

Allocation and Rationing of Health Care Resources: Patients' Challenges to Decision-Making

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I. CANADIAN CONSTITUTIONAL CONTEXT

The successes of health technology in prolonging life, diagnosing and managing disease, saving newborns and, more recently, assisting reproduction, have become one of its major problems. "Each year medicine can do more and, despite some cost savings, will cost more, whereas our resources will remain relatively constant".¹ Thus, some very tough decisions must be made as to the allocation and rationing of health care.

In the present context, allocation refers to fixing the amounts of resources that go to health care at the expense of allocation to other purposes. It includes dividing the health care budget into various areas such as prevention, care, treatment and research, and deciding which of various treatment regimes will be funded. This should not be confused with rationing, which refers to deciding which individuals among those with a need will get a particular health service that is in short supply.² The term "macro-allocation" has been applied to allocation, and "micro-allocation" to rationing.³

Our challenge as a society is to make allocation and rationing decisions that are in keeping with the egalitarian ideal of the Canadian health care system.⁴ The problems are complex and require a multidisciplinary approach guided by economic analysis, socio-scientific assessment of alternative procedures, education of the public as to the huge cost of unrestrained health care, and open ethical discussion. While the long term solutions must be social and political, a legal approach may help to foster the public debate necessary for long term solutions by pointing to problems in the present system.

There are various players in the health care system, each with their own interests in allocation and rationing.⁵ These players include physicians and other health care providers, medical associations, research and service units, hospital administrators, and the provincial and federal governments. From the legal perspective, we need to examine where decision-making power lies to know where challenges might occur.

The division of power set out in the Canadian constitution appears to give limited power to the federal government in the area of health.⁶ Yet the federal government has

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1. M. MacGregor, "Technology and the Allocation of Resources", (1989) 320 *New Eng. J.Med.* at 118-119.
 2. This short supply may be real, as in organ transplant or when an allocation decision reduces the number of renal dialysis machines, M.D. Reagan, "Health Care Rationing: What Does it Mean?", (1988) 319 *New Eng. J.Med.* 1149.
 3. See for example R.W. Evans, "Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions" Part II, (1983) 249 *J. Amer. Med. Assn.* 2208.
 4. The egalitarian quality of Canadian health care "reflects a society that attaches a higher value to social equality than does the United States", J.K. Iglehart, "Canada's Health Care System", (1986) 315 *New Eng. J.Med.* 202, 778, 1623 at 781.
 5. R.G. Evans, "Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control", (1990) 15 *J. Health Politics, Policy & L.* 101.
 6. Federal power derives mainly from the *Constitution Act, 1867* ((U.K.), 30 & 31 *Vict. c.3*), under the residual power of section 91, and section 91(27), criminal law. That of the provinces derives mainly from section 92(7), authority over hospitals (other than marine hospitals which are under federal jurisdiction)

attained considerable control through its spending power⁷ in conjunction with a federal-provincial agreement by which the federal government shares costs with the provinces for health care through a scheme of tax abatement and transfer of funds. Attached to the transfer payment is a set of conditions with which the provinces agree to comply. Under the *Canada Health Act*, extra billing by physicians and extra charges by hospitals are forbidden. The provinces are required to provide a health care delivery system that is publicly administered, comprehensive, universal, accessible, and portable between provinces.⁸

Currently, the formula for federal health care spending is based on the gross national product and the population of the province. Because of this link with economic growth, the provinces bear the financial burden of health care expenditures that exceed the overall cost of living.⁹

Each province has a health insurance act setting out the services to be provided, the conditions for their insurance, and the remuneration to professionals offering services. Private insurance is prohibited for services covered in the public health plan.¹⁰ Under these plans, Canadians are given wide coverage of health care by physicians of their choice. Health care institutions negotiate with the provincial government for a global operating budget. Any capital expenditures from private funding (such as donations) must be approved by the provincial government.¹¹

Physicians are paid a fee for service that is negotiated between the provincial government and the provincial medical association. Neither clinical decisions nor treatment protocols are reviewed by the responsible ministry but aggregate billing must be within the negotiated limit.¹²

Thus, provincial governments attempt to control costs through control of hospital operating budgets, limiting major capital expenditure, and negotiating physicians' fee

under sections 91(11), 92(13), property and civil rights, and section 92(16) local and private matters.

7. Deriving from the *Constitution Act, 1867*, (*ibid.*) section 91(3) giving the federal government power to raise money by taxation, section 106, the power to appropriate funds for public service, and section 91A the power to legislate with respect to public debt and property. Section 36 of the *Constitution Act, 1982* (being Schedule B of the *Canada Act 1982* (U.K.), 1982, c.11), sets out a commitment to promote equal opportunity which may help to justify federal spending within provincial jurisdiction: P.W. Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985) at 125.
8. *Canada Health Act*, R.S.C. 1985, c. C-6, s.7. Under this scheme the federal government awards tax points and cash grants to the provinces. The latter may be held back from the province if the conditions are not complied with. For extra-billing or hospital charges, the amount held back will be proportionate to those charges (*supra* note 4 at 207).
9. *Supra* note 4 at 779.
10. Thus, patients may have private insurance to cover the cost of private or semi-private accommodation not covered under the public plan (*supra* note 4 at 780).
11. This allows government to control the location of technological services (*supra* note 4 at 784). See also, R.G. Evans, "Controlling Health Expenditures — The Canadian Reality", (1989) 320 *New Eng. J. Med.* 571.
12. *Ibid.* at 575. Five provinces have ceilings or targets on medical services delivered by physicians, J.K. Iglehart, "The United States Looks at Canadian Health Care", (1989) 321 *New Eng. J. Med.* 1767 at 1771.

schedules.¹³ Provincial health insurance acts determine the extent to which the responsible ministry can regulate these matters.

Attempts have also been made by some provincial governments to control the geographic distribution of physicians.¹⁴ While the Ontario and Manitoba governments instituted voluntary programs with financial incentives, Quebec and British Columbia attempted more coercive means.¹⁵ As discussed below, the latter have been successfully challenged in the courts.

In 1984 and 1985 the Quebec cabinet issued directives that foreign trained physicians, other than those from the U.S., were required to take an examination and to do a rotating internship. Those selected for one of the allotted places had to sign an agreement to practice in a designated area for three years or pay a substantial financial penalty. Normally, directives are not subject to judicial review. However, the Quebec Court of Appeal¹⁶ held that the geographic requirement was not administrative but regulatory in nature since it imposed an obligation. Since such a regulation could not be supported by enabling legislation, it was held to be *ultra vires*.¹⁷

Similarly, in *Mia c. Medical Services Commission of B.C.*¹⁸ a British Columbia physician succeeded in challenging a directive prohibiting qualified physicians from billing unless issued with a billing number by the Medical Services Commission, which controlled the provincial health plan. British Columbia has Canada's highest physician-population ratio, but, like other provinces, there are areas where there is a shortage of physicians. The scheme set out in the directive was aimed at remedying this by directing physicians to areas of shortage. Where a billing number was issued, it might only permit a physician to practice in a region where services were needed. The British Columbia Supreme Court held that the Medical Services Commission had no jurisdiction to put the scheme in place without the appropriate enabling legislation.¹⁹ Such power had to be legislated. The government subsequently legislated this power, whereupon physicians successfully challenged the legislation²⁰ on the grounds that it infringed section 7 of the *Charter*.

13. *Supra* note 4 at 778.

14. There is also a Federal/Provincial Advisory Committee on Health and Human Resources with representation by government and by the medical profession. This committee has addressed such issues as the means of restricting foreign medical graduates into Canada (*ibid.* at 1627).

15. *Ibid.* at 1625-1626.

16. *Dlugosz c. Quebec (A.G.)*, [1987] R.J.Q. 2312 (C.A.).

17. The Minister of Health had power to make health services available to the population but the court held that the directive went beyond this discretionary power. The government could have legislated such a power, which would then be subject to Charter review requiring the government to justify any infringement.

18. *Mia c. Medical Services Commission of B.C.*, (1985) 61 B.C.L.R. 273 (B.C.S.C.).

19. The court also held that the scheme infringed the petitioner's right to mobility (s.6) and liberty (s.7) of the *Charter*.

20. *Wilson c. Medical Services Commission of B.C.*, (1988) 30 B.C.L.R. (2d) 1 (B.C.C.A.); leave to appeal to the Supreme Court of Canada denied, November 3, 1988.

