British Columbia. In 1990/1991, British Columbians spent $850,000 per hour on health care through public and private budgets. Some new money may be available, but the principle task facing British Columbians is to find ways of making more effective use of the extensive resources now devoted to health care. To do this, it will be necessary to redirect some of these resources to the services and programs which provide the greatest benefit to the people of this province.
>
> ...
>
> In Canada, as in most of the countries of western Europe, publicly financed health care systems were developed to improve access to care, to distribute the costs of health care more fairly, and to increase substantially the resources dedicated to health care. As these public systems expanded, however, priorities shifted, and at some time during the 1970's, most of the countries,

> including Canada, found ways to limit the growth of their health care systems to approximately the same rate of growth as their economies ....
>
> Since the early 1980's, however, a marked slowing of general growth rates has meant that the scope for expansion of health care has almost disappeared unless resources can be taken away from other sectors of the economy. The fundamental reality of constrained resources, both public and private, is that the process of cost control has become more rigorous and contentious and the pressure of competing priorities is increasing. As far as anyone can see at the moment, these circumstances are likely to persist indefinitely.
>
> B.C. has been part of this general pattern. Expanding expectations, competing priorities, and static or diminishing resources are all well represented in submissions to the commission. But if these conflicting demands are not resolved, they might lead to the collapse, or more likely the slow disintegration, of a system of health care finance and delivery which almost all British Columbians, Canadians, and an increasing number of foreigners, regard as one of our country's finest achievements.
>
> Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA pp. 636, 637, 640
> Testimony of Dr. Gary Curtis, COA p. 285, ll. 3-9

105. The Commission noted that "health care finance is the largest expenditure item in every provincial budget, and the most complex management task faced by provincial governments." In a general sense, British Columbia's health care system is a closed system in that its funding is limited. Its funding could only be opened up, as the Commission noted, in one of three ways: deficit financing, increased taxation, or withdrawing from other public programs. None of these options are palatable for reasons which are obvious and which were succinctly described by the Commission it its report.

> Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA pp. 639-640
> Judgment at Trial, 464, l. 26- p. 465, l. 6

106. Within our closed system of health care, choices regarding the allocation of health care dollars to health care services and demands must be made. These choices, difficult under any circumstances, are made more difficult by the sheer volume of demands or requests for health care services. The Ministry of Health of British Columbia receives hundreds of letters each day, many of which were requests from health care practitioners, advocacy groups and consumers, for the

expansion of existing services or for new services. Receipt of these requests for services are viewed as part of the ongoing business of the Ministry.

Testimony of Dr. Gary Curtis, COA p. 284, ll.2-11
Testimony of Peter van Rheenan, COA p. 239, l. 42- p. 240, l. 1

107. Not every health care dollar in British Columbia is spent on curing the sick. Indeed, as part of its health care strategy, the Commission recommended that "more money should be spent on the prevention of illness or injury and on protecting health. The least amount possible should be spent on providing the necessary high quality curative services." It is apparent from this example of the application of a kind of reverse triage, that health care policy, and the consequent decisions concerning the allocation of health care dollars, is a complex matter. Every health care dollar spent represents a dollar that might have been spent some other way, on some other service, to address some other strategy within the health care system.

Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA p. 562

108. It is in the nature of British Columbia's health care system that not all health care needs or demands can be met. The system is such that it can provide a core group of medical services to all eligible applicants. It may also be able to respond to additional needs some of the time. However, the system cannot meet all of the public's health care needs all of the time. Health policy makers must choose from among any number of competing demands, many of which are equally valid, some perhaps more expensive than others. Whatever choice is made, that choice will undoubtedly be guided by the clash between expectations and limited resources in a health care context. This is the context within which this Honourable Court should consider the decision not to fund interpreter services for the deaf.

Objective of the Legislation

109. At paragraph 109 of their factum, the plaintiffs allege that the objective of the legislation is "to provide reasonable access to quality medical care to all British Columbians." While that objective is the ultimate goal of the statute, there are other goals as well. In particular, the preamble to the statute recognizes the need for "judicious use of medical services in order to

maintain a fiscally sustainable health care system". It is recognized that providing "reasonable access" necessarily means that limits will be placed on the services paid for under MSP. Therefore, the objective of MSP can best be stated as being to fund a core of medical services. The objective cannot be to fund all services which might have effect of improving health care.

