The Implications of Canadian Law for Economic Approaches to Allocating Health Care Resources: The Round Hole and the Square Peg

by

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A thesis submitted in conformity with the requirements for the degree of Ph.D.
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Abstract
Title: The Implications of Canadian Law for Economic Approaches to Allocating Health Care Resources: The Round Hole and the Square Peg
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Chapter one explains that the purpose of this thesis is to analyze legal principles at issue when attempts are made to ground allocation policies in economics.

Chapter Two examines the ethical values reflected by economics and law. It explores the tensions between the philosophical perspectives of consequentialism and deontology and describes options for bringing normative theories to practice. The purpose of this chapter is to provide the reader with the ethical context of law and economics.

Chapter Three describes and analyzes the contribution economics can bring to resource allocation. The chapter addresses four utilitarian based methods of priority setting: cost-minimization analysis, cost-benefit analysis, cost-effectiveness analysis and cost-utility analysis. These are formal methods of comparing costs and consequences of medical interventions to determine whether they are worth funding.

Chapter Four examines the legal implications of making allocation decisions according to economic principles. It focuses on the areas where economics and law conflict in relation to resource allocation, the legal theory behind the values at issue in resource allocation and the potential for reconciliation of economic and legal principles.

The areas of law focused on are the principles of comprehensiveness, accessibility, public administration, universality and portability under the Canada Health Act, the doctrines of legitimate expectations, public interest standing and rules around discretion in administrative law, the right to equality (s.15), available remedies (s.24) and the principles of pressing and substantial, and proportionality (s.1) under the Canadian Charter of Rights and Freedoms (Charter).

Chapter Five of the thesis concludes that the legislative objective of making allocation decisions that respect economic principles can be accomplished to the extent that allocation decisions do not violate Canadian law. In recent cases, courts have shown a new willingness to expand the range of issues they are willing to address and consider the legality of government allocation decisions, an area that has traditionally been left to the discretion of government. Evolving case law suggests that allocation policies focusing on consequentialism expressed by economics will have to be compromised if Canadian allocation policy is to accommodate legally binding deontological values entrenched in law.
Medical Research could in theory find a scientific solution for most of the disease problems of our times. There are not, and cannot be, enough resources or scientific skills to attack all the problems that cry out for solutions or to apply all the theoretical knowledge that has been developed. The question will be what of all the things that could be done should be done. In all cases these decisions will involve criteria that transcend scientific knowledge and judgement. They will have to be made on the basis of social and ethical values.

René Jules Dubos, 1968
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1. Introduction

Over the last decade those engaged in the issues of priority setting have been examining - the usefulness of economic principles for Canadian health reform. Many factors have been the impetus for this examination including increased government spending on health care services, access concerns and concerns over the cost effectiveness of health services supplied. Because the amount of resources that will ever be allocated to the funding of health care services will always be less than the potential demand for health care services. maintaining a publicly funded health care system, particularly one that meets the five principles of the Canada Health Act (CHA), can be assisted by information gained through economic analysis of policy options.

This thesis is intended to be an analysis of principles at issue when attempts are made to ground allocation policies in economics. It is intended as a resource for policy formation. Using legally entrenched rights as a benchmark which economically based allocation policies must satisfy focuses attention on the structure of government obligations.

Though it might seem that the best way to maintain the financial security of the health care system and the best way to allocate its resources are separate issues and easier to address separately, the rationale for a bioethics approach is to prevent isolated commentaries on health care problems and to integrate the insights of various disciplines. Bioethics makes explicit, assumptions and conflicts that are often merely implicit or unnoticed in unidisciplinary analyses of resource allocation policy. The interdisciplinary

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approach of bioethics supports an examination of the values at the heart of economic and legal principles and the extent to which economic analysis meets and conflicts with legally entrenched standards in relation to allocating health care resources.

Traditionally discussions of resource allocation have taken place within the discipline of philosophy in the area of distributive justice. Legal analysis can build upon the rich philosophical literature at both the theoretical and practical levels. While a legal conceptual model for resource allocation does not necessarily represent the moral pinnacle of resource allocation theory, the law is rather one of several significant sources of priority setting principles. It is significant for two reasons. First, because of the nature of legal evolution, laws related to resource allocation have stood the test of some time, considerable debate and the need to be consistent with other laws that ideally reflect the values of many Canadians. Second, it is significant because until changes are entrenched, current law is enforceable against parties that would breach it. Economic and legal principles relevant to allocating health care resources in Canada reflect the ethical theories of utilitarianism and deontology respectively. The challenge for allocation policy arises when efficient allocation options conflict with legally entrenched values. The health care services available in Canada can be adjusted so as to balance the deontologically based legal requirements with utilitarian economic principles.

While this thesis does not claim to provide the uniquely appropriate method for addressing allocation issues, it is intended to emphasize the significance of bringing a particular range of disciplinary perspectives to this issue. By bringing ethics and law to
an otherwise economic discussion of priority setting, an understanding can be achieved of the values at stake and some of the challenges that would be confronted in trying to implement economically based allocation policies.

Given the relevance of ethics, economics and the law for Canadian allocation policy, this thesis is divided into three main chapters, addressing and integrating these three disciplinary perspectives of ethics, economics and law.

Chapter Two examines the ethical values reflected by economics and law. This chapter explores the tensions between the philosophical perspectives of consequentialism and deontology and describes options for bringing normative theories to practice. While these philosophical perspectives of consequentialism and deontology do not correspond exactly to the disciplines of economics and law they identify and clarify the values at stake in adopting or dismissing economic and legal principles. The purpose of this chapter is to provide the reader with the ethical context of law and economics.

Chapter Three describes and analyzes the contribution economics can bring to resource allocation. The chapter addresses four utilitarian based methods of priority setting: cost-minimization analysis, cost-benefit analysis, cost-effectiveness analysis and cost-utility analysis. These are formal methods of comparing costs and consequences of medical interventions to determine whether they are worth funding.
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Chapter Five of the thesis concludes that the legislative objective of making allocation decisions that respect economic principles can be accomplished to the extent that allocation decisions do not violate Canadian law. In recent cases, courts have shown a new willingness to expand the range of issues they are willing to address and consider the legality of government allocation decisions, an area that has traditionally been left to the discretion of government. Evolving case law suggests that allocation policies focusing on consequentialism expressed by economics will have to be compromised if Canadian allocation policy is to accommodate legally binding deontological values entrenched in law.
2. Ethics

2.1 Introduction

Principles of egalitarianism and equity of access have been stated goals of many macro and meso allocation policies in Canada. These principles are being challenged as the fiscal dimension of health care funding comes under increasing strain. In response to the scarcity of resources politicians, bureaucrats, academics, health care providers and consumers are faced with the need to balance these principles with the goal of utility and implications of allocating scarce health care dollars according to economic principles. The increasing complexity of the allocation challenges and dilemmas seems to call for contributions from several disciplinary perspectives.

2.1.1 Why Look to Ethics?

Ethics is a generic title that refers to systems that seek to bring sensitivity and method to the human task of decision making in the arena of moral values. The articulation of principles and theories has a "normative force in moral reasoning and understanding" and helps us to (1) "locate and refine" our moral values, (2) identify conceptual confusions or logical inconsistencies and (3) increase our ability to understand and

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respect the viewpoints of others. Ethical analysis can therefore serve as a heuristic to analyze the morality and consistency of health care policies and laws.

How important are ethical theories for the analysis of health care allocation policy? By understanding the ethical basis of a law or policy option one gains insight into the values and interests it implicitly protects. One can thereby expose and improve laws and policies which may be selective and biased in their effects. Constructive reflection on a paradigm shift from Canadian egalitarianism to utility can benefit from the examination of ethical theories defending the moral acceptability of each paradigm.

There are three levels at which ethical reasoning can affect allocation laws and policies: the macro (government), meso (institutional) and micro (health care provider) levels and each of these levels are affected by decisions made by courts, legislatures, departmental or inter-departmental policy groups, commissions, health care providers and patients. Decisions are made differently depending on where they are made: each setting has unique scopes of conflict reflecting the different groups in power.

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2.1.2 Purpose of Chapter

The purpose of this chapter is to describe the moral theories that best reflect (1) the use of economic principles to allocate scarce health care resources and (2) the laws relevant to allocating health care resources at the macro and meso levels. This chapter is not an attempt to normatively weigh economic policies and current health laws but rather to identify the ethical assumptions and presumptions made by them. This ethics chapter is an integral part of a bioethical analysis. Such analysis makes explicit assumptions and beliefs that are often merely implicit in “uni-disciplinary” analysis.9 In examining the compatibility of law and economics to make allocation decisions I want to expose any unrecognized assumptions. Critically examining the values that underlie allocation policies (whether or not they are legally entrenched) aims at greater clarity as well as a more comprehensive and effective contribution. As long as Canadians are unaware of the values that underlie our choices and options, we are not able to truly evaluate policy proposals, or develop policies that best reflect our common goals. The theories presented in this chapter will be drawn upon throughout the upcoming chapters: they will constitute some of the language or vocabulary of the upcoming analysis.

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2.2 Normative Theories

Moral theories of distributive justice are attempts to specify and render coherent diverse principles, rules and judgments. They are justification for government and judicial intervention in the health care system. A theory of distributive justice attempts to connect the characteristics of groups of persons with morally justifiable distributions of benefits and burdens.\(^\text{10}\) There are four theories of distributive justice most commonly discussed with respect to the allocation of health care resources. They are libertarianism, utilitarianism, egalitarianism and communitarianism. Libertarian theory holds free choice as the key to justice. It opposes government collecting resources from certain individuals through for example taxes, to benefit another group of individuals through for example government funded health care. Much of the American health care system is rooted in libertarianism. Apart from Medicaid (government funded health care program aimed at the poor) and Medicare (government funded health care programs aimed at the elderly). health care services in the United States are privately funded and privately delivered. Utilitarianism is a consequentialist theory that supports redistribution where such redistribution of resources will maximize the greatest good for the greatest number of people. Egalitarian theories of justice support some redistribution to ensure that individuals are given an equal share of at least some goods and services to ensure some basic human functions. Communitarian theory also supports redistribution to ensure

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\(^{10}\) Beauchamp and Childress supra note 8 at 334.
equal share of resources, in recognition of equal membership and participation in community.\textsuperscript{11}

The following is a discussion of the two theories, consequentialism and deontology, which reflect distributive issues that arise when allocating resources according to economic principles and those that arise when making allocation decisions in accordance with the law.

2.2.1 Consequentialism

According to consequentialism, moral obligation and virtue are to be understood in terms of good or desirable consequences. Central to consequentialist normative theories is the value of the consequences of actions. According to consequentialist theories, one's primary ethical task is to act in such a way as to bring about as much as possible of whatever the theory designates as valuable. For example, if a theory designates pleasure as the only thing valuable in itself, then one should act so as to bring about as much pleasure as possible. The goals of a consequentialist theory itself are threefold:

1. to specify and to defend some thing or list of things that are good in themselves,
2. to provide some technique for measuring and comparing quantities of these intrinsically good things.

\textsuperscript{11} For a fuller discussion of these issues see Colleen Flood, International Health Care Reform: A Legal, Economic and Political Analysis (Routledge: New York, 2000) at p.27
3. to defend some practical policy for those cases where one is unable to determine which of a number of alternative actions will maximize the good thing or things.12

For consequentialism, the distinction between "instrumentally" good things and "intrinsically" good things is significant. Instrumentally good things are good only insofar as they play some role in bringing about intrinsically good things. Conversely, intrinsically good things are good for their own sake and not because of their relationship with other things. Their goodness is independent because they are constituted by the kind of thing the good thing is. Therefore, a specific consequentialist theory may state that only pleasure is intrinsically good, but that other things, can be instrumentally good if they contribute to pleasure.13 Health care, for example, might be regarded as instrumentally good by such a theory since health care is likely to contribute to maximizing human happiness. Even if health care is typically instrumentally good, however, situations may arise in which one could maximize pleasure by not seeking medically necessary medical care. In such cases, a consequentialist theory would hold that one should not seek the medically necessary medical care. According to this view, there is nothing about health care in itself that is good. Consequentialist theory holds that the right is a function of the good, specifically of intrinsically valuable ends or consequences.14 Within such a theory one determines what should be done by asking

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13 Ibid at 741
whether an act or class of acts would probably produce the greatest possible balance of good over evil.

a. Utilitarianism:

Consequentialist theories have been well represented in modern thought, especially in the work of such British utilitarians as Jeremy Bentham, John Stuart Mill and Henry Sidgwick. These classical utilitarians claimed that the only intrinsically good thing is human happiness, which they understood as constituted by pleasure and the absence of pain. The utilitarian maxim “Act always in such a way as to promote the greatest happiness of the greatest number.” has been the paradigmatic consequentialist moral principle and has inspired many more recent consequentialists. The basic idea here is that human actions should be evaluated in terms of their tendencies to advance the general welfare or social good. The ethical principle given priority in utilitarian allocations is the principle of utility. It holds that the arrangement of resources that produces the greatest possible overall net good is morally best.

Utilitarian consequentialists regard pleasure or the satisfaction of desire as the sole intrinsic human good, and pain or dissatisfaction as the sole, intrinsic evil or ill, and they conceive our moral obligations as grounded entirely in considerations of pleasure and pain. The idea that one should always act to secure the greatest good of the greatest number is simply a way of saying that whether an act is right or wrong depends solely on whether its overall and long-term consequences for human (or sentient) well-being are at
least as good as those of any alternative act available to a given agent. Since classical utilitarianism conceives human good or well-being in terms of pleasure or satisfaction, it holds that the rightness of an action always depends on whether it produces, overall and in the long run, as great a net balance of pleasure over pain as could have been produced by performing any of its alternative.

In addition to the idea that ethics is concerned with well-being or preference satisfaction, utilitarianism is also built around the concept of reason or rational choice. Accordingly, a rational person will seek a rational preference ordering in his or her own life. -i.e. to arrange and give priority ranking to his or her various competing preferences or desires in order to insure that as many preferences as possible get satisfied. According to the utilitarian, something comparable should be the moral goal of society as a whole - a feature of utilitarianism that has made it compelling for many economists. For policy makers, this moral theory serves as a tool for deciding what to do. namely, whichever action produces on balance. the greatest net amount of happiness. Happiness is alleged to be something empirical. something both measurable and comparable. In principle therefore, utilitarianism provides definite answers to the question of how to choose amongst competing options. Just as an individual attempts to order his or her preferences in a way that will most efficiently balance his or her psychological "budget", so should society (treating the claims of each group or service competing for funds in the same way that an individual treats the competing claims within his or her own nature) attempt to
balance these claims against each other in order that preference satisfaction will be maximized.

Another important feature about utilitarianism is its impartiality. The utilitarian does not say, "The goodness of an action is determined by the amount of happiness it produces for me." Rather, the good is determined by the overall net happiness achieved. The utilitarian considers his or her own happiness but no more than the happiness of others. In weighing the effects of an action, utilitarianism holds that we must take into consideration all of the relevant parties and that all parties shall be given equal consideration. Therefore some forms of utilitarianism are committed to the value of equality.16

Utilitarianism has been influential not only in expanding our notion of "who counts" morally, but also in focusing attention on long-term, as well as short-term, results. Many decisions and actions performed today have an impact on the future. Remoteness in time is not, in principle, a reason to ignore a consequence, (although of course, our knowledge about the future is obviously less certain than our knowledge of the present). This is particularly important when we think of issues such as genetic engineering and gene

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15 Note: some economists are troubled by classical utilitarianism and have developed devices such as Pareto optimality as a test for social rationality that allows them to articulate and defend a more complex view of social choice. For further discussion see chapter 2.

16 How far does this equality extend? In the 19th century, women were not considered the equals of men. Women were largely under the control of their father before marriage and their husbands after. They could not vote, and their ability to own property was greatly restricted. Mill rejected such inequality. He supported equal rights for women and opposed slavery. Indeed Mill thought that any creature capable of being happy or miserable - "all sentient creation so far as possible" - was deserving of moral concern.
therapy, which may have a profound impact on the genetic makeup of people in future generations. Utilitarianism encourages policy setting that has decisionmakers consider not only the immediate effects of our actions, but also their long-term consequences.

b. Challenging Utilitarianism:

At first glance utilitarianism can be understood as justifying sacrificing some to the "greater good". Such critiques are unsuccessful, for a utilitarian theory can be constructed that not only will condemn scapegoating and victimizing but will defend the claim that persons have the right not to be victimized. For example, general rules assigning certain rights to persons like for example, the right not be experimented on without one's consent can be consistent with utilitarianism. In building rules that forbid such experimentation into law, utilitarians would hold that the reason we adopt this rule is because of our belief that the majority of people will be happier in the long run living in a society having a rule (conferring a right) of this nature. If citizens had no protection against simply being used by the state whenever the state believed that general welfare could be promoted by such use, then they would never be secure, would never be able to live lives of stability and predictability, and therefore could not be happy. Whatever the short-run gains of performing a particular act of victimization, the long-run disutility of allowing the state to act in this way would be enormous. Rights are therefore justified for instrumental reasons. They are not ultimate or final goods; they are rather derivative

Contemporary utilitarians, like Peter Singer, have argued that nonhuman animals should count equally with humans, and that therefore painful experimentation on animals is wrong.
goods - protections and guarantees that are valuable because of what they lead to, because the societies that accord them will be happier. There is therefore a place for important moral concepts as justice, fairness, rights, merit or desert. What the utilitarian does not want to do is regard rights as having the ultimate or primary or fundamental value; only utility (the promotion of general welfare) can have that. Much that we traditionally respect and value (liberty, equality, autonomy, rights, justice, even the past and tradition itself) would be preserved if it could be shown that such preservation would as a practice, have instrumental value of promoting the general welfare. 17

Another objection to utilitarianism is that it requires the impossible task of calculating the probable consequences of every action. The calculations alone would prevent anyone from doing anything. In response, policy analysts should note that Bentham thought of utilitarianism as primarily a guide to legislative policy, rather than a guide to individual behaviour. No one thinks it unreasonable to ask for impact studies on the likely consequences of legislation. These are sometimes called “cost-benefit” analyses, and they seem to be the direct descendants of classical utilitarianism.

A final challenge is how to compare and weigh the happiness of one person against that of another. How would a utilitarian evaluate an action that would make one person intensely happy but leave several people somewhat depressed? What of the fact that some people feel things more intensely than others? Is the strength of desires relevant to

the calculation? One could argue that it is a relevant factor since the intensity of an individual's happiness or unhappiness affects the total amount, and utilitarianism tells us to maximize happiness. What if it were shown that terminally ill patients appreciate access to expensive health care services significantly more than curable ill people - would that justify giving them priority? On the other hand, one could argue that favouring the passionate over the indifferent would conflict with Bentham's dictum that everyone counts for one, nobody for more than one.

Under the utilitarian theory the total net good for all in society is taken as the goal. Therefore services funded should be those which would contribute the most to society. The policy challenge is deciding who counts as "society" and who should be defining society's views as to what is most valuable. The idea of allocating health care dollars to the individuals considered most socially valuable has generally been rejected in theory. In fact, the very process of trying to identify the most useful members of society is viewed as so threatening and counterproductive that it may not even be defensible on utilitarian grounds. Most who think in a utilitarian framework have replaced social utility with what is called medical utility. Robert Veatch has noted that medical criteria are not exempt from value and may turn out to be surrogates for social criteria. Dollars could be allocated to those who would receive the greatest medical benefit; measured in the numbers of life years a life would be prolonged or through the reduction of morbidity. Sophisticated utilitarian analysis uses units that attempt to combine mortality and
morbidity measures by utilizing “quality adjusted life years” or “well-being index scales.” The ones who would predictably get the most benefit would get the services regardless of their social value. It is important to note that there is no valid theoretical reason why a true utilitarian would limit the relevant good to medical benefit. Only if the disutility of attempting to measure social utility were greater than the expected benefits would a true utilitarian consider only medical benefits.

Allocation based solely on medical utility raises severe doubts concerning ethical acceptability. In general utilitarian allocations can be criticized as being unfair. They do not give priority to the moral principle of justice. Allocation policies based on justice begin with the principle that allocations are fair to the extent that they give priority to the least well off. It is quite common in medicine that giving resources to the worse off patients would do less good that giving them to better-off patients. In such cases allocation based on medical utility would purposely give the priority to the healthier but still sick patient. This outcome is the commonly held theory of triage, in which better-off patients get priority if they will receive more benefit. One based on justice would give the priority to the sicker individual, knowing that such an allocation was less efficient. It is considerations of this kind that in the past might have lead legislatures to reject utilitarian thinking and give priority to other factors.

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2.2.2 Deontology

Moral judgments of action are central to deontological normative theories.

Deontological theories regard the fundamental ethical task for persons as one of doing the right thing - or, perhaps more commonly, of avoiding doing the wrong thing.

Deontological theories characteristically guide action with a set of moral principles or moral rules. These rules may refer to particular circumstances and have the following form:

Actions of type T are never (always) to be performed in circumstances C.

or, they may be absolute in that they forbid or require certain actions in all circumstances and have the following form:

Actions of type T are never or always to be performed.

The essential task of deontological theory, then is, twofold:

1. to formulate and to defend a particular set of moral rules
2. to develop and to defend some method of determining what to do when the relevant moral rules come into conflict. 21

The state of character ethically most important in a deontological view is conscientiousness - that state of character that disposes persons to follow rules punctiliously, whatever the temptations may be to make an exception in a particular case.

To advocates of a deontological view, conscientiousness does not have value in itself, but

21 Encyclopedia Bioethics supra, note 11 at 740.
it has value derivatively, because it is the most important state of character for ensuring that persons follow rules, and therefore do what is right.  

Deontological theories have affinities with legalistic modes of thought characteristic of both Judaic and later Roman thought. The Decalogue (Ten Commandments), although it functions in a religious context, provides a model of a set of rules of conduct that are basic in much the same way rules function in a deontological theory. One must follow the rules in the Decalogue because they are the commandments of G-d. and reason can be given why it is appropriate to do what G-d commands. When a deontological theory is used in a secular context, however, this reason for rule-following is absent. Deontologists cannot require that rules be followed only because doing so is necessary to bring about certain consequences. This justification would allow for not following rules if there were seen to be better ways of achieving that outcome. If they took this route it would become a consequentialist theory. For a health policy or law to be truly deontological, it must claim that an agent’s fundamental ethical task is to perform or not perform certain actions and that the value of the task not be dependent on the value of consequences.  

Deontology treats moral obligations as requirements to act, essentially independent of the effects our actions may have on our own good or well-being, and to a large extent, even independent of the effects of our actions on the well-being of others. Deontological  

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22 Ibid.
23 Ibid.
theories therefore hold that some features of acts other than, or in addition to their consequences make them right or wrong. They insist that the concept of right or duty is not wholly derivative from the concept of good. Deontologists hold that at least some acts are wrong and others right, independent of their consequences.

a. Kantianism:

Deontology was developed in its most popular form by the modern German philosopher Immanuel Kant. Kant’s ultimate answer to questions about how we discover the correct set of moral rules is that only by following the dictates of reason can we be genuinely free. Whereas Mill said that the right act is the one with the best consequences. Immanuel Kant argued that consequences can never make an action right or wrong; an action that brings about the greatest amount of happiness might still be wrong. One must never act wrongly in order to bring about good consequences. The ends do not justify the means.24 If we want to know if a proposed action is morally permissible the right question to ask, Kant said, is not “What are the likely consequences of doing or not doing this action?” but rather “Can I, as a rational agent, consistently will that everyone in a similar situation should act this way?” If we convert this question into an imperative, we get “Act always on that maxim (or principle) that you can consistently will as a principle of action for everyone similarly situated.” Kant called this rule the Categorical Imperative, and it is the foundation of his ethical system. The idea here is that morality

requires that we not make exceptions of ourselves. If the proposed action is one that
would be wrong if done generally, then the particular action is wrong too - even if it
would not, in the case at hand have harmful consequences or would lead to beneficial
consequences.

The ability to universalize is only one value in Kantian ethics, the other is respect for
persons. The basic difference between utilitarians and Kantians is on the question of why
(and with what priority) they value rights. Kantians will attempt to make the case that
though some rights may simply be socially useful conventions, not all rights are to be
analyzed this way. The most important human rights are not simply conventions that we
adopt for instrumental or consequential reasons (e.g. to promote general happiness) but
are ways of expressing and respecting the status of each person as precious, as an object
of intrinsic value. According to Kantianism, not all rights are grounded in utility. There
is on this view, the possibility of ultimate conflicts between utility and some rights - a
possibility that is logically ruled out by the utilitarian analysis, which regards all
legitimate rights simply as derivative from utilitarian values. It is a central tenet of
Kantianism that when basic human rights (rights based on the intrinsic value of persons)
conflict with claims based on utility, the basic rights have priority.

Kantian ethics is also about how to respect the freedom of rational beings - where respect
is concerned with leaving people alone in what Robert Nozick calls their own “moral
space” to control their own destinies by their own choices even if this tends to produce
social and individual unhappiness. If society thinks it may legitimately balance people the way people balance their own desires or preferences - it is according to Kantians, morally degenerate. It is one thing if I suffer a loss because I brought it on myself through my own free choices, it is quite different and unacceptable if I suffer a loss because others brought it on me for their benefit. On this theory, some human rights (e.g. the right that informed consent be secured before medical procedures are instituted) function not merely to produce beneficial social consequences (e.g. freedom from fear or insecurity about what the medical profession might do) but primarily to insure that the special status of persons as rational choosers be respected. It seems that there are some things we must not do even if doing them would accomplish great good. What if we would maximize happiness by deliberately hurting innocent people or by violating their rights. The extent to which such action may be acceptable in Canadian society will depend on what rights are being violated and by whom. For example, while some argue that taxation is a violation of the rights of the few for the good of many, it is a form of wealth redistribution that is accepted in Canadian society, compulsory kidney donation, in contrast, is not. Nonetheless, the argument can still be made that it matters not just what happens but how it comes about - this is reflected in the legal and ethical concepts of procedural justice. “Always act” wrote Kant “so that you treat rational persons as ends in themselves and never as means only.” Let me consider the example of a family who could not find an acceptable bone marrow transplant donor for their child who suffered from a rare form of cancer. In order to gain acceptable bone marrow they decided to have an additional child, hoping that the child would provide the match. Kantian theory would

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find this action unacceptable, as the baby would be used as a means, rather than an end of its own.

b. Challenging Kantianism:
There have been several criticisms of Kantian ethics relevant to policy application. The first is that the exceptionless character of Kant’s moral philosophy makes it too rigid for policy formulation. Allocation decisions are so varied that it is impossible to create rules that can guide decision makers in all circumstances. Second, the nature of political decision making is such that politicians are acutely mindful of re-election and it is therefore unrealistic to expect them to disregard the probable consequences of their allocation decisions. Even good intentions can sometimes lead to harm. It is often the spirit of a principle or law, rather than the letter of the law that provides the arena for good decisions. Finally it is possible to be faced with a conflict between several duties equally supported by an imperative. Edge and Groves give the example of a nurse who promises not to reveal that a patient has asked questions about euthanasia and who is asked by the family if the matter was discussed.26

c. The Search for Equity - Rawls:
An essential aspect of deontology expressed in Kant’s categorical imperative is the notion of consistency or evenness of behaviour. Many deontological critics of utilitarianism
have criticized the theory's potential impact upon the distribution of health care, and in particular at the lack of explicit interest in issues of equity.\textsuperscript{27} The basic dilemma is whether we should seek to optimize utility without regard to the pattern of distribution of that utility across identifiable groups within society - such as age groups, the sexes, social classes etc.

Several medical ethicists have analyzed this problem. Winslow, for example, has argued for the limitation of utilitarian considerations and for the establishment of a basic presumption in favour of equity, by which he means equal access to health care for those in equal need.\textsuperscript{28} He has pointed to philosopher John Rawls' egalitarian theory of justice, as a coherent model of a just society which achieves a defensible distributive balance between utility and equality.\textsuperscript{29} Rawls' theory has been much quoted in this connection and warrants closer attention.

Further development of Kantian ethics received a significant impetus from John Rawls. Rawls's principal work, \textit{A Theory of Justice}. It is a strong attack on utilitarianism and seeks to base its own positive conception of morality and social justice on an understanding of Kant's ethics that disregards the metaphysical assumptions Kant was thought to have made about absolute freedom and rationality. Rawls seeks to root his model of society firmly by asking us to imagine a group of rational decision-makers

\textsuperscript{28} Ibid Winslow Triage.
gathered together to create a society from scratch. They are all self-interested and equal. They operate behind a “veil of ignorance”, by not knowing in advance how any of their decisions will affect them personally. These decision-makers will have knowledge of certain primary goods that any rational person would be expected to desire, including rights and liberties, opportunities and powers, income and wealth, and self-respect. Interestingly, good health and access to health care do not comprise one of these basic primary desires in Rawls’ system, although this has not deterred health care philosophers from adopting his approach. Rawls argued that these rational participants would accept two fundamental principles. First that of equality in the assignment of basic rights and duties and second that social and economic inequalities would be accepted as just only if they resulted in compensating benefits for everyone. The second of these is known as the Maximin rule which states that “inequalities are permissible when they maximize...the long-term expectations of the least fortunate group in society”.

Rawls further argued that the participants in this whole process would be most unlikely (because of the veil of ignorance) to propose a social organization in which a majority achieved great happiness at the expense of an enslaved minority.

d. Challenging Rawls:

Rawls’ theory uses a series of steps of intuitive reasoning to build a social structure based on specified assumptions. While some philosophers of health care have drawn on it as the inspiration behind much of their thinking, others have criticized Rawls’s work as an

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30 Ibid.
attempt to construct a model using idealized assumptions about an unrealistically simple system.\textsuperscript{31} Some philosophers also find the inequity implicit in Rawls' Maximin rule unacceptable.\textsuperscript{32}

Rawls's theory of justice has been criticized as dependent upon problematic notions of rationality - specifically, a fundamental aversion to risk. Is it clear that all rational people behind the veil of ignorance would necessarily opt for equality of the difference principle? A gambler for example might be willing to take a relatively small risk of being impoverished for the chance at becoming very wealthy.\textsuperscript{33}

If we compare Rawls's vision of "justice as fairness" with utilitarianism, we see some striking differences. The most significant difference concerns the respective theories of the "good" and the "right," and the way these important moral concepts are related. Utilitarian theories define the good independently of the right; first the good is defined as happiness, then the right is defined as that which maximizes happiness. Because justice is defined as a function of utility, it cannot limit the claims of utility. By contrast, Rawls sees the concepts of right and justice as preceding the concept of good.\textsuperscript{34} He stated that for desires to have any value or to play any role in ethical calculations, they must be consistent with the principles of justice.

\textsuperscript{33} Arras & Steinbock supra, note 24 at 19.
\textsuperscript{34} Rawls supra, note 29 at 31.
2.2.3 Utilitarian Response to Deontology:

With regard to equity, a strict utilitarian might argue that all that is required in order to incorporate concerns about equity into the utilitarian model is to attach substantial negative utility to the inequitable distribution of health care.\textsuperscript{35} The overarching unified utilitarian system would thereby be restored. There are dangers, perhaps, in the endless elaboration of utilitarianism to incorporate deontological considerations. The first is the practical danger that the model will run far ahead of our actual abilities to develop and use appropriate measuring instruments. The tools in current use (such as the QALY) seek only to incorporate utilities relating to health status. We may be falsely reassured by knowing that we could in principle, and with sufficient time and effort, incorporate these elements of utility, while continuing in practice to make decisions without them.\textsuperscript{36}

The second problem relates to the results that might emerge even if it were possible to determine the utility attached by the public to equity. What happens if the population does not value equitable distribution particularly highly? Philosophers who attach great importance to it are unlikely to find this acceptable, since they value equity as a morally correct attribute regardless of its popularity. If this were to be the case the apparent synthesis of utilitarian and distributive concerns would prove illusory. Some evidence already exists that the general population is inclined to weight differently the utilities of


\textsuperscript{36} See Joanna Coast, Jenny Donovan & Stephen Frankel, Prioriity Setting: The Health Care Debate (West Sussex, England: John Wiley & Sons Ltd., 1996).
different social groups. Utilitarians who support efforts to mirror the public’s utilities as precisely as possible are likely to find themselves in continuing conflict with others for whom equity and justice are major, if not overriding considerations.

To the egalitarian, the arrangement of resources is considered morally right when it patterns the benefits and harms so they are distributed as equally as possible. Equality of net benefit is considered a morally right arrangement independent of the aggregate amount of good.

One problem with the egalitarian approach is what is sometimes called the “bottomless pit” or the “infinite demand.” If the goal of an ethical allocation of resources is to produce equality of outcome, meaning the distribution of health care according to need, then a seriously ill and incurable patient would continue to command all of our health care resources as long as the investment provided him or her even a minimal amount of good. He or she is therefore a bottomless pit. Some people at this point would insist that we must return to other principles, especially the principle of utility. We must somehow trade the principle of justice off against the principle of utility so that neither efficiency nor equity are entirely lost. Robert Veatch has discussed types of limitation which can be placed on medical compensation to avoid infinite demand situation.38

38 See Veatch I supra, note 18.
We get only partial success from these theories in bringing coherence and comprehensiveness to our fragmented vision of macroallocation and access. The challenges of these theories reflect the challenges Canadian health laws and policies confront. We seek to provide the best possible health care for all Canadians while promoting the public interest through cost-containment initiatives. These desirable goals of superior care, equality of access, freedom of choice and efficiency are difficult to reconcile in a single theory. Different conceptions of the just society underlie them and one goal seems to diminish another. While the varying conceptions are all good, at issue is how to balance them or trade them off against one another.

