No. S-090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO, WALID KHALFALLAH by his litigation guardian DEBBIE WAITKUS, and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH OF BRITISH COLUMBIA, and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

AND:

DR. DUNCAN ETCHES, DR. ROBERT WOOLLARD, GLYN TOWNSON, THOMAS McGREGOR, BRITISH COLUMBIA FRIENDS OF MEDICARE SOCIETY, CANADIAN DOCTORS FOR MEDICARE, MARIËL SCHOOFF, DAPHNE LANG, JOYCE HAMER, MYRNA ALLISON, and the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY

INTERVENORS

RESPONSE TO FOURTH AMENDED CIVIL CLAIM

Filed by: Medical Services Commission of British Columbia, Minister of Health of British Columbia and Attorney General of British Columbia (the "defendants")

Part 1: RESPONSE TO NOTICE OF CIVIL CLAIM FACTS

Division 1 – Defendants' Response to Facts

1. The facts alleged in paragraphs 1, 7, 77, 79-83, and 85 of Part 1 of the Fourth Amended Notice of Civil Claim are admitted.

2. The facts alleged in paragraphs 8-12, 15, 17, 76, 78, 84, and 86-97 of Part 1 of the Fourth Amended Notice of Civil Claim are denied.

3. The facts alleged in paragraphs 2-6, 13, 14, 16, and 18-75 of Part 1 of the Fourth Amended Notice of Civil Claim are outside the knowledge of the defendants.

Division 2 – Defendants' Version of Facts

4. The defendant Minister of Health (the "Minister") is the provincial minister responsible for the Medical Services Plan (the "MSP") and the Medical Services Commission, pursuant to the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 (the "Act") and the *Ministry of Health Act*, R.S.B.C. 1996, c. 301, as amended.

5. The defendant Attorney General of British Columbia is Her Majesty's Attorney for British Columbia and the Chief Law Officer of the Crown.

The Medical Services Commission

6. The defendant Medical Services Commission (the "Commission") is a nine member statutory body continued pursuant to the Act. Three members are appointed from among three or more nominated by the British Columbia Medical Association ("BCMA"). Three members are appointed on the joint recommendation of the Minister and the BCMA to represent beneficiaries. Three members are appointed to represent the government of British Columbia (the "Province"). The Commission reports to the Minister.

7. The Commission's function, as set out in section 3(3) of the Act, is to facilitate, in the manner provided for in the Act, reasonable access throughout British Columbia to

quality medical care, health care, and diagnostic facility services for British Columbia residents under the MSP.

8. The Commission's responsibilities include administering the MSP, under which medically required services ("benefits") are provided by enrolled physicians to residents of British Columbia who are enrolled in the MSP ("beneficiaries").

9. In particular, under section 5 of the Act, the Commission has the responsibility and the authority to determine whether a service is a benefit, and whether any matter is related to the rendering of a benefit.

The Medical Services Plan

10. The MSP is a publicly funded plan that aims at promoting and improving the health of all citizens and providing high quality patient care that is medically appropriate and that ensures reasonable access to medically necessary services consistent with the *Canada Health Act*, R.S.C. 1985, c. C-6, which expressly forbids extra-billing and user charges. The residents of British Columbia enrolled in the plan are called "beneficiaries".

11. The purpose of the Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay.

12. This purpose is central to the preservation of the public health care system and the *Canada Health Act*'s principles of universality, comprehensiveness, accessibility, portability, public administration, and sustainability.

13. The Province is entitled, under the *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. F-8, to annual payments intended, *inter alia*, to protect the principle that care is

allocated on the basis of need and not ability to pay and to further the *Canada Health Act* principles (the "Canada Health Transfer").

14. In the most recent fiscal year (2014-15), the Canada Health Transfer contributed $4.439 billion toward the cost of funding the public health care system in British Columbia, or approximately 26.1% of the total expenditure by the Province of $17.0 billion.

15. If the Province permits access to medical care in British Columbia to be impeded or precluded by allowing beneficiaries to be charged, it will be denied part or all of the Canada Health Transfer by the Governor General in Council and/or the federal Minister of Health.

16. Certain medical services are excluded from coverage under the MSP, such as those that are not considered to be "medically required," including purely cosmetic surgery and medical examinations related to employment or insurance applications.

17. Also excluded are services provided for under the *Workers' Compensation Act*, R.S.B.C. 1996, c. 492, and services which the Province cannot constitutionally limit, as discussed in Part 3 below.