Provision of health care services, as well as being influenced by governmental decisions, may be influenced by hospital administrators, by professional medical associations who regulate conditions of practice, and by individual health care providers. The degree to which hospital administrators may determine the kinds of services their establishments will offer, and the terms and conditions attached to giving and receiving of such services, will depend on the legislative, regulatory and executive powers of the particular ministry of health.²¹ However, even without express legislative authority, hospital administrators and the medical profession may influence the quality of health care.²²

To what degree, then, are decisions of the government, administrators and professionals that affect patients' access to health care challengeable under the principles of administrative law? We will look at two areas of law: first, challenges involving the general principles of administrative law, and second, those that bear on the *Canadian Charter of Rights and Freedoms*.

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21. For a discussion of the limits of public law challenges by potential beneficiaries in Quebec, see L. Lussier, "Le processus d'attribution des ressources par les établissements aux bénéficiaires: Impact sur le droit aux services et sur la responsabilité `publique'", (1990) 20 R.D.U.S. 285.
 22. S.L. Martin, *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms and the Canada Health Act* (Ottawa: Canadian Advisory Council on the Status of Women, 1989) at 8 gives the example of abortion services in Prince Edward Island which are effectively prohibited by a dictate of hospital administrators that physicians will lose their hospital privileges if they perform abortions.

II. ADMINISTRATIVE LAW

A. Power to legislate

1. Constitutional division of power

Because of the constitutional limitation of express federal power to legislate in the domain of health care, such legislation might be subject to challenge where it is not criminal in nature, where it does not fall within the residual power of section 91, or where it goes beyond federal spending power.²³

In order for federal legislation to fit within the residual power of section 91 on the grounds of national dimension, certain criteria have to be met.²⁴ The problem being addressed must be single, distinct and indivisible such that the legislation does not unduly intrude on provincial constitutional jurisdiction, taking into consideration the effect of failure of the province to legislate adequately and uniformly on the matter.²⁵

Provincial constitutional competence may also be challenged. For example, the question before the Saskatchewan Court of Appeal in *Re Freedom of Informed Choice (Abortion) Act*²⁶ was whether a provincial regulation requiring a married woman seeking an abortion to have written consent of her husband, and a minor that of her parents or guardian was constitutional. The Court held that it was not because it infringed federal criminal law jurisdiction.

The case of *Morgentaler c. New Brunswick (A.G.)*²⁷ suggests that where a province pays for certain medical procedures performed in another province for its residents, any conditions attached to such payment must be legally enacted if they are to have extra-territorial effect. That is, a province cannot merely make an informal policy restricting payment with conditions that do not accord with the conditions set in the province where the procedure is done.

23. For the latter see *infra* note 28.

24. *R. c. Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401 at 432-434.

25. For example, failure to provide services in one province might increase demand in another province and unduly burden both health-care consumers and institutions.

26. *Re Freedom of Informed Choice (Abortion) Act*, (1985) 25 D.L.R. (4th) 751 (Sask. C.A.).

27. *Morgentaler c. New Brunswick (A.G.)*, (1990) 98 N.B.R. (2d) 45 (N.B.Q.B.T.D.).

2. The Canada Health Act

The balance of opinion is that federal spending agreements with the provinces are constitutional.²⁸ Thus, if the province accepts federal funding, it must ensure that it complies with the conditions set out in the *Canada Health Act*, whose purpose is "to establish criteria and conditions that must be met before full payment may be made".²⁹ The meaning of some of the five conditions (publicly administered, comprehensive, universal, portable and accessible) is far from clear. Their meaning must be interpreted in light of the objective of the Act, which 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".³⁰ While the mandate appears broad, the meaning of "reasonable access" in the objective of the Act is unclear.

In order to fulfil the requirement for *comprehensiveness*, a provincial health plan must cover "all insured health services"³¹ which means services that are "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability".³² It is not clear how much leeway the provincial government has in determining the meaning of this condition.

The requirement for *universality* calls for "uniform terms and conditions". This implies similarity between regions with respect to accessibility to medical services. The condition of *accessibility* also requires uniformity of terms and conditions so as not to "impede or preclude, either directly or indirectly [...] reasonable access"; payment for services and hospitals; and reasonable compensation for practitioners.

Where the public funding of a medically necessary service by a provincial government is non-existent, inadequate, or conditional, the court's interpretation of the conditions of the *Canada Health Act* will be crucial to the outcome of a court challenge. But, even if it could be shown that a province was not meeting its obligations to patients under the *Canada Health Act*, would a patient have standing to sue on administrative grounds?

The *Canada Health Act* does not give an individual a private right to bring an action for a provincial government's failure to comply with the conditions set out in the Act.³³ However, the case of *Ministry of Finance of Canada c. Finlay* suggests that a private party

28. Hogg, *supra* note 7. *Contra*: A. Lajoie & P.A. Molinari, "Partage Constitutionnel des Compétences en Matière de Santé au Canada", (1978) 56 Can. Bar Rev. 579. The majority view is illustrated in the case of *Winterhaven Stables Ltd. c. A.G. of Canada*, (1988) 53 D.L.R. (4th) 413, (Alta C.A.).

29. *Supra* note 8, s.4.

30. *Ibid.* s.3.

31. *Ibid.* s.9.

32. *Ibid.* s.2.

33. *Ibid.* Section 15 allows the federal government to withhold funds for non-compliance, at the discretion of the cabinet.

may have standing to bring a declaratory action.³⁴ The plaintiff, Finlay, was a resident of Manitoba who received public assistance under a municipal act. Through an administrative error, he received more money than he was entitled to. A provincial act allowed recovery of overpayment by docking 5% from entitled benefits. This brought the plaintiff below the basic requirements set out in the transfer agreement between the federal and provincial governments.

The issue in the case was whether a private individual has an interest to sue to ensure that a government enforces a law. The Supreme Court of Canada held that the question of provincial compliance with the transfer agreement is a question of law; thus, it is subject to judicial review. Furthermore, a private person can sue for declaratory relief without the consent of the Attorney General, if interference with a public right is demonstrated. The issue in such a case must be justiciable and serious, and the citizen must have a genuine interest in a settlement.

Having won on the issue of standing, the *Finlay* case proceeded through the courts on its merits. In July of 1990, the Federal Court of Appeal upheld the trial judge's ruling that the federal transfer payments to Manitoba are illegal so long as the province continues to allow deductions for overpayment.³⁵ The court disallowed the injunction issued by the Trial judge against the federal Minister of Finance, which enjoined him from transferring funds to the province. The Court's reasoning was that it would be "totally out of proportion to the mischief sought to be remedied" and that the declaration as to illegality, which was maintained, would undoubtedly be honoured by the governments.³⁶

Thus, where the public funding of a medically necessary service by a provincial government is non-existent, inadequate, or conditional, a citizen may have standing to seek judicial review if the province accepted federal funding under the *Canada Health Act*. The ambit of standing under the *Canada Health Act* remains to be defined.

B. Power to regulate

If a provincial government passes regulations concerning health care, the regulatory power must be shown to derive from the enabling act. But, if a regulation is within statutory power, the court will only intervene where decisions taken under the regulation were procedurally unfair or where discretion has been exercised unreasonably. If the court finds that the regulation is *ultra vires*, it will be struck down.

1. No jurisdiction to regulate

34. *Ministry of Finance of Canada c. Finlay*, [1986] 2 S.C.R. 607 [hereinafter *Finlay*].

35. See *Finlay c. Canada (Minister of Finance)*, (1990) 71 D.L.R. (4th) 422 (F.C.A.).

36. *Ibid.*

In *B.C. Civil Liberties Assn. c. British Columbia (A.G.)*³⁷ the provincial cabinet passed a regulation purporting to establish that abortion was not a medically required service and thus not insured under the province's *Medical Services Act*. The plaintiff succeeded in having the regulation struck down on the grounds that the enabling legislation did not give the cabinet power to decide what was medically required. Had the cabinet merely regulated abortion as an uninsured service, the regulation would have been *intra vires*.³⁸

In the case of *Jasmin c. Cité de la Santé de Laval*³⁹ the administrative board of a Quebec hospital passed by-laws giving priority of services to residents and admission privileges to physicians within the district of Laval. An action was brought by a physician whose private office was outside the district and by two patients residing outside the district who claimed that the by-laws were illegal.⁴⁰

Under section 4 of the Quebec *Health and Social Services Act*,⁴¹ "[e]very person has the right to receive adequate, continuous and personal health services and social services". However, this right is qualified by the phrase "taking into account the organization and resources of the establishments providing such services". The hospital pleaded that they were required to restrict admissions in order to decrease the hospital deficit as required by the Minister of Health, and that the by-laws were within the jurisdiction conferred on them to preserve the quality of services. The court did not accept this argument. Even though the Ministry approved of the means of decreasing the deficit, the by-laws had not been adopted under the *Health and Social Services Act*. In granting a declaratory judgement, the court expressly refused to take account of the hospital's alleged lack of resources.