2.3 Normative Theories in Practice

Now that I have introduced the ethical theories most relevant to issues of macro and meso allocation. I will explore the competing perspectives on their application. There is general disagreement, about how these theories can be used in practice to resolve the normative problem of allocating scarce health care resources. There are several theoretical models of how general ethical thinking could be put into practice. While some of these models seem associated with specific ethical theories, there is not a fixed or necessary connection between them. The conflicts among the ethical theories cut across the conflicts among the models for relating normative theory to practice. A range of

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There is research currently being conducted by Peter Singer and Mita Giacomini addressing how allocation decisions are made, but here I will be addressing how normative theories could be put into practice.
models include: (1) Deductivist model, (2) dialectical model (3) principles model, (4) casuist model, and (5) situation ethics model.\textsuperscript{40}

\subsection*{2.3.1 Deductivist Model}

The Deductivist model holds that ethical theory should guide action through the development of highly abstract and general first principles that, together with some factual description of a particular allocation challenge, will entail concrete action guides. According to this model, moral principles developed and defended within normative ethical theory will act as premises in deductive arguments for ethical judgments about allocation challenges. This model of application is consistent with deontology and consequentialism. It is associated with forms of justification in contemporary epistemology that suggest that all justification must come from some set of foundational claims in the area in question. It looks to the normative theory itself for all of the justification for the principles. There is no “bottom up” justification from particular moral beliefs to general principles, as will be found in some of the other models.\textsuperscript{41}

\subsection*{2.3.2 Dialectical Model}

Perhaps as a result of concerns regarding the foundationalist nature of deductivism, some moral theorists perceive the relationship between normative theory and practice as a

\textsuperscript{40} Jean Bethke Elshtain in Encyclopedia of Bioethics, supra, note 11 at 745.

\textsuperscript{41} Ibid.
dialectic. Instead of supposing that justification is exclusively "top down," they suggest that there is a dialectical relationship between the principles in a normative theory and particular moral judgments. Normative principles may be adjusted if they are inconsistent with our core moral beliefs, in the same way as our particular beliefs may be adjusted to be made consistent with principles. Whether people alter principles or particular judgments will depend on their degree of commitment to each and to the other beliefs they might hold. Just as the deductivist model has a lot in common with foundationalist theories in epistemology, the dialectical model has a lot in common with coherentist epistemological theories, which suggest that justification in general is to be understood as a function of how large sets of propositions cohere.\footnote{Ibid.} An example of the dialectical model is John Rawls's "method of reflective equilibrium," which he uses to support his deontological normative theory.

2.3.3 Principlist Model

For some philosophers normative theory would not be important for resolving ethical allocation problems. They hold, for example, that consequentialist and deontological normative theories in most cases mandate the same actions, and that it is only in exceptional cases that differences are detected. They suggest that the exceptional cases are likely to be so challenging to resolve that both consequentialists and deontologists disagree among themselves about what normative theory requires. They conclude that general ethical reflection should focus on what they call "middle-level" principles, that is,
not the most general principles in any normative theory but those that are likely to be acceptable to adherents of different normative theories. They expect that agreement may be easier to achieve in practical matters if the premises for practical arguments are not sought at the deepest level of normative theory. This model was developed by Tom Beauchamp and James Childress and has been particularly influential in bioethics. It is the most discussed contemporary defense of principlism. The middle level principles Beauchamp and Childress propose are: autonomy (one ought to allow people to act intentionally, with understanding and without controlling influences that determine the action), beneficence (one ought to do or promote good), nonmaleficence (one ought not inflict evil or harm) and justice (distributive justice may imply distribution on the basis of any of the following: equal share, need, effort, contribution, merit or free market exchange). Decisionmakers could use any of these principles as a basis for allocation decisions. The claim of Beauchamp and Childress is that these principles, when suitably refined, are likely to be acceptable to both rule consequentialists and deontologists.

2.3.4 Casuistical Model

Some ethicists regard practical action-guides as distinct from classical ethical theories discussed earlier. They explain that the appropriate model for practical reflection is found in the case-based approach popular in late medieval and early modern thought. According to this approach, ethical reflection should focus on certain paradigm cases of morally good action or morally bad action. Arguments from these paradigm cases to

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43 Beauchamp & Childress supra, note 8.
more problematic cases may be made by analyzing similarities and differences between
the two. In the area of research ethics, for example, the atrocities of Nazi medicine still
serve to exemplify unethical dealing with human subjects. From this signal case, one
then branches out to analogous cases of greater complexity and difficulty, such as
research on children or the demented elderly, proceeding by a method akin to "moral
triangulation." As one goes from case to case, responding to the particularities of
different settings, treatments and categories of research subjects, principles emerge and
become increasingly refined and complex. This approach does not attempt to formulate
goodness or badness of paradigm cases in abstract and general principles, and emphasizes
alogical as opposed to deductive reasoning. Albert Jonsen and Stephen Toulmin44 have
been the leading advocates of this model in recent normative ethics. Their book *The
Abuse of Casuistry* is the most important recent discussion of the casuistical model.

2.3.5 Situation Ethics Model

Some might suggest that situation ethics is not so much a model for practical thinking as
a rejection of any model. It claims that one should approach the resolution of a specific
resource allocation problems by eschewing all general action guides in favour of
concentrated attention to the details of the particular situation. In some of its versions it
may look a bit like the casuistical model; but in its most radical formulations it would
mandate that even paradigm cases should play no central role in particular reflection

because they could deflect the agent’s attention from the particular features of the case under consideration. Among contemporary thinkers, Joseph Fletcher\textsuperscript{45} has been the most prominent advocate of this view, although his early commitment to situation ethics developed later into a more general commitment to consequentialism. In his formulation of situation ethics, he suggests that reflection on particular cases should be guided by the general principle, “Do the loving thing!” However, he is insistent that this principle does not play the role of a premise in any deductive practical argument.

When the disagreement about the correct approach to concrete ethical reflection is added to the disagreement among classical ethical theories, it is easy to see why contemporary applied ethics involves conflict of such depths and complexity. One is confronted not only with competing normative theories, but also with competing conceptions of how such theories would relate to concrete allocation problems.

\textbf{2.3.6 The Legal Model of Moral Reasoning}

Out of all the above models, the casuistical method has the most in common with the method of common law. Given the central role of legal cases such as Nancy B. Henry Morgentaler, Malette and Shulman, and in the United States, Karen Quinlan, Nancy Cruzan in the recent history of bioethics it is not surprising that some bioethicists began ethically analyzing cases using a similar method to law. Now, in both casuistry and law, we seem to reason from the “bottom up” (from specific cases to principles) rather than

from the “top down” (as in most versions of applied ethics); the principles themselves are consequently “open textured,” always subject to further revision and specification; and our final judgments usually turn on a fine-grained analysis of the particularities of the case.46

Casuists would hold that whatever “weight” a principle might have in relation to competing principles must be a function of the particularities of an individual allocation challenge and not in the abstract. John D. Arras and Bonnie Steinbock47 give the example of physicians and nurses at a nursing home who wish to study the refusal to eat of many elderly patients with Alzheimer’s disease. They further suppose that informed consent to participate in the study cannot be expected from this impaired patient population. According to the dictates of their paradigm case - e.g. the infamous and lethal experiments of the Nazi doctors - the principle of respect for persons always requires the free and informed consent of the research subject. But according to the casuists, whether the principle of beneficence can be applied in nursing home research should be determined in the context of a sensitive investigation into the “who” (enslaved ethnic populations versus patients with Alzheimer’s disease); the “what” (experiments designed to kill versus studying and filming patients’ eating behaviours); the “where” (death camps versus a regulated nursing home with a competent research review board); and the “when” (after capture and before execution versus after the consent of family, the loss of decisionmaking capacity, and the approval and ongoing oversight of an ethics

committee). Rather than assigning a timeless relative weight to a certain principle, casuistry holds that the weight lies in the details. In this hypothetical situation, a proposed protocol might be so far removed from our paradigm of unethical research, and the potential benefits to future patients might be so great, that our moral approval may be justified even without the patient’s consent.

While some extreme casuists reject principles entirely, more moderate versions of casuistry can accommodate principle, theories and cultural norms, insisting on the centrality of the particular challenge. It is another way of calling for a reflective equilibrium between principles and cases. Contrary to deductivism, moral certainty does not lie in either principles or theory; and contrary to extreme casuistry, certainty does not lie only in our responses to paradigmatic cases. Instead, any moral certitude lies at the intersection between our abstract norms and our responses to cases.

2.4 Bringing Theory to Practice

The balance between allocation policies and general norms will most likely never reach equilibrium. Even well thought out allocation policy judgments will always be in a state of constant though slow flux and concepts and principles and rules will always be provisional and subject to further refinement and specification in meaning and fluctuation in importance in relation to other norms.

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Often when making or analyzing an allocation decision, one is faced with a range of alternatives, none of which conflict with the categorical imperative. They are all permissible. How then does one decide which alternative to choose? Kantian ethics gives less guidance, more latitude than utilitarianism which requires us to choose the act that has the best consequences. It seems that the categorical imperative functions as a kind of necessary condition of morality and not as a sufficient condition that would specify the right allocation option, from a list of permissible allocation options. Abstract principles and theories provide only general guidelines when specific allocation policies must be formed, so that further moral argument and balancing of competing claims, is needed to determine which specific aspects of an allocation decision are morally relevant and decisive in forming a reasoned judgment.

At this point the key question is: Can the values being appealed to be reconciled or are the values mutually exclusive, therefore suggesting ultimate real incompatibility between the policies reflecting these values? Both deontological and consequentialist ethics are problematic as the sole guide of allocation decisions. As an example, if we take the question of the sanctity of life and an absolutist view prevails, modern medicine and technology might be placed on the side of saving every living individual from death, regardless of intolerable costs, suffering to patient and family, or inability to restore life in a meaningful sense. Conversely if a utilitarian view prevails, we might see certain

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48 Arras & Steinback supra, note 24 at 16.
49 Beauchamp & Childress supra note 8 at 334.
categories of persons discriminated against. More appropriate for policy formation might be the combination of theories.

Both deontology and consequentialism seem highly plausible. Each has an important perspective to offer on ethics even if it remains unclear of how to integrate them into one coherent tool for guiding allocation policy. Utilitarians are certainly right that achieving human happiness is an important goal of morality, but nonconsequentialists are also right in insisting that other values such as justice and autonomy are also important and that they may not always be reduced to happiness. It seems that the various theoretical alternatives are not mutually exclusive claims to moral truth, but rather partial contributions to a comprehensive, although fragmented, moral vision.\(^{50}\)

One way of balancing the two theories may be to defend the special obligations towards the health of all persons in Canada by asserting that these attributes of our health care system themselves produce utility - so called *process* utility\(^{51}\) - and that without them utility will remain suboptimal.\(^{52}\) It is therefore suggested that total (aggregate) utility is the sum of utility which arises from the consequences of actions (outcome utility) and utility which flows from the manner in which those consequences are achieved (process utility). What this formulation achieves is to represent deontological concerns as a special type of utility within a utilitarian framework. While this is theoretically attractive, it fails to satisfy a more fundamental objection to utilitarianism articulated by some

\(^{50}\) Arras & Steinbock supra note 24 at 9.
\(^{51}\) Mooney & McGuire 1988 supra, note 35 at 36.
deontologists - namely their rejection of the whole utilitarian calculus, and of the empirical possibility of determining the moral rightness of actions in such a way.53

Another option is to affirm all the principles upon which the theories are based and insist that they be balanced so that none gets priority. Beauchamp and Childress emphasize the need to provide the most comprehensive health care by balancing cost and demand in light of the various theories of justice.54 Baruch Brody has suggested that there is not one adequate moral theory of decisionmaking, requiring an overhaul of the several existing theories.55 While attractive, this approach still poses some serious difficulties. For example, once utility is permitted in the mix, the rights of individuals can, in theory, be swamped by enough social good. Since there are potentially infinite numbers of future generations, good for future citizens could always overpower autonomy, then compulsory participation in health care, even dangerous experimental health care would, in principle, be justified if only enough good were envisioned.

The bottomless-pit problem is amenable to other solutions. For example, as long as autonomy, promise-keeping and other non-consequence maximizing principles are allowed to offset justice, justice will be held in check. If promises have been made to others, these might justify failing to give infinite resources to the sickest or the incurable patient. The principle of autonomy will also come into play. Some who are worse off with incurable illnesses will exercise their autonomy to decline the care to which they are

54 See Beauchamp & Childress supra, note 8 at 265-301.
entitled in the name of justice. They might do this either out of altruism or out of a sense that the marginal benefits from the extensive medical intervention simply are not worth it. On the other hand, the relationship between autonomy and justice is more subtle. While one could envision that autonomy might lead a patient who has a claim of justice to decline the benefit, that does not mean that autonomy always has a claim against justice. It seems that only for the basic minimum of health care does justice take priority over autonomy. Once we get above the basic floor of services signified by the notion of a decent minimum, it may well be that autonomous choice has a more legitimate place.

Veatch\textsuperscript{56} considered two real allocation examples involving children. In the first, a public health officer wanted to screen school girls for asymptomatic bacteriuria.\textsuperscript{57} Since there were not enough funds to screen everyone, he conducted a study to see which of two methods would find cases most effectively.\textsuperscript{58}

The utilitarian cost-benefit assumption would be that the method that caught the most cases per unit of investment would be morally preferable. After identifying the method that found the cases per unit of investment, the officer discovered that while the method was more efficient it tended to find middle-class cases at the expense of lower-class

\textsuperscript{55} See A. Baruch, Brody \textit{Life and Death Decision Making} (1988) 6-11.
\textsuperscript{56} R.M. Veatch, “Child Health & Theories of Right Allocation” (1994) 4(1) \textit{Health Matrix} 75-92 at 82.
\textsuperscript{57} See Gordon Rich et al., \textit{Cost-Effectiveness of Two Methods of Screening For Asymptomatic Bacteriuria}, 30 Brit J. Of Preventive & Soc. Med. at 54, 54-59 (reviewing a study which compares the cost-effectiveness of screening of children of different social classes and which favours a high output result).
\textsuperscript{58} Ibid. at 55-59 (noting that the two methods used were a home method and a supervised method, with the supervised costing around 40% more than the home method).
The problem then became whether he wanted to find as many cases (that is to do as much good as possible) regardless of the pattern of distribution, or whether he purposely ought to choose the method that was less efficient, but found cases more equitably among all social classes. One principle of justice favoured the less efficient, more equitable one.

In the second example, the National Institute of Health ("NIH") Consensus Conference on Dental Sealants debated what to recommend for a community policy on the use of sealants on children’s teeth. It turns out that for technical reasons it is more efficient to seal teeth of children living in communities that have community fluoridated water.

The NIH panel was divided between utilitarians who favored the most efficient use of the sealants, regardless of the pattern of distribution, and egalitarians who held that justice required giving all children an equal chance to get their teeth sealed. The latter maintained their position because it was not the fault of the children who did not get fluoride that their teeth were somewhat less efficient to seal. The utilitarians chose the most efficient plan knowing that the distribution of the benefits would be inequitable. The egalitarians chose an equitable distribution of the benefits, despite knowing that their choice was less efficient.

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99 Ibid.
90 In 1983 a panel of 11 dental professionals, sponsored by the NIH, recommended that all children, beginning at the age two, should get their teeth sealed in order to combat tooth decay. See Victor Cohn, NIH Panel Urges Teeth Be Coated To Fight Decay, Wash Post, Dec 8, 1983, at A01.
91 Sealants, developed in the 1960s and 1970s are placed on the surface of teeth forming a thin, clear plastic layer which helps guard against decay. See Jeffrey P. Cohn, Shrink Wrap For Molars: Plastic Coating Seals Teeth So Bacteria Can’t Cause Cavities, Wash Post, Jul 17, 1990, at Z16. Sealants are most effective when applied to children when their permanent molars begin to come in. Ibid.
92 The fluoride prevents cavities on the surface between teeth while the sealant protects the occlusal [biting] surfaces. Those children without fluoridation would have to have their sealant destroyed to fill the larger number of cavities between the teeth, making the sealant more efficient on the children getting the fluoride.
Egalitarians hold to a principle of justice in the narrow sense. They believe that the pattern counts that all children have an equal claim to benefits regardless of the fact that the aggregate benefit will be less.

2.5 Conclusion

In summary, two ethical theories expressed in deontology and consequentialism stand out as reflected in laws and policies relevant to allocating scarce health care resources in Canada. Each influential normative theory of distributive justice is a philosophical reconstruction of a valid perspective on the moral life, but one that only partially captures the range of diversity of that life. The richness of our moral practices, traditions and theory helps explain why diverse theories of justice find themselves reflected in current laws and policy proposals.

63 Ibid. (urging that sealants be given to those children who were poor and either obtained deficient dental care or suffered from extreme decay).
3. Economics

3.1 Introduction - Purpose of Chapter

This chapter considers the way advocates of economic analysis suggest economics can be used to guide the allocation of scarce health care resources. In so doing, it makes explicit some of the choices, conflicts and compromises that using economic analysis for allocating scarce health care resources inescapably entails. Chapter one outlined the ethical language with which economic consequentialist concepts can be analyzed and then evaluated. This chapter examines how these consequentialist values are expressed in the principles of economics. Section 3.2 of this chapter describes the meaning of economic analysis as applied to resource allocation in health care, focusing on its objectives and context. Section 2 discusses the basic economic models of evaluation, including cost-minimization, cost benefit analysis, cost-effectiveness and cost utility analysis. While this is not an economics thesis, it is necessary to set out the key elements of this analytic tool in order to evaluate their consistency with current Canadian law in Chapter 3. Section 3 of this chapter alerts the reader to some of the assumptions made by economic analysis. It addresses the need to define which costs and consequences are being considered by the analysis, the point of view of the analysis, the goal of efficiency as well as the way ethical values are hidden in technical language. Section 4 discusses some analytical challenges associated with using economic models for making allocation decisions. It highlights the goals and limitations of quality adjusted life-years, issues around cost-effectiveness analysis, and the conflict between the philosophical value of equality and the economic goal of efficiency. Section 5 looks at the application of economic analysis in health allocation policy. It explores (i) some short case examples,
(ii) a study designed to solicit values of an interdisciplinary group of prospective jurors, medical ethicists and medical decision makers in choosing between two screening tests, (iii) the challenging experience of residents living near buried radioactive waste negotiating with governments focused on economic analysis, and finally (iv) the famous health policy example of the Oregon Plan. The chapter finally concludes that while economic analysis is not a complete decision making process, the information it provides is crucial to making good allocation decisions.

By way of putting the following work into context it should be noted that the way in which moral issues identified throughout the chapter are balanced in the setting of allocation policy, will always be a matter of value judgement. Priority setting does not clearly flow from objective formulas. What is ethically appropriate priority setting at one level of decision making, may not be appropriate at another. The micro level of the bedside is a different decision making context than the meso level of the hospital boardroom, which is again a different policy setting context from the macro level of the legislature. Factors that are relevant to allocating budget dollars may not be the same as those relevant to allocating treatments or individuals.
3.2 What is Economic Analysis? Definition and Goals

The purpose of economic analysis is to “compare alternatives in terms of their costs and consequences, and select the one which gives the highest expected value.” Economic evaluations cannot be done in a vacuum. They each compare an intervention or course of action with at least one other alternative. Economic evaluations can then produce detailed comparative analysis by measuring the costs associated with health care treatments and policies, and the consequences, including but not restricted to health outcomes of these treatments or polices. Examples of possible consequences include but are not limited to changes in life expectancy, length of hospital stay, frequency of physician visits and/or changes in quality of life.

In terms of the role economic analysis can and should play in allocation decision making, it is significant to differentiate between “the process of analysis (the role of analysts) from the process of decision making (and the role of decision makers)” Analysis should not be considered a replacement for responsible decision making, but rather a necessary component of the process or an aid to such decision making. Economic analysis permits us to evaluate and compare alternatives with respect to what and how

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65 Economic analysis generally refers to dollar values because it is the “common language of exchange” and there are several mechanisms to modify this dollar figure to best reflect actual costs. In acknowledgment of the fact that a dollar in the future will be worth less than a dollar is today, economists generally “discount” costs and benefits which will occur in the future and compute a “net present value”.

66 Evaluating quality of life is complex and may involve assessing such factors as emotional well-being, ability to perform daily functions and ability to continue employment. This field is methodologically complex and beyond the scope of this thesis. Nonetheless, health economists are working hard to develop common measurement approaches and clarify assumptions.
much value we are getting for our money. Given the information accessible through economic analysis, it seems essential to making informed and morally defensible allocation policy.

While the purpose of economic analysis is to determine the best way to allocate scarce resources among alternative uses, there is not a common consequentialist view of how this might best be achieved. There are various descriptions within the consequentialist tradition. One school believes that social policy should be created in such a way as to reach an optimal level of utility from public expenditure. This has been called preference or welfare utilitarianism (efficiency).\(^6^8\) Alan Maynard's statement of purpose is arguably the closest to strict welfare utilitarianism. Having defined inefficiency as a situation in which costs are not minimized and benefits are not maximized, he proposes quite simply that "Inefficiency is unethical".\(^6^9\) Mooney and Drummond, for example, explain that "economics is about getting better value from the deployment of scarce resources".\(^7^0\) Mooney and McGuire\(^7^1\) emphasize the fact that "the end sought by economic policy - the

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\(^6^8\) A. Brown, Modern Political Philosophy. (Harmondsworth: Penguin, 1986). Welfare economics or welfare theory is a normative branch of economics concerned with the development of principles for maximizing social welfare and economic output. It is based on the assumptions (1) that individuals maximize a well defined preference function and (2) that the overall welfare of a society is a function of these individual preferences. In context of welfare economics - welfare economics is concerned with the means by which we can assess the desirability from a societal point of view - of alternative allocations of resources. See: R.W. Broadway and N. Bruce, Welfare Economics (Oxford: Basil Blackwell Ltd., 1984). The key question is whether we focus on individuals welfare, or societal welfare i.e. is societal welfare merely aggregation of individual welfare. This interesting debate is beyond the scope of this thesis.


maximization of benefits - is based upon an aggregation (i.e. they fall into that school) of...the utility derived...from the resource allocation process". Culyer suggests that: "...the objective of health services is to promote health and, moreover, to do so in such a fashion as to maximize the impact on the nation’s health of whatever resources are available to this end".72

Other descriptions accept a less than optimum utility and balance the focus on utility enhancement with attention to the distribution of benefits (equity) within society.73 Mooney and Jensen74 focus on the importance of having a health care system concerned about distributive issues. From this quick survey of several leading health economists own descriptions of goals, it is evident that within the economic tradition there is heterogeneity, ranging from utility optimization to more flexible kinds of consequentialism which acknowledge the significance of equity considerations.

3.2.1 Assumptions

The adoption of economics as a mode of analysis implies the making of several assumptions. This section alerts the reader to assumptions related to various aspects of

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73 This school of thought is reflected in the Beveridge Report of 1942. Its focus of attack was on want, disease, ignorance, squalor and idleness and a cornerstone of Beveridge’s remedy was the principle of universal insurance coverage. He was attacked for this by welfare economists, in terms that have been repeated more recently, for his failure to target resources so as to achieve the maximum possible improvement in his chosen parameters. See A.M. Rees, TH Marshall's Social Policy in the Twentieth Century (London; Hutchinson, 1985).
economic analysis. Economic analysis makes the assumption that resources are limited and therefore it is impossible for the Canadian health care system to insure all services that may extend life or improve the quality of life. In terms of the funding of health care services, there exists a constant conflict between alternative uses of resources, and a constant need to choose among alternative allocations.

Economists define the real cost of an activity (for example, provision of hospital services) as the other outputs that must be given up (for example, other health services such as immunizations, or non-health services or commodities such as defense or vehicles) because resources are committed to it. Economists refer to this concept as opportunity cost. Given that resources are limited, resources allocated to one area are unavailable to be allocated elsewhere. The cost of a given allocation of resources, therefore is the lost opportunity of doing something else with them. The opportunity cost of doing X is not doing Y or Z, the loss of benefits which results from using finite resources for one purpose rather than another. While the calculation of opportunity costs is rarely done in making allocation decisions the assumption of opportunity costs is essential if an economic analysis is to include consideration of financial as well as social consequences. Described in terms of opportunity costs, allocation decisions are between or among different options. When assessing opportunity cost one considers options relative to other possible options that may be equally or even more beneficial.  

3.2.2 Which Costs and Which Consequences?

It is important to acknowledge that in practice, economic analysis will address only a portion of possible costs and consequences. For example, cost effectiveness analysis, initiated by allocation concerns, generally focuses on costs and consequences closely linked with treatment. This generally involves clinical outcomes, direct agency costs, and patient earning lost or reestablished by treatment. Such studies rarely address issues such as the effect of the increased or decreased productivity of a patient on the Canadian economy or the opportunity costs of the resources used. All forms of economic analysis tend to factor in only part of the relevant information by including only those costs and consequences which can neatly be measured and disregards the relevant "intangibles".  

The difficulty is that costs and consequences from health care allocation decisions such as pain and suffering are difficult to quantify. While economics is not the only theory with input relevant to allocation decisions, the results of economic analysis are biased towards factors that can easily be quantified. Though pain and suffering, quality of life, and equity can be noted, if they are not quantified, they will not be recognized in the numerical results. For many allocation decisions this theoretical model is inherently incomplete and the results need to be merged with the insights of other disciplines.

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76 Fried, Deber supra note 2 at 634.
78 Ibid.
Insufficient data is another factor limiting the potential comprehensiveness of economic analyses. For example, data on the funds spent on specific illnesses are not easily accessed. Epidemiological data are also limited on the incidence and prevalence of a disease and its effects on mortality and morbidity. Without such data the effect of a particular technology or health care service is unpredictable. Efforts are now being made in the U.S. National Center for Health Statistics and academic centers to compile the interactive effects of multiple causes of death into mortality data.\textsuperscript{79} There may be a greater likelihood of patients with specific chronic illnesses dying from an acute illness. but common disease-specific life tables may not consider these relationships.

3.2.3 Point of View

In appreciating the significance of any economic analysis, it is vital to recognize that each assumes a particular point of view, or perspective. The point of view determines which costs and consequences will be included in the analysis. Economic analysis can be undertaken from the perspective of society, the government or Ministry of Health, the institution, a professional body, patients as a group or an individual. The viewpoint taken determines the costs and consequences used in the analysis. For example, the costs that a patient bears such as distance traveled, waiting time, out of pocket expenses and pain will be more important to individual patients, but will not be costs to hospital facilities. Indeed, some of these costs, such as parking fees will be income to the hospital. While it

\textsuperscript{79} Ibid. See R. Klein, "Puzzling Out Priorities: Why We Must Acknowledge That Rationing is a Political Process" (1998) 317 BMJ 959-960.
may not be relevant to the Ministry of Health how quickly or even if, a patient can return to work, it is of great importance to the individual, the person's employer and even another government Ministry from whose budget the disability payments will come. Costs and benefits to society as a whole may be distinct from those of a patient or a provider facility. Differences in viewpoint or perspective inhibit general comparisons across studies that could be most relevant to broader macro and meso allocation policy questions.

3.2.4 Efficiency

Economic analysis assumes the goal of efficiency. While as a lay term efficiency means "getting the biggest bang for your buck." in the discipline of economics efficiency has technical meanings. The three key requirements of efficiency are: (1) resources should not be wasted (2) output should be produced at the least cost and (3) the types and amount of output which people value most are the ones that should be produced. An efficient allocation of resources is one which concurrently satisfies each of these requirements. The first two requirements refer to production; the third deals with

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consumption, thereby joining together the “supply” and “demand” sides of the exchange of output.\textsuperscript{83}

The first requirement of efficiency demands that for any measure of output the amount of inputs employed to produce it are minimized; maximum output should be generated from any combination of inputs.\textsuperscript{84} If this requirement is not satisfied, then allocators of scarce health care resources may acquire more output through an alternative combination of resources, or by allocating some of the resources to different uses without sacrificing any current output. This condition of efficiency is called “technical efficiency.” Hospitals that are larger than is necessary to attend to their communities are an example of technical inefficiency. There will usually be various technically efficient combinations of outputs (for example, combinations of labour and capital) for a given level of output. A given treatment or program is technically inefficient if the same result can be reached with less or fewer costs. Accordingly, a move in the direction of technical efficiency means reduction in costs but not a reduction in benefits. Economists call these “Pareto superior improvements.”

This version of cost-effectiveness is a morally favourable goal. Inefficient treatments or delivery systems waste resources that could be put to productive use. It would be difficult to justify a more costly treatment when a less expensive one would be “just as effective.” This concept of “just as effective” however, can be interpreted more or less

\textsuperscript{83} The concept of supply and demand are explained in more detail below.
literally. Examples where lower cost options are "just as effective" or yield exactly the same benefits are uncommon. For example, the lower cost treatment may offer somewhat less benefit, or have increased risks or negative side-effects. A less expensive delivery system may be of somewhat lesser quality than a higher cost system. In such cases, the issue is whether reduced benefit is worth the reduced cost. This is ultimately an ethical question that cannot be resolved on technical calculations alone.  

The second requirement of efficiency builds on the first but considers the comparative cost of different inputs. It demands that, in addition to technical efficiency being achieved, inputs be arranged so as to minimize the cost of any given output. For example, if labour is abundant and inexpensive relative to capital in one economy compared to another, then least-cost production methods will employ relatively more labour in the first economy. This element of efficiency is called "cost-effectiveness" by non-health economists. For any output in a health care setting there will generally be only one combination of inputs that will be the most cost-effective. One can only conclude that a particular combination of inputs is cost-effective in generating a specific output if it has been compared to one or more alternative combinations of inputs used for

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86 The authors of some economic texts do not make the distinction between technical efficiency and cost-effectiveness. Some use the term technical efficiency to include both concepts see. A. McGuire, J. Henderson and G. Mooney, The Economics of Health Care: An Introductory Text (London: Routledge and Kegan Paul LTD, 1988).
the same purpose.87 However, most health policy analysis does not use cost-effectiveness in this way, instead reserving the term for the results of a cost-effectiveness or cost-utility analysis (i.e. what's the cost/QALY?).

The third requirement of efficiency connects the supply outputs to the demand for them by expanding the analysis to include the choices and values of the members of society who consume the outputs. It demands that in addition to satisfying the requirements of technical efficiency and cost-effectiveness, resources be used to generate the kinds and quantity of outputs which people value most. Economists refer to this comprehensive concept of efficiency as "allocative efficiency." In basic economic theory allocative efficiency occurs when resources are allocated in such a way that it is no longer possible to alter the quantity or kinds of outputs being produced to make someone better off without making someone else worse off. This is often referred to as "Pareto efficiency." An allocation of resources can be both technically efficient and cost-effective but allocatively inefficient if producers are supplying too much or too little of any good or service relative to consumers’ wishes. If parents of young children want counseling services for behavioural problems instead of repeated well-child check-ups, then allocative efficiency might be enhanced by modifying the type of primary care services made available even if the well-child examinations were being conducted cost-effectively. Efficiency refers to both "doing things right" (technical efficiency and cost-effectiveness), and "doing the right things" (allocative efficiency).

87 While cost-effectiveness can provide insights with regard to how to produce an output at least cost, it
3.2.5 Hidden Ethical Values

Raisa Deber has argued that “[E]conomic analysis often tries to finesse questions of values and priorities by attempting to disguise them as technocratic choices.”88 To the extent that technical economic theory or labels such as “futility” and “effectiveness” camouflage value judgments, they are inconsistent with the ethical principle that value considerations in allocation decisions should be as explicit as possible. If for example, the consideration of patient interests is the motivation for limiting treatment, details about how and by whom these interests are determined may be neglected by using terms such as futility. Truog, Brett and Frader hold that “[j]udgments about what is in the patient’s interest are properly grounded in the patient’s perspective. whereas judgments cast in the language of futility falsely assume that there is an objective and dispassionate standard for determining benefits and burdens.”89

The likelihood that futility judgments may have the effect of diverting attention away from the fact that economic implications are being factored into allocation decisions is a real barrier to explicit policy making. The barrier is that health care services which are felt to be not worth the cost will be labeled futile. While policy makers may be justified in limiting treatment based on cost considerations, any decisions to do so should be made

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explicit. Truog, Brett and Frader maintain that it "offers a reason to limit therapy without the need to define a fair procedure for allocating resources."\(^0\)

Because they are faced with such uncertainties and ambiguities, allocation decisions based on effectiveness have a subjective element. To the extent that the concept of "worth" is added to this subjective element, these policy decisions are, essentially, value judgments. For example, the declaration that a particular treatment is ineffective may mean that it is not "worth doing" even though it provides a slight chance of benefit, or a certainty of slight benefit. Or it could mean that the benefit is so slight that it is not "worth the cost." Such consideration of worth, whether triggered by interest in the welfare of the individual patient or by economic priorities, obviously include moral as well as factual considerations.

Allocation policy decisions based on similar determinations of effectiveness, such as for example, "inappropriateness," "not clinically indicated," "futility," or "not medically necessary" are likewise value-laden. While these designations are often treated as objective, their definitions are based on subjective values as well as the circumstances under which they will be applied. Of particular significance in the policy arena is the fact that they are also used to make normative prescriptions. This point is well illustrated with reference to the concept of futility.\(^1\) Judgments of futility are mistakenly interpreted as descriptions of objective situations. What often follows from such a pronouncement is

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\(^0\) Ibid at 1562.