18. A person is a "beneficiary" under the Act if the person is a "resident" of British Columbia who is enrolled in accordance with the Act. A resident may choose whether or not to be a beneficiary, and thus be entitled to have payments made for benefits in accordance with the Act. The Commission may cancel the enrolment of a beneficiary on application of the beneficiary. Thus a British Columbia resident who wishes to buy medical services privately is free to do so by opting out of the Act.

19. Physicians must enroll with the Commission in order to be entitled to submit claims. A physician may choose whether or not to apply to be enrolled, and an enrolled

physician may cancel his or her enrolment by giving notice of the cancellation to the Commission. Thus a physician is free to provide medical services privately, and charge for them, by opting out of the Act.

20. Once they are enrolled, physicians are reimbursed by the Commission in accordance with the Payment Schedule established by the Commission under s. 26 of the Act, which specifies the amounts that may be paid to a physician for rendering benefits to beneficiaries.

21. An enrolled physician has the option of electing, under section 14 of the Act, to be paid for benefits directly by beneficiaries. When such an election has been made, the physician must not submit a claim to the Commission with respect to services rendered after the date the election becomes effective. If such an election is in effect, a beneficiary who pays a physician directly may request reimbursement from the Commission, either directly or through the physician. An enrolled physician may revoke his or her election under s. 14.

22. No physician is required to enroll with the Commission. Any physician is free to provide medical services to whomever they wish, and a non-enrolled physician is permitted to charge whatever amount they see fit to charge in connection with services they provide, so long as they are provided elsewhere than in a hospital or a community care facility.

The Billing System

23. Most physicians who are enrolled with the Commission (and have not opted out under s. 14) and who provide medically required services to beneficiaries are compensated by the Commission. This method of compensation is known as the "fee-for-service" system, whereby physicians are compensated based on the number and type of services performed. Generally speaking, an enrolled physician who provides services to a

beneficiary in a hospital, such as surgical services, will submit a claim for those services to the Commission.

24. A minority of enrolled physicians are not paid via the fee for service system, but are paid via an alternative payment method, in accordance with contractual terms they have agreed with a health authority.

25. A medical opinion rendered by a physician, if medically required, is a benefit under the MSP whether the opinion is requested by another physician or on self-referral by a beneficiary.

26. Unless otherwise provided in the Act or in regulations or by the Commission, section 17(1) of the Act prohibits a person from charging a beneficiary for a benefit and prohibits a person from charging a beneficiary for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit. As set out in paragraph 19, this prohibition does not apply to physicians who have not enrolled with the Commission.

27. Section 18 of the Act sets limits on direct or extra billing for services by physicians. Information regarding payment rules and services that are or are not benefits is available to all physicians enrolled with the Commission.

28. Section 45 of the Act prohibits the issuance of insurance to a beneficiary for the payment, reimbursement, or indemnification of all or part of the cost of services that would be benefits if performed by a physician. There are exemptions in s. 45 for, among other things, the costs of services provided by opted-out physicians for which a beneficiary cannot be reimbursed by the Commission, and for health care costs incurred outside Canada.

29. The effect of sections 14, 17, 18, and 45 of the Act (the "Impugned Provisions") is to put limits on the ability of physicians to charge beneficiaries for benefits. The Impugned Provisions do not preclude physicians from providing medical services. With respect to physicians who are not enrolled under the Act, the limits only apply to charges for medical services provided in the facilities referred to in subsections 18(2)(a) and (b) of the Act (hospitals and community care facilities).

30. The prohibitions contained in sections 17, 18, and 45 of the Act are essential to enable the Commission to fulfill its function, as set out in paragraph 7 above, and the purpose of the Act, as set out in paragraph 11 above. In particular, they are essential to ensure that access to necessary medical care in British Columbia is based on need and not an individual's ability to pay.

The Patient Plaintiffs

31. Each of the plaintiffs Chris Chiavatti, Mandy Martens, Krystiana Corrado, and Walid Khalfallah (the "Patient Plaintiffs"), as well as Erma Krahn, were appropriately assessed by their treating physicians, and prioritized for treatment according to their need, in accordance with their treating physicians' professional judgment.

32. In the alternative, to the extent that the Patient Plaintiffs or Erma Krahn, or any of them, experienced unnecessary or unreasonable pain or suffering as described in the Fourth Amended Notice of Civil Claim, that pain or suffering was not caused by the Impugned Provisions, but by decisions made by, and actions taken or not taken by, their treating physicians.

