Attorney General of British Columbia and Medical Services Commission of British Columbia
Appellants/Respondents on cross-appeal

v.

Connor Auton, an Infant, by his Guardian *ad litem*, Michelle Auton, and the said Michelle Auton in her personal capacity, Michelle Tamir, an Infant, by her Guardian *ad litem*, Sabrina Freeman, and the said Sabrina Freeman in her personal capacity, Jordan Lefaivre, an Infant, by his Guardian *ad litem*, Leighton Lefaivre, and the said Leighton Lefaivre in his personal capacity, Russell Gordon Pearce, an Infant, by his Guardian *ad litem*, Janet Gordon Pearce, and the said Janet Gordon Pearce in her personal capacity
Respondents/Appellants on cross-appeal

and

Attorney General of Canada, Attorney General of Ontario, Attorney General of Quebec, Attorney General of Nova Scotia, Attorney General of New Brunswick, Attorney General of Prince Edward Island, Attorney General of Alberta, Attorney General of Newfoundland and Labrador, Canadian Association for Community Living and Council of Canadians with Disabilities, Women's Legal Education and Action Fund and DisAbled Women's Network Canada, Autism Society Canada, Michelle Dawson, Families for Effective Autism Treatment of Alberta Foundation, Friends of Children with Autism, and Families for Early Autism Treatment of Ontario
Interveners

Indexed as: Auton (Guardian *ad litem* of) *v*. British Columbia (Attorney General)

Citation: [2004] 3 S.C.R. 657, 2004 SCC 78.

File No.: 29508.

9 June 2004, 19 November 2004.

Present: McLachlin C.J. and Major, Bastarache, Binnie, LeBel, Deschamps and Fish JJ.

The judgment of the Court was delivered by

THE CHIEF JUSTICE —

I. Introduction

1 This case raises the issue of whether the Province of British Columbia's refusal to fund a particular treatment for preschool-aged autistic children violates the right to equality under the *Canadian Charter of Rights and Freedoms*. The petitioners are autistic children and their parents. They argue that the government's failure to fund applied behavioral therapy for autism unjustifiably discriminated against them. In the background lies the larger issue of when, if ever, a province's public health plan under the *Canada Health Act*, R.S.C. 1985, c. C-6 ("*CHA*"), is required to provide a particular health treatment outside the "core" services administered by doctors and hospitals.

2 One sympathizes with the petitioners, and with the decisions below ordering the public health system to pay for their therapy. However, the issue before us is not what the public health system should provide, which is a matter for Parliament and the legislature. The issue is rather whether the British Columbia Government's failure to fund these services under the health plan amounted to an unequal and discriminatory denial of benefits under that plan, contrary to s. 15 of the *Charter*. Despite their forceful argument, the petitioners fail to establish that the denial of benefits violated the *Charter*.

3 The government must provide the services authorized by law in a non-discriminatory manner. Here, however, discrimination has not been established. First, the claim for discrimination is based on the erroneous assumption that the *CHA* and the relevant British Columbia legislation provided the benefit claimed. Second, on the facts here and applying the appropriate comparator, it is not established that the government excluded autistic children on the basis of disability. For these reasons, the claim fails and the appeal is allowed.

II. History of the Case

4 The four infant petitioners suffer from autism, a neuro-behavioural syndrome caused by a dysfunction of the central nervous system that impairs social interaction, hinders communication and results in repetitive, stereotyped behaviour. The symptoms and effects of autism vary from mild to severe. Over 90 percent of untreated autistic children end up in group homes or other residential facilities.

5 The cause and cure of autism remain unknown. However, a 1987 study published by a Texas researcher, Dr. O. Ivar Lovaas, suggested that applied behavioural therapy based on the repetitive use of stimuli and emphasized cues might help some autistic children between ages three and six. The therapy is intensive and therefore expensive — between $45,000 and $60,000 per year. It is not always successful; the trial judge found only that in "some cases" it may produce "significant results" (2000 BCSC 1142, (2000), 78 B.C.L.R. (3d) 55, 2000 BCSC 1142, at para. 51). While increasingly accepted, Applied Behavioural Analysis ("ABA") or Intensive Behavioural Intervention ("IBI") therapy is not uncontroversial. Objections range from its reliance in its early years on crude and arguably painful stimuli, to its goal of changing the child's mind and personality. Indeed one of the interveners in this appeal, herself an autistic person, argues against the therapy.

6 The infant petitioners received Lovaas therapy. Their parents, the adult petitioners, funded the treatment, although Connor Auton's mother ultimately became unable to continue for financial reasons. Until the government forbade it on the ground that new options were being evaluated, some families used funds for support services from the Ministry of Children and Families to help finance Lovaas therapy for their children with the tacit support of Ministry workers in some regions. Over a period of years, the petitioners and others lobbied the Ministers of Health, of Education, and of Children and Families for funding for Lovaas therapy, without success. In 1995, the petitioners commenced this action.

7 In the years leading up to the trial in 2000, the government funded a number of programs for autistic children and their families. This was done through the Ministry of Children and Families, which in 1997 had been given responsibility for child and youth mental health. The programs included infant development, supported child care, at-home respite, respite relief, contracted respite, occupational therapy, physical therapy, speech and language therapy, homemaker and home support services, hearing services, child care workers and specific behavioural support. Under the latter category, some programs attempted to positively treat autism. The Ministry provided services to autistic children through contracted agencies, some of which employed some behavioural analysis techniques. However, the focus was on teaching families the techniques to enable them to work themselves with the children.