\(^1\) "The analysis of futility judgments given here could be applied as well to other judgments of effectiveness. For an analysis of the phrase "not clinically indicated" along similar lines see T. Hope, D. Sprigings & R. Crisp, "Not Clinically Indicated: Patients' Interests or Resource Allocation?" (1993) 306 British Medical Journal at 379-381.
the description of another policy option, or use for the funds. Usually, the declaration that a treatment or service under consideration for a particular patient or group of patients is futile is accepted as are explanations for it not being funded. Declaring a treatment futile implies that it is "not worth it." This judgment of worth may then be rationalized with regard to the good of the patient, or, more questionably, with reference to the aim of using resources sparingly. The distinction between determining what harmful and beneficial consequences can be expected from a treatment or policy decision and deciding whether the benefit is worth the risk, or, even more problematical, worth the cost is a significant one. This difference is often obscured or masked by the label futility.

If the determination of futility clearly meant that a treatment or policy being considered was truly ineffective and promised no benefit, and if this claim could be proven objectively, the move from description (no benefit) to prescription (ought not to be offered) would be undisputed. No one would lobby for funding a service that offers no benefit. Unfortunately, those treatments likely to be labeled as futile are usually not characterized by objective description. If the descriptive claim expressed in the determination of futility is controversial, so too will be any prescriptive claim that might follow. Policy analysts should also be cognizant of the fact that however one might define futility, in practice, research reveals that it is a slippery concept when used or misused by clinicians.92

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92 M. Solomon, “Futility” as Criterion in Limiting Treatment (letter to editor), (1992) 327(17) New England Journal of Medicine 1239 - in a study conducted at a Harvard teaching hospital, Solomon (1992) found that “physicians used the concept of futility and the word itself in multiple and contradictory ways” (p.1239). Almost invariably, he points out, futility judgments were based on quality of life considerations, and “only rarely were they used to designate treatments that were medically inefficacious.” Although the
Utilization review, outcome measurement, quality assurance and needs assessment have only recently become a high priority on the research agenda. Previously there were very few researchers gathering and organizing information necessary to make informed allocation decisions. A significant issue is that fact and value, or empirical and moral judgments are often merged in these research areas. Even something as basic as the choice of outcome measure has moral implications. Researchers must choose between using program-specific measures, lives saved, years of life saved, quality of life, and quality adjusted life years. They must decide how quality of life is to be defined and measured and what will count as a successful outcome. They must decide how far into the future they want to monitor outcomes.

The ethical scope of these questions is highlighted when pertinent information is camouflaged under headings of effectiveness, cost-effectiveness and cost-benefit. By placing a health service under one of these headings one is commenting on what its funding status should be. Ineffectiveness is almost by definition not worth funding. A health policy service that is not cost-effective is usually considered a “waste” or misuse of resources. A service or policy that is not cost-beneficial is usually seen as not “worth” the cost. Because such judgments affect what services will be available it is vital that the

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physicians were making value judgments, they “did not talk overtly about values,” and indeed tended “to frame value judgments as medical decisions.”

grounds on which they are made and the assumptions that they embody are made as clear as possible.

A recent study conducted by Wiktorowicz and Deber,\textsuperscript{94} evaluating the “values matrix” of health care stakeholders reveals that there are a number of decision-makers, all with different perspectives / interests and different “rational choices.” When asked to respond to the statement - “New drugs should be approved only if it is more effective or less expensive than the existing products” - there were distinctly different responses. Pharmaceutical industry representatives and regulators disagreed with the statement; payers and hospitals agreed with the statements; and scientific experts were neutral. Payers and hospitals were sensitive to the cost-effectiveness of products while industry and regulators were less concerned with affordability as an important criterion of decision making. At the very least, this exposes the different interests and perspectives at work in the decision-making process in Canadian health care.

Wiktorowicz’s study exposes the presence of different interests involved in the health care industry and the degree to which these different interests see their realities differently, assess evidence differently, and may have fundamentally different objectives. The science of economic evaluation cannot be completely removed from value judgments. It is incorrect to assume that the evidence and economic models provide a value-free analysis. There are biases hidden in the construction of the questions asked and the interpretation of the answers. Economic evaluative studies can result in
disciplined descriptions of evidence, and can require analysts to consider the difficult
issues, but the allocation decisions that have to be made will always involve distributional
issues that are based on value judgments. For example, is it better to decrease cold
suffering by one day for all Canadians, or add twenty years to the life of 100 individuals?
This is a stark presentation of a broader issue: is it better to deliver minimal benefits to
the many, or significant benefit to the few? How much more are we willing to pay for
how much increased benefit? Or alternatively, how much decline in benefit are we
willing to endure for decreased costs? These types of questions are perhaps easier to
answer with regards to purchasing shoes or automobiles, but in the realm of health care
goods and services, where the product is a social good, and where distribution has ethical,
moral and equity components, these are difficult questions that come down to value
judgments.

The issues explored above do not reflect objections to addressing cost considerations
when making allocation decisions at the meso or macro levels. They are based on the
value of explicitness in allocation decisions. A valid objection is rather with hiding the
fact that one is basing a decision on economic factors by describing the factors as
objective. Judgments of effectiveness that are made by considering costs are essentially
cost-effectiveness judgments, and should be described clearly as such if explicitness is to
be respected. In this way the benefit of economic analysis, as a tool for clarification, can
be realized.

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3.3 Basic Forms of Economic Analysis

There are several analytical models used to measure and evaluate costs and consequences. They are all the same with regard to how one measures costs (and evoke the same sorts of issues) but differ in how one measures consequences. Culyer has lamented the fact that there are many inadequate measures in the medical and social science literature. He gives the example of the survival after five years measure, commonly used in cancer studies. He points to the ethical assumptions reflected in this measure. First is that survival for less than five years is of no value. Second is that survival for more than five years is of no additional value. Third is that the quality of life of survivors is irrelevant and fourth, that the identity of survivors is immaterial. Culyer appropriately states that what is needed is an economic measure that makes explicit and acceptable ethical assumptions, is sensitive to the possible differences in outcome that there may be, and that enables cross-program comparisons of outcome and finally leads to efficiency. I acknowledge that the distinctions among the various models are emphasized for pedagogic reasons. In actual Canadian macro and meso policy deliberations the distinctions are generally not highlighted as clearly.

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3.3.1 Cost-Minimization Analysis (CMA)

Cost-minimization analysis is an abbreviated economic analysis. It is conducted when it is known that two or more alternatives will have equivalent outcomes. The goal is to establish the least expensive alternative. A cost minimization study would be appropriate, for example, once some form of evaluation has established the equivalency of two treatment options i.e. generic drugs. An example of a study evaluating options for minor surgery is Russell et al.'s look at day-case surgery for hernias and haemorroids. In this cost-minimization analysis, the short-stay alternative was compared with traditional in-patient treatment.

3.3.2 Cost-Benefit Analysis (CBA)

Cost-benefit analysis attempts to value the consequences of programs in terms of money, so as to make them commensurate with costs. This is a broad form of analysis, where one can determine whether the beneficial consequences of a program justify the costs. Cost-benefit analysis compares the monetary costs and consequences of two or more alternatives: both costs and outcomes are measured in monetary units. The goal in terms of health care policy, is to establish which health care alternative produces the best

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98 Fried, Deber supra, note 65 at 634.
monetary return. This involves translating all consequences into monetary units. Of all
the forms of economic analysis, cost-benefit studies adhere most closely to the economic
definitions of cost and were the earliest to be used in analyses of public services.\footnote{Fried, Deber supra, note 65 at 634.} There
are several modes of monetary valuation of consequences. The monetary translation of
costs and consequences allows health care policy analysts to compare funding options
that have different types of consequences. For example, health-care programs could be
compared to other social programs because the costs and consequences are translated into
monetary units.\footnote{See P. O'Byrne, L. Cuddy, D.W. Taylor, S. Birch, J. Morris & J. Syrotuik, “Efficacy and Cost Benefit of
Inhaled Corticosteroids in Patients Considered to Have Mild Asthma in Primary Care Practice” (1996) 3
Canadian Respirology Journal 169-175.} The CBA, therefore has the potential to conduct cross-sectoral
economic evaluations.

Cost benefit analysis entails establishing the costs and benefits of a certain health care
service to yield a ratio of cost per benefit, which can be used to compare different health
services or rates of return. This unit of comparison is useful insofar as the measure of
benefit is in a significant way the “same” for different alternatives. However, in health
care, benefits are usually measured by changes in mortality and morbidity. Attempts to
translate such benefits into dollar terms are often difficult and contentious. Comparing
cost per orange with cost per apple does not indicate which of the two is the better choice.
In many ways, the benefits yielded by different health services are as different as apples
and oranges, and all the more so the greater the difference in purpose and expected
medical benefit of the services. While it may be appropriate in the comparing
hemodialysis and kidney transplants it would be less useful in comparing hemodialysis and hip replacements, let alone hemodialysis with income supports or child care or road building.

An example of a cost-benefit study is that by Weisbrod et al., which attempted to quantify and value various costs and benefits on conventional hospital oriented versus community-based programs for mental illness. The study concluded that although the community-based programs for mental illness was more costly, this was more than offset by its extra value in terms of patients being able to take up or maintain employment.

3.3.3 Cost-Effectiveness Analysis (CEA)

Cost-effectiveness analysis measures the consequences of programs in the most appropriate natural effects or physical units, such as "years of life gained" or "cases correctly diagnosed" etc. Because analysts do not attempt to "value" the consequences, it is presumed that the consequence in question is valuable. The only difference between CEA and CBA is that CEA measures benefits in terms of some standard clinical outcome or effectiveness, such as mortality rates, years of added life or quality-adjusted life years, whereas CBA converts these benefits into a monetary value. The underlying goal of both models is to determine which option provides maximum aggregate health benefits for a

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102 B.A. Weisbrod, M.A. Test & L.I Stein "Alternatives to Mental Hospital Treatment: Economic Cost-benefit Analysis" (1980) 37 Arch. General Psychiatry at 400.
given level of resources or which option provides a given level of health benefits at the lowest price.\textsuperscript{103}

Cost-effectiveness analysis is a model designed to evaluate the comparative impacts of expenditures on various health interventions.\textsuperscript{104} Cost-effectiveness analysis compares the costs and consequences of different approaches to a common outcome. This is different from CMA in that in addition to the costs, consequences of the health services or policies being evaluated are compared in terms of their ability to achieve that single outcome.\textsuperscript{105}

For example, if one does a CEA evaluating two drugs designed to lower blood pressure, the single "outcome" is lower blood pressure, defined by specific parameters. Any related conditions or outcomes are not essential to comparatively evaluating the two products. CEA is based on the assumption that "for any given level of resources available, society...wishes to maximize the total aggregate health benefits conferred."\textsuperscript{106}

For example, we might wish to know whether spending a certain amount of money on a public campaign to stop smoking will have greater or lesser effect on health than spending the same amount on colorectal screening. The results of this analysis are generally expressed in a cost-effectiveness ratio, where the denominator reflects the increase in health from a proposed treatment (measured in terms of for example, years of life gained, premature births averted, or sight years gained) and the numerator reflects the

\textsuperscript{103} Valueing Health Care: Costs, Benefits and Effectiveness of Pharmaceutical and Other Medical Technologies Frank A Sloan ed. (New York: Cambridge University Press, 1996) at 4.

\textsuperscript{104} Gold et al. supra, note 81 at 26.


costs of attaining that health benefit. Cost effectiveness analysis requires that the costs and benefits each be measured in any single unit, thereby allowing the benefits to be calculated in non-dollar terms. Effectiveness is generally measured in “life years.” If the analysis is intended to measure morbidity rather than mortality, an analyst could substitute “life years” with “symptom free years.” The key issue is that all significant consequences must be measurable in the chosen unit. A cost-effectiveness ratio is then calculated (cost per outcome unit) which reveals the amount of resources required to reach one unit of outcome. For allocation policy those ratios are used to compare alternative policy options with similar objectives.\textsuperscript{107}

An example of when a cost-effectiveness analysis would be appropriate is if one were interested in allocating resources towards the prolongation of life after renal failure and wanted to compare the costs and consequences of hospital dialysis versus kidney transplantation. Though the relevant outcome common to both options is life years gained, the two programs would have different success rates in prolonging life and as well as have different costs. In comparing these two options one would calculate the life years gained and compare cost per unit of effect (i.e. cost per life-year gained). Such analysis where costs relate to a single common effect which may differ in measure between various program options is an example of cost-effectiveness analysis.

\textsuperscript{107} Fried, Deber supra, note 65 at 634.
To date, cost-effectiveness analysis has been the most popular type of economic evaluation of health care interventions. Government agencies that have proposed or adopted economic criteria for funding health programs or paying for new drugs seem to favour CEA. Cost-effectiveness analysis requires only that a quantitative measure of health effectiveness, be defined. Typically, effectiveness is measured by life years (LYs).

This analysis can be applied in the context of resource allocation. Given a budget constraint (the macro governmental allocation issue), an explicit outcome such as LYS, and a set of alternative programs, such as treatments, that use resources and contribute to the objective (effectiveness), the optimal resource allocation is to rank order the programs according to their CE ratios and to select them from lowest to highest to the point where the resource budget is depleted. However, this approach treats all LYS equally. A year in a coma would be treated as equivalent to a year in perfect health.

3.3.4 Cost-Utility Analysis (CUA)

Cost-utility analysis is a broader form of analysis than cost-effectiveness analysis but is a version of that general approach. In cost-utility analysis states of health associated with the outcomes are valued relative to one another. This means that one can assess the

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quality of life-years, for example, not being restricted to the purely quantitative numbers of years.

Cost utility analysis establishes a ratio of cost per benefit gained. By translating the benefit gained from a number of health services into a common measure, it organizes them in such a way as to facilitate comparisons in terms of the benefit they deliver per cost. The cost-utility analysis, like the cost-effectiveness analysis, compares the costs and consequences of different health care services or policies. The main innovation of CUA over CEA is that CUA adjusts life years by their "quality." Cost utility analysis adapts the measuring of outcomes in recognition of the fact that life years can be of varying degrees of quality. For example, a symptom-free year would be much preferred to a year of being either comatose or bedridden.110

The cost-utility ratio can be used as a yardstick for measuring the relative priority of health interventions that compete for limited resources. CUA requires the assessment of preferences, or values, attached to various health outcomes. It does this by evaluating outcomes in terms of "utility." These are usually measured as Quality Adjusted Life Years (QALYs); results are rendered as the cost in dollars per QALY. The QALY is intended to represent both the quantity, or mortality, and quality, or morbidity, of various health outcomes.111

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110 Fried, Deber supra, note 65.
The QALY tries to assess health care outcomes according to a generic scale. It determines the extent to which and the length for which a treatment improves the quality of a patient’s life. For this model there is a sliding scale on which the best outcome (usually perfect health) is scored as 1.0 and the worst outcome (usually death) is scored as 0, with other health outcomes falling between these values. Therefore, if the improvement in health after treatment is both significant and long-lasting, the patient earns units and scores high on both the quantity and quality of life. If the treatment is comparatively inexpensive, then the cost per unit of quality is low. The model prefers treatments which generate the greatest increase in quality adjusted life years, for the least cost. Conversely, if the cost of medical intervention is high, and the relative improvement in the condition of the patient is small, or capable of being enjoyed for a short period of time only, then the cost per QALY will be comparatively high.

Accordingly, the funding of health care services or health policies which produce the largest number of QALYs will be those which spend money most efficiently.\textsuperscript{112} Health service managers claim to be interested in applying the QALY analysis.\textsuperscript{113} They generally take a "cutoff" and assume that anything whose cost/QALY is less than that should be done.


An example of a cost-utility analysis is that by Oldridge et al.\textsuperscript{114} which examined a formal post-myocardial infarction rehabilitation program.

3.4 The Virtues of Economic Analysis

Health care resources such as money, people, time, facilities, equipment and knowledge are scarce. Choices must be made with respect to their allocation. Economic analysis provides a systematic tool for organizing consideration of factors relevant to a decision to commit resources to one use instead of another. It allows for a systematic analysis whereby relevant alternatives can be clearly identified. For example in deciding whether or not to introduce a new acute care program, economic analysis would involve describing existing options, an alternative program or option to which the new proposal would be compared. Depending on the objective of the new program, preventive programs may represent a more efficient use of resources and would be added to the set of programs competing in the evaluation. Drummond et. al. give the example of deciding whether or not to introduce a rehabilitation program in a special center for chronic lung disease. Economic analysis would use the episodic care given by family physicians in their offices as an alternative program to which the new proposal would be compared. If the objective is the reduction of morbidity due to chronic lung disease, then preventive

programs such as the abatement of cigarette smoking to the set of programs competing in the evaluation, may prove to be a more efficient use of resources.\textsuperscript{115}

Without real measurement, decision makers would have little upon which to base judgements about value for money. The real cost of any proposed health care program or service is not the finite number of dollars needed to fund the service but rather the health outcomes achievable in some other program which have been forgone by committing the resources in question to the first program. This "opportunity cost" is what economics attempts to estimate and compare with other allocation options.

3.5 The Drawbacks

3.5.1 Practice

It is important to recognize that although economic evaluation provides important information to decision-makers, it addresses only one dimension of health care program decisions.\textsuperscript{116}


a. Practical Uses

While economic models such as CEA and CUA involve the comparing of two or more treatment or policy options, the allocation of scarce health care dollars sometimes involves the consideration of one program at a time. Freid et al. suggest that because the program is not being compared with other programs, this sort of analysis be best referred to as "cost-outcome studies."

Another practical challenge is in trying to apply economic models of analysis to allocation decisions and specifically determining the value of a technology or health care policy with multiple uses or effects. Because for example a pneumococcal vaccine could provide immunity against several of the pneumococcal diseases besides pneumococcal pneumonia, analysis of pneumonia alone overestimates the cost-effectiveness ratio of the vaccine.\textsuperscript{117} If pneumococcal meningitis were included for example, vaccination costs would remain unchanged but costs of treating pneumococcal diseases would fall. mortality would fall, and costs and morbidity from other diseases would barely change. The multiple effects of diagnostic technologies pose an especially great challenge. In conducting a cost effectiveness analysis of a particular technology one evaluates it as compared to an alternative for a specific medical problem. The cost effectiveness of a technology with several possible uses such as a CT scanner, is determined by the range of illnesses for which it is used.\textsuperscript{118}

\textsuperscript{117} OTA 1979c
\textsuperscript{118} Wagner 1979
3.5.2 Theoretical / Ethical

a. Cost-Effectiveness Analysis:

One controversy around the application of CEA is the fact that judgments about the efficacy of a given treatment or health service are generally uncertain. There is often clinical uncertainty about the likely effectiveness of a particular treatment. Statistical data from research and other applications may still be insufficient to accurately predict the effectiveness of treatment for a particular patient or population. While it is possible to state that a given treatment has proven to be effective after it has been successfully used, it is often impossible to accurately predict outcomes when making a funding policy.

The allocation of scarce health care resources to ineffective treatments or services would generally be considered unethical. First, they may actually harm patients, and second, the resources would be wasted rather than allocated in such a way as they could benefit patients. For similar reasons, a treatment or health care service that is more effective is preferable to one that is less effective. Effectiveness, therefore, is a crucial concept in allocating scarce health care resources, and the goal of rejecting ineffective services, or the inappropriate use of otherwise effective services, should be considered prior to the important goal of allocating effective resources equitably (e.g. bone marrow transplants turned out to be an ineffective therapy for breast cancer).
Notwithstanding its popularity, results from CEA are very hard to apply. CE ratios may not be comparable within medical care if the effects differ. Michael Yeo\(^{119}\) holds that the more abstract the measure of comparison, the more questionable the comparison. When the measure is the immediate consequence of alternative treatments for the same condition (e.g., health status of people with end stage renal disease following transplants versus following dialysis), comparing them is similar to comparing apples. However, truly different health consequences (e.g., the proximate outcome of hip replacement and of a coronary by-pass) are "translated" into a common measure of benefit (e.g. lives saved, quality adjusted life years), the comparison may be seen as more problematic.

It is significant to acknowledge that cost effectiveness analysis does not infer or demand any specific philosophy about how priorities should be set. Eddy contends that the weaknesses said to be associated with cost-effectiveness analysis\(^{120}\) should more appropriately be aimed at particular philosophical perspectives. Eddy describes Oregon’s initial philosophical orientation as "medical egalitarianism." This meant that it was equally valuable to avert an invisible or statistical death by a public health measure as it was to avert an extremely publicized death by a heroic high-technology media-pleasing treatment.\(^{121}\) He notes, however, cost effectiveness analysis could be used to support either objective. The policy makers ultimately must decide whether to assign a greater value to preventing visible deaths than statistical deaths. Cost effectiveness analysis per se is not equivalent to utilitarianism, nor is utilitarianism inconsistent with the rule of

\(^{120}\) See D.C. Hadorn “Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue” (1991) 265 JAMA 2218-2225.
rescue. According to utilitarianism, the highest ethical good provides the greatest happiness to the greatest number of people. This is compatible with the vicarious utility (happiness) at the heart of the rule of rescue. The key to using cost effectiveness analysis for allocation policy is to define the measure of benefit in a correct manner.\textsuperscript{122}

Economic analysis is consequentialist but does not specify how the consequences should be evaluated and ranked. As such, it can be compatible with for example classic utilitarianism or egalitarianism, as long as it is possible to compute the "benefit." It is not deontological since it ignores fundamental rights and process.

b. The Attack:

There are three bases of objection to economic analysis. two come from within the consequentialist paradigm and one comes from outside it. The first asks whether or not one can measure benefit accurately. The second asks which rule (i.e. egalitarianism or greatest good for the greatest number) should be used to select from among various allocation options. The third is from outside consequentialism and that is deontology itself.

Analysts have argued that it is unlikely that outcome measures such as QALY’s will be useful for more than providing general support for decisions which have already been made on other grounds.\textsuperscript{123} They focus on the challenge of quantitatively measuring and representing the degree of improvement in a patient’s health after treatment. They argue

it would be difficult to do such an analysis objectively. Illness manifests itself with infinite degrees of severity and, in the same patient, in infinite combinations of diseases. The scale could not be sensitive enough to differentiate for example, between intensive care units for premature babies, hip replacements for those over fifty-five, and a patient with hemophilia complicated by liver disease and blindness.\textsuperscript{124}

While outcome measurements operationalize the concept of health ‘need’ as the ability to benefit from treatment, it is also relevant to consider the broader aspects of ‘need’, where suffering is most severe, or which illnesses are the major causes of death and disease. Newdick gives the example of a young child with cerebral palsy. He refers to the inevitability, of that child needing more expensive treatment than his or her contemporaries, and the fact that both the quality and quantity of his or her life may be more limited. Measured by means of a QALY, the returns on the money invested in that child may be smaller than those achieved by equivalent sums spent on other groups of children in need of care.\textsuperscript{125} One could however, argue that the deontologically based respect for the inherent value of a person would make it unethical to deny the treatment that would assist that child in realizing his or her potential would be unethical. It is clear that the allocation of scarce health care dollars on this basis would not generate the most QALYs and, to that extent, would not be the most efficient, but it might still be consistent with values and goals of most Canadians.

\textsuperscript{123} Newdick - Book supra, note 113 at 26.
\textsuperscript{124} Ibid.
The use of cost per benefit as a prioritization criterion is grounded in a utilitarian philosophy. The key principle, which is most often associated with, but not necessarily implied by, cost-utility analysis, is that resources ought to be allocated so as to maximize utility. "The underlying premise," Weinstein and Stason\textsuperscript{126} argue "is that, for any given level of resources available, society... wishes to maximize the total aggregate health benefits conferred." This utilitarian perspective also justifies Eddy's suggestion that if it is not feasible to fund all effective treatments, "treatments should be given priority according to the amount of benefit they provide for their cost".\textsuperscript{127} QALYs allow us to compare otherwise incommensurate options in terms of costs and benefits, and to this extent at least support the principle of maximizing benefit. If our aim is the maximization of benefit, and if we accept QALYs as our measure of benefit, it is consistent to prefer health services with lower cost per QALY to ones with higher cost per QALY, since they give us "more bang for the buck." If benefit maximization in aggregate is the stated objective of the health care system, prioritizing options on the basis of their relative cost per QALY is a good means to this end.

At this point, it is significant to distinguish benefit measured in terms of individual preferences and benefit measured in terms of social utility. Distributing benefits to individuals based on average measures of what will generate the most benefit according to individual preferences is different from distributing benefits to individuals based on

\textsuperscript{125} Newdick -Book supra note 113 at 27.


calculations of what will generate the most benefit to society as a whole. For example, QALYs do not factor in benefits and harms to family members and to society in general when assigning to individuals. Kuhse and Singer argue that "...how much it costs to add one quality-adjusted life year to a patient's life takes no account of the impact on others affected by the treatment. Since most of us have ties with family and friends, any treatment that prolongs life or improves the quality of life will have some impact on others."^{128}

While Weinstein and Stason's assertion that society "wishes to maximize the total aggregate health benefits." is compelling, this is not the only thing that society wishes. Equality and meeting needs, for example, are also highly valued in our society. In terms of these values, it is relevant how benefits are distributed, or, as Veatch puts it, "it matters who is helped and harmed."^{129} Therefore an objection to using cost per benefit as the criterion for making allocation decisions is the same one that was made in the last chapter against utilitarianism, which is that it tends to neglect "the distribution of benefits and costs."^{130}

An important issue from a resource allocation or health policy perspective is that economic analysis does not usually address the importance of the distribution of costs and

consequences among various patient or population groups. In many cases, the identity of
the recipient group may be significant for assessing the desirability of a service or
program. It may be significant to know if resources are being allocated to the poor, the
aged, working mothers or geographically remote communities. This may reflect the
purpose of the policy in the first place.

The simple aggregation of QALYs in a cost-utility analysis implied that QALY is being
valued the same no matter whom it refers to. Therefore, when applied to policy
formation it is difficult to divorce equity considerations from the economic evaluation.
Decision makers must be aware of this when selecting a particular analytic technique.

It has been suggested that QALYs discriminate against the elderly, since the evaluation of
the potential number of "quality years" which could be gained for this population would
be lower than the average. It has been argued that QALYs may vary depending on the
criteria used (e.g., how health states are described, how outcomes are reported, etc.) and
that they do not consider the therapeutic benefits of less tangible provider activities (e.g.,
talking with patients). 133

131 Drummond supra, note 96 at 44.
132 See P. A. Singer et al., "Double Jeopardy and the Use of QALYs in Health Care Allocation" (1995) 21
J. Medical Ethics 144.
c. Conflicts Between Equality and Efficiency:

A challenge facing policy makers is the multi-disciplinary approach to allocation decisions. Economic criteria are not the only criteria for judging the distribution of resources. Many jurisdictions have formal mandates requiring that health care be distributed fairly or equitably.134 "It is important to keep in mind... that equity is the goal for all sides in a distributive conflict; the conflict comes over how the sides envision the distribution of whatever is at issue."135

Challenges pertaining to equality are relevant to even the most basic discussions of efficiency.136 Simply eliminating the waste in the current health system will not by itself attend to this second challenge, which questions the extent to which the current system is addressing equally the health needs of all Canadians.

Another aspect of efficiency is its focus on preventing rather than curing illnesses. The rationale here is that less resources are consumed in preventing illness than are required to treat it. To the extent that people with the least financial resources are also among the sickest, this is a second significant aspect of health reform where issues of equality and efficiency may be at the fore. The accuracy of this argument rests on whether or not the

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135 Stone supra, note 2 at 39.
health status of those with few economic resources are linked to social conditions that are outside the reach or mandate of the health system. The extent to which the health care system should be responsible for the fact that certain low paying jobs, for example, are bad for people's health is unclear.

Efficient policies such as, for example, offering hip surgery to those younger than seventy-five but not to those over seventy-five, would not qualify as equal treatment for younger and older people. It might more appropriately be called ageist.

The tension in allocation policy intensified by research indicating that those persons with less financial resources are more likely be faced with more serious medical illnesses than persons with more financial resources and with less financial means to lobby government to assure that these needs are met.

The final challenge of efficiency to be discussed here is raised by reforms to the health system that reduce the cost to governments of funding health care services, but increase the cost to the public of these services in either time or money. A common example of this sort of a reform is shortened hospital stays, which are less expensive for hospitals and therefore less expensive for the government. The cost to the affected public is greater where they are paying for home care or depending on the time and energy of family

members or friends. In making funding policy we must be aware that such reforms transfer the cost from the citizen as taxpayer to the citizen as consumer of health services.

3.5.3 Application of Economic Analysis in Health Allocation Policy

a. Short Case Examples:

One of the aims of economic analysis applied to health care is to illustrate how to maximize health benefits within a limited health care budget.

(1) In a 1996 study conducted by members of the Massachusetts Medical Society, prospective jurors, medical ethicists, and experts in medical decision making were asked to choose between two screening tests for a population at low risk for colon cancer.\(^{137}\)

One test was more effective than the other but because of budget constraints was too costly to be provided to the entire population. By using the more effective test for only half the population, 1100 lives could be saved at the same cost as that of saving 1000 lives by using the less effective test for the entire population.

Fifty-six percent of the prospective jurors, fifty-three percent of the medical ethicists and forty-one percent of the experts in medical decision making recommended offering the less effective screening to the entire population, even though 100 more lives would be saved by offering the more expensive test to only part of the population. Most of the

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participants in this research study justified this position on the basis of equity. A smaller number stated either that it was not politically feasible to offer a test to only half the population or that the increased benefit of the more expensive test (100 more lives saved) was too small to justify offering it to only a portion of the public.

This case example suggests that people value equity perhaps even more than cost-effectiveness analysis. Even many experts in medical decision making, many of whom routinely conduct cost-effectiveness analysis, stated discomfort with some of its implications. Basing health care priorities on cost-effectiveness may not be possible without incorporating explicit considerations of equity into cost-effectiveness analysis or the process used to develop health care policies on the basis of such analyses.

(2) In his book *The Economy of the Earth*, Mark Sagoff described a conference he attended regarding Lewiston New York, the site of the Lake Ontario Ordinance Works, where the U.S. federal government years ago disposed of residues from the Manhattan project. Residents said that these buried radioactive wastes cause radon gas to blow through the town. Several parents at the conference described their terror of learning that cases of leukemia had been found among area children. Government officials from New York State as well as local corporations argued that the fears were unwarranted. They responded that people who smoke, drink alcohol or cross the street take greater risks than people who live near waste disposal sites. He argued that the waste facility brought enough income and employment to the town to compensate for any hazards the residents might face. Residents were not comforted by the willingness of politicians to pay for
safety, or their risk-benefits analysis. The residents did not care about the technical economic theory. They focused on ethical questions, the manipulation and the distribution of power in society, not the abstract reciting of benefits and costs.\textsuperscript{138}

b. The Oregon Plan

This section describes some of the insights we can gain from Oregon’s experience using economic analysis to help make allocation policy.\textsuperscript{139} An application of the greatest good for the greatest number of patients was proposed in Oregon, USA. The Oregon initial ranking system was “The first large scale public attempt to set priorities for medical services”.\textsuperscript{140} The Oregon Health Decisions program was created in 1982, to enhance public awareness and establish consensus on bioethical issues such as (1) the relative priority to be given to curative versus preventive medical services and (2) the ways in which values could influence a policy of rationing such health care services. There was extensive consultation on these issues, by way of public meetings, telephone polls, and three “Citizens Health Care Parliaments.” Participants were invited to list the values that are most significant for health care. Prevention and quality of life received the highest ratings.\textsuperscript{141}

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{138} Mark Sagoff, \textit{The Economy of the Earth: Philosophy, Law and the Environment} (Melbourne, Australia: Cambridge University Press, 1988) at 24.
\end{enumerate}
\end{footnotesize}
In 1989, Oregon adopted the Basic Health Services Act, which applied the results of the consultation process to the allocation of public health care resources. The act was intended to assure universal access to basic medical care for all currently uninsured Oregon residents, while in recognition of economic constraints restricting insured services to what the State felt it could afford to provide. To meet this goal, the Oregon Health Services Commission classified all medical services into three categories: essential, very important and valuable to certain individuals and then ranked those within each category. Each of these services was to be costed, and then a cutoff point within this list was determined which was contingent upon funds allocated to the program in any given year. All citizens would have access to these services, but those who could afford supplementary insurance coverage or who could pay their own medical bills, would still be able to secure supplementary health care services.

The Oregon plan has received substantial criticism, for focusing health care rationing on poor people.142 Supporters of the plan have argued that most poor people in Oregon would have better access to health care services under this plan than without it, and that it was hoped that the plan would eventually evolve into a system of setting priorities for health services for the vast majority of Oregon’s citizens.143

143 C.J. Dougherty “Setting Health Care Priorities: Oregon’s Next Steps” (1991) 21(3) Hastings Center Report at 1-10. The plan did not satisfy legal requirements and it is currently under revision. See next chapter for discussion of legal deficiencies.
An important contribution from Oregon is that it established an open and explicit process for addressing the state's health care needs (as opposed to the needs of each individual). David Eddy explains that this significance extends beyond the immediate goals of the Basic Health Services Act. It gives a framework and orderly process for review, debate, and resolution.\textsuperscript{144} The Oregon plan reflected the importance of making allocation decisions, and balancing public and private interests through the political process. Daniel Callahan explains that "only by submitting technical considerations and moral evaluations to a decent political process will anyone get a chance to see their values reflected in a basic health care package."\textsuperscript{145}

Of particular interest to those concerned with Canadian allocation policy is the plan's explicit list of services that were, and were not to be accessible, and in the public consultation process to the current policy making system where the average citizen has barely any input into significant decision making.

