

**ONTARIO
SUPERIOR COURT OF JUSTICE**

B E T W E E N:

LINDSAY McCREITH and SHONA HOLMES

Plaintiffs

- and -

THE ATTORNEY GENERAL FOR THE PROVINCE OF ONTARIO

Defendant

STATEMENT OF DEFENCE

1. The defendant admits the allegations contained in paragraph 21 of the statement of claim, with the proviso that the words “all or” be added before the words “a portion”.
2. The defendant admits the allegations contained in paragraph 22 of the statement of claim, with the proviso that the words “or the identical or equivalent service is not performed in Ontario” be added after the words “tissue damage” and with the proviso that prior approval is not required in emergency circumstances.
3. The defendant admits the allegations contained in paragraph 25 of the statement of claim, with the proviso that a small number of physicians who engaged in “direct billing” prior to the enactment of the *Commitment to the Future of Medicare Act, 2004* are permitted to continue “direct billing” their patients, and that subparas. c. and d. only apply to insured services.
4. The defendant admits the allegations contained in paragraph 31 of the statement of claim, with the proviso that the words “who practiced outside of the

- government healthcare system” be replaced with the words “who were permitted to bill their patients directly”.
5. The defendant admits the allegations contained in paragraphs 37-39 of the statement of claim.
 6. The defendant admits the allegations contained in paragraph 40 of the statement of claim, with the proviso that the words “essential medical services to patients” be replaced with “insured services to insured residents” and with the proviso that individuals are subject on conviction to a maximum penalty of \$10,000.
 7. The defendant admits the allegations contained in paragraph 41 of the statement of claim, with the proviso that the words “essential medical services to patients” be replaced with “insured services to insured residents”.
 8. The defendant admits the allegations contained in paragraph 45 of the statement of claim, with the proviso that the word “certain” be added before the words “contracts of insurance”.
 9. The defendant admits the allegations contained in paragraph 46 of the statement of claim, with the proviso that the words “in certain circumstances” be added after the words “Ontario residents”.
 10. The defendant admits the allegations contained in paragraph 47 of the statement of claim, with the proviso that the words “for essential medically necessary services” be replaced with “for medically necessary insured services rendered in Ontario in respect of which “extra billing” is prohibited”.
 11. The defendant admits the allegations contained in paragraph 50 of the statement of claim, with the proviso that the words “MRIs may only be provided” be replaced with “Medically necessary insured MRIs rendered in Ontario may only be provided”.
 12. The defendant admits the allegations contained in paragraph 51 of the statement of claim, with the proviso that the words “independent health facilities” be

- replaced with the word “persons” and with the proviso that the words “OHIP-eligible” be replaced with the word “insured”.
13. The defendant admits the allegations contained in paragraph 52 of the statement of claim, with the proviso that the words “physicians and independent health facility operators” be replaced with the word “persons”.
 14. The defendant admits the allegations contained in paragraph 90 of the statement of claim, with the proviso that the words “Ontario Health Insurance Plan” be replaced with the words “General Manager”, and with the proviso that an appeal of the refusal is pending before the Health Services Appeal and Review Board.
 15. The defendant denies the allegations contained in paragraphs 4-20, 23, 24, 26-30, 32-36, 42, 43, 44, 48, 49, 53-68, 88, 89, 91, 110-114, 116 and 117 of the statement of claim.
 16. The defendant has no knowledge in respect of the allegations contained in paragraphs 2, 3, 69-77, 78 (with the proviso that the words “Due to the length of time Mr. McCreith would have to wait for an MRI in the government healthcare system” and “as a result of the legislative provisions being challenged in this action” are denied), 79, 80 (with the proviso that the words “Due to the legislative provisions that are being challenged in this action” are denied), 81-87, 92-109, 111 and 115 of the statement of claim.