8 An early intervention ABA/IBI program called LEAP had been established in Ladner but it was underfunded and equipped to serve only six children. Other centres and groups provided some ABA/IBI but the Crown's expert, Dr. Glen Davies, testified that these programs were not intensive, not delivered early enough in the child's development, and were rarely of sufficient duration to maximize the child's development. Finally, in May 1999, the Ministry announced an Autism Action Plan and an Autism Action Implementation Plan, which acknowledged the importance of early intervention, diagnosis and assessment, but

stated that services for autistic children had to be balanced with services to children with other special needs. Moreover, the plan did not specifically target ABA/IBI therapy. As of the date of trial a year or so later, the Ministry had not produced much. No new funding had been provided and a concrete plan for intensive early treatment remained to be developed.

9 In a nutshell, at the time of trial the government funded a number of programs for young autistic children, and appeared to be moving toward funding some form of early intervention therapy. However, it had not established funding for intensive, universal ABA/IBI therapy available to all autistic children between the ages of three and six.

10 This delay appears to have been due to a number of factors. The first was the 1997 decision to transfer child and youth mental health from the Ministry of Health to the Ministry of Children and Families, which put a non-medical slant on treatment. The second was financial constraint: in 1998, the deputy ministers of the ministries of Health, Education, and Children and Families informed families that the government was not "in a resource position" to fund ABA/IBI therapy.

11 A final factor may have been the emergent and somewhat controversial nature of ABA/IBI therapy, although by the time of the trial the evidence was sufficient to convince the trial judge that it was "medically necessary" (para. 102). At the time of trial in 2000, ABA/IBI funding for autistic children was only beginning to be recognized as desirable and was far from universal. Alberta established funding for it in 1999, as did Ontario. Prince Edward Island was providing up to 20 hours of ABA/IBI per week at the time of trial, and Newfoundland and Manitoba had instituted pilot projects in 1999. In the United States "several jurisdictions" included ABA/IBI in educational or Medicaid programs, and the New York State Department Guidelines and the 1999 U.S. Report of the Surgeon General on Mental Health recognized ABA/IBI as the treatment of choice (trial judgment, at para. 82).

12 The petitioners sought funding for Lovaas therapy, a particular type of ABA/IBI therapy, from all three ministries. However, the trial judge dealt only with the claim against the Ministry of Health because she considered the issue "to be primarily a health issue" (para. 88).

13 Having thus narrowed the claim, the trial judge went on to find that applied behavioural therapy is a "medically necessary" service for autistic children. I note that she used the term "medically necessary" to mean, in a general way, a medical service that is

essential to the health and medical treatment of an individual. She ruled that by denying a "medically necessary" service to a disadvantaged group (autistic children, a subset of the mentally disabled), while providing "medically necessary" services to non-autistic children and mentally disabled adults, the government discriminated against autistic children, since "[t]he absence of treatment programmes for autistic children must consciously or unconsciously be based on the premise that one cannot effectively treat autistic children . . . [which is] a misconceived stereotype" (para. 127). She concluded, at para. 139:

> The Crown has failed to take into account and accommodate the infant petitioners' already disadvantaged position, resulting in differential treatment. That unequal treatment, which is based on the enumerated ground of mental disability, is discriminatory. Here the only accommodation possible is funding for effective treatment.

14 The trial judge went on to find that the discrimination was not justified under s. 1 of the *Charter*. She accepted that the government was entitled to judicial deference in allocating finite resources among vulnerable groups, but held that this did not immunize its decision to deny funding for ABA/IBI from *Charter* review, given that the exclusion of ABA/IBI therapy undermined the "primary objective" of medicare legislation, namely the provision of "universal health care" (para. 151).

15 The trial judge granted: (1) a declaration that failure to fund ABA/IBI breached s. 15 of the *Charter*; (2) a direction that the Crown fund early intensive behavioural therapy for children with autism; and (3) a "symbolic" award of $20,000 under s. 24(1) of the *Charter* to each of the adult petitioners as damages for the financial and emotional burdens of litigation (2001 BCSC 220, (2001), 197 D.L.R. (4th) 165, 2001 BCSC 220, at paras. 64-65). She did not direct funding or reimbursement for the specific therapy requested and used, Lovaas therapy, on the ground that it was up to the government, not the court, to determine the nature and extent of ABA/IBI therapy funded on appropriate professional advice (para. 25).

16 The Court of Appeal agreed with the trial judge that the government had discriminated contrary to s. 15 of the *Charter* and that this could not be justified under s. 1 (2002 BCCA 538, (2002), 220 D.L.R. (4th) 411, 2002 BCCA 538). The discrimination lay in "the failure of the health care administrators of the Province to consider the individual needs of the infant complainants by funding treatment" (para. 51). This, to the appellate court, constituted "a statement that their mental disability is less worthy of assistance than the transitory medical problems of others", thus creating a "socially constructed handicap" that worsened the position of an already disadvantaged group (para. 51).

17 The government was unable to satisfy its justificative burden under s. 1 of the *Charter*. It failed to establish a rational connection or proportionality between the objective of properly allocating limited resources between multiple demands and the denial of ABA/IBI therapy, given the importance of meeting the needs of autistic children and the potential benefits for the children and the community that would flow from ABA/IBI treatment. The Court of Appeal allowed the cross-appeal by adding funding for ABA/IBI treatment pursuant to medical opinion.

18 The government now appeals to this Court, and asks that these decisions be set aside.

III. Analysis

A. *Did the Government's Conduct Infringe the Petitioners' Equality Rights Under Section 15 of the Charter?*

19 Section 15(1) of the *Charter* provides:

> Every individual is equal before and under the law and has the right to the 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.

20 This case engages s. 15's guarantee of "equal benefit of the law without discrimination . . . based on . . . mental . . . disability".