The Oregon plan was originally intended to use a form of cost-effectiveness analysis during the early 1990's. With data collected through a telephone survey, the state asked people to rank various functional limitations and other symptoms on a quality-of-life scale. This was intended to determine a quality-of-life score and cost figure for every health-related intervention so that these interventions could be prioritized for budgetary


\textsuperscript{145} D. Callahan, "What is a Reasonable Demand on Health care Resources: Designing a Basic Package of Benefits" (1992) 8 Jnl of Contemporary Health Law and Policy 1.
purposes. Reliable cost data ended up being extremely difficult to ascertain, and so the quality-of-life data was used basically to identify which interventions resulted in the most benefit, irrespective of costs.\textsuperscript{146} In the end, certain rankings had to be altered. The state recognized that interventions producing minimal health benefits, if inexpensive enough could rank higher than much more beneficial interventions.

As the Oregon Health Services Commission concluded, the first formula used to rank its priorities was too blunt an instrument.\textsuperscript{147} There were several technical challenges that led it to produce counterintuitive results and its ineffectiveness can be explained irrespective of the use of cost effectiveness analysis. There is nothing inherent in cost effectiveness analysis that precludes it from being used as one factor in a priority setting exercise such as the Oregon Plan.

\subsection*{3.6 Conclusion}

In determining the moral significance of economic analysis in resource allocation policy formation, one must appreciate the context in which such analysis is being pursued. In Canada this means examining it in the context of aiming for more responsible decision making and as one of numerous significant factors relevant to such policy formation. The merit of economic analysis in making resource allocation decisions should be assessed keeping in mind our current focus on getting good value for our money. Weinstein and

\footnote{\textsuperscript{146} Michael J. Garland, "Justice, Politics and Community: Expanding Access and Rationing Health Services in Oregon" (1992) 20 (1) Law, Medicine and Health Care 2 at 67-81.}
Stason summarized the options well: "[R]esource allocation decisions do have to be made, and the choice is often between relying upon responsible analysis, with all its imperfections, and no analysis at all. The former, in these times of increasingly complex decisions, difficult trade-offs and limited resources, is by far the preferred choice." ¹⁴⁸ In response to the claim that each of the models of economic analysis discussed in this chapter is technically and ethically flawed, one must acknowledge that the current policy process or status quo is imperfect as well.

The options Weinstein and Stason present do not reflect merely two groups of ethical principles but rather represent a choice between principle-driven decision making and decision making driven by an ad hoc group of factors, many of which are also controversial on moral grounds. Examples of these would include political considerations such as calming of the public following media-generated frenzy about individual cases, competition between hospitals, catering to the "squeaky wheel", aggressive lobbying and marketing by pharmaceutical and medical equipment manufacturers, attitudes of some providers focused on preserving their power and income, and a technological imperative according to which progress in health care is regarded as the development of new technologies.

While economic consequentialist analysis may not be a sufficient basis for priority setting decisions this does not however mean that the sort of analysis that such models strive for

¹⁴⁷ Ibid.
is inherently flawed. Economic evaluation provides some of the information necessary to making priority setting decisions in Canada. While it is clear that these tools will continue to be refined well into the future, currently, judgment must be made as to whether the insights from welfare economics, QALY indicators, CEA etc. are beneficial as they stand for the purpose of making allocation decisions. Economic analysis is useful even if it cannot protect us from difficult decisions and human judgment. Health economics can be used to provide further insight into issues where thus far only qualitative judgments could be made and to clarify complex issues so as to aid the judgment of decision makers.

Even with its limitations economic analysis can be a useful guide to allocation decisions. As a transparent, verifiable exposition of cost and clinical effectiveness, health economics is an important tool of evaluation that should be accessible to as wide an audience as possible. While having the relevant information is necessary for making responsible decisions, it is not sufficient. When all the relevant information has been considered the moral questions will still remain to be addressed. Health economics will not provide the answers to how society should allocate health care resources, it will not provide information which can help identify the tradeoffs associated with different decisions, it will not be a substitute for careful judgment and wisdom. It will however, be a useful aid. It offers the potential of introducing improved degrees of accountability, reliability

and comparability into health care decision-making specifically, and social and public policy more generally.

Other important public values cannot be incorporated into economic analysis. This reflects the fact that health allocation strategies affect things other than health. For example, society’s value on individuals’ rights can affect the desirability of some health interventions: the right to privacy has made mandatory human immunodeficiency virus (HIV) testing unacceptable outside of special situations such as the military, even though life-threatening treatments are available for individuals diagnosed early. Allocation policy in the real world of Canadian health care is complex. Economic analysis provides relevant information about tradeoffs in the allocation of health care resources, but other factors warrant consideration as well;\textsuperscript{149} concepts of fairness and justice are not fully reflected in economic calculations. Thus the measures of health outcomes using economic analysis remain an incomplete representation of societal goals and values. While the information economic analysis provides may be crucial to good allocation decisions, it is not a complete decision making system. While medical necessity, medical benefit and other economic models do not give us a decision making formula for resolving distributive dilemmas, economics provides us with information relevant to policy formation.
3.6.1 Looking to the Law

Gold et al. make the important point that there are limitations to all forms of economic analyses. They explain that resource allocation decisions should never be made by the technical ranking of economic ratios. These ratios reflect information about one type of "value": health benefit per allocated dollar. Society has other values such as considerations of distributive justice and fairness discussed in Chapter one, which require that economic analysis be regarded as a tool for informing allocation decisions rather than the decision maker itself.150 Recognizing the value of economic analysis does not imply that distributional concerns are less important than efficiency considerations.151

"[E]conomics has relatively little value in terms of formulating social objectives, it has greater legitimacy as a tool of design."152 Many Canadian social objectives are expressed in the law and the next chapter examines the consistency of economic analysis with these legally entrenched social objectives. While it makes sense to try to achieve health care objectives in the most efficient way possible (using fewer resources lets us fund more health care services and other social objectives) is there a point at which allocation policies must pass on efficiency in favour of justice?

Justice cannot be ignored as a goal for the Canadian health care system. If justice is disregarded, it will cost the system in other ways. The goal must not be to focus only on

150 Gold et al. supra, note 81 at Introduction.
151 Flood, supra, note 11 at Chapter 2.
152 Ibid.
the economic bottom line but to create a system that allocates resources as efficiently as possible while satisfying its collective vision of justice.

As Menzel has argued "the first and most important standard that a health care system’s resource policies should meet is accurate reflection of patients’ actual or presumed prior consent to limiting care in specific ways in order to retain resources for other more valuable things in their lives. In that way the rationing of health care can be made consistent with complete respect for most patients as persons even when it disadvantages them in their particular situations." As Raisa Deber has explained "economics can give us extraordinarily useful tools to analyze the best way of allocating scarce resources to achieve a given goal...Economics can’t tell us what goals are important." The making of allocation decisions would be served in many cases if the decisive tradeoffs between health and other goals were more explicitly identified. The next chapter highlights where deontologically based values entrenched in Canadian law conflict with consequentialist values expressed in economics.

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4. Law

4.1 Introduction

The goal of containing health care costs within acceptable boundaries cannot be achieved by an economic approach alone. Economics offers numerous models by which health care dollars can be allocated more efficiently, or in more cost-effective, cost-beneficial or cost minimizing ways. Before implementing allocation policies based on these principles, the significance of adopting any one of these models must first be examined in the context of legally entrenched values. To the extent that the focus on economic principles conflicts with legally entrenched values, efforts must be made to balance the need to allocate efficiency with the values of humanity and justice entrenched in Canadian law.

A single focus on efficiency has the potential to compromise the goals of the Canadian health care system reflected in the Canada Health Act, and breach the Canadian Charter of Rights and Freedoms' right to equality. The Canadian health care system is based on the value that all people are entitled to reasonable access to quality medically necessary services. Legal analysis will allow politicians and those who struggle with priority setting of health care services to understand priority setting within a frame of legally defined social acceptability and justice. In spite of government efforts to allocate resources in accordance with the economic principle of efficiency, Canadians still regard health care as something distinct from ordinary commercial goods. All Canadians have

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156 While further discussion of a philosophical right to health care services is beyond the scope of this thesis the following are scholars who have argued for the primacy of health care among social values based on its
a genuine interest in allocation decisions that are economically sound and balanced against the values our society protects through the law. Fair access to medical care services is used as a rough proxy for access to health.\textsuperscript{157} Even in a time of cost constraints, allocating health care resources involves several goals beyond those of economic efficiency.

Sunstein has described the role of "incompletely theorized agreements"\textsuperscript{158} in law. This is where people agree on general principles without agreeing on what the principles will entail in particular cases. He has explained that "while we agree that murder is wrong, we disagree on whether abortion is wrong. We favo[u]r racial equality, but are divided on affirmative action".\textsuperscript{159} A similar description can be made of the principles we bring to resource allocation. While we value equality and efficiency we disagree on the primacy of efficiency should take in policy formation.

4.1.1 Purpose and Summary of Chapter:
\textsuperscript{157} See Flood supra, note 11.
\textsuperscript{158} Cass R. Sunstein, Legal Reasoning and Political Conflict (New York: Oxford University Press, 1996) at 35. [hereinafter Sunstein]
\textsuperscript{159} Ibid at 15.
making allocation policy decisions focused on financial considerations, using such principles. This chapter focuses on the point at which the two goals of efficiency and legally recognized equality rights, challenge or even conflict with each other, the legal theory behind the values at issue and potentially at stake in resource allocation and areas of potential legal reconciliation. This chapter highlights the points at which principles such as efficiency come head to head with legal principles of comprehensiveness, accessibility and of course equality and ways in which section 1 of the Charter and the law around discretion can accommodate some economic analysis.

Section 4.1.2 of this chapter introduces the significance of legal analysis in the context of resource allocation. Section 4.2 explores government jurisdiction over health care through a discussion of division of powers. Section 4.3 outlines the statutory foundation of the Canadian health care system. Section 4.4 analyzes the Canada Health Act (CHA), focusing on those provisions most relevant to resource allocation. Section 4.5 brings insights from administrative law to the balancing of law and economics in allocating health care resources. It highlights the doctrines of legitimate expectations, public interest standing and discretion. Section 4.6 is an analysis of specific sections of the of Canadian Charter of Rights and Freedoms (Charter): section 15 (posing the greatest challenge to economic argumentation) section 1 (most accommodating to economic argumentation), and section 24 (as the range of possible remedies for breaches of Charter rights).

160 Canada Health Act, R.S.C. 1985, c.6. [hereinafter CHA]
In 4.7 the chapter concludes that while there are several examples of Canadian law that are inconsistent with strict adherence to economic strategies, there are many examples in which the law can and does accommodate economic principles as well. Determinations of efficiency do not determine the assignment of legal rights.\textsuperscript{162} The determination of a particular efficiency solution involves a normative and selective choice as to whose interests will be accommodated, who will realize gains and who will realize losses.\textsuperscript{163} It is an expression of policy either consistent or inconsistent with legally entrenched rights.

\subsection*{4.1.2 Legal Analysis in Context}

The principles of common or statutory law do not have any problem per se with cost saving, efficiency, or effectiveness. It is only at the level of discrimination, access to justice, or unmet expectations that the law is triggered. The essence of the legal standard, or the round hole in the title of this thesis, is a review process where government political allocation policies are evaluated against broad principles of justice. Though law and politics both affect the allocation of health care resources, the relationship is a hierarchical one. The rules of constitutional law are the ultimate criteria of what

\textsuperscript{161} \textit{Canadian Charter of Rights and Freedoms} is Part I of The Constitution Act 1982, Schedule B of the Canada Act 1982, c.11 (U.K.) [hereinafter Charter of Rights]


constitutes legitimate authority, and to that extent politics is subordinate to the law.\textsuperscript{164} Were this not so, it would allow those entrusted with developing the rules and regulations governing the distribution of health care resources to exercise coercive powers of the state inconsistently and out of proportion to legally entrenched Canadian values.\textsuperscript{165}

The discourse of constitutional analysis with respect to allocation policy rather than focusing exclusively on individual rights, includes principles of justice, political accountability and social obligation.\textsuperscript{166} The role of constitutional law is to resolve disputes about how the powers of the state should be applied. The rules of administrative and constitutional law are what judges have resort to when adjudicating the competing claims of government and citizens over the legitimacy of specific allocation policies. Canadian case law\textsuperscript{167} demonstrates that a court can assess a complex body of evidence to determine whether or not provincial governments are meeting their commitment to provide reasonably accessible services to the public. As Choudhry has stated, "[t]he question is not one of competence, but of judicial will."\textsuperscript{168}

\textsuperscript{164} See David Beatty, \textit{Constitutional Law in Theory and Practice} (Toronto: University of Toronto Press, 1995) at 156. [hereinafter Beatty]
\textsuperscript{165} See generally Beatty ibid at 164.
\textsuperscript{166} See Beatty supra, note 164 at 160.
\textsuperscript{168} S. Choudhry, "Enforcement of the Canada Health Act" (1996) 41 McGill Law Journal 462 at 491. [hereinafter Choudhry]
4.2 The Division of Power - Government Authority Over Health Issues

The Canadian constitution divides power between the federal and provincial governments. Each level of government has distinct legitimate areas of authority. The constitution and subsequent judicial interpretation assign issues of national relevance to the federal government and matters of local relevance to the provincial government. If a government’s action exceeds its constitutionally specified sphere of responsibility that action can be challenged in court. Legislation held to be unconstitutional can be struck down.

With the exception of hospitals, which are the responsibility of the provinces by virtue of s.92(7) of the Constitution Act, health is not a matter assigned solely to one level of government. It is generally agreed, however, that the hospital insurance and Medicare programs in force in Canada come within the exclusive jurisdiction of the provinces under ss.92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature).

The federal government’s constitutional power in matters relating to health care is quite limited. The government’s authority includes among other things, health issues involving

169 Constitution Act, 1867, U.K., 30 & 31 Victoria, c.3. [hereinafter Constitution Act 1867]
a national concern.\textsuperscript{172} The constitution and judicial decisions assign the provinces the majority of the constitutional responsibility for health care.

This has not prevented the federal Parliament from playing a role in the provision of medical care throughout the nation. It has done so by employing its inherent spending power to set national standards for provincial Medicare programs.\textsuperscript{173} While provinces have the legislative right to control most aspects of health care within their borders, the federal government retains some limited legislative authority over health matters with a national dimension or which raise issues of public morality and safety.\textsuperscript{174} In the 1982 case of \textit{R. v. Schneider} Estey J. stated:

\begin{quote}
[H]ealth is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.\textsuperscript{175}
\end{quote}

\subsection*{4.3 Statutory Foundation of the Canadian Health Care System}

The legal foundation of our national health care system is primarily based on two statutes: the \textit{Canada Health and Social Transfer}\textsuperscript{176} and the \textit{Canada Health Act}\textsuperscript{177}

The first is the vehicle through which funds are transferred from the federal government to provinces in support of hospital and medical insurance programs defined by the CHA

\begin{footnotesize}
\begin{enumerate}
\item[172] Tobacco and narcotics control legislation is one example of federal use of this power.
\item[174] Constitution Act, 1867, supra, note 169 sections 91 and 92.
\item[175] Schneider supra, note 170 at 142.
\item[176] \textit{Canada Health and Social Transfer} R.S.C. 1996.
\item[177] CHA supra, note 160.
\end{enumerate}
\end{footnotesize}
(as well as for postsecondary education and the programs formerly funded under the
Canada Assistance Plan. The second, the Canada Health Act (CHA), outlines the
federal/provincial cost-sharing arrangement with respect to health care. It is within the
federal government's discretion whether or not to deduct money from provincial transfer
payments to enforce the five criteria of the Canada Health Act.\textsuperscript{178} Should the government
decide to deduct money, the amount of the deduction is within the discretion of the
Governor General and is what he or she "considers to be appropriate, having regard to the
gravity of the default."\textsuperscript{179} In cases of extra-billing, the Minister of Health must deduct on
a dollar-for-dollar basis from the provincial transfer payments, the amounts paid in the
province as extra-billing or user charges for services that should be freely available in the
public sector.\textsuperscript{180}

The federal government also contributes towards Medicare through tax points transferred
to the provinces. In 1997-1998 this worked out to $12.743 million.\textsuperscript{181} Tax points are
provided by reducing federal income tax rates, thereby allowing provinces to raise
additional revenues without increasing the overall tax burden on Canadians. As a result,
because of the tax points, the financial impact on the provinces from reduced federal
funds is less onerous that it seems if only considering cash contributions. Another effect
of the reduction in cash transfers is to reduce the federal government's ability to enforce
compliance. The government can only withhold cash transfers under the Act, there is no

\textsuperscript{178} CHA supra, note 160 at section 14 and 15.
\textsuperscript{179} CHA supra, note 160 at section 15(1)(a).
\textsuperscript{180} CHA supra, note 160 at s.20.
\textsuperscript{181} Flood supra, note 11 at 25.
provision allowing for the withholding of tax points from provinces not complying with
the five criteria of the CHA.

The result is that provinces are, in theory, free to accept or reject the federal funds.
Therefore, there would be no cause of action under this Act if the province, in
implementing an economically based cost saving scheme, chose not to insure certain
medically necessary services and received less federal money as a result. If they accept
the federal money they are taken to have accepted it subject to the attached federal
stipulations.
What is significant however, is the value Canadians place on access to health care
services according to values entrenched in the CHA and the Charter. Canadian health
economist Robert Evans holds that equality before the healthcare system is as important
to Canadians as is equality before the law.¹⁸²

4.4 The Canada Health Act
4.4.1 Underlying Philosophy
Canada does not have one single-payer publicly funded health care system. Its health
care system is rather made up of ten provincial and two territorial health insurance
systems that are linked through the binding national requirements delineated in the CHA
to secure federal funding. The underlying philosophy of the CHA is that all residents are

¹⁸² See Robert G. Evans, "‘We’ll Take Care of It for You’: Health Care in the Canadian Community" (1988) 117:4 Daedalus 155 at 165.
entitled to reasonable access to medically necessary health services. Medically necessary services\textsuperscript{183} are provided based on people's medical need and not ability to pay. "Medically necessary" is not a term defined in the CHA. Through the tax system, individuals prepay for medical services. The criteria of the CHA are framed in wide terms and are intended to establish broad norms of social justice. For example, section 3 states:

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

The preamble to the CHA is equally explicit that "continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians." \textsuperscript{184}

\textbf{4.4.2 Weakness: Clarity and Enforcement}

While the goals of the Act are clear and are reflected in the five criteria of comprehensiveness, accessibility, universality, portability, and public administration, these criteria are problematic.\textsuperscript{185} First, they are undefined and their ambiguity allows them to be used by different people to mean radically different things. Second, these legal norms are extremely difficult for a private citizen to enforce, even when a provincial

\textsuperscript{183} See T. Caulfield, "Wishful Thinking: Defining 'Medically Necessary' in Canada" (1996) 4 Health L.J. 63.

\textsuperscript{184} CHA supra, note 160 at Preamble.

plan fails to meet each of these criteria and is in breach of the CHA. By way of remedy, the Act specifies that the federal government can withhold or deduct cash transfer payments from any province that does not comply with the five federal conditions, after consulting with the offending province. While judgments about compliance with some of the conditions are discretionary, there is an automatic requirement of dollar-for-dollar reductions in the federal cash contributions for extra-billing or user charges. The Act does not itself suggest that individuals can either enforce its protections or claim compensation if their province fails to supply comprehensive, reasonably accessible, medically necessary services. Although it is difficult to enforce the CHA, the requirements contained in it may be sufficiently powerful to force political action resulting from public discontentment when the priority given to cost minimization seems to overshadow the principles specified in the Act.

4.4.3 Statutory Provisions

The CHA sets out the terms and conditions according to which provinces must provide reasonable access to medical services before they qualify for full federal payments under the federal/provincial cost sharing program established for health care in Canada.

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

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186 See Choudhry supra, note 168.
187 Other possible challenges may be available. Citizens may invoke the Charter or administrative law principles in some cases. There may be a claim for unjust enrichment under private law if it can be shown that the province is receiving an improper benefit when its residents are forced to individually bear the costs of their medical treatment.
(a) public administration;
(b) comprehensiveness;
(c) universality
(d) portability; and
(e) accessibility.\(^{188}\)

A provincial plan which fails to meet even one of these criteria is in breach of the CHA. While theoretically these criteria are independent and cumulative, in practice the combination of legislative goals and vaguely framed criteria results in considerable overlap. Because of this overlap, a purposive and contextual interpretation emphasizes that certain types of provincial conduct may contravene more than one criterion and therefore breach more than one section. Because none of the five criteria is clearly or unambiguously defined in the Act, each criterion must be interpreted according to the natural and ordinary meaning of the words used, the presumed intention of the legislators, and a purposive interpretation which is consistent with the other sections of the Act. Therefore, whether a provincial allocation plan contravenes the CHA will depend primarily upon the interpretation of these criteria.

a. Comprehensiveness:

Section 9 of the Act\(^{189}\) states that, to be comprehensive, a province’s health care insurance plan must cover all “insured health services”\(^{190}\) provided by hospital and medical

\(^{188}\) CHA supra, note 160 at s.7.
\(^{189}\) s.9 “In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.” (1984, c.6. s.9).
\(^{190}\) s.2 of the Canada Health Act (1984, c.6) defines “insured health services” as “hospital services, physician services and surgical-dental services provided to insured persons…”
practitioners. This important term refers to those hospital services and physician services provided to insured persons, who are defined as residents. ¹⁹¹ "Physician services are defined in the Act as "any medically required services rendered by medical practitioners."

There are at least two ways of interpreting the ambiguity resulting from "medically necessary" and "medically required" not defined in the Act. The first interpretation of "comprehensiveness" grants the province the latitude to exclude many services. In deference to provincial jurisdiction over local matters, "insured health services" may mean only those services which have been formally designated as such by the province. According to this argument, there is no normative content to the term "insured health services" and the province must only insure the medical services it actually decides to insure for its residents. The concept of "insured health services" becomes the federal concept that individual provinces are free to define as they see fit. This interpretation is a weak one because, if accepted, no provincial system could be anything but "comprehensive." ¹⁹² If the province need only insure the services it has decided to

¹⁹¹ S.2 continues to state: "hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely, (a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required, (b) nursing services, (c) laboratory, radiological and other diagnostic procedures together with the necessary interpretations, (d) drugs, biologicals and related preparations when administered in the hospital, (e) use of operating room, case room and anesthetic facilities, including necessary equipment and supplies, (f) medical and surgical equipment and supplies, (g) use of radiotherapy facilities, (h) use of physiotherapy facilities, and (i) services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

¹⁹² The restriction to care provided in hospitals and by doctors is significantly outdated. Modern technology allows much care to be "provided in community or home settings and to be delivered by nonphysicians" R. Deber, L. Narine, P. Baranek, N. Sharpe, K. M. Duvalko, R. Zlotnik Shaul, P. Coyte, G. Pink, A.P.
insure, then its system could never be underinclusive. An alternative interpretation must be sought because this one tends to make the words superfluous, or meaningless.

A second interpretation is that comprehensive coverage requires some basic level of services. It seems that only when comprehensiveness has such a normative content are the health needs satisfied and the goal of universally accessible medical services achieved. This approach to comprehensiveness is consistent with Emmett Hall’s Health Charter for Canadians and the report of the Royal Commission on Health Services. Both of these documents helped lay the foundation for our current national health care system and the criteria enunciated in the CHA. In the “Health Charter” “comprehensiveness” was defined to mean “all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide.”

Similarly, the Royal Commission thought the following types of programs would be required in a comprehensive system: medical services, dental services for children and expectant mothers and public assistance recipients, prescription drugs services, optical services for children and public assistance recipients, prosthetic services, home-care services, and mental-health services.

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195 See M.G. Taylor, Health Insurance and Canadian Public Policy - the Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes 2nd ed. (Kingston: McGill - Queen’s University Press, 1987).
Emmett Hall’s 1980 national study on the health care system concluded that extra-billing by physicians violated this criterion because “[a] program whose benefits do not meet the full costs of the services provided can in no way be considered comprehensive...”\(^{197}\) This conclusion also suggests that comprehensiveness requires provinces to insure more than what they have decided to pay for.

That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of health sciences available to all our residents without hindrance of any kind.\(^{198}\)

An interpretation which ensures that at least the basic requirements of the person in need are satisfied is consistent with the principle that a court, faced with general language or contending interpretation arising from ambiguous statutory language, should adopt an interpretation which best assured adequacy of assistance.\(^{199}\) In *Kerr v. Metropolitan Toronto (Departments of Social Services, General Managers)*,\(^{200}\) the Ontario Court (General Division), Divisional Court said: “The price of ambiguity in a social welfare statute is that the ambiguity will be resolved in favour of the applicant.”\(^{201}\)

In the United States, courts have adopted the same principle. In *Brown v. Bates*,\(^{202}\) it was stated that:

> The Court does not believe Congress chose by enactment of the Work-Study program to draw the cycle of poverty tighter, but rather was attempting to break

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\(^{196}\) Health Charter supra, note 194 at 11.

\(^{197}\) E.M. Hall, *Canada’s National-Provincial Health Program for the 1980’s* (Ottawa Health and Welfare Canada, 1980) at 41. Medicare was in place from 1971; this was an assessment which basically argued that the unfinished business from the first Hall report needed attention.

\(^{198}\) Royal Commission supra, note 195 at 10.

\(^{199}\) In the context of this discussion “assistance” is analogous to “health care.”

\(^{200}\) *Kerr v. Metropolitan Toronto (Departments of Social Services, General Managers)* (1991), 4 O.R. (3d) 430 (D.C.).

\(^{201}\) Ibid. at 445.

its bonds upon untrained poor. The Court will not allow the defendants to defeat this beneficent purpose by their own interpretation of the law, especially when that interpretation, however faithful it may be to the letter of the law, totally defeats the spirit of the law, and services only a sterile administrative purpose.\textsuperscript{203}

The implication of \textit{Canada (Minister of Finance) v. Finlay (no.3)}\textsuperscript{204} is that there must be a minimum content to provincial plans for federal schemes such as the Canada Assistance Plan (and, it has been argued, the CHA\textsuperscript{205}) to be effective. Failing to give meaning to the requirement of comprehensiveness would defeat the whole point of Medicare.

The case law supports an evaluation of allocation policy which considers (1) the importance of the service to the people who require it and (2) the consequences of de-insuring the service on both its availability and the burden imposed on those people who will be forced to pay for it.

\textbf{b. Accessibility:}

The CHA's criterion of accessibility focuses on how services must be provided. In some cases there is significant overlap between the criteria of comprehensiveness and accessibility because, an uninsured medical service is inaccessible to those who cannot afford to pay for it. Section 12(1) of the Act outlines the criteria for accessibility:

\begin{quote}
12(1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province
\end{quote}

\textsuperscript{203} Ibid. at 902-3.
\textsuperscript{204} \textit{Canada (Minister of Finance) v. Finlay (no.3)}, [1993] 1 S.C.R. 1080.
\textsuperscript{205} Choudhry supra, note 168 at.
(a) must provide insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
(c) must provide for reasonable compensation for all insured health services [defined as being in hospitals or by doctors] rendered by medical practitioners or dentists [in patient surgical dental services only, 99% of dental services are private]; and
(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

It could be argued that reasonable access implies an absence of financial, geographical, and regulatory barriers. To the extent that the CHA is Canada’s “charter of health rights”. this provision may be seen as its guarantee of equality and non-discrimination.

Therefore, it can be expected to raise issues of approach and interpretation similar to those which arise under section 15 of the Charter.

There are two aspects to subsection 12(1)(a) of the Act: first, the provincial plan must provide the insured health services according to uniform terms and condition: second the province cannot use its powers over health care to impede or preclude reasonable access to medically necessary services. In relation to the first, how the term “uniform” is defined and the choice of which insured health services must be uniformly available determines the content and extent of this protection.

In the Concise Oxford Dictionary, “uniform” is alternatively defined to mean not changing in form or character, constant, conforming to some standard of rules or
pattern. Hypothetically, an approach to “uniformity” based on complete conformity would merely seem to require formally identical treatment. Accordingly, as long as each insured service is available on the same terms and conditions the section would not be breached. For example, a provincial law requiring either the approval of a second physician for all abortions or that all abortions be performed in a hospital would meet the requirement of accessibility as long as there was conformity within the designated class, i.e. that all abortions were available on identical terms. Under this approach, there would be no comparison outside the category of the procedure involved and no inquiry into the impact of the requirements imposed. If this is all the requirement of uniform terms and conditions means, then the criteria of accessibility would only operate to prevent the most blatant examples of different treatment, such as one rule for men and one rule for women or variable terms and conditions for those in urban and rural cases.

The Supreme Court’s recognition that true equality may require more than formally identical treatment supports a larger and more liberal interpretation of the concept of uniformity. A reasonable reading of “uniformity” would require the similar treatment of like medical procedures or the more result-oriented standard of an equal availability of medically necessary services. As many commentators and courts have cautioned, restricting equality to formally identical treatment often reinforces existing inequities.

A gender-neutral interpretation may actually interfere with the goal of quality health care

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for all if it does not accommodate the unique health care needs of different health care consumers.

c. Public Administration, Universality and Portability:

The remaining criteria of public administration, universality, and portability contained in sections 8, 10 and 11 respectively of the CHA may also serve as a source of restriction to those making allocation decisions. The "universal" coverage protected in section 10 of the Act was defined by the Royal Commission in 1964 to mean "that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic

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209 In order to satisfy the criterion respecting public administration, (a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province; (b) the public authority must be responsible to the provincial government for that administration and operation; and (c) the public authority must be subject to audit of its accounts and financial transactions by such authority as it is charged by law with the audit of the accounts of the province.” (1985, c.6 s.8).
210 In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.” (1985, c.6, s.10).
211 In order to satisfy the criterion respecting portability, the health care insurance plan of a province (a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services; (b) must provide for and be administered and operated so as to provide for the payments of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that (i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or (ii) where the insured health services are provided in Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and (iii) must provide for an be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reasons of
Inconsistent provincial access falling below what can reasonably be deemed medically necessary may therefore infringe this principle. Variable provincial tariffs and the rate at which one province will pay for services performed in another province may also raise issues concerning the criterion of portability.

4.5 Some Insights from Administrative Law

4.5.1 Doctrine of Legitimate Expectation and the Route to Judicial Review

Administrative law addresses limitations on government action that affect individual entitlements. While it is related to constitutional law, constitutional law looks at the course of governments' legislative authority, and administrative law examines the granting of power within the legislation itself. Administrative law is concerned with both substance and process.

A claimant may challenge government funding policies by alleging that he or she was not accorded procedural fairness. The duty of procedural fairness applies to allocation decisions. The fact that a funding decision is administrative and affects "the rights, privileges or interests of an individual" is sufficient to trigger the application of the duty of fairness. The existence of a duty of fairness, does not however determine what requirements will be applicable in a given set of circumstances. According to Cory J. in Knight v. Indian Head School Division No. 19 "the concept of procedural fairness is having become residents of that other province, on the same basis as though they had not ceased to be residents of the province. (1984, c.6, s.11).

Royal Commission vol.1, supra, note 195 at 11.

For example the federal government's authority to legislate in the realm of health care, i.e. the CHA derives from federal spending power.

eminently variable and its content is to be decided in the specific context of each case."216 Several factors have been recognized in the jurisprudence as relevant to determining what is required by the common law duty of procedural fairness in a given set of circumstances.217 One factor which may determine what procedures the duty of fairness requires in given circumstances is the legitimate expectations of the person challenging the decision. The Supreme Court has held that in Canada, this doctrine is part of the doctrine of fairness or natural justice and that it does not create substantive rights.218 As applied in Canada, if a legitimate expectation is found to exist, this will affect the content of the duty of fairness owed to the individual or individuals affected by the decision. If the claimant has a legitimate expectation that a certain procedure will be followed this procedure will be required by the duty of fairness.219 Nonetheless, the doctrine of legitimate expectations cannot lead to substantive rights outside the procedural domain. Where it is applicable, it can only create a right to make representations or to be consulted. The doctrine does not apply to the legislative process. The government is not constrained by the doctrine when introducing a Bill to Parliament. This doctrine, as applied in Canada, is based on the principle that the "circumstances" affecting procedural fairness take into account the promises or regular practices of administrative decision-makers, and that it will generally be unfair for them to act in contravention of

218 Old St Boniface supra, note 219 at 1204; Reference Re Canada Assistance Plan (B.C.), [1991] 2 S.C.R. 525 at 557.
representations as to procedure, or to backtrack on substantive promises without according significant procedural rights.\textsuperscript{220}

The question for those wishing to challenge government allocation policies is whether or not the CHA, and specifically its five principles, could be considered a promise or representation by government with regard to how health care services will be funded in Canada.

4.5.2 Public Interest Standing

An interesting issue is whether or not an individual would have standing to bring a legal challenge to federal transfer payments for health care. In recent years, the traditional standing requirements for injunctions and declarations\textsuperscript{221} have been liberalized, prompted by the recognition of “public interest” standing in cases involving challenges to the constitutionality of legislation.\textsuperscript{222}


In the case of Canadian Council of Churches v. Canada (Minister of Employment and Immigration) \(^{223}\) Cory J. described some of the complexities associated with modern society. He described the need for government regulation of, for example, modern types of transportation and energy sources. Out of the increase in state intervention developed the concept of public rights, where the validity of government intervention must be reviewed by the courts. Even before the Charter, the Supreme Court considered the merits of broadening access to the courts against the need to conserve scarce judicial resources. It expanded rules of standing in a trilogy of cases: Thorson v. Attorney General of Canada,\(^ {224}\) Nova Scotia Board of Censors v. McNeil,\(^ {225}\) Minister of Justice of Canada v. Borowski,\(^ {226}\) setting forth the conditions which a plaintiff had to satisfy in order to be granted standing.