33. If those treating physicians, or some of them, had exercised their professional judgment appropriately, and taken advantage of options that are and were available to them within the public health care system, the unnecessary or unreasonable pain or

suffering of which the Patient Plaintiffs complain could have been treated appropriately in the public system.

Division 3 – Additional Facts

The Public Health Care System

34. The public health care system in British Columbia consists of much more than simply physicians and hospitals. The Legislature appropriates funding for:

(a) Regional health sector funding, for the management and delivery of health services, including mental health services to adults, public and preventive health services, acute care services, provincial programs, and home and community care services;

(b) MSP funding, for benefits provided by physicians, health care practitioners, diagnostic facilities, and human resource and planning initiatives with respect to physicians;

(c) PharmaCare funding, to pay the full or partial cost of designated prescription drugs, dispensing fees, and other approved items and services that compliment PharmaCare programs;

(d) Various capital and debt servicing costs, for a share of debt servicing and amortization of capital costs related to health facility and equipment capital projects;

(e) Health benefits operations funding, for the administration of the MSP and PharmaCare;

(f) Emergency health services funding, for the administration, operation, and delivery of specified services;

(g) Vital statistics funding, for the expenses associated with the administration, registration, record maintenance, certification, statistical analysis, and reporting of births, deaths, and marriages in British Columbia; and

(h) Executive and support services funding, for (in part) direction to health authorities and other health providers, support to partners in delivering health care services, monitoring of health authority compliance and performance, general services to support program delivery, development of the policy and legislative framework for the health system, development of long-term health care plans, monitoring and regulation of professional associations, and public health reports on population health through the Provincial Health Officer.

35. Although it is referred to, in this pleading and generally, as a "public" health care system, the health care system in British Columbia, as in the rest of Canada, is largely publicly financed, but mainly delivered by physicians who are independent, private actors.

36. The health care system in British Columbia is in fact a complex network of participants including the Ministry of Health, regional health authorities created pursuant to the *Health Authorities Act*, R.S.B.C. 1996, c. 180, the Provincial Health Services Authority or "PHSA," individual hospitals, other facilities, and individual professionals. Each of these participants has a role in the delivery of medical services in British Columbia, although individual physicians exert the greatest degree of control over the timing of the delivery of surgery to any given patient.

37. In particular, most physicians in British Columbia are independent professionals who decide for themselves where they will practise, set their own hours of practise, determine themselves how many patients they will accept and who those patients will be, and determine how best to address their patients' medical needs. The Province's role, aside from setting the terms and conditions on which their billings are paid, is essentially to facilitate the work of the physicians.

38. In addition, most hospitals in British Columbia are neither owned nor managed by the Province. Except for a small number of hospitals owned and managed by not-for-profit organizations, they are owned and managed by health authorities.

39. The province's six health authorities are primarily responsible for the planning and delivery of health services in British Columbia. Five regional health authorities deliver a full continuum of health services within their respective geographic regions.

40. A sixth health authority, the PHSA, is responsible for managing the quality, coordination, and accessibility of services and province-wide health programs. These include the specialized programs provided by the following entities:

(a) British Columbia Cancer Agency;

(b) British Columbia Centre for Disease Control;

(c) British Columbia Children's Hospital and Sunny Hill Health Centre for Children;

(d) British Columbia Women's Hospital and Health Centre;

(e) British Columbia Provincial Renal Agency;

(f) British Columbia Transplant ~~Society~~;

(g) Cardiac Services British Columbia;

(h) British Columbia Emergency and Health Service; Health Shared Services British Columbia;

(i) British Columbia Mental Health Addiction Services; and

(j) Perinatal Services British Columbia.

41. Health authorities are required to plan and deliver, either directly or through contracted service providers, a range of programs and services appropriate to the needs of the beneficiaries who are resident in their region. The statutory obligations imposed on each of the health authorities include:

(a) developing and implementing a regional health plan that includes

i. the health services provided in the region, or in a part of the region,

ii. the type, size and location of facilities in the region,

iii. the programs for the delivery of health services provided in the region,

iv. the human resource requirements under the regional health plan, and

v. the making of reports to the Minister on the activities of the board in carrying out its purposes;

(b) developing policies, setting priorities, preparing and submitting budgets to the Minister and allocating resources for the delivery of health services in the region under the regional health plan;

(c) administering and allocating grants made by the Province for the provision of health services in the region;

(d) delivering regional services through its employees or entering into agreements with the Province or other public or private bodies for the delivery of those services by those bodies;

(e) developing and implementing regional standards for the delivery of health services in the region; and

(f) monitoring, evaluating, and complying with Provincial and regional standards and ensuring delivery of specified services applicable to the region.