The court also referred to the administrative law principle that "[i]n theory, the power to regulate does not include the power to discriminate. Accordingly, where a statute contains no authorization, express or implied, a discriminatory regulation may be challenged and set aside".⁴² In this particular case, the law expressly gave patients the freedom to choose the physician who would treat them and to choose the hospital where treatment would be done.⁴³ Thus, a power to discriminate could not be implied.

To the cases where there is no clear power in the legislation to regulate, we may add those where a regulation is disguised as a directive. We saw this in cases involving provincial government attempts to control the location of practice of physicians within a province. Thus,

37. *B.C. Civil Liberties Assn. c. British Columbia (A.G.)*, (1988) 4 W.W.R. 100 (B.C. S.C.).

38. *Ibid.* at 105 (obiter). The petitioners also claimed that there was a loss of jurisdiction because the cabinet failed to take into account relevant considerations and thus had "failed to exercise a delegated discretion in accordance with proper principles". However, since the court found that the cabinet had no jurisdiction to make the decision, it did not rule on whether there was loss of jurisdiction for unreasonableness.

39. *Jasmin c. Cité de la Santé de Laval*, [1990] R.J.Q. 502 (C.S.) Vaillancourt J. [hereinafter *Jasmin*].

40. The plaintiffs also argued that the regulations contravened the Quebec and the Canadian Charter, see text accompanying *infra*, note 121.

41. *Health and Social Services Act*, R.S.Q., c. S-5, S.4, as amended.

42. *Forget c. Quebec (Attorney General)*, [1988] 2 S.C.R. 90 at 105.

43. *Supra* note 41, s.5.

where cabinet directives have the same effect as regulations, they are subject to review and there must be enabling legislation to legitimate them.⁴⁴

This principle could apply to decisions affecting patients as well as physicians, although patients are less likely to be aware of their rights in order to challenge such decisions.

2. Loss of jurisdiction for unfairness

The principles of natural justice and fairness are flexible. In general, they require that administrative or quasi-judicial decisions provide for a hearing, unbiased adjudication, and fairness. However, the content of these procedural elements will depend on the importance of the right being infringed. Thus, an oral hearing before the decision-maker may not be required in all cases. It may be adequate that the parties are given an opportunity to put forward their arguments.⁴⁵

There are no cases in Canada where the principles of natural justice and fairness have been invoked concerning refusal of health care services. However, an English case is of interest to illustrate the kind of challenge that might occur.

In *R. c. St. Mary's Hospital ex parte Harriott*,⁴⁶ the plaintiff, a married woman, asked to have *in vitro* fertilization (IVF) under the National Health Service because of her inability to conceive. Her request was refused by the medical consultant who initially misled the plaintiff as to the reason for the refusal. The plaintiff persisted and was eventually told that the refusal was based on the fact that she had previously been turned down by adoption agencies. The refusals of the adoption agencies were based on her criminal record, which included allowing premises to be used as a brothel and soliciting for prostitution. The policy of the IVF unit was that to be eligible for IVF, a couple first had to satisfy the suitability criteria for adoption, established by adoption agencies. The medical consultant asked the local ethics committee for advice and was told that she would have to decide for herself whether to treat the plaintiff.

The eligibility policy was not challenged by the plaintiff. The plaintiff also accepted that the local ethics committee had no statutory power or duty to make the decision as to whether she would get treatment. Her claim was that once the committee was asked to advise the medical consultant, it had a duty to investigate. The judge ruled that the court was not prepared to force the committee to hear evidence from the plaintiff, and that the committee's advice was unobjectionable.

44. *Dlugosz*, *supra* note 16 and *Mia*, *supra* note 18.

45. S.A. De Smith, *Judicial Review of Administrative Action*, 4th ed. by J.M. Evans (London: Stevens, 1980). The principles apply in Canada as in England: D.P. Jones & A.S. De Villars, *Principles of Administrative Law* (Toronto: Carswell, 1985) at 162-178.

46. *R. c. St. Mary's Hospital ex parte Harriott*, 137 New L.J. 1038 (Q.B.), discussed by D. Jabbari, "The Role of Law in Reproductive Medicine: A New Approach", (1990) 16 J. Med. Ethics 35 at 39.

The plaintiff challenged the medical consultant's refusal on the grounds that she had not acted fairly. The judge allowed that the consultant's conduct might be open to criticism. However, he held that the plaintiff had since had the opportunity to present more information to the consultant and the health authority to try to convince them to treat her. There was no evidence before the court that they had acted unfairly by refusing to consider new arguments and new facts. The judge, having decided not to go beyond the bounds of what was necessary to decide the case, declined to decide whether, in principle, judicial review would lie for such a decision to refuse treatment.

Whether the plaintiff would have fared better in a Canadian court on this administrative challenge is open to conjecture. The content of the procedural elements of natural justice and fairness will depend on the importance the court attaches to the right being infringed.⁴⁷ Furthermore, even if the court had ordered the medical consultant and health authority to reconsider their decision because of procedural unfairness, there is no guarantee that the decision would have been decided in favour of the plaintiff, on the merits.

3. Loss of jurisdiction for unreasonableness

Where administrators are given discretion to carry out certain objects of a statute, there are limits which, if exceeded, will bring the decision within the ambit of judicial review. One such limitation is that discretion cannot be exercised unreasonably.

"Unreasonable" exercise of discretion as defined in English law is conduct that "no sensible authority acting with due appreciation of its responsibilities would have decided to adopt".⁴⁸ This may be, but is not necessarily, the result of the decision-maker failing to take account of what is relevant and failing to ignore what is not.⁴⁹ The court, in reviewing such a decision, is dealing with its effects rather than just the procedure by which the decision was reached.

In Canada, as in England, the courts are reticent to intervene where administrators have been given discretionary power.⁵⁰ This is particularly so where the decision-maker is a government minister because such a decision-maker is responsible to the parliament or legislature.⁵¹

47. Jones & De Villars, *supra* note 45 at 236.

48. *Secretary of State for Education and Science c. Tameside Metro Borough Council*, [1977] A.C. 1014 at 1064 (C.A.).

49. *Associated Provincial Picture Houses Ltd c. Wednesbury Corp.*, [1948] 1 K.B. 223 at 233-234 (C.A.).

50. However, in *Bell c. R.*, [1979] 2 S.C.R. 212 at 222-223, the majority held that even though the doctrine of unreasonableness was limited, it still exists. The municipal by-laws in dispute were found to fall within the ambit established in English law as being "such oppressive or gratuitous interference with the rights of those subject to them as could find no justification in the minds of reasonable men".

51. R. Dussault & L. Borgeat, *Administrative Law: A Treatise*, vol. 1, 2d ed. (Toronto: Carswell, 1985) at 430-443; See also, J.M. Evans, *Administrative Law: Cases, Texts and Materials*, 3d ed. (Toronto: Emond Montgomery, 1989) at 721-24.

We may ask whether a decision of a provincial health minister could be reviewed for unreasonableness where funding cuts result in failure to meet the object and conditions of the *Canada Health Act*, or additional duties set out in the provincial legislation. The British experience suggests a limited likelihood of success of such a challenge.

In Britain, under the National Health Service, the Secretary of State for Social Services, like our ministers of health, has a duty to provide comprehensive health services. In 1980, the British Court of Appeal rendered a judgement in a case where patients awaiting surgery sought a declaration that the Secretary of State had failed to fulfil this duty.⁵² The patients did not succeed. The court held that within the section imposing the duty, the words "such as can be provided within the resources available" must necessarily be implied.⁵³ Otherwise the Secretary of State would have a duty that was impossible to fulfil.