21 Different cases have formulated the requirements for a successful s. 15(1) claim in different ways. Nevertheless, there is "broad agreement on the general analytic framework": *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at para. 58. In *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, at pp. 168 *et seq*. — this Court's seminal statement on the interpretation of s. 15(1) —, the s. 15 analysis was described in two steps: first, whether there is unequal treatment under the law; and, second, whether the treatment is discriminatory. Similarly in *Eldridge*, *supra*, which also concerned a claim for medical services, La Forest J., at para. 58, put the test as follows:

> A person claiming a violation of s. 15(1) must first establish that, because of a distinction drawn between the claimant and others, the claimant has been denied "equal protection" or "equal benefit" of the law. Secondly, the claimant must

show that the denial constitutes discrimination on the basis of one of the enumerated grounds listed in s. 15(1) or one analogous thereto.

22 The dual requirements of *Andrews*, *supra*, and *Eldridge*, *supra*, were broken into three requirements in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, at para. 88: (1) differential treatment under the law; (2) on the basis of an enumerated or analogous ground; (3) which constitutes discrimination.

23 There is no magic in a particular statement of the elements that must be established to prove a claim under s. 15(1). It is the words of the provision that must guide. Different cases will raise different issues. In this case, as will be discussed, an issue arises as to whether the benefit claimed is one provided by the law. The important thing is to ensure that all the requirements of s. 15(1), as they apply to the case at hand, are met.

24 A complicating factor is that however one states the requirements for s. 15(1), they inevitably overlap. For example, the nature of the benefit, the enumerated or analogous ground at issue, and the choice of a correct comparator play a role in all three steps: see *Hodge v. Canada (Minister of Human Resources Development)*, [2004] 3 S.C.R. 357, 2004 SCC 65. Frameworks thus do not describe discreet linear steps; rather, they serve as a guide to ensure that the language and purpose of s. 15(1) are respected.

25 Whatever framework is used, an overly technical approach to s. 15(1) is to be avoided. In *Andrews*, *supra*, at pp. 168-69, McIntyre J. warned against adopting a narrow, formalistic analytical approach, and stressed the need to look at equality issues substantively and contextually. The Court must look at the reality of the situation and assess whether there has been discriminatory treatment having regard to the purpose of s. 15(1), which is to prevent the perpetuation of pre-existing disadvantage through unequal treatment.

26 In this case, the following issues arise from an application of the language of s. 15(1) to the facts:

(1) Is the claim for a benefit provided by law? If not, what relevant benefit is provided by law?

(2) Was the relevant benefit denied to the claimants while being granted to a comparator group alike in all ways relevant to benefit, except for the personal characteristic associated with an enumerated or analogous ground?

(3) If the claimants succeed on the first two issues, is discrimination established by showing that the distinction denied their equal human worth and human dignity?

(1) Is the Claim for a Benefit Provided by Law?

27 In order to succeed, the claimants must show unequal treatment under the law — more specifically that they failed to receive a benefit that the law provided, or was saddled with a burden the law did not impose on someone else. The primary and oft-stated goal of s. 15(1) is to combat discrimination and ameliorate the position of disadvantaged groups within society. Its specific promise, however, is confined to benefits and burdens "of the law". Combatting discrimination and ameliorating the position of members of disadvantaged groups is a formidable task and demands a multi-pronged response. Section 15(1) is part of that response. Section 15(2)'s exemption for affirmative action programs is another prong of the response. Beyond these lie a host of initiatives that governments, organizations and individuals can undertake to ameliorate the position of members of disadvantaged groups.

28 The specific role of s. 15(1) in achieving this objective is to ensure that when governments choose to enact benefits or burdens, they do so on a non-discriminatory basis. This confines s. 15(1) claims to benefits and burdens imposed by law. As stated in *R. v. Turpin*, [1989] 1 S.C.R. 1296, at p. 1329:

> The guarantee of equality before the law is designed to advance the value that all persons be subject to the equal demands and burdens of the law and not suffer any greater disability in the substance and application of the law than others. [Emphasis added.]

29 Most s. 15(1) claims relate to a clear statutory benefit or burden. Consequently, the need for the benefit claimed or burden imposed to emanate from law has not been much discussed. Nevertheless, the language of s. 15(1) as well as the jurisprudence demand that it be met before a s. 15(1) claim can succeed.

30 In this case, the issue of whether the benefit claimed is one conferred by law does arise, and must be carefully considered. The claim, as discussed, is for funding for a "medically necessary" treatment. The unequal treatment is said to lie in funding medically required treatments for non-disabled Canadian children or adults with mental illness, while refusing to fund medically required ABA/IBI therapy to autistic children. The decisions

under appeal proceeded on this basis. The trial judge, affirmed by the Court of Appeal, ruled that the discrimination lay in denying a "medically necessary" service to a disadvantaged group while providing "medically necessary" services for others. Thus the benefit claimed, in essence, is funding for all medically required treatment.

31 This raises the question of whether the legislative scheme in fact provides anyone with all medically required treatment. An examination of the scheme shows that it does not: see Appendix A (Relevant Legislative and Regulatory Provisions) and Appendix B (Interaction of the Relevant Legislative and Regulatory Provisions).

32 The scheme designates two distinct categories of funded treatment based on service. First, the scheme provides complete funding for services delivered by medical practitioners, referred to as "core" services. This is required by the *CHA*. Many medically necessary or required services, including ABA/IBI therapy for autistic children, fall outside this core.

33 Secondly, the *CHA* permits the provinces at their discretion to fund non-core medical services — services that are not delivered by physicians. British Columbia does this by naming classes of "health care practitioners" whose services may be partially funded. It then falls to the Medical Services Commission, an administrative body, to designate particular practitioners and procedures within these categories for funding.