42. The Ministry of Health, through the Minister, is responsible for establishing high level expectations and goals for health authority performance and for monitoring and evaluating health authority performance against those expectations. The Ministry sets province-wide standards for the health authorities and enters into performance and funding agreements for health service delivery by the health authorities.

43. The Ministry has a very limited role in direct service delivery; rather, the Ministry's role is that of "steward" of the health care system, which it carries out through funding decisions, development of social policy, and the establishment of the legislative framework for the health care system.

44. Consistent with this role, the Ministry has established wait time targets for health authorities for some types of surgeries. Also, the Ministry has established a policy pursuant to which health authorities are expected to monitor the accuracy of the data submitted by physicians respecting the physicians' wait lists to ensure accuracy of data for public reporting.

45. Health authorities are primarily responsible for the planning, management and delivery of health care services within their respective regions. The PHSA coordinates and provides provincial programs and specialized services such as cardiac care and transplants.

46. The health authorities and the PHSA collaborate with the Ministry on financial and infrastructure planning to ensure capital investments in the health care system are strategic and cost effective. However, health authorities are primarily responsible for the allocation of annual operating funding to the various health care programs within their regions, in order to meet the needs of their respective populations and achieve the Ministry expectations and goals.

Wait Lists

47. Wait lists occur in every health care system, regardless of the mix of public and private financing or delivery.

48. A functioning health care system must prioritize differently for elective conditions than for urgent, emergency, or high priority conditions. The prioritization process takes into account the fact that no risk of death arises with respect to elective surgery.

49. Physicians in British Columbia control their own wait lists, and determine which patients are seen and in what priority relative to each other. There is no central wait list for elective surgery administered or controlled by the Province. The health authorities do not

control the wait lists either, but do attempt to ensure that physicians are administering them appropriately.

50. In British Columbia, physicians have the ability, and are expected, to prioritize their patients on the basis of medical need, and not ability to pay.

51. The Province has significantly increased funding to the public health care system in order to address the demands on that system. In the fiscal year ending 30 April 2002, the Legislature allocated $9.5 billion to the public health care system; in the fiscal year ending 30 April 2007, the amount was $12.2 billion; in the fiscal year ending 30 April 2012, the amount was $15.7 billion, and in the fiscal year ending 30 April 2016, the amount was $17.4 billion.

52. The Province has also instituted and facilitated improvements to the public health care system to assist physicians in dealing appropriately with their patients' needs, and it continues to do so.

53. Surgery "on demand" is not always advisable; sometimes waiting is the best clinical response to a patient's condition, and all surgery comes with attendant risks to the patient.

54. Specialist surgeons do not operate on every patient they see. In fact, the majority of their patients are treated through non-surgical means. The time spent by a specialist operating in a private clinic is time that he or she is not available to treat such patients, and to thereby reduce his or her wait list.

55. British Columbia beneficiaries who experience unreasonable pain or suffering while awaiting treatment by their chosen physician have several options available to them:

(a) They can opt to be treated by a different physician who is able to see them more quickly;

(b) Their family physician can identify an appropriate physician elsewhere in British Columbia, or elsewhere in Canada, who is able to treat them more quickly; or

(c) In appropriate cases, their family physician, or other specialist physician, can seek approval to have them treated by an appropriate physician outside Canada.

56. Family physicians are expected to ensure that their patients receive appropriate care within medically appropriate time lines. There are many tools and initiatives available to assist them.

57. None of the Patient Plaintiffs, were compelled to seek assistance outside of the public health care system in order to address their medical needs in an appropriate and timely way. Their needs could all have been addressed within a reasonable period of time had the family physicians or other physicians responsible for their care taken appropriate steps that were available to them within the public health care system.

Elective Surgery

58. Private clinics like the plaintiffs Cambie Surgeries Corporation ("Cambie") and Specialist Referral Clinic (Vancouver) Inc. ("SRC") only provide a limited range of services. In particular, they do not deal with urgent or emergent medical conditions, or with complex surgical procedures. Surgical clinics like Cambie only offer elective surgery.

59. To the extent that enrolled physicians operate in private clinics like Cambie and SRC, they are not only unavailable to provide elective surgery in the public system, but also to provide diagnosis and triage of patients and, further, they are also unavailable to treat urgent and emergent medical conditions.

60. This unavailability interferes with the ability of the public health care system to provide appropriate and timely medical care to beneficiaries.