If ever modern society was faced with complexities it is with the issue of allocating scarce health care resources and all the possible motivations behind each choice.

The Charter represents the first restraint placed on the sovereignty of Parliament to pass legislation that fell within its jurisdiction.\(^ {227}\) The Charter enshrines the rights and freedoms of Canadians. The courts have jurisdiction to enforce those rights. The courts fulfill this role by ensuring that legislation does not infringe the provisions of the Charter.

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\(^{224}\) McNeil supra, note 225.

\(^{225}\) McNeil supra, note 225.

\(^{226}\) Borowski supra, note 225.
By its terms the Charter indicates that a generous and liberal approach should be taken to the issue of standing.

Parliament and the legislatures are required to act within the bounds of the Charter. The courts are the final arbiters as to when that duty has been breached. Courts use their discretion so that standing is granted when it is required to ensure that legislation conforms to the constitution and the Charter.

On the basis of public interest standing, the Court used its discretion to recognize the status of the applicant to seek a declaration. The public interest in holding the administration to the limits of its lawful authority was considered as great as the public interest in holding the legislature to the limits of its constitutional authority. The same policy considerations which supported the recognition of public interest standing in constitutional matters were accepted for public interest standing in a case involving a challenge to the vires of an administrative action. The challenge to the legality of the federal government’s action raised a justiciable issue. This was a question of law which could be determined by the courts, even though the Supreme Court acknowledged that the issue of provincial compliance with federal cost-sharing arrangements might sometimes raise issues which are inappropriate for judicial resolution. Further, the applicant raised a serious issue in which he had a genuine interest as a person in need, in receipt of social assistance, he could not be regarded as a mere busybody. And finally, the court was

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227 Canadian Council of Churches supra, note 226 at 9.
satisfied that the issue of legality was raised by someone with a direct interest in its resolution.²²⁸

Following the enactment of the Charter, the issue of standing was first considered in Finlay v. Canada (Minister of Finance).²²⁹ In that case Le Dain J. extended the scope of the trilogy and held that courts have discretion to award public interest standing to challenge an exercise of administrative authority as well as legislation. He founded his arguments on the underlying principle of discretionary standing which he defined as a recognition of the public interest in maintaining respect for "the limits of statutory authority." The whole purpose of granting status is to prevent the immunization of legislation and government acts from any challenge.

The standard set by the Supreme Court for public interest plaintiffs to receive standing also recognizes the issue of the appropriate allocation of judicial resources. This is achieved by limiting the granting of status to situations in which no directly affected individual might be expected to initiate litigation. In Finlay, Le Dain J. specifically addressed the traditional concerns about widening access to the courts.

…the concern about the allocation of scarce judicial resources and the need to screen out the mere busybody; the concern that in the determination of the issues the courts should have the benefit of the contending points of view of those most directly affected by them; and the concern about the proper role of the courts and their constitutional relationship to the other branches of government. These concerns addressed by the criteria for the exercise of the judicial discretion to

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²²⁸ Jones supra note 225 at 561.
recognize public interest standing to bring an action for a declaration that were laid down in Thorson, McNeil and Borowski.\textsuperscript{230}

Canadian Council of Churches stressed that it was essential that a balance be struck between ensuring access to the courts and preserving judicial resources.

The jurisprudence holds that when public interest standing is sought, consideration must be given to three issues.

1. Is there a serious issue raised as to the invalidity of the legislation or action in question.
2. Has it been established that the plaintiff is directly affected by the legislation / action or policy, or if not does the plaintiff have a genuine interest in its validity?
3. Is there another reasonable and effective way to bring the issue before the courts?\textsuperscript{231}

For the purposes of reviewing government allocation decisions, the significance of Finlay is in its recognition of a broader, discretionary concept of public interest standing of non-constitutional challenges to administrative action. It paves the way for challenges to the CHA. Accordingly, a claimant seeking judicial review of government allocation policies under the CHA would meet the standard for public interest standing. The funding of health care services raises an issue serious to all Canadians. All Canadian have a genuine interest in how the CHA is enforced. Finally, there are no other reasonable ways of bring such challenges before the Courts.

\textsuperscript{230} Ibid at 631.
The issue of whether the concept of public interest standing would be recognized in cases involving non-constitutional challenges to administrative action was addressed by the Supreme Court in *Finlay v. Canada (Minister of Finance)*. This case addressed the legality of payments made by the federal government to the Province of Manitoba under a cost-sharing agreement. The applicant in the case, was a recipient of provincial social assistance and he sought a declaration that these payments were *ultra vires*. In particular, he stated that the payments were unauthorized under the federal legislation because the province, in implementing the scheme for which the funds were provided, had failed to adhere to the conditions proscribed by this legislation.

Choudhry has argued that the lack of a legal remedy against an erring provincial government may be of little consequence. Because the concern in the judicial review of federal payments under the CHA would be the compliance of a provincial government with federal criteria, a declaratory judgment against the federal government would be politically harmful for the erring provincial government. Given the political popularity of the CHA principles and the media attention given to compromised access to health care services, it would politically unwise for a provincial government not to address issues brought out in a judicial review.

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231 Canadian Council of Churches supra, note 226 at 253; See *Hy and Zel's Inc. v. Ont. (Attorney General) [1993]* 3 S.C.R. 675; *Paul Magder Furs Inc. v. Ont. (Attorney General)*, [1993] 2 S.C.R. 675. where standing was denied based on this point.

232 *Finlay* 1986 supra, note 232.

233 Choudhry supra note 168 at 507.
4.5.3 Discretion

The CHA and the Ministry of Health Act delegate considerable discretion to the Minister on deciding how health care resources will be allocated. The concept of discretion refers to decisions where the law does not dictate a specific outcome, or where the decision maker is given a choice of options within a statutorily imposed set of boundaries. A public officer has discretion whenever the effective limits on his or her power leave him or her free to make a choice among possible courses of action or inaction.

It is necessary in considering the allocation of scarce resources to approach judicial review of administrative discretion taking into account the "pragmatic and functional" approach to judicial review that was first articulated in U.E.S., Local 298 v. Bibeault. Typically, administrative law has distinguished between the review of decisions classified as discretionary and those seen as involving the interpretation of rules of law. The rule has traditionally been that decisions classified as discretionary can only be reviewed on limited grounds such as the exercise of discretion for an improper purpose, the use of

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234 Ministry of Health Act R.S.O.
irrelevant considerations or the bad faith of decision-makers,\textsuperscript{237} and at times the general
doctrine of "unreasonableness".\textsuperscript{238} These doctrines incorporate two central themes: (1) that discretionary decisions, like all other administrative decisions, must be made within
the bounds of the jurisdiction conferred by the statute, but that (2) considerable deference
will be given to decision-makers by courts in reviewing the exercise of that discretion and
determining the scope of the decision-maker's jurisdiction. These doctrines recognize
that it is the intention of a legislature, when using statutory language that confers broad
choices on administrative agencies, that courts should not readily interfere with such
decisions, and should give substantial respect to decision-makers when reviewing the way
in which discretion was used. Nonetheless, it is still required that discretion be exercised
in a manner that is within a reasonable interpretation of the "margin of maneuver
contemplated by the legislature".\textsuperscript{239} in accordance with the principles of the rule of law.\textsuperscript{240}
in line with general principles of administrative law governing the exercise of discretion
and consistent with the Charter.\textsuperscript{241}

It is worth emphasizing that currently there is not a rigid distinction between
"discretionary" and "non-discretionary" decisions. Most administrative decisions involve
the exercise of implicit discretion in relation to many aspects of decision making. As
well, there is no clear distinction between interpretation and the exercise of discretion.

\textsuperscript{237} See for example, \textit{Maple Lodge Farms Ltd. v. Government of Canada}, [1982] 2 S.C.R. 2 at pp. 7-8;
\textsuperscript{238} \textit{Associated Provincial Picture Houses, Ltd. v. Wednesbury Corporation}, [1948] 1 K.B. 223 (C.A.).
[hereinafter Wednesbury]
\textsuperscript{239} Baker supra, note 220 at para.53.
Interpreting legal rules involves considerable discretion to clarify, fill in legislative gaps, and make choices among various options.\textsuperscript{242} The "pragmatic and functional" approach acknowledges that standards of review for error of law should be viewed as a spectrum, with specific decisions being entitled to more deference, and others entitled to less.\textsuperscript{243} Three standards of review have been put forward: patent unreasonableness, reasonableness \textit{simpliciter} and correctness.\textsuperscript{244} According to L'Heureux-Dube J. in \textbf{Baker}, the standard of review of the substantive aspects of discretionary decisions is best attempted within this framework, especially given the challenge of making definite classifications between discretionary and non-discretionary decisions. The pragmatic and functional approach/analysis considers issues such as the expertise of the tribunal, the nature of the decision being made, and the language of the provision and the surrounding legislation. It considers factors such as whether a decision is "polycentric" and the intention put forth by the statutory language. The amount of choice left by Parliament to the administrative decision-maker and the nature of the decision being made are also important issues in the analysis. The spectrum of standards of review can incorporate the principle that, in certain cases, the legislature has demonstrated its intention to leave greater choices to decision-makers than in other, but that a court must intervene where such a decision is outside the scope of the power accorded by Parliament. The Supreme Court also applied this framework to statutory provisions that confer significant choices on administrative bodies, for example in

\begin{itemize}
  \item \textsuperscript{242} Donald J.M. Brown, John M. Evans, \textit{Judicial Review of Administrative Action in Canada} ( Toronto: Canvasback, 1998) (loose-leaf) ; Baker supra, note 220 at para.54.
  \item \textsuperscript{243} Pezim supra, note 239 at 589-90; Southam supra, note 239 at para.30; Pushpanathan supra, note 239 at para.27.
  \item \textsuperscript{244} Southam supra, note 239 at para. 54-56.
\end{itemize}
reviewing the exercise of the remedial powers conferred by the statute at issue in

Southam.\textsuperscript{245}

Incorporating judicial review of decisions that involve significant discretion into the pragmatic and functional analysis for errors of law is not a reduction of the level of deference given to decisions of a highly discretionary nature. Differential standards of review can give significant leeway to the discretionary decision-maker in determining the “proper purposes” or “relevant considerations” involved in making a given determination. The pragmatic and functional approach can consider the fact that the more discretion that is left to a decision-maker, the more reluctant courts should be to interfere with the way in which decision-makers have made for example, allocation decisions among various options. Notwithstanding the fact that discretionary decisions will normally be given considerable respect, that discretion must be exercised in accordance with the boundaries described in the statute, the principles of the rule of law, the principles of administrative law, the fundamental values of Canadian society, and the principles of the Charter.\textsuperscript{246}

Cameron held that so long as a procedure is not funded in accordance with a reasonable government policy made in compliance with provincial law, the lack of funding does not contravene the law. The question comes down to the extent to which basing allocation decisions on economic principles will be accepted as reasonable.

\textsuperscript{245} Southam supra, note 239.

\textsuperscript{246} Baker supra, note 220 at para. 56.
It was emphasized in Eldridge\(^\text{247}\) that not every conferral of statutory discretion may be interpreted consistently with the Charter. Some grants of discretion will necessarily infringe Charter rights notwithstanding that they do not expressly authorize that result.\(^\text{248}\)

In such cases it will generally be the statute, and not its application, that attracts Charter scrutiny. Discretion accorded to the government or hospitals is to determine whether a service will qualify for funding.\(^\text{249}\) While it is of course possible for the government or hospital administrators to infringe s.15(1) in the course of exercising their authority the government exercise of discretion does not necessarily threaten equality rights set out in s.15(1) of the Charter. That possibility is incidental to the purpose of discretion which is to ensure reasonable access to medically required services.

The Supreme Court has consistently held that s.15(1) of the Charter protects against discrimination. In Andrews McIntyre J. found that laws which appear neutral in their language may be discriminatory in their effect. "It must be recognized at once...that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality."\(^\text{250}\)

Section 15(1), the Supreme Court has held, was intended to ensure a measure of substantive and not merely formal equality.


\(^{250}\) Andrews supra, note 210 at 164 and see Big M Drug Mart Ltd. Supra, note 48 at 347.
The Supreme Court has also held that a discriminatory purpose or intention is not a required condition of a s.15(1) violation. A legal distinction must not be inspired by the intention to disadvantage an individual or group in order to violate s.15(1). It is adequate if the effect of the legislation is to deny someone the equal protection or benefit of the law. As McIntyre J. stated in Andrews "[t]o approach the ideal of full equality before and under the law...the main consideration must be the impact of the law on the individual or the group concerned." The Supreme Court of Canada has taken a different path than the United States Supreme Court, which requires a discriminatory intent in order to ground an equal protection claim under the Fourteenth Amendment of the Constitution.

While there is no such thing as truly unfettered statutory discretion, there is no consensus with respect to the standard by which it should be reviewed. An option for review is the "patently reasonable" test, in the English case of Associated Provincial Picture Houses Ltd. v. Wednesbury Corporation.

It is true to say that if a decision on a competent matter is so unreasonable that no reasonable authority could ever have come to it, then the courts can interfere...but to prove a cause of that kind would require something overwhelming.

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252 Andrews supra, note 210 at 165.
255 Wednesbury supra, note 241.
256 Ibid at 230.
This standard gives a high level of deference toward administrative decision-makers.

While the “Wednesbury rule” has not been embraced by the Supreme Court of Canada, it has been adopted by some provincial courts of appeal. Its deferential approach would provide an easy answer for judges wanting to avoid evaluating a government allocation policy. In a case where guidance was issued by the Secretary of State for the allocation of resources for the Environment to Local Authorities, it was challenged for being "Wednesbury unreasonable" the judge explained:

...we are being asked to review the exercise by the Secretary of State of an administrative discretion which inevitably requires political judgement on his part...I cannot accept that it is constitutionally appropriate, save in very exceptional circumstances, for the courts to intervene on the ground of 'unreasonableness' to quash guidance framed by the Secretary of State and by necessary implication approved by the House of Commons. the guidance being concerned with the limits if public expenditure by local authorities and the incidence of the tax burden as between taxpayers and ratepayers...these are matters of political judgment for him and for the House of Commons. They are not matters for the judges.

Consequently, the level of resources invested by the central government is considered outside the jurisdiction of the British courts.

Support for this argument is rooted in the doctrine of separation of powers. It is more appropriate that the executive, which is accountable to the democratically elected legislature and through it, to the public, make decisions of an economic and social nature than an unelected and unaccountable judiciary. The weakness with this line of reasoning


is that it places a high level of faith on the venues of political accountability, which may function poorly in practice.260

In cases where patients in the U.K. have challenged resource allocation, decisions under the National Health Service show that patients do not have a legal right to immediate treatment.261 In the case of R. v. Secretary of State for Social Services and Others, Ex parte Hinks and Others262 orthopaedic patients at a Birmingham hospital were forced to wait longer than was medically advisable for hip replacement surgery because of a shortage of facilities. The patients sought declarations that the Secretary of State, the Regional Health Authority and the Area Health Authority (the respondents) were in breach of their duties under the National Health Services Act.263 These actions failed because the courts found no right of action for an individual aggrieved patient to sue for a declaration and damages with regard to protracted pain and suffering caused by a failure to prove more hospital services. Lord Denning explained that the Minister, or Secretary of State, could be considered to have failed in his or her statutory duty only if his exercise of discretion was so thoroughly unreasonable that no reasonable Minister could have reached the same conclusion. The court also recognized that Ministers face long term financial planning and constraints. The public purse was not to be viewed as a bottomless pit. The Court of Appeal decided that the statute could not be interpreted to

260 Chourhy supra, note 168 at 495.
impose an absolute duty to provide services, irrespective of economic decisions taken at
the national level. The duty to fund services must be interpreted in light of the
Secretary of State's duty "to meet all reasonable requirements such as can be provided
within the resources available," which "must be determined in light of current
Government economic policy." British courts are therefore reluctant to adjudicate
competing claims for health care resources.

An academic comment on this case addressed the possibility of a future claim in this area:

[...] the courts did not entirely abdicate control over the Minister. A public-spirited
patient, resigned to getting no damages himself, might try again for an order
against any Minister which he alleged had totally subverted the health services.
for example, a Minister using his position and powers exclusively to benefit
private medicine at the expense of the NHS. Chances of success are not high.
and, of course, the government of the day could always change the law, but they
can be made to do it openly and not permitted to pay lip services to a duty to a
health service which might have been abandoned.

A similar argument could be made in Canada where a patient might try for an order
against government who he or she feels is abandoning his or her duty to the health care
system in the interest of cost saving.

While aggrieved patients have also sued health authorities for failure to provide a
particular treatment, such claims have not met with much success. In the case of Re
Walker the Court of Appeal dismissed a mother's application for judicial review of the

263 National Health Services Act, 1977, ch.49
264 Hinks supra, note 265 at 94.
265 Ibid at 95.
266 Hinks supra, note 265 at 97.
267 Margaret Brazier, Medicine, Patients and the Law 22 (2d ed. 1992).
Central Birmingham Health Authority's decision to postpone carrying out necessary heart surgery on her baby. The surgery was postponed five separate occasions due to the lack of specially trained nurses and accompanying facilities, which did not allow the expansion of the intensive care unit. The baby was not in any immediate danger, and other more urgent cases were being treated. While not directly referred to, the lack of resources was arguably a result of allocation policies implementing the economic goal of cost minimization.

The Court held that the authority's decision was legal. There were no procedural defects and the health authority's decision was not unreasonable to the point of irrationality. The trial judge deprecated any suggestion that patients should be encouraged to think that the court had a role in such cases. The application was also dismissed by the Court of Appeal stating:

...that it was not for the court to interfere and substitute its own judgment for that of those responsible for the allocation of resources. It would only interfere if there had been a failure to allocate funds in a way which was "unreasonable" in the Wednesbury sense...or where there were breaches of public-law duties.269

The Court of Appeal case of R. v. Central Birmingham Health Authority Ex parte Collier270 dismissed a similar application related to a similar set of facts. The court applied the reasoning in Re Walker. One judge in Collier argued that the principles were the same even if there was an immediate danger to health. Another judge stated "[T]his court and the High Court have no role of general investigator of social policy and of the

269 Re Walker Ibid.
allocation of resources." If courts held firmly to this statement, then governments, policy makers and hospitals would be free to use base allocation decisions purely on economic analyses.

Another constraint on unfettered discretion is the requirement that it be used to promote the purposes of the Act which confers it. In the case of Padfield v. Minister of Agriculture the Minister refused to exercise his statutory discretion to refer a complaint about a milk-pricing scheme to a committee of investigation. The House of Lords proceeded to issued a writ of mandamus directing him to do so, because the purpose of the Statute was to convene a hearing for aggrieved parties. Lord Ried said:

Parliament must have conferred the discretion with the intention that it should be used to promote the policy object of the Act...if the Minister, by reasons of his having misconstrued the Act or for any other reason, so uses his discretion as to thwart or run counter to the policy and objects of the Act, then our law would be very defective if persons aggrieved were not entitled to the protection of the court.

The purposive approach to reviewing statutory discretion was applied by the Supreme Court of Canada in Shell Canada Products Ltd. v. Vancouver (City of). The Vancouver City Council passed resolutions directing the City of Vancouver to stop doing business with Shell Canada, because of Shell’s involvement in South Africa. Shell Canada applied to have the resolutions quashed, because they were ultra vires the enabling statute. The Court held that the resolutions did not promote the purpose of the Statute, because they

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270 R. v. Central Birmingham Health Authority Ex parte Collier (1988) (unreported) [hereinafter Collier]
271 Ibid. as per Lord Justice Ralph Gibson.
274 Shell supra, note 240.
did not "provide for the good rule and government of the city", but were, rather, "based on matters external to the interests of the citizens of the municipality".

These cases indicate that statutory discretion may be required to meet a stricter standard of review than patent unreasonableness. In Collett v. Ontario (A.G.) the Court supported this position, when it explained that the CHA "intended that the Governor in Council have a great deal of discretion in relation to its option should a health insurance plan cease to satisfy the federal criteria." A different perspective is presented in Morgentaler v. Prince Edward Island (Minister of Health and Social Services) where the court struck down a regulation de-insuring abortions unless: (1) they were performed in a hospital, and (2) they were deemed necessary by a provincial agency or its advisory committee. The regulation was established by the agency approved by the provincial Cabinet. The issue the court was addressing was that of discretion. Consistent with Padfield, the court held that the regulation did not further any of the purposes of the parent legislation.

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275 Vancouver Charter, S.B.C. 1953, c.55.
276 Vancouver Charter, S.B.C. 1953, c.55 at s.189.
277 Shell, supra, note 240 at 279.
279 Collett ibid. at 430. The issue in Collett was whether the limitation of hospital coverage for treatment outside of Canada by O.H.I.P. was ultra vires section 45(1)(H) of the Ontario Health insurance Act, R.S.O. 1990, c.H.6, which authorized the provincial cabinet to prescribe amounts payable by O.H.I.P. for insured services except in a manner which "would disqualify the Province of Ontario under the [CHA], for the contribution by the Government of Canada because the [Ontario Health insurance] Plan would no longer satisfy the criteria under that Act". The court held that the application was premature because the consultation process set out by section 14 of the CHA had not yet been followed.
281 See Health Services Payment Act, R.S.P.E.I. 1988, c.H-2. These purposes were sustaining or advancing the role of hospitals, controlling the medical profession, ensuring the health of patients and controlling costs. (see Morgentaler v. P.E.I., ibid. at 750-51) A crucial element of the decision was that the provincial
The English courts have traditionally been reluctant to place judgment on the spending decisions. In R. v. Central Birmingham Health Authority \textit{ex parte} Walker\textsuperscript{282} Macpherson J. held that the court had no jurisdiction to investigate:

\begin{quote}
...any case where the balance of available money and its distribution and use are concerned. Those are of course questions which are of enormous public interest and concern...but they are questions to be raised, answered and dealt with outside the court.\textsuperscript{283}
\end{quote}

In \textit{R. v. Central Birmingham Health Authority \textit{ex parte} Collier}\textsuperscript{284}, a case where a shortage of adequate facilities lead to a child's heart operation was canceled on three occasions. Gibson LJ said that the court:

\begin{quote}
...has no role of general investigator of social policy and of allocation of resources. Its jurisdiction...is limited to dealing with breach of duties under the law, including decisions made by authorities which are shown to be unreasonable.\textsuperscript{285}
\end{quote}

In \textit{R. v. Cambridge Health Authority \textit{ex parte} B.}, Sir Thomas Birmingham MR observed:

\begin{quote}
Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.\textsuperscript{286}
\end{quote}

In these cases, the court was asserting the traditional role of ministerial responsibility and a restricted interpretation of judicial review. Commentators have argued that while courts

\footnotesize
\begin{itemize}
\item \textsuperscript{282} Walker supra note 272.
\item \textsuperscript{283} D. Longley \textit{Public Law and Health Service Accountability} (Buckingham: Open University Press , 1993) at 81. [hereinafter Longley]
\item \textsuperscript{284} Collier supra note 274.
\item \textsuperscript{285} Longley supra, note 287 at 81.
\item \textsuperscript{286} \textit{R. v. Cambridge Health Authority \textit{ex p. B}} (1995) 2 All ER 129 (CA) at 137, Sir Thomas Bingham, MR.
\end{itemize}
should not interfere in priority setting decisions, the role of courts should be to strengthen the way in which decisions are made. They, and others like Newdick argued that the reasons behind decisions should be made clear and open to challenge. In reference to the Child B case, Newdick argued:

For the court to review the reasons for such a decision does not require it to substitute its own evidence...the very fact that such clinical evidence were required would focus minds on ensuring that these unenviable decisions are reasonable and defensible, and would help to satisfy patients and the public that the question has been properly addressed.

Notwithstanding this traditional willingness to leave discretion for allocation of resources in the hands of government at the macro level, hospital administrators at the meso level and physicians at the micro level, there seems to be a move towards courts limiting this discretion. The trial judge in the British Columbia case of Law Estate v. Simice criticized physicians for offering the explanation that they felt too constrained by the provincial medical insurance plan and their provincial medical association's standards to order a diagnostic CT scan. Although a finding of negligence was made on other grounds, the judge noted that while physicians may consider the financial impact of their decisions, financial considerations cannot be decisive. The physician's first duty is to the patient.

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288 Newdick supra, note 113 at 132-3.

It is accepted in law that while there is no liability for making decisions that prove to be wrong\textsuperscript{290} there may be liability for making a decision wrongly. A decision is made wrongly if demands for economy distort the physician's judgment with respect to the care that is owed to the patient. An error in clinical judgment is not actionable, because the risk of being wrong is inherent in every exercise of judgment. However, to take decisive account of secondary concerns and subordinate the primary concern of care (the patient's well being) to a budgetary issue is the wrong way for a physician to make a treatment decision.\textsuperscript{291}

As the Supreme Court of Canada has emphasized on several occasions, "[d]eference must not be carried to the point of relieving the government of the burden which the Charter places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable."\textsuperscript{292}

4.6 The Canadian Charter of Rights and Freedoms

The purpose of this section is to outline the relevance of the Charter to allocating resources according to economic principles. The first section describes the Charter as somewhat of an umbrella document and as a unifying set of national standards. The second section explores the scope of its application. The third section examines several

\textsuperscript{290}Whitehouse v. Jordan (1981), 1 All ER 267 (HL).
principles of Charter interpretation. The fourth section focuses on the Charter's equality provision (s.15). The fifth section discusses the extent to which government is afforded discretion to base allocation decisions on economic principles by appealing to section 1. The sixth section looks at remedies afforded by the Charter.

4.6.1 A National Document

Because federalism involves a distribution of responsibilities among at least two levels of government, the Charter assumes a vital role in defining the nature of that distribution and serves as a reference point for the settlement of disputes or disagreements. The Charter is important to Canadian allocation policies as a source of certain fundamental rights and principles. These rights are especially important to minorities within the wider population. It is intended to serve as a source of protection against the abuse of power by the majority which may be inclined to ignore the rightful claims of the minority, either willfully or simply through blindness of neglect.²⁹³

While the Charter is significant to the evolution of priority setting policies, we must be cognizant of its abilities and limitations. The framers of the Charter could either not foresee all social policy challenges or chose to express a particular viewpoint of what was most important to Canadians. The Charter is therefore ill equipped to respond to all the

²⁹³ A Renewed Canada - The Report of the Special Joint Committee of the Senate and the House of Commons, Chairpersons, Hon. G. Beaudoin and D. Dobbie (Ottawa: Queens' Printer, 1992) at 12.
intricacies of economically based resource allocation policies. What the Charter can do is provide the ground rules, the framework, the goals and the spirit in light of which economic strategies can be evaluated.

A constitution is more than a legal document. It reflects both what we are as a society and what we would like to be. Inclusion of certain rights and principles in the constitution says a great deal about their stature and importance; omission of others has the same effect. The Charter guarantees the right to equality and provides protection against discrimination by government. It also endorses the adoption of special affirmative measures to redress persistent inequalities.394 Clear guidelines about the appropriate scope, content and nature of such possible equity initiatives have not however, been provided. Given this vagueness, courts and adjudicators are being asked to fill in the gaps left by legislators.

4.6.2 Method

The structure of a Charter claim related to the allocation strategies focused on economic principles would allege that the state breached a protected right, defined according to core norms expressed in the text of the Charter and interpreted in the light of precedent, comparative references, history and other interpretive resources. The fact of the breach is a matter of the specific interaction between the rightholder and the government, proved by the presentation of evidence, testimony and argument. The government's response
may take a number of forms. It may deny that the right arises in the interaction in question or simply deny the breach. It may also argue that the breach is excused or justified on the basis of further evidence and/or argument. The result of the process is the validation or invalidation of the impugned action, in whole or in part. The courts often show respect for the legislative process, if not its product, by giving the legislature some time period in which to determine its next course of action. The legislature is bound only by the court's reasoning and may choose to re-make the law or set the policy within those confines. If the legislature has a different way to achieve its economically sensitive policies in compliance with stated norm, it is free to do so.

4.6.3 Scope

The purpose of this section is to review briefly the principles governing the scope of the application of the Charter. This is significant to the thesis because some health care services are provided by non-governmental agencies under contract with or receiving funding from the Ministry. Different agencies have different service limits and eligibility criteria, the result of which may be that persons with similar needs may be provided with different services. Accordingly, it is essential to determine whether Charter analysis is to be applied to these agencies in their allocation of health care resources.

Section 32 of the Charter tells us that it applies to legislative and governmental decisions:

294 See Charter supra, note 7 at sections 15(1) and (2).
296 Weinrib ibid at 40.
32(1) This Charter applies
(a) to the Parliament and government of Canada in respect of all matters within
the authority of Parliament including matters relating to the Yukon Territory and
Northwest Territories; and
(b) to the legislature and government of each province in respect of all matters
within the authority of the legislature of each province.\textsuperscript{297}

The \textit{Charter} applies to legislation\textsuperscript{298} and to actions of government.\textsuperscript{299} It will apply even
where the provision of a service appears totally discretionary.\textsuperscript{300} First, legislation may be
found to be unconstitutional on its face because it violates a \textit{Charter} right and is not saved
by s.1. In such cases, the legislation will be invalid and the Court compelled to declare it
of no force or effect pursuant to s.52(1) of the \textit{Constitution Act}.\textsuperscript{301} Second, and more
relevant to the subject of this thesis, the \textit{Charter} may be infringed, not by the legislation
itself, but by the actions of a delegated decision maker in applying it. In such cases, the
legislation remains valid, but a remedy for the unconstitutional action may be sought
pursuant to s.24(1) of the Charter.

In \textit{Eldridge}, La Forest J. quoted Professor Hogg in explaining the rationale for this
second type of Charter violation.

Action taken under statutory authority is valid only if it is within the scope of that
authority. Since neither Parliament nor a legislature can itself pass a law in
breach of the Charter, neither body can authorize action which would be in breach

\textsuperscript{297} Charter supra, note 161 at s.32.
\textsuperscript{298} See Retail, Wholesale and department Store Union, Local 580 et al. v. \textit{Dolphin Delivery Ltd.}, [1986] 2
S.C.R. 573. [hereinafter Dolphin Delivery]
\textsuperscript{299} \textit{Operation Dismantle Inc. v. The Queen}, [1985] 1 S.C.R. 441 (S.C.C.) [hereinafter Operation
Dismantle].
\textsuperscript{300} See e.g., \textit{Silano v. The Queen In Rights of British Columbia} (1987) 42 D.L.R. (4th) 407 (B.C.S.C.) at
414-15 [hereinafter Silano], where the Supreme Court of British Columbia held that “even though
payments are discretionary, a regulatory scheme which, for all practical purposes controls the exercise of
that discretion, must be amenable to the reach of the \textit{Charter of Rights.”} (per Spencer J.).
\textsuperscript{301} The \textit{Constitution Act} 1982, Schedule B of the Canada Act 1982, c.11 (U.K.).
of the Charter. Thus, the limitations on statutory authority which are imposed by
the Charter will flow down the chain of statutory authority and apply to
regulations, by-laws, orders, decisions and all other action (whether legislative,
administrative or judicial) which depends for its validity on statutory authority.302

La Forest J. also pointed to the words of Lord Atkin in James v. Cowan303 where he wrote

"The Constitution is not to be mocked by substituting executive for legislative
interference with freedom."

The Charter has expanded the scope of judicial review to include not only subordinate
legislation but executive action and laws.304 Thus, both the provincial and the federal
government must ensure that their legislation complies with the Charter.

The executive may also be subject to judicial review. Justice Wilson in Operation
Dismantle v. A.G. Canada305 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 defense, we
would conclude that it is not appropriate. However, if what we are being asked to
do is 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.306

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302 Hogg, supra, note 171 at 34-9.
304 The latter were formerly challengeable only as to the legislative competence of their makers under
section 91 and 92 of the Constitution Act, 1867 U.K., 30 & 31 Victoria c.3. under the residual power of
s.91 and s.91(27).
305 Operation Dismantle supra note 141. 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 v. B.C. (A.G.), [1986] 2 S.C.R. 539
(S.C.C.) the Supreme Court of Canada similarly held that executive powers must conform to constitutional
dictates.
306 Ibid. at 472. She goes on to illustrate with hypothetical examples, situations where the court could and
could not review executive decisions.
The Charter does not apply, however, to the actions of private parties which are completely unconnected to government.\textsuperscript{307}

There would be two distinct Charter application issues in a case where allocation policies were based on economic analysis. The first would be to identify the precise source of the alleged violations (i.e. s.15(1)). Limiting funding on the basis of economic analysis does not necessarily involve problematic legislation. It would more commonly be the result of actions of hospitals or government in exercising discretion conferred by legislation. The second issue would deal with the fact that since Eldridge et al. v. Attorney General of British Columbia et al.\textsuperscript{308} the Charter is seen to apply to both in that they act according to the powers granted to them by the statutes.