Medicare Protection Act, preamble, enacted by *Medical and Health Care Services Amendment Act, 1995*, S.B.C. 1995 c. 52, s. 1

110. While MSP long predates the report of the Commission on Health Care and Costs, its findings confirm that limiting health care expenditures is critical to the sustainability of the public health care system. The Commission confirms the correctness of the decision by government to legislate a Plan which imposed spending limits on a system subject to virtually insatiable demand.

111. At paragraph 111 of the plaintiff's factum, they suggest that the objectives behind the government's failure to fund interpreting services are twofold:

a) The reduction of the cost of medical services; and

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

Neither of these suggested objectives accurately reflects the objective that the government puts forward as pressing and substantial, although they do represent means to that objective. The relevant pressing and substantial objective of the impugned legislation is to ensure the fiscal sustainability of our health care system. One of the means by which the government seeks to achieve this objective is limiting the types of health care services that are funded under MSP.

112. It is true that one of the rationales for not funding interpreter services for deaf persons was that to do so would set a precedent. The government was concerned about "the potential costs of the program itself and other programs like it". It considered that there was no relevant distinction between providing interpreter services for deaf people and providing such services for others (particularly recent immigrant populations) who cannot communicate in English.

Testimony of Dr. Gary Curtis, COA, p. 282, ll. 41-45

113. While some pronouncements by this Honourable Court have indicated that purely economic considerations will not justify *Charter* infringements, other cases have explicitly taken economic factors into account in a section 1 analysis. While saving money alone will never justify an infringement of rights, such an infringement may be justified where the very sustainability of laudable objectives is contingent upon finding an appropriate allocation of limited resources. In *McKinney*, for instance, the majority of this Honourable Court said:

> The majority in [*Irwin Toy v. Quebec*, [1989] 1 S.C.R. 927] made it clear that the reconciliation of claims not only of competing individual or groups but also the proper distribution of scarce resources must be weighed in a section 1 analysis.
>
> *McKinney v. University of Guelph, supra*, at 288

114. In *McKinney* itself, this Honourable Court upheld as pressing and substantial the objective, which was stated to be:

> [T]o enhance and maintain [the University's] capacity to seek and maintain excellence by permitting flexibility in resource allocation ..."

If unlimited resources had been attributed to the Universities in McKinney, it is obvious that the system of mandatory retirement would not have been upheld. But, as Sopinka J. notes in *Egan*, "It is not realistic for the court to assume that there are unlimited funds to address the needs of all."

> *McKinney v. University of Guelph, supra*, at 281, 286
> *Egan v. Canada, supra*, at 572

115. In the case at bar, the Royal Commission Report on Health Care and Costs makes it abundantly clear that fiscal restraint in the allocation of resources is critical to the very survival of the health care system. The objective of "providing reasonable access to health care" cannot be divorced from the objective of ensuring that the scheme is fiscally sustainable.

116. It is therefore clear that the government has a pressing and substantial objective in limiting expenditures on health care.

Rational Connection

117. The pressing and substantial objective of the Province requires it to allocate limited public funds among a seemingly infinite number of public health needs and demands Clearly, in order to meet this objective, MSP must of necessity limit the breadth of services funded by government. In that regard, the scheme of MSP, which allows government to list the services it will fund, thereby excluding other services, is rationally connected to the plan's objective.

118. The executive committee of the Ministry of Health considered that the potential cost for sign language interpretation and other interpretation services for people who cannot speak English would be high. This assertion was not challenged at trial. It is inappropriate, as the plaintiffs now do at paragraph 118 of their factum, to speculate that interpreter services are actually a cost-saving measure on the basis of alleged "evidence" (which is not cited). Such a theory should have been put to the witnesses for the respondents in order to allow them to respond to it. The uncontraverted evidence at trial was that the provision of interpreter services to those who could not communicate in English would be a costly measure, and represent an additional demand on the health care budget. Certainly no evidence was led to suggest that funding these services would decrease the cost of health care.

Testimony of Dr. Gary Curtis, COA p. 282, ll. 4-45
Exhibit 3, Tab 1, Briefing Note prepared for Ministry Executive Committee, COA p. 306

119. It seems obvious that the most straightforward manner of limiting the costs of publicly funded health care services is to place limits on the services that are covered. Limiting the services to the professional fees of physicians and similar health care professionals is rationally connected to the objective of maintaining a fiscally sustainable public health care insurance scheme.