I. The plaintiffs’ claims

17. The plaintiffs have both made applications to OHIP for payment for the costs associated with their out-of-country medical expenses. The General Manager has denied their applications. The plaintiffs have appealed these denials to the Health Services Appeal and Review Board [“the HSARB”]. Their appeals are now pending before the HSARB. Until the plaintiffs’ appeals have been disposed of, this claim is premature.

18. The defendant denies that the plaintiffs have been prevented from accessing timely medical treatment as a result of the challenged provisions. The challenged provisions ensure that insured medical services in Ontario are available to Ontario residents, including the plaintiffs, on the basis of medical need and not ability to pay. The challenged provisions protect the integrity of the public plan and the quality of the services insured under the public plan.
19. The defendant denies that the plaintiffs have standing to challenge subsections 10(1) and (3) of the *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5, subsections 14(1) and (2), 15(1) and (2), and 15.1(1) and (2) of the *Health Insurance Act*, R.S.O. 1990, c. H.6, and subsections 3(3) and (3.1) of the *Independent Health Facilities Act*, R.S.O. 1990, c. I.3, or any of them. The plaintiffs cannot show that they have been directly affected by these provisions. Nor do the plaintiffs meet the test for public interest standing with respect to these provisions, as there are other reasonable and effective ways in which the validity of these provisions may be brought before the courts.
20. The defendant denies that subsections 10(1) and (3) of the *Commitment to the Future of Medicare Act, 2004*, subsections 14(1) and (2), 15(1) and (2), and 15.1(1) and (2) of the *Health Insurance Act*, and subsections 3(3) and (3.1) of the *Independent Health Facilities Act*, or any of them, deprive the plaintiffs of the right to life, liberty and security of the person under s. 7 of the *Charter*.
21. In the alternative, subsections 10(1) and (3) of the *Commitment to the Future of Medicare Act, 2004*, subsections 14(1) and (2), 15(1) and (2), and 15.1(1) and (2) of the *Health Insurance Act*, and subsections 3(3) and (3.1) of the *Independent Health Facilities Act* are consistent with the principles of fundamental justice. They are not arbitrary, irrational, overbroad or manifestly unfair. Rather, these provisions further the important government objective of ensuring that virtually all of the medically necessary physician and hospital services in the province, as well as the services that support, assist or are a necessary adjunct to insured

- services, can be accessed by all Ontario residents on the basis of medical need and not on the basis of ability to pay.
22. In the further alternative, subsections 10(1) and (3) of the *Commitment to the Future of Medicare Act, 2004*, subsections 14(1) and (2), 15(1) and (2), and 15.1(1) and (2) of the *Health Insurance Act*, and subsections 3(3) and (3.1) of the *Independent Health Facilities Act* are reasonable limits that are demonstrably justified in a free and democratic society under s. 1 of the *Charter*.
 23. In addition, the defendant denies that the plaintiffs have standing to challenge the constitutional validity of the penalties in subsections 19(1), (2) and (4) of the *Commitment to the Future of Medicare Act, 2004*, in subsections 44(1) and (2) of the *Health Insurance Act*, or in subsections 39(1), (4) and (5) of the *Independent Health Facilities Act*. The plaintiffs have not been charged with any offences under these Acts and thus cannot show that they have been directly affected by these penalties. Nor do the plaintiffs meet the test for public interest standing with respect to these provisions, as there are other reasonable and effective ways in which the validity of these provisions may be brought before the courts.
 24. In addition, the penalties in subsections 19(1), (2) and (4) of the *Commitment to the Future of Medicare Act, 2004*, in subsections 44(1) and (2) of the *Health Insurance Act*, and in subsections 39(1), (4) and (5) of the *Independent Health Facilities Act* are consistent with the principles of fundamental justice and do not infringe s. 7 of the *Charter*. In the alternative, these penalties are reasonable limits that are demonstrably justified in a free and democratic society under s. 1 of the *Charter*.
 25. In addition and in the alternative, the defendant denies that the plaintiffs are entitled to any of the remedies sought in paragraph 1 of the statement of claim.
 26. The defendant submits that the claim should be dismissed with costs.