In 1987, an application for judicial review under the *National Health Service Act* was turned down by the Court of Appeal in a case where a baby with a congenital heart defect was awaiting surgery.⁵⁴ The Court affirmed that it could review decisions of the National Health Service but that the power of review would be used sparingly. The Court reiterated the principle that the decision-maker, in exercising discretion, must consider what he is bound to consider and exclude what is irrelevant. Otherwise, the decision could be held to be unreasonable.⁵⁵

Whereas in the above case the patient would have received the necessary services had there been signs of deterioration, this was not so in another case reported in the British press.⁵⁶ In this case, rather than wait-listing patients, all dialysis procedures were stopped at a hospital for lack of funds. A blind diabetic who was in end stage renal failure with an estimated 10 days to live won emergency legal aid to take the health authorities to court. The court action was averted when money was provided by the Secretary of State to the renal unit.

It has been suggested that a decision to simply cut off funding for all patients could be successfully challenged as unreasonable exercise of discretion.⁵⁷ The threat of such a challenge could encourage governments to make explicit and reasoned allocation decisions.

52. *R. c. Secretary of State for Social Services, West Midlands Regional Health Authority, ex parte Hincks* (18 March 1980), Supreme Court Library 274 [unreported]. The case is discussed by D. Brahmans, "Enforcing a Duty of Care for Patients in the NHS", (1984) II *Lancet* 1224.

53. Thus, the court read in to the ministerial duty a qualification that is explicit in Quebec's health care legislation, *supra* note 41.

54. C. Dyer, "Going to Law to get Treatment", (1987) 295 B.M.B. 1554. On the same day as the application was heard, the baby received the operation.

55. See also *supra* note 37, where the petitioners made this argument with respect to a cabinet decision to cut abortion services.

56. *Supra* note 54.

57. *Ibid.*

III. THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS

A. Application of the Charter

The *Canadian Charter of Rights and Freedoms*⁵⁸ has expanded the scope of judicial review to include not only subordinate legislation but executive action and laws.⁵⁹ Section 32 of the Charter tells us that it applies to legislative and governmental decisions. Thus, both the provincial and the federal governments must ensure that their legislation complies with the Charter. The executive may also be subject to judicial review. Justice Wilson in *Operation Dismantle c. The Queen*⁶⁰ stated:

"[I]f we are to look at the Constitution for the answer to the question whether it is appropriate for the courts to 'second guess' the executive on matters of defence, we would conclude that it is not appropriate. However, if what we are being asked to do is to decide whether any particular act of the executive violates the rights of citizens, then it is not only appropriate that we answer the question; it is our obligation under the Charter to do so."⁶¹

Individuals who are exercising power they derive from a statute will be subject to judicial review under the *Charter*.⁶² However, if actions are deemed not to involve the government or legislature, they are said to be within the private sphere, and the *Charter* will not apply.⁶³ The actions of hospitals and health care workers have been held not to fall under the Charter in *Stoffman c. Vancouver General Hospital*⁶⁴ the Supreme Court of Canada held that the Charter was inapplicable because government is not involved in public hospitals' day to day routine management.

58. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982* being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

59. The latter were formerly challengeable only as to the legislative competence of their makers under sections 91 and 92 of the *Constitution Act, 1867*, *supra* note 6.

60. *Operation Dismantle c. Canada (A.G.)*, [1985] 1 S.C.R. 441. The government of Canada agreed to allow the U.S. to test air-launched cruise missiles in Canada. The respondent organization challenged the decision on the grounds that it would infringe the right to life and security of the person under section 7 of the *Charter*. The court held that no infringement had been demonstrated. In *Air Canada c. British Columbia (A.G.)*, [1986] 2 S.C.R. 539, the Supreme Court of Canada similarly held that executive powers must conform to constitutional dictates.

61. *Operation Dismantle*, *ibid.* at 472. She goes on to illustrate with hypothetical examples, situations where the court could and could not review executive decisions.

62. *Slaight Communications Inc. c. Davidson*, [1989] 1 S.C.R. 1038.

63. *Retail, Wholesale & Department Store Union, Local 580 c. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573. See also *McKinney c. University of Guelph*, (1990) 76 D.L.R. (4th) 545 (S.C.C.). It was not disputed that the Universities are statutory bodies performing a public service. As such, they may be subjected to the judicial review of a certain decision, but the Supreme Court found that this does not in itself make them part of government within the meaning of section 32 of the Charter.

64. *Stoffman c. Vancouver General Hospital*, (1991) 76 D.L.R. (4th) 700 (S.C.C.) [hereinafter *Stoffman*].

The respondents in *Stoffman* were a group of physicians who objected to the adoption and administration of a hospital by-law that established differential criteria for granting hospital privileges to physicians on the basis of a cut-off age of 65 years. In their *factum* presented to the Supreme Court of Canada, the respondents argued that since the by-law did not come into effect until approved by the provincial Minister of Health, the by-law and its administration fell within the executive branch of the government as a form of delegated legislation. The respondents proposed a test for activities that are governmental in nature so as to attract the application of the Charter. They argued that the Charter should apply to an entity satisfying one or more of three tests:

i) it performs the functions of making and applying laws of general application [government function test];

ii) the executive branch of either the federal or provincial order of government is extensively involved in its operations [close connection test]; or

iii) it performs a function pursuant to statutory authority specifically granted to it to enable it to further, on behalf of either the federal or provincial order of government, some object the government seeks to promote in the broader public interest [public entity test].

The Supreme Court majority distinguished ultimate from routine or regular control of entities, and found the public hospital to be too remote from government in the routine aspects of its operation for it to constitute an agency under government control.⁶⁵

When provincial statutes directly affect hospital practices, at least some of their actions may be reviewable under the Charter.⁶⁶

B. Relevant sections of the Charter

The sections of the Charter that are the most relevant subject matter of health care are: section 7, the right to life, liberty and the security of the person; section 15, the equality provision; and section 1, which allows for limits on these rights. In determining whether a Charter right has been infringed, it is necessary to look not only at the purpose of the impugned statute, regulation or common law principle, but also at its effect.⁶⁷ To do so, one needs first to define the right that is protected.

65. *Ibid.* at 739.

66. J. Fleming, "Hospital Transfers into Nursing Homes: A Potential Charter Remedy for Unwilling Transferees", (1985) 1 J. Law and Social Policy 50 at 53, but see note 62 regarding University status.

67. *R. c. Big M Drug Mart*, [1985] 1 S.C.R. 295.

U.S. jurisprudence may be relevant in some instances to define rights in the Canadian Charter.⁶⁸ However, caution must be exercised in interpreting Canadian social policy by U.S. standards, especially when dealing with entitlement. The two countries have different political traditions and have devised different health care systems as well as constitutional instruments. "The U.S. approach to regulation of its health care system [...] reflects [its] legal system's close historical ties to the economic philosophy of regulated capitalism, with its emphasis on private markets and limited governmental intervention in the economy."⁶⁹ While Canada shares this "capitalist penchant for profit making"⁷⁰ its approach to health care reflects a decided egalitarian, socialist trend.⁷¹

This historical perspective is important in the judicial resolution of the tension between liberty and equality in defining the limits of our right to health care. One author in discussing this tension writes:

If equality is the likely foundation for a collective rights model, then liberty would be the basis of an individualistic model. One problem with a judicial emphasis on liberty is that it tends to work to the advantage of those who already have it, rather than those seeking to attain it.... The doctors protesting Ontario's legislation banning extra-billing are a vivid illustration of the likely beneficiaries of a broad liberty approach to the Charter. Freedom to earn money even at the expense of providing unequal medical services is hardly the basis for an egalitarian revolution.⁷²

Thus, in resolving conflicts in health care, the courts will not only have to define the content of section 7 and section 15 rights, but will have to resolve conflicts between liberty and equality and between individual and communal interests.

1. Section 7

68. J. Cameron, "The Motor Vehicle Reference and the Relevance of American Doctrine in Charter adjudication" in R.J. Sharpe, *Charter Litigation* (Toronto: Buttersworths, 1987) 69.

69. A.M. Capron, "United States of America" in H.L. Fuenzalida-Puelma & S.S. Connor, *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington: Pan American Health Organisation, 1989) 498 at 503.

70. *Supra* note 4 at 204.

71. *Ibid.* at 781.

72. A.W. MacKay, "Judging and Equality: For Whom Does the Charter Toll?", (1986) 10 Dal. L.J. 35 at 56. The physicians challenges, taken by the Canadian Medical Association and the Medical Association of Ontario have not succeeded. MacKay points out at page 98 that on occasion, section 7 has been used to promote collective interests; *Singh c. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, and *Operation Dismantle*, *supra* note 59.