Minimal Impairment

120. In the Court of Appeal judgment below, Lambert J.A. asked whether the courts could ever strike the appropriate balance among competing priorities in the funding of medical services. He

noted that the allocation of resources to one service may result in an infringement of the Charter rights of another group, or the denial of perhaps even more crucial medical services for another. The polycentric nature of these choices makes it very difficult for a court to determine whether the Province has hit a constitutionally valid marker in this case. Difficulty alone does not, of course, exclude this kind of decision from judicial review. However, where the difficulty lies in determining what is the range of constitutionally permissible options, the question is to what degree these types of decisions on resource allocation ought to be scrutinized by the courts.

Judgment of the Court of Appeal, per Lambert J.A., COA p.533, l. 16 - p. 534, l. 18

121. As the Royal Commission on Health Care and Costs noted, health care finance is the most complicated management task faced by government today. By necessity, health care policy makers must choose from among the disadvantaged. Virtually everyone in the health care system who is denied a service will either be medically disadvantaged or could argue that a medical disadvantage will arise from the lack of service. Most of these disadvantages would constitute a disability under section 15 of the Charter. Therefore, most funding decisions under the Medical Services Plan will have some impact on the Charter rights of some group.

122. This Honourable Court has recognized that governments may from time to time be required to make choices among disadvantaged groups and that such choices are not only legitimate, but that government must be granted a measure of deference in so doing.

Tétreault-Gadoury v. Canada, supra, at 43-44, per, La Forest J.
Egan v. Canada, supra, at 573, per Sopinka J.

123. As is evident from the following quote judicial deference merely expresses the well-established notion that government ought to bear responsibility for certain difficult choices:

> When striking a balance between the claims of competing groups, the choice of means, like the choice of ends, frequently will require an assessment of conflicting scientific evidence and differing justified demands on scarce resources. Democratic institutions are means to let us all share in the responsibility for these difficult choices. Thus, as the courts review the results of the legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of the legislature's representative function..."

Irwin Toy Ltd. v. Quebec, supra, at 993-94, referred to by La Forest J. in *McKinney v. University of Guelph, supra*, at 399

124. Taking into account the reality that British Columbia cannot allocate unlimited resources to its health care system, and considering the complexity in allocating health care dollars, and the choices that must inevitably be made among the disadvantaged, the question, at the end of the day, is simply whether the government can show it has a reasonable basis for concluding it impaired the rights of the plaintiffs as little as possible given its objective.

McKinney v. University of Guelph, supra, per La Forest J. at 399-402

125. The plaintiffs argue that the rough estimate of "over $150,000" for the provision for interpreter services for deaf persons is so insignificant compared to the Ministry's overall budget that the provision of such services must be mandated by the Charter. If this were the case, one could anticipate a similar stream of endless claims that would also be mandated by the Charter on the ground that they are relatively cheap. At some point, those claims would, in the aggregate, cease to be relatively low-cost.

Testimony of Dr. Gary Curtis, COA, p. 282, l. 41 -p. 284, l. 10

126. In any event, the evidence demonstrates that the Ministry executive did not consider that this request was distinguishable from similar demands that would be generated by non-English-speaking communities. This was seen as a potentially very expensive proposition. In its report, the Royal Commission on Health Care and Costs reported that immigration into Canada, and British Columbia, has been rising since 1975 and is expected to increase in the future. In the Chapter entitled "Cultural Diversity and Medicare", the Commission noted that many people of minority, ethic background were not using existing medical services in British Columbia because those services were not culturally responsive or accessible to them. Illiteracy in English was identified as a major barrier and of primary concern for health care workers dealing with immigrants.

Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA pp. 708-710

127. At trial, Dr. Gary Curtis testified that in considering whether to inaugurate a program for government funding of medical sign language interpreting:

> Executive Committee was very well aware of the rapidly growing immigrant population in British Columbia and also the fact that [the] nature of the immigrant population has changed quite dramatically over the last 10 years from one that used to be principally from Europe to one that is now principally from ...Asia. So we ...we were very aware ... of the context of the discussion of a ... growing multicultural population with settlement needs and language difficulties.

Testimony of Dr. Gary Curtis, COA, p. 282, ll. 21 - 31

128. The fact that the Ministry took into account the potential precedential value of funding this service did not make the decision not to fund the service unreasonable. There is obviously a clear link between funding medical interpretive services for deaf persons and similar services for non-English-speaking patients. While some non-English-speaking persons may well eventually learn English, it is ludicrous to suggest that this fact is at all relevant since only non-English-speaking patients will need interpreters. Indeed, it would seem that those who cannot communicate in English may have a more acute need for interpreters, since they are unable to communicate in English either orally or in writing. Further, it is unimaginable that this Honourable Court would accept as legitimate a distinction between the provision of interpreter services for deaf persons and for non-English speaking persons that was based on the proposition that non-English-speakers had a greater potential to learn English.