Legislation conferring a discretion must be interpreted, in so far as possible, consistently with the Charter. Lamer J. (as he then was) explained in Slaight Communications Inc. v. Davidson:\textsuperscript{309}

As the Constitution is the supreme law of Canada and any law that is inconsistent with its provisions is, to the extent of the inconsistency, of no force or effect, it is impossible to interpret legislation conferring discretion as conferring a power to infringe the Charter, unless, of course, that power is expressly conferred or necessarily implied. Such an interpretation would require us to declare the legislation to be of no force or effect, unless it could be justified under s.1. Although this Court must not add anything to legislation or delete anything from it in order to make it consistent with the Charter, there is no doubt in my mind that it should also not interpret legislation that is open to more than one interpretation so as to make it inconsistent with the Charter and hence of no force or effect. Legislation conferring an imprecise discretion must therefore be interpreted as not allowing the Charter rights to be infringed. Accordingly, an

\textsuperscript{307}Dolphin Delivery supra, note 302 at 593.
\textsuperscript{308}Eldridge supra, note 250.
\textsuperscript{309}Slaight supra, note 244 at 1038.
adjudicator exercising delegated powers does not have the power to make an order that would result in an infringement of the Charter, and he exceeds his jurisdiction if he does so.\textsuperscript{310}

Law has been broadly defined for the purpose of s.15 to encompass virtually all types of government activity (\textit{McKinney v. University of Guelph}).\textsuperscript{311} Funding-related policy is related to statutes and regulations and is "law" for the purpose of Charter challenges.\textsuperscript{312}

A private entity may be subject to the Charter in respect of certain inherently governmental actions. \textit{McKinney} makes it clear that the Charter applies to private entities in so far as they act in furtherance of a specific governmental program or policy. The rationale is that government should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities.\textsuperscript{313} In order for the Charter to apply to a private entity, it must be found to be implementing a specific governmental policy or program.

In providing medically necessary services, hospitals carry out a specific governmental objective. Hospitals are merely the vehicles the legislature has chosen to deliver this comprehensive social program.\textsuperscript{314} Even though hospitals existed well before the CHA and the Charter, the interlocking federal-provincial Medicare system is a vital

\textsuperscript{310} Ibid at 1078. (Lamer J.)
\textsuperscript{313} See A. Anne McLellan and Bruce P. Elman, “To Whom Does the Charter Apply? Some Recent Cases on Section 32” (1986) 24 Alta. L. Rev. 361 at p. 371.
\textsuperscript{314} See Eldridge supra, note 250 at par 50.
government policy. Although this system has retained some of the trappings of the private insurance model from which it derived, it has come to resemble more closely a government service than an insurance scheme.\textsuperscript{315}

Case law describes the provision of services within a hospital as not simply a matter of internal hospital management but rather as an expression of government policy.\textsuperscript{316} Some may disagree with this characterization, arguing that there is considerable flexibility and that such a provision of services is not analogous to, for example, giving out pensions. Therefore, while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act. The legislature, upon defining its objective as guaranteeing access to a range of medical services, cannot evade its obligations under s.15(1) of the Charter to provide those services without discrimination by appointing hospitals to carry out that objective. In so far as they do so, hospitals must conform with the Charter.

Given that the Supreme Court has concluded that the Charter applies to hospitals in their provision of health care services, the next step is to analyze whether the specific allocation arrangements that limit patient access to services infringes the appellants' equality rights under s.15(1) of the Charter.

\textsuperscript{315} See Canadian Bar Association Task Force on Health Care, supra, note 170 at 9.
\textsuperscript{316} Eldridge supra, note 250 at par 51.
4.6.4 Subsection 15(1):

Section 15(1) provides as follows:

15(1) Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.

It guarantees the equal treatment of individuals by the government without discrimination. The concepts of “equality” and “discrimination”, their meaning and how they are established are fundamental to analyzing whether and how Canadian governments breach rights to equality by limiting access to health care services in the name of economic principles.

a. Andrews:

In discussing the requirement of differential treatment, McIntyre J. in Andrews explained that equality is a comparative concept “the condition of which may only be attained if discerned by comparison with the condition of others in the social and political setting in which the question arises.”[317] In Law Iacobucci J. added to this concept by explaining that it is impossible to evaluate a s.15(1) claim without identifying specific personal characteristics or circumstances of the individual or group bringing the claim, and comparing the treatment of that person or group to the treatment accorded to a relevant comparator.[318]

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317 Andrews supra, note 210 at 164.
Andrews also stated that identical treatment does not necessarily lead to real equality.

Formal distinctions in treatment will be appropriate in certain contexts in order to recognize the differences between individuals and lead to substantive equality.319 Similarly, a law or even funding policy for health care services which applied uniformly to all may still violate a claimant’s equality rights. The key issue is the impact of the law on the individual or group to whom it applied as well as upon those whom it excludes from its application.320 Determining the of the impact of the legislation or policy must be done in a contextual manner, taking into account the content of the law, its purpose and the characteristics and circumstances of the claimant. In fact, in some circumstances even a distinction based on an enumerated or analogous ground may not be discriminatory. Such a permissible distinction would take into account the actual differences in characteristics or circumstances between individuals in a manner which respects and values their dignity and difference.

In Andrews McIntyre J. defined “discrimination” as follows:

...discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed on others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual’s merits and capacities will rarely be so classed.321

319 Andrews supra, note 210 at 164-69.
320 Andrews supra, note 210 at 165.
321 Andrews supra, note 210 at 174-75.
The role of the enumerated grounds of discrimination listed in s.15(1) "reflect the most common and probably the most socially destructive and historically practiced bases of discrimination" but a s.15(1) claim may also be brought on an analogous ground, in accordance with the provision's wording and with a proper interpretation of its remedial purpose. In *Andrews* Wilson J. explained that a ground may qualify as analogous to those listed in 15(1) if persons characterized by the trait in question are, among other things, "lacking in political power", "vulnerable to having their interests overlooked and their rights to equal concern and respect violated", and "vulnerable to becoming a disadvantaged group" on the basis of that trait.

...this is a determination which is not to be made only in the context of the law which is subject to challenge but rather in the context of the place of the group in the entire social, political and legal fabric of our society. While legislatures must inevitably draw distinctions among the governed such distinctions should not bring about or reinforce the disadvantage of certain groups and individuals by denying them the rights freely accorded to others.

The basic approach taken in *Andrews* was repeatedly adopted in subsequent Supreme Court cases. Each of the elements of the approach to s.15(1) described by the Court in *Andrews* and confirmed in later cases has developed and been enriched by the subsequent jurisprudence.

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322 Andrews supra, note 210 at 175.
323 Andrews supra, note 210 at 152.
324 Andrews supra, note 210 at 152.

b. Purpose:

Notwithstanding certain distinctions within the s.15(1) caselaw, there has been real continuity in the jurisprudence of the Supreme Court on the purpose of the equality provision.\(^{327}\) In Andrews all the judges were of the same view as McIntyre J. who wrote that the purpose of s.15 was to promote a society in which all people are secure in knowing that they are recognized at law as human beings equally deserving of concern, respect and consideration.\(^ {328} \)

The purpose of s.15(1) has been expressed in a variety of ways by the judges of the Supreme Court. In McKinney, Wilson J. (writing in dissent) described the purpose of s.15(1) as both the protection "against the evil of discrimination by the state whatever form it takes"\(^ {329} \) and the "promotion of human dignity."\(^ {330} \) Similar descriptions were made in Miron by McLachlin J. and in Egan by L'Heureux-Dube J. and Cory J., all of whom wrote that the essential purpose of s.15(1) is the protection of human dignity. Cory J. made the deontologically based statement in Egan that the equality guarantee "recognizes and cherishes the innate human dignity of every individual."\(^ {331} \) He went on to explain that the "existence of discrimination is determined by assessing the prejudicial

\(^{326}\) Law supra, note 322 at par 35.

\(^{327}\) Ibid at 42.

\(^{328}\) Andrews supra, note 210 at 171.

\(^{329}\) McKinney supra, note 315 at 385.

\(^{330}\) McKinney supra, note 315 at 391.

\(^{331}\) Egan supra note 329 at para. 128.
effect of the distinction against the fundamental purpose of s.15 of preventing the infringement of essential human dignity".332

In *Vriend* Cory and Iacobucci JJ. described the purpose of s.15(1) as being to take a further step in the recognition of the fundamental importance and the innate dignity of the individual, and the recognition of the intrinsic worthiness and importance of every individual...regardless of the age, sex, origins, or other characteristics of the person.333 Such a description reflects deontological values.

All of these descriptions have several common themes. Iacobucci J. in *Law* described them as the fact that the purpose of s.15(1) is to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice. and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society equally capable and equally deserving of concern, respect and consideration. Legislation [or government policies] which effects differential treatment between individuals or groups will violate this fundamental purpose where those who are subject to differential treatment fall within one or more enumerated or analogous grounds, and where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, or otherwise has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society. Alternatively, differential treatment will not likely constitute discrimination within the purpose of s.15(1) where it does not violate the human dignity or freedom of a person in this way, and in particular where the differential treatment also assists in ameliorating the position of the disadvantaged within Canadian society.334

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332 Ibid. at para.179.
333 Vriend supra, note 296 at 67.
334 Law supra, note 322 at para.51.
Iacobbucci J. acknowledged the abstract nature of terms such as “equality” and “discrimination” and conceded that often, even the terms used to define these terms are as abstract in nature. While one can look back to Chapter 1 for a fuller philosophical exploration of deontologically grounded rights, it is appropriate that in Law Iacobucci J. spent some time addressing the meaning of “human dignity.” Human dignity after all goes to the heart of the values behind the CHA and the justification for “universal” health care.

While philosophically speaking there can be many definitions of human dignity, for the purpose of s.15(1) of the Charter the caselaw refers to a specific though non-exhaustive definition. In Rodriguez v. British Columbia (Attorney General) Lamer C.J. stated that s.15(1) addresses the realization of personal autonomy and self-determination. Human dignity requires that individuals or groups experience self-respect and self-worth. It deals with physical and psychological integrity and empowerment. Human dignity is compromised by unjust treatment based on personal traits or circumstances which do not relate to individual needs, capacities, or merits. It is reinforced by laws and policies which take into account the needs, capacities, and merits of different individuals, being sensitive to the context underlying their differences. Human dignity is also compromised when individuals and groups are marginalized, ignored or devalued and is reinforced when laws acknowledge the full place of all individuals and groups within Canadian society. Human dignity according to s.15(1) is not concerned with the status or position

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335 Law supra, note 160 at 52.
336 Rodriguez supra, note 254 at 554.
of a person in society, but rather is concerned with the way in which a person legitimately feels when confronted with a specific law or government policy.\textsuperscript{337} The central concern with protecting and promoting human dignity, combined all of the elements of the discrimination analysis. In terms of a law or policy limiting access to health care services, s.15(1) would be concerned with whether this limit is treating those affected unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law or policy. This could be described as a deontological limit to an otherwise consequentialist policy.

c. Approach:

S.15(1) is not intended to be a fixed or limited formula. A purposive\textsuperscript{338} and contextual approach to discrimination analysis is intended to best realize the remedial purpose of the equality guarantee.

The approach adopted by the Court focuses on three main issues:

(1) whether a law or policy imposes differential treatment between the claimant and others, in purpose or effect;\textsuperscript{339}

(2) whether one or more enumerated or analogous grounds of discrimination are the basis for the differential treatment;\textsuperscript{340} and

\textsuperscript{337} Law supra, note 322 at 53.

\textsuperscript{338} Hunter v. Southam Inc., [1984] 2 S.C.R. 145; Big M.supra, note 210 344. Andrews supra, note 210 at 171; Turpin supra, note 329 at 1333; Weatherall v. Canada (Attorney General), [1993] 2 S.C.R. 872 at 877-78; Eaton supra note 329 at para. 66; McKinney supra, note 315 at 385; Swain supra, note 329 at 992; Egan supra note 329 at para.128; Miron supra note 329 at para. 131; Vriend supra note 296 at para. 67; Law supra note 322 at 51.
whether the law or policy in question has a purpose or effect that is discriminatory within the meaning of the equality guarantee.

The first issue of differential treatment is related to but is not determinative of the issue of equality for the purpose of s.15(1). This is an important point with respect to analyzing limited access to health care services because by nature of availability of services, it is only those services that address one’s individual health care needs that should ever be made available. This issue holds that a difference in access to health care services alone does not in and of itself constitute a breach of s.15(1). The second and third issues determine whether the differential treatment in question constitutes discrimination according to s.15(1).

The recent 1999 case of Law v. Minister of Human Resources Development was a conscious effort by the entire Supreme Court of Canada to describe an analysis of s.15(1) they could all agree upon. The result is a detailed articulation of the history, meaning, purpose and application of s.15(1). According to the test laid out in Law a court called upon to determine a discrimination claim under s.15(1) should consider the following issues:

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341 Eaton supra, note 329 at 66-67; Eldridge supra, note 250 at para. 60-80; Vriend supra, note 296 at para. 72.
342 See Andrews supra, note 210; Turpin supra, note 329; Miron supra, note 329, Egan supra, note 329; Symes supra note 167 at para. 138.
343 Law supra note 322.
344 “Unfortunately, the unanimity of the court seems to have been achieved at the expense of simplicity and clarity.” Kirsten Craven, “S.C.C. Unity on s.15 Charter Cases Said at the Expense of Simplicity, Clarity” The Lawyers Weekly (28 April 2000) 3.
345 Law supra, note 322 at para. 88.
(1) Does the impugned law or policy (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant’s already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?

(2) Is the claimant subject to differential treatment based on one or more enumerated or analogous grounds?

(3) Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in ways which reflect the stereotypical application of presumed group or personal characteristics, or which otherwise have the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect and consideration?

Purpose:

The existence of a conflict between the purpose or effect of an impugned law or policy and the purpose of s.15(1) (discussed above) is essential in order to found a discrimination claim. The determination of whether such a conflict exists is to be made through an analysis of the full context surrounding the claim and the claimant. The contextual factor referred to in Law is the question of whether the impugned legislation or policy has an ameliorative purpose or effect for a group historically disadvantaged in the context of the legislation. An ameliorative purpose or effect which
is consistent with the purpose of s.15(1) of the Charter will generally not violate the human dignity of more advantaged individuals where the exclusion of these more advantaged individuals essentially corresponds to the greater need or the different circumstances experienced by the disadvantaged group being targeted by the legislation or even allocation policy. This issue will presumably only be relevant where the person or group that is excluded from the scope of the ameliorative legislation or policy is more advantaged in a relative sense. Underinclusive ameliorative legislation that excludes from its scope the members of an historically disadvantaged group will likely be considered discriminatory.\textsuperscript{345} A funding policy which is directed at a particular health care need could be characterized as having an ameliorative purpose or effect. This could help to establish that human dignity is not violated where the person or group that is excluded is more advantaged with respect to the circumstances addressed by the policy.

Another contextual issue referred to in Law\textsuperscript{346} was the nature of the interests affected by an impugned piece of legislation or government policy. Referring to Egan Iacobucci J. in Law stated that the discriminating caliber of differential treatment cannot be truly appreciated without addressing whether the distinction in question restricts access to a fundamental social institution or affects a basic aspect of full membership in Canadian society, or constitutes a complete non-recognition of a particular group. In Canada, restricting access to health care services would likely qualify as "restricting access to a

\textsuperscript{344} Ibid. at para.72.
\textsuperscript{345} See Vriend supra, note 296 at 94-104 (per Cory J.).
\textsuperscript{346} Law supra, note 322 at para74.
fundamental social institution" and as restricting access to "basic aspects of full membership in Canadian society".

Comparative Approach:
The equality guarantee is a comparative concept, which ultimately requires that a court recognize one or more comparators. The claimant usually chooses the person, group or groups with which he or she wishes to be compared for the purpose of the discrimination inquiry. However, where the claimant’s characterization of the comparison is insufficient, a court may, within the scope of the ground or grounds pleaded, refine the comparison presented by the claimant where warranted. Locating the relevant comparison group requires consideration of the subject-matter of the legislation and its effects, as well as a full appreciation of the context.

Context:
The contextual factors which determine whether legislation has the effect of demeaning a claimant’s dignity must be construed and examined from the point of view of the claimant. The focus of the inquiry is both subjective and objective. The necessary perspective is that of the reasonable person, in circumstances similar to those of the claimant, who takes into account the contextual factors relevant to the claim.

There are several factors which may be brought forth by a s.15(1) claimant in order to demonstrate that a law or policy demeans his or her dignity. The list of factors remains
open. Guidance as to these factors may be found in the s.15(1) jurisprudence and by analogy to recognized factors.

Some significant contextual factors influencing the determination of whether s.15(1) has been infringed are, among others:

(1) pre-existing disadvantage, stereotyping, prejudice, or vulnerability experienced by the individual or group at issue. The effects of a law or policy as they relate to the serious purpose of s.15(1) in protecting individuals or groups who are vulnerable, disadvantaged, or members of "discrete and insular minorities" should always be a central consideration. Although the claimant's association with a historically more advantaged or disadvantaged group or groups is not in and of itself determinative of an infringement, the existence of these pre-existing factors will favour a finding that s.15(1) has been infringed.

(2) The correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others. Although the mere fact that the impugned legislation takes into account the claimant's traits or circumstances will not necessarily be sufficient to defeat a s.15(1) claim, it will generally be more difficult to establish discrimination to the extent that the law takes into account the claimant's actual situation in a manner that respects his or her value as a human being or member of Canadian society, and less difficult to do so where the law fails to take into account the claimant's actual situation.

(3) The ameliorative purpose or effects of the impugned law upon a more disadvantaged person or group in society. An ameliorative purpose or effect which accords with the
purpose of s.15(1) of the *Charter* will likely not violate the human dignity of more advantaged individuals where the exclusion of these more advantaged individuals largely corresponds to the greater need or the different circumstances experienced by the disadvantaged group being targeted by the legislation. This factor is more relevant where the s.15(1) claim is brought by a more advantaged member of society.

(4) The nature and scope of the interest affected by the impugned law or policy. The more severe and localized the consequences of the legislation for the affected group, the more likely that the differential treatment responsible for these consequences is discriminatory within the meaning of s.15(1).

While the s.15(1) claimant has the onus of establishing an infringement of his or her equality rights in a purposive sense through reference to one or more contextual factors, it is not necessarily the case that the claimant must adduce evidence in order to show a violation of human dignity or freedom. Frequently, where differential treatment is based on one or more enumerated or analogous grounds, this will be sufficient to found an infringement of s.15(1) in the sense that it will be evident on the basis of judicial notice and logical reasoning that the distinction is discriminatory within the meaning of the provision.

In the case of Brown *v.* BC Minister of Health, the plaintiffs maintained 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 the section 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 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 section 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 many preoccupations of legislatures.\(^\text{348}\)

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

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\(^{347}\) Brown v. B.C. Minister of Health (1990), 42 B.C.L.R. (2d) 294 (S.C.) [hereinafter Brown]

\(^{348}\) Andrews supra, note 210 at 168.
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.\textsuperscript{349}

In \textit{Ontario Nursing Homes Assn. v. Ontario}\textsuperscript{350} a judge accepted that a difference in government funding between nursing homes and homes for the aged was "illogical and unfair", but nonetheless concluded that a patient receiving care at a lesser level of funding was not denied any equality right under the Charter. He held that any discrimination was based upon the type of residence occupied by the nursing-home patient and that this was not one of the enumerated grounds in section 15(1). In effect, the "place of residence is not a personal characteristic”.

Other issues that may be changeable in the courts include those related to selection criteria for individuals seeking particular medical procedures. For example, there is the question of whether individuals with alcohol related liver disease should be excluded from having liver transplants. At least one center in Canada has decided that discrimination on this basis would be unethical and not in keeping with the ideals of the Canadian Charter.\textsuperscript{351} Alcoholism has been recognized as a disability by a provincial Human Rights Commission\textsuperscript{352} and thus, could be considered under one of the listed

\textsuperscript{349} Brown supra, note 351 at 315.
\textsuperscript{352} The Law of Charter supra, note at 125.
grounds of section 15. However, evidence of non-compliance with an alcohol abstinence regime might qualify as a medical ground for exclusion.\textsuperscript{353}

Section 15 could be applied to the use of medical criteria for rationing organs for transplants. A disadvantage caused to a group need not be intended.\textsuperscript{354} 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.\textsuperscript{355}

The relevant debate questions whether or not persons with similar needs should be entitled to similar services without regard to their enumerated status under section 15 and whether differences in services to those with similar needs offend the Charter. The argument that such differences infringe section 15 is relatively straightforward. A person is denied the equal benefit of the law because he or she suffers from a particular disability, or is a certain age. These distinctions are explicitly enumerated in section 15 and would appear to constitute discrimination under the definition advanced by the Supreme Court in Andrews.

\textsuperscript{353} Camire \textit{v.} Winnipeg (1989), [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".

\textsuperscript{354} Andrews supra note 210; Turpin supra note 329; Brooks \textit{v.} Canada Safeway Ltd., [1989] 1 S.C.R. 1219 [hereinafter Brooks]

Regarding potential justifications under section 1 (discussed in detail below), a lot will turn on the general attitude of the courts when confronting a constitutional challenge. It is possible that the legislative economic objective could be considered important enough in all of these cases; the issues will turn on the perceived reasonableness of the use of the particular categories to determine eligibility or to set levels of benefits.

Although not a constitutional case, the above mentioned Supreme Court of Canada decision in Brooks v. Canada Safeway Limited is significant for the way it dealt with the discriminatory denial of a non-governmental benefit program under human rights legislation.\footnote{356 Brooks, supra, note 358.} This is particularly so in light of McIntyre J.'s statement in Andrews that “the principles which have been applied under the Human Rights Acts are equally applicable in considering questions of discrimination under section 15(1)”.\footnote{357 Andrews, supra, note 210 at 175.}

In Brooks the Respondent employer provided a group insurance plan covering loss of pay due to accident or sickness. The plan covered pregnant employees subject to an exclusion coverage shortly prior to and following the expected date of delivery, regardless of the reason for the absence from work. The Court held that the plan discriminated on the basis of pregnancy and sex. The decision is known for its progressive recognition that pregnancy discrimination is a form of sex discrimination. The fact that the plan did not discriminate against all women, and therefore only affected
part of an identifiable group did not make the impugned distinction any less discriminatory. The Court also explained that “those who bear children and benefit society as a whole should not be economically or socially disadvantaged”.

One of the arguments made in support of the limitations of coverage for pregnant women was that mere underinclusiveness does not constitute discrimination. It was suggested that “the decisions to exclude pregnancy from the scope of the plan is not a question of discrimination, but a question of deciding to compensate some risks and to exclude others”\textsuperscript{359} This is the sort of argument one could imagine being made for economic reasons. Dickson CJ, however, rejected this argument:

\begin{quote}
Underinclusion may be simply a backhanded way of permitting discrimination. Increasingly, employee benefits plans have become part of the terms and conditions of employment. Once an employer decides to provide an employee benefit package, exclusions from such schemes may not be made in a discriminatory fashion...Benefits available through employment must be disbursed in a non-discriminatory manner.\textsuperscript{360}
\end{quote}

The Court’s approach to the basis of discrimination is as important as its understanding of the nature of inequality. Having established the health related purpose of the benefits plan and that pregnant women’s health related needs are as valid if not always the same as those covered, the Court concluded that the exclusion of pregnant women from the plan constituted discrimination. “Removal of such unfair impositions [imposing a

\textsuperscript{358} Brooks, supra, note 358 at 1243.  
\textsuperscript{359} Ibid. at 1239.  
\textsuperscript{360} Ibid. at 1240.
disproportionate amount of the costs of pregnancy] upon women and other groups in society is a key purpose of anti-discrimination legislation”. 361

4.6.5 Implications of the Equality Jurisprudence for Health Care Benefits:

a. Application of s.15(1) to Limited Access Based on Age:

The preliminary issue is whether a regulation denying access to dialysis for example to individuals aged over 65 draws a distinction on the basis of one or more personal characteristics, between a 65 year old person in need of dialysis and persons 64 and younger in need of dialysis, resulting in unequal treatment by the government. As in Eldridge and Eaton the policy affects a group of people (the elderly) already in a disadvantaged position (i.e. mandatory retirement etc.) within Canadian society.

The province funds dialysis for persons in need who are 64 years of age and younger. however the benefit of such health care service, in this hypothetical example, is not available for persons over 65 years of age. This reduced entitlement to benefit constitutes a denial of equality benefit of the policy under the first step of the equality analysis.

The same argument could be made that legislation or policy whereby individuals 65 years of age or older received only maintenance care as opposed to proactive treatment such as

361 Ibid. at 1238.
hip replacements could be considered discriminating.\textsuperscript{362} Age is one of the enumerated grounds of discrimination in s.15(1) of the Charter.

The key question in this case is whether the age distinction imposes a disadvantage upon the claimant as a person over 65 years of age in a manner which constitutes discrimination under s.15(1). Relatively speaking, people over the age of 65 have been consistently and routinely subjected to the sorts of discrimination faced by some of Canada's discrete and insular minorities. For this reason, it is easier as a practical matter for a court to conclude, from the facts of which a court may properly take judicial notice, that the legislative distinction at issue violates the human dignity of the claimant.

The claimant would argue that the regulatory distinction infringed s.15(1) in both its purpose and effect. The claimant would submit that the original intent underlying the distinctions created by the regulation was to give priority to health care services that would contribute to the most economically productive life years, based on an assumed correlation between increased age and one's ability to enter or re-enter the workforce following renal failure. The claimant would argue that the effect of the impugned regulation is to demean the dignity of adults 65 year of age and older and to treat them as being less worthy than younger persons, by stero-typing them as being less valuable.

The aim and effect of the regulation, in containing health care costs and funding what is economically efficient, impose a substantive long-term disadvantage on older people in this class. The regulation on its face treats older people differently and the differential treatment reflects and promotes the notion that they are less deserving of concern, respect and consideration. It perpetuates as well the view that people in this class are less worthy of recognition or value as human beings or as members of Canadian society. Given the contemporary and historical context of the differential treatment and those affected by it, the regulation stereotypes, excludes and devalues adults aged 65 years and older.

Andrews and the cases which followed it indicated a change in the Supreme Court’s approach to equality jurisprudence under the Charter. Most litigation before Andrews dealt with allegations of discrimination on bases of distinction which clearly do not violate section 15.

The Supreme Court’s decisions in Andrews, Turpin and Brooks indicate that the purpose of the equality guarantee is to benefit individuals and groups who have had unequal access to social, economic, political and legal resources, either because of direct discrimination or because of the adverse effects of facially “neutral” policy or legislation. Section 15 therefore rejects laws and government policies that create or shape disadvantage, and provides constitutional support for government action that promotes the equal enjoyment of the valued social interests historically limited to the advantaged persons in Canadian society. Consequently, section 15 often requires remedial treatment, to the extent that disadvantaged groups have not benefited from the existing social organization. It also requires a review of existing standards, to the extent that social
institutions are not designed to meet the needs of those who have been without the power to shape them. In this way, the constitutional right to equality at law may fulfill the goal of achieving equality in society.

This approach to equality acknowledges that disadvantaged groups must be the beneficiaries of positive action on the part of government. It does not suggest that these ameliorative, equality-promoting steps are immune from review. An employer’s disability plan must not be sex discriminatory. Welfare benefits for sole support mothers must not impose criteria based on sexual stereotype. Section 15(2) provides that section 15(1) does not preclude ameliorative programs and as such can be understood as an interpretative guide to section 15(1); it does not prevent a challenge of remedial programs where some aspect is discriminatory.

The Supreme Court’s recent equality decisions also suggest that where benefits programs are reviewed because they deny eligibility on a discriminatory basis, or a program does not address the needs of disadvantaged groups on an equal basis, the section 15 violation is for “underinclusiveness”. Unlike the similarly situated test where the concern of section 15 was the same treatment of those who are alike, the Supreme Court’s purposive approach is directed at achieving “an equality of benefit and protection and no more of the restrictions, penalties or burdens” for the disadvantaged as compared to the advantaged. Once the government offers a benefit, it cannot exclude disadvantaged groups or not address their needs on a discriminatory basis. This understanding of
equality is inherently different from that which formed the basis of the government statute audits prior to section 15 coming into force. Government actors now have a constitutional obligation to go back to make the benefits they provide inclusive of disadvantaged groups and their needs.

In principle, Canadian\textsuperscript{364} courts have held that the amount of resources devoted to a program is constitutionally relevant. Nonetheless, courts were traditionally hesitant about interfering with how government allocates its resources.\textsuperscript{365} In Eldridge the courts showed a willingness to address what it saw as blatantly underinclusive government spending, thereby further limiting allocation discretion.

Where cost-effectiveness analysis leads to criteria that are based on medically justifiable grounds, the courts will not interfere.\textsuperscript{366} Distinction on the basis of type of sickness or one that singles out an identifiable group of patients may also be problematic where that identifying feature is the reason for the different treatment.\textsuperscript{367} Discrimination may also be found where a decision has an adverse effect on an identifiable group even though one was not intended.

\textsuperscript{363} Andrews supra, note 210 at 165.
\textsuperscript{364} Finlay v. Canada (Min. of Finance), [1993] 1 S.C.R. 1080 (S.C.C.) [hereinafter Finlay 1993].
\textsuperscript{365} Illustrative of this judicial attitude is the case of R. v. King et al. (1988), 64 O.R. (2d) 768 (C.A.), where the Ontario Court of Appeal rejected a constitutional challenge to the Day Nurseries Act R.S.O. 1980 ch.111 brought by an operator of a day nursery who was charged with operating such a nursery without a requisite license required by the Day Nurseries Act. In the course of rejecting the argument Dubin A.C.J.O. rejected an argument that the Day Nurseries Act offended s.15 of the Charter. In passing he wrote that "public funding of daycare facilities is a social problem which is beyond the reach of the court." (at 774).
\textsuperscript{366} Brown supra, note 351.
The infringement of section 15 is not based on relative differences in funding per se; it is rather a result of someone being denied the equal benefit of a law or policy in a discriminatory manner. Where differences in benefits flow from differences in funding this might pose a constitutional issue, but it is the difference in benefits that is the constitutionally relevant consideration.

In Cameron\textsuperscript{368} the judge declined to define the term "medically required" or its equivalent of "medically necessary." He stated that what a court will do though is assess whether governments are complying with the process set out in legislation for determining if a procedure should be funded and will, when asked, ensure that government is not acting in a discriminatory manner that is contrary to the Charter, when determining which services it insures.

4.6.6 Section 15(2)

The equality guarantee provides a strong line of protection for the disadvantaged and disempowered, including the permissibility of affirmative action.\textsuperscript{369}

The purpose of section 15(2) is to ensure that affirmative action programs are not prevented by any interpretation of section 15(1). As Lepofsky and Bickenbach have argued, the general purpose of section 15(2) is:

\textsuperscript{367} Certain illnesses have been considered by the courts to be physical disabilities (e.g. AIDS see Brown supra note 189 at 309; cancer see Ont. (HRC) v. Gaines (1993), 16 O.R. (3d) 290 (Gen Div)).

\textsuperscript{368} Cameron supra, note 316.

\textsuperscript{369} Law supra, note 322 (discrimination based on age in pension scheme); Eldridge supra, note 250 at 624 (discrimination based on physical disability in provision of health services); Vriend supra, note 296 at 493
...to sanction the power of government to undertake programs, implement policies and enact laws which assist those groups in society whose social, economic or legal equality has traditionally been ignored. Section 15(2) is a safety valve which ensured that a court will not employ the Constitution in a manner which would thwart the goal of social and legal equality for disadvantaged groups in society.  

It seems that one cannot discuss the purpose of section 15(2) without considering the relationship between section 15(1) and 15(2). As courts and academics have begun considering whether and to what extent section 15(1) is relevant in determining the objective of section 15(2) they have developed two approaches to section 15(2). The first approach interprets section 15(2) as an exception to section 15(1). Section 15(2) is only implicated if a law or policy is found to be discriminatory under section 15(1), and then functions to insulate that law or program from being struck down. This appears to be the prevalent approach in the caselaw. For example, the Manitoba Court of Queen's Bench characterized section 15(2) in the following way:

...the guarantees in section 15(1) are qualified by 15(2) and programs which otherwise offend 15(1) are constitutionally acceptable where there is compliance with 15(2). In the result, section 15(2) creates a safe haven for government action designed and implemented to serve the objective spelled out in that statutory provision. I recognize that section 15(2) is narrow in scope as compared to the general equality provision of section 15(1).

The second approach to the relationship between section 15(1) and (2) implies that section 15 ought to be read as a whole, and that section 15(2) is an interpretative guide for

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establishing the meaning of the equality rights set out in section 15(1). Taking this approach, Black and Smith have argued:

If section 15(1) does not itself provide for the amelioration of conditions of disadvantaged individuals and groups, the two subsections would seem to reflect views of equality that are fundamentally at odds with one another.

According to the second approach, the purpose of section 15(2) cannot be established independent of section 15(1). This leads to an interpretation of section 15 as a provision designed to promote social equality for disadvantaged individuals and groups, a characterization that is consistent with the general conception of equality advanced by the Supreme Court.

There have not been many cases interpreting section 15(2) of the Charter. In the few reported cases, there has been very little discussion of the meaning and scope of the section and no discussion of how it would be applied to health care benefits. As well, there are no Supreme Court decisions interpreting section 15(2), so we remain without authoritative guidance on a number of important interpretative issues. For these reasons, an examination of the following cases should not be taken as an indication of how a court will react to a challenge to a health care policy or statute. What follows from the case law


and the academic commentary is that some judicial review of affirmative action programs is appropriate. The mere declaration by government that a particular program was designed to improve the conditions of a disadvantaged group has not been and ought not be sufficient to determine its constitutionality. The difficult issue is how much and in what circumstances is such review appropriate.

Although most judges have found “underinclusive” laws or benefits programs in violation of section 15(1), the case of Brown v. British Columbia (Minister of Health)\footnote{Brown supra, note 351 at 139 (B.S.S.C.)}, mentioned above, is an example of a limited benefits program being upheld under section 15(1). In this case, the Plaintiff challenged the Ministry of Health’s policy of funding drugs for cancer and organ transplant patients, but not for those with AIDS.