Inequality

61. Private for-profit medical clinics, including Cambie and SRC, exist for the purpose of maximizing the income of their owners and of the physicians who practise there.

62. Physicians are able to earn more money for the same, or less, effort in private clinics such as Cambie and SRC as compared with practising in public hospitals and otherwise in the public health care system.

63. Because such practice is more lucrative and less demanding, there is a tendency for physicians to prefer private practice over practice in the public health care system, with a corresponding reduction over time in both the quantity and the quality of medical care available to British Columbia residents who are unable to afford the cost of care at private clinics.

64. The inevitable result of encouraging a truly parallel private health care system is to increase the wait times experienced by beneficiaries who cannot afford treatment in that system.

65. There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems to encourage their patients to seek treatment from them privately by:

(a) Maintaining long wait lists;

(b) Failing to provide beneficiaries with accurate information regarding wait times for treatment in the public system; and

(c) Withholding from beneficiaries information regarding options available to them in the public system.

66. There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems, and who have an ownership interest in a private clinic, to refer beneficiaries to the private clinic for care and treatment that is not appropriate.

67. The Impugned Provisions are intended to, and do, inhibit the development of such inequitable provision of medical care to British Columbian beneficiaries.

Foreign Health Care Systems

68. Each jurisdiction has its own unique approach to addressing the health care needs of its population, and every health care system design is a complex product of history and politics. Each system requires the balancing of a matrix of competing considerations, some of which include:

(a) the country's overall wealth;

(b) what goods and services ought to be included within the boundary of the publicly-financed system;

(c) the appropriate balance between public and private insurance and out-of-pocket-payments;

(d) how to prioritize limited resources (manpower, technology, etc) to ensure care is provided to those most in need of it;

(e) how to ensure the safe, effective, and timely delivery of health care employing a mixture of public, not-for-profit, and for-profit providers;

(f) the cultural appropriateness of different forms of financing and delivery;

(g) appropriate governance mechanisms;

(h) the level of compensation required to ensure an adequate supply of medical practitioners; and

(i) the demographics and existing and future health care needs of the population.

69. Contrary to the assertion found at paragraph 120 of Part 3 of the Fourth Amended Notice of Civil Claim, the experience of other jurisdictions does not demonstrate that a parallel private health care system allows the public health care system to thrive.

70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:

(a) The demand for duplicate private health care insurance is associated with reduced quality of publicly funded health care;

(b) Individuals with high income and education levels are more likely than others to purchase, and benefit from, duplicate private insurance;

(c) Individuals who cannot afford duplicate private insurance have more limited access to care and coverage;

(d) Wait times in the public health care system are not reduced by the existence of the parallel private system;

(e) Wait times in the public health care system can increase, particularly when physicians are permitted to work in both the public and private systems;

(f) When physicians are permitted to work in both the private and public health care systems, higher remuneration in the private system provides them with an incentive to delay surgery in the public system so that patients are attracted or forced into the private system;

(g) Ethical concerns may arise when physicians have ownership interests in the private clinics to which they refer privately insured patients;

(h) Private clinics restrict their practices to less complicated cases, leaving public hospitals with a relatively more complex and expensive case mix;

(i) The existence of private insurance does not simply shift demand from the public to the private system, but stimulates an overall increase in demand

for health care; and

(j) Because the private and public health care systems must compete for a finite supply of physicians, nurses, and technicians, the overall cost of those health human resources increases, and the cost to the public health care system of maintaining the same level of service is increased.

71. Striking down the Impugned Provisions would neither create, nor compel the creation of, a health care system similar to a supposedly preferable system in some other jurisdiction. Instead, it would simply create a health care system in which medical care is provided preferentially to those who are more able to pay for it.

Private Insurance

72. Where truly parallel and separate public and private health care systems co-exist, the private health care system is only financially viable if insurance is widely available.

73. If the two systems offer comparable levels of care, however, individuals will not purchase insurance. They will only purchase insurance if the quality of care offered in the private system is superior to the quality of care offered in the public system.

74. In addition, insurance will only be affordable to, and purchased by, the more affluent. The inevitable result is that medical care will not be equally accessible on the basis of need, but will be preferentially accessible on the basis of ability to pay.

75. Further, in the absence of the kind of extensive regulation typically found in jurisdictions that feature parallel public and private health care systems, insurance will not be available to persons with pre-existing conditions and will be prohibitively expensive to persons with ongoing chronic conditions.