II. The Ontario Health Insurance Plan [“OHIP”] and the *Canada Health Act*

27. Health care is, for the most part, a provincial responsibility that is funded at both the federal and provincial level. Ontario receives funding from the federal government for health care through the Canada Health Transfer (“CHT”). In 2008-2009, the CHT to Ontario was more than \$8.7 billion. This funding is conditional on the province’s health insurance plan satisfying five criteria set out in s. 7 of the *Canada Health Act*, R.S.C., 1985, c. C-6: public administration, comprehensiveness, universality, portability, and accessibility. If the province’s health insurance plan does not comply with all of these five criteria, the province is liable to lose federal funding under the CHT.
28. In addition, under the *Canada Health Act* the provinces may lose federal funding if their health insurance plans permit “extra billing” or “user charges”.
29. The five *Canada Health Act* criteria and the prohibitions against extra billing and user charges are reflected in the legislative and operational structure of OHIP and of Ontario’s *Health Insurance Act*. These parameters affect the health insurance entitlements of insured Ontario residents.
30. OHIP is publicly administered. It is operated on a non-profit basis by the Minister of Health and Long-Term Care [“the Minister”]. A General Manager is appointed by the Lieutenant Governor in Council as the chief executive officer of OHIP.
31. OHIP is comprehensive. A wide range of medically-required physician and hospital services and other health-care services is insured. There are three categories of services which are insured under OHIP: prescribed services of hospitals and health facilities, prescribed medically necessary services rendered by physicians, and prescribed health care services rendered by specified practitioners (*e.g.* optometrists and dental surgeons).
32. The list of insured physician services is set out in a fee schedule called the Schedule of Benefits for Physician Services. This fee schedule is prescribed as

part of Regulation 552 under the *Health Insurance Act*. It includes approximately 4,800 insured physician services. Sections 7 and 8 of Regulation 552 list in-patient and out-patient hospital services to which an insured person is entitled without charge. In accordance with the *Canada Health Act*'s criterion of comprehensiveness, the scope of these services is extensive. Services include: laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations that are prescribed by an attending physician in accordance with accepted practice and administered in a hospital; and the use of operating room facilities.

33. OHIP is universal. Coverage is provided to all insured residents of Ontario regardless of the state of their health or their medical history. Every insured resident of Ontario is entitled to payment (whether to the resident, or on his or her behalf) for insured services in the prescribed amounts and subject to any prescribed conditions.
34. OHIP is portable. It generally insures medically necessary physician and hospital services provided to Ontario residents while temporarily absent in another province or territory. Emergency health services rendered to OHIP-insured residents who are traveling or working temporarily outside of Canada are also insured but are payable in limited amounts and under limited conditions.
35. OHIP is accessible. It is available to all insured residents regardless of their financial means. Ontario's health insurance legislation, including the *Health Insurance Act* and the *Commitment to the Future of Medicare Act, 2004*, contains a number of provisions intended to ensure that health care in Ontario is made available to insured residents on the basis of their medical need, not their ability to pay. Ontario's restrictions against "two-tier" medicine (i.e. a system where private and public payment for medically necessary physician and hospital services co-exist), including the legislative provisions challenged in this action, are designed to ensure that virtually all of the medically necessary physician and