In rejecting the Plaintiff’s arguments Coultas J. stated:

Comparing cancer and transplant patients to HIV patients, the treatment therapies used are very different. The cancer and transplant societies were established to encourage reliance on the expertise developed by them in the administration of complicated and constantly changing medical and drug protocols. The protocol for AZT is not ever changing nor is it complicated. In my view, the distinction between HIV therapy and cancer and transplant drug therapy is and accommodation of the medical difference, it is not the sort of inequality addressed by s.15 of the Charter.\footnote{Brown Ibid. at 157.}

In Brown, Coultas J. held that even if section 15(1) were infringed, the special drug funding programs could be saved under section 15(2). In the Robert case, it was concluded that while age limitations in the disability subsidy program were discriminatory, the program could be upheld pursuant to the special programs provisions
in the Ontario Human Rights Code. In reaching this conclusion, Chairperson Backhouse seemed especially concerned about leaving virtually all special programs open to a challenge of underinclusiveness. As she put it, “it is unlikely that any affirmative action yet designed could operate on a completely inclusive basis.”

In Shewchuk v. Ricard the British Columbia Court of Appeal struck down the provision of the Child Paternity and Support Act on the basis of section 15. With regard to section 15(2), Justice MacFarland wrote:

Section 15(2) excuses discrimination under section 15(1) if the object of the discrimination is the amelioration of conditions of disadvantaged individuals or groups.

The majority held that the provisions excluding men from applying for a remedy under the Act could not be construed as ameliorating the conditions of the disadvantaged group, i.e. children. The Act was nonetheless upheld as not infringing section 15(1). In a concurring judgment, Nemetz, J.A. underlined the need to scrutinize carefully programs under the subsection, although he would have supported the provisions under section 15(2):

Affirmative action programs contemplated under section 15(2) inevitably provide preferential treatment for certain disadvantaged groups... [I]t is my opinion that affirmative action laws or programs must be carefully scrutinized to ascertain (a) whether the law or program is in fact an ameliorative one for disadvantaged individuals or groups including those set out in section 15(2), and (b) if

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379 Shewchuk supra, note 376.
380 Ibid at 376.
ameliorative, or whether the effect of the law or program is so unreasonable that it is grossly unfair to other individuals or groups. 381

In Re MacVicar and Superintendent of Family & Child Services, 382 the Supreme Court of British Columbia refused to save provisions regarding adoption proceedings under section 15(2). The court stated with regard to the general purpose of the section:

It was included in the Charter to silence the debate that rages elsewhere over the legitimacy of affirmative action...It was not intended to save from scrutiny all legislation intended to have a positive effect...

Section 15(2) is intended to protect legislation which singles out a group for preferential treatment in order to cure a disadvantage. There must be a rational connection between the preferential treatment and the disadvantage. Section 15(2) excuses discrimination under section 15(1) if the persons in favour of whom the distinction is made are disadvantaged and the object of the discrimination is the amelioration of that disadvantage... 383

With regard to the provision in question, the Court stated:

If this provision could be saved, little discriminatory legislation could ever be attacked successfully, for almost all positive law has as its stated object the betterment or amelioration of the condition in our community of a disadvantaged individual or group. The general object was the only one suggested by the superintendent as justification for the provisions: this legislation is for the welfare of children disadvantaged by the marital status of their parents. That is not enough, in my view, to invoke the saving provision in section 15(2). 384

Similarly, in Reference Re the Family Benefits Act (N.S.), the Nova Scotia Court of Appeal held that the infringement of section 15(1) was not justifiable under section 15(2) since family benefits could not be considered as affirmative action:

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381 Shewchuk supra, note 376 at 330.
383 Re MacVicar Ibid. at 502.
384 Re MacVicar supra, note 386 at 503.
There is no evidence that benefits payable under the Family Benefits Act can be classified as an affirmative action program. The object of the program is clearly the relief of poverty. There is nothing new in the purpose of the legislation. The history of the legislation clearly shows that it was not designed to overcome past discriminatory practices.\textsuperscript{185}

In \textit{Friesen v. Gregory}\textsuperscript{186} the Saskatchewan Unified Family Court upheld a provision of the Unmarried Parents Act which allowed a woman to bring an action against the supposed father of her child to require him to pay support for the child, without giving a correlative right to the father. The provision was upheld under section 15(2) on the grounds that it was to ameliorate the conditions of a disadvantaged group, namely single mothers. It was argued that before section 15(2) could apply, it must be demonstrated that the discriminatory aspects of the legislation are required to achieve the ameliorative purpose of the legislation. The court proceeded on the basis that this was required, stating that “it would appear, therefore, that discrimination against putative fathers is required to attain the ameliorative object of the Act”.\textsuperscript{187}

In the Court of Appeal of British Columbia decision of \textit{Harrison v. University of British Columbia}\textsuperscript{188} it was held that in order for a program to have as its object the amelioration of a disadvantaged group, the group given a special advantage must be shown to be disadvantaged in comparison with persons denied the advantage. A program comes within section 15(2) only if the legislative purpose was to assist a disadvantaged group


\textsuperscript{187} Ibid. at 248.

and the need to exclude others from the benefits conferred by the legislation was properly considered.

A very strict standard of judicial review was imposed in *Manitoba Rice Farmers Association v. Human Rights Commission* (Man.)\(^{389}\) striking down a program (approved by the Human Rights Commission) giving native people the first option to license new production areas for wild rice.

In order to justify a program under section 15(2), I believe there must be a real nexus between the object of the programs as declared by the government and its form and implementation. It is not sufficient to declare that the object of a program is to help disadvantaged groups if in fact the ameliorative remedy is not directed towards the cause of the disadvantage. There must be a unity or interrelationship amongst the elements in the program which will prompt the Court to conclude that the remedy in its form and implementation is rationally related to the cause of the disadvantage.\(^{390}\)

The program was struck down in light of the impact on non-natives, on grounds that the disadvantage suffered by native people did not flow from an inability to get licenses, but rather flowed from a lack of resources more generally.

The *Manitoba Rice* decision was overturned by the Court of Appeal, on grounds that the trial judge did not have jurisdiction to set aside the approval of the Human Rights Commission to the scheme. In the interim, the plan had been amended, and the Court of Appeal did not address whether the original scheme violated section 15(1) or was saved by section 15(2). Nevertheless, it did cast doubt on the persuasive authority of the

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\(^{389}\) *Manitoba Rice* supra, note 376 at 101-2.

\(^{390}\) Ibid.
judge's opinion in the lower court since the order which he made consequential upon his decision has been set aside.

Many of the arguments made in the 1989 report prepared for the Ministry of Community and Social Services on the impact of the Charter on the provision of adult social services in Ontario are supportable.\(^{391}\) In particular, the tension highlighted by Friesen and Harrison, where it was held that the government must prove that the measures are necessary to achieve the legislative purposes, is convincing. On the one hand, this does not seem required by the language of section 15(2), and it would appear to impose too strict a standard on government. On the other hand, there is no denying that the effect of some programs will be to exclude certain individuals and groups from a benefit or opportunity which they would otherwise have expected to receive. I also recognize that the issue of affirmative action is controversial, and courts may be troubled by programs that do not extend benefits to all who arguably require them. Accordingly, it seems prudent to design programs as rationally and reasonably as possible, (this is also required by section 1) justifying the need to do so and minimizing to the extent possible the exclusion of similarly situated groups. This seems to be the thrust of the approach suggested by Black and Smith, where they write the following:

Affirmative action plans are necessarily limited to certain specified groups. As a result, they will inevitably exclude some people who have suffered comparable disadvantage, and those people may claim a denial of equal benefit of the law.

\[T\]he appropriate guide [to resolve these conflicts] is that a provision which adversely affects other must contribute significantly to the achievement of the

goals of an affirmative action program. In addition, we derive guidance from the fact that section 15(2) specified that the program should have as its object the amelioration of conditions of disadvantaged groups. This wording suggests that a law or program is not saved by section 15(2) if the benefit to a disadvantaged group is an accidental side-effect rather than the purpose of the provision. We also think a program would be suspect if the criteria for inclusion in the program were inconsistent with the goal of ameliorating disadvantage... if the most severely disadvantaged members of a group were excluded, for example.392

The suggestion in the Nova Scotia Family Benefits Reference that there needs to be a finding of past discrimination to justify a program under section 15(2) is unpersuasive. This imports a requirement from U.S. constitutional law that is not appropriate given the different language and structure in our constitution.393 It should be sufficient that the group is disadvantaged.394

This begs the question of whether there need be a prior finding of "disadvantage" before section 15(2) is available.395 Although the text of section 15(2) is inconclusive, a number of practical considerations suggest that such a finding would be preferable. First, it seems obvious that courts will assume the authority to determine for themselves whether a particular group is disadvantaged for the purpose of section 15(2).396 Equally obvious is the fact that there will be strong self-imposed pressures on the court to defer to a

392 S.15, Meaning, supra note at 597-98.
393 One might note that some scholars argue that equality is a universal imperative which is not dependent upon the text or structure on a constitution. Gold supra, note 396.
395 Ibid. at 261.
396 See, e.g., Manitoba Rice, supra, note 376, where the Court ultimately conceded that native people were a disadvantaged group.
legislative judgment that such a group is disadvantaged. To the extent that such a legislative finding includes evidence respecting the disadvantaged position of a given group, this information will improve the perceived legitimacy of the remedial measures under review. Second, it is important to remember that section 15(2) operates only with respect to section 15(1). A prior determination that a target group is disadvantaged will assist the task of the person seeking to uphold the program, at least inasmuch as it would confirm the "reasonableness" (if not the necessity) of the remedial measures impugned.

First, the point of saying that s. 15 is a positive right is that guaranteeing equality is not merely a matter of removing hurdles but of building bridges. That is, if equality is a positive right, then if it is infringed the government may be required to provide services or implement programs that will actually remedy the unequal state of affairs. If, for example, a developed mentally disabled person is held by the court to have been deprived of his or her right to equality, because there are no special education facilities available...the court may instruct the provincial government to provide those facilities.

It seems that section 15(2) directs a court to be relatively deferential to legislated programs designed to ameliorate the conditions of disadvantaged groups. This does not mean however, that all challenges to such programs will fail, or that all challenges should fail. And it certainly does not mean the government, in the discharge of its obligations under the Charter, is relieved of the duty to ensure that its programs are effective and properly inclusive of those in need.

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397 See Turpin, supra, note 329.
4.6.7 Residence

While place of residence is not a prohibited ground of discrimination listed in section 15, a number of courts have considered distinctions based on residence to violate the Charter. In R. v. Turpin, discussed earlier, the Supreme Court left open the possibility that distinctions based on province of residence could be discriminatory under section 15.

I would not wish to suggest that a person’s province of residence...could not in some circumstances be a personal characteristic of the individual or group capable of constituting a ground of discrimination. I simply say that it is not so here.

It seems to follow that distinctions based upon place of residence within a province could also be discriminatory. There is no principled reason to distinguish between the two for the purposes of the Charter. Until the matter is resolved in the courts, it may be assumed that place of residence could be considered an analogous ground under section 15. This does not necessarily mean that a province is no longer entitled to allocate its services selectively within a province. Nor does it necessarily mean that differences in the availability of services between different areas of the province will violate the Charter or that variation in the use of economic principles to limit funding of services will violate the Charter.

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400 Turpin supra, note 329.
401 Turpin, supra, note 329 at 143.
Equality does not mean identical treatment. If there is a specific need in one area but not in another, a government decision to establish a program in that area of need will not infringe equality rights. It is appropriate to create programs that address the greatest needs and where numbers warrant the provision of services at public expense.\textsuperscript{402}

Challenges based upon section 15 would be directed to the legislation or program considered as a whole. So long as the program as a whole can be justified, the fact that an individual is denied a service or is provided with a service under less-advantageous conditions will not breach the \textit{Charter}.

While inconsistent access to medically necessary health care services exists between provinces and territories, residence may not qualify as a ground of discrimination recognized under section 15 because diversity on matters within provincial or territorial jurisdiction is generally to be expected. But where a recognized national standard exists and where provinces have promised uniform obligations under a plan like the federal/provincial cost sharing programs, inter-provincial comparisons will be appropriate. Nevertheless, it may be difficult to make an analogy between provincial or territorial residence and the enumerated grounds in section 15, a task which the Supreme Court suggests forms part of the test of recognizing an unenumerated ground of distinction.\textsuperscript{403} It may also be inappropriate to refer to all provincial or territorial residents as the type of powerless, "discrete and insular minority" to which the Supreme Court has

\textsuperscript{402} E.g. Katherine Hankins study of HIV prevalence (CMAJ)

\textsuperscript{403} Andrews supra, note 210.
said the Charter’s equality protections will be extended.\textsuperscript{404} It may be easier to establish protections on the basis of residence within a specific province or territory, such as divisions based on urban or rural residence, because they do not raise issues relating to division of power or jurisdiction.

The principles of section 36 of the Constitution\textsuperscript{405} may be used to support the recognition of provincial or territorial residence as an analogous ground warranting constitutional protection. Section 36 reads:

\textit{36(1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to (a) promoting equal opportunities for the well-being of Canadians; (b) furthering economic development to reduce disparity in opportunity; and (c) providing essential public services of reasonable quality to all Canadians.}

This provision establishes a federal/provincial or territorial commitment to standardized services. Promoting equal opportunities for the “well-being” of Canadians has a clear physical component and relates directly to health services. Subsection 36(1)(c) works as a general reaffirmation of the principle of regional equality presented by the criteria of comprehensiveness, accessibility, universality and portability in the CHA. Therefore, this section may provide some support to a constitutional grouping around residency.

In \textit{Jasmine v. Cite de la Santa de Laval}\textsuperscript{406} a section 15 Charter infringement was invoked in a Quebec case involving a hospital by-law. The plaintiffs challenged a by-law that

\textsuperscript{404} Ibid.
\textsuperscript{405} Constitution Act 1982 [en. by Canada Act, 1982 (U.K.), c.11, s.1].
gave preference to residents of the district to receive obstetrical care in the hospital. The Quebec Superior Court held that the by-law infringed section 15 of the Charter. 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.407

Geographic location may be one of the unlisted grounds for which discrimination is prohibited. However, whether one could argue a Charter case on the basis of regional differences in health care between provinces is uncertain. As mentioned above, in the case of R. v. Turpin408 the Supreme Court 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.409

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 Turpin case. But the scope for allowable difference in health legislation is reduced by the commitment to national equality found in the Canada Health Act410 and the Charter.


407 R.S.Q., s.5, as amended.

408 Turpin supra, note 329.

409 Ibid. at 133.

410 Canada Health Act supra note 6 at Section 36 of the Constitution Act, 1982, supra note 248 contains a commitment to the promotion of "equal opportunities for the well-being of Canadians" and of "essential
The case of Pontiff (Town) v. Saskatchewan\(^{411}\) focused on the issue of equal availability of medical services, within a reasonable distance from one’s residence. In this case an application was brought for an interlocutory injunction to prevent what was perceived as reduced emergency nursing services at a local hospital. The Court found that changes had arisen as a result of the government’s conclusion, in 1993, that significant alternatives were necessary in the delivery of health care services in Saskatchewan. The Court rejected the applicants’ position that all people in Saskatchewan are entitled to the same standard of medical care regardless of where they choose to reside.

This, of course is a physical and economic impossibility for any government. It is surely incongruous in the extreme to expect that people who choose to reside, for example, on the north shore of Lake Athabaska, should be entitled to the same standard of health care on that north shore as is readily available to the people who live in Regina or Saskatoon. I cannot hold that the Charter requires government to do that which is physically or economically impossible and patently unreasonable.\(^{412}\)

4.6.8 Implications of Section 1 Allocation Decisions:

Section 1 requires that the government justify its infringement of a Charter guarantee by demonstrating conformity with the rules imposed on the legislature and executive by the Charter, as the supreme law of the land. The government can limit a specified right only if it satisfies the normative test of justification. Mere enactment is insufficient.\(^{413}\)

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\(^{411}\) Pontiff (Town) v. Saskatchewan, unreported, September 16, 1994 (Sask.Q.B.).

\(^{412}\) Ibid at para.22.

\(^{413}\) Eisenstat Weinrib supra, note 299 at 33.
Section 1 of the Charter provides for the limitation of rights and freedoms. Section 1 provides:

The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

The person seeking a remedy has the initial burden if establishing the unconstitutionality of the impugned legislation or official action. This involves interpreting the meaning of the Charter right or freedom engaged, and determining whether it has been infringed by the law or policy. If a court concludes that the Charter has been violated, the burden shifts to the party defending the law or action to justify it under the terms of section 1 of the Charter. The responsibility of the court is to determine whether the purpose of the legislation being challenged is important enough to justify the infringement of the Charter right or freedom, and whether the means chosen to achieve that purpose are themselves reasonable and justified in terms of the objectives sought. The court will state whether or not the Charter violation has been justified under section 1, and depending on the nature of the case, the court may provide a remedy or remedies under section 24.

For a law to comply with section 1 it must meet the requirements set out in Regina v. Oakes, the burden of proof is on the government or other defender of the violative legislation or government action to demonstrate the sufficiency of the state interest it asserts and to establish that the means employed are reasonable and justified in terms of the objectives sought. In contrast to Charter rights that are deontologically based, the

414 The basic framework was set on R. v. Oakes, [1986] 1 S.C.R. 103 (S.C.C.) at 138-140. [hereinafter Oakes]
balancing of interests which is integral to s.1 analysis is also grounded in and recognizes
the value of consequentialism. In attempting to fulfill its burden, the government will
have to be able to provide the court with evidence and arguments to support its general
claim of justification. In a challenge of allocation policy this would likely involve
demonstrating why the government made certain policy choices and why it considered
these choices to be reasonable in the circumstances. Policy choices, such as the
allocation of health care resources, which require the balancing of competing claims and
the evaluation of complex and conflicting social science research have been described as
more appropriately addressed by government than courts.

Joel Bakan has argued that the four criteria set out in Oakes are themselves indeterminate
and seem to rely on judicial choice and discretion. The first and fourth criteria seem to
demand it. Whether or not efficiency in resource allocation is considered a purpose
"sufficiently significant to warrant overriding a constitutionally guaranteed right" and
whether its importance outweighs the "deleterious effects" of a particular policy, are
matters of opinion, not legal necessity. In most cases the Court has found that the
"sufficient importance" of the legislation in question is self-evident. It seems to avoid the
balancing of legislative objective against effects contemplated by the fourth criterion as a
ground for not upholding legislation under section 1.

417 J. Bakan, Just Words: Constitutional Rights and Social Wrongs (University of Toronto Press: Toronto,
1997) at 28. [hereinafter Bakan]
By contrast, the second and third criteria have been more commonly used by the Court to strike down legislation and government policy. Both criteria address the relationship between the means chosen by the legislature and the objective of the legislation. The requirement of means/ends proportionality seems to imply a level of technical objectivity when the determining factor is whether there is a sufficiently tight fit between the means and the end.\textsuperscript{418} In determining whether or not limiting access to a particular health care service for example fits the purpose of cost constraint or efficiency, that it was designed to achieve, the courts cannot avoid making controversial choices concerning the wisdom and desirability of the allocation policy.

The criteria "rationally connected" and "impair as little as possible" are indeterminate as well. Even judges differ how connected the means and the ends must be to satisfy the requirement of "rationally connected" and on how little a law or policy must impair a right or freedom to qualify as impairing that right or freedom "as little as possible".\textsuperscript{419}

In addition the way the Court describes the purpose of a government policy will affect the argument about the proportionality of means and end. The tightness of the fit will be determined by the language used to describe the purpose. If the purpose is described as tautologically equivalent to the allocation policy, then there will be a perfect fit. If the purpose is defined in general abstract terms, while the allocation policy is very specific

\textsuperscript{418} Bakan supra, note 422 28.
\textsuperscript{419} While in cases such as RJR-MacDonald supra note -- the Court has rigidly applied the least restrictive means test, there are several examples of the Court moving away from a rigid application of this test i.e. McKinney supra note 315; \textit{R. v. Keegstra}, [1990] 3 S.C.R. 697, \textit{R. v. Butler}, [1992] 1 S.C.R. 452.
then the fit will seem much looser. For example if the purpose of a policy is to increase the efficiency of allocating health care dollars and only services found to be economically efficient are funded, there is a tight fit. If the purpose is characterized as improving the health care system and funding is limited to economically efficient health care services, then the fit is looser.

To do so the government must prove that the purpose of the legislation or policy is "of sufficient importance to warrant overriding a constitutionally protected right or freedom"; the measures adopted are rationally connected to the objective"; the measures, "even if rationally connected to the objective in the first sense.... impair as little as possible the right to freedom in question"; and the deleterious effects" of the measures "are outweighed by the importance of the objective". The complainant has the onus of showing that her or his right has been infringed and then the government must demonstrate why it should override the constitutionally protected interests. The Supreme Court seems to be divided in terms of how to apply section 1 of the Charter; there is considerable literature exploring the inconsistent application of section 1. While in some cases, courts have demanded that government justify its laws very strictly, in the area of social and economic legislation, courts have shown a considerable degree of deference to the legislature.

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420 Oakes supra, note 419 at 136-8.
In *RJR MacDonald Inc.* McLachlin J. described the reasoning process involved in justifying a measure under section 1 as one where the question is whether the measure can be justified by application of the processes of reason. In the legal context, reason imports the notion of inference from evidence or established truths. This is not to deny intuition its role, or to require proof to the standards required by science in every case, but it is to insist on a rational, reasoned defensibility.

The analytical method for determining whether a law constitutes a “reasonable” limit that can be “demonstrably justified in a free and democratic society” under s.1 was first set out by Dickson C.J. in *R. v. Oakes.* While it has been fine-tuned through subsequent cases, “the general approach is now well established”.

In considering the implications of this section for policy formation that limits access to health care services it is important to appreciate the underlying principles animating this general approach. In *Oakes* Dickson C.J. deontologically stated that the inclusion of the words “free and democratic” as the standard of justification in s.1 of the *Charter*

> ...refers the Court to the very purpose for which the *Charter* was originally entrenched in the Constitution; Canadian society is to be free and democratic. The Court must be guided by the values and principles essential to a free and democratic society which I believe embody, to name but a few, respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society. The underlying values and

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423 *RJR* supra, note 296 at 382.
424 *Oakes* supra, note 419.
425 M. supra note 420; See Egan supra, note 329 per Cory and Iacobucci JJ. at para. 182; Eldridge supra, note 250 at para. 84 per La Forest J.; Miron supra, note 329 at para. 163, per McLachlin J.; *Vriend* supra, note 296 at para 108 per Cory and Iacobucci JJ.
principles of a free and democratic society are the genesis of the rights and freedoms guaranteed by the Charter and the ultimate standard against which a limit on a right or freedom must be shown, despite the effect to be reasonable and demonstrably justified.\footnote{Oakes supra, note 419 at 136.}

In Vriend it was explained that the introduction of the Charter brought about

"redefinitions of our democracy".\footnote{Vriend supra, note 296 at 134.} At the heart of this democratic ideal is a relationship of mutual respect between the courts and the legislatures\footnote{M. supra, note 420 at para.78.} which encompasses the idea that:

[i]n carrying out their duties, courts are not to second-guess legislatures and the executives; they are not to make value judgements on what they regard as the proper policy choice; this is for the other branches. Rather, the courts are to uphold the Constitution and have been expressly invited to perform that role by the Constitution itself. But respect by the courts for the legislature and executive role is as important as ensuring that the other branches respect each others' role and the role of the courts.\footnote{...}

a. Pressing and Substantial Objective:

Under the section 1 test set out in R. v. Oakes\footnote{...}, the first inquiry is whether the government objective relates to concerns which are pressing and substantial in a free and democratic society. The second inquiry involves a proportionality test. In Andrews, Justice McIntyre suggested that the first aspect of the Oakes test is too stringent when applied to breaches of the equality guarantees. He would alter the standard requirement that the state interest must be pressing and substantial and replace it with the less onerous test of whether the government can establish a desirable social objective. The majority of
the Supreme Court did not, however, endorse this lower level of judicial scrutiny in the case of a breach of section 15. The Court therefore split on both the interpretation and application of section 1. According to the majority judgment of Justice Wilson, the government will still be required to demonstrate a pressing and substantial state interest, regardless of whether the breach of the infringed right occurred under section 7 (life, liberty and security of the person) or section 15 (nondiscrimination). This is an important aspect of the decision because a lower level of judicial scrutiny for equality infringements may impair the evolution of equality theories and discourage the use of equality arguments.

A government attempting to establish its pressing and substantial interest in the funding of health care services, research etc., could be expected to ground its arguments in both deontology and consequentialism. It might argue that in order for the government to truly respect the inherent value of all persons, it must be prudent in its spending so as not to overburden the health care system. Under section 1, a court would evaluate the propriety of the legislative goal proposed and then assess the proportionality of the means to attain those ends.

In *Waldman*\(^{431}\) the petitioners Waldman, Wong and Biro were all medical doctors. They applied to the Medical Services Commission of British Columbia to be issued billing numbers entitling them to bill the Medical Services Plan of British Columbia for medical

\[^{429}\text{Vriend supra, note 296 at 136.}\]
\[^{430}\text{Oakes supra, note 257.}\]
services provided by them to patients. They had been issued restricted billing numbers. Waldman and Wong were entitled to bill the Plan 50% of the fees established by the Commission for services provided to patients or to practice as locum tenens in place of established doctors. Dr. Biro could bill the Plan 100% of the fee schedule but only for services provided to patients at the Prince George Regional Hospital. In this case quality health care and cost control were considered pressing and substantial objectives.

The "objective" being analyzed is sometimes characterized as the objective of a policy or legislation and other times the objective of the omission. When dealing with underinclusive policies it is important to consider the impugned omission when defining the objective. Often, allocation policies do not only further one goal but rather strike a balance among several goals, some of which may conflict. The balancing at the heart of the policy may only be recognized by asking in the case of underinclusive funding of health care services, whether there is any objective being furthered by the impugned policy. A consideration of what is omitted from legislation or policy may also lead a court to refine its interpretation of the objectives of the impugned legislation, possibly reducing its scope. In M v. H, it was argued that if the omission is not taken into account in construing the objective, then it is more likely that the omission will cause the impugned policy to fail the rational connection step of the proportionality analysis.

432 M. supra, note 420 at para.100.
Therefore, in analyzing an allocation policy the economic goal of cost-containment, or
efficiency should be factored into the objective. If described solely as a policy
implementing the funding of health care services, it is more likely that its
underinclusiveness will be considered a breach of the Charter.

b. Proportionality Analysis:

(a) Rational Connection:

Next the focus of the s.1 analysis shifts from the objective alone to the nexus between the
objective of the policy or provisions being evaluated and the means chosen by the
government to implement the objective. The means chosen include both the impugned
policy and the omission in question. The government must demonstrate that there is a
rational connection between the objective and the means.433

In Waldman Leaven J. found that the governmental respondents provided no evidence of
the significance of the savings expected or of the economic effects of these measures as
compared with other cost-saving measures contemplated or implemented. The judge
found that the respondents’ submissions made a leap of logic from the pressing and
substantial importance of controlling health care costs to the conclusion that restricting
the rights of new entrants to the medical profession is rationally connected to that
objective. It was found that the respondents failed to prove on the balance of
probabilities that there was a rational connection between the objectives of quality
medical care and controlling health care costs and the infringement of the petitioners' mobility and equality rights under the Charter.

(b) Minimal Impairment

When government action impairs constitutional rights, the government must demonstrate that the impairment is no more than is reasonably necessary to achieve its goals.434

McLachlin J. in RJR MacDonald Inc.435 summarized that proportionality required that the government show that the measures at issue impair the right of free expression as little as reasonably possible in order to achieve the legislative objective. The impairment must be "minimal", that is, the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternative, the courts will not find it overboard merely because they can conceive of an alternative which might better tailor objective to infringement.

(a) Proportionality Between the Effect of the Measure and the Objective

In order for an impugned allocation policy to survive the final stage of s.1 scrutiny there

...must be a proportionality between the deleterious effects of the measures which are responsible for limiting the rights or freedoms in question and the objective,

433 Oakes supra, note 419 at 141; Vriend supra, note 296 at 118.
434 Eldridge supra, note 250 at para.86; Miron supra, note 329 at 163.
435 RJR supra, note 296 at 342.
and there must be a proportionality between the deleterious and the salutary effects of the measures.\textsuperscript{436}

The Supreme Court of Canada has confirmed that the application of the \textit{Oakes} test requires close attention to the context in which the impugned legislation or policy operates.\textsuperscript{437} The Supreme Court also held that where the legislation under consideration involves the balancing of competing interests and matters of social policy, the \textit{Oakes} test should be applied flexibly, and not formally or mechanistically.\textsuperscript{438} There are competing perspectives from the court with respect to government funding discretion. The Supreme Court of Canada has stated that while financial considerations alone may not justify \textit{Charter} infringements,\textsuperscript{439} governments must be afforded wide latitude to determine the proper distribution of resources in society.\textsuperscript{440} On the other hand, members of the Court have suggested that deference should not be accorded to the legislature merely because an issue is a "social" one or because a need for governmental "incrementalism" is shown.\textsuperscript{441}

As Dickson C.J., Lamer and Wilson JJ. stated in \textit{Irwin Toy},

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 meant to let us all share in the responsibility of these difficult choices. Thus, as courts review the result of the

\textsuperscript{438} See Keegstra supra, note 424 at p.737, McKinney supra, note 315; \textit{Irwin Toy} supra, note 421 at 999-1000, \textit{Committee for the Commonwealth of Canada v. Canada}, [1991] 1 S.C.R. 139 at p. 222 (per L'Heureux-Dube J.) and RJR- supra, note 296 at par. 63 (per la Forest J.) and at pars 127-138 (per McLachin J.).
\textsuperscript{440} See McKinney supra, note 315 at 288 and Egan supra, note 329 at para 104 (per Sopinka J.)
\textsuperscript{441} See Egan supra, note 329 par 97 (per L'Heureux-Dube J.) and at par. 215-216 (per Iacobucci J.).
legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of legislatures' representative function.\textsuperscript{442}

With respect to the concept of deference, McLachlin J. in \textit{RJR MacDonald Inc.}\textsuperscript{443} explained that as with context, care must be taken not to extend the notion of deference too far. Deference must not be carried to the point of relieving the government of the burden which the \textit{Charter} places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable. Parliament has its role: to choose the appropriate response to social problems within the limiting framework of the Constitution. But the courts also have a role: to determine, objectively and impartially, whether Parliament's choice falls within the limiting framework of the Constitution. The courts are no more permitted to abdicate their responsibility than is Parliament. To carry judicial deference to the point of accepting Parliament's view that limiting the funding of medical services based on economic principles simply on the basis that the problem is serious and the solution difficult, would be to diminish the role of the courts in the constitutional process and to weaken the structure of rights upon which our constitution and our nation are founded.

It appears as if the amount of funding that the Ministry of Health provides for the cost of certain devices such as hearing aids, wheelchairs and the like has been tied to the age of

\textsuperscript{442} Irwin Toy supra, note 421 at 993.
\textsuperscript{443} RJR supra note 296 at 332.
the client. To the extent that there remain any age-based limitations or distinctions, they would have to be justified under section 15 and 1 of the Charter. In order to meet the civil burden of proof 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.

The essence of the similarly situated test has not disappeared from equality analysis under the Charter. Wherever a legislative distinction burdens one group at the expense of another such that section 15 is infringed, the section 1 analysis must confront the question of whether there are differences between these two groups that would justify the different treatment. Accordingly, section 15 will still require an analysis of whether persons with similar needs ought to be provided with the same services, but the analysis will take place at a different stage in the inquiry. If a government action restricts a Charter guarantee, section 1 requires that it must be only “to such reasonable limits prescribed by law” that

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445 Oakes supra note 419 at 139.
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.\(^447\)

The “prescribed by law” requirement means that the law or policy must specify the criteria by which the right will be limited, or it must be implicit from its terms or operating requirements.\(^448\) It “cannot be vague, undefined, and totally discretionary” leaving limits “to the whim of an official.” That is, legislators cannot make “blank cheque” laws,\(^449\) i.e. need firm rules, not nuanced judgements.

Where the 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 Jasmine case, mentioned earlier,\(^450\) there was no analysis of section 1. However, the Quebec Superior Court did not accept that the hospital’s need to decrease its deficit was a sufficient reason to restrict admission to patients within the district. Wilson J. in Singh\(^451\) made it clear that administrative convenience is not a sufficient reason to override a Charter guarantee.

\(^447\) Some sections have internal limits. For example, section 15 appears to require an evaluation of whether an inequality amount to “discrimination”. Whether the review occurs within the section or under section 1 is important 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 at 264-272.


\(^450\) Jasmine supra, note 411.

It is unclear whether special program provisions should be used to justify discriminatory underinclusive programs. It can be argued that when the individual challenging the program is a member of a socially disadvantaged group, neither section 15(2) of the Charter, nor special program provisions in human rights legislation should be relied upon to insulate a partial program from legal scrutiny. Nevertheless, it may be possible to justify underinclusiveness by interpreting special program provisions as requiring an assessment of the competing equality claims at issue in the particular case. Alternatively, recourse may be had to section 1 of the Charter. Section 1 of the Charter has already been relied on to justify underinclusive legislative provisions. In McKinney, for example, the Supreme Court accepted the constitutional validity of an incremental approach to the addressing of serious social problems. As noted above, at issue was the provision in the Ontario Human Rights Code that limited protection against age discrimination to those under the age of sixty-five, therefore leaving individuals subject to mandatory retirement policies without any recourse under human rights legislation.