34 It was suggested that the reference by the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 ("*MPA*"), to "medically required" services is an indication that all medically required or necessary non-core services must be funded. However, the Act does not say this. Section 1 uses the phrase "medically required services" in conjunction with the services of doctors or "medical practitioners" or an "approved diagnostic facility" (s. 1 "benefits", paras. (a) and (c)). Only these services are funded on the basis of being "medically required". "Medically required" in the *MPA* does not touch the services of "health care practitioners" which are funded only if the Province chooses to place a class of health care practitioner on an "enrolled" list by legislation or regulation: *MPA*, s. 1 "benefits", para. (b).

35 In summary, the legislative scheme does not promise that any Canadian will receive funding for all medically required treatment. All that is conferred is core funding for services provided by medical practitioners, with funding for non-core services left to the

Province's discretion. Thus, the benefit here claimed — funding for all medically required services — was not provided for by the law.

36 More specifically, the law did not provide funding for ABA/IBI therapy for autistic children. The British Columbia *MPA* authorized partial funding for the services of the following health care practitioners: chiropractors, dentists, optometrists, podiatrists, physical therapists, massage therapists and naturopathic doctors. In addition, provincial regulations authorized funding for the services of physical therapists, massage therapists and nurses. At the time of trial, the Province had not named providers of ABA/IBI therapy as "health care practitioners", whose services could be funded under the plan.

37 It followed that the Medical Services Commission, charged with administration of the *MPA*, had no power to order funding for ABA/IBI therapy. The Commission, as an administrative body, had no authority to enlarge the class of "health care practitioners". That could be done only by the government. Since the government had not designated ABA/IBI therapists as "health care practitioners", the Commission was not permitted to list their services for funding. This is how things stood at the time of trial. British Columbia's law governing non-core benefits did not provide the benefit that the petitioners were seeking.

38 The petitioners rely on *Eldridge* in arguing for equal provision of medical benefits. In *Eldridge*, this Court held that the Province was obliged to provide translators to the deaf so that they could have equal access to core benefits accorded to everyone under the British Columbiamedicare scheme. The decision proceeded on the basis that the law provided the benefits at issue — physician-delivered consultation and maternity care. However, by failing to provide translation services for the deaf, the Province effectively denied to one group of disabled people the benefit it had granted by law. *Eldridge* was concerned with unequal access to a benefit that the law conferred and with applying a benefit-granting law in a non-discriminatory fashion. By contrast, this case is concerned with access to a benefit that the law has not conferred. For this reason, *Eldridge* does not assist the petitioners.

39 However, this does not end the inquiry. Courts should look to the reality of the situation to see whether the claimants have been denied benefits of the legislative scheme other than those they have raised. This brings up the broader issue of whether the legislative scheme is discriminatory, since it provides non-core services to some groups while denying funding for ABA/IBI therapy to autistic children. The allegation is that the scheme is itself discriminatory, by funding some non-core therapies while denying equally necessary ABA/IBI therapy.

40 This argument moves beyond the legislative definition of "benefit". As pointed out in *Hodge*, *supra*, at para. 25:

> . . . the legislative definition, being the subject matter of the equality rights challenge, is not the last word. Otherwise, a survivor's pension restricted to white protestant males could be defended on the ground that all surviving white protestant males were being treated equally.

We must look behind the words and ask whether the statutory definition is itself a means of perpetrating inequality rather than alleviating it. Section 15(1) requires not merely formal equality, but substantive equality: *Andrews*, *supra*, at p. 166.

41 It is not open to Parliament or a legislature to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment: *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203. On the other hand, a legislative choice not to accord a particular benefit absent demonstration of discriminatory purpose, policy or effect does not offend this principle and does not give rise to s. 15(1) review. This Court has repeatedly held that the legislature is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory manner: *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28, at para. 61; *Nova Scotia (Attorney General) v. Walsh*, [2002] 4 S.C.R. 325, 2002 SCC 83, at para. 55; *Hodge*, *supra*, at para. 16.

42 A statutory scheme may discriminate either directly, by adopting a discriminatory policy or purpose, or indirectly, by effect. Direct discrimination on the face of a statute or in its policy is readily identifiable and poses little difficulty. Discrimination by effect is more difficult to identify. Where stereotyping of persons belonging to a group is at issue, assessing whether a statutory definition that excludes a group is discriminatory, as opposed to being the legitimate exercise of legislative power in defining a benefit, involves consideration of the purpose of the legislative scheme which confers the benefit and the overall needs it seeks to meet. If a benefit program excludes a particular group in a way that undercuts the overall purpose of the program, then it is likely to be discriminatory: it amounts to an arbitrary exclusion of a particular group. If, on the other hand, the exclusion is consistent with the overarching purpose and scheme of the legislation, it is unlikely to be discriminatory. Thus, the question is whether the excluded benefit is one that falls within the general scheme of benefits and needs which the legislative scheme is intended to address.

43 The legislative scheme in the case at bar, namely the *CHA* and the *MPA*, does not have as its purpose the meeting of all medical needs. As discussed, its only promise is to

provide full funding for core services, defined as physician-delivered services. Beyond this, the provinces may, within their discretion, offer specified non-core services. It is, by its very terms, a partial health plan. It follows that exclusion of particular non-core services cannot, without more, be viewed as an adverse distinction based on an enumerated ground. Rather, it is an anticipated feature of the legislative scheme. It follows that one cannot infer from the fact of exclusion of ABA/IBI therapy for autistic children from non-core benefits that this amounts to discrimination. There is no discrimination by effect.

44 The correctness of this conclusion may be tested by considering the consequences to the legislative scheme of obliging provinces to provide non-core medical services required by disabled persons and people associated with other enumerated and analogous grounds, like gender and age. Subject to a finding of no discrimination at the third step, a class of people legally entitled to non-core benefits would be created. This would effectively amend the medicare scheme and extend benefits beyond what it envisions — core physician-provided benefits plus non-core benefits at the discretion of the Province.