- hospital services in the province are available to the public plan, where they can be accessed on the basis of medical need and not on the basis of ability to pay.
36. Public policy decisions concerning the financing and delivery of health care in Ontario involve complex, polycentric and interrelated issues including comprehensiveness of service, equity of access and fiscal sustainability. Changes to these public policy decisions (as enacted in health care legislation, including the provisions challenged in this action) would have far-reaching effects on the quality and timeliness of care and the fairness of access to medical services in Ontario.
 37. Permitting the expansion of a parallel system of private payment for insured services would have a number of detrimental effects on the services insured under the public plan. This expansion would, *inter alia*, necessarily divert medical resources, including, most critically, physicians and other health care professionals, from the public plan, with the inevitable result that access to publicly-funded services would be adversely affected and that wait times for insured services under the public plan would be increased. These results would be contrary to the legislative objective of ensuring that medically necessary physician and hospital services can be accessed on the basis of medical need and not ability to pay.
 38. Multiple-payer funding for health services in Ontario would lead to an overall increase in health care expenditures and in operating costs. The expansion of a parallel system of private payment for insured services would also distort medical service delivery patterns by siphoning off high-revenue patients while refusing coverage to patient populations with high risk, thus contributing to the problems of cost and access. Clinical care for those in the public system would deteriorate. These results would be contrary to the legislative objective of ensuring the universal provision of comprehensive physician and hospital services that is accessible to all insured Ontario residents regardless of their financial means.

III. The challenged provisions

A. Restrictions on “direct billing”

39. Section 10(3) of the *Commitment to the Future of Medicare Act, 2004* provides:

A physician or designated practitioner shall not accept payment or benefit for an insured service rendered to an insured person except,

(a) from the Plan, including a payment made in accordance with an agreement made under subsection 2 (2) of the Health Insurance Act;

(b) from a public hospital or prescribed facility for services rendered in that public hospital or facility; or

(c) if permitted to do so by the regulations in the prescribed circumstances and on the prescribed conditions.

40. This provision prohibits “direct billing” (i.e. billing an individual or a private firm for the cost of an insured service) by physicians and designated practitioners unless permitted by regulation (a small number of physicians who engaged in “direct billing” prior to the enactment of the *Commitment to the Future of Medicare Act, 2004* are permitted to continue “direct billing” their patients, who are in turn reimbursed by OHIP for the cost of the insured services). Similarly, ss. 15(1) and (2) and 15.1(1) and (2) of the *Health Insurance Act* restrict “direct billing” by requiring physicians and practitioners to submit all of their accounts for the performance of insured services rendered to an insured person directly to OHIP, unless permitted to do otherwise by the Minister. As with the prohibition on “extra billing”, the restrictions on “direct billing” require physicians and other practitioners to make their insured services available within OHIP and thereby ensures that virtually all of the medically necessary physician services in Ontario are available to all Ontario residents under the public plan, where they can be accessed on the basis of medical need and not ability to pay.

B. Prohibition against “extra-billing”

41. Section 10(1) of the *Commitment to the Future of Medicare Act, 2004* provides:

A physician or designated practitioner shall not charge more or accept payment or other benefit for more than the amount payable under the Plan for rendering an insured service to an insured person.

42. The prohibition against “extra-billing” removes economic incentives for physicians and designated practitioners to seek payment for the provisions of medically necessary services from privately-funded sources (i.e. individuals or firms) rather than from OHIP. The prohibition against “extra-billing” encourages physicians and designated practitioners to make their services available within OHIP and thereby ensures that medically necessary physician services are available to all Ontario residents under the public plan.

43. The prohibition against “extra-billing” also complies with ss. 18 and 20 of the *Canada Health Act*, which provide for mandatory deductions from a province’s transfer payment if the province permits “extra-billing”. The remedy sought by the plaintiffs would trigger a mandatory deduction to the federal contribution to health care in Ontario.

C. Restrictions on direct billing of “facility fees”

44. Independent Health Facilities (IHF) are facilities that are licensed by the Director of Independent Health Facilities and regulated under the *Independent Health Facilities Act*. Licensed IHFs are authorized to bill the Ministry of Health and Long-Term Care [“the Ministry”] for “facility fees.”