In upholding the limited protection pursuant to section 1 of the Charter, La Forest J. wrote:

> In looking at this type of issue, it is important to remember that a legislature should not be obliged to deal with all aspects of a problem at once. It must surely be permitted to take incremental measures. It must be given reasonable leeway to deal with problems one step at a time, to balance possible inequalities under the law against other inequalities resulting from the adoption of a course of action, and to take account of the difficulties, whether social, economic or budgetary, that would arise if it attempted to deal with social and economic problems in their entirety.\(^\text{452}\)

\(^{452}\) Note the different outcome in Re Blainey and Ontario Hockey Association (1986), 54 O.R. (2d) 513 (C.A.) [hereinafter Blainey]; leave to appeal denied [1986] 1 S.C.R. where limitations on protections for
In support of this perspective, La Forest J. cited Dickson C.J.'s comments in *R. v. Edwards Books and Art Ltd.*\(^{453}\) to the effect that legislative reforms can be directed at "sectors in which there appear to be particularly urgent concerns or to constituencies that seem especially needy."\(^{454}\) Therefore, section 1 of the *Charter* provides a possible way to justify economically based limitations on special programs and/or exclusions from protection. The onus rests on the government to justify its decision to limit the provision of benefits.

It is important to note that the leeway to be granted to the state is not infinite. Governments must demonstrate that their actions infringe the rights in question no more than is reasonably necessary to achieve their goals.\(^{455}\)

### 4.6.9 Remedies

One of the most critical concerns raised by concluding that a partial or underinclusive law may be discriminatory is the question of the appropriate remedy. One issue is whether or not courts and tribunals should strike down a program altogether, thereby disentitling those currently benefiting from the program, or whether the program should be extended

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sex discrimination under the Code were struck down. See also *Haig v. Canada* 1992, 9 O.R. (3d) 494 (C.A.) finding federal human rights legislation underinclusive for failing to provide protection against discrimination on the basis of sexual orientation and thus constituting a violation of the guarantee of the equal benefit of the law.

\(^{453}\) Edwards Books supra, note 427.

\(^{454}\) Ibid. at 772.

\(^{455}\) Tetreault-Gadoury, supra note 296 at 44.
by the court. Another issue is whether some type of individual or group exemption would be possible that would leave a program intact, but insulate certain social groups from its discriminatory effects. The remedial implications of a finding of discrimination may even affect whether or not an underinclusive program is considered discriminatory. There is considerable academic commentary that examines the difficult issue of reconciling democratic limits on the role of the judiciary with the need for creative and sometimes extensive adjudicative remedies. The Supreme Court has explored these questions and provided underlying guidelines to be taken into account when considering whether an underinclusive law should be extended by judicial order.

Section 24 of the Charter and section 52 of the Constitution Act expand not only the scope of judicial review, but also the remedies available to an offended party.

Charter:
Section 24(1) Anyone whose rights or freedoms, as guaranteed by this Charter have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

Constitution Act:
Section 52(1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

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457 Schacter, supra, note 444.
Under section 52(1) of the *Constitution Act, 1982* the courts have authority 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 "anyone whose rights or freedoms, as guaranteed by this Charter have been infringed or denied". The infringement does not need to be the result of statutory law, but may also result from government action in administering laws. A remedy under the Charter must be effective given the right in question and the manner in which it is infringed. The topic headings within the Charter itself indicate that it encompasses legal, political and egalitarian rights. Where legal rights involving the freedom from government action are at stake, striking down is an effective remedy because it ensures individuals' freedom from government intrusion. On the other hand, positive rights, including political and egalitarian rights, call for positive remedies. It would obviously undermine the practical value of constitutionally entrenched rights if the court's discretion regarding remedies under the Charter were restricted in such a way as to mean that effective remedies are available only for one group of Charter rights. Where the right is an affirmative one, such as the right to vote or the right to equal benefit of the law, a remedy extending the benefit is especially appropriate.

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458 Although section 52(1) is technically not part of the *Charter*, this section is part of the Constitution and is relevant to *Charter* remedies.
459 The entire law need not be invalidated; the provision directs the court to strike down the law" to the extent of its inconsistency."
460 Therefore 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?"
461 For example, Hunter supra, note 342 at 148; Big M supra, note 210 at 313; Mortgentaler supra, note 284 at 80.
In the leading case on constitutional remedies *Schacter v. Canada*\(^{63}\) and more recently *Vriend*, the Supreme court of Canada has stated that the first step in choosing an appropriate remedy is to determine the extent of the inconsistency between the impugned legislation or policy and the *Charter*. Given the issues around allocation policies, where the inconsistency originates from underinclusiveness, the exclusion of for example the aged, or another historically disadvantaged group, from necessary health care services, will violate the equality rights guaranteed in s.15 of the *Charter* and would not survive any of the stages of review that compromise the s.1 analysis.

Having identified the extent of the inconsistency, the court must then determine the appropriate remedy. *Schacter* provides several options for dealing with allocation policies that have been held to breach a *Charter* right. (1) "striking down" - a court may hold that the allocation strategy is of no force or effect; or (2) "severance" - a court may hold that only the offending portion of a statute or regulation stating what will be funded is of no force or effect and that the rest of the Act will remain in force; or (3) "reading in/reading down" - a court may use a combination of reading in and reading down so as to replace the offending words with language that will include the wrongly excluded group or (4) "striking down, severance, or reading in / reading down with a temporary suspension of a court's order so that the government has an opportunity to enact a constitutionally valid allocation strategy."
In determining whether the reading in 'reading down option is preferable to either striking down or severance, the court must consider how the remedy can be worded, the budgetary implications, the implications of the remedy on the remaining portion of the CHA, the significance or long-term nature of the remaining portion and the extent to which a remedy would interfere with legislative objectives of the CHA.\textsuperscript{464}

In cases where reading in is inappropriate, the court must choose between striking down the legislation in its entirety and severing only the offending options of the statute.\textsuperscript{465} As stated by Lamer C.J. in Schacter:

[w]here the offending portion of a statute can be defined in a limited manner it is consistent with legal principles to declare inoperative only that limited portion. In that way, as much of the legislative purpose as possible may be realized.\textsuperscript{466}

The Court in Schacter emphasized that extension of a special benefits program (or “reading in” to the legislation to use the Court’s phrase) is only justified where all of the following criteria are clearly met:

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

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

C. severance or reading in would not involve an intrusion into legislative

\textsuperscript{463} Schacter supra, note 444.
\textsuperscript{464} See M. supra, note 420 at 139, Egan supra, note 329 at 223 and Vriend supra, note 296 at 155.
\textsuperscript{465} M. supra, note 420 at 143.
\textsuperscript{466} Schacter supra, note 444 at 697.
budgetary decisions so substantial as to change the nature of the legislative scheme in question.467

The Court also stated that in some cases it would be appropriate to suspend the declaration of invalidity to give a legislature time to amend its legislation so as to conform to the Charter. Such a remedial approach would be warranted if the immediate striking down of an unconstitutional law would result in the deprivation of benefits to deserving persons without thereby benefiting the individual whose rights have been violated.468

a. Purposive Approach to Remedies:

It has been held that with respect to remedies, as well as substantive rights, the Charter should be given a generous and purposive interpretation. In selecting the appropriate remedy, the court should consider what best achieves the purpose of section 15(1) of the Charter, which has been found to promote equality and to alleviate the effect of disadvantage, not merely to create sameness or to eliminate distinctions. The structure of the Charter itself makes it clear that equality is to be promoted and disadvantage alleviated both by the Charter and in legislation.469

467 Ibid. at 718.
468 Schacter supra note 444 at 719.
If advantaged persons cannot use the Charter to roll back legislation intended to improve the condition of disadvantaged persons, it follows that the court should not devise an approach to remedies that means that genuine attempts by the disadvantaged to enforce their rights under the Charter would result in other (or the same) disadvantaged persons losing their rights under the legislation. Ensuring that groups or individuals have the same entitlements to no benefits is contrary to the purpose of the equality guarantee in section 15, and produces only sameness not equality. The principle that equality cannot be achieved by reducing existing benefits has also been recognized in legislation.\(^{470}\)

b. An Approach to the Extension Remedy:

The Legal Education and Action Fund’s (LEAF) arguments in Schacter\(^{471}\) are compelling. As intervenors, LEAF argued that a provision which itself promotes the equality of disadvantaged groups should not be struck down in the name of equality of another

\(^{470}\) Pay Equity Act, 1987, S.O. 1987, c.34, s.9(1); Employment Standards Act, R.S.O. 1980, c.137, s.33; Canadian Human Rights Act, R.S.C. 1985, c.33, s.11; British Columbia Human Rights Code, R.S.B.C. 1979, c.186, s.6; Individual Rights Protection Act, R.S.A. 1980, c.L-2, s.6; Labour Standards Act, R.S.S. 1978, Ch. L-1, s.17.

\(^{471}\) LEAF’s factum for their intervenor arguments in Schacter, supra, note 278. Feminism started as a critique of traditional ethical theories as representing the experiences of men, not women. Feminist approaches to morality seek to correct this underlying bias. Feminism is not a monolithic theory; thus there is no one definition of “feminist ethics.” Feminism incorporates a variety of social and political beliefs, and there are even differing conceptions of feminism itself. All varieties of feminism are characterized by a concern for the welfare of all women, and a belief that women have historically been - and continue to be - oppressed by patriarchal societies. As Alison Jaggar writes in "Feminist Ethics: Some issues for the Nineties," in Contemporary Moral Problems, 4th ed., edited by James E White (St. Paul, MN: West Publishing Company, 1991) at 61 , “Feminist approaches to ethics are distinguished by their explicit commitment to rethinking ethics with a view to correcting whatever forms of bias it may contain” They all seek to unmask and challenge the oppression, discrimination, and exclusion that women have faced. Thanks to the efforts of feminist scholars, and organizations like LEAF (the Legal Education and Action Fund) government and judges are presented with feminist insights. See also Susan Sherwin Coordinator, The Politics of Women’s Health: Exploring Agency and Autonomy The Feminist Health Care Ethics Research Network (Temple University Press: Philadelphia, 1998); Susan Sherwin No Longer Patient: Feminist Ethics and Health Care (Temple Univ. Press: Philadelphia, 1992).
disadvantaged group unless to do so would promote, or safeguard, the equality of both
groups without resort to further legislative action. Where striking down would not
promote the substantive equality of both groups, then another alternative should be
sought, and can be sought, given the provisions of section 24 of the Charter. In
considering which alternative to striking down it should implement, the court has several
options: striking down with a suspensive provision, a mere declaration, various structural
remedies, and extension.472

In structuring the remedy, the court should consider the principle that the result should
promote, or sustain, the equality of both the plaintiff (who has successfully established
entitlement to Charter guarantees) and the group protected by the legislation. In
designing the remedy, the court should also set against its traditional respect for
legislative balancing of interests, the realization that the Charter clearly sets out a role for
the judiciary in protecting the interests of discrete and insular minorities. While the court
may be cautious in reconciling its own role in vindicating minority interests with the role
of Parliament in balancing a plurality of interests, the Charter seems to indicate that such
cautions should not stop the judiciary from appropriately exercising its role. Should
Parliament conclude that the court has overstepped its mandate in protecting the
disadvantaged, it may use the override ("notwithstanding") provided in section 33 to
reassert its majoritarian will.

472 Manitoba Language (striking down with a suspensive provision); Philips and Lynch v. A.G.N.S. (1986),
c. Canadian and American Approaches to Remedy:

In interpreting the Charter, courts have considered the case law from other jurisdictions, frequently citing American case law. While the Supreme Court has been influenced by arguments based on an American jurisprudence, it has deliberately noted the differences between the U.S. and Canadian statutes, and in some cases, has refused to abide by U.S. law or to incorporate American terminology into the language of the Charter.473

In exercising the broad discretion granted to them by section 24(1) of the Charter, Canadian courts may be persuaded by the approach taken by courts in the United States in similar circumstances. A remedy extending benefits has been granted under the U.S. Constitution where a law is found to be invalid not because its substance is impermissible but because it is underinclusive. This remedy has clearly been adopted to extend benefits to fathers as a corrective to sex-discrimination patterns affecting women.474

The remedial route adopted by the trial judge is consistent with other cases where legislation has been found to be inconsistent with section 15(1) because benefits given to one group are denied to another and courts have granted remedies extending the benefit to

Marchand supra, note 467 (structural remedy).

473 See Big M., supra, note 210; Operation Dismantle supra, note 303; Reference Re Section 94(2) of the Motor Vehicle Act (B.C.), [1985] 2 S.C.R. 486 (S.C.C.).


Courts interpreting section 15 of the Charter have granted remedies which have extended benefits. These extensions have been accomplished by striking out provisions which make exceptions to or exclusions from the benefits of the law.\footnote{Blainey supra, note 457 at 531-533. Silano supra, note 304 at 755; Hebb v. R. (1989), 69 C.R. (3d) 1 (N.S.S.C.T.D.) at 20-23.} It seems that the availability of such an extension of rights should not depend on whether the obstacle to extension is a specific limitation, or legislative silence. Most legislation was drafted without the possibility of this effect in mind. Consequently, there is no predictable pattern in statutory construction: sometimes a benefit is withheld by means of an explicit limitation and sometimes by silence. The availability of an effective remedy should not depend upon the style of a legislative draftsperson who never turned her or his mind to the issue.\footnote{Hoogbruin supra, note 467 at 5-6; Dixon v. A.G.B.C. [1989] 4 W.W.R. 393 (B.C.S.C.), at 427-429; Knodel v. British Columbia (1991) 58 B.C.L.R. (2d) 356 (B.C.S.C.).}
d. Relationship of Sections 24 and 52:

Hogg has suggested\textsubscript{479} that the courts will apply a presumption in favour of severance, consistent with section 52 of the \textit{Constitution Act, 1982} which provides that "any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."

In \textit{Schacter v. Canada}\textsuperscript{479} Lamer C.J.C. explained that the basis of the doctrine of severance was to ensure that courts interfere with the laws adopted by the legislature as little as possible. Where the offending portion of a statute can be defined in a limited manner it is consistent with legal principles to declare inoperative only that limited portion. In that way, as much of the legislative purpose as possible may be realized.\textsuperscript{480} This concern is reflected in the classic statement of the test for severance in \textit{A-G. Alta v. A.-G. Can.}\textsuperscript{481} The real question is whether what remains is so inextricably bound up with the part declared invalid that what remains cannot independently survive or, as it has sometimes been put, whether on a fair review of the whole matter it can be assumed that the Legislature would have enacted what survives without enacting the part that is ultra vires at all.

Where the \textit{Charter} rights are infringed by legislation, neither section 24 nor section 52 of the \textit{Constitution Act, 1982} provides the sole remedial route. Although legislation which

\textsuperscript{479} Hogg - Book supra, note 171 at 37-8 - 37-10
\textsuperscript{479} Schacter supra, note 444 at 11.
\textsuperscript{480} Schacter ibid at 12.
is inconsistent with the Charter is of no force or effect pursuant to section 52, it seems that nothing in that section or in the constitution establishes that this is the exclusive remedy. An individual whose rights have been infringed is entitled to a remedy which is appropriate and just in the circumstances.\textsuperscript{482} In the case of\textit{Mahe v. Alberta}\textsuperscript{483} it was recognized that where legislation is inconsistent with the rights under the Charter not because of what it contains but because it fails to extend far enough, or because officials have failed to take appropriate steps under it, the courts are not required to strike down the legislation under section 52 but rather, should grant a remedy under section 24. It has been held that the effect of the court's broad remedial power under section 24 is not merely that an appropriate remedy is available for the violation of a Charter right, but that the court is able to grant a remedy which constitutes the "best possible solution".\textsuperscript{484}

While it has been argued that reference to legislative history and debates is of limited assistance and that it is the wording of statutes which rule\textsuperscript{485} the history or debates may nevertheless be useful in confirming the appropriateness of a particular statutory interpretation.\textsuperscript{486} The legislative history of section 24(1) and 52(1) does not suggest that where a law is inconsistent with the Charter there is no role for section 24(1). The

\begin{footnotes}
\item[483] \textsuperscript{483} \textit{Mahe v. Alberta}, [1990] 1 S.C.R. 342 (S.C.C.) at 392
\item[484] \textsuperscript{484} \textit{Re Kodellas et al. and Saskatchewan Human Rights Commission} (1989), 60 D.L.R. (4th) 143 at 201 (Sask.C.A.).
\end{footnotes}
Special Joint Committee of the Senate and the House of Commons recommended in its Senate Report (October 10, 1978) that the Constitutional Amendment Bill contain a provision clearly establishing the supremacy of the Charter over all other laws to ensure that the Charter would be interpreted as an overriding statute. Such a provision was, arguably, necessary to establish a clear departure from the principle of the supremacy of Parliament, and from the deference to that principle which had been embodied in the Canadian Bill of Rights. The Committee also recommended that the Charter contain a provision by which effective remedies would be available where rights were violated.

In effect, the courts should have the power to grant whatever remedy may be appropriate in the circumstances, including pecuniary damages, to enforce the protected rights and freedoms. Moreover, the courts should have the specific obligation placed upon them to grant an effective remedy where a denial of rights has occurred. They must not be allowed to decline to intervene.

Section 52 of the Charter is to some extent, a legacy of the division of powers conflicts that characterized constitutional law before the creation of the Charter. In validating ultra vires legislation, a solution to disputes between governments, can be compared to the context of a dispute under the Charter between an individual and one level of government. However, the Charter specifically recognizes that invalidation will not be an appropriate remedy in all such cases. Section 24(1) of the Charter is based on the premise that the Charter gives rights to individuals, not governments, and that the creation of new rights for individuals in relation to the state requires the creation of more remedies than those which were developed to deal with the jurisdictional disputes of

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488 Second Report supra, note 492 at 423.
government actors. Remedy has been defined to be a means of providing “reparation, redress, relief”. In medicine, it is something which “alleviates pain and promotes restoration to good health.” This plain English meaning of the term used in section 24 is inconsistent with the idea that violation of the Charter must in all or most cases result in invalidation under section 52.

It seems that the scope of the equality guarantee in section 15 was intended to address the problems of the old “equality before the law” definition. The conceptual change brought by this changed definition has been recognized by the Supreme Court.

It is readily apparent that the language of section 15 was deliberately chosen in order to remedy some of the perceived defects under the Canadian Bill of Rights.

> It is clear that the purpose of section 15 is to ensure equality in the formulation and application of the law... It has a large remedial component.\(^{491}\)

The language of section 24(1) clearly requires that a remedy be available where Charter rights have been infringed or denied, whether the infringement arises because of a statute or because of the actions of government officials. It would considerably limit the effectiveness of the Charter guarantees if courts were restricted under section 24 of the Charter to the remedial approach developed in relation to the division of powers under the Constitution.\(^{492}\)


\(^{490}\) Ibid.


4.6.10 Impact of Spending Power

Parliament's authority over spending is like all exercises of governmental power, subject to the Charter. There is no basis in the Constitution for finding that the Charter has a limited reach which does not extend to all exercises of governmental authority. The executive branch of government has been found to have a duty to act in accordance with the dictates of the Charter. While the courts have recognized that, as matter of constitutional law, they do not have authority to require a Minister of the Crown to make a specific expenditure, they have done so where there is no legislation requiring the expenditure and no other provisions of the Constitution are involved.

In the Charter context, the Supreme Court has recognized that although Parliament requires flexibility in choosing between various policy options, it must comply with the Charter when granting benefits under the Unemployment Insurance Act, 1977.

Even allowing the government a healthy measure of flexibility in legislating in this area, the complete denial of unemployment benefits is not an acceptable method of achieving any of the government objectives...

The historical roots of Parliament's executive jurisdiction over spending are found in the context of restraints on arbitrary exercises of power by the executive branch of...
government. Parliamentary authority in this area was originally intended to balance the exercise of despotic power by the Crown.

The convention which has traditionally governed the relations between the judiciary and the legislature is that of Parliamentary sovereignty. It is the source of virtually complete judicial deference to legislative choices in a legal and political system that does not have entrenched guarantees of rights to which legislatures themselves are subject, and which are interpreted by the courts. Accordingly, it seems that one must not look to the implications of the "spending" convention for guidance as the appropriate role of the court in such instances but rather to the implications of the tradition of Parliamentary sovereignty and its modifications by the fundamental guarantee of the Charter.

If the "spending convention" is relevant to the relations between Parliament and the courts, it seems that while the convention is flexible it is not the sole source of wisdom on the appropriate relationship between the two institutions.\(^{496}\) For example, the House of Commons itself has had to legislate in the area of control over money bills, in order to refresh its traditional supremacy vis-à-vis the House of Lords.\(^{497}\)

It has been held by the Supreme Court that the purpose of constitutional conventions is "to ensure that the legal framework of the constitution will be operated in accordance

\(^{496}\) Const. & Admin. Law supra, note at 43–44.

with the prevailing constitutional principles of the period.\textsuperscript{498} It would be inconsistent with this approach to allow a constitution developed in the height of Parliamentary sovereignty (now limited by the Charter) to prevent the judiciary from creating remedies consistent with the Charter's equality guarantees.\textsuperscript{499} In determining both the force and applicability of a constitutional convention the crucial questions must always be whether or not a particular class of action is likely to destroy respect for the established distribution of authority and whether or not it is likely to maintain respect for the constitutional system by changing the distribution of authority. This distribution of authority implies the maintenance of limited monarchy, representative government, responsible government and efficient government; it implies also that constitutional rules must be comparable with the realities of practical politics.\textsuperscript{500}

On this test, the remedy of extension, granted in the appropriate situations, actually fosters respect for basic constitutional values and representative institutions by providing for the protection of vulnerable minorities through the interplay of court and legislature. In fact, the entrenchment of rights and freedoms in the Charter, and the courts' rule in ensuring that governments respect those rights, are in keeping with that spirit of resistance to arbitrary exercises of power by the dominant which is at the root of Parliament's original assertion of its authority over spending vis-à-vis the monarch.

\textsuperscript{498} \textit{Re Resolution to Amend the Constitution}, [1981] 1 S.C.R. 753 (S.C.C.) at 880.
\textsuperscript{499} Const. & Admin. Law supra note at 35, 37.
\textsuperscript{500} Const. & Admin. Law supra note at 35, 37.
It is also consistent with the relationship between reviewing courts and legislatures which has evolved over the years. For example, in non-Charter adjudication the courts have traditionally made orders which affect, directly or indirectly, Parliament’s authority over spending and the allocation of governmental resources. Where the Crown has been found liable for breach of trust and breach of fiduciary duty, for example, courts have made damage awards against the Crown. The Crown is not excused from paying such awards on the basis that they have not been authorized by Parliament. 501

In the development of the fairness doctrine in administrative law it has been accepted that the courts’ decisions would require resources to be allocated to provide the procedures necessary for fair process. These decisions involve the courts in their traditional role of developing the law and, although they may have had a significant impact on legislative or parliamentary decisions about spending, were not considered to usurp the spending power. 502 In cases where legislation has been reviewed on federalism grounds the courts have grabbed remedies which have the result of requiring an expenditure of public funds. While Parliament’s power over revenues is constitutionally entrenched, its exercise of that power must comply with the Constitution and is subject to review by the courts. 503

The power to raise money through income taxes was called into question in the case of Prior v. Canada. 504 The Federal Court of Appeal in that case found that it did not have

502 For example, Re Nicholson and Haldimand-Norfolk Regional Board of Commissioners of Police, [1979] 1 S.C.R. 311.
jurisdiction to interfere with the power. However, the court did not conclude that it
would lack jurisdiction to determine whether or not the exercise of that power in a
specific piece of legislation was in conformity with the Charter. The courts have always
had the jurisdiction to consider whether legislation regulating taxation was validly
enacted pursuant to the powers in the constitution, and the Supreme Court has stated that
“action taken under the Constitution Act 1867, is of course subject to Charter review” in
order “to supervise and on a proper occasion curtail the exercise of a power to
legislate”. 505

The decision in Schacter506 did not override the functions of Parliament, carve out a new
legislative role for the courts or interfere with Parliamentary authority over revenue and
expenditures. The Court in Schacter accurately applied the following well-established
principles: it took a purposive approach to Charter rights, it granted the remedy which it
considered most appropriate and just in the circumstances and which was consistent with
the purpose of the Charter, it carried out the purpose of alleviating disadvantage as
opposed to rolling back the gains made in legislation, it rejected pure consequentialism in
favour of the deontologically based principle that administrative cost and inconvenience
do not justify the infringement of rights and it did not interfere with Parliament’s
authority to choose among various policy options and enact legislation which conforms
with the Charter

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4.7 Conclusion

While it seems clear from the jurisprudence discussed that courts are reluctant to intervene in the detailed allocation of health care resources, the cases do indicate that the door is left open for judicial review and for constitutional challenges under s.15(1) of the Charter. Some have argued that "[l]aw is to play any constructive role in keeping the health care system within a democratic framework, it may have to shed its "hands-off" attitude toward economic decisions."\(^{507}\) It appears however that the courts may be shedding their traditional reluctance.

This chapter has reviewed legal issues that may arise from focusing allocation policies on utilitarian based economic principles at the expense of deontologically based principles of the CHA and the Charter. If the goals of government are cost effectiveness and cost containment in health care spending it must pursue these goals while respecting legally entrenched values. The law structures the relationship between the individual and the state on the basis of entitlements and obligations informed by the values of autonomy, equal human dignity and human flourishing.\(^{508}\) These legally entrenched values are relevant to balancing utilitarian and deontologically based priorities in the health care.

\(^{506}\) Schacter supra, note 444.


\(^{508}\) Weinrib supra, note 426 at 43.
5. Conclusion

There has been a lot of economically derived and economically oriented change occurring in Canadian health policy. Governments have reduced health care budgets, limited entitlements to health care services, privatized services and introduced efficiency measures into the provision of medical and hospital services. This economically conscious climate has created many opportunities for improvement, while at the same time creating significant risks for egalitarianism, or deontologically based values.509

This analysis revealed that efficiency and equality can co-exist with careful efforts given to the balance of priority. An attempt to balance worthy yet competing principles has a dual benefit. First, it preserves a health care system that has served Canadians well and second it shows respect for ourselves in the values we give content to.

Rights determination is a normative activity with consequences for the efficient allocation of health care resources. Legal rights and obligations in the end determine which distribution of benefits and costs will be adopted.510 There is no unique optimal use of resources that can be implemented independent of identified rights or values. It is through the Canadian legal system that distributional goals of universality, fairness and justice and efficiency will be pursued. Most texts on economic theory describe economists as believing that making distributional judgments is a matter for the

politicians, not for economists. What the economist offers, rather is an assessment of the relative efficiency of various distributional options. To the extent that the law entrenches principles such as universality, comprehensiveness, fairness and justice, while politicians advocate a greater role for efficiency within policy formation, a tension will continue.

There seem to be two extreme orientations, neither of which is satisfactory for those making allocation policies. The first orientation holds that society ought to make allocation decisions with a single focus on efficiency or economic rationale. This position would hold that those who believe that efficiency should not be the primary social value have the burden to demonstrate why an allocation policy based on justice or fairness, that imposes avoidable costs should nonetheless be adopted. The second position would argue that once questions of justice and fairness are brought to bear to make or evaluate allocation policies, there is little, if any, room left for concerns regarding efficiency, thereby removing the role for economics. A credible position lies in a middle ground of considering both efficiency and justice concerns. The problem remains that while this seems attractive in theory, in practice, it is difficult to know how to proceed. One way of recognizing both would be to give relative weight to efficiency up to the point of breach of fundamental values. It seems wise to attempt to achieve social objectives in the most efficient way possible. This is because the fewer resources

511 Ibid at 188.
512 See generally Economics and the Law supra, note – at 189.
514 See Mercuro supra note 515 at 189.
used to realize a particular social or noneconomic objective, the more resources available to achieve other valued objectives.\textsuperscript{515}

Focusing on the economic issues could allow health care resources to be allocated for society without confronting the overriding social issues as stake. The prism of the law enhances the chance that values entrenched in the law will be incorporated into the allocation strategies and not be overlooked.

Traditionally, administrative and constitutional law have played a minimal role in the allocation of health care resources. Frustration with limited access to health care services have prompted individuals to seek redress through the courts. While the United Kingdom has been leading the way with several cases based on administrative law addressing the allocation of health care resources, Australia\textsuperscript{516}, New Zealand\textsuperscript{517} and Canada\textsuperscript{518} are beginning to have similar cases before the courts. The future impact of administrative and constitutional law may be to increase the transparency of the allocation process and to familiarize the government, health care providers, and patients with the values at issue.

Government has traditionally been able to get around scrutiny of allocation decisions by passing the responsibility for such decisions down to the hospitals. Recent cases such as

\textsuperscript{515} Flood supra, note 11 at 15.  
\textsuperscript{518} Eldridge, supra, note 250, Cameron supra note 316.
Eldridge no longer accept such sheltering or limited notion of government and will hold decisions made at the hospital level to standards of government.

With an increased willingness of the courts to consider allocation decisions the judiciary may eventually need to limit this expanded jurisdiction so as not to prevent the appropriate exercise of government discretion and policy creation. One benefit of this new found judicial willingness to address such issues is that individuals who feel wronged on the basis of limited health care resources may now have better access to the courts in challenging access policies.

This thesis provides ministers of health, hospitals administrators, regional health boards, health care providers, patients and all other readers with an understanding of the context in which allocation decisions will be considered by the courts. It provides insights into what is at stake and what one can expect as government and the courts attempt to strike a balance between individual needs and the wider national or provincial interests. In other words between justice and efficiency.

The remaining dilemmas are where the courts will draw the line defining the point at which government allocation decisions will be left to their discretion. While it seems clear that the courts have moved the line over enough to give themselves jurisdiction to address very clear examples of unreasonable allocation decisions that do not have huge financial implications, the courts have yet to show their willingness to force government to allocate large sums of money in an attempt to redress unreasonable access situations. A
clearly untenable situation would be one where courts issue blanket requirements for
government to continue to increase funding refusing to either consider consequentialist
analysis or defer to the consequentialist analysis of government.

To date these concerns remain speculative and the legislative objective of bringing
economic principles into the process of priority setting policy can be accomplished. The
law ensures that this is done with safeguards to protect individuals' rights.\textsuperscript{519} So far
judicial review is not "a veto over the politics of the nation,"\textsuperscript{520} but instead an impetus for
dialogue on how best to reconcile the individualistic values of the Charter with the
accomplishment of economic principles for the benefit of the community as a whole.\textsuperscript{521}
The law relevant to resource allocation helps all those affected by economically based
policies to explore the impact of those policies. The legal requirements frame a healthy
and ongoing debate, as the advocates on behalf of individuals and specific groups seeking
health care services as well as those who seek to limit access, must equally frame their
arguments in terms of our legally entrenched values. The goal is therefore not to create
purely efficient consequentialist allocation policies, but rather to design allocation
policies that as efficiently as possible meet. at a minimum, legally entrenched and often
deontologically based standards of justice. A primary focus on consequentialism
expressed through economics will have to be somewhat compromised if Canadian

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\textsuperscript{519} Peter W. Hogg, Allison A. Bushell, "The Charter Dialogue Between Courts and Legislatures: (Or
Perhaps the Charter of Rights Isn't Such a Bad Thing After All)" (1997) 35(1) Osgoode Hall L.J. 74 at 105.
[hereinafter Hogg 2]
\textsuperscript{521} Hogg 2 supra, note 524 at 105.
\end{flushright}
allocation policy is to accommodate legally binding deontological values entrenched in law.

5.1 Future Research:

While the current research provides insight into how allocation decisions will be evaluated by the courts. As yet there are no widely accepted models for legitimate and fair allocation of health care resources. In the absence of such models, decision makers are left without clear guidance in their attempts to set legitimate and fair priorities.

Daniels and Sabin have outlined a model of priority setting that focuses on issues of process and is referred to as "Accountability for Reasonableness". This model is intended to address two key problems at the heart of priority setting: legitimacy and fairness. The legitimacy problem presents the question, under what conditions should authority over priority setting be placed in the hands of a particular organization, group or person? The fairness problem presents the question, when does a patient or clinician have sufficient reason to accept as fair, particular priority setting decisions? Daniels and Sabin claim that to the extent that an institution is accountable for the reasonableness of its priority setting activities, it will have a valid claim to legitimacy and fairness. They argue that institutional activities are accountable for reasonableness if they satisfy four conditions: publicity, relevance, appeals and enforcement. In a recent article Peter A

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Singer describes the strong influence the Accountability for Reasonableness model has had in the priority setting literature.\(^{523}\)

Now that the current research has explored the compatibility between economics and law, valuable future research would (1) analyze the role for economics in this philosophically based model for legitimate and fair allocation decisions and (2) to develop a model of Accountability for Reasonableness that it harmonized with Canadian law. Such analysis would result in information about the legal foundations and justifications for Accountability for Reasonableness and legal options for operationalizing its four conditions.\(^{524}\) Following the methodology used in the current research, future research addressing this issue should be normatively grounded and legally informed. Such future research would offer guidance to government, hospital administrator and health care providers in making decisions that are both legitimate and fair and also perceived to be so by the public.

\(^{523}\) Peter A. Singer, "Recent Advances in Medical Ethics" (2000) 321 British Medical Journal 282-285. Singer explains that the Accountability for Reasonableness model has been cited in 23 original articles in the Science Citation Index (which is more that the most cited articles from 1998 found using a search for "rationing" or "priority setting". He also points to the frequency with which other authors refer to this work in the recent book based on the 1998 international conference on priorities in health care. A.S. Coulter, C. Ham, eds. The Global Challenge of Health Care Rationing. (Buckingham: Open University Press, 2000).

\(^{524}\) I will be pursuing this research as part of a Post Doctoral Fellowship at the Hospital for Sick Children, Toronto, Canada starting September 18, 2000.
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