76. Further, insurance that is intended to provide access to the kind of medical care offered by the plaintiffs Cambie and SRC does not cover catastrophic or chronic

conditions, meaning that the treatment of such conditions is left to the public health care system.

77. All of these outcomes are antithetical to the purpose of the Act, as set out in paragraph 11.

For-Profit Health Care is Lower Quality Health Care

78. Where health care is delivered by for-profit entities, such as the plaintiffs Cambie and SRC, the quality of care may be lower than where health care is delivered by public or private non-profit entities. The evidence shows that, in general, permitting health care to be delivered by for-profit entities results in higher mortality rates and lower quality outcomes.

Part 2: RESPONSE TO RELIEF SOUGHT

1. The defendants consent to the granting of the relief sought in none of the paragraphs of Part 2 of the Fourth Amended Notice of Civil Claim.

2. The defendants oppose the granting of the relief sought in paragraphs 98-102 of Part 2 of the Fourth Amended Notice of Civil Claim.

3. The defendants take no position on the granting of the relief sought in none of the paragraphs of Part 2 of the Fourth Amended Notice of Civil Claim.

Part 3: LEGAL BASIS

Section 7 of the Charter

1. Contrary to the assertion found at paragraph 105 of the Fourth Amended Notice of Civil Claim, section 7 of the *Canadian Charter of Rights and Freedoms* does not guarantee a right of access to necessary and appropriate healthcare within a reasonable time.

2. In order to establish a breach of s. 7 of the *Charter*, the plaintiffs must establish that:

(a) the Impugned Provisions deprive them of their life, liberty, or security of the person; and

(b) that deprivation is not consistent with the principles of fundamental justice.

3. The defendants say that none of the Impugned Provisions, either individually or in combination, have the effect of depriving the plaintiffs, or any of them, of their life, liberty, or security of the person.

4. Further, and in the alternative, the defendants say that if the plaintiffs, or any of them, have in fact been deprived of life, liberty, or security of the person by the Impugned Provisions, any such deprivation was consistent with the principles of fundamental justice.

No Deprivation

5. As set out in paragraphs 31-33 and 55-57 of Part 1 above, the plaintiffs have not been deprived of life, liberty, or security of the person by the Impugned Provisions. In particular:

(a) There is no causal connection between the Impugned Provisions and any deprivation of life, liberty, or security of the person experienced by the Patient Plaintiffs;

(b) Whatever deprivation of life, liberty, or security of the person the Patient Plaintiffs have experienced could have been avoided within the existing public health care system within the restrictions imposed by the Impugned Provisions;

(c) Alternatively, whatever deprivation of life, liberty, or security of the person the Patient Plaintiffs have experienced would have occurred even if the Impugned Provisions had not existed; and

(d) Alternatively, and in any event, the Patient Plaintiffs have not experienced any deprivation of life, liberty, or security of the person.

Arbitrariness

6. A law will only be arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind it.

7. As set out in paragraphs 29, 30, and 47-78 of Part 1 above, the Impugned Provisions are both related to and consistent with the objective of the Act, as set out in paragraph 11 of Part 1.

8. In the absence of the Impugned Provisions, the MSP would be unable to ensure that access to medical care in British Columbia would be based on need, and not on ability to pay.

9. Paragraphs 121-129 of the Fourth Amended Notice of Civil Claim are irrelevant to the legal issue of arbitrariness.

9a. In further response to paragraph 126(a) of the Fourth Amended Notice of Civil Claim, the exemptions from the Impugned Provisions referred to therein are not comparable to "private funding," but rather represent alternative sources of public funding for medically necessary services.

Overbreadth

10. A law will only be overbroad if it is clear that it infringes a right protected by section 7 in a manner that is broader than necessary to accomplish the law's purpose.

11. The purpose of the Act, and of the Impugned Provisions, is set out in paragraph 11 of Part 1 above. For the reasons set out in paragraphs 29, 30, and 47-78 of Part 1, this purpose cannot be effectively realized by some narrower prohibition.

12. The Impugned Provisions are therefore not overbroad.

Gross Disproportionality

13. A law will only be grossly disproportionate if it is so extreme that it is *per se* disproportionate to any legitimate governmental interest.

14. For the reasons set out in paragraphs 29, 30, and 47-78 of Part 1 above, the Impugned Provisions are not in any sense disproportionate to the purpose of the Act, let alone grossly disproportionate.

Vagueness

15. A law will only be unconstitutionally vague if it does not provide an adequate basis for legal debate and analysis, does not sufficiently delineate any area of risk, or is not intelligible.