Analysis of section 7 involves two steps. First it must be established that a state action has deprived someone of the right to "life, liberty and the security of the person",⁷³ the three elements of which are considered to be distinct.⁷⁴ Second, this deprivation must be contrary to the principles of fundamental justice.

Although the notion of "life" does not seem to pose serious jurisprudential problems, the concept of liberty is not well developed in Canadian constitutional law. In the case of *R. c. Morgentaler*,⁷⁵ Wilson J., the only judge to rest her decision on the infringement of "liberty", cited Dickson C.J.C. in *Big M Drug Mart*⁷⁶ as issuing an invitation to explore the purpose of the right to liberty. The view expressed by Dickson C.J.C. in that case is the importance, both for the individual and for a democratic society, of human dignity generated by individual autonomy in decision-making. In taking up the invitation, Wilson J. relied largely on U.S. constitutional authorities dealing with a right to privacy.

While bodily integrity is protected in section 7 under the rubric of "security of the person", the latter phrase encompasses more than physical integrity. As is evident from the *Morgentaler*⁷⁷ decision, it also protects against serious state-imposed psychological stress, at least in the criminal context.⁷⁸ Thus, where a criminal law blocks access to medical services necessary to protect "security of the person", that law will be struck down.⁷⁹

The principles of fundamental justice impart a substantive as well as a procedural aspect⁸⁰ although the ambit of the substantive right remains unclear.⁸¹ The principles of fundamental justice are sought in the common law, international covenants and the Charter and are "essential elements of a system for the administration of justice which is founded upon a belief in the dignity and worth of the human person and the rule of law".⁸²

As we have seen, procedural justice is a flexible concept. The content of the procedural requirements will depend on the importance of the right being infringed.⁸³ In

73. *Singh, ibid.* did away with the distinction between rights and privileges and instead concentrated on the consequences of the deprivation.

74. *Singh, ibid.*

75. *R. c. Morgentaler*, [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].

76. *Supra* note 67.

77. *Supra* note 75.

78. *Ibid.* Dickson C.J.C. at 56, Beetz J. at 105, Wilson J. at 173.

79. *Ibid.*

80. *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486 at 500. Thus the concept of fundamental justice includes at least the principles of natural justice and fairness from administrative law, *supra* note 45.

81. However, it involves a determination of whether the law complies with "the basic tenets of our legal system", *ibid.* at 503.

82. *Ibid.* at 512.

83. De Smith, *supra* note 44. See also *Singh*, (*supra* note 72 at 213) where it was held that "procedural fairness may demand different things in different contexts."

*Morgentaler*⁸⁴ the majority of the court held that the review procedure for obtaining an abortion was procedurally unfair and arbitrary because it caused long delays and restricted access.

Laws may also be considered procedurally unfair because of the variability that may be engendered in their application. So held Dickson C.J.C. in *Morgentaler*⁸⁵ with respect to the word "health", which was undefined in section 251 of the Criminal Code. This resulted in uncertainty as to whether a woman's health status would necessarily qualify her for an abortion. Dickson C.J.C. said: "When the decision of the therapeutic abortion committee is so directly laden with legal consequences, the absence of any clear legal standard to be applied by the committee in reaching its decision is a serious procedural flaw".⁸⁶ Procedurally then, section 7 can, at least, be said to require that the principles of fundamental justice "be observed in the institutional design of rules of conduct and in the secondary process for the administration of the system".⁸⁷

Future interpretation of the scope of section 7 is likely to be important in evaluating allocation decisions. In so doing, the courts will examine rights that individuals have at common law, or by statute.⁸⁸ Thus, the *Canada Health Act*⁸⁹ is relevant in determining the minimum obligations that a provincial government has agreed to. For example, section 12(1) of the *Act* speaks to accessibility. It requires a province to "provide for insured health services [...] on a basis that does not impede or preclude, either directly or indirectly whether by charges made to the insured person or otherwise, reasonable access to those services by insured persons." Insured services are defined in section 2 of the *Act* as those "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability". Whether a provincial government's obligations are greater than this will depend on the particularities of its health care statutes.

The *Canada Health Act* has not yet been invoked as a basis of a Charter right to health care. In the context of administrative law, we have seen that a plaintiff may have standing to bring a declaratory action against a provincial government where provincial funding of social services does not comply with a federal-provincial transfer agreement.⁹⁰ A plaintiff may also have a Charter claim if a provincial funding policy constitutes an infringement of the life or security guarantee. If, for example at least certain forms of organ replacement were not provided, this could constitute an infringement of the section 7 right to security of the person on the grounds that the procedure is "medically necessary for the purpose of maintaining health". The outcome of such a case would depend on the interpretation a court gives to "reasonable access".

84. *Supra* note 75.

85. *Ibid.* at 68-69, Lamer J. concurring.

86. *Ibid.* at 69.

87. E. Colvin, "Section Seven of the Canadian Charter of Rights and Freedoms", (1989) 68 Can. Bar. Rev. 560 at 585.

88. *Singh, supra* note 72.

89. *Supra* note 8.

90. Finlay, *supra* note 34 and accompanying text.

In the British case of *R. c. Secretary of State for Social Services, West Midlands Regional Health Authority, ex part Hincks*, mentioned earlier,⁹¹ the Secretary of State's duty was to provide services "to such extent as he considers necessary to meet all reasonable requirements." While this duty has a discretionary element not expressed in the *Canada Health Act*, the interpretation of "reasonable requirements" in that case is of interest. Lord Denning said that "it cannot be supposed that the Secretary of State has to provide all the kidney machines which are asked for, or for all the new developments, such as heart transplants, in every case where people would benefit from them."⁹²

Canadian courts may face the task of reconciling the wording, "reasonable access" in the *Canada Health Act* and the guarantees of life and security of the person in the Charter with the reality of financial scarcity of medical resources. At a minimum, procedural fairness will be required in allocation decisions.

Allocation decisions may not always fall within the ambit of the *Canada Health Act*. For example, it might be difficult to establish that techniques of assisted reproduction are "medically necessary for the purpose of maintaining health" even if "health" is given a broad meaning.⁹³ Thus a right of access to techniques of assisted reproduction may depend on whether there is a right to reproduce.⁹⁴ In *Re Eve*,⁹⁵ which concerned the sterilization of a legally incompetent adult, the Supreme Court of Canada chose not to deal with the Charter issue raised, that sterilization would be an infringement of the section 7 right to liberty. In the *Morgentaler*⁹⁶ decision, Wilson J., who was the only judge to rest her decision on a right to liberty, gave it a broad meaning. She said that it "guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their personal lives".⁹⁷ In the same decision⁹⁸ the majority of the court held that the right to security of the person included psychological well-being, at least in the criminal context.⁹⁹ These conceptions of liberty and security of the person could support a claim to non-interference with the right to procreate. However, they would not support a right to state-funded medically assisted reproduction.

Most provinces specify in their health care statutes that *in vitro* fertilization (IVF) is an uninsured service.¹⁰⁰ However, even if it were not expressly specified as uninsured, a

91. *Supra* note 52.

92. As cited by Brahams, *supra* note 52 at 1224.

93. The World Health Organization defines it as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

94. See Law Reform Commission of Canada, *Medically Assisted Procreation*, Working Paper (Ottawa: LRC, 1991) in preparation.

95. *E. (Mrs.) c. Eve*, [1986] 2 S.C.R. 388.

96. *Morgentaler*, *supra* note 75.

97. *Ibid.* at 171.

98. *Ibid.*

99. *Ibid.*

100. Ontario and the Yukon Territory do not; 1988-1989 *Canada Health Act Annual Report* (Ottawa: Ministry of Supply and Services, 1989).

government has no obligation to underwrite any procedure if it is not medically necessary. Of course, if a government should choose to specify that this service is insured, then its administration will likely be subject to the Charter.¹⁰¹

101. Where the service is provided by the private sector, its administration will be out of reach of the *Charter*, *supra* note 61 and accompanying text.

Other allocation decisions may be more clearly excluded from the ambit of the *Canada Health Act*. For example, "hospital services" as defined in the Act includes "drugs, biologicals and related preparations when administered in the hospital".¹⁰² Experimental drugs could be excluded since, by definition, they are not proven to be "medically necessary".