129. If the issue is access to health care, as it is in this case, there is no meaningful distinction between the access issues faced by deaf persons and non-English-speaking persons. Additionally, these are not the only access issues faced by persons in British Columbia who seek health care services. In its report on Health Care and Costs, the Royal Commission identified significant access issues for persons living outside the lower mainland region of our Province. The Commission found that First Nations residents suffered a disproportionate lack of access to health care over the period of their lifetimes.

Exhibit 12 (Volume II), Report of the British Columbia Royal Commission on Health Care and Costs, COA pp. 616-618, 696 - 706

130. As discussed by Lambert J.A. in the Court of Appeal in this case, the health care funding decisions facing a government are manifold and reflect the polycentric concerns:

> The *Medical and Health Care Services Act* stops short of providing for perfect health care coverage in many ways. In most cases the lack of coverage arises from what the Act does not cover rather than what it does cover. So the lack of coverage is not a direct effect of the Act but an adverse effect of the restricted scope of the Act. The Act does not cover services by clinical psychologists, occupational therapists, speech therapists, nutritional counsellors or dentists. There is only limited coverage for dental surgeons, podiatrists, optometrists, chiropractors, and physiotherapists. The Act does not provide payment for artificial limbs, hearing aids, wheelchairs or other prosthetic devises. The people who need all of those services are people suffering from disabilities yet the Legislature has not chosen to extend direct benefits to the provision of those services.
>
> There is a national debate underway at the moment about the reduction of funds to be transferred from Canada to the Provinces in the future for Health, for Welfare, and for Education. There is a debate underway in each Province about the expenditure priorities for the reduced funds. In the allocation of scarce financial resources each Province will be required to make choices about spending priorities. Will medical equipment be bought for city hospitals or for small rural hospitals? Will the health care services in remote communities or in First Nations communities be improved? Is the best form of expenditure to raise the scale of payment for doctors and other health care workers? Should improved public facilities be provided for detection of cervical cancer, prostate cancer or breast tumours?
>
> Judgment of the Court of Appeal, per Lambert J.A., COA p. 532, l. 10 - p. 533, l. 12

131. The failure of government to provide funding for what the Learned Trial Judge described as "non-medical, ancillary services", does not prevent persons from acquiring those services through private funding. Given the objective of the legislation, it is submitted that in the circumstances of this case, the decision not to initiate funding of interpreter services constituted a minimal impairment of the rights of deaf persons.

> Reasons for Judgment at Trial, COA p. 484, ll. 17-28

Adverse Effects

132. The effects of limiting the types of health services that are funded by the government of British Columbia are not so severe as to outweigh its pressing and substantial objective in this case. The evidence regarding the health care histories of both the Warrens and Mrs. Eldridge reveal that the plaintiffs have found the lack of public funding for interpreter services inconvenient and perhaps frustrating. There is no question, however, that the plaintiffs, are not hesitant to use the health care system. Evidence which is perhaps more telling regarding the effect of interpreter services for the Warrens at least is the fact that : (a) they switched from a signing physician to a non-signing physician in order to save 15 minutes on the drive to the physician's office; and (b) at the time of the pre-mature birth of their twins, Mr. Warren made only one attempt to contact an interpreter during the 11 hours they were in hospital between the time Mrs. Warrens' water broke and the time she began to experience contractions.

Testimony of John Warren, COA p. 22, l. 41- p. 23, l. 10
Testimony of Linda Warren, COA p. 33, ll. 5-16; p. 37, ll. 14-18

133. Mrs. Warren's physician, Dr. Gibb, testified that she provided Mrs. Warren with adequate care. Mrs. Eldridge's treating physician, Dr. Tildesley was unable to convince the Learned Trial judge that there was any link between Mrs. Eldridge's inability to manage her diabetes and the absence of a publicly funded interpreter. In a similar vein, Dr. Rodda failed to convince the Learned Trial judge that deaf people are often misdiagnosed. On this point the Learned Trial judge simply accepted that a deaf person could be misdiagnosed.

Testimony of Dr. Victoria Gibb, COA, p. 129, ll. 3-6
Reasons for Judgment at Trial, COA 456, ll. 14-20; p. 459, l. 16 - p. 460, l. 8

134. The plaintiffs are clearly receiving adequate medical services. The evidence does not disclose effects from the lack of publicly funded interpreter services which are so adverse as to outweigh the government's objective.