16. The fact that the Commission is delegated authority by the Act to determine what services are "medically necessary" does not render the Impugned Provisions vague.

17. The manner in which the Commission exercises its delegated authority cannot render the Impugned Provisions vague.

18. The Impugned Provisions are not vague.

Section 15 of the Charter

19. A breach of section 15 of the *Charter* will only be made out where a claimant can show that the law creates a distinction based on a ground that is listed in, or is analogous to a ground listed in, section 15(1). The claimant must also show that the distinction in issue creates a disadvantage by perpetuating prejudice or stereotyping.

20. The plaintiffs' claim under s. 15 is addressed not to the Impugned Provisions, but to section 27 of the *Medical and Health Care Services Regulation*, B.C. Reg. 426/97 (the "Regulation") and the Commission's Minute 97-068. The plaintiffs have not, however, sought relief with respect to either the Regulation or the Minute.

21. In any event, none of the Impugned Provisions, the Regulation, or the Minute creates a distinction in a way prohibited by section 15. In particular, they do not disadvantage any of the plaintiffs based on the grounds of either "disability" or age as pleaded by the plaintiffs.

21a. Further, "interests of fundamental importance" as referred to in paragraphs 142 and 145(a) of the Fourth Amended Notice of Civil Claim, are not enumerated or analogous grounds, and as such s. 15 does not prohibit discrimination on the basis of such interests.

21b. In any event, even if section 15 did prohibit such discrimination, none of the Impugned Provisions, the Regulation, or the Minute create a distinction on such a basis.

22. Further, none of the Impugned Provisions, the Regulation, or the Minute creates a disadvantage by perpetuating any prejudice or stereotyping.

23. The plaintiffs have failed to make out a breach of their rights under s. 15.

Universality of Prohibition

24. In addition, however, the plaintiffs' claim under s. 15 ignores the bases for the existence of the exemptions from the Act found in the Regulation and the Minute.

25. The Act can only constitutionally apply to persons who are within the legislative competence of the Legislature.

26. Health care benefits provided to individuals who fall within the legislative competence of the Parliament of Canada cannot constitutionally be restricted by provincial legislation. Such individuals include those entitled to health care benefits pursuant to:

(a) The *Aeronautics Act*, R.S.C. 1985, c. A-2;

(a.1) The *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, S.C. 2005, c. 21;

(b) The *Civilian War-Related Benefits Act*, R.S.C. 1985, c. C-31;

(b.1) The *Corrections and Conditional Release Act*, S.C. 1992, c.20;

(c) The *Government Employees Compensation Act*, R.S.C. 1985, c. G-5;

(d) The *Merchant Seaman Compensation Act*, R.S.C. 1985, c. M-6;

(e) The *National Defence Act*, R.S.C. 1985, c. N-5;

(f) The *Pensions Act*, R.S.C. 1985, c. P-6;

(g) The *Royal Canadian Mounted Police Pension Continuation Act*, R.S.C. 1970, c. R-10; and

(h) The *Royal Canadian Mounted Police Superannuation Act*, R.S.C. 1985, c. R-11.

27. Members of the Canadian Forces and inmates of federal penitentiaries are also excluded from the definition of "insured persons" under the *Canada Health Act*, R.S.C. 1985, c. C-6.

28. The *Canada Health Act* also excludes from the definition of "insured health services" any health services that a person is entitled to and eligible for under any other Act of Parliament or under any provincial legislation that relates to worker's compensation.

29. British Columbia's worker compensation legislation has provided for full coverage of employee work-related injuries since the enactment of the *Workmen's Compensation Act*, S.B.C. 1916, c. 77. As such, it pre-dates the Impugned Provisions by some seven decades.

30. Payment for treatment of injured workers pursuant to the *Workers' Compensation Act*, R.S.B.C. 1996, c. 492, is not comparable to private payment for treatment; it represents, rather, an alternative source of public funding for treatment.

31. Contrary to the assertions found at paragraphs 87 and 122 of the Fourth Amended Notice of Civil Claim, neither the Commission nor any of the other defendants have ever treated services provided by physicians to beneficiaries under the *Insurance (Vehicle) Act* as not being subject to the restrictions contained in the Impugned Provisions.

32. Section 27 of the Regulation, referred to at paragraph 86 of the Fourth Amended Notice of Civil Claim, applies to services provided by "health care practitioners," defined by the Act as persons "entitled to practise as (a) a chiropractor, a dentist, an optometrist or a podiatrist in British Columbia under an enactment, or (b) a member of a health care profession or occupation that may be prescribed". The health care professions or occupations that have been prescribed are: physical therapy; massage therapy; naturopathic medicine; midwifery; and acupuncture. The section has no application whatsoever to services provided by physicians.