45. Facility fees are billed and paid in respect of services or operating costs that support, assist or are a necessary adjunct to an insured services but *are not part of* the insured service. They compensate the IHF for overhead costs incurred in connection with the provision of OHIP-insured services (e.g. the facility’s equipment, supplies, premises and personnel). For example, a patient may be referred to an IHF for a magnetic resonance imaging [“MRI”] exam. The

physician's interpretation of the MRI exam is an insured OHIP service; the overhead costs incurred in providing the diagnostic testing component of the insured service (e.g. lease of the premises, the MRI machine and the facility's personnel) are costs which may be billed to the Ministry as facility fees.

46. Under s. 3 of the *Independent Health Facilities Act*, IHFs are prohibited from charging or receiving payment for those costs from anyone other than the Ministry. Facility fees cannot be charged directly to patients. This restriction on "direct billing" of facility fees ensures that IHFs in Ontario provide services that support, assist or are a necessary adjunct to insured services, without cost to the patient, in accordance with Ontario's publicly funded health care plan.

D. Restrictions on private health insurance

47. Section 14 of the *Health Insurance Act* provides:

14. (1) Every contract of insurance, other than insurance provided under section 268 of the Insurance Act, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,

(a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;

(b) compensation for loss of time from usual or normal activities because of disability requiring insured services;

(c) any part of the cost that is not paid by the Plan for such other services as may be prescribed when they are performed by such classes of persons or in such classes of facilities as may be prescribed,

performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for

insuring against the costs payable by the Plan and no person shall enter into or renew such a contract.

(2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection (1) whereby the resident or his or her dependants may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service.

48. This provision prohibits private insurance for the cost of insured services rendered in Ontario. However, because of the restrictions on “direct billing”, patients cannot generally be charged for insured services; in any event, patients who are charged can only be charged at the OHIP rate (because of the prohibition on “extra-billing”), for which they are entitled to full repayment by OHIP. Consequently there is no cost to the patient against which to insure privately in respect of insured services rendered in Ontario.
49. There is no prohibition against payment for medical services rendered in other provinces or out of the country, nor is there any prohibition against obtaining private insurance against these costs. Insurance for emergency and non-emergency out-of-province and out-of-country services is available for sale in Ontario. There is no prohibition against private insurance for the cost of services that are not insured by OHIP.

IV. Wait times

50. All Canadian provinces and all countries are faced with concerns about timely access to health care services, regardless of the role played by private payers in their health care systems.
51. The Ministry does not control the “supply” of medical services, particularly with respect to the supply of health human resources (in particular, physicians and nurses). The government funds (and assists with funding) the education and training of physicians. It assists the College of Physicians and Surgeons of

- Ontario [“CPSO”], a self-governing College, with funding and otherwise to encourage the Canadian-equivalency training of foreign trained physicians. The CPSO establishes the eligibility criteria for licensure as a physician in Ontario.
52. The majority of jurisdictions in the world are facing shortages of physicians, both general practitioners and specialists. There is intense competition between jurisdictions in recruiting physicians. This is to a large extent also true of nurses and nurse practitioners. The demand for physicians is not unique to nor is it caused by conditions in Ontario (including the legislative provisions challenged in this action), or even in Canada.
 53. Wait times for health services depend on the type of procedure in question and the patient’s condition. Ontario has implemented a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, and MRI and computed tomography [“CT”] exams.
 54. Patients whose illnesses are more serious or life-threatening receive treatment before those with the same illness but whose condition is less serious and not life-threatening. Physicians prioritize available resources, including human resources, in order to ensure that patients with more pressing medical needs are assessed and/or treated prior to those with less pressing medical needs. This prioritization is necessarily dependent on a physician’s clinical judgement of the urgency of a patient’s medical needs. A patient’s physician is in the best position to assess the patient’s condition and determine the stage at which treatment is required in order to maintain the patient’s optimal level of health. It is the physician’s responsibility, and not the government’s, to triage patients in order to ensure that priority cases are dealt with quickly. Once a diagnosis has been made, the triage process is effective in ensuring that cases of pressing medical need are dealt with quickly.
 55. When a patient’s physician believes that a waiting period for an insured service will result in death or medically significant irreversible tissue damage for a

patient, the patient's physician is responsible for applying to OHIP for payment for out-of-country medical services. OHIP staff deals with such applications expeditiously.