E. Remedy

135. If the plaintiffs succeed in this appeal, it is submitted that the appropriate remedy would be to grant a declaration that the failure to fund medical interpreter services for the deaf is unconstitutional. As the evidence clearly discloses, the allocation of health care dollars is a complex task which must take into account numerous variables. There is a range of solutions from which a government might choose and not all of the solutions are immediately apparent.

136. For example, the government might respond to a declaration by instituting a program to encourage physicians to learn American Sign Language. It might create special clinics for deaf people. It might decide to provide interpreter services directly. It is not at all apparent that funding through MSP is the only or most desirable solution.

137. As well there are practical problems with the inclusion of interpreter services within MSP. Unlike existing service-providers who are entitled to bill MSP for their services, there is no self-governing profession in existence. Problems concerning who is qualified to provide the service, what group will monitor the propriety of billings, the creation of a fee schedule and the actual enrollment of service-providers must all be addressed before a system of coverage can be implemented. While none of these problems is insuperable, they all need to be addressed in legislation. The level of detail required is not appropriately within the purview of this Honourable Court.

138. This is, therefore, not a case where it would be appropriate to simply "read in" or include in MSP a "fee for service" called interpreter services for deaf persons.

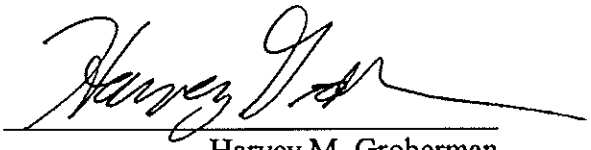
PART IV

NATURE OF ORDER SOUGHT

139. These respondents seek an Order dismissing the Appeal.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

DATED at Victoria, British Columbia, this 21st day of February, 1997.



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PART V

TABLE OF AUTHORITIES

Statutes **Page(s)**

Canadian Charter of Rights and Freedoms, s. 1 28-38

Canadian Charter of Rights and Freedoms, s. 15 9-27

Hospital Insurance Act, R.S.B.C. 1979, c. 180 9-13

Hospital Insurance Act Regulations, B.C. Reg. 25/61, s. 5.1 10

Medical and Health Care Services Amendment Act, 1995, S.B.C. 1995 c. 52 ..... 9, 31

Medicare Protection Act, S.B.C. 1992, c. 76 ..... 9, 10, 13, 15, 16, 30, 31

Cases **Page(s)**

A.G. Canada v. Mossop [1993] 1 S.C.R. 554 19

Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143 ..... 17, 19, 20, 22, 24

Bliss v. Attorney General of Canada, [1979] 1 S.C.R. 183 ..... 20, 23, 24

Brooks v. Canada Safeway, [1989] 1 S.C.R. 1219 ..... 23, 24, 25

Eaton v. Brant County Board of Education (February 6, 1997), not yet reported, S.C.C. No. 24668 14

Egan v. Canada, [1995] 2 S.C.R. 513 ..... 14, 19, 24, 32, 34

Gibbs v. Battlefords and District Co-operative Ltd. (October 31, 1996), not yet reported, S.C.C. No. 24342 26

Irwin Toy v. Quebec, [1989] 1 S.C.R. 927 ..... 32, 35

Knodel v. *British Columbia* (1991), 58 B.C.L.R.(2d) 356 ..... 22, 26

McKinney v. University of Guelph, [1990] 3 S.C.R. 229 ..... 12, 17, 32, 35

Miron v. Trudel, [1995] 2 S.C.R. 418 14

Ontario Human Rights Commission and O'Malley v. Simpsons-Sears, [1985] 2 S.C.R. 536 ..... 18, 19

R.W.D.S.U. v. Dolphin Delivery Ltd., [1986] 2 S.C.R. 573 11

Regina v. Big M Drug Mart, [1985] 1 S.C.R. 295 17

Regina v. Dersch, [1993] 3 S.C.R. 768 12

Regina v. Swain, [1991] 1 S.C.R. 933 13

Ross v. School New Brunswick School District No. 15, [1996] 1 S.C.R. 825 28

Stoffman v. Vancouver General Hospital, [1990] 3 S.C.R. 483 10-12

Symes v. Canada, [1993] 4 S.C.R. 695 ..... 13, 14, 23

Tétreault-Gadoury v. Canada, [1991] 2 S.C.R. 22 ..... 17, 34

Thibaudeau v. Canada, [1995] 2 S.C.R. 627 14