45 Had the situation been different, the petitioners might have attempted to frame their legal action as a claim to the benefit of equal application of the law by the Medical Services Commission. This would not have been a substantive claim for funding for particular medical services, but a procedural claim anchored in the assertion that benefits provided by the law were not distributed in an equal fashion. Such a claim, if made out, would be supported by *Eldridge*, *supra*. The argument would be that the Medical Services Commission violated s. 15(1) by approving non-core services for non-disabled people, while denying equivalent services to autistic children and their families.

46 Such a claim depends on a prior showing that there is a benefit provided by law. There can be no administrative duty to distribute non-existent benefits equally. Had the legislature designated ABA/IBI therapists (or a broader group of therapists which included them) as "health care practitioners" under the *MPA* at the time of trial, this would have amounted to a legislated benefit, which the Commission would be charged with implementing. The Commission would then have been obliged to implement that benefit in a non-discriminatory fashion. However, this is not the case. Here, the legislature had not legislated funding for the benefit in question, and the Commission had no power to deal with it.

47 I conclude that the benefit claimed, no matter how it is viewed, is not a benefit provided by law. This is sufficient to end the inquiry. However, since this is the first case of this type to reach this Court, it is appropriate to consider whether the petitioners would have

succeeded had they established that ABA/IBI therapy was a benefit provided by law, by being designated as a non-core benefit.

(2) Denial of a Benefit Granted to a Comparator Group, on an Enumerated or Analogous Ground

48 This question first requires us to determine the appropriate comparator group, and then to ask whether, as compared with people in that group, the petitioners have been denied a benefit.

49 The first task is to determine the appropriate comparator group. The petitioners suggested that they should be compared with non-disabled children and their parents, as well as adult persons with mental illness. A closer look reveals problems with both suggested comparators.

50 The law pertaining to the choice of comparators is extensively discussed in *Hodge*, *supra*, and need not be repeated here. That discussion establishes the following propositions.

51 First, the choice of the correct comparator is crucial, since the comparison between the claimants and this group permeates every stage of the analysis. "[M]isidentification of the proper comparator group at the outset can doom the outcome of the whole s. 15(1) analysis": *Hodge*, *supra*, atpara. 18.

52 Second, while the starting point is the comparator chosen by the claimants, the Court must ensure that the comparator is appropriate and should substitute an appropriate comparator if the one chosen by the claimants is not appropriate: *Hodge*, *supra*, at para. 20.

53 Third, the comparator group should mirror the characteristics of the claimant or claimant group relevant to the benefit or advantage sought, except for the personal characteristic related to the enumerated or analogous ground raised as the basis for the discrimination: *Hodge*, *supra*, at para. 23. The comparator must align with both the benefit and the "universe of people potentially entitled" to it and the alleged ground of discrimination:*Hodge*, at paras. 25 and 31.

54 Fourth, a claimant relying on a personal characteristic related to the enumerated ground of disability may invite comparison with the treatment of those suffering a different type of disability, or a disability of greater severity: *Hodge*, *supra*, at paras. 28 and 32. Examples of the former include the differential treatment of those suffering mental disability from those suffering physical disability in *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, and the differential treatment of those suffering chronic pain from those suffering other workplace injuries in *Nova Scotia (Workers' Compensation Board) v. Martin*, [2003] 2 S.C.R. 504, 2003 SCC 54. An example of the latter is the treatment of persons with temporary disabilities compared with those suffering permanent disabilities in *Granovsky*, *supra*.

55 Applying these criteria, I conclude that the appropriate comparator for the petitioners is a non-disabled person or a person suffering a disability other than a mental disability (here autism) seeking or receiving funding for a non-core therapy important for his or her present and future health, which is emergent and only recently becoming recognized as medically required. It will be recalled that in many jurisdictions ABA/IBI therapy remained unfunded at the time of trial. Indeed, it was only in the year preceding the trial that two Canadian provinces had authorized funding for ABA/IBI therapy to autistic children. The comparators, as noted, must be like the claimants in all ways save for characteristics relating to the alleged ground of discrimination. People receiving well-established non-core therapies are not in the same position as people claiming relatively new non-core benefits. Funding may be legitimately denied or delayed because of uncertainty about a program and administrative difficulties related to its recognition and implementation. This has nothing to do with the alleged ground of discrimination. It follows that comparison with those receiving established therapies is inapt.

56 The petitioners' comparators were deficient in that they focussed on the non-existent medical benefit of medically required care, as discussed above. However, even if I were to assume that the benefit is one provided by law — more particularly, that the B.C. legislation had listed ABA/IBI therapists as "health care practitioners" whose services could be considered funded benefits — the petitioners' comparators would still be deficient, because they have left the recent and emergent nature of ABA/IBI therapy out of the equation. This error was replicated in the decisions below.

57 The remaining question is whether, applying the appropriate comparator, the claimant or claimant group was denied a benefit made available to the comparator group. Differential treatment having regard to the appropriate comparator may be established either by showing an explicit distinction (direct discrimination) or by showing that the effect of the government action amounted to singling the claimant out for less advantageous treatment on the basis of the alleged ground of discrimination (indirect discrimination). In indirect

discrimination, the terms on which the claimants are denied the benefit operate as a proxy for their group status. For example, in *British Columbia (Public Service Employee Relations Commission)v. BCGSEU*, [1999] 3 S.C.R. 3, facially neutral physical requirements for firefighters were set at aerobic levels not generally attainable by female firefighters — levels, moreover, which were not required for performance of the job. The specified aerobic levels made no mention of gender. On their face, they did not discriminate. Yet, in effect, they excluded women, not on the basis of ability to do the job, but on the basis of gender. The aerobic levels served as a proxy for gender. Hence, they were held to discriminate on the basis of gender.