Take-home drugs or those administered to individuals in long-term care facilities need not be insured at all, unless the province so specifies. For example, the British Columbia "Pharmacare" plan specifies that persons on social assistance or in long-term care facilities do not pay for drugs, seniors pay a small fee, and others pay a maximum of \$2,000 per year. Patients being treated for cancer or with immunosuppressants for organ transplant are exempt because the complexity of treatment is said to require regulation.¹⁰³

In 1987, the British Columbia Ministry of Health decided to place AZT, an experimental drug for the treatment of AIDS, on the Pharmacare plan. Thus, unlike in other provinces where the drug was administered free to all patients in experimental studies, patients in British Columbia not on social assistance or in long term care facilities were billed after treatment. The British Columbia government's decision not to provide the drug free to all patients was condemned by the Federal/Provincial Advisory Committee on AIDS.¹⁰⁴ A court challenge, however, as we will discuss, was not successful.

In *Brown v. B.C. (Minister of Health)*¹⁰⁵ two AIDS patients who did not qualify for free AZT brought an action claiming that the government policy violated sections 7 and 15 of the Charter. The plaintiffs claimed that their physical and psychological security was affected, and that the decision imposed on them "stress, stigma, perception of discrimination and loss of self-esteem."¹⁰⁶

The British Columbia Supreme Court accepted that the payment of \$2,000 per year imposed a serious financial burden on patients with limited income. However, the judge held that there was no direct infringement of life, liberty or the security of the person because the deprivation was a result of their illness, not the law,¹⁰⁷ and that the claim rested on economic deprivation.¹⁰⁸ Furthermore, individuals with one of a number of other debilitating diseases were required to pay for their drugs and the procedure for deciding who pays was not procedurally flawed or unfair.

102. *Supra* note 8, s.2.

103. *Brown v. B.C. (Minister of Health)*, (1990) 42 B.C.L.R. (2d) 294 (B.C.S.C.) at 303.

104. *Ibid.* at 307.

105. *Ibid.*

106. *Ibid.* at 318.

107. *Ibid.* at 319.

108. *Ibid.* The court noted at page 318 that in the case of *Wilson*, *supra* note 20, the British Columbia Court of Appeal held that "'liberty' in section 7 was broad enough to encompass the opportunity of a qualified and licensed doctor to practice medicine in the province without restraint as to place, time, or purpose, even though there was an incidental economic component to the right being asserted." The court in *Brown* did not find a non-economic component to the plaintiffs' section 7 claim.

Court challenges involving health care allocation are few. However, one author has examined the potential for a section 7 Charter challenge where patients are inadequately prepared prior to their transfer from a hospital to a nursing home, supposing (as the Supreme Court of Canada denied in *Stoffman*) *governmental accountability*.¹⁰⁹ The basis of such a right cannot be found in the Ontario regulations¹¹⁰ dealing with hospital discharge but might be found in the common law of tort where there is a right not to be abandoned. Other sources of such a right can be found in codes of professional ethics and in the doctrine of natural justice. Such a claim would require evidence that transfer causes trauma; this exists.¹¹¹ Thus an argument could be made that in order for transfer to take place, procedural fairness and natural justice require that there be an adequate program in place to avoid transfer trauma.

2. Section 15¹¹²

In determining whether section 15 of the Charter has been infringed, it must first be determined that one of the four equality rights guaranteed by the section has been violated.¹¹³ Next, the court will look to whether the law, by design or impact, is discriminatory by placing burdens, obligations or disadvantages on the individuals in question that are not imposed on others, or by withholding or limiting access to opportunities, benefits and advantages that are available to others.¹¹⁴

Section 15 will apply to those in one of the categories listed¹¹⁵ in section 15 such as age, and mental and physical disability¹¹⁶, or any group that is analogous with respect to powerlessness or group disadvantage.¹¹⁷ However, the Supreme Court of Canada in *Andrews c. Law Society of British Columbia* was unanimous in its refusal to limit the unlisted

109. Fleming, *supra* note 66.

110. Note that in the Quebec case, *Favre c. Hôpital Notre-Dame*, [1984] C.S. 182, the court held that a patient cannot prevent inter-establishment transfer by injunction from a hospital to a long term care facility on the basis of a right to care and choice of hospital as set out in the *Health and Social Services Act*. There was no Charter argument made.

111. Fleming, *supra* note 65; M.A. Sager, "Changes in the Location of Death after Passage of Medicare's Prospective Payment System: A National Survey", (1989) *New Eng. J. Med.* 320, 433, suggests that more study is needed to determine whether the increased rate of death in nursing care is a result of medically inappropriate transfer.

112. See D. Gibson, *The Law of the Charter: Equality Rights* (Toronto: Carswell, 1990).

113. "Every individual is equal before and under the law and has a right to the equal protection and equal benefit of the law without discrimination".

114. The Supreme Court of Canada set the framework for this analysis in *Andrews c. Law Society of British Columbia*, [1989] 1 S.C.R. 143.

115. The term "listed" is preferred to "enumerated" since section 15 does not number the grounds (Gibson, *supra* note 112 at 143).

116. As well as race, national or ethnic origin, colour, religion, and sex.

117. Wilson J. in *Andrews c. Law Society of British Columbia*, *supra* note 114. The concept of disadvantage is not elaborated upon.

grounds.¹¹⁸ Thus, the Court may, in the future, accept non-specified forms of discrimination that are not, strictly speaking, analogous to those listed in section 15. In *Andrews*, McIntyre J. considered the listed and analogous characteristics to be those based on personal characteristics, and not the result of a person's merits or capacities.¹¹⁹

The *Canada Health Act* may serve as a measure of the content of the section 15 equality guarantee in health care, particularly the provision in the Act on accessibility,¹²⁰ which requires reasonable access with uniformity of terms and conditions, and freedom from impediment by monetary or other means. This will be important in allocation decisions that affect particular disadvantaged groups, or rationing decisions that expressly give preference to, or exclude, certain groups.

The *Canada Health Act* has not yet been invoked as a basis of a right to equality in health care. However, a section 15 Charter infringement was invoked in a Quebec case involving a hospital by-law. As mentioned earlier, in *Jasmin c. Cité de la Santé de Laval*,¹²¹ the plaintiffs challenged a by-law that gave preference to residents of the district to receive obstetrical care in the hospital. The Quebec Superior Court, supposing the Charter to be applicable, held that the by-law infringed section 15 of the Charter.¹²² There was no analysis in the case with respect to geographic location as a ground for section 15 protection. However, the provincial legislation expressly gave patients the freedom to choose the hospital where they were to receive treatment.¹²³

Geographic location may be one of the unlisted grounds for which discrimination is prohibited. However, whether one could make a Charter claim on the basis of regional differences in health care between provinces is uncertain. The case of *R. c. Turpin*¹²⁴ concerned the right of a certain category of accused to elect for trial by judge alone in Alberta but not elsewhere. The Supreme Court of Canada held that the differential treatment did not constitute discrimination because those accused outside Alberta could not be considered a group vulnerable to disadvantage. However, Wilson J. went on to say that in the appropriate circumstances a person's province of residence might constitute a ground for discrimination.¹²⁵

Because of the constitutional division of power, there is more scope for the provinces to differ from one another in health care provisions than in criminal law, the subject of the *R. c. Turpin* case. But, the scope for allowable difference in health legislation is

118. *Ibid.* McIntyre J. at 174.

119. *Ibid.* at 174-175.

120. *Supra* note 8, s.12.

121. *Supra* note 39.

122. The court also held that there was infringement of section 15 of the Quebec Charter and set out the elements necessary to establish this (*ibid.* at 28).

123. *Supra* note 41.

124. *R. c. Turpin*, [1989] 1 S.C.R. 1296.

125. *Ibid.* at 1333.

reduced by the commitment to national equality found in the *Canada Health Act*.¹²⁶ Thus if a government action has a disparate and deleterious effect on an individual protected under section 15, such action may be subject to court challenge under the Charter.

As we saw in the case of *Brown v. B.C. Minister of Health*¹²⁷ a provincial policy may fall outside the scope of the *Canada Health Act*. The plaintiffs in the *Brown* case claimed that the government's decision not to provide the drug AZT free of charge infringed section 15 of the Charter. They claimed that it discriminated against them as an identifiable group of AIDS patients, 90% of whom were homosexual or bisexual.

The judge held that AIDS was a physical disability and thus fell within the listed grounds for section 15 protection. Furthermore, he found that sexual orientation was protected under section 15 as an unlisted ground, having acknowledged that homosexuals were a group historically subject to discrimination. However, the judge found no direct discrimination against this group by the Minister of Health despite inflammatory remarks about AIDS victims made in the press by him. Neither did the province's policy not to fund AZT constitute direct discrimination because the province had the constitutional power to have such a policy.