V. Payment for out-of-country services

56. Regulation 552 under the *Health Insurance Act* provides for payment by OHIP, on application by a patient's physician, for medical services obtained outside Canada in specified circumstances and when certain conditions are met. Under s. 28.4 of Regulation 552, services that are rendered outside Canada at a hospital or health facility are insured by OHIP if:

(a) the service is generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person;

(b) the service is medically necessary;

(c) either,

(i) the identical or equivalent service is not performed in Ontario,
or

(ii) the identical or equivalent service is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage;

(d) in the case of a hospital service or a service rendered in a health facility, the service, if performed in Ontario, is one to which the insured person would be entitled without charge; and

(e) in the case of an in-patient service, in Ontario, the insured person would ordinarily have been admitted as an in-patient of a public hospital to receive the service.

57. Section 28.4 of Regulation 552 creates a “safety valve” whereby an insured Ontario resident can (subject to the legislative conditions) obtain coverage from OHIP for the cost of medical services provided out-of-country, in the event that a delay in receiving those services in Ontario would result in death or medically significant irreversible tissue damage. Payment for medical services obtained out-of-country extends not just to “treatment” but also to specialist consultations and diagnostic testing by any medically-accepted modality.
58. Subsection 28.4(4) of Regulation 552 provides that payment by OHIP for out-of-country medical services must be approved by the General Manager before the services are rendered, except in emergency circumstances (*i.e.* medical circumstances in which the patient faces immediate risk of death or medically significant irreversible tissue damage). By requiring that applications for out-of-country treatment receive prior approval (except in emergencies), the regulation ensures that Ontario is able to fund out-of-country services at a reasonable cost, and that patients are notified in advance of the full extent of their OHIP coverage for obtaining such services. The requirement of prior approval also permits the Ministry to canvass the available health care resources in Ontario to determine whether the services are in fact available in Ontario.
59. Nothing in section 28.4 of Regulation 552 prevents individuals from seeking, obtaining or paying privately for medical services out-of-country should they wish to do so, as the plaintiffs did in this case. Rather, the Regulation provides a benefit to Ontario residents (namely, public payment for the expense of out-of-country medical services) that is subject to conditions necessary to protect the integrity of the public plan. The challenged provisions do not prohibit individuals from obtaining insurance against the cost of medical services rendered out-of-country.

July 14, 2009

**THE ATTORNEY GENERAL OF
ONTARIO**

Constitutional Law Branch
720 Bay Street, 4th Floor
Toronto, ON M5G 2K1

Janet E. Minor / LSUC #14898A

Tel: 416-326-4137

S. Zachary Green / LSUC #48066K

Tel: 416-326-8517

Fax: 416-326-4015

Of Counsel for the Defendant

TO: **BOGHOSIAN + ASSOCIATES
PROFESSIONAL
CORPORATION**

Litigation Counsel
65 Queen Street West
Suite 1000
Toronto, ON M5H 2M5

Avril Allen / LSUC #43007K

Tel: 416-367-5558

Fax: 416-368-1010

Solicitors for the Plaintiffs

**LINDSAY McCREITH and
SHONA HOLMES**
Plaintiffs

**and THE ATTORNEY GENERAL FOR
THE PROVINCE OF ONTARIO**
Defendant

Court File No. 07-CV-339454PD3

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceedings commenced at Toronto

STATEMENT OF DEFENCE

**THE ATTORNEY GENERAL OF
ONTARIO**

Constitutional Law Branch
720 Bay Street, 4th Floor
Toronto, ON M5G 2K1

Janet E. Minor / LSUC #14898A
Tel: 416-326-4137

S. Zachary Green / LSUC #48066K
Tel: 416-326-8517
Fax: 416-326-4015

Of Counsel for the Defendant