58 As discussed, the appropriate comparator in this case is a member of a non-disabled group or a person suffering a disability other than a mental disability that requests or receives funding for non-core therapy important to present and future health, but which is emergent and only recently becoming recognized as medically required. On the evidence adduced here, differential treatment either directly or by effect is not established. There was no evidence of how the Province had responded to requests for new therapies or treatments by non-disabled or otherwise disabled people. We know that it was slow in responding to the demands for ABA/IBI funding for autistic children. But we do not know whether it acted in a similar manner with respect to other new therapies.

59 Indeed, the conduct of the government considered in the context of the emergent nature of ABA/IBI therapy for autistic children raises doubts about whether there was a real denial or differential treatment of autistic children. The government put in place a number of programs, albeit not intensive ABA/IBI therapy, directed to helping autistic children and their families. In the year before the trial, the government had announced an Autism Action Plan and an Autism Action Implementation Plan which acknowledged the importance of early intervention, diagnosis and assessment. The government's failing was to delay putting in place what was emerging in the late-1990s as the most, indeed the only known, effective therapy for autism, while continuing to fund increasingly discredited treatments.

60 As discussed earlier, the delay in providing funding for ABA/IBI therapy seems to have been related to three factors. The first was the inauspicious decision to transfer child and youth mental health from the Ministry of Health to the Ministry of Children and Families, which meant that the decision makers lacked medical and psychiatric expertise and viewed autism from a social rather than medical perspective. The second was financial concerns and competing claims on insufficient resources. The third was the emergent nature of the recognition that ABA/IBI therapy was appropriate and medically required.

61 With hindsight, it is possible to say that the government should have moved more quickly. But on the evidence before us, it is difficult to say that the government in purpose or effect put autistic children and their families "on the back burner" when compared to non-disabled or otherwise disabled groups seeking emergent therapies. Rather, to use the trial judge's phrase, the government's failing was that its actions to that point did not meet the "gold standard of scientific methodology" (2000), 78 B.C.L.R. (3d) 55, at para. 66).

62 The issue, however, is not whether the government met the gold standard of scientific methodology, but whether it denied autistic people benefits it accorded to others in the same situation, save for mental disability. There is no evidence suggesting that the government's approach to ABA/IBI therapy was different than its approach to other comparable, novel therapies for non-disabled persons or persons with a different type of disability. In the absence of such evidence, a finding of discrimination cannot be sustained.

(3) Discrimination

63 If differential denial of a benefit provided by law on a ground enumerated in s. 15(1) or analogous thereto were established, it would still be necessary to examine whether the distinction was discriminatory in the sense of treating autistic children as second-class citizens and denying their fundamental human dignity. The failure to establish the basis for a claim for discrimination deprives us of the necessary foundation for this final inquiry.

B. *Did the Government's Conduct Infringe the Petitioners' Rights Under Section 7 of the Charter?*

64 Section 7 of the *Charter* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

65 The petitioners raise s. 7 on cross-appeal. The trial judge found it unnecessary to consider this argument, having found a violation of s. 15. Saunders J.A., for the majority of the Court of Appeal, addressed the question briefly and found that no violation had been established.

66 Section 7 was raised only fleetingly in written and oral submissions before this Court. The petitioners do not clearly identify the principle of fundamental justice which they allege to have been breached by the denial of funding for Lovaas or other ABA/IBI-based therapy. Nor do they argue that the denial of funding or the statutory scheme violate the prohibition against arbitrariness or requirements for procedural safeguards. To accede to the petitioners' s. 7 claim would take us beyond the parameters discussed by this Court in *R. v. Malmo-Levine*, [2003] 3 S.C.R. 571, 2003 SCC 74, at para. 113, and *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, [2004] 1 S.C.R. 76, 2004 SCC 4, at para. 8. The record before us does not support taking this step.

67 Thus, the limited submissions before us do not permit us to conclude that the government's conduct in the case at bar infringed the petitioners' s. 7 rights.

IV. Conclusion

68 The Province of British Columbia's appeal is allowed. The cross-appeal of the petitioners is dismissed.

69 I would answer the constitutional questions as follows:

1. Do the definitions of "benefits" and "health care practitioner" in s. 1 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286, and ss. 17-29 of the *Medical and Health Care Services Regulation*, B.C. Reg. 426/97, infringe s. 15(1) of the *Canadian Charter of Rights and Freedoms* by failing to include services for autistic children based on applied behavioural analysis?

   No.

2. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

It is unnecessary to answer this question.

3. Do the definitions of "benefits" and "health care practitioner" in s. 1 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286, and ss. 17-29 of the *Medical and Health Care Services Regulation*, B.C. Reg. 426/97, infringe s. 7 of the *Canadian Charter of Rights and Freedoms* by failing to include services for autistic children based on applied behavioural analysis?

No.

4. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

It is unnecessary to answer this question.

APPENDIX A

Relevant Legislative and Regulatory Provisions

(1) *Canada Health Act*, R.S.C. 1985, c. C-6

2. In this Act,

. . .

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"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 service,

(*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 anaesthetic 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 therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

. . .

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

. . .

"physician services" means any medically required services rendered by medical practitioners;

. . .

CANADIAN HEALTH CARE POLICY

3. 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.

PURPOSE

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

. . .

PROGRAM CRITERIA

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:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

. . .

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.

10. 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.

. . .

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(*a*) must provide for 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 rendered by medical practitioners or dentists; 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.

. . .

(2) *Medicare Protection Act*, R.S.B.C. 1996, c. 286

Preamble

WHEREAS the people and government of British Columbia believe that medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations;

WHEREAS the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability and public administration as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity;

WHEREAS the people and government of British Columbia recognize a responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system for future generations;

AND WHEREAS the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay.