The judge accepted that discrimination need not be intentional and that the funding policy affected an identifiable group. However, he held that other identifiable groups with catastrophic illness also were required to pay for their drugs. In answer to the fact that funding was provided for drugs for cancer and transplant patients he cited McIntyre J. in *Andrews*, who said:

*It is not every distinction or differentiation in treatment at law which will transgress the equality guarantees of s.15 of the Charter. It is, of course, obvious that legislatures may — and to govern effectively — must treat different individuals and groups in different ways. Indeed, such distinctions are one of the main preoccupations of legislatures.*¹²⁸

The judge in *Brown* held that the distinction of funding drugs for cancer and transplant patients and not funding the drug AZT for AIDS was due to the complexity of treatment of the former that did not apply to the latter, and that this was "not the sort of inequality addressed by section 15 of the Charter".¹²⁹

Other issues that may be challengeable in the courts include those related to selection criteria for individuals seeking particular medical procedures. For example, there

126. *Supra* note 8. Section 36 of the *Constitution Act, 1982* (*supra* note 7), contains a commitment to the promotion of "equal opportunities for the well-being of Canadians" and of "essential public services of reasonable quality to all Canadians". However, it is clear from the opening phrase that this does not constitute a legally enforceable obligation: "Without altering the legislative authority of Parliament or of the provincial legislature, or the rights of any of them with respect to the exercise of their legislative authority".

127. *Supra* note 103.

128. *Supra* note 114 at 168.

129. *Brown*, *supra* note 103 at 315.

is the question of whether individuals with alcohol related liver disease should be excluded from having liver transplants. At least one centre in Canada has decided that discrimination on this basis would be unethical and not in keeping with the ideals of the Canadian Charter.¹³⁰ Alcoholism has been recognized as a disability by a provincial Human Rights Commission¹³¹ and thus, could be considered under one of the listed grounds of section 15. However, evidence of non-compliance with an alcohol abstinence regime might qualify as a medical ground for exclusion.¹³²

The use of medical criteria for rationing of organs for transplant may not necessarily escape scrutiny under section 15. A disadvantage caused to a group need not be intended.¹³³ Unintentional discrimination may occur against the poor by using medical criteria to ration organ transplantation. Individuals of low socio-economic class tend to be in somewhat poorer health and thus, on the average, would rate more poorly on medical criteria as candidates for transplantation.¹³⁴

As we have already discussed, high cost technology such as *in vitro* fertilization to assist reproduction is generally not covered under provincial health care plans.¹³⁵ Furthermore, even if such techniques are government funded, it is unlikely that eligibility criteria set within a clinical unit will be considered governmental action so as to fall within the ambit of the Charter.¹³⁶

3. Section 1

If a governmental action restricts a Charter guarantee, section 1 requires that it must be only "to such reasonable limits prescribed by law" that can be "demonstrably justified in a free and democratic society". It is not yet clear whether section 1 will be applied differently to different sections of the Charter.¹³⁷

130. C. Stiller, *Life Gifts: The Real Story of Organ Transplants* (Milwaukee: Stoddard, 1990).

131. *Supra* note 112 at 240.

132. In *Camire c. Winnipeg (City)*, (1990) 43 C.R.R. 180 (Man. C.A.), the Manitoba Court of Appeal was asked to decide whether it was discriminatory to withhold social assistance unless an alcoholic recipient agreed to live in a supervised environment to ensure compliance. The Court held that such a restriction did not constitute an infringement of section 7 or 15 of the Charter. The Court did not comment on whether alcoholism was a "disability".

133. *Andrews, supra* note 113; *R. c. Turpin, supra* note 124; *Brooks c. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219.

134. *Supra* note 3 at 2217.

135. *Supra* note 100.

136. *Supra* notes 60 to 68 and accompanying text. However, discriminatory selection procedures based on family or marital status, age, or sexual orientation could be the subject of a complaint under provincial human rights codes.

137. Some sections have internal limits. For example, in section 7 the deprivation must be contrary to the principle of fundamental justice and section 15 appears to require an evaluation of whether an inequality amounts to *discrimination*. Whether the review occurs within the section or under section 1 is important

The "prescribed by law" requirement means that the law or regulation must specify the criteria by which the freedom will be limited, or it must be implicit from its terms or operating requirements.¹³⁸ It "cannot be vague, undefined, and totally discretionary" leaving limits "to the whim of an official".¹³⁹ That is, legislators cannot make "blank cheque" laws.

"Reasonable" and "demonstrably justified" mean that the state must have a sufficient interest to justify the restriction, and the means used to attain the objective must be proportional to the legislative ends. They must be rational and fair, not arbitrary, and impair as little as possible the guarantee in question. Any effect cannot be disproportionate to the objective¹⁴⁰ that actually¹⁴¹ prompted the legislation (the proportionality test).

In order to meet the civil burden of proof¹⁴² the government must present evidence to support their position that the Charter limitation has a valid purpose that can best be achieved by the means the government has chosen and not by some other means. This evidence may include social science data, reports from Royal Commissions and Parliamentary Committees, and laws in other free and democratic nations as evidenced by treatises on comparative law, and in international covenants.¹⁴³

Where a Charter guarantee has been infringed by an allocation or rationing decision, an economic objective may or may not be considered of sufficient importance to justify the restriction. In the *Jasmin* case mentioned earlier¹⁴⁴ there was no analysis of section 1. However, the Quebec Superior Court did not accept that the hospital's necessity to decrease its deficit was a sufficient reason to restrict admissions to patients within the district. Wilson J. in *Singh*¹⁴⁵ made it clear that administrative convenience is not a sufficient reason to override a Charter guarantee.

If the example given earlier, on transfers from hospitals to nursing homes were to involve Charter accountability, the government would probably argue the high cost of

because the plaintiff has the burden of proof for the former and the government for the latter. For a discussion of the relationship between sections 1 and 15, see Gibson, *supra* note 112 at 264-272.

138. *R. c. Therens*, [1985] 1 S.C.R. 613 at 675.

139. *Re Ontario Film & Video Appreciation Society and Ontario Board of Censors*, (1983) 41 O.R. (2d) 583 (Ont. Div. Ct) at 592, affirmed (1984) 45 O.R. (2d) 80 (Ont. C.A.). See also *Re Luscher and Deputy Minister, Revenue Canada*, (1985) 17 D.L.R. (4th) 503 (F.C.A.); at 506. The requirement for clarity is also evident in *R. c. Therens*, *ibid.*; *R. c. Hufsky*, [1988] 1 S.C.R. 621; and *R. c. Thomsen*, [1988] 1 S.C.R. 640.

140. *R. c. Oakes*, [1986] 1 S.C.R. 103.

141. *Big M Drug Mart*, *supra* note 67 at 366.

142. *R. c. Oakes*, *supra* note 140.

143. The opposing party will be responsible for rebutting this evidence. M. Manning, "Proof of Facts in Constitutional Cases" in G.-A. Beaudoin, ed., *Charter Cases 1986-87* (Cowansville, Que.: Yvon Blais, 1987) 271. See also, K. Swinton, "What do the Courts want from the Social Sciences?" in R.J. Sharpe, ed., *Charter litigation* (Toronto: Butterworths, 1987).

144. *Supra* note 39.

145. *Supra* note 72.

maintaining patients in acute care facilities and that nursing care facilities adequately meet the patients' needs. However, where there is wide discretion left to the physician as to discharge, without guidelines, the "prescribed by law" criterion of section 1 may not be met. Where appropriate counselling services are not in place to help prevent transfer trauma, the proportionality test may not be met.¹⁴⁶

C. Remedies

If a law or regulation is held to be *ultra vires* it will be struck down. Prerogative remedies such as injunction, *certiorari* and *mandamus* may also be available for illegal governmental acts. However, as we saw in the *Finlay* case¹⁴⁷ these are discretionary remedies. The court in that case allowed a declaratory action that the government acted illegally, but did not allow an injunction.

The Charter expands not only the scope of judicial review, but also the remedies available to an offended party. Under section 52(1) of the *Constitution Act, 1982*¹⁴⁸ the courts have power to invalidate unconstitutional laws. Under section 24(1) of the Charter, the courts may award "such remedy as the courts consider appropriate and just in the circumstances". Section 24(1) is directed to "[a]nyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied".¹⁴⁹ Thus, the infringement need not be by way of the black letter of the law but may also result from government action in administering laws.