Section 1 of the Charter

33. In the alternative, if the Impugned Provisions constitute a breach of either section 7 or section 15 of the *Charter*, any such breach is a reasonable limit prescribed by law that can be demonstrably justified in a free and democratic society.

34. The Impugned Provisions were enacted in furtherance of the objective of ensuring that access to medical care in British Columbia is based on need and not on individual ability to pay, as set out in paragraph 11 of Part 1 above.

35. The Impugned Provisions are rationally connected to that objective as set out in paragraphs 29, 30 and 47 - 78 of Part 1 above, and impair the rights protected by sections 7 and 15 of the *Charter* no more than necessary to achieve that objective.

36. Finally, the Impugned Provisions do not have a disproportionately severe effect on the persons to whom they apply.

37. The Defendants plead and rely on:

(a) The *Medicare Protection Act*, R.S.B.C. 1996, c. 286;

(b) The *Ministry of Health Act*, R.S.B.C. 1996, c. 301;

(c) The *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. F-8;

(d) The *Workers' Compensation Act*, R.S.B.C. 1996, c. 492;

(e) The *Workmen's Compensation Act*, S.B.C. 1916, c. 77;

(f) The *Health Authorities Act*, R.S.B.C. 1996, c. 180;

(g) The *Aeronautics Act*, R.S.C. 1985, c. A-2;

(h) The *Civilian War-Related Benefits Act*, R.S.C. 1985, c. C-31;

(i) The *Government Employees Compensation Act*, R.S.C. 1985, c. G-5;

(j) The *Merchant Seaman Compensation Act*, R.S.C. 1985, c. M-6;

(k) The *National Defence Act*, R.S.C. 1985, c. N-5;

(l) The *Pensions Act*, R.S.C. 1985, c. P-6;

(m) The *Royal Canadian Mounted Police Pension Continuation Act*, R.S.C. 1970, c. R-10;

(n) The *Royal Canadian Mounted Police Superannuation Act*, R.S.C. 1985, c. R-11;

(o) The *Canada Health Act*, R.S.C. 1985, c. C-6;

(p) The *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3;

(q) The *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11;

(r) The *Medical and Health Care Services Regulation*, B.C. Reg. 426/97;

(s) The *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. G-5;

(t) The *Health Authorities Act*, R.S.B.C. 1996, c. 180;

(u) The *Hospital Insurance and Diagnostic Services Act*, S.C. 1957, c. 28;

(v) The *Jobs, Growth and Long-term Prosperity Act*, S.C. 2012, c. 19, s. 377;

(w) The *Medical Care Act*, S.C. 1966, c. 64;

(x) The *Medical and Health Care Services Act*, S.B.C. 1992, c. 76;

(y) The *Medical Grant Act*, S.B.C. 1965, c. 25;

(z) The *Medical Grant Regulations*, B.C. Reg. 110/65;

(aa) The *Medical Services Act*, S.B.C. 1967, c. 24;

(bb) The *Medical Services Act Regulations*, B.C. Reg. 144/68;

(cc) The *Medicare Protection Amendment Act, 2003*, S.B.C. 2003, c. 95;

(dd) The *Insurance (Vehicle) Act*, R.S.B.C. 1996, c. 231;

(ee) The *Corrections and Conditional Release Act*, S.C. 1992, c. 20; and

(ff) The *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, S.C. 2005, c. 21.

WHEREFORE the defendants the Medical Services Commission, the Minister of Health of British Columbia, and the Attorney General of British Columbia submit:

(a) The plaintiffs' claim should be dismissed; and

(b) The defendants should be awarded their costs of this claim against the plaintiffs Cambie and SRC.

Defendants' address for service:

Ministry of Justice
Legal Services Branch
PO BOX 9280 STN PROV GOVT
1001 Douglas Street
Victoria, B.C. V8W 9J7

Fax number address for service (if any): Facsimile: (250) 356-9154

E-mail address for service (if any): Jonathan.Penner@gov.bc.ca

Date: **26 February 2016**

Signature of Jonathan Penner
Solicitor for Defendants,
MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA,
MINISTER OF HEALTH OF BRITISH COLUMBIA
and ATTORNEY GENERAL OF BRITISH COLUMBIA

[ ] filing party [x] lawyer for filing party