1 In this Act:

. . .

"beneficiary" means a resident who is enrolled in accordance with section 7, and includes that resident's spouse or child who is a resident and has been enrolled under section 7;

"benefits" means

(a) medically required services rendered by a medical practitioner who is enrolled under section 13, unless the services are determined under section 5 by the commission not to be benefits,

(b) required services prescribed as benefits under section 51 and rendered by a health care practitioner who is enrolled under section 13, or

(c) unless determined by the commission under section 5 not to be benefits, medically required services performed

(i) in an approved diagnostic facility, and

(ii) by or under the supervision of an enrolled medical practitioner who is acting

(A) on order of a person in a prescribed category of persons, or

(B) in accordance with protocols approved by the commission;

. . .

"commission" means the Medical Services Commission continued under section 3;

. . .

"health care practitioner" means a person registered as

(a) a chiropractor under the *Chiropractors Act*,

(b) a dentist under the *Dentists Act*,

(c) [Repealed 1999-12-13.]

(d) an optometrist under the *Optometrists Act*,

(e) a podiatrist under the *Podiatrists Act*, or

(f) a member of a health care profession or occupation that may be prescribed;

"medical practitioner" means a medical practitioner as defined in section 29 of the *Interpretation Act*;

. . .

"practitioner" means

(a) a medical practitioner, or

(b) a health care practitioner

who is enrolled under section 13;

. . .

Purpose

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

PART 1 — MEDICAL SERVICES COMMISSION

. . .

Special committees respecting health care practitioners

4 (1) After consultation with the appropriate licensing body, the Lieutenant Governor in Council may establish one or more special committees to exercise the powers, duties or functions of the commission under this Act that are specified by the Lieutenant Governor in Council for a body of health care practitioners.

(2) A special committee established under subsection (1) is composed of the persons the Lieutenant Governor in Council specifies and exercises its powers, duties or functions on the terms and conditions the Lieutenant Governor in Council specifies.

(3) A special committee established under subsection (1) may establish a panel and the powers, duties and functions of the special committee may be exercised, subject to the regulations, by the panel.

. . .

Responsibilities and powers of the commission

5 (1) The commission may do one or more of the following:

. . .

(h) determine whether a person is a medical practitioner or a health care practitioner;

(i) determine for the purposes of this Act whether a person meets the requirements established in the regulations for premium assistance;

(j) determine whether a service is a benefit or whether any matter is related to the rendering of a benefit;

. . .

(u) exercise other powers or functions that are authorized by the regulations or the minister.

(2) The commission must not act under subsection (1) in a manner that does not satisfy the criteria described in section 7 of the *Canada Health Act* (Canada).

. . .

PART 5 — PAYMENTS

Payment schedules and benefit plans

26 (1) The commission

(a) must establish payment schedules that specify the amounts that may be paid to or on behalf of practitioners for rendering benefits under this Act, less applicable patient visit charges, and

(b) may establish different categories of practitioners for the purposes of those payment schedules.

. . .

(3) The commission may, at any time, amend the payment schedules

(a) in any manner that the commission considers necessary or advisable, and

(b) without limiting paragraph (a), by increasing or decreasing any amount in a payment schedule.

(4) An amendment referred to in subsection (3) (b) may apply

(a) to a specified geographical area,

(b) to a category of practitioners,

(c) to a category of practitioners within a specified geographical area, or

(d) to a specified benefit or class of benefits within a specified geographical area.

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

Definition of health care practitioner

17 The following health care professions and occupations are prescribed for the purposes of paragraph (f) of the definition of "health care practitioner" in section 1 of the *Medicare Protection Act*:

(a) physical therapy;

(b) massage therapy;

(c) naturopathic medicine.

. . .

Nursing services

22 (1) Subject to section 27, the extended role services of a registered nurse are benefits if

(a) an arrangement for the rendering and for the payment of these services is approved by the commission,

(b) a medical practitioner is not normally available at the place in British Columbia where these services are rendered, and

(c) the services are described in an adequate clinical record.

(2) A registered nurse performing the services described in subsection (1) is a health care practitioner for the purposes of paragraph (f) of the definition of "health care practitioner" in the *Medicare Protection Act*.

. . .

Supplemental services

25.1 (1) Subject to section 27, a chiropractic, massage, naturopathic, physical therapy or non-surgical podiatric service is a benefit if the service is

(a) listed in a payment schedule for supplemental services,

(b) rendered in British Columbia to a beneficiary who

(i) is receiving premium assistance under section 10, 11, 12 or 13, or

(ii) pays no premiums as a result of section 13,

(c) rendered by an enrolled health care practitioner, and

(d) described in an adequate clinical record.

(2) Subject to subsection (1), chiropractic, massage, naturopathic, physical therapy and non-surgical podiatric services are benefits up to a combined maximum of 10 visits during each calendar year.

(4) *Interpretation Act*, R.S.B.C. 1996, c. 238

Expressions defined

29 In an enactment:

. . .

"medical practitioner" means a person entitled to practise under the *Medical Practitioners Act*;

APPENDIX B

Interaction of the Relevant Legislative and Regulatory Provisions

Under the *Constitution Act, 1867*, delivery of health care services lies primarily with the provinces. The federal government, however, has authority under its spending power to attach conditions to financial grants to the provinces that are used to pay for social programs. This authority is the foundation of the *Canada Health Act*, R.S.C. 1985, c. C-6 ("*CHA*"), which allows the federal government to set broad boundaries around the provinces' design and administration of their health insurance plans if the provinces are to access federal funds for health care. As the framework within which the provinces operate, the *CHA* forms a backdrop to this appeal.