In the case of *Schachter c. Canada*¹⁵⁰ a man challenged the *Unemployment Insurance Act* claiming that it infringed section 15 of the Charter by giving parental benefits to adoptive parents and pregnancy benefits to the biological mother of a child but not to the biological father. The trial judge agreed that section 15 had been infringed and granted a remedy entitling natural parents to the same benefit as adoptive parents. The issue before the Federal Court of Appeal in this case was the relationship between section 24(1) of the Charter and 52(1) of the *Constitution Act, 1982* in granting a remedy that altered legislation and required the expenditure of government funds.¹⁵¹

146. Fleming, *supra* note 66 at 71-75.

147. *Supra* note 35.

148. *Supra* note 7. The entire law need not be invalidated; the provision directs the court to strike down the law "to the extent of its inconsistency."

149. Thus, section 52 of the *Constitution Act, 1982* responds to the question — "is the law constitutional", and section 24(1) of the *Charter* to the question — "has an individual's *Charter* right or freedom been infringed".

150. *Schachter c. Canada*, (1988) 52 D.L.R. (4th) 525 (F.C.T.D.); upheld by the Federal Court of Appeal (16 February 1990) F.C.T.D. No. 127, Action No. A-1002-88 (F.C.A.); appeal of the Crown to the Supreme Court of Canada June 6, 1990 reserved.

151. One of the remedies possible under section 24 of the *Charter* is a declaratory judgement that the law in question is invalid. This will put strong political pressure on the government to amend the offending provision. Thus the effect of the remedy is similar to that of section 52(1) of the *Constitution Act, 1982*.

The Crown argued that section 52 of the *Constitution Act, 1982* operates automatically to invalidate a law that the court holds to be unconstitutional and thereby precludes the operation of section 24 of the Charter. Heald J., speaking for the majority, rejected this submission and held that the trial judge was correct in fashioning a positive remedy.¹⁵² When a court does this, it is not usurping the role of the legislature, which can legislate another constitutionally valid option or invoke section 33, the "notwithstanding clause", of the Charter. Heald J. pointed out that the alternative of invalidating the law, which the government argued for, was just as much a judicial amendment as the positive remedy since it would deprive others of a benefit that the government intended them to have under the legislation. Furthermore, the imposition of a remedy that requires a government to expend funds is not new. It has been used to ensure fair trials, to provide French education facilities, and to provide full oral hearings for refugee claimants.¹⁵³

This encouraging development for the enforcement of Charter rights may aid in arriving at appropriate remedies where courts hold that section 7 or section 15 rights were infringed, either directly or indirectly, by administrative decisions in health care.¹⁵⁴

CONCLUSION

How effective can judicial review be in achieving equitable health care in Canada? The answer is as yet unclear. There are three general grounds for review: first, jurisdictional incompetence of a government; second, provincial regulatory offenses against the *Canada Health Act* or a provincial health statute; and third, a Charter infringement.

A. Jurisdictional incompetence

We saw that the federal government, legislating in health care, must be acting within its jurisdiction under the *Constitution Act, 1867* of criminal law, residual power of section 91, or federal spending power. The provinces cannot regulate on subjects legitimately occupied by federal criminal law jurisdiction such as abortion, and a province that agrees to

However, this kind of negative remedy may not get the plaintiff what he or she wants, and it may be harmful to others in denying them an entitlement they would have had under the law. See Gibson, *supra* note 112 at 339-350.

152. He refers to *Brooks c. Canada Safeway Ltd.*, *supra* note 133 where the plaintiffs brought an action under Manitoba's *Human Rights Act* against their employer whose group insurance plan excluded pregnant employees for a 17 week period. The court held that discrimination on the basis of pregnancy is discrimination on the basis of sex. The case was remitted to an adjudicator for determination of the appropriate remedy.
153. The latter case is *Singh c. Minister of Employment and Immigration*, *supra* note 72, involving an infringement of section 7.
154. In the case of *Jasmin*, *supra* note 39, the Quebec Superior Court held that the hospital must provide services to patients and give admitting privileges to physicians regardless of whether they resided in the district. The hospital was left to find another way to decrease its deficit.

pay for an out-of-province medical procedure cannot enact regulations with extra-territorial effect on the province performing the service.

B. Regulatory offenses against the *Canada Health Act* or a provincial health statute

There have been no challenges by a patient claiming that a province has not lived up to its obligations under the *Canada Health Act*. However, the *Finlay* case, brought against the Minister of Finance of Canada concerning transfer payments for social services, suggests that a patient may have standing to bring a case before a court where the conditions of comprehensiveness, universality or accessibility are not met by a province. Whether such a challenge would be successful on the merits will depend on the courts' interpretation as to entitlement under the *Act*, in particular as to the meaning of "medically necessary", "reasonable access" and "unfair terms and conditions".

The *Canada Health Act* sets minimum standards, and if a province offers a greater entitlement, it must live up to that standard. Thus, in the Quebec case of *Jasmin c. Cité de la Santé de Laval*, a hospital was obliged to offer its services to patients outside its district as is required in the provincial legislation. However, where a service is outside the scope of the *Canada Health Act*, a province is within its jurisdiction in not providing it. We saw this in *Brown c. B.C. (Minister of Health)* where the province was not required to provide the drug AZT free of charge to all AIDS patients.

Where the executive, government or administrators pass regulations under a provincial health statute, they must ensure that they have the power to do so. Thus, in *B.C. Civil Liberties Assn* where the legislation allowed the cabinet to declare certain services as uninsured, this did not give it power to declare them medically unnecessary. In the Quebec case of *Jasmin c. Cité de la Santé de Laval*, legislation conferring on the hospital a duty to preserve the quality of services did not give it jurisdiction to exclude patients from outside the district in order to remedy budgetary problems.

Principles of administrative law dictate that the results of administrative decisions be arrived at fairly and be reasonable in effect. Although the scope of these principles is limited, the possibility of such a challenge may encourage decision-makers to make explicit and reasoned allocation and rationing decisions in an open and fair manner.

C. Charter infringements

Legislative and governmental decisions, including those of the cabinet, will be subject to scrutiny under the Charter. However, administrative decisions of hospitals and hospital personnel do not usually fall within the ambit of Charter review.

The sections most likely to be invoked in available challenges concerning health care are sections 7 and 15. The meaning of "security of the person" in section 7 is not well defined

outside the criminal law context. The meaning of "liberty" in section 7 has had even less attention in the Supreme Court of Canada.

The courts may be asked to determine whether the requirement for reasonable access under the *Canada Health Act* has been breached so as to infringe section 7. Where allocation decisions are outside the ambit of the *Canada Health Act*, as in *Brown v. B.C. (Minister of Health)*, patients may have difficulty in establishing entitlement that, if not provided, threatens their life or security. That case says that it is not enough that the patient be deprived; it must be a result of government action and not their illness. Furthermore, if the court categorized the effect of the government policy as economic, section 7 will not apply.

If the life, liberty or security of the person is held to be infringed under section 7, the court will have to determine whether this was according to the principles of fundamental justice. The *Morgentaler* decision tells us that decisions as to access to health care must be, at least, procedurally fair and not arbitrary.

The analysis of the right to equality under section 15 of the Charter is evolving. Few cases have been heard by the Supreme Court of Canada. If an infringement of one of the four equality rights is found, it will not necessarily be held to be discriminatory. This is what the British Columbia Supreme Court decided in *Brown v. B.C. (Minister of Health)*. Where a court decides to limit the right to equality by this means, the government does not have the onus of justifying an infringement under section 1 of the Charter.

Whether differences in health care between provinces will be subject to review under section 15 will depend on whether geographic distribution will be considered as a legitimate unlisted ground for the prohibition of discrimination. The *Canada Health Act* imposes a duty on the provinces to provide services under uniform terms and conditions. However, as we have seen, a health care policy may be outside the ambit of this Act.

Further challenges involving section 7 or 15 of the Charter are likely to occur concerning the allocation or rationing of high cost medical resources. If it is established that a *Charter* right has been infringed, the government or its agents will be required to justify their policy decisions under section 1 as being clear, rational and proportionate to a legitimate state goal.

As to remedies, the Federal Court of Appeal ruling in *Schachter* suggests that if a patient could convince the court of a legitimate Charter claim, the government could be forced to expend funds to remedy the infringement.