To receive federal funding, the provinces must adhere to the five principles set out in the *CHA*: public administration, portability, universality, comprehensiveness and accessibility. The most important of these principles for this appeal are universality and comprehensiveness.

The principle of "universality" requires a provincial plan to provide one hundred percent of qualified provincial residents with insured services on uniform terms and conditions: *CHA*, s. 10. "[I]nsured health services" are "hospital services, physician services and surgical-dental services provided to insured persons", but do not include health services under any other Act: *CHA*, s. 2. "[H]ospital services" are "medically necessary" services provided to patients at a hospital, while "physician services" are "medically required" services rendered by medical practitioners: *CHA*, s. 2. The principle of "comprehensiveness" requires a provincial health insurance plan to "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": *CHA*,s. 9. What this means is that the scheme set up by the *CHA* requires provincial health insurance schemes to cover services provided by hospitals and physicians, but leaves coverage of a broader

assortment of services up to the province. The former may be termed “core services”, and the latter “non-core services”.

In British Columbia, the relevant legislation is the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 (“*MPA*”). The Preamble confirms the principles of the *CHA*, refers to medicare as “one of the defining features of Canadian nationhood”, recognizes “responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system”, and states that it is “fundamental” that a person’s “access to necessary medical care be solely based on need”. The purpose of the *MPA* is “to preserve a publicly managed and fiscally sustainable health care system forBritish Columbia in which access to necessary medical care is based on need and not an individual’s ability to pay”: *MPA*, s. 2.

The *MPA* establishes and regulates the British Columbia Medical Services Plan. It entitles British Columbia residents enrolled as beneficiaries in the plan to have payment made to service providers for benefits they receive. “Benefits” are medically required services provided by a “medical practitioner” or “required services prescribed as benefits under section 51 and rendered by a health care practitioner”: *MPA*, s. 1.

The difference between services provided by a “medical practitioner” and those provided by a “health care practitioner” in the *MPA*corresponds to the distinction between core and non-core services found in the *CHA*. Services provided by “medical practitioners” encompass hospital and physician services, and must be provided to all residents on a fully funded basis to comply with the *CHA*. These core services are supplemented by partially funded, non-core services provided at the option of the province. In British Columbia, these include services provided by “health care practitioners”, namely chiropractors, dentists, optometrists, podiatrists, and, by regulation, physical therapists, massage therapists, and nurses. Many potential service providers are not designated as health care practitioners by legislation or regulation, and hence are not eligible for funding by the scheme: for example, clinical psychologists, nutritional counsellors, and osteopaths. A service cannot be a benefit under the Medical Services Plan unless it is provided by a medical practitioner or by a health care practitioner, named in the Act or in a regulation.

The *MPA* also constitutes and defines the tasks of the Medical Services Commission, the regulatory agency charged with implementing aspects of the Medical Services Plan. It is composed of nine members: three from the British Columbia Medical Association; three from the provincial government; and three representing the public interest. Its powers and duties are specific and limited by statute. Section 5(1)(j) gives it authority to determine whether a service is a benefit or whether any matter relates to the rendering of a benefit; s. 5(1)(h) allows the Commission to determine whether an individual is a medical practitioner or a health care practitioner. When the Commission determines that a service is a benefit, it can be added to the tariff of insured services. The Commission does not have discretion to fund a service that is not provided by a medical practitioner. It has no legislative or regulatory power.

The process by which new benefits are added to the roster of insured services differs according to whether they are provided by medical practitioners (core benefits) or by other individuals (non-core benefits). The Medical Services Commission has the statutory discretion to add core benefits, since they are provided by medical practitioners under the Act. If the Commission is satisfied that the service is medically required and provided by a physician, it may add the service to the payment schedule. Where a service is provided by a health care practitioner listed in the Act or prescribed by regulation, a request for funding for that therapy is determined by a Supplementary Practitioner Special Committee, operating in the same manner as the Medical Services Commission. A Special Committee exists for each of the groups of approved supplementary health care practitioners. Where a potential provider of a non-core service has not been designated as a "health care practitioner" by regulation or by legislation, neither the Medical Services Commission nor the Special Committees has power to order funding for the service.

Limited provision of non-core benefits within the sole discretion of the province complies with the *CHA*. British Columbia, for example, insures only a narrow range of non-core services. Moreover, even when provided, non-core benefits are limited in terms of cost and in terms of the number of annual treatments. For example, at the time of the trial, chiropractic services were insured to a maximum of 12 visits per year for BritishColumbians under 65, with payment of a small patient visit charge. Beyond 12 visits, the responsibility for payment rested with the patient. Insured diagnostic services by an optometrist were limited to one examination every two years for British Columbians between 16 and 65 years of age. No service by a health care practitioner is fully insured.

The *MPA* requires that a potential benefit be determined to be "medically required" before it is added to the roster of insured services. This term is not defined, however. No service is "medically required" under the statute until it has been designated as a benefit. An individual's physician may view a particular non-core service as "medically required" for his or her personal health. However, this does not make it "medically required" under the Act. That power rests solely with the provincial government.

To summarize, the *CHA* is a framework by which provinces must abide if they are to receive federal funding for health care. The framework rests on the principles of universal provision of insured benefits and comprehensiveness of coverage for insured core services, largely those provided by physicians and hospitals. Insurance of non-core services is left to provincial discretion.

In British Columbia, the *MPA* follows this model. Core services are those provided by medical practitioners and are fully funded. Non-core services may be funded if they are provided by health care practitioners, a limited list of occupations defined within the Act itself or by regulation by the Lieutenant Governor in Council. Only partial coverage of non-core services is provided. The Medical Services Commission may at its discretion add new therapies to the roster of insured core services provided they are delivered by a health care practitioner designated by the Act